MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Virtual Meeting
Via
GoToWebinar

Thursday, January 14, 2021
10:47 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

AGENDA PAGE

Assessing payment adequacy and updating payments: Hospital inpatient and outpatient services; and Mandated report: Expanding the post-acute care transfer policy to hospice
- Alison Binkowski, Jeff Stensland, Dan Zabinski
- Ledia Tabor, Carolyn San Soucie, Kim Neuman..........3

Assessing payment adequacy and updating payments: Physician and other health professional services
- Ariel Winter, Geoff Gerhardt, Rachel Burton,
- Ledia Tabor...26

Assessing payment adequacy and updating payments: Ambulatory surgical center services; outpatient dialysis services; hospice services
- Dan Zabinski..41
- Nancy Ray...50
- Kim Neuman..57

Assessing payment adequacy and updating payments: Skilled nursing facility services; home health agency services; inpatient rehabilitation facility services; long-term care hospital services
- Carol Carter..63
- Evan Christman......................................73
- Jamila Torain.......................................77
- Kathryn Linehan.....................................83

CMMI’s development and implementation of alternative payment models
- Geoff Gerhardt, Rachel Burton.......................90

Expansion of telehealth in Medicare
- Ariel Winter, Ledia Tabor..........................168

Adjourn...233

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

2 [10:47 a.m.]

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

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

13 MS. BINKOWSKI: Hi. Good morning. The audience
14 can download a PDF version of these slides in the handout
15 section of the control panel on the right-hand side of the
16 screen. This presentation will provide a very brief
17 summary of our December 2020 presentation that assessed the
18 adequacy of Medicare's payments for hospital services,
19 followed by two forecast updates since our December
20 meeting. The presentation will then conclude with a draft
21 recommendation for updating hospital payments in 2022 as
22 well as the results of a mandated report on expanding post-

1 acute care transfer policy to hospice. Additional details,
2 including additional information on the characteristics of
3 relatively efficient hospitals requested by Commissioners
4 are in the mailing materials.

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

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

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

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

1 workforce and material effects on hospitals and other
2 providers.
3 As in past years, to recommend payment updates
4 for the upcoming year, we start with indicators of payment
5 adequacy based on the most recent available and complete
6 data, which this year is generally 2019. We then consider
7 preliminary newer data from 2020 and evaluate current law
8 and expected environmental changes in 2020, 2021, and 2022
9 to develop the draft update recommendation for 2022.
10 To the extent the coronavirus effects are
11 temporary or vary significantly across providers, they are
12 best addressed through targeted temporary funding policies
13 rather than a permanent change to all providers' payment
14 rates in 2022 and future years.
15 As we described in December, indicators of
16 hospital payment adequacy were generally positive.
17 Specifically, beneficiaries maintained good access to
18 hospital care, as indicated by hospitals' aggregate
19 occupancy rate remaining stable in 2019 at 64 percent,
20 hospitals' marginal profit on Medicare inpatient and
21 outpatient services remaining over 8 percent, and fewer
22 closures in 2020 than in 2019. The quality of hospital

1 care improved modestly, including modest decreases in risk-
2 adjusted mortality and readmission rates. Hospitals'
3 access to capital improved in 2019, including the aggregate
4 all-payer total margin reaching a record high of 7.6
5 percent, and hospitals' aggregate Medicare margin remained
6 negative in 2019 but improved, including the margin of
7 relatively efficient hospitals increasing to near zero.
8 And we project that hospitals' margin will continue to
9 improve in 2021.
10 Since our December meeting, there have been two
11 key changes. First, CMS reduced its forecast of the 2022
12 update to hospital rates under current law; and second,
13 Congress extended the suspension of the Medicare
14 sequestration, which affected our projection of hospitals'
15 Medicare margin in 2021.
16 Since December, CMS updated its forecast of
17 changes in the annual update to hospital payment rates for
18 2022 from 2.7 percent down to 2.4 percent. Specifically,
19 CMS decreased its estimate of the market basket 0.1
20 percentage points and increased its estimate of
21 productivity growth by 0.2 percentage points.
22 As a reminder, this is still just a forecast.

1 The actual update in 2022 will depend on the most recent
2 forecasts at the time the IPPS final rule is published in
3 summer of 2021.
4 As in December, we project that IPPS hospitals'
5 overall Medicare margin will increase from its 2019 level
6 of minus 8.7 percent. However, with the suspension of the
7 2 percent sequestration on Medicare payments extended
8 through March 2021, we have updated our estimate of IPPS
9 hospitals' overall Medicare margin in 2021 to minus 6
10 percent.
11 On the environmental front, since early 2020, the
12 coronavirus has been a human tragedy. It has also affected
13 hospital services, as described in more detail in your
14 mailing materials.
15 In particular, inpatient and outpatient volume
16 declined in April 2020, followed by partial summer rebounds
17 that varied by type of service. Some more details are in
18 your mailing materials
19 The collection of quality data was suspended,
20 making it hard to assess the quality of hospital care
21 Hospitals' access to capital remained strong due
22 to federal support of over $70 billion in supplemental

1 funds to help hospitals rise to the pandemic challenge. As
2 of now, we find no evidence of widespread financial
3 struggles at hospitals in 2020; however, the circumstances
4 of individual hospitals may vary substantially. Some
5 hospitals may have struggled with access to capital, while
6 several large hospital systems have returned some relief
7 funds they received as they exceeded their pandemic related
8 losses.
9 We estimate that both Medicare payments and costs
10 per stay increased in 2020, as Congress increased Medicare
11 payments to help offset hospitals' increased costs during
12 the public health emergency, including the suspension of
13 the 2 percent sequestration and a 20 percent increase for
14 COVID-19 inpatient stays.
15 While the third wave of the coronavirus is having
16 tragic effects on beneficiaries and health care workers,
17 the increased cases have not necessarily hurt hospitals'
18 financial performance.
19 In conclusion, while the effect of the
20 coronavirus on hospitals varied substantially across
21 hospitals and time periods, at this time, we do not
22 anticipate any long-term changes to the hospital landscape

1 that will persist past the end of the public health
2 emergency and therefore warrant inclusion in the annual
3 update to hospital payment rates.
4 With those updates and environmental changes in
5 mind, we turn to considerations for the draft
6 recommendation. These include maintaining payments high
7 enough to ensure beneficiaries' access to care and close to
8 hospitals' cost of efficiently providing high-quality care,
9 maintaining fiscal pressure on hospitals to constrain
10 costs, and minimizing differences in payment rates across
11 sites of care consistent with our site-neutral work.
12 Clearly, there are tensions between these
13 objectives that require a careful balance in the draft
14 recommendation.
15 Furthermore, as we mentioned previously, to the
16 extent the COVID-19 public health emergency continues, any
17 needed additional financial support should be targeted to
18 affected hospitals that are necessary for access and done
19 outside the annual update process.
20 With that, the draft recommendation reads "For
21 fiscal year 2022, the Congress should update the 2021
22 Medicare base payment rates for acute care hospitals by 2

1 percent."

2 Recall that there was a lower increase in 2019,
3 1.35 percent, and hospitals maintained their patient care
4 margins. Therefore, we believe that hospitals will be able
5 to maintain or increase their margins in 2022 with the
6 draft update.

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

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

22 We do not expect these changes to affect

1 beneficiaries' access to care or providers' willingness to
2 treat Medicare beneficiaries relative to current law.
3 Lastly, we also want to remind you on results of
4 a mandated report. The Bipartisan Budget Act of 2018
5 mandates that MedPAC evaluate the expansion of the post-
6 acute care transfer policy to hospice and its effect on
7 beneficiaries' access to hospice service and on hospital
8 payments.
9 Under the post-acute care transfer policy, IPPS
10 hospitals receive per-diem payments for certain conditions
11 instead of the full amount when a Medicare beneficiary has
12 a short inpatient stay and is transferred to a post-acute
13 care setting.
14 Starting in 2019, hospice was added to the
15 existing list of post-acute care settings to which the
16 transfer policy applies. Our analysis indicates that the
17 policy change produced savings, about $300 million in
18 fiscal year 2019, without any discernable changes in
19 Medicare beneficiaries' timely access to hospice care.
20 And with that, I turn it back to Mike.
21 DR. CHERNEW: Great. Thank you so much.
22 We're about to move to a vote. First, let me ask

1 if there are any -- I will make a comment in a minute, but
2 let me ask if there are any other comments that folks might
3 want to make before we move to a vote or before hearing my
4 comments.
5 DR. RILEY: Yes. Mike, this is Wayne. I have a
6 question.
7 DR. CHERNEW: Wayne, please.
8 DR. RILEY: Yes. Good morning, Commissioners.
9 Alison, thank you for your presentation. Just a
10 question on the sequestration moratorium. From my read of
11 it, it appears that there's a difference between the
12 moratorium applied to inpatient versus outpatient because
13 of the use of the federal fiscal year in one of those and
14 the calendar year in the other. So just from my read of
15 it, it looks like there will be a difference in terms of
16 the sort of protection that the moratorium on the
17 sequestration will have on those two sort of buckets of
18 hospital activity. Can you expound on that, please?
19 MS. BINKOWSKI: So you're correct that the
20 suspension was extended through the end of March 2021 in
21 inpatients on a fiscal year basis while outpatients are on
22 a calendar year basis. For the purposes of our projected

1 margin, which we do at an aggregate hospital level across
2 all services, we do that on a fiscal year basis.
3 DR. RILEY: Very well. Second question would be
4 you mentioned that that does not look -- that you see no
5 evidence, that the staff sees no evidence of sort of a
6 negative impact to hospital margins vis-à-vis the public
7 health emergency. Can you walk us through how you derived
8 at that Gestalt around that?
9 MS. BINKOWSKI: I can, but I'll let Jeff jump in
10 to say something more articulate.
11 DR. STENSLAND: I would say this is when we did
12 this in the fall, where we looked at how much did the
13 reduction in certain services like scheduled surgeries and
14 that kind of thing, which certainly had a big hit on
15 hospitals in the spring, and then we looked at, well, how
16 big was that hit relative to the aid that the hospitals
17 received through the pandemic relief funds. And I think in
18 the fall, we talked about that and it looked like there may
19 be some differences amongst hospitals, but on average, we
20 didn't see anything that was clear that was going to be a
21 net -- a big negative. And then we saw some big systems,
22 HCA and Mayo, reported that they recovered faster than they

1 thought and gave a lot of the money back, and so it's not
2 clear right now how much of that money that was given back
3 will be recycled to other providers. And that's pretty
4 much as much of the data that we have through the third
5 quarter of 2020.
6 Now, the fourth quarter has ended, but we haven't
7 actually seen those results yet of what happened in the
8 fourth quarter. And it may be better; it may be worse.
9 When we looked back at the results from early on
10 in the year, it wasn't that clear that hospitals that were
11 in areas of the country where there was lots of COVID did
12 worse financially than hospitals in the country where there
13 was less COVID. I think it was certainly a tragedy not
14 just for the patients but for all those employees of those
15 hospitals that we're dealing with.
16 In some cases, we saw that if you were in a high-
17 COVID area, your revenue declines were lower than if you
18 were in a low-COVID area because you did get some revenue
19 from your COVID patients, which is not something that
20 anybody wants to happen, but it is what happened.
21 So that's kind of all the puts and takes that
22 come in there to say that it's not a clear -- it's not

1 clear how much of a financial hit there will be from
2 hospitals, and it's not clear if the hit will be worse,
3 bigger than the amount of funds that they get through the
4 pandemic relief funds.

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

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

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

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

20 One of the bedrocks of care and quality in a
21 hospital is the nurses, not so much us doctors, but nurses.
22 I see my nursing colleagues smiling because I learned that

1 a long time ago, especially your interns. Nurses really
2 make the best caregivers, and they do more work than we
3 ever have acknowledged in hospitals.
4 So I'm worried about labor costs going forward.
5 I'm worried about a post-COVID hangover or overhang on
6 certain sectors of the hospital industry that care for
7 Medicare beneficiaries. So I would just say that as a
8 commission, we need to have our antenna up about that going
9 forward. So thank you for that.
10 DR. CHERNEW: Wayne, first, I agree, and we are
11 definitely challenged in the environment we're in. We've
12 tried to make a recommendation accordingly for what we
13 think will be doing on in 2022, but your points a very well
14 taken. And we will be continuing to monitor all of this
15 going forward.
16 Remember this is a shorter session in the path
17 because a lot of the material was present in December, and
18 so we only have about 10 more minutes left. And that
19 includes the vote. I have two people on the list, and if
20 you could be short and if we could go through that, that
21 would be great. The first is going to be Bruce, and then
22 we're going to have Jon Perlin, so Bruce.

1 MR. PYENSON: Yeah. Thank you very much.
2 Alison, I wonder if you could go to the summary slide.
3 I've got a context question, or perhaps presentation
4 question. Of course -- let's see. I'm sorry. The summary
5 of the recommendation, which shows the inpatient and the
6 outpatient detail, along with the HVIP. Of course, I'm
7 hopeful and even optimistic that the standing HVIP
8 recommendation will occur.
9 So my question is, why isn't the recommendation,
10 that it's 2 percent update, but if HVIP is implemented then
11 it's a 1.2 percent update? And maybe that's a question for
12 Mike.
13 DR. CHERNEW: Yeah, I can answer that question.
14 So the first point is the assessment of the criteria,
15 including things like the margin for the efficient hospital
16 in 2022, are all based on the 2 percent update. So, for
17 example, the estimate would be, recognizing all of the
18 noise and how hard it is to do this estimate, that with the
19 2 percent update alone the efficient hospital would have a
20 positive margin in 2022. There's a lot of noise around
21 those types of things, and Wayne points out some of the
22 challenges legitimately.

1 The HVIP recommendation, which is a separate
2 recommendation, was made in the past. It is still a
3 standing recommendation. It is a general rule. We don't
4 tie all of our recommendations together. It's too
5 difficult, as a matter of course, to say if you take
6 Recommendations A and B, then our Recommendation C would be
7 this, or vice versa. So I think you should think about
8 these as separate recommendations, where the criteria
9 applied to this recommendation is the criteria we use for
10 all of the updates, and the HVIP recommendation, which is
11 discussed in much more detail in the chapter where we made
12 the HVIP recommendation -- that was a previous cycle -- is
13 there, and we will continue to do that. Obviously, if the
14 HVIP recommendation were implemented, that would affect the
15 results for future updates.
16 But you would view the recommendations as, in
17 some sense, standalone, but that being said, if both were
18 adopted then you would see the information that's on the
19 slide. I'm not sure if that was a good enough answer. It
20 was a longer answer given I wanted everybody to be brief,
21 and even worse I'm going to ask Jim if he wants to say
22 anything else.

1 DR. MATHEWS: So again, the current iteration of
2 the recommendation reflects our best assessment as to where
3 the Commission as a whole was at the December meeting,
4 where there was some appetite for both the 2 percent update
5 for inpatient and outpatient but a preponderance of
6 Commissioners who also expressed rerunning the prior HVIP
7 recommendation alongside. Had we not done that, the
8 impacts of the update recommendation alone, shown on the
9 slide, would have resulted in a reduction in payments to
10 hospitals relative to current law, and I do not think that
11 was the thinking of the majority of the Commissioners at
12 the December meeting.
13 MR. PYENSON: Well, I'm -- well, thank you for
14 the explanations. I'm concerned that the optics of this
15 present an upside that's perhaps not our intent. But thank
16 you.
17 DR. CHERNEW: Jon Perlin.
18 DR. PERLIN: Well, thank you, and let me thank
19 the staff for a very thoughtful and generally well-
20 researched chapter. And let me just say at the outset that
21 I'm going to support the recommendation of the Chair.
22 But respectfully I'm going to defer on the

1 assessment that the effects of coronavirus are temporary.
2 Heaven help us. We believe coronavirus, COVID, is
3 temporary, but I think the health system is forever
4 changed. We'll deal with that in areas such as telehealth
5 on the positive side, but some of the durable effects are
6 going to leave a somewhat wounded provider candidate.
7 Let me just put the context -- and I want to also
8 emphatically agree that our policy has to support the
9 durable context, not the things that we believe are
10 transient. But I want to enumerate the things that do
11 converge in 2021 and 2022, the year, of course, we're
12 making the recommendation for, that the hospital
13 environment will be facing.
14 So the moratorium on the sequester ends at the
15 end of March for both outpatient and inpatient, and that is
16 essentially a 2 percent hit, in real terms, to the
17 revenues. Second, on the CARES Act -- and thanks, Jeff,
18 you mentioned that our organization happened to return all
19 of the funds, so I think I can say this with a broader
20 perspective -- which is that for those entities that
21 actually haven't repaid the accelerated payments on their
22 Medicare, which helped to tide them through the difficult

1 period of very decreased volume, there is a 25 percent
2 garnishment going to a 50 percent garnishment, terminating
3 at 29 months, that actually comes due with interest. So
4 these things converge, so you could actually have
5 tantamount to a 52 percent negative update against what
6 we're recommending.
7 There are also, I think, some transient effects
8 when we look at 2020 and the effect of COVID. You
9 mentioned the HRSA supplement for taking care of complex
10 COVID patients. That, of course, corresponds to the
11 duration of public health emergency. Second, and, you
12 know, it's been well reported, and you've indicated this as
13 well, is that Medicare beneficiaries stayed away from
14 health care because of concerns about entering the hospital
15 environment, which had the ultimate effect, not only at the
16 outset, of decreasing all volume, but ultimately
17 concentrating the volume of higher acuity on absolutely
18 unavoidable activities, and those tended to have higher
19 margins which were transiently not offset by the lower
20 margin activity. I just note that these factors converge.
21 Finally, I want to address labor. Dr. Riley
22 mentioned the impact on nursing. You know, there's been a

1 lot of attrition. It's an absolute seller's market in the
2 environment, and I see some of my nurse colleagues nodding
3 their heads, that the compensation is unprecedented at the
4 moment.
5 By the way, in conjunction with the changes in
6 the physician fee schedule, certain of the hospital-based
7 physicians who themselves have lower volume on the pro
8 fees, actually are requiring greater supplementation from
9 the hospitals that also adds to the cost of operation.
10 To the point that was raised about HVIP, you
11 know, my recollection is that still requires statutory
12 change to get past the current penalty programs, and I'd
13 also note that HVIP is an earned incentive and will be
14 distributed differently, perhaps even further challenging
15 some of the rural or safety net or other vulnerable
16 hospitals.
17 Finally, in terms of the broader context on
18 quality, one of the things that we've seen proven to us is
19 a lack of surge capacity. I think our country needs to
20 take a look at whether we invest in just adequate or
21 capacity for expansion. You know, this doesn't support
22 that sort of surge capacity that we would all want.

1 And finally, in the chapter, it notes that 80
2 percent of costs are variable. What are variable costs?
3 The variable cost is labor, and there are only three ways -
4 - fewer individuals, lower paid individuals, or supplement
5 by capital-intensive technologies. And I just draw this
6 out not because I don't support the recommendation. I do,
7 because I agree with the philosophy of the durable policy
8 matching the durable need, and I think that's right. But I
9 do, for these reasons, diverge on the assessment that the
10 effects of coronavirus are not longer lasting. These are
11 bridges we'll have to cross in the future, but I just felt
12 compelled to share a sort of ground-level view from an
13 organization that's not taking care of over 100,000 COVID-
14 positive inpatients, as some breadth of perspective.
15 Thanks so much.
16 DR. CHERNEW: Yeah. Jon, thank you so much. I
17 want now to call this to a vote in our virtual environment.
18 And I think the way this is going to work is Dana Kelley,
19 you are going to call folks' names and folks are going to
20 vote. So Dana.
21 MS. KELLEY: Okay. If everyone could just answer
22 with yes, meaning you support the draft recommendation; no,

1 you do not; or indicate if you are abstaining from the
2 vote.
3 Paul?
4 DR. PAUL GINSBURG: Yes.
5 MS. KELLEY: Larry?
6 DR. CASALINO: Yes.
7 MS. KELLEY: Brian?
8 DR. DeBUSK: Yes.
9 MS. KELLEY: Karen?
10 DR. DeSALVO: Yes.
11 MS. KELLEY: Marge?
12 MS. MARJORIE GINSBURG: Yes.
13 MS. KELLEY: David?
14 DR. GRABOWSKI: Yes.
15 MS. KELLEY: Jonathan Jaffery?
16 DR. JAFFERY: Yes.
17 MS. KELLEY: Amol?
18 DR. NAVATHE: Yes.
19 MS. KELLEY: Jon Perlin?
20 DR. PERLIN: Yes.
21 MS. KELLEY: Bruce?
22 MR. PYENSON: Yes.

1 MS. KELLEY: Betty?

2 DR. RAMBUR: Yes.

3 MS. KELLEY: Wayne?

4 DR. RILEY: Yes.

5 MS. KELLEY: Jaewon?

6 DR. RYU: Yes.

7 MS. KELLEY: Dana?

8 DR. SAFRAN: Yes.

9 MS. KELLEY: Sue?

10 MS. THOMPSON: Yes.

11 MS. KELLEY: Pat?

12 MS. WANG: Yes.

13 MS. KELLEY: And Mike.

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

22 DR. CHERNEW: So we're going to transition now to

1 discussing the updating rules for the physician other
2 health professional services chapter, and I think I'm
3 turning it over to Rachel. Rachel?
4 MS. BURTON: Good morning. In this session,
5 Ariel Winter and I will give a high-level recap of our
6 assessment of the physician fee schedule's payment adequacy
7 and the draft recommendation for 2022. We will also
8 identify new material added to our paper, which was sent to
9 Commissioners prior to this meeting, and contains more
10 information than we will cover here today. Our colleagues,
11 Geoff Gerhardt and Ledia Tabor, will be on hand to help
12 answer questions. As noted earlier, the audience can
13 download a PDF of these slides from the Control Panel on
14 the right side of their screen, under the Handouts section.
15 As a quick recap, the fee schedule is used to pay
16 physicians and other health professionals for about 8,000
17 different services. These fee schedule payments are on top
18 of payments clinicians may qualify for if they practice in
19 certain settings, such as a hospital or a nursing facility.
20 In 2019, Medicare paid $73.5 billion to 1.3 million
21 clinicians for fee schedule services.
22 Under current law, there is no update to base

1 payment rates for 2022, but clinicians can potentially
2 receive a positive or negative performance-based adjustment
3 to their payment rates if they are in the Merit-based
4 incentive payment system (or MIPS), or they can receive a 5
5 percent bonus if they are in an advanced alternative
6 payment model.
7 In response to Commissioners' comments at the
8 December meeting, we have added new information to our
9 draft chapter on physician payment adequacy.
10 Pat, you asked if we could break out some of our
11 access-to-care results by age groups. When we went back to
12 the office and checked with our survey vendor, it turned
13 out we could do this, so we now compare access for
14 beneficiaries of different ages, and find that there are
15 very few differences between them. We actually find that
16 the oldest beneficiaries tend to have slightly better
17 access than younger elderly beneficiaries. Specifically,
18 we find that in 2020, fewer beneficiaries in their 80s or
19 older reported being dissatisfied with their care, or
20 having difficulty finding a new primary care provider, or
21 foregoing care.
22 We have also reviewed more recent months of data

1 on service volume and revenues in 2020, and find that these
2 have largely rebounded since the initial months of the
3 pandemic. Among Medicare beneficiaries, we find that
4 primary care visits and certain other services largely
5 recovered in the summer and remained steady through
6 November. For privately insured patients, we find that
7 revenues are now higher than they were at the same time
8 last year, and have been since July.
9 Our chapter now also identifies the percent of
10 Medicare beneficiaries who had a clinician encounter in
11 2019. It is 98 percent.
12 Since there was some interest in December in
13 addressing the imbalance between payments for primary care
14 clinicians and specialists, this slide provides a recap of
15 the Commission's prior work in this area and some future
16 plans.
17 In 2011, the Commission recommended that CMS
18 collect data to establish more accurate RVU values for
19 services. In 2015, we recommended that Medicare pay new
20 supplemental payments per beneficiary per month to primary
21 care providers. And in 2019, we recommended that CMS
22 collect better information on the specialties that APRNs

1 and PAs practice in, so that we can determine what percent
2 of these clinicians are primary care providers. We are
3 currently unable to measure this using claims data.
4 In 2019, staff also presented information on
5 scholarships and loan forgiveness programs for primary care
6 providers, and then last November we presented findings
7 from interviews with stakeholders on other ways to attract
8 more physicians to primary care. At that last meeting,
9 Commissioners expressed interest in focusing on the
10 geriatrician workforce, which is what Ariel and I are now
11 researching and expect to come back to you on next cycle.
12 For context, we also note that in early December,
13 CMS finalized increases to the RVUs for E&M, office, and
14 outpatient visits. This will disproportionately benefit
15 primary care clinicians, and is consistent with the policy
16 in our June 2018 report.
17 CMS also proposed a new add-on code for E&M
18 visits, which we opposed. Since re-evaluations of codes
19 must be budget neutral, CMS planned to reduce the fee
20 schedule's conversion factor by 10 percent in 2021. In
21 late December, Congress delayed the new add-on code by
22 three years and provided about $3 billion to partially

1 offset the reduction to the conversion factor. These
2 additional funds are only provided for 2021 and not in
3 subsequent years.
4 The net results of all of these changes is that
5 pay rates for E&M office visits will still increase, and
6 most other codes will experience only small reductions.
7 I'll now turn things over to Ariel.
8 MR. WINTER: Some Commissioners raised concerns
9 at the December meeting about payment differences between
10 settings, so this slide summarizes our prior work on site-
11 neutral payments. The issue is that Medicare often pays
12 hospital outpatient departments more than freestanding
13 physician offices for the same service, such as an E&M
14 office visit. This is because an HOPD service leads to two
15 payments: one for the HOPD and one for the clinician's
16 professional service, which is paid under the physician fee
17 schedule. So the total payment is higher than if the
18 service was provided in a physician's office.
19 Hospitals have responded to this incentive by
20 buying physician practices and converting them to HOPDs,
21 which increases Medicare program spending and beneficiary
22 cost sharing. For example, we estimate that in 2019,

1 Medicare spent $1.4 billion more than it would have if
2 payment rates had been the same in both settings, and
3 beneficiaries' cost-sharing was $360 million higher.
4 To address this problem, the Commission
5 recommended aligning the total payments for E&M office
6 visits and selected other services by reducing HOPD rates.
7 In 2015, Congress reduced payment rates for all
8 services in new, off-campus HOPDs beginning in 2017.
9 Subsequently, CMS reduced rates for E&M visits in all off-
10 campus HOPDs beginning in 2019, but this policy is the
11 subject of ongoing litigation.
12 Please let us know if there's additional work
13 that you'd like us to pursue in this area.
14 Returning to our payment adequacy analysis,
15 payments appear to be adequate. Most beneficiaries report
16 good access to care even during the pandemic. The number
17 of clinicians billing Medicare is increasing, and the
18 number of clinician encounters per beneficiary is also
19 growing.
20 Turning to quality, it is difficult to assess the
21 quality of individual clinicians, but our findings using
22 population-based quality measures show opportunities for

1 improvement. There is wide geographic variation in the
2 rates of ambulatory care sensitive hospitalizations and ED
3 visits, and there is substantial use of low-value care.
4 In terms of payments and costs for clinicians,
5 Medicare payments per beneficiary are growing. The MEI
6 continues to increase. The ratio of commercial payment
7 rates to Medicare rates for clinician services grew
8 slightly, and physician compensation from all payers has
9 been rising, although there are still substantial
10 disparities between primary care physicians and certain
11 specialties.
12 This leads us to the draft recommendation, which
13 reads: For calendar year 2022, the Congress should update
14 the 2021 Medicare payment rates for physician and other
15 health professional service by the amounts determined under
16 current law.
17 Current law calls for no update in 2022, but
18 about a million clinicians receive positive adjustments of
19 up to almost 2 percent under MIPS or get 5 percent bonuses
20 for being in an advanced alternative payment model.
21 In terms of implications, there would be no
22 change in spending compared with current law, and this

1 should not affect beneficiaries' access to care or
2 providers' willingness and ability to furnish care.
3 This concludes our presentation, and I'll now
4 turn things back over to Mike.
5 DR. CHERNEW: Thank you. Again, we are in
6 another shortened session because of similarities where we
7 were before. I will have one quick comment possibly when
8 we get through, but first I want to go to Betty and then to
9 Larry.
10 DR. RAMBUR: Okay. Thank you very much. My
11 comment probably looks more towards looking forward, but I
12 think it's important to have it on the record.
13 The data in the material suggests that Medicare
14 beneficiaries are accessing primary care and that care is
15 increasingly delivered by nurse practitioners and PAs. And
16 I know we have recommendations about trying to encourage
17 more physicians to enter primary care. I'm personally not
18 overly optimistic about that. It's clear that medical
19 students and residents are not looking towards primary
20 care, and nurse practitioners and PAs are.
21 I'd just like to briefly share data: 89.7
22 percent of nurse practitioners are educated in primary

1 care, but only 69.7 percent deliver primary care. That's
2 still a big number. But the difference there, I assume, is
3 also related to payment policy that favors specialty care.
4 We discussed physician compensation adequacy as
5 being a positive piece and noted the difference between
6 specialty physicians and primary care physicians, but
7 didn't note the large gap between primary care physicians
8 at 254,000 a year, nurse practitioners at 110,000, and PAs
9 at 111,000. So, looking forward, I think that it will be
10 important to include greater focus on those that are
11 increasingly delivering primary care, and the issue of
12 claims data that was mentioned is so important, and I know
13 you've gone on record, but just to say it again, it will be
14 critical that incident to billing is gone so that we can
15 really track these data more clearly by delivery of
16 services.
17 And, finally, I just wanted to share that,
18 according to 2020 data from the American Association of
19 Nurse Practitioners, even the nurse practitioners who are
20 not working in primary care, who are working specialty
21 area, it's often psych mental health or hospice and
22 palliative care.

1 So I support our recommendation, but I do think
2 in the future we need to focus more broadly on the primary
3 care workforce.
4 Thank you.
5 DR. CHERNEW: Great, Betty. Thank you. Larry.
6 DR. CASALINO: Yeah, I'll support the
7 recommendation as well, and great work by the staff. I did
8 just want to emphasize -- I think I said this at the last
9 meeting -- the optics of current law which results in no
10 increase for the majority of clinicians doesn't sit well, I
11 think, with, let's just say, the physician labor force, and
12 I suspect not with advanced practitioners either. So I
13 hope we'll think about the current law in the future.
14 Current law is intimately tied to MIPS. I don't know if
15 there's anybody who thinks that MIPS is a success, really.
16 I know we've had recommendations about MIPS in the past,
17 and I would like the Commission, if possible, to try
18 thinking some more about MIPS and then the link to
19 physician fee schedule updates on a future agenda.
20 Then the only other thing I'll say is, again, if
21 need be, going forward, when these lawsuits are settled, I
22 hope the Commission will land again on neutrality in terms

1 of site-specific payments for physician services. But I
2 will support the recommendation this year at least.
3 DR. CHERNEW: Larry, thank you, and it is a
4 continuing concern, the trajectory of physician updates
5 overall. I have a request to talk from Amol. Amol.
6 DR. NAVATHE: Thank you. So I just actually
7 wanted to pick up on Larry's points. I had an inkling of
8 where he was going to go. So I agree with his point, which
9 is in ongoing work it would be nice if we can consider
10 MIPS, and specifically if you think about how in some of
11 the other sectors, like in the hospitals case, even in our
12 recommendations, we describe what would happen if we
13 followed HVIP and what would happen if the penalties were
14 withdrawn.
15 In future work, it would be nice if we
16 considered, you know, what would happen hypothetically if
17 we could remove MIPS, since I think we're kind of placed in
18 an awkward situation here where the Commission has
19 recommended MIPS be stopped, and at the same time we're, of
20 course, having to understandably base our recommendations
21 right now based on MIPS continuing and what that means for
22 adjustments to physicians. And so as we go forward, it

1 would be nice to articulate, you know, if MIPS were indeed
2 stopped, based on the Commission's recommendation, how
3 would we determine and then update the physician fee
4 schedule accordingly, the payment updates to the physician
5 side? I think it would be -- it would sort of behoove us,
6 the same way that we kind of do it for some other sectors
7 as we go forward, but I will support the recommendation
8 this time.

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

21 So I very much hear the spirit that all three of
22 you raised about where we are going, and we are going to

1 continue on that path to understand what's going on in the
2 market for professional services. So that is good. And I
3 think the key point here is right now, by the criteria that
4 we use, we seem to be okay with the recommendation where it
5 is. So I guess we'll find out as we are about to vote, but
6 at least that was the thinking in it. And by no means is
7 it meant to preclude the fact that we need to do a lot of
8 continued work on access, heterogeneity and access, what's
9 going on with MIPS, what's going on with the workforce
10 outside of the physicians, and all the things that have
11 been raised. I could not agree with those comments more.
12 So I'm now turning it back to Dana Kelley, whose
13 face has disappeared, but I assume she's still here.
14 MS. KELLEY: Okay. I will take the roll again.
15 Yes if you support the recommendation, no if you do not.
16 Paul?
17 DR. PAUL GINSBURG: Yes.
18 MS. KELLEY: Larry?
19 DR. CASALINO: Yes.
20 MS. KELLEY: Brian?
21 DR. DeBUSK: Yes.
22 MS. KELLEY: Karen?

1 DR. DeSALVO: Yes.

2 MS. KELLEY: Marge?

3 MS. MARJORIE GINSBURG: Yes.

4 MS. KELLEY: David?

5 DR. GRABOWSKI: Yes.

6 MS. KELLEY: Jonathan Jaffery?

7 DR. JAFFERY: Yes.

8 MS. KELLEY: Amol?

9 DR. NAVATHE: Yes.

10 MS. KELLEY: Jon Perlin?

11 DR. PERLIN: Yes.

12 MS. KELLEY: Bruce?

13 MR. PYENSON: Yes.

14 MS. KELLEY: Betty?

15 DR. RAMBUR: Yes.

16 MS. KELLEY: Wayne?

17 DR. RILEY: Yes.

18 MS. KELLEY: Jaewon?

19 DR. RYU: Yes.

20 MS. KELLEY: Dana?

21 DR. SAFRAN: Yes.

22 MS. KELLEY: Sue?

1 MS. THOMPSON: Yes.

2 MS. KELLEY: Pat?

3 MS. WANG: Yes.

4 MS. KELLEY: And Mike?

5 DR. CHERNEW: Yes.

6 MS. KELLEY: All right then.

7 DR. CHERNEW: All right then.

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

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

22 MS. KELLEY: Yes, Dan Zabinski is up first. Dan,

1 are you on?

2 DR. ZABINSKI: Yep.

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

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

10 For ambulatory surgical centers, at the December
11 2020 meeting, we presented update information for
12 ambulatory surgical centers, or ASCs, and provided draft
13 recommendations.

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

19 And then for a number of Commissioners, we added
20 a footnote that explains some of the reasons for the large
21 differences in the number of ASCs that exist among states.
22 Reasons include differences in certificate-of-need laws

1 among states and the global budget system for Maryland
2 hospitals.
3 So in today's presentation, we'll provide an
4 abbreviated version of the payment adequacy analysis for
5 ASCs that we presented in December.
6 First, important facts about ASCs in 2019 include
7 that Medicare fee-for-service payments to ASCs was $5.2
8 billion. The number of fee-for-service beneficiaries
9 served in ASCs was about 3.5 million. And the number of
10 Medicare certified ASCs was about 5,800. Also, since we
11 last met, CMS has updated the ASC payment rates by 2.4
12 percent for 2021.
13 Now, our analysis of ASC data shows that
14 indicators of payment adequacy are positive. For 2019 we
15 found that the volume per fee-for-service beneficiary
16 increased by 2.7 percent; the number of fee-for-service
17 beneficiaries served in ASCs increased by 0.9 percent; and
18 the number of ASCs increased by 2.5 percent. In addition,
19 Medicare payments per fee-for-service beneficiary increased
20 by 8.3 percent.
21 Also, the growth in the number of ASCs suggests
22 that access to capital has been adequate. For example,

1 there has been a fair amount of acquisitions and
2 partnerships with ASCs by corporate entities, which also
3 requires access to capital.
4 Measures of quality in ASCs improved from 2013
5 through 2017 and were largely unchanged from 2017 to 2018.
6 However, we do have some issues with the quality measures
7 in the ASC system. We believe that CMS should add more
8 claims-based outcomes measures, and we are concerned about
9 CMS' decision to delay use of the CAHPS-based patient
10 experience measures.
11 Finally, a limitation of our analysis is that we
12 can't assess margins or other cost-based measures because
13 ASCs do not submit cost data to CMS, even though the
14 Commission has frequently recommended that these data be
15 submitted.
16 So for the ASC update for 2022, we have two draft
17 recommendations.
18 First, for calendar year 2022, the Congress
19 should eliminate the update to the 2021 conversion factor
20 for ambulatory surgical centers. Given our findings of
21 payment adequacy and our stated goals, eliminating the
22 update is warranted. This is consistent with our general

1 position of recommending updates only when needed.
2 The implication of this recommendation for the
3 Medicare program is that, relative to current law, it would
4 decrease spending by $50 million to $250 million over one
5 year and by less than $1 billion over five years.
6 Also, this recommendation is not expected to have
7 any effect on beneficiaries' access to ASC services or
8 providers' willingness or ability to furnish those
9 services.
10 Now, the Commission has long argued that ASCs
11 should submit cost data to help determine accurate payment
12 rates for ASCs and guide future updates. So, once again,
13 we have this draft recommendation: The Secretary should
14 require ambulatory surgical centers to report cost data.
15 The importance of this recommendation is that the
16 Commission has recommended this policy for over a decade.
17 At the same time, CMS has been largely neutral on
18 committing to collecting cost data from ASCs.
19 The Secretary could limit the burden on ASCs by
20 using a streamlined system of cost submission.
21 Implementing this recommendation would not change Medicare
22 program spending. We anticipate no effect on

1 beneficiaries. However, ASCs would incur some added
2 administrative costs.
3 Now I turn it back to the Chair for discussion.
4 DR. CHERNEW: Okay. Thank you. I think we have
5 time for one comment, and I think the person who wants to
6 make that comment is Brian. And I think the way this is
7 going to work, Dana, just before Brian speaks, is we're
8 going to do each of these sequentially, so we're going to
9 go to the vote on ASCs before we go to the next sector. Is
10 that right, Dana?
11 MS. KELLEY: Yes, that's correct.
12 DR. CHERNEW: Okay. So, again, we're going very
13 quickly, so we'll have in the expedited voting session as
14 expedited comment, so, Brian.
15 DR. DeBUSK: Yes, thank you. I just wanted to
16 make one brief comment. I'm going to support the
17 recommendation as written, but I do hope in future work we
18 will revisit this idea that ASCs are growing at an adequate
19 rate.
20 You know, when I see 0.9 percent growth in
21 beneficiaries served and 2.5 percent growth in the number
22 of ASCs against a backdrop of a service that has 46 percent

1 savings to taxpayers and to beneficiaries, to me that is
2 alarmingly low growth. If this were a program that was
3 just marginally less expensive or marginally beneficial
4 financially, I would understand it. But, you know, we're
5 in a Medicare world where 2 percent or 3 percent or 4
6 percent savings is huge, and this is a sector that's
7 offering 10 to 20 times those savings. So I do hope in
8 future work that we'll go back and revisit this with ASCs.
9 Thank you.
10 DR. CHERNEW: Brian, thank you, and I think we
11 should move on to the ASC vote, and I think that's the next
12 step. Then I think we'll move to dialysis. So, Dana, do
13 you want to go with the vote?
14 MS. KELLEY: Yes. For the first draft
15 recommendation regarding the update to the conversion
16 factor, Paul?
17 DR. PAUL GINSBURG: Yes.
18 MS. KELLEY: Larry?
19 DR. CASALINO: Yes.
20 MS. KELLEY: Brian?
21 DR. DeBUSK: Yes.
22 MS. KELLEY: Karen?

1 DR. DeSALVO: Yes.
2 MS. KELLEY: Marge?
3 MS. MARJORIE GINSBURG: Yes.
4 MS. KELLEY: David?
5 DR. GRABOWSKI: Yes.
6 MS. KELLEY: Jonathan Jaffery?
7 DR. JAFFERY: Yes.
8 MS. KELLEY: Amol?
9 DR. NAVATHE: Yes.
10 MS. KELLEY: Jon Perlin?
11 DR. PERLIN: Yes.
12 MS. KELLEY: Bruce?
13 MR. PYENSON: Yes.
14 MS. KELLEY: Betty?
15 DR. RAMBUR: Yes.
16 MS. KELLEY: Wayne?
17 DR. RILEY: Yes.
18 MS. KELLEY: Jaewon?
19 DR. RYU: Yes.
20 MS. KELLEY: Dana?
21 DR. SAFRAN: Yes.
22 MS. KELLEY: Sue?

1 MS. THOMPSON: Yes.

2 MS. KELLEY: Pat?

3 MS. WANG: Yes.

4 MS. KELLEY: And Mike?

5 DR. CHERNEW: Yes.

6 MS. KELLEY: And for the second recommendation

7 regarding the collection of cost report data for ambulatory

8 surgical centers, Paul?

9 DR. PAUL GINSBURG: Yes.

10 MS. KELLEY: Larry?

11 DR. CASALINO: Yes, capital letters, vehemently.

12 MS. KELLEY: Brian?

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

14 letters.

15 MS. KELLEY: Karen?

16 DR. DeSALVO: Yes. Friendly amendment to capital

17 letters with an exclamation point.

18 MS. KELLEY: Marge?

19 MS. MARJORIE GINSBURG: Yes.

20 MS. KELLEY: David?

21 DR. GRABOWSKI: Yes.

22 MS. KELLEY: Jonathan Jaffery?

1 DR. JAFFERY: Yes.

2 MS. KELLEY: Amol?

3 DR. NAVATHE: Yes.

4 MS. KELLEY: Jon Perlin?

5 DR. PERLIN: Yes.

6 MS. KELLEY: Bruce?

7 MR. PYENSON: Yes.

8 MS. KELLEY: Betty?

9 DR. RAMBUR: Yes.

10 MS. KELLEY: Wayne? Have we lost Wayne?

11 DR. RILEY: Yes.

12 MS. KELLEY: Oh, there he is. Jaewon?

13 DR. RYU: Yes.

14 MS. KELLEY: Dana?

15 DR. SAFRAN: Yes.

16 MS. KELLEY: Sue?

17 MS. THOMPSON: Yes.

18 MS. KELLEY: Pat?

19 MS. WANG: Yes.

20 MS. KELLEY: And Mike?

21 DR. CHERNEW: Yes.

22 MS. KELLEY: All right then.

1 DR. CHERNEW: Okay. So I think now we're going
2 to go to Nancy and Andy to talk about dialysis. Nancy and
3 Andy.
4 MS. RAY: Good morning. Today's presentation on
5 assessing the payment adequacy of outpatient dialysis
6 services consists of three sections. First, I will answer
7 a question raised during the December meeting. Then I will
8 summarize the indicators of payment adequacy that we
9 reviewed in December. Lastly, I will present a draft
10 update recommendation for your consideration. The update
11 analysis and recommendation will be included as a chapter
12 in our March 2021 report. Also, this is an abbreviated
13 version of the information presented at the December
14 meeting.
15 As background, in 2019, there were roughly
16 395,000 fee-for-service dialysis beneficiaries treated at
17 7,700 dialysis facilities. Total Medicare fee-for-service
18 spending was about $12.9 billion for dialysis services.
19 The revised chapter includes additional material
20 about a number of issues raised at the December meeting.
21 What I'd like to highlight for the presentation addresses
22 many commissioners' requests for information about the

1 supplemental sources of health coverage for fee-for-service
2 dialysis beneficiaries.
3 As shown on the table, in 2019, fee-for-service
4 dialysis beneficiaries were more likely to be eligible for
5 Medicaid and less likely to have other supplemental sources
6 of health coverage than fee-for-service non-dialysis
7 beneficiaries. Twenty-four percent of both groups had no
8 source of supplemental coverage.
9 Next, I will summarize the payment adequacy
10 analysis. The indicators assessing adequacy are generally
11 positive, and you have seen all of this information in
12 December.
13 Regarding access to care, there is a net increase
14 of about 200 facilities between 2018 and 2019.
15 Regarding capacity, the growth in dialysis
16 treatment stations exceeded the growth in the number of
17 fee-for-service dialysis beneficiaries between 2018 and
18 2019. And looking at volume changes, the growth in the
19 number of fee-for-service dialysis beneficiaries and
20 Medicare-covered treatments remains steady.
21 The 25 percent marginal profit suggests that
22 providers have a financial incentive to continue to serve

1 Medicare beneficiaries.

2 Moving to quality, the percent of dialysis
3 beneficiaries using home dialysis increased over the past
4 five years, and that's a good thing. Hospital admissions
5 and mortality and percent of hospitalized beneficiaries
6 with a readmission have held steady.

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

12 Moving to our analysis of payments and costs, in
13 2018, the Medicare margin is 8.4 percent, and the 2021
14 projected Medicare margin is 4 percent.

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

20 This draft recommendation is a change from the
21 December draft recommendation based on Commissioners'
22 comments about the equity of update recommendations across

1 sectors.

2 In terms of spending implications, this draft
3 recommendation is expected to decrease relative to current
4 law, a spending decrease relative to current law of 50- to
5 $250 million over one year and $1 billion to $5 billion
6 over five years.

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

12 I now turn it back to the Chair.

13 DR. CHERNEW: Thank you so much, Nancy.

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

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

19 As we have discussed in the past, dialysis is
20 sort of like an extreme example of consolidation in the
21 service market. Two organizations provide 75 percent of
22 dialysis services. They also happen to be vertically

1 integrated, supplying many of the materials and so forth
2 that are required to deliver their services to Medicare
3 beneficiaries.
4 We've talked about it before. I think that it
5 would be helpful going forward for the staff to tease out
6 whether there is a better way, a broader view of financial
7 performance behind the Medicare cost report simply because
8 it seems like a vertically integrated, very large
9 organization with means of production included that the
10 Medicare cost report may not be giving us the full picture
11 of what's really going on. So some kind of enterprise-wide
12 view of the relevant portions of vertical integration that
13 feed into a service that is provided on the Medicare cost
14 report, I think, would be helpful for context going
15 forward.
16 Thank you.
17 DR. CHERNEW: Yeah. Pat, thank you. I must say,
18 just broadly, how we deal with the increasing complexity
19 and vertical integration in the health care sector in a
20 world in which we're making updates by these sectors of IP
21 schedules is a sort of keep-you-up-at-night kind of
22 comment. I wish I had something deeper to say, other than,

1 as you know, it's a topic we continue to look at, and we
2 will continue to do so. And that is certainly relevant
3 here.
4 But that said, given the task at hand, I think
5 we're going to go to the vote.
6 MS. KELLEY: Okay.
7 DR. CHERNEW: Dana?
8 MS. KELLEY: All right. For the end-stage renal
9 disease PPS base rate update recommendation, Paul?
10 DR. PAUL GINSBURG: I vote yes and want to point
11 out that Pat's comment is very valuable for our future
12 considerations.
13 MS. KELLEY: Larry?
14 DR. CASALINO: Yes.
15 MS. KELLEY: Brian?
16 DR. DeBUSK: Yes.
17 MS. KELLEY: Karen?
18 DR. DeSALVO: Yes.
19 MS. KELLEY: Marge?
20 MS. MARJORIE GINSBURG: Yes.
21 MS. KELLEY: David?
22 DR. GRABOWSKI: Yes.

1 MS. KELLEY: Jonathan Jaffery?
2 DR. JAFFERY: Yes.
3 MS. KELLEY: Amol?
4 DR. NAVATHE: Yes.
5 MS. KELLEY: Jon Perlin?
6 DR. PERLIN: Yes.
7 MS. KELLEY: Bruce?
8 MR. PYENSON: Yes.
9 MS. KELLEY: Betty?
10 DR. RAMBUR: Yes.
11 MS. KELLEY: Wayne?
12 DR. RILEY: Yes.
13 MS. KELLEY: Jaewon?
14 DR. RYU: Yes.
15 MS. KELLEY: Dana?
16 DR. SAFRAN: Yes.
17 MS. KELLEY: Sue?
18 MS. THOMPSON: Yes.
19 MS. KELLEY: Pat?
20 MS. WANG: Yes.
21 MS. KELLEY: And, Mike?
22 DR. CHERNEW: Yes.

1 Okay. Thank you all, and for the last sector in
2 this particular expedited voting session. We have hospice,
3 and that means we have Kim.
4 Kim, you're up.
5 MS. NEUMAN: Good morning.
6 Now we're going to review the indicators of
7 hospice payment adequacy and discuss the draft hospice
8 update recommendation for 2022 and a policy to modify the
9 hospice aggregate cap.
10 We discussed these issues at the December
11 meeting, and there's more detail in your mailing materials.
12 We revised the materials based on your December
13 discussion. For example, we added an analysis of new
14 hospices in California and Texas and included more
15 discussion of the implications of the hospice cap policy.
16 So, first, a few key facts about hospice. In
17 2019, over 1.6 million Medicare beneficiaries used hospice
18 services, including more than half of beneficiaries who
19 died that year. Over 4,800 Medicare hospice providers
20 furnished services to those beneficiaries, and Medicare
21 paid those hospice providers about $20.9 billion.
22 So now we'll look at our indicators of payment

1 adequacy which are strong. In terms of access to care, the
2 supply of hospice providers continues to grow, increasing
3 about 4 percent in 2019. Hospice use also increased. Both
4 the share of Medicare decedents using hospice and average
5 length of stay increased in 2019.
6 Marginal profit in 2018 was 16 percent, which
7 suggests providers have an incentive to accept new Medicare
8 patients.
9 Quality data are limited. Process measures are
10 mostly topped out. Visits at the end-of-life increased
11 slightly while Hospice CAHPS survey performance was stable.
12 A study by the OIG identified a group of about
13 300 hospices based on survey and complaint data that were
14 poor performers.
15 Indicators of access to capital appears good.
16 The number of providers continues to grow, suggesting that
17 capital is accessible. Financial analyst reports suggest
18 the sector is viewed favorably by investors.
19 So this brings us to margins. For 2018, we
20 estimate an aggregate Medicare margin of 12.4 percent, and
21 for 2021, we project an aggregate margin of 13 percent.
22 Our 2021 margin projection increased slightly from the

1 December presentation, from 12 to 13 percent, because of
2 the recent legislation suspending the sequester for three
3 additional months, through March 2021.
4 So now let's switch gears and talk about the
5 hospice aggregate cap. The cap limits total payments a
6 hospice provider can receive in year. The cap is an
7 aggregate limit, not a patient-level limit. If a
8 provider’s total payments exceed the number of patients
9 served by that provider, multiplied by the cap amount, the
10 provider must repay the excess to Medicare.
11 Currently, the cap is about $30,684, and the cap
12 is not wage-adjusted.
13 In 2019, about 16 percent of hospices exceeded
14 the cap. These providers would have had very high margins
15 if not for the cap.
16 In lieu of an across-the-board payment reduction
17 last year in March 2020, the Commission recommended the cap
18 be wage-adjusted and reduced 20 percent. This cap policy
19 recommendation would make cap more equitable across
20 providers and focus payment reductions on providers with
21 high margins and long stay. Congress has not acted on that
22 recommendation.

1 So given the margin in the industry and our other
2 positive payment adequacy indicators, the Commission has
3 developed a two-part draft recommendation similar to last
4 year. The draft recommendation would keep the payment
5 rates unchanged in 2022 at the 2021 levels for all
6 providers, and it would also reiterate the Commission's
7 hospice cap policy recommendation, which would focus
8 payment reductions on providers with disproportionately
9 long stays and high margins.
10 The draft recommendation reads "The Congress
11 should for fiscal year 2022 eliminate the update to the
12 2021 Medicare base payment rates for hospice and wage
13 adjust and reduce the hospice aggregate cap by 20 percent."
14 In terms of implications, the draft
15 recommendation would reduce spending relative to current
16 law by between $750 million to $2 billion over one year and
17 between $5 billion and $10 billion over five years.
18 In terms of implications, we expect that
19 beneficiaries would continue to have good access to care,
20 given the current indicators of payment adequacy and
21 margins in the industry. We also expect continued provider
22 willingness and ability to care for Medicare beneficiaries.

1 So that concludes the presentation, and I turn it
2 back to Mike.
3 DR. CHERNEW: Great. Kim, thank you so much.
4 This is another sector we've done a lot of work in. Much
5 of that work has been outside of the specific update
6 factors, and it's obviously a particularly important area.
7 So I don't see anyone wanting to make a comment.
8 So I'm going to pause for one second. Then I'm going to go
9 to the vote.
10 [Pause.]
11 DR. CHERNEW: Okay. Dana?
12 MS. KELLEY: All right. For the draft
13 recommendation on the hospice update and the aggregate cap.
14 Paul?
15 DR. PAUL GINSBURG: Yes.
16 MS. KELLEY: Larry?
17 DR. CASALINO: Yes.
18 MS. KELLEY: Brian?
19 DR. DeBUSK: Yes.
20 MS. KELLEY: Karen?
21 DR. DeSALVO: Yes.
22 MS. KELLEY: Marge?

1 MS. MARJORIE GINSBURG: Yes.
2 MS. KELLEY: David?
3 DR. GRABOWSKI: Yes.
4 MS. KELLEY: Jonathan Jaffery?
5 DR. JAFFERY: Yes.
6 MS. KELLEY: Amol?
7 DR. NAVATHE: Yes.
8 MS. KELLEY: Jon Perlin?
9 DR. PERLIN: Yes.
10 MS. KELLEY: Bruce?
11 MR. PYENSON: Yes.
12 MS. KELLEY: Betty?
13 DR. RAMBUR: Yes.
14 MS. KELLEY: Wayne?
15 DR. RILEY: Yes.
16 MS. KELLEY: Jaewon?
17 DR. RYU: Yes.
18 MS. KELLEY: Dana?
19 DR. SAFRAN: Yes.
20 MS. KELLEY: Sue?
21 MS. THOMPSON: Yes.
22 MS. KELLEY: Pat?

1 MS. WANG: Yes.
2 MS. KELLEY: And Mike?
3 DR. CHERNEW: Yes.
4 Okay. I think we are now going to continue
5 moving into sort of the next session of expedited voting,
6 but it's going to feel very much like the last session.
7 And we're going to start not with the SNF, the skilled
8 nursing facility session, and I believe that's going to be
9 Carol.
10 DR. CARTER: That's right.
11 Before the PAC group starts its presentations, I
12 want to note that PDF versions of the slides can be found
13 in the handout sections of the control panel on the right-
14 hand side of the screen. In this session, each of us will
15 present high-level summaries of our sector that was
16 discussed at length at the December meeting. Details of
17 the analyses and findings can be found in the papers.
18 We'll start with the update to Medicare's
19 payments to skilled nursing facilities. This chapter now
20 includes information that was requested at the December
21 meeting.
22 Marge, you asked about closures by ownership.

1 Betty, you noted the need for accelerated quality
2 improvement, and, Pat, you asked about differences in
3 Medicaid shares between SNFs with high and low Medicare
4 margins.
5 Let's start with an overview of the SNF industry
6 in 2019. There were about 15,000 providers, most of which
7 also provide long-term care services.
8 About 1.5 million beneficiaries, or about 4
9 percent of fee-for-service beneficiaries, used SNF
10 services.
11 Program spending totaled almost $28 billion.
12 Medicare makes up a small share of most nursing
13 facilities' volume and revenue, about 9 percent of days and
14 about 16 percent of revenues.
15 As we reviewed in detail in December, our
16 indicators are generally positive. Beneficiaries appear to
17 have access to services. SNFs made small improvements in
18 the two quality measures. SNFs have adequate access to
19 capital, and this is expected to continue. The low total
20 margin reflects the low payments from other payers. The
21 2019 Medicare margin was 11.3 percent, and the margin for
22 the efficient provider was even higher. Both of these

1 indicate that Medicare's payments are too high relative to
2 the cost of care. The Medicare margin for 2021 is
3 projected to be 10 percent.
4 This brings us to the Chair's draft
5 recommendation. It reads "For fiscal year 2022, the
6 Congress should eliminate the update to the 2021 Medicare
7 base payment rates for skilled nursing facilities."
8 The level of Medicare's payments indicate that a
9 reduction is needed to more closely align aggregate
10 payments to aggregate costs. However, the effects of the
11 coronavirus and impacts of the new case-mix system are
12 uncertain. Therefore, the Commission will proceed
13 cautiously in recommending reductions to payments. A zero
14 update would begin to align payments with costs while
15 exerting some pressure on providers to keep their cost
16 growth low.
17 In terms of implications, relative to current
18 law, this recommendation would lower program spending by
19 between $750 million and $2 billion for fiscal year 2022
20 and by between $1 billion and $5 billion over five years.
21 Spending would decrease relative to current law
22 because the current law update for the year is projected to

1 be 2 percent.
2 Given the high level of Medicare's payments, we
3 do not expect adverse impacts on beneficiaries. Providers
4 should continue to be willing and able to treat
5 beneficiaries.
6 And with that, I'll turn things back to Mike for
7 your vote.
8 DR. CHERNEW: Thank you, Carol.
9 Again, we've spoken a lot about COVID and concern
10 about it overall, and that's certainly true of all the
11 sectors. I must say this sector has been particularly hard
12 hit.
13 Again, we do have time for a question, and this
14 time, it is going to go to Marge. So, Marge?
15 MS. MARJORIE GINSBURG: Yes. And perhaps I
16 should remember this, but as I recall from earlier
17 information about SNFs, that nonprofit SNF's margin is
18 really very tiny compared to for-profit. So I will be
19 voting yes to this, but I wonder if there is any
20 information specifically on the implications for nonprofit
21 SNFs.
22 DR. CHERNEW: Carol?

1 DR. CARTER: You are right that they're in
2 general, but I would say over the last 10 years, there's
3 been about a 10-point spread between the profit margins
4 between nonprofits and for-profits. That reflects several
5 factors, including they have higher costs per day, and
6 they've had typically much higher cost growth. So they
7 have not managed their costs as well as the for-profit
8 sector.
9 They've also, in the past, tended to have lower
10 shares of the highest intensive therapy patients that were
11 the most profitable.
12 So I think we understand the differences,
13 somewhat anyway, between the sectors, but it has not led us
14 to, say, recommend differential updates between the two
15 groups of providers.
16 MS. MARJORIE GINSBURG: One follow-up question.
17 This may seem a little bizarre. Have we ever made
18 recommendations that differentiate for-profit from
19 nonprofit?
20 DR. MATHEWS: We have not.
21 DR. CARTER: No.
22 DR. CHERNEW: No.

1 And I think it would be particularly hard, by the
2 way, to do so, but I think the point you make, which is a
3 broader point, Marge, is that in all of these sectors,
4 there's heterogeneity across providers. And again, I think
5 it illustrates just the challenges with running the system
6 the way the system is run because this is certainly not the
7 only sector where I worry about some providers more so than
8 others.
9 But our recommendation and the way the fee
10 schedules work is common across all the providers and
11 doesn't take ownership into account, ownership type into
12 account.
13 David, I think you also have a quick comment.
14 DR. GRABOWSKI: Yes. I'll be very brief, Mike.
15 So I'm also very supportive of the
16 recommendation. As you noted, Mike, we know that COVID has
17 had this devastating impact on individuals receiving care
18 in SNFs and also the individuals working there.
19 Jon Perlin said it really well with respect to
20 hospitals. The pandemic will thankfully end, but the
21 effects will be felt for quite some time. Some sectors, I
22 think, will have a shorter recovery than others. They will

1 return to pre-pandemic utilization levels.

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

12 Thanks.

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

15 DR. MATHEWS: Yeah. Mike, sorry, just one more
16 comment in response to Marge, and Carol, I could use a gut
17 check here. Part of the difference in financial
18 performance between for-profit and nonprofit SNFs over time
19 is what Carol said about differences in case mix, that for-
20 profits seem to be more selecting highly profitable rehab
21 patients and nonprofit SNFs have a disproportionate share
22 of medically complex patients that are less profitable. In

1 prior recommendations, going back to 2008, we recommended
2 changes to the payment system that would minimize
3 differences in profitability by case type, and CMS
4 implemented changes not inconsistent with what we
5 recommended this year.
6 So I think we would expect the differences in
7 profitability that are attributable to differences in mix
8 of patients to start to mitigate over time.
9 DR. CARTER: I agree.
10 DR. CHERNEW: Thank you. Thank you, Jim, and
11 back to your comment, Dave, and I think this is true
12 throughout, as it's my first year of being Chair, having to
13 do it in the midst of COVID, which means we can't see each
14 other in person and all of the understanding about what
15 happens going forward is complicated by the impact that
16 COVID will have on every sector, by the way, although
17 admittedly SNF is probably top of the list in terms of some
18 of the challenges they've faced. At least clinically
19 that's certainly true.
20 Nevertheless, I don't want to diminish the
21 challenges that everybody has had in COVID, and I will just
22 say, for the listening, we will spend a lot of time, and do

1 spend a lot of time thinking about this, and I might add a
2 shout-out to the staff who, under very difficult
3 circumstances, worked into every chapter a really
4 thoughtful discussion about a really difficult topic about
5 how COVID will affect things now and in the future. And,
6 of course, the durable point matters because there's
7 obviously been a bunch of other support for these
8 providers, for the direct stuff, the durable stuff, what
9 matters. The durable part is also the hardest part to
10 anticipate, for a range of reasons. So we will continue to
11 do that, and I really do thank the staff for all of their
12 hard work in doing something that really they have not had
13 to do before, because COVID is something none of us have
14 had to do before, thankfully.
15 So with that said, I'm going to pause for a
16 second and then go to the vote.
17 All right. Dana?
18 MS. KELLEY: Okay. For the skilled nursing
19 facility update draft recommendation. Paul?
20 DR. PAUL GINSBURG: Yes.
21 MS. KELLEY: Larry?
22 DR. CASALINO: Yes.

1 MS. KELLEY: Brian?

2 DR. DeBUSK: Yes.

3 MS. KELLEY: Karen?

4 DR. DeSALVO: Yes.

5 MS. KELLEY: Marge?

6 MS. MARJORIE GINSBURG: Yes.

7 MS. KELLEY: David?

8 DR. GRABOWSKI: Yes.

9 MS. KELLEY: Jonathan Jaffery?

10 DR. JAFFERY: Yes.

11 MS. KELLEY: Amol?

12 DR. NAVATHE: Yes.

13 MS. KELLEY: Jon Perlin?

14 DR. PERLIN: Yes.

15 MS. KELLEY: Bruce?

16 MR. PYENSON: Yes.

17 MS. KELLEY: Betty?

18 DR. RAMBUR: Yes.

19 MS. KELLEY: Wayne?

20 DR. RILEY: Yes.

21 MS. KELLEY: Jaewon?

22 DR. RYU: Yes.

1 MS. KELLEY: Dana?
2 DR. SAFRAN: Yes.
3 MS. KELLEY: Sue?
4 MS. THOMPSON: Yes.
5 MS. KELLEY: Pat?
6 MS. WANG: Yes.
7 MS. KELLEY: And Mike.
8 DR. CHERNEW: Yes.
9 Okay. I believe now we are going to turn to Evan
10 and home health. I didn't have to look at my notes. It
11 turns out it's on the screen. So Evan, you're up.
12 MR. CHRISTMAN: Thank you, Mike. Now we will
13 review the indicators for home health using the same
14 framework you saw for the other sectors.
15 As an overview, Medicare spent $17.8 billion on
16 home health services in 2019, and there were over 11,300
17 agencies participating. The program provided about 6.1
18 million episodes to 3.3 million beneficiaries.
19 Turning to our framework, here is a summary of
20 the indicators. Virtually all beneficiaries, 99 percent,
21 live in an area served by home health. Episode volume
22 declined slightly, but this was unrelated to payment, and

1 home health agencies have positive marginal profits of 18
2 percent in 2019. For quality measures, the rate of
3 hospitalization decreased slightly in 2019, which is an
4 improvement, while the of rate successful discharge to the
5 community increased slightly, which is also an improvement.
6 The all-payer margins were almost 6 percent in
7 2019, and access to capital for large for-profit home
8 health agencies is adequate, according to financial
9 analysts. Home health agencies had margins of 15.8 percent
10 in 2019, and we estimate margins of 14 percent in 2021.
11 The financial performance of the sector under
12 Medicare is strong, and these are among the highest margins
13 of any fee-for-service provider you will see this cycle.
14 This brings us to our draft recommendation, which
15 reads, for calendar year 2022, the Congress should reduce
16 the 2021 Medicare base payment rate for home health
17 agencies by 5 percent. The implications are that this
18 would decrease spending relative to current law by $750
19 million to $2 billion in 2022, and over $10 billion over
20 five years.
21 For beneficiary and providers, we expect access
22 to care will remain adequate. It should not affect the

1 willingness of providers to serve beneficiaries but it may
2 increase cost pressure for some providers.
3 This concludes my presentation.
4 DR. CHERNEW: I'm going to see for a second. We
5 do have time for a comment if someone pops up.
6 Okay, Dana, I think we're going to go for a vote.
7 MS. KELLEY: Okay. On the home health update
8 recommendation. Paul?
9 DR. PAUL GINSBURG: Yes.
10 MS. KELLEY: Larry?
11 DR. CASALINO: Yes.
12 MS. KELLEY: Brian?
13 DR. DeBUSK: Yes.
14 MS. KELLEY: Karen?
15 DR. DeSALVO: Yes.
16 MS. KELLEY: Marge?
17 MS. MARJORIE GINSBURG: Yes.
18 MS. KELLEY: David?
19 DR. GRABOWSKI: Yes.
20 MS. KELLEY: Jonathan Jaffery?
21 DR. JAFFERY: Yes.
22 MS. KELLEY: Amol?

1 DR. NAVATHE: Yes.
2 MS. KELLEY: Jon Perlin?
3 DR. PERLIN: Yes.
4 MS. KELLEY: Bruce?
5 MR. PYENSON: Yes.
6 MS. KELLEY: Betty?
7 DR. RAMBUR: Yes.
8 MS. KELLEY: Wayne?
9 DR. RILEY: Yes.
10 MS. KELLEY: Jaewon?
11 DR. RYU: Yes.
12 MS. KELLEY: Dana?
13 DR. SAFRAN: Yes.
14 MS. KELLEY: Sue?
15 MS. THOMPSON: Yes.
16 MS. KELLEY: Pat?
17 MS. WANG: Yes.
18 MS. KELLEY: And Mike.
19 DR. CHERNEW: Yes. Okay. Notice how rapidly
20 these expedited things go by. So we're going to move on
21 now to Jamila, and that's going to take us to inpatient
22 rehab.

1 DR. TORAIN: Thanks, Mike. Good afternoon. We
2 continue with the date to Medicare's payments to inpatient
3 rehabilitation facilities. This chapter includes
4 information about IRF and the utilization that was
5 requested at the December meeting. Now we will review the
6 indicators for IRF using the same framework you saw in the
7 other sectors.
8 Here is a reminder of the IRF industry in 2019.
9 There were about 1,152 IRFs; 25 percent of IRFs were
10 freestanding but these IRFs tend to be bigger, so they
11 accounted for over half of Medicare discharges. The
12 average length of stay was 12.6 days in 2019. Medicare
13 accounted for about 58 percent of IRFs' discharges. There
14 were 409,000 stays to 363,000 beneficiaries, and program
15 spending totaled $8.7 billion.
16 In summary of the materials we discussed in
17 December and were included in your mailing materials, we
18 found that the IRF's payment adequacy indicators were
19 positive.
20 With regards to beneficiaries' access to care,
21 IRFs continue to have capacity that appears to be adequate
22 to meet demand. With regards to quality of care, our risk-

1 adjusted outcome measures have remained relatively stable
2 since 2015. With regards to IRFs' access to capital, IRFs
3 maintain good access to capital markets. The all-payer
4 margin for freestanding IRFs is a robust 10.4 percent.
5 With regards to Medicare payments and IRFs costs indicators
6 they were positive. In 2019, the aggregate Medicare margin
7 was 14.3 percent. We project a margin of 16 percent in
8 2021.
9 So, to summarize, we observe capacity that
10 appears to be adequate to meet demand and that providers
11 should have an incentive to take more Medicare
12 beneficiaries that qualify for IRF-level care given the
13 strong marginal profits for both freestanding and hospital-
14 based facilities.
15 And so that brings us to the update for 2022.
16 Based on the strength of the payment adequacy indicators
17 and because the indicators were positive in 2019, it reads:
18 For the fiscal year 2022, the Congress should reduce the
19 2021 Medicare base payment rate for inpatient
20 rehabilitation facilities by 5 percent.
21 To review the implications:
22 On spending, relative to current law, spending

1 would decrease by between $750 million and $2 billion in
2 2022, and by between $5 billion and $10 billion over five
3 years. Current law would give an update of 2.2 percent.
4 On beneficiaries and providers, we anticipate no
5 adverse effect on Medicare beneficiaries' access to care.
6 The recommendation may increase financial pressure on some
7 providers.
8 This recommendation would be accompanied by a
9 reiteration of our March 2016 recommendations to the
10 Secretary to conduct focused medical record review and to
11 expand the outlier pool to increase outlier payments for
12 the costliest cases.
13 And with that, I will turn it back to Mike. Thank
14 you.
15 DR. CHERNEW: Jamila, thank you. That was very
16 good. We do have a comment from Pat, so Pat, you're up.
17 MS. WANG: Thanks, Mike. This is more of a
18 question. Jamila, can you remind us whether between the
19 freestanding and the hospital-based sectors whether there
20 is a difference in the mix of services provided?
21 DR. TORAIN: The mix of services provided between
22 hospital-based and freestanding?

1 MS. WANG: Yeah. Is it a different focus from
2 freestanding and hospital-based? Same proportion?
3 DR. TORAIN: Exactly.
4 MS. KELLEY: Well, Jamila, I think there is a
5 difference in the types of cases that they tend to admit.
6 MS. WANG: That's what I mean, yeah.
7 DR. TORAIN: Oh, you mean the cases. So yeah,
8 we're doing more work in that area. We're trying to look
9 in to see -- we do see differences between for-profit and
10 nonprofit in hospital-based and freestanding. But we are
11 doing more work into seeing why exactly there are
12 differences in the cases that are selected between the two.
13 MS. WANG: Okay. And that leads to sort of the
14 second question, which I'm sorry, I just don't remember.
15 In the reform of post-acute care payment, was it possible
16 at that time -- and maybe this is question for Carol, to
17 see whether there were impacts on freestanding versus
18 hospital-based margins? Because your modeling did show
19 some shifts in margin according to hospice as well as sort
20 of organizational status, I guess. And I just can't recall
21 whether that was also true for the IRF.
22 MS. KELLEY: Is Carol still on?

1 DR. CARTER: Yeah, I'm on. So when we modeled
2 the PAC PPS, in general, money did -- the payments would
3 increase for hospital-based and for nonprofit facilities,
4 given their mix of patients and the medical complexity,
5 moving money towards those patients and away from
6 rehabilitation-only patients.
7 MS. WANG: Thank you. The comment then is
8 underscoring the importance of broader payment reform
9 beyond the straight updates, specifically in the PAC PPS.
10 And to Jim's point earlier, paying for the same service,
11 comparably, wherever it might occur. Thank you.
12 DR. CHERNEW: Yes, and so I agree, and, of
13 course, in certain areas -- Brian would mention this in the
14 case of ASCs, there's complicated case mix adjustment
15 issues that go on. So I guess for those listening, you
16 hear a lot of, I think, consensus amongst the Commissioners
17 on this point, and in each of the different particular
18 clinical areas the nuances in the data and the analytics
19 vary. But directionally, I think, we're largely in
20 agreement about what we would like to be able to do.
21 So that said, I think we are now going to go for
22 a vote on this. Dana?

1 MS. KELLEY: Okay. On the update recommendation
2 for inpatient rehabilitation facilities. Paul?
3 DR. PAUL GINSBURG: Yes.
4 MS. KELLEY: Larry?
5 DR. CASALINO: Yes.
6 MS. KELLEY: Brian?
7 DR. DeBUSK: Yes.
8 MS. KELLEY: Karen?
9 DR. DeSALVO: Yes.
10 MS. KELLEY: Marge?
11 MS. MARJORIE GINSBURG: Yes.
12 MS. KELLEY: David?
13 DR. GRABOWSKI: Yes.
14 MS. KELLEY: Jonathan Jaffery?
15 DR. JAFFERY: Yes.
16 MS. KELLEY: Amol?
17 DR. NAVATHE: Yes.
18 MS. KELLEY: Jon Perlin?
19 DR. PERLIN: Yes.
20 MS. KELLEY: Bruce?
21 MR. PYENSON: Yes.
22 MS. KELLEY: Betty?

1 DR. RAMBUR: Yes.

2 MS. KELLEY: Wayne?

3 DR. RILEY: Yes.

4 MS. KELLEY: Jaewon?

5 DR. RYU: Yes.

6 MS. KELLEY: Dana?

7 DR. SAFRAN: Yes.

8 MS. KELLEY: Sue?

9 MS. THOMPSON: Yes.

10 MS. KELLEY: Pat?

11 MS. WANG: Yes.

12 MS. KELLEY: And Mike.

13 DR. CHERNEW: Yes.

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

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

19 As we discussed in December, LTCH care is
20 relatively expensive and infrequently used. The average
21 fee-for-service Medicare payment for LTCH case was about
22 $41,000 across all cases, and approximately $47,000 across

1 cases meeting the LTCH PPC criteria. Fee-for-service
2 Medicare beneficiaries had about 91,000 stays, and total
3 Medicare spending was approximately $3.7 billion in 2019
4 for care furnished in 361 LTCHs.
5 In summary of the indicators we discussed in
6 December and that were detailed in your mailing materials,
7 access to care indicators were consistent with changes to
8 the payment system. Occupancy rates across the industry
9 were steady in 2019. Although volume of LTCH services
10 continued to decline in 2019, this is in large part due to
11 reduction in non-qualifying cases.
12 In terms of quality of care, unadjusted mortality
13 rates were stable, as were risk-adjusted rates of
14 hospitalization. Risk-adjusted rates of discharge to the
15 community declined slightly between 2018 and 2019.
16 The effect of fully implementing the dual-payment
17 rate system, will continue to limit industry growth and
18 access to capital in the near term. The aggregate margin
19 for LTCHs with a high share of cases meeting the LTCH PPS
20 criteria was 2.9 percent in 2019. Our projected margin for
21 these LTCHs in 2021 is 2 percent, which reflects the three-
22 month extension of the suspension of the sequester in the

1 coronavirus/omnibus spending bill passed in late December
2 2020.
3 There is no statutory update for Medicare
4 payments to LTCHs. However, CMS historically has used the
5 LTCH market basket as a starting point for establishing the
6 LTCH update. Therefore, we make our recommendation to the
7 Secretary.
8 The draft recommendation reads, for fiscal year
9 2022, the Secretary should increase the fiscal year 2021
10 Medicare base payment rate for long-term care hospitals by
11 2 percent.
12 This 2 percent update is expected to reduce
13 federal program spending relative to the expected update by
14 less than $50 million in 2022, and by less than $1 billion
15 over five years. We anticipate that LTCHs can continue to
16 provide Medicare beneficiaries who meet the LTCH PPS
17 criteria with access to safe and effective care.
18 And with that, I will turn it back to Mike.
19 DR. CHERNEW: Great. Thank you. That was, I
20 think, very clear in a sector that is complex and changing,
21 and, of course, how all of this payment works across the
22 different post-acute sectors is complex.

1 I'm just waiting for a second to see if someone
2 was going to say something.
3 All right. Dana, we're going to go to a vote.
4 MS. KELLEY: Okay. For the update recommendation
5 for long-term care hospitals. Paul?
6 DR. PAUL GINSBURG: Yes.
7 MS. KELLEY: Larry?
8 DR. CASALINO: Yes.
9 MS. KELLEY: Brian?
10 DR. DeBUSK: Yes.
11 MS. KELLEY: Karen? I think we've lost Karen.
12 All right. I'll continue on and we'll come back
13 to her. Hopefully she will quickly join us again.
14 Marge?
15 MS. KELLEY: Marge?
16 MS. MARJORIE GINSBURG: Yes.
17 MS. KELLEY: David?
18 DR. GRABOWSKI: Yes.
19 MS. KELLEY: Jonathan Jaffery?
20 DR. JAFFERY: Yes.
21 MS. KELLEY: Amol?
22 DR. NAVATHE: Yes.

1 MS. KELLEY: Jon Perlin?
2 DR. PERLIN: Yes.
3 MS. KELLEY: Bruce?
4 MR. PYENSON: Yes.
5 MS. KELLEY: Betty?
6 DR. RAMBUR: Yes.
7 MS. KELLEY: Wayne?
8 DR. RILEY: Yes.
9 MS. KELLEY: Jaewon?
10 DR. RYU: Yes.
11 MS. KELLEY: Dana?
12 DR. SAFRAN: Yes.
13 MS. KELLEY: Sue?
14 MS. THOMPSON: Yes.
15 MS. KELLEY: Pat?
16 MS. WANG: Yes.
17 MS. KELLEY: And Mike.
18 DR. CHERNEW: Yes.
19 MS. KELLEY: I don't see Karen back on. She must
20 have dropped off. One thing we could do is ask for her
21 vote at the start of the next session.
22 DR. CHERNEW: From what I understand that might

1 be the only thing we could do. Jim, do you have any
2 suggestion here?
3 DR. MATHEWS: If you are willing to do that, I
4 think we can accommodate it. Otherwise, I think we would
5 mark her as not present.
6 DR. CHERNEW: Yeah. Well, I think we should
7 absolutely do that, and we will see that when we return for
8 the next session. See, that's the beauty of rambling. If
9 you ramble enough --
10 DR. DeSALVO: Are you all looking for me? I'm
11 sorry.
12 DR. CHERNEW: That's all right. Karen, we are
13 looking for your vote on that recommendation.
14 DR. DeSALVO: Yes. Sorry.
15 MS. KELLEY: Thank you.
16 DR. CHERNEW: And that was the other strategy for
17 me, just to keep talking until the problem goes away.
18 So we are all good. That was indeed a full
19 series of expedited sessions. I want to thank everybody
20 for their discipline and for their comments. We are now
21 going to adjourn until -- I think we come back at 1:45,
22 when we will start with the alternative payment model

1 chapter. Is that right? Does anyone want to add, Jim or
2 Dana? Are we good?
3 DR. MATHEWS: We are good.
4 DR. CHERNEW: Okay. Thank you for your morning,
5 everybody. We will be back at 1:45. Please join a little
6 bit sooner so we can get going right on time.
7 [Whereupon, at 12:31 p.m., the meeting was
8 recessed, to reconvene at 1:45 p.m. this same day.]
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23

1 AFTERNOON SESSION

2 [1:47 p.m.]

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

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

19 MS. BURTON: Thanks, Mike. This afternoon, Geoff
20 Gerhardt and I will discuss the Center for Medicare and
21 Medicaid Innovation and explore policy options related to
22 its development and implementation of alternative payment

1 models. Today's discussion picks up from our October
2 discussion on this topic and fleshes out some ideas raised
3 by Commissioners.
4 The audience can download a PDF of these slides
5 from the control panel on the right side of their screen,
6 under the "Handout" section.
7 Today we'll start out with some background on the
8 Center for Medicare and Medicaid Innovation, or CMMI, and
9 identify some of the goals, objectives, and factors it
10 considers when selecting models to implement.
11 We'll briefly summarize the impacts achieved so
12 far by its flagship models and touch on some barriers that
13 models may be experiencing.
14 Geoff will then present three policy options that
15 would change how CMMI manages its portfolio and invite your
16 discussion of these and any other topics.
17 CMMI was established in the Affordable Care Act
18 of 2010 to test innovative payment and service delivery
19 models that reduce Medicare or Medicaid spending while
20 preserving or enhancing care quality.
21 Congress included 27 potential models for CMMI to
22 consider in its authorizing statute and appropriated $10

1 billion every ten years, in perpetuity, to CMMI.

2 CMMI models are typically implemented for three

3 to five years, but can be expanded into a permanent,

4 nationwide program -- without requiring an act of Congress

5 -- if they are found to decrease spending without

6 decreasing quality or to increase quality without

7 increasing spending.

8 In 2015, Congress passed a law creating a new 5

9 percent bonus for clinicians in certain types of payment

10 models that have come to be known as "advanced" alternative

11 payment models, or A-APMs.

12 These models require providers to assume "more

13 than nominal" financial risk. The models must also use

14 quality measures comparable to those in the Merit-based

15 Incentive Payment System, and they must require providers

16 to use electronic health records that meet federal

17 standards.

18 The 5 percent A-APM bonus is available annually

19 from 2019 through 2024 to clinicians with a sufficient

20 percent of payments or patients in A-APMs.

21 Starting in 2026, clinicians in A-APMs will

22 qualify for higher annual updates to fee schedule rates

1 than clinicians not in these models.

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

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

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

14 First, CMMI funds the Health Care Payment
15 Learning & Action Network, known as "the LAN," which brings
16 together payers and other stakeholders to encourage them to
17 align with HHS' goals for payment reform. Back in 2015,
18 when the LAN was formed, HHS' goals were simply to increase
19 the percent of payments linked to quality and value and the
20 percent of payments in alternative payment models.

21 Over the years, the LAN has helped HHS develop
22 more specific goals: first, encouraging payers to pursue

1 one- and two-sided shared savings models, shown in the
2 purple column, and partial and full capitation models,
3 shown in the green column.
4 Then this last year, the LAN and HHS narrowed
5 this goal by no longer encouraging movement into one-sided
6 shared savings models -- shown inside the dotted circle in
7 the purple column.
8 The LAN conducts an annual payer survey, to
9 measure the percent of payments in the U.S. that flow throw
10 their preferred types of payment models.
11 Moving from HHS' broad goals to more specific
12 objectives, HHS has advised that when selecting models to
13 implement, it prefers those that are transparent, in that
14 they empower consumers to drive value through choice;
15 simple, by which HHS means the model focuses on measures
16 that matter, rather than check-the-box requirements; and
17 accountable, in that they encourage risk and financial
18 accountability, to align incentives and drive behavior
19 change.
20 On a more practical level, CMMI also considers
21 the 20 factors listed on this slide, including a model's
22 potential for cost savings and quality improvement, the

1 strength of the evidence base supporting a model, the
2 extent of clinical transformation envisioned in a model, a
3 model's potential overlap with other models, the
4 feasibility of operating and evaluating a model, and the
5 feasibility of scaling it up if it is successful.
6 CMMI has used the goals, objectives, and factors
7 just mentioned to develop dozens of payment models over its
8 first ten years, many of which have attracted large numbers
9 of participating providers.
10 In 2020, CMMI was actively operating 24 models by
11 our count. This includes some successors to earlier
12 versions of models that were previously tested with
13 slightly different designs. Currently, seven of CMMI's
14 models are considered A-APMs, since they involve financial
15 risk for providers. Clinicians in these models can qualify
16 for the 5 percent bonus I mentioned earlier.
17 In CMMI's history, only four of its models have
18 been certified by CMS' actuaries as having met the criteria
19 to be expanded into a permanent, nationwide program. Only
20 one of these was an A-APM. It was the Pioneer ACO model.
21 CMS incorporated lessons learned from Pioneer into Track 3
22 of the Medicare Shared Savings Program, which in turn

1 evolved into the current "enhanced" track. MSSP is the
2 only A-APM not operated by CMMI; instead, it is a large,
3 permanent program created by Congress.
4 To get a sense of the impacts produced by CMMI's
5 payment models, we reviewed the most recent evaluation
6 report for each of the seven A-APMs, plus their predecessor
7 models, and we also looked at studies of the MSSP.
8 Among these 15 models, we found that nine
9 produced gross savings for Medicare before factoring in new
10 payments made to providers in these models.
11 Among the nine models, five generated net savings
12 once model payments were factored in.
13 As a side note, I'll mention that CMMI is not
14 required to expand successful models and has the discretion
15 to continue iterating on such models if it chooses.
16 We also found that about seven models improved
17 quality and that quality improvement tended to accompany
18 net savings.
19 I'll now turn things over to Geoff to talk about
20 some barriers that may be preventing models from having
21 greater impacts.
22 MR. GERHARDT: It's worth taking a moment to

1 consider why more models have not generated net savings for
2 Medicare or led to substantial improvements in quality.
3 Achieving these goals depends in large part on
4 whether providers change their behavior in response to
5 financial incentives in APMs to reduce the volume and
6 intensity of services and place greater emphasis on health
7 outcomes.
8 Since many APMs are layered on top of fee-for-
9 service payment systems, the incentives in fee-for-service
10 to increase provider revenue by maximizing volume may
11 outweigh the APM's incentives to reduce volume.
12 And while incentives under fee-for-service are
13 relatively easy for providers to understand and respond to,
14 the parameters and incentives in APMs can be extremely
15 complex and difficult for providers to fully understand.
16 The complexity of models may be suppressing provider
17 participation and limiting the effectiveness of incentives
18 for providers to change behavior.
19 Certain providers, especially those who are
20 employed by health care organizations, may be partially or
21 completely shielded from the financial incentives in APMs.
22 Models are often implemented as independent initiatives and

1 are not necessarily integrated with other APMs being
2 tested.
3 The lack of alignment between models can cause
4 performance payments from shared savings to be attributed
5 in unpredictable ways. This unpredictability can alter
6 incentives for providers and cause operational challenges
7 for model participants.
8 Models where participation is voluntary or
9 providers have choices about what services and spending
10 they are financially accountable for may predominantly
11 attract providers that expect to be able to receive
12 performance bonuses without substantially changing their
13 behavior.
14 And, finally, beneficiaries attributed to an APM
15 may not have any incentive to change their own behavior,
16 putting the onus for improvement entirely on providers.
17 At the October meeting, some Commissioners
18 expressed interest in exploring three policy options
19 related to how CMMI manages its portfolio of payment
20 models.
21 One option is to reduce the number of models CMMI
22 implements and ensure that a smaller group of models are

1 more coordinated.

2 Another option is for CMMI to focus on

3 implementing models that show the most promise, especially

4 when it decides to develop second- and third-generation

5 versions of models.

6 The third option is for CMMI to make fewer, if

7 any, changes to a given model's parameters once it is

8 underway. On the next several slides, I'll walk through

9 these policy options and review a number of pros and cons

10 for you to consider. A more extensive list of pros and

11 cons for each option is included in your mailing materials.

12 The first policy option is that CMMI should seek

13 to implement a smaller suite of coordinated models designed

14 to support a clear set of strategic goals.

15 Under this option, CMMI would find it easier to

16 create a system of models that align with and support each

17 other more than the current models do.

18 By reducing the number of models and making sure

19 they are more coordinated, this option could reduce

20 unintended interactions between different models, including

21 conflicting model rules and financial incentives.

22 On the other hand, a smaller number of models

1 could have drawbacks. It would likely decrease the
2 diversity of models being implemented, which could have a
3 negative impact on finding models that meet the law's
4 criteria for expansion.
5 Similarly, it could constrain CMMI's ability to
6 develop models that are tailored to meet the needs of
7 subgroups of providers and beneficiaries.
8 As part of a desire to reduce the number of
9 models being implemented, some Commissioners have said CMMI
10 should focus more on models that show the most promise.
11 Therefore, the second policy option would be for
12 CMMI to only develop second-generation models if one or
13 more of a set of specified criteria are met within a given
14 time frame.
15 The criteria could include clear and evidence-
16 driven metrics related to changes in spending, improvements
17 in key health outcome measures, and how well a given model
18 aligns with other models that CMS is implementing.
19 Such a process would make decisions about which
20 models to continue and relaunch more transparent and
21 objective.
22 It could also help reduce the overall number of

1 models by discouraging CMMI from implementing multiple
2 generations of models that have consistently failed to meet
3 expansion criteria or other policy goals.
4 A potential disadvantage of this policy could be
5 to create incentives for CMMI to put its focus on models
6 that will meet the continuation criteria, rather than
7 achieving the statutory goals of reducing spending without
8 reducing quality or improving quality without increasing
9 spending.
10 The policy also might not provide CMMI with
11 sufficient time or flexibility to fully test potentially
12 promising approaches if they fail to meet the continuation
13 criteria.
14 The third policy option addresses concerns among
15 Commissioners that CMMI is making too many unplanned
16 changes once models are being implemented. Unplanned
17 changes are mid-course changes that CMMI makes which were
18 not included in the model's original specifications.
19 There are a range of ways this policy option
20 could be carried out. One way would be to simply freeze
21 all of a model's parameters and rules for the life of the
22 model once it is launched. Another approach would be to

1 make only minor technical changes to a model in the field,
2 but this raises questions about what kind of changes would
3 be considered "minor." Another option would be to apply
4 changes only to subsequent cohorts of model participants
5 and allow the initial cohort of participants to continue
6 under the original parameters.
7 Although the specifics of this policy would need
8 to be worked out, it should help make models simpler and
9 less burdensome for participating providers.
10 The policy would also make models more stable and
11 predictable, which could encourage more providers to make
12 investments in infrastructure and care improvement
13 initiatives.
14 On the other hand, if there are flaws with the
15 model and CMMI doesn't address them, providers may exit
16 models, in which case participation would drop.
17 If the problems with a model lead to increases in
18 spending or other negative effects, and CMMI's doesn't have
19 the ability to fix those problems, CMMI would either need
20 to let the flawed model continue or shut it down
21 prematurely.
22 Now that we have walked through some pros and

1 cons, I will circle back to the three top-line policy
2 options.
3 Based on today's discussion, any policy options
4 that Commissioners would like to pursue will be presented
5 for further consideration at a meeting this spring.
6 We are happy to answer any questions you might
7 have and look forward to your input.
8 I'll now turn it back to Mike.
9 DR. CHERNEW: Geoff, thank you, and, Rachel,
10 thank you.
11 So I'll take Round 1 comments in a moment, but
12 before going to Round 2, I have a for example people in the
13 queue. Let me make a general introductory point, given how
14 much I care about this topic.
15 The first point is the main goal that I see here
16 is that we think through the policy directions to try and
17 figure out where we might want to go this cycle for a
18 recommendation. I will tell you I'm particularly
19 interested in the first point about having a coordinated
20 set of models, what I would call "changing the basic
21 paradigm of what's going on." But obviously, comments on
22 the other two are really important. So the first point is

1 getting to recommendations.
2 The second one is please understand that as we do
3 this, I view this as a multi-cycle activity. So some of
4 the things we might want to do, we will be picking up again
5 in future years. There's only so much, I think, we're
6 going to be able to do right now and lots to be done.
7 The third point I'd like to make is there are
8 many important points I'd really like to hear from you all
9 about things that might actually show up in the commentary
10 of a chapter, even not directly in a recommendation. So I
11 have a lot of thoughts on the literature of what we know
12 and where we should go, but I'm going to hold them to
13 myself for a moment and see as we go through the questions
14 and get your feedback on those particular things.
15 So in Round 1, I think, from your message, you
16 had a Round 1 question, and I see Sue has a Round 1
17 question. So let's go Marge and Sue before we start Round
18 2.
19 MS. MARJORIE GINSBURG: Okay, great. Thank you.
20 I'm interested -- I don't know if we have ever
21 talked about this vis-à-vis this whole topic, and that is
22 the extent to which physicians are both original Medicare

1 and Medicare Advantage, patients that cover both realms. I
2 ask this because I can't help but conclude that if
3 physicians have a foot in both camps that what they do
4 under MA may influence ultimately what they do under OM,
5 and it seems to me it would be very interesting to see the
6 extent to which the success of these models may be
7 influenced by the role that physicians have across both
8 domains.
9 The second question, which is sort of related to
10 that, is on page 10 of the report that shows the LAN
11 interest, where they show that Medicare Advantage, 30
12 percent, 50 percent, and 100 percent, the same as
13 traditional Medicare, but that's their goal.
14 So I guess I'm not sure. I always think about
15 this whole area as applying only to fee-for-service under
16 original Medicare, but maybe that's not true. Maybe this,
17 in fact, also pertains to Medicare Advantage plans, but
18 until I saw this chart and some of the write-ups, I never
19 got that impression.
20 So I don't know. Is that too confusion, the
21 questions asked?
22 DR. CHERNEW: Rachel and Geoff, can I jump in

1 with an answer?

2 [No response.]

3 DR. CHERNEW: I'll take that as maybe a yes. Can

4 you hear me?

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

6 fine.

7 DR. CHERNEW: So, first of all, I would argue --

8 and, again, Rachel and Geoff can correct me -- that most

9 physicians that are in APMs are probably also in an MA by

10 the nature of the way they work, and basically, physicians

11 serve patients from all over. If there's a lot of MA in an

12 area and there's APMs in the area, the physicians are

13 almost surely serving both. There may be some examples.

14 Kaiser, for example, might be an exception, but I'm not

15 even sure about that.

16 In any case, it's also true that there's clearly

17 spillover between physician practice patterns. If you

18 change the way physicians are practicing, in general, they

19 will change the practice patterns for other providers.

20 That means what MA does will spill over to fee-for-service,

21 and what fee-for-service does will spill over to MA. And

22 there's a lot of evidence, I believe, on that.

1 The third point is from an administrative
2 standpoint, the APMs are limited to people in the fee-for-
3 service sector. The Medicare Advantage plans, of course,
4 can pay physicians however they want, using whatever models
5 they want, but the models that we're generally talking
6 about here are in the fee-for-service sector. There are
7 some multi-payer-type models and some other things that
8 could conceivably be broader, but I think for the most
9 part, when we think about how Medicare is thinking about
10 alternative payment models, I think -- and again, I'm happy
11 if people want to be broader, but the way that I would
12 think of the gist of this discussion is changing the way
13 that Medicare fee-for-service pays providers, understanding
14 that those changes will influence care not only in Medicare
15 Advantage but frankly also in the commercial market. And I
16 think there's pretty strong evidence of that.
17 MS. MARJORIE GINSBURG: Well, if I may follow up
18 on this. So this is what I find confusing because I --
19 well, part of it is the use of our term "fee-for-service,"
20 which originally I thought only applied to original
21 Medicare, but we know that in Medicare Advantage plans,
22 physicians are paid fee-for-service.

1 DR. CHERNEW: Yes.
2 MS. MARJORIE GINSBURG: So now it starts to get a
3 little mucky.
4 DR. CHERNEW: Yes.
5 MS. MARJORIE GINSBURG: Are we assuming that --
6 DR. CHERNEW: Yes.
7 MS. MARJORIE GINSBURG: -- this whole discussion
8 is focusing on original Medicare, not Medicare Advantage,
9 or are we assuming, no, it has nothing to do with which
10 domain? It only has to do with how the physician is paid?
11 DR. CHERNEW: I think, Marge, the answer is we
12 use the term "Medicare fee-for-service" more to distinguish
13 it from Medicare Advantage as opposed to how the physician
14 is actually paid.
15 So, again, I'll let Geoff and Rachel jump in, but
16 for the most part of this discussion, you should assume
17 this is only what we might call "traditional Medicare," the
18 original Medicare. This is not really about how physicians
19 are paid in general. It is how Medicare outside of
20 Medicare Advantage pays the physicians. Medicare Advantage
21 can pay fee-for-service, as many do. Some don't. But this
22 discussion is the payment systems that Medicare uses

1 outside of Medicare Advantage and what we might call
2 "traditional Medicare," although sometimes that used
3 synonymally with Medicare fee-for-service, and that's not
4 really right.
5 Geoff and Rachel, did I say anything wrong?
6 MS. BURTON: I just want to chime in that
7 technically A-APMs include models by any type of payer. So
8 you can get the 5 percent bonus if you are in a Medicare
9 fee-for-service A-APM plus some other payers' A-APMs that
10 can help you reach the percent threshold you have to hit in
11 order to get the 5 percent bonus.
12 DR. CHERNEW: That's true, but the
13 recommendations I think we're going to be talking about are
14 largely going to be recommendations about how we should
15 design those models in the original Medicare system because
16 that's where CMS really has the authority of what they can
17 do. They can encourage things elsewhere and you're happy
18 to talk about.
19 But I want to keep moving along because there's
20 some other Round 1 questions. I think I've lost a little
21 bit of track of my list. Paul had a question, a Round 1
22 question, and Bruce has a Round 1 question. And I'm going

1 to keep looking, and I have several for Round 2.

2 DR. PAUL GINSBURG: Okay. I'll begin. I learned

3 a lot from your paper and presentation, and it was really,

4 really good work.

5 You know, thinking about the strategy, the

6 strategy is to get as much of the delivery systems into

7 good models, presumably as fast as possible, but your

8 presentation was just talking about different models. You

9 know, you go from first generation to second generation,

10 and my question is, is the legislation that authorizes CMMI

11 -- is that very restrictive, perhaps too restrictive as far

12 as CMMI's ability to move the system into the successful

13 model so that if there's a successful first generation,

14 perhaps the second generation is mandatory and no longer an

15 experiment, or is it just the way that CMMI has been run,

16 not to be eager to progress into models that are part of

17 the system?

18 MS. BURTON: I think that CMMI --

19 MR. GERHARDT: Well --

20 MS. BURTON: Go ahead, Geoff.

21 MR. GERHARDT: I was going to say the authorizing

22 legislation gives CMS or CMMI a lot of leeway in terms of

1 implementing and testing models. It doesn't put a lot of
2 parameters around those. It doesn't have a lot of language
3 around what they need to do to demonstrate that a model
4 should be tested or continued or turned into a second
5 generation.
6 The restriction really comes in in terms of its
7 ability to expand the model in scope and duration, and
8 that's where that test comes in about saving money,
9 improving quality, or some combination thereof, and the
10 requirement that it be looked at by OACT and approved by
11 OACT.
12 But before that stage, they have a ton of
13 flexibility in terms of what they can do.
14 DR. CASALINO: Mike, very briefly on this point?
15 DR. CHERNEW: Go ahead, Larry.
16 DR. CASALINO: Yeah. I think Paul was asking, if
17 I understood what he was asking, a slightly different
18 question, which is fairly subtle. It's one thing to meet
19 the criteria for expanding the model, but this could be a
20 model that is made permanent but that not everybody has to
21 participate in.
22 I think Paul was asking if CMMI had the authority

1 to make a model permanent and mandatory for everyone that
2 would be -- all providers that would be eligible for the
3 model, so to speak. I think it's a little different
4 question than we usually talk about, which is what are the
5 criteria for making a program permanent. Paul is asking
6 can they make it mandatory, and I don't think they can.
7 Can they, or can't they?
8 MR. GERHARDT: They essentially can. The home
9 health value-based purchasing model, it's not really an
10 APM, but it was just approved to be expanded from a select
11 number of states to all states and all home health
12 providers in those states. So, essentially, that can be
13 expanded not just nationally and permanently but also to
14 all providers.
15 DR. CASALINO: Okay. So they have two options
16 that are not mutually exclusive? They can do one, the
17 other, or both? They can make something permanent -- well,
18 they can make it permanent and mandatory or permanent and
19 not mandatory, I guess? It partly depends on what the
20 program is and if that providers are included, I guess. Is
21 that correct?
22 MR. GERHARDT: Yes.

1 DR. CHERNEW: Okay. I was wrong about Bruce's
2 comments in Round 2, but I see that Sue Thompson has a
3 Round 1 question. So, Sue, you're up.
4 MS. THOMPSON: Thank you, Michael.
5 My question does relate to the question that Paul
6 asked, I think, and it's probably even more basic. But do
7 we know by model how many providers have participated in
8 the various models that CMMI have proposed? Going back to
9 the pioneer and then through the years, what do we know
10 about the growth, the increase in numbers of providers that
11 are participating? Are they employed? Are they part of a
12 system? And what other characteristics are happening? I
13 think that's one of the sort of basic components that would
14 be good to understand.
15 And depending upon how we're going to measure
16 success here, but certainly, as we work to get -- and it's
17 probably a Round 2 comment, but as we're working to move to
18 value, it just strikes me to understand really well. How
19 are we pulling in more and more providers to this work? Do
20 we know that? Do we know those numbers?
21 MS. BURTON: I can take this. We know how many
22 providers are in each model, and usually, evaluation

1 reports will provide some descriptive statistics, breaking
2 out what we know about the providers, like what types of
3 providers they are.
4 What we don't know is how many clinicians in
5 total have ever been in an CMMI model because they're kind
6 of counted separately, and they don't kind of link up
7 across all the models to figure that out.
8 MS. THOMPSON: Thank you.
9 DR. CHERNEW: Okay. Dana Kelley, I think that
10 finishes our -- oh, Larry, do you have another Round 1
11 question?
12 DR. CASALINO: My other one was a clarification,
13 but yeah, this is very brief.
14 Rachel and Geoff, in terms of evaluation of the
15 model, CMS has their own evaluators, but it probably would
16 be a useful thing if other people could evaluate the
17 programs as well, as has been done to some extent, for
18 example, with the ACO program.
19 With some of the programs I know, like the ACO
20 program, it is possible -- you basically have to know for a
21 program, what organizations are in it and what physicians
22 are in it, right? You have to basically know the NPIs so

1 you can evaluate the program.

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

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

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

21 So I would say it seems like a little bit more
22 than the majority of programs seem to be evaluatable, if

1 you will, by these external researchers, but there are
2 some. For example, CPC, CPC+, they have not published
3 those lists. So if you go looking for evidence for those,
4 you'll note that there's the evaluation reports that were
5 done, but there are no external researchers who have been
6 able to study that program, to my knowledge.
7 MS. BURTON: And it's probably above my pay grade
8 to opine on whether the data sets should be available for
9 external research.
10 DR. CHERNEW: Yeah.
11 DR. CASALINO: That was kind of a backhanded way
12 of giving a Round 2 comment into Round 1, but we can talk
13 about it later, maybe.
14 DR. CHERNEW: Okay.
15 So, actually, I will say, just as an aside as
16 someone who's done this, there are a lot of external
17 evaluations of ACOs. I've done a large number of them
18 myself. I can tell you my personal view is unambiguously
19 that population-based payment models save a little bit of
20 money net. There's been a lot of evaluations and episode-
21 based payment models. Amol has done a lot of those. So
22 I'll defer to Amol who is going to talk in a minute, but my

1 read of that aperture is in certain types of episode, they
2 unambiguously save money. But across the board, it's not
3 clear that all episodes would save money, and advanced
4 primary care is a much more challenging area. That's my
5 view of the literature. That's based on both the official
6 evaluation and these external evaluations, a very, very
7 active academic group of researchers working on
8 evaluations.
9 That said, Amol, I hope I didn't steal any of
10 your thunder, but you're going to be first. And then we're
11 going to go to Jonathan.
12 DR. NAVATHE: Great. Thanks. No, no, Mike, you
13 didn't steal any of my thunder.
14 First off, let me just express a lot of support
15 for this line of work. Rachel and Geoff, you guys have
16 done a very nice job of laying out a lot of information.
17 As Mike just alluded to, there's a tremendous amount of
18 activity here within CMS but then also kind of studying
19 what CMS has done, and you guys have done a very nice job
20 of synthesizing it. So thank you for that.
21 I also appreciate the direction that we're going
22 generally, which is to broaden our aperture around APMs and

1 to consider APMs overall, in fact, payment reform overall,
2 and I think that this general direction, I'm very, very
3 supportive of.
4 That being said, I would like to highlight kind
5 of six big points, and then I'll jump into them. First, I
6 think we should be clear from a framing perspective that
7 what we're talking about here is really Medicare payment
8 reform. It's broader than CMMI. So perhaps we don't want
9 to restrict ourselves to CMMI and how we frame this.
10 Second big point is -- and I'm going to jump into
11 each of these with a little bit more narrative shortly.
12 Second big thing is I think it might be time for us as a
13 commission to revisit and revamp our value-based payment
14 principles that were alluded to earlier or were mentioned
15 early in the paper.
16 Third point -- and we talked about this, I think,
17 earlier in the earlier APM sessions that we've had -- it
18 may be very helpful at this point for MedPAC to help offer
19 a strategic plan over, say, the next decade for payment
20 reform, maybe not that long, but I think that could
21 actually be very helpful to Medicare and CMMI.
22 Fourth point, there may be some reasons to

1 suggest or recommend to Congress to change the CMMI, to
2 adapt the CMMI statute, now that we're entering the second
3 decade of CMMI, particularly in terms of shifting its focus
4 from being kind of purely a testing entity to one perhaps
5 that is consolidating lessons from the last decade and
6 trying to be more strategic against key goals. For
7 example, should CMMI actually be at least in part trying to
8 address issues around the hospital trust fund solvency or
9 affordability long run?
10 Fifth big point is I strongly, personally,
11 believe that we're missing equity as a focus. I do believe
12 there is a way that it fits into the CMMI statute, and I'll
13 talk about that later.
14 And then the last point is I think this work is
15 incredibly important. I think it's fundamentally critical,
16 and in fact, there may be some really key ways that we can
17 offer criteria or principles that could be fundamentally
18 important to how CMMI and CMS are able to run their
19 programs, in fact, to cancel programs because of some of
20 the challenging, other stakeholder and political
21 environment factors that exists.
22 So I'm trying to take each of these and not take

1 too long. So broader than CMMI, I won't say any more than
2 that. I think that we should just widen the aperture here
3 and realize that this is CMS payment reform. Many
4 programs, notably MSSP, is not within CMMI, so I think it's
5 just a fit issue.
6 Second point, so we need to revisit, revamp, and
7 refresh the Commission's principles on value-based payment.
8 Right now, when I take a look at those principles, they
9 seem kind of like having blinders on and looking at one
10 model at a time. The reality here is we have a portfolio
11 of models. And so how would the Commission recommend, at
12 least in terms of principles again, the way that these
13 models should function? What should their goals be? What
14 are the types of metrics we should use? Just like we've
15 done other work, I think, that has been really foundational
16 and guides all of the rest of the MedPAC work, I think we
17 can actually take a step back and kind of revisit that in a
18 way that would be very impactful, and, in fact, for us, as
19 the Commission, over time be helpful to ensure that we're
20 consistent against a set of principles that we lay out
21 ourselves.
22 The three areas, the three policy options that

1 we've laid out here I think are three critical policy
2 options, and I like all of them. That being said, I also
3 think it may make sense for us to take a step back, because
4 each of these cascades into a whole other set of issues,
5 and it may be actually quite challenging to take on one of
6 these issues without taking on other related issues.
7 So, for example, if you look at the first one,
8 which I agree with the policy option recommendation
9 language here, implement a smaller suite of coordinated
10 models, that sounds great. I would be 100 percent behind
11 it. But the question is, so what is that smaller suite of
12 coordinated models? How do we determine whether a model
13 is coordinated or not? What does that actually mean?
14 So I think there it's important that we perhaps
15 take a step back, pick one of these, and then recognize
16 that there's a whole litany of other factors that are at
17 play here that we may not be able to immediately address in
18 this chapter, for example, in 2021, but that may lay the
19 foundation for where our work is going. For example,
20 overlap between models would be important. We know risk
21 adjustment, benchmark setting, mandatory participation
22 versus voluntary participation. I won't go through a

1 checklist. I have actually made one and I'm happy to share
2 it. But I think the principle is an important piece here.
3 The fourth point I mentioned was shifting the
4 focus for CMMI. CMMI, as I understand it, in the first
5 decade, was extraordinarily successful in a proof of
6 concept of can we test models, and can we test a variety of
7 models that touch primary care, specialty care, post-acute
8 care, hospital care? There are so many models that it's
9 very impressive what's been done to date.
10 But now we have lessons from the last decade to
11 actually learn from and to guide where we're going in the
12 future. And I think there could actually be some language
13 that we could recommend to change the statute just a little
14 bit to acknowledge that there could be more of a strategic
15 decision-making from CMMI around which models to test and
16 how we might select those. In particular, as I understand
17 it, there is language in the statute now committing CMMI to
18 testing a certain volume of models in terms of dollars.
19 That may or may not make a lot of sense.
20 So I would submit to you all that maybe we should
21 consider recommending a slight change to the language of
22 the statute for flexibility that we could recommend to the

1 Congress.

2 The next point I had was missing equity. I think
3 COVID has obviously laid bare inequities. These are
4 inequities that have existed. One of the challenges,
5 perhaps, is in CMMI statute there is no specific language
6 on equity. One thing we could do is recommend to change
7 that. Another thing is there is quality language within
8 the statute, and equity, I think, is fundamentally
9 intertwined with improving quality, particularly improving
10 quality for populations that face health care and outcome
11 disparities.

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

17 The last point is just highlighting the
18 importance of our work. I think in my experience working
19 with CMMI, formally and informally, it seems incredibly
20 difficult to cancel models once participants are in a model
21 and you've had a stakeholder community move behind it. I'm
22 using this as an example of why our work could be so

1 important. If we could lay out things like criteria on how
2 CMMI could make decisions around that, that may actually
3 provide the right external validation, if you will, of
4 decision-making that could enable those kinds of difficult
5 decisions that perhaps otherwise would be too challenging.
6 So thank you so much for listening, and I look
7 forward to the coming dialogue here, and once again, Geoff
8 and Rachel, thank you so much for a great chapter.
9 DR. CHERNEW: So we are about to go to Jonathan
10 but Amol, there was a ton there, so I want to jump in to
11 help direct the conversation. Many of your points -- and
12 we'll consider all of them -- are things that we can write
13 about in the chapter about things that are important but
14 don't necessarily flow into a recommendation. There were
15 some things that were very specifically I can see them
16 going into a recommendation, things like coming up with a
17 somewhat different paradigm for how they think about APMs
18 as opposed to test and launch, test and launch, and discuss
19 that. I very much believe that, and it sounds like you
20 believe that too, and I think we can continue to go in that
21 direction.
22 The issue about the specifics, exactly what that

1 set of models should look like, my personal view is that's
2 going to take us another cycle to get to, because that's
3 going to require a lot of analysis. I'm scared of your
4 checklist, Amol, but I'm not going to dwell on it now. We
5 will have to get there, but it will probably require a lot
6 to get to real recommendations.
7 So that's my current thinking. So for the other
8 Commissioners, as you talk, it would be useful for me to
9 understand how you feel about that one particular point,
10 which is a sort of not just fewer models but fewer models
11 done in a harmonized way, if that makes sense, as opposed
12 to test-launch, test-launch, test-launch, and introducing
13 an ever-expanding number of models. I would like people's
14 thoughts on that.
15 The first person who is going to give thoughts on
16 that, plus any other thoughts, is going to be Jonathan.
17 DR. JAFFERY: Great. Thanks, Mike, and I also
18 want to just thank Rachel and Geoff and the rest of the
19 staff for the chapter and the discussions we've been having
20 this whole cycle. This is a really important topic, one I
21 care a lot about, and I think there's a ton of interest and
22 excitement across the provider community as well, and so

1 it's really important that we keep helping make this work
2 better.
3 I want to make a few quick comments about sort of
4 three different areas, and then jump into, quickly, comment
5 specifically about these two policy options, including
6 addressing exactly what Mike just asked about.
7 The first thing is around some thoughts about
8 program design and evaluation. This kind of builds on a
9 number of things that Amol was saying about helping form a
10 strategic plan for CMMI, or I think one of the things we've
11 talked about is a concern over it's not clear what the
12 overarching vision is at this point. And like Mike was
13 saying, I don't think that we're going to get to all of
14 those specifics this cycle but we can start to. And there
15 may be some elements that we want to be very specific
16 about, like should models be mandatory. You know, Paul has
17 commented in the past, I think, about DRGs, and I don't
18 want to say that these are exactly the same kind of thing,
19 but if DRGs hadn't been mandatory -- if they were voluntary
20 we still wouldn't have them in the way we have them now.
21 So we should think about that.
22 My understanding, in looking on page 5, the

1 figure in the reading, it seems to suggest that the
2 evaluators, thinking about the question about researchers
3 doing evaluations, the evaluators are selected after the
4 model design and implementation approach is described. And
5 I'm not sure to what extent that is, in fact, how it works,
6 but if it does, I think there is a specific thing that
7 might be helpful for us to think about evaluation. It's
8 always struck me that that has been an issue policy program
9 implementation, that if those evaluators aren't involved in
10 discussions up front it makes it more challenging to get
11 some good evaluations.
12 And then I think one other principle is thinking
13 about, when we talk about net savings how holistic can we
14 really be? I mean, we've had some discussions about that
15 but, as an example, when we look at ACOs, what is the
16 impact on MA benchmarks? We've talked about that with the
17 Commission before, but I don't know that I've seen that as
18 a principle in terms of evaluations. And so that's a
19 factor.
20 The next area is about the too many models. And
21 so I absolutely think there are too many models. I wonder
22 about PTAC's role and if that kind of exacerbates this

1 notion of lots of different models out there. And I worry
2 that it might be a little bit disengaging for providers and
3 others to be asked to put in ideas for models that, as was
4 noted, don't get taken up. So obviously they could be
5 taken up in the future, but I think that complicates
6 things.

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

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

21 Also talk about the payment model incentives
22 being hard to understand, and I think to quote the chapter,

1 it may require substantial changes in provider workflow,
2 infrastructure, and behavior in order to be successful, and
3 that's absolutely true. So every time we change these
4 models that does end up causing people to think about
5 altering their workflows, and that's very difficult to keep
6 track of.
7 So to speak to these three policy options, I
8 think they are all important to be thinking about. Number
9 one is the clearest to me, that implementing a smaller
10 suite of coordinated models, to me, a set of strategic
11 goals is super important, and I just want to make sure we
12 call out that that needs to include MSSP and how CMS runs
13 that.
14 I'm a little less confident about the second-
15 generation model issue. I do think we need to think about
16 specific criteria. Clearly we don't have those fleshed out
17 now. But I think there might be a first-order question
18 here as well, and that is, what does it mean to be a
19 second-generation model? So if direct contracting is a
20 second-generation model after Next Gen, I'm not sure that's
21 always clear to me how one thing follows, because as we
22 were talking about direct contracting earlier today, there

1 are a number of elements that are sort of brand new and
2 very, very different. And I can see how a Next Gen program
3 could build on some of the direct contracting but in other
4 ways I struggle to think about that as a second-generation
5 model.
6 And then the final point, reducing or eliminating
7 changes, again, I think we will need to flesh out how
8 exactly we would set those criteria of what a reduction
9 would mean and how big a change could be made. But I think
10 that's absolutely true as well, that it's very challenging.
11 And this gets to a previous comment about infrastructure
12 changes and workflows. Every time these things change it
13 causes providers to have to rethink some of those things,
14 and some of the issues may just be timing. So if there's
15 going to be a programmatic change, what's our philosophy
16 about how long providers would need advance notice to
17 eliminate those changes? Sometimes we get significant
18 changes that are going to be in place just a couple of
19 months ahead of when they're announced, and that makes
20 making those adjustments very, very challenging.
21 So again, thanks for a great chapter and for the
22 opportunity to comment.

1 MS. KELLEY: Mike, we can't hear you.
2 DR. CHERNEW: I was saying we have Brian, and
3 then after Brian we have Betty.
4 DR. DeBUSK: Thank you, and I'd like to echo the
5 other comments. This is a great chapter and I'm really
6 excited that we're addressing this topic.
7 I think the chapter touches on a pretty
8 interesting tradeoff between trying to address the model
9 fibrillation that's going on right now, because to me
10 that's what it feels like, is sort of a fibrillation,
11 without hamstringing CMMI so that it can still pursue its
12 mission of innovation. So there is a tradeoff there, and
13 it gets specifically to the policy options.
14 I like and support the fewer models idea. I'd
15 like to propose an adjustment to that. I think when you
16 say "fewer models" there's broad agreement that we need
17 fewer models. But I think everyone who agrees is going to
18 make the assumption that it's not their model that gets
19 cut. And Amol, I'm going to pick on you. You know, I
20 think if we said, "Gosh, we need fewer models, let's cut
21 episodes," that probably wouldn't be the direction -- that
22 isn't the cut that you're envisioning.

1 But what I would propose is maybe we consolidate,
2 and this is just illustrative because, Michael, I realize
3 this is a downstream cycle issue, but just illustratively,
4 let's say we agree, number one, that we're going to
5 standardize everything that we can standardize. So, for
6 example, the waivers. Why don't we go ahead and
7 standardize the waivers across all the models, and maybe
8 even do that in statute, so participants know that those
9 aren't going to vary from model to model?
10 But beyond that, what if we had, say, three --
11 and again, this is illustrative -- three categories, maybe
12 an episode category, an accountable care category, and some
13 type of primary care or chronic care category. And then we
14 focus on standardizing how those three compartments work,
15 so, for example, how the savings are split between the
16 models. And if you did that, I think you'd get some of the
17 feature, you'd see a lot less sprawl, you'd see a lot less
18 complexity, because if a new episode model was launched, I
19 would know it still has to adhere to the rules, when it
20 interacts with an ACO model, for example, with attribution
21 or shared savings or whatever facet you want.
22 So maybe we categorize models, standardize the

1 interaction between categories, and then just see what the
2 appropriate number of models in each category would be.
3 Because, for example, episodes might have quite a few
4 submodels within that broader category.
5 The second policy question, about doing a second
6 generation or a second launch of a model, I'm not sure that
7 that's something that we can even effectively work on,
8 because how do we differentiate a model that maybe
9 struggled and they want to relaunch it in a second phase
10 versus an all-new model? You know, let's say there was
11 something that would keep you from doing, say, CPC+ once
12 you've done CPC. Well, what's to keep them from launching
13 something that looks a whole lot like CPC or CPC+, just
14 calling it something differently?
15 So I was a little concerned about that second
16 policy option, because it almost seems like we could get
17 into hair-splitting over, well, what's the definition of a
18 new versus a relaunched model.
19 And then for the final policy option, this idea
20 of doing model changes. I saw this in BPCI. A lot of the
21 orthopedic physicians got really frustrated with
22 adjustments to the original BPCI program. And here's what

1 I would propose. Let's steal a page from the Medicare Part
2 D midyear formulary change procedures. If I remember
3 correctly, plans can make midyear changes to formularies
4 that are beneficial, but they can't necessarily make
5 changes that are detrimental.
6 So imagine if you're participating in an APM, if
7 an adjustment needs to be made that is beneficial to the
8 participants, let's create a very easy track to do that.
9 But then if an adjustment had to be made that was
10 detrimental, I don't think you allow those midyear -- I
11 mean, if a model is just so fundamentally flawed and we
12 missed it that it needs a dramatic midyear adjustment for
13 financial solvency, my question would be just cancel the
14 model and relaunch it.
15 But those are my three comments on the policy
16 options, and again, thank you. I really enjoyed this
17 chapter.
18 DR. CHERNEW: Brian, thank you. We're up to
19 Betty.
20 DR. RAMBUR: Thank you so much. Thank you so
21 much to the staff and the comments from the Commissioners
22 I've heard so far. Of all the many important pieces of

1 work that MedPAC does, I personally think this is one of
2 the most important for the longest potential impact, and
3 I'm just going to limit my comments for now to the first
4 item.
5 I would definitely support smaller, coordinated,
6 provided it's associated with unrelenting momentum towards
7 mandatory models with substantial risk sharing or full risk
8 bearing. I think that that -- I strongly support that. I
9 know there's a lot of work to figure out how that would
10 work, but I strongly believe until providers have to do it
11 many won't, and when they have to they will.
12 One of the things I liked a lot about the MIPS
13 piece -- and I wasn't there for the conversation of your
14 earlier decision -- is that one way or another, providers
15 were going to be taking on more accountability for costs
16 and outcomes. They either might do it consciously through
17 a qualified alternative payment model or over time through
18 the rewards of the penalty in MIPS. And so I think that
19 that clarity is so important, and obviously MIPS didn't
20 provide the clarity, but to have fewer and clearer and have
21 that momentum be really unrelenting towards real change
22 would be something I'd be very excited about.

1 Thank you.
2 DR. CHERNEW: Betty, thank you. Next we have
3 David, who is going to be followed by Bruce.
4 DR. GRABOWSKI: Great. Thanks, Mike, and thanks
5 to the staff for this great work. I'm also very supportive
6 of the direction that this is going.
7 It seems like when it comes to testing these
8 APMs, CMMI is taking an approach of trying to maximize the
9 shots on goal with the hope that at least one goes in.
10 That seems great if you're playing soccer, not so great if
11 you're trying to reform payment.
12 You know, a large number of poorly coordinated
13 programs is obviously creating issues with overlap,
14 conflicting incentives, constructing comparison groups,
15 agency and provider bandwidth, issues around fixed costs
16 and probably lots of other things that are on Amol's
17 checklist. I feel pretty strongly, to use Amol's word of
18 "portfolio," that really a coordinated approach in which we
19 consider the entire portfolio is really the way to go.
20 And just to make one other comment, beyond the
21 construction of the portfolio, when do we make changes to
22 the programs that are in that portfolio, I've been very

1 confused over the last several years about why we've made
2 major changes to some of the programs, and I realize that
3 the MSSP, for example, is now permanent, but I think some
4 of the more recent changes to that model haven't been steps
5 forward necessarily. And Mike mentioned a lot of the work
6 that he and others -- I participated in some of that
7 research as well. All of that, Mike, predated the changes,
8 the pathways -- maybe there's been some more recent work,
9 but I think this evolution of the model and why the program
10 has taken the steps that it has isn't always clear. And so
11 it's not just the sort of fewer models and more coordinated
12 models, but also thinking about why we're making the
13 changes that we are. And I don't think that we've been
14 very deliberate in some instances, and I don't think we've
15 made changes that have necessarily moved the program
16 forward.
17 So I'll stop there and say thanks.
18 [Pause.]
19 DR. MATHEWS: Mike, we can't hear you.
20 DR. CHERNEW: Thank you. We have Bruce and then
21 Jaewon.
22 MR. PYENSON: Thank you, and my compliments to

1 the staff for putting together some really valuable
2 information. I have to say in listening to the discussion
3 that I'm not sure that these three points are quite the
4 options that we want, but I think the discussion is heading
5 in a very useful direction. And what jumped out at me is
6 the need for a clear set of strategic goals and the role
7 MedPAC could play in helping that develop.
8 You know, I have to say that the quality of
9 thinking that has come out of CMMI is much better than what
10 you find from private payers. But part of that is because
11 they have a billion dollars a year, so CMMI perhaps in the
12 world of real-world health care could be seen as like one
13 of the national institutes, like the National Institute of
14 Health, funding a certain kind of research and a certain
15 kind of development that the private sector wouldn't.
16 So it's kind of fascinating to see that emerge.
17 The question is: Are we getting the value that we should
18 or are we optimizing that? And there are a couple of
19 things, I think the strategic goals is really important to
20 optimize that. And part of that -- I've got a couple of
21 thoughts on that. One is really the necessity for that
22 kind of thinking to incorporate the non-Medicare population

1 as well. But that somehow has to be part of the work they
2 do, and I think in so many ways, if the programs for
3 Medicare are going to be successful, they'll be successful
4 if they also are useful to the commercial world or the
5 Medicaid world.
6 I think another issue from a program evaluation
7 standpoint is that understanding the value to the providers
8 is critically important, and I don't just mean shared
9 savings. I have the view -- perhaps it's an informed
10 anecdotal view -- that many of the advanced alternate
11 payment mechanisms are of immense value to the providers
12 and that CMS doesn't get as much value as the providers do
13 because they're looking at it from a shared savings
14 perspective.
15 Now, that's anecdotal. I think there's enormous
16 value in some of the behaviors and the ability to expand
17 markets or -- which is -- sometimes the term used is
18 "coordinate care." So I think the value to the provider
19 and understanding that is something that the assessments by
20 CMMI have to get into. And I haven't seen a lot of that.
21 Some of that probably gets into issues like related party
22 transactions or transfer pricing or a strategy and market.

1 But I think that's properly some of the work that program
2 evaluations need to do, especially if the thinking is to
3 transform the system.
4 Finally, I think an important issue that I
5 haven't seen a lot of work done on is scale and
6 scalability. And by that, I don't mean whether a
7 demonstration can be expanded nationally. What I mean is
8 what size organization do you need in order to have the
9 resources and the wherewithal to actually succeed? And in
10 that, people talk about the capital investment and other
11 kinds of investment, but I think probably bigger than any
12 of those is the need for leadership and the ability to
13 devote time and expertise, which is very hard in small
14 organizations to do that, which is one reason why something
15 like the Geo direct contracting entity might become much
16 more successful than others because of the kinds of scale
17 that Medicare Advantage plans, many Medicare Advantage
18 plans have.
19 So just to wrap up, I really think the discussion
20 that we've been having is really very good. I'm not sure
21 it's that consistent with these three policy options, but I
22 think putting them up there has created a really useful

1 discussion. So thank you.

2 DR. CHERNEW: Thank you, Bruce. I think now

3 we're going to Jaewon and then Pat.

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

5 point?

6 DR. CHERNEW: Yes.

7 DR. MATHEWS: So, Bruce, could you say a little

8 bit more detail surrounding the first things that you

9 raised? I think you said something like these are not

10 necessarily the policy options that we want. And the

11 reason I'm pressing on this point is when we last discussed

12 these, you know, the set of issues at the October meeting,

13 from my perspective at least, these were the three that had

14 the most support among the Commissioners to pursue to the

15 policy option and then potentially the recommendations

16 stayed. So if we've missed the mark, you know, just say

17 that, and I can take responsibility for that. But we did

18 indeed try to characterize where the Commission was in

19 October.

20 MR. PYENSON: Well, I don't think you

21 mischaracterized where the Commission was in October, but I

22 think these three points perhaps generated conversation. I

1 think Amol has offered, you know, perhaps six options or
2 six points, so I would say -- compliment the process that
3 these three points have created a terrific discussion. I
4 am especially struck by the interest in a clear set of
5 strategic goals and other roles that MedPAC can play. Does
6 that clarify?
7 DR. CHERNEW: Yeah, so let me jump in. Bruce,
8 that is helpful, but let me say, again, we will take this
9 whole discussion and see where we're going, and I plan to
10 summarize at the end. But given your comment, I'll say
11 something quickly now. Where I'm hearing a consensus
12 develop is, if you look at Option 1 in the blue there, it's
13 not just about what the strategic goals are. And, frankly,
14 I think the broader strategic goals of improving quality,
15 access, equity, whatever you want to say is the actual
16 goal, the key thing that I'm hearing is that we want to
17 have a system of payment models that will help us achieve
18 those as opposed to -- and I've said this before, and I
19 think Amol said this, but I honestly can't remember given
20 all that was said -- moving away from a test, test, test,
21 test, test to try and accomplish a specific thing. I
22 actually think at the end of the day the strategic goals

1 are not going to be that different from the overall
2 strategic goals that we would have CMS or CMMI have, which
3 is helping to control spending, helping to improve quality,
4 helping to make sure access is okay.
5 I think Amol's point about equity is very well
6 taken, but more broadly, getting them to develop strategic
7 goals or CMS to have strategic goals is important. Where I
8 hear a consensus working around is to develop -- and this
9 is the key word. I said this, I think, the last meeting in
10 October -- a portfolio of models to meet those goals as
11 opposed to a paradigm of just test, relaunch, test again.
12 I don't want to have a big debate on that point
13 right now. This is the policy option side. We will look
14 over the whole transcript and come back with something when
15 we come up with actual wording for a recommendation. But
16 that's the connection that I hear, at least for the first
17 one. Some of the other ones we'll also hear when we look
18 back in the transcript at what other people have said.
19 But I would like to move on to Jaewon.
20 DR. RYU: Thanks, Mike, and like many others, I
21 think this is a great discussion and great topic for us to
22 be tackling. I also feel very passionately about the area,

1 and thank you for the chapter, Rachel and Geoff.
2 I think these policy options feel directionally
3 like the right ones to me. I think just a couple
4 reflections as I go through them.
5 I think number 3, it feels like that should have
6 a little bit of a balance to it because I think it is
7 important, especially to the extent there are models that
8 are not as proven -- or not as established or mature, I
9 should say, for there to be an ability to be somewhat
10 nimble and agile and course-correct mid-flight, if you
11 will. And I don't know if that looks kind of like what I
12 think Brian was saying where maybe there's some caveats if
13 a change can be beneficial, either to the participants, to
14 the program, you know, maybe it limits the circumstances in
15 which those changes can happen. But I do think that
16 there's a balancing between setting it and then leaving it
17 for a while versus the ability to have some capability to
18 correct as you go.
19 I think on the first one, I firmly believe that
20 the smaller, simplified and, I think, Mike, you may have
21 used the term "harmonized" is exactly the way to go. I
22 think it helps to focus attention. And if we were to say

1 that a lot of these alternative payment models are intended
2 to spark the right delivery system transformation and
3 initiatives, I think the fewer, the better; the more
4 focused, the better.
5 I also think, though, it gets back to our MA
6 discussion earlier, where ideally it would be nice to have
7 better line of sight into how providers are paid by health
8 plans in MA because if we're trying to harmonize programs
9 and harmonize them so that the right care transformation
10 can happen in a more focused way, I think that goes hand in
11 hand with how the MA world pays providers and what
12 providers have as far as incentives in that world.
13 So those are just the couple comments that I had.
14 DR. CHERNEW: Jaewon, thank you. We're now going
15 to go to Pat, and after Pat will be Dana.
16 MS. WANG: Thanks so much. I echo the comments
17 that have been made about the quality of the chapter and
18 also the discussion, which has been great.
19 Two sort of high-level points, I guess, or
20 statements about the topic. One is it's been referred to
21 in terms of other payers. If the goal here is delivery
22 system reform, at a minimum the number of payment reform

1 experiments that states submit through 1115 waivers that
2 really are not kind of in sync with some of the things that
3 CMMI have done -- maybe they are, maybe they aren't. It
4 would be wonderful if -- and I realize fully that Medicaid
5 is a completely different legislative structure with the
6 states having so much more discretion on how they run the
7 program, how they set payment rates, et cetera. But I
8 think that one of the things that is missing from payment
9 reform overall, whether it's an 1115 waiver, CMMI, and
10 MSSP, is that there are not consistent signals to the
11 delivery system.
12 So I was going to suggest that, you know, within
13 this bucket of strategic goals, because I'm not sure what
14 that means, that we should seriously consider that signals
15 to the delivery system are consistent or thought through
16 and intentional throughout whatever models CMMI in the
17 future develops, and that the Medicaid side of CMS at a
18 minimum have these in mind, also somehow to bring some
19 perspective into some of the other demonstration projects
20 that are happening, because, you know, everybody has a
21 different experience with this, but if you're in a state
22 and you're doing Medicaid commercial and Medicare, the

1 delivery system has so many administrative burden on the
2 delivery system, which is in all these things is
3 unbelievable. And, you know, if the quality metrics used
4 were the same, if the sort of end expectation about, for
5 example, being able to manage a global risk arrangement in
6 the following area were the same, I think it would go a
7 long way to sort of moving the needle for the entire
8 delivery system, not just Medicare. And Medicare, of
9 course, is kind of the gold standard when it comes to
10 payment, so it has an incredibly important role to play in
11 leadership here.
12 I really appreciate Amol's inclusion explicitly
13 of strategic goals around equity. I think, you know,
14 people could talk about it being sort of implicit in all of
15 -- in access and all the rest, but I think it's very worth
16 sort of calling out and evaluating different general models
17 around whether or not they advance health equity.
18 I think that in the -- so the first principle
19 here I think is very much a good one. I would include in
20 strategic goals, as I said, perhaps more specificity around
21 signals to the delivery system, which would include how
22 things are administered, quality metrics, risk adjustment,

1 if there's consistency, and one message to the delivery
2 system, I think it will go a lot harder personally -- you
3 know, I run a Medicare Advantage plan, I run a Medicaid
4 plan. The quality metrics are more aligned between those
5 two programs, but when it comes to the ACOs, you know, it's
6 very burdensome because the providers are chasing a
7 bazillion different quality metrics, and it would be
8 wonderful if we could sort of align around the core set.
9 Some of the other principles, I guess, that I
10 would suggest just off the top are in the strategic goals,
11 you know, increased coordination of care, reduction of
12 avoidable per value care, inclusion of resources outside of
13 the medical delivery system. We have -- and I think it's
14 related to the equity conversation, but not limited to the
15 equity conversation. There are many other resources that
16 affect people's health that are not explicitly in these
17 models, and I just think it's something that perhaps could
18 be considered going forward.
19 The access, the desire to increase access is
20 critically important. I would love to see a little bit
21 more specificity around how that actually gets measured. I
22 think it's a critically important challenge for many

1 populations, appropriate access to care, and those are just
2 a few off the top of my head.
3 One hopes that the second and the third
4 principles here flow from the first, if it's done
5 correctly, and Amol and others have pointed out the
6 complexity of what coordinated models means. But just
7 speaking of -- so I hope that those -- like once you have
8 your base portfolio, that the second and the third buckets
9 become less volatile in changing your program.
10 I personally on the third point of eliminating
11 sort of mid-course corrections, it makes me a little
12 nervous because I think that people should always be able
13 to tweak if they see that something's not working. But
14 hopefully if the first bucket is set correctly, there won't
15 be as much need for it.
16 Thanks.
17 DR. CHERNEW: Pat, thank you very much, and I
18 very much agree with your point that, hopefully, the second
19 and third would flow from the first.
20 Dana Safran, and then we will have Paul Ginsburg.
21 DR. SAFRAN: Thanks, Mike.
22 And just piling on with my appreciation with

1 Rachel and Geoff for the excellent work here. This is so
2 important.
3 I'd like to make three points, and then I'll
4 comment on the policy options.
5 The first point I want to make is I think we
6 undersell a little bit in our tone, if not in our
7 substance, the real significant accomplishment that APMs
8 represent. You look across your Table 1, and you see far
9 more of the models than not did achieve gross savings.
10 Only a few didn't achieve any savings.
11 When we contrast that with the conversations
12 we've had over the past several meetings about the fact
13 that Medicare Advantage now in its third decade, fourth
14 decade still hasn't produced savings, I really think that
15 we can't have that double standard.
16 In addition, in the years that Michael and I were
17 working together on evaluating the Blue Cross Massachusetts
18 Alternative Quality Contract, there was always controversy
19 around gross savings and net savings, and absolutely, both
20 are important. But one of the things that I think we
21 rightly emphasized was when you see gross savings, you know
22 that behavior is changing, and that is an absolutely

1 critical accomplishment. I don't think we have any other
2 interventions we can point to that are producing behavior
3 change in the delivery system leading to gross savings.
4 The net savings are a function of how smart the
5 incentive models are, and that, we can adjust. But the
6 gross savings tell us we're pointing in the right
7 direction. So I want to make that point.
8 Second is that I think that the way that you
9 summarized the literature so far is very impressive and
10 helpful but still needs some enhancement, because all of us
11 know that there's been a lot of thought about, written
12 about, to some extent, studied on different features of
13 models and what makes a model work or not work. And to
14 some of the points that other Commissioners have made and
15 that I think Amol tees us up with in his thinking about the
16 future of CMMI, you really have to start to be able to
17 synthesize the lessons learned.
18 So I'd really like to see what do we know across
19 these models about two-sided versus one-sided risk, about
20 physician-led versus hospital-led models, about global
21 versus episode-based accountability, and also about single-
22 versus multi-payer, right? So I think there's a lot that

1 we need to start synthesizing about those kind of
2 characteristics. And also, that will actually help us with
3 your question about what some of the barriers to change
4 have been.
5 One of the barriers that I didn't see you mention
6 and that I know I mention almost every time we talk about
7 APMs, but I'll say it again, is that many organizations
8 have very mixed incentives. In particular, we've seen more
9 and more consolidation over this past decade. We have so
10 much of payment reform happening in the context of
11 hospital-led organizations, and hospitals for sure still
12 continue to have incentives that are volume-based.
13 So at least in the experience that I had when I
14 was leading this work at a large commercial plan, it was
15 very clear that those organizations would do as much as
16 they had to do to win in the model and achieve some savings
17 but not enough to actually hurt their own revenue that they
18 get from volume in the hospital side of the business.
19 Ultimately, we, MedPAC, and CMS have to address
20 payment for hospitals and the mixed incentives there. I
21 have pointed to that, I know, before, but I'll just
22 continue to.

1 Then the third point is -- one thing I didn't see
2 us address that I think is really critical is the
3 importance of the next generation of quality measures,
4 because we all understand that we're trying to get a more
5 outcomes-oriented system. We've been saying for, going on
6 a decade at this point, that we need that next generation
7 of measures, but I don't see us making progress on that.
8 And it will be very hard to justify continuing to do value-
9 based payment if our measures of value continue to be
10 largely focused on processes of care as opposed to
11 outcomes.
12 On that point, I'll just make one small thing
13 about global payment versus global budgets. CMS and LAN
14 both really emphasize that fourth, whatever they call it,
15 Stage 4, Level 4, whatever it is, where it's capitated
16 payment, and I know there are many, especially our provider
17 colleagues, who will say how liberating and how important
18 that is. We can't lose sight of the fact that with that,
19 we lose access to claims data unless we can successfully
20 deal with dummy claims in ways that we haven't so
21 successfully done yet in the MA system.
22 So those were my three points, and then I'll be

1 very quick on your three policy options. I would say
2 absolutely yes to number one. Like the other
3 Commissioners, I'm all in favor of more coordinated models
4 and in fact really loved Amol's articulation of offering a
5 strategic plan, and Michael's reference to that is
6 harmonizing. I'd say let's also harmonize with Medicare
7 Advantage. Pat started to point to that. We shouldn't
8 have just different ways that we do risk adjustment,
9 different ways we set benchmarks, different ways we measure
10 quality. We can harmonize some of those things, and we
11 should.
12 Second, I think it depends on your number two,
13 and so I'll just leave it there on that.
14 And then on the third, I'd say we should reduce.
15 I don't think we can eliminate changing model features once
16 they're in the field, and I kind of thought your Points 3B
17 and 3C on your slide were right based on my own experience.
18 And what I mean by that is we had five-year contracts, and
19 we made a commitment not to change things midstream once it
20 was in motion for a provider cohort unless there was
21 something we discovered that was really wrong with the
22 model. Honestly, the only things we changed were things

1 that were wrong that we could see were hurting provider
2 success, and so I think those are where your 3B point about
3 making tweaks once things in motion, but not planning to,
4 not the way that quality benchmarks were at least in the
5 early years designed to change every year because the way
6 that they were set were based on last year's performance.
7 That just makes such an impossible task for those who are
8 trying to plan the resources for improvement.
9 And your point 3C, I think, is exactly right,
10 that as you launch the next cohort, then you can, you know,
11 change the model and continue to evolve it with lessons
12 learned.
13 So I hope those are useful points. Thanks very
14 much for the opportunity to comment on this important work.
15 DR. CHERNEW: Dana, thank you.
16 We're going to go to Paul Ginsburg, then Sue
17 Thompson.
18 DR. PAUL GINSBURG: Okay. Thanks, Mike.
19 I think in this area, what we're seeing and what
20 I'm very much in favor of is MedPAC shifting its focus from
21 some very concrete details issues to strategies? Because
22 as Amol said, I think there is a need to change the CMMI

1 approach away from just doing a lot of testing and coming
2 up with better and better models towards seeing itself as
3 having a strategy to get as much of the delivery system as
4 possible into an environment where they'll perform better
5 potentially as quickly as possible.
6 So when I look at the three policy options, I see
7 number one as really a strategy, something I'm very
8 enthusiastic about, but numbers two and three, with your
9 tactics -- and I don't think it's worth as much of MedPAC's
10 time to be focusing on them as on strategies. I really
11 like the idea that AMOL suggested other strategic plan for
12 not just CMMI but for CMS, for the entire effort.
13 And final comment is on equity. I'm intrigued
14 with adding equity as one of the key goals. To me, it
15 seems as though the legislation that authorized all the
16 work on alternative payments was enacted today rather than
17 saying years ago it would have included equity. It's an
18 issue about how to operationalize that.
19 But, anyway, I think we've had a wonderful
20 discussion today, and I think with the work in the papers,
21 it really set us up to have some better impacts.
22 DR. CHERNEW: Paul, thank you.

1 So we're going to go to Sue Thompson and then
2 Larry.
3 MS. THOMPSON: Thank you, Mike.
4 Yes. Thank you for this very good chapter.
5 There's been a lot of great conversation. I feel as though
6 I have the battle scars of having worked with CMMI since
7 its inception, having been a part of the Pioneer ACO and
8 then Next Gen and continuing on to today, working to come
9 to some conclusion about where do we go from here.
10 I know when we discussed this at our last
11 meeting, I was quite enthusiastic about the suggestion of
12 reducing the number of models and putting a lot more
13 framework around it, and as I read the chapter, I'm going
14 to maybe come up 40-, 50-, 60,000 feet, what's -- and as I
15 listen to the conversation today, I am conflicted about the
16 intention of the beginning of CMMI to be a warehouse of
17 innovation and to come up with as many good, great ideas as
18 possible about how to structure payment reform for our
19 country and how excited we were.
20 And yeah, as an innovation center, they've done,
21 I think, what they were asked to do. This was through two
22 very different administrations. We have a lot of ideas.

1 Some, we like; some, we don't. Some, we've tested. Some,
2 we've been very confused about. I've lived the war of
3 trying to figure out is this beneficiary in that model or
4 that model. Are we under some mandatory obligation to be
5 in this bundle, and if we are, is that in the context of
6 this ACO contract? And it is confusing, but that's the
7 messy business of innovation when we're trying to innovate
8 this payment structure in our country.
9 So as I listen to us attempt to put framework and
10 constraint and definition and strategy construct around
11 this innovation model, I just want to make sure that we are
12 aware of the consequences.
13 If you do any reading about innovation, roughly,
14 6 percent of ideas that come out of any innovation group
15 actually get to production -- 6 percent. In CMMI,
16 according to my rough checking into, I think they have
17 actually had 40 models, and of those 40 models, two of them
18 -- two of them have made it into actual CMS Medicare. This
19 is the real world we're going to go. That's 5 percent. So
20 they're operating at about roughly what innovation centers
21 do.
22 So as we think about these policies, I want to

1 make sure we're ready to move from innovation to mandate
2 and be very thoughtful about that. I feel conflicted even
3 saying these things out loud because I've lived the
4 ugliness of the difficulty of having to fit and sort and
5 wonder and be confused about where we're going to end up at
6 the end of the year. It is a front-line battle scar that I
7 feel I have on my chest.
8 So doing fewer models, we certainly need clarity
9 about the overlap that happens. So I would fine-tune the
10 fewer models to making very clear about where overlap
11 exists in these beneficiaries and in which world are we
12 operating.
13 There's certain criteria, I think, that follows
14 nicely in the question of fewer models. I don't have a
15 great deal more to say about the particular suggestion
16 around certain criteria, but in terms of limiting change
17 during implementation, when operating in these models, we
18 desperately needed to be able to constantly run PBCA and
19 modify and go back to CMMI with recommendations on what we
20 were finding and what we were learning through
21 modifications too. So I'm very cautious about supporting
22 limiting change during implementation.

1 So those are my comments, and I thank you for the
2 opportunity to make them here.
3 DR. CHERNEW: So let me jump in before we go to
4 Larry. Sue, that was very helpful.
5 I will say it is important, I believe, to
6 continue having CMMI be able to innovate. I appreciate
7 what you said about overlap. My concern has been that in a
8 world in which you want to let a thousand flowers bloom,
9 you won't get any of them to work. Even if you find four
10 that are great, they won't work if you plant them all in
11 the same hole.
12 Another thing to say is you might like the steak,
13 you might like the fish, you might like the pasta. Your
14 meal won't be that good if you have to eat all of them at
15 the same time. So I think that's sort of how I view the
16 thinking about this bit of coordinating and where to go.
17 That doesn't mean to stop innovation, but understand we
18 don't live in a world where the success of Model A, even if
19 it seemed to work well versus placebo, will work well if
20 you introduce in a world with Models C, D, E, and F for a
21 bunch of reasons. And I think we have to think through
22 that, and that's kind of the spirit of where we have to go,

1 I believe, on Policy Option 1, and a lot of that will have
2 to be in the text.
3 Relatedly, there's been a big discussion about
4 whether things should be mandatory or not or if we move
5 towards mandatory, and I think that's been a very good and
6 useful discussion. I think it's a very important
7 discussion to have.
8 I think we're not quite ready yet to talk about
9 that. That will have to be a next-cycle issue for two
10 reasons. One of them is I think we have to do a lot more
11 assessment and analysis, but also we can't mandate
12 something until we know what set of things we have so we
13 can decide what to mandate. So I think it is a sort of
14 second stage, not second order, but second stage thing that
15 fits a long with all the other issues, how do we set
16 benchmarks, how do we set quality measures, how do we set
17 risk adjustment, how do we set attribution, a whole slew of
18 other things.
19 So my hope is that at this cycle, we can get to
20 sort of -- I will have to spend some time thinking about
21 what strategic goals means or vision or harmonizing. There
22 will be some semantics in the next thing you read, but the

1 point is once we get that big sort of, what I would call
2 "paradigm shift recommendation," broadly speaking, don't
3 test launch, test launch, but instead, think about where
4 you want the system to go. We will then have a series of
5 strategic, much more concrete discussions, I hope, in
6 future cycles.
7 I don't know if that was clear. I didn't mean to
8 get into such a big summary before getting to Larry, but
9 you triggered me.
10 So, Larry, I'm sorry that you're post my being
11 triggered, but, Larry, you're up. As far as I can tell,
12 you also get the quasi-last word.
13 DR. CASALINO: Thanks, Mike. I'll try to leave
14 some time.
15 Geoff and Rachel, a big chapter to write. A lot
16 of information. A difficult chapter. You did a great job.
17 It's very informative. But I agree very much with the
18 first option as a direction. The further two, I think,
19 give us, as Paul said, some tactical thoughts for further
20 discussion, if and when we want to go there.
21 I do just want to give a compliment to CMMI, and
22 frankly -- well, let me just put it this way. I think more

1 is happening than we think, if we just look at the
2 evaluations. Provider behavior is changing, and Dana
3 talked briefly about the evidence for that. But more
4 broadly, at a higher level, I think that CMMI has been
5 instrumental in what I would call organizing an atmosphere,
6 and that is really important, even though it's kind of
7 fuzzy.
8 What CMMI has done -- and it's not just CMMI, but
9 I think CMMI has been probably the most important --
10 they've made it kind of a taken-for-granted thing in U.S.
11 health care that change is coming, that people have to pay
12 attention to costs and value, that population health
13 defines narrowly as your population of patients is
14 important, and you're going to have to get good at it. I
15 think that's really widely recognized now, and that's a
16 really important achievement.
17 Along with that there has been development of the
18 infrastructure within the delivery system, and within the
19 payer system, to some extent, to foster better results with
20 population health. So there's a concept in institutional
21 sociology called "taken for grantedness," and when
22 something becomes taken for granted, yes, of course, we do

1 that, that sends a signal of major change even if we don't
2 have evaluation data yet to show it. So I think that is
3 important.
4 Also, CMMI has given a cover to commercial
5 insurers, and I think that, in some way, we should point
6 this out early on in our chapter, first of all because it's
7 true and important, and secondly because I honestly think
8 CMMI will be much more interested in what we have to say if
9 we say this.
10 CMMI leadership is really important. If you look
11 at individuals' incentives, which I think is always
12 important to do, you know, if you're a CMMI staffer, what's
13 your job? Your job is to create models, right, and then
14 your job is to make them better. And if you're not doing
15 that, what are you doing?
16 So it's not surprising -- I think there are other
17 reasons, but it's not surprising that is we had large
18 tests, large tests, large tests, and I think the only way
19 that will change in an organization that has a billion
20 dollars a year is if leadership is cognizant of this
21 problem and really believes that the first option that
22 we're offering is the way to go.

1 I think, as Paul said, this work that we're
2 starting to engage in is a bit different from the work we
3 usually do. At least our most important goal here, the
4 first option we're talking about, is not recommending a
5 payment update or some relatively narrow thing. It's much
6 broader than that. I actually don't think we want to
7 advocate putting constraints on CMMI. So even if we could
8 come up with a good rule about thou shalt not launch a
9 second-generation model unless -- I'm not sure that we
10 actually want to do that, although it's worth talking about
11 when one should be launched, and then we may want to have a
12 role in that. So I would try to give them cover and ideas
13 for their strategic direction as more than narrow
14 constraints.

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

1 little attention to, and really in thinking about strategic
2 directions even.
3 Yeah, one that didn't come up is the size of the
4 incentives. They haven't been very large, and that can be
5 a reason for things not working very well. One or two
6 people have mentioned, and Dana, for sure, the problem with
7 when hospitals are involved it's always going to be pretty
8 hard to reduce utilization unless the hospital is part of
9 something that is fully capitated, if we want to call it
10 that way, to use that term, or fully budgeted or fully
11 paid. This is a huge issue and I think it gets mentioned
12 in a sentence in the text, but I think it should be called
13 out more explicitly.
14 And the last thing I'll say -- well, two last
15 things, very briefly. One is we haven't really talked
16 about how difficult it is, on the one hand, to limit the
17 number of models but on the other hand to include all kinds
18 of providers, you know, this specialty, that specialty that
19 wants to be included. I think that's a really important
20 issue. It's a hard one to solve, and I don't think we can
21 just talk about Option 1 without, in some way, coming up
22 with some ideas about that, if we can.

1 And the last thing I would say is that -- and
2 this is kind of a completely separate point -- I think a
3 lot of pressure should be put on CMS to make the data
4 available so that outside evaluators can evaluate models
5 and not just the ones they contract with. I realize there
6 are some issues with that with PECOS and so on, but I think
7 we would get better evaluations that way. And that's it.
8 DR. CHERNEW: Okay, Larry, that was terrific. I
9 would wrap up, although I think I already wrapped up. So
10 I'm just simply going to say to everybody thank you for all
11 of your comments. There is a lot for us to chew on. We
12 will be revisiting this with some text around a draft
13 recommendation come March, and I think, at least in my
14 mind, I have a direction to go which will prioritize
15 building on some of these comments and becoming more
16 specific around where we are on this Policy Option 1, and I
17 think we'll review those discussions with the staff and see
18 where we go on 2 and 3. There's obviously a lot of
19 tradeoffs but I do hear a lot of support for the idea of
20 putting a stake in the ground about where the paradigm of
21 CMMI should go going forward, and for anybody listening,
22 you should understand I'm a huge supporter of CMMI and what

1 they have done, and the progress that's been made. And the
2 question now is the most productive way to go forward, and
3 how we can be constructive in that.
4 DR. CHERNEW: So with that I'm going to say thank
5 you, take a deep breath, and we're going to move on to
6 another incredibly important topic, where I know there's a
7 lot of passion, which is telehealth. Ariel, are you
8 kicking us off, and it's Ariel, and is Ledia here?
9 MS. TABOR: Hi, this is Ledia. I'll be starting
10 off.
11 DR. CHERNEW: Oh, Ledia is starting off, and then
12 we'll go to Ariel, perhaps. But okay. Ledia. Telehealth.
13 You're up.
14 MS. TABOR: Great. Thank you. Good afternoon.
15 The audience can download a PDF version of these slides in
16 the Handouts section of the Control Panel on the right-hand
17 of the screen. We would like to thank Bhavya Sukhavasi,
18 Rachel Burton, and David Glass for their input into this
19 work.
20 During the COVID-19 public health emergency, CMS
21 has temporarily expanded coverage of telehealth services,
22 giving providers broad flexibility to furnish telehealth

1 services to ensure that beneficiaries continue to have
2 access to care and reduce the risk of exposure to COVID-19.
3 The PHE has been extended several times and is currently
4 expected to end in April. Without legislative action, many
5 of the telehealth changes will expire at the end of the
6 PHE.

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

15 We know from several sources that physicians and
16 other providers have responded to the PHE and the
17 telehealth expansions by rapidly adopting telehealth to
18 provide continued access to medical care for their
19 patients. Even before the COVID-19 pandemic, there was
20 growing interest in expanding Medicare telehealth coverage.
21 Advocates assert that telehealth can expand access to care
22 and reduce costs relative to in-person care. However,

1 others contend that telehealth services have the potential
2 to increase use and spending under a fee-for-service
3 payment system. Telehealth has recently been implicated in
4 several large fraud cases related to the ordering of
5 durable medical equipment and cancer genetic tests.
6 Current evidence on how telehealth services
7 impact quality of care is limited and mixed. A key issue
8 is how to achieve the benefits of telehealth while limiting
9 the risks.
10 Based on your discussions, we present a policy
11 for expanding Medicare's coverage of telehealth services
12 that would apply to all clinicians billing fee-for-service
13 Medicare after the public health emergency. We would now
14 like your confirmation that this policy option reflects
15 your views to include it is a chapter in the upcoming March
16 report.
17 Overall this policy option seeks to balance
18 improving beneficiary choice and access with program
19 integrity. We also assume that policymakers will continue
20 to gather more information about telehealth services during
21 the public health emergency.
22 During previous meetings, some Commissioners

1 expressed interest in allowing additional flexibilities for
2 alternative payment model participants. Under this policy
3 option, we assume that CMS will continue to offer waivers
4 for alternative payment model participants. For example,
5 Next Generation ACOs currently have a waiver to offer
6 telehealth services outside of an originating site and in
7 an urban areas and can waive Part B beneficiary cost-
8 sharing.
9 I am now going to begin describing the potential
10 permanent policy option for telehealth expansion. Prior to
11 the PHE, Medicare paid for telehealth services provided to
12 beneficiaries who lived in rural areas and who received the
13 service at certain facilities, known as "originating
14 sites." During the PHE, Medicare temporarily expanded
15 payment for telehealth services provided to all Medicare
16 beneficiaries, including telehealth visits to patients at
17 their home. Under the potential policy option for your
18 discussion today, the expansion would become permanent.
19 In our focus groups in the summer of 2020,
20 clinicians and beneficiaries were generally supportive of
21 maintaining expanded access to telehealth services with
22 some combination of in-person visits. The Commission has

1 discussed potential benefits of using telehealth for
2 follow-up visits with patients with chronic conditions.
3 Since about 70 percent of beneficiaries have at least one
4 chronic condition, this would mean covering telehealth
5 services for the majority of beneficiaries.
6 Because this option would allow all fee-for-
7 service beneficiaries to receive certain telehealth
8 services from their homes, companies that offer direct-to-
9 consumer telehealth services for urgent care and behavioral
10 health, primarily to new patients in their homes, will be
11 able to bill Medicare. Although these DTC services would
12 potentially improve access, they also raises concerns about
13 care fragmentation. In response to the Commissioners'
14 discussion at the November meeting, we have added a text
15 box to the paper that discusses this point in more detail.
16 Prior to the PHE, CMS allowed clinicians to bill
17 for about 100 services provided by telehealth to
18 beneficiaries in rural areas. CMS has temporarily added
19 over 140 services to the list of telehealth services during
20 the PHE. Under this policy option, after the PHE, CMS
21 should revert back to the formal review process that it
22 used before the PHE to decide whether to cover telehealth

1 services including the ones temporarily added during the
2 PHE.
3 CMS has established criteria and a process to
4 review whether a service should be payable as a telehealth,
5 which can include if there is clinical benefit. Because of
6 the rapid adoption of telehealth during the PHE, this is an
7 opportune time to better understand its effects, so CMS has
8 allowed some telehealth services to be billable for all of
9 2021 to gather more evidence of clinical benefit.
10 Consistent with our 2018 report to the Congress
11 that telehealth services should be added when they balance
12 the principles of cost, quality and access, CMS should be
13 given the authority to consider the impact on program
14 spending when determining whether to add a service.
15 According to CMS, there is a statutory
16 requirement that telehealth services payable by Medicare
17 must be furnished using an interactive telecommunications
18 system that includes two-way, audio/video communication
19 technology. Under authority during the PHE, CMS
20 temporarily allows audio-only interactions to meet the
21 requirements for some telehealth services based on the
22 agency's clinical assessment. For example, CMS pays for

1 most behavioral health services that are provided through
2 audio-only interaction, but not audio-only physical therapy
3 or eye exams.
4 Under this policy option, the Congress should
5 give CMS the authority to continue covering some telehealth
6 services when they are delivered through an audio-only
7 interaction if they meet criteria established by CMS, which
8 should include evidence of clinical benefit. This would
9 improve beneficiary choice and access to care, particularly
10 for beneficiaries who do not have access to technology for
11 a telehealth visit. CMS can implement criteria and a
12 review process similar to the review of allowable
13 telehealth services which includes evidence of clinical
14 benefit.
15 Prior to the PHE, Medicare only paid for
16 telephone communication as part of a brief virtual check-in
17 of five to ten minutes between a clinician and an
18 established patient. During the PHE, CMS began temporarily
19 paying for three audio-only E&M services. Under this
20 policy option, Medicare should permanently cover audio-only
21 E&M visits or virtual check-insurance, which are similar to
22 audio-only E&M visits, for established patients.

1 During the November 2020 meeting, Commissioners
2 supported the continued coverage of audio-only E&M visits
3 with established patients to improve beneficiary choice and
4 access to care. These services would not go through the
5 CMS review process mentioned on the previous slide.
6 Limiting these services to established patients would help
7 ensure that beneficiaries receive care from clinicians that
8 have access to previous medical history and diagnoses from
9 a previous in-person or telehealth visit.
10 Consistent with the code descriptions, these
11 services should not be covered if they originate from a
12 related E&M service provided within the previous 7 days or
13 leads to an E&M service within the next 24. This
14 restriction would increase the likelihood that these
15 services would be provided as substitutes for, instead of
16 in addition to, in-person and telehealth visits.
17 I will now turn it over to Ariel to continue the
18 discussion of the policy option.
19 MR. WINTER: Prior to the PHE, CMS paid for
20 telehealth services under the physician fee schedule at the
21 lower, facility-based, rate, in all cases. But during the
22 PHE, Medicare pays either the facility rate or the higher,

1 in-office rate, depending on where the service would have
2 been provided if it were furnished in person.
3 Under this policy option, Medicare would pay
4 lower rates for telehealth services than for in-person
5 services, after the PHE. The rationale is that services
6 delivered via telehealth probably have lower practice costs
7 than services provided in a physical office, because they
8 require less space, equipment, supplies, and staff time.
9 Therefore, continuing to set rates for telehealth services
10 that are equal to rates for in-office services could
11 distort prices, and could lead clinicians to favor
12 telehealth over comparable in-person services.
13 In the short term, CMS should return to paying
14 for telehealth using the fee schedule's facility rate. But
15 in the long term, CMS should collect data from practices
16 and other entities on the costs of providing telehealth
17 services, and use this information to set payment rates.
18 In addition, under this option, Medicare would pay less for
19 audio-only services than for telehealth services, because
20 they don't require video technology.
21 During the PHE, the Office of Inspector General
22 allows clinicians to reduce or waive beneficiary cost

1 sharing for telehealth services. Under this policy option,
2 we would encourage OIG to discontinue this policy after the
3 PHE.
4 Requiring beneficiaries to pay a portion of the
5 cost of telehealth services could reduce the possibility of
6 overuse. Because telehealth services are more convenient
7 for patients to access, they have a higher risk of overuse
8 than in-person services. This is particularly relevant in
9 a fee-for-service payment system, because providers have a
10 financial incentive to bill for more services.
11 At the last meeting, Larry raised a concern that
12 requiring clinicians to collect cost-sharing for telehealth
13 services with low payment rates could impose a burden on
14 them. But we don't think this would be the case because
15 clinicians currently collect cost-sharing for in-person
16 services with low payment rates, such as
17 electrocardiograms. In addition, clinicians don't need to
18 bill beneficiaries with Medigap coverage for cost sharing.
19 Medicare sends the claim information to the Medigap plan,
20 which then pays the clinician directly.
21 After the PHE, CMS should establish additional
22 safeguards to protect the program and beneficiaries from

1 unnecessary spending and potential fraud related to
2 telehealth. On the next three slides, we describe four
3 types of safeguards that would apply after the PHE.
4 At the November meeting, we talked about setting
5 a flat limit on the use of telehealth services, either at
6 the clinician or beneficiary level. But we decided that
7 this policy would be problematic because it would probably
8 impose a burden on clinicians, and confuse beneficiaries.
9 Therefore, we are suggesting a different approach
10 here. CMS should apply additional scrutiny to outlier
11 clinicians. Outlier clinicians could be those who bill for
12 many more telehealth services per beneficiary than their
13 peers, or those who bill for a very high number of
14 telehealth services in a week or a month. This option does
15 not assume that all outliers are providing unnecessary
16 care. It only means that they would receive more scrutiny
17 from CMS.
18 CMS could perform a targeted review of claims
19 submitted by outlier clinicians to ensure that they are
20 billing appropriately, for example, reviewing medical
21 records to ensure that their claims meet billing rules.
22 The second safeguard would require clinicians to

1 provide a face-to-face, in-person, visit with a
2 beneficiary, before they order high-cost DME items or lab
3 tests. As we discussed in November, telehealth companies
4 have recently been implicated in very large fraud cases
5 involving unnecessary DME, genetic tests, and pain
6 medication.

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

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

1 physician to bill for the services they perform.

2 In 2019, we recommended that the Congress

3 eliminate "incident to" billing for services provided by

4 advanced practice registered nurses and physician

5 assistants. This policy would expand this recommendation

6 by applying it to other clinicians who can bill Medicare

7 directly -- such as physical and occupational therapists --

8 when they perform telehealth services. It would give CMS

9 more information about the clinicians who provide

10 telehealth and enable CMS to better monitor the use of

11 telehealth to prevent overuse.

12 The fourth safeguard would require clinicians who

13 bill for "incident to" services to provide direct

14 supervision in person, instead of virtually.

15 Under the rules for "incident to" billing, the

16 billing clinician must provide direct supervision for the

17 service in most cases, which means that they must be

18 present in the office suite and immediately available to

19 furnish assistance and direction.

20 However, CMS temporarily allows clinicians to

21 provide direct supervision virtually through real-time,

22 audio and video technology, instead of in person. This

1 policy applies until the end of 2021 or the end of the year
2 in which the PHE ends, whichever comes later.
3 There is a concern that virtual supervision could
4 pose a safety risk to beneficiaries because the clinician
5 is not physically available in the office suite to provide
6 assistance.
7 Allowing virtual supervision could also enable a
8 clinician to "supervise" multiple individuals in multiple
9 locations at the same time, which could raise safety
10 concerns and lead to higher spending.
11 I want to note that there are two key differences
12 between the policy on this slide and the policy on the
13 prior slide.
14 First, the policy on the previous slide would
15 only apply to "incident to" services performed by
16 clinicians who can bill Medicare directly; whereas, the
17 policy on this slide would apply to "incident to" services
18 performed by any individual, whether or not they can bill
19 Medicare directly.
20 Second, the policy on the prior slide would only
21 apply to telehealth services, but the policy on this slide
22 would apply to supervision of both telehealth and in-person

1 services.

2 For your discussion, we are looking for

3 confirmation that this revised policy option reflects your

4 views, and we are planning to include it in a chapter on

5 telehealth in our March report.

6 This concludes our presentation, and I will turn

7 things back over to Michael.

8 DR. CHERNEW: Thank you, Ledia and Ariel.

9 I think we will go -- Larry mentioned that he had

10 a Round 1 question first, and then I have one from Bruce

11 and Jonathan, so, Larry.

12 DR. CASALINO: Yeah, Ariel, nice work. Just one

13 quick question. In the chapter and also when you presented

14 just now, you mentioned high-cost DME and clinical lab

15 tests. I just want to confirm. Do you mean high-cost DME

16 and high-cost clinical lab tests, not all clinical lab

17 tests? Is that correct?

18 MR. WINTER: That's right.

19 DR. CASALINO: Okay. You might clarify that

20 because it stopped me each time in the chapter, and even

21 when you said it today I was listening to the way you --

22 just the nuance of your voice, and it made me not sure

1 which you meant. So maybe just "high-cost" twice.

2 MR. WINTER: Sure. Thank you.

3 DR. CHERNEW: Great. Bruce and then Jonathan.

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

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

1 drug to a beneficiary in a physician's office and is being
2 supervised virtually by a physician who's in a different
3 location.
4 MR. PYENSON: So could you give a case example of
5 direct supervision of the sort you're proposing to require?
6 What would that look like physically?
7 MR. WINTER: In the case of telehealth?
8 MR. PYENSON: Well, the patient -- the person in
9 contact with the patient and the direct supervisor.
10 MR. WINTER: Sure. So in the case of an in-
11 person service, going back to the one I gave earlier, an RN
12 Is administering a Part B drug to a beneficiary in a
13 physician's office. The physician who is billing for that
14 service under "incident to" is physically in the office
15 suite and available to provide direction and assistance if
16 necessary.
17 MR. PYENSON: Okay. Now, what would that look
18 like if the patient were getting a telehealth service?
19 MR. WINTER: Right. So going back to the example
20 I gave earlier, if a mental health counselor is providing a
21 telehealth service to a beneficiary, then the physician
22 who's billing for that service under "incident to" would be

1 in the same office suite as that mental health counselor.
2 MR. PYENSON: What would the supervision
3 consistent of?
4 MR. WINTER: It's hard for me to answer that, not
5 having a clinical background, and CMS does not specify what
6 supervision is required for each individual service. It
7 just says that they have to be available to provide
8 direction and assistance if necessary. So if a mental
9 health counselor needed -- you know, had a question come up
10 or needed assistance in some other way, I imagine that's
11 what would be -- that's what supervision would involve in
12 that circumstance.
13 MR. PYENSON: I'm wondering if any of the
14 clinicians could give an example of how that might work in
15 their system. I'm just struggling to understand why we --
16 how that would -- why we would even permit it or why anyone
17 would want it.
18 DR. RAMBUR: I guess I could go on that. I can
19 imagine a situation where I'm doing some sort of complex,
20 you know, wound care piece or something, and I have
21 questions or problems, and so if the physician is there,
22 the physician can come and assist. So that's how I would

1 envision it. But I in general have been opposed to
2 "incident to" billing because oftentimes it's a way of
3 enhancing revenue, in my view, without the physician
4 actually being there to provide the service. And I know
5 many clinicians who have been required to bill that way,
6 even though there's just no exposure of the physician to
7 the patient.
8 MR. PYENSON: Betty, in that example, you would
9 be dealing with a wound care patient by telehealth.
10 DR. RAMBUR: My understanding in this first
11 example, as a nurse practitioner, if I can bill directly, I
12 would not be able to do the "incident to" billing through
13 telehealth because in a sense it's just an additional
14 charge or additional delta. My understanding, if I'm
15 reading this correctly, the difference in the second is
16 that we're in the physical space where I really may need
17 help for something that feels uncomfortable or something
18 untoward that happens.
19 MR. PYENSON: So it would be -- and, Mike, feel
20 free to cut me off because I'm getting in the weeds here.
21 DR. CHERNEW: I'm just about there, Bruce. We've
22 got a lot of things we really have to get to.

1 MR. PYENSON: I'll cut myself off. Thank you.
2 DR. CHERNEW: All right. The irony about that is
3 Brian wants to extend something that you were saying, so,
4 Brian, please, quickly, because I have Jonathan next in the
5 queue. But I know you wrote that you wanted to talk on
6 this particular point.
7 DR. DeBUSK: Okay. Well, one quick aside. And
8 the clinicians here, please, please, correct me if I'm
9 wrong. But, Michael, I will be brief, to your ask.
10 For example, a patient goes into a clinic, sees a
11 physician. They have a wound. The physician does an
12 assessment. They do a dressing change. The physician
13 decides that the patient needs to come back in two days,
14 three days, for a dressing change.
15 Let's say on the next visit that physician, the
16 original physician, isn't even in the building, so the
17 patient comes back in, sees the nurse practitioner or a PA.
18 Normally that would be billed at 85 percent of the fee
19 schedule.
20 Now, if by just some coincidence there happens to
21 be a physician in the building, maybe this physician has
22 never met the patient; maybe this physician doesn't even

1 know the patient exists. That billing automatically
2 escalates to 100 percent of the fee schedule simply by
3 virtue of that person being physically present in the
4 building. And the concern there with telehealth is watch
5 what happens with telehealth. You could have a nurse
6 practitioner or a PA in a building doing telehealth visits
7 one right after another, and it just so happens that a
8 physician happens to be physically present. Again, the
9 physician has no knowledge that any of these patients
10 exist. And you're automatically paying a 15 percent
11 premium simply because that person's in the building. And
12 I believe that's how it works unless I'm badly mistaken.
13 DR. CHERNEW: Okay. That was helpful. We are
14 going to move on. Jonathan.
15 DR. JAFFERY: Yeah, thanks, Mike, and thanks,
16 Ledia and Ariel. Great work. It took a huge amount of
17 policy considerations and distilled them into something
18 really digestible I think both for the chapter and the
19 presentation.
20 My question is, when we're thinking about audio-
21 only visits versus video visits, and, you know, we're still
22 in a place where, of course, we've talked about the

1 technology is a big iffy for beneficiaries and Internet
2 access is challenges in some places, and so I know a lot of
3 places have a very well prescribed default mechanism; if
4 the video technology fails, then it will default back to an
5 audio-only.
6 So have you thought about what the implications
7 of that might be in terms of a differential payment for an
8 audio-only visit versus a video visit?
9 MS. TABOR: I think we did think about that and
10 landed on that it still requires less technology to do an
11 audio-only visit. But I would also ask the Commissioners
12 as part of that to discuss whether audio should be paid
13 less than telehealth because of the difference --
14 DR. JAFFERY: I may come back to that in Round 2,
15 but just to finish that thought, thinking if the idea is
16 that it costs less to make the investment in the
17 infrastructure in the scenario just described, the
18 investment on the provider's side had to be made up front,
19 and it was -- regardless of what the visit ended up being,
20 as opposed to a group of providers or telemedicine group at
21 least only doing audio visits.
22 DR. CHERNEW: Okay. Ledia, Ariel, we're okay?

1 MS. TABOR: I look forward to the discussion
2 about that issue.
3 DR. CHERNEW: Yeah, well, good. So we're going
4 to go to Amol, and then we're going to kick off Round 2.
5 DR. NAVATHE: Thanks. In the paper, I think on
6 page 10 and page 11, we noted A-APM flexibility around
7 telehealth when there was a comment about whether it would
8 be -- that flexibility would be designated at the clinician
9 level or the provider level or whether it would be at the
10 beneficiary level. And I noted that we don't have anything
11 about A-APM flexibility in the recommendations here, so I
12 just wanted to ask, was that deliberately set aside? Is
13 that showing up somewhere else? Just so we don't lose that
14 whole train of thought, because that's obviously important.
15 MR. WINTER: Sure, and Mike maybe would want to
16 address this, too. So the feedback we got after our
17 initial presentation in September was to focus more on
18 flexibilities that would apply to all fee-for-service
19 clinicians and kind of set aside, for now at least, whether
20 there should be additional flexibilities for advanced APM
21 clinicians. And as we thought about it more, it seems to
22 us that because advanced APMs, at least those under CMMI --

1 CMMI already has authority to grant all kinds of waivers
2 for telehealth. They've done that in the case of Next
3 Generation ACOs, as you know, as we talk about in the text
4 box, for example, allowing them to bill for telehealth
5 provided to beneficiaries in any location, even in their
6 home. And a similar authority exists for certain kinds of
7 MSSP ACOs.
8 So because CMMI already has the authority, it
9 seemed to us why should we -- does it make sense for us --
10 if we're already expanding fee-for-service pretty broadly,
11 as we're proposing to do in some cases, does it make sense
12 to -- and those expansion would also apply to advanced APM
13 clinicians. So what additional flexibility should we be
14 offering to advanced APMs that they wouldn't already have
15 either through fee-for-service or through waivers under
16 CMMI? So that's kind of why it ended up as a text box.
17 DR. CHERNEW: So can I jump in on that? The
18 challenge was whether the flexibility was for the APM
19 provider or for APM patients or for the APM patients when
20 the service is provided by the APM provider. There's
21 problems with all of those -- right? -- in various ways.
22 If you make it for the APM provider for all patients, it

1 becomes problematic if they're just in one APM and they're
2 treating a lot of patients that aren't part of it. If you
3 make it for only APM patients, you really want that limited
4 to the APM provider so they're not getting a lot of care
5 done by, say, other direct-to-consumer type people,
6 providers, for example, people that aren't part of their
7 APM. And if you try and make it both, it becomes
8 problematic because some of the APMs might have
9 retrospective assignment, so you don't even know who the
10 APM patient is until you're sort of after the fact.
11 All of that made it hard to get to sort of a
12 policy option on APMs, and given that CMMI has the
13 authority to do things where it makes sense and, in fact,
14 they do use that authority, we've sort of been a little
15 more silent on that point. But it's a much more
16 complicated point than where we could get to.
17 That brings me to the last thing I want to say
18 before we jump into Round 2. These are policy options, but
19 they're slightly different than where we were in the
20 previous discussion of APMs because the APM policy options
21 we're going to try and mold into a draft recommendation and
22 a recommendation for a vote. There will be a March chapter

1 on telehealth, but we are not going to be taking these
2 policy options and voting on them in a future month. Our
3 goal is to get, for lack of a better word, a rough
4 consensus on where the Commission is to help the staff and
5 me when we engage with folks on the Hill or other
6 policymakers. But we're not going to have the same process
7 we often do going to a draft rec and then a vote. So that
8 means that the sort of comments here are going to be
9 important in shaping a general sense of where the
10 Commission is.
11 That is a little complex -- is at least enough
12 complex of a statement that I'm going to pause and see if
13 Jim wants to see if I've mischaracterized where we're going
14 or add anything to that to make sure we have the ground
15 rules right about what this discussion is about. Jim?
16 DR. MATHEWS: That is exactly right. Nothing to
17 add.
18 DR. CHERNEW: That's just the type of thing you
19 say to someone who's loosely your boss.
20 So, in any case, I hope that is all clear about
21 where we're going. And just so you know, everything I said
22 was just stuff Jim told me to say, so just to make sure you

1 understand who's really the power here.

2 Anyhow, so we have a few people in Round 2, and

3 I'm going to begin to work through the queue. But we're

4 going to start with Larry, and then we're going to go to

5 Dana and Marge.

6 DR. CASALINO: Thanks, Mike.

7 So Ledia and Ariel did a great job, I think, in

8 taking a big and controversial topic on responding to the

9 Commissioners' comments from previous meeting and previous

10 paper. I thought it was really good.

11 I actually agree with all the recommendations on

12 the slide, except for the last sub-bullet, the second

13 "incident to" sub-bullet. The first "incident-to" sub-

14 bullet, I do agree with. The last one, I think, just needs

15 more specification and discussion. Bruce was pushing on

16 that, but I'm not going to comment on that.

17 I just want to comment on three things that

18 actually are recommendations. I think it's fair to call

19 them that. They're in the chapter and to some extent in

20 the presentation today, even though they don't show up

21 explicitly on the recommendation slide.

22 The one to make for me that's the most important

1 is the direct-to-consumer telehealth vendors. I know we
2 brought that up, I think, kind of toward the end last time,
3 and you guys did a nice text box on it. But I think they
4 needed more thought. They're a pretty big deal already,
5 and they are poised to become -- if the recommendations
6 here are followed, for example, and they are allowed to
7 deliver services to people at home, for example, which I
8 think they should be, they could really take over the
9 industry.
10 Now, I'm not going to talk about impact on
11 fragmentation. You mentioned a possible impact there. I'm
12 not going to talk about quality or what the implications of
13 the lack of having a history on the patient, the lack of
14 access to the patient's EHR from their provider
15 organization. I'm not going to talk about those things,
16 although they are important.
17 I want to talk about what they get paid. So at
18 the bottom of the text box, on the bottom of page 13, you
19 say the policy option contemplated in this paper would
20 allow providers to bill for telehealth services for new
21 patients plus allowing the direct-to-consumer telehealth
22 vendors to bill Medicare. And then here's the key

1 sentence: Payer rates for DTC telehealth providers would
2 be the same as payment rates for other types of providers.
3 And that's something that, you know, certainly, I'm open to
4 being convinced differently, but as I see it now, I would
5 be strongly opposed to that.
6 My concern is -- and I'm leaving quality and
7 fragmentation out. Just costs and structure the industry.
8 Pure telehealth companies, companies that don't provide
9 bricks-and-mortar care, they have much lower costs than
10 clinicians who work in an organization that provides brick-
11 and-mortar care, right? So if you're a Teladoc or another
12 telehealth direct-to-consumer vendor, you don't have to
13 have -- or you don't have to rent space to see patients.
14 You don't have to have supplies. You don't have to have
15 nursing. You don't have to have medical assistants. You
16 don't have to have receptionists. Your costs are way, way
17 lower to deliver the service you provide.
18 So if they're paid at the same rate as I am, say,
19 if I'm at Weill Cornell delivering the telehealth service,
20 they're basically going to drive a lot of brick-and-mortar
21 providers, especially ones that provide a lot of primary
22 care or cognitive care, out of business, because the cost

1 difference in delivering the service would be so huge, and
2 therefore, the profit for the telehealth company so much
3 greater.
4 And we talk often in the Commission about wanting
5 to get a sense of what the costs are for a provider and
6 then paying them a bit more than that, but we don't want to
7 pay them 15 percent more or 20 percent more or 25 percent
8 more. In fact, this morning, when it looked like we were,
9 in fact, doing that for certain kinds of providers, we
10 recommended actually pay cuts. So I don't know why we
11 would treat telehealth vendors differently from that and
12 pay them the same price for general brick-and-mortar
13 provider. We need brick-and-mortar providers, right? I
14 mean, some things have to be done in person.
15 So I'll just leave it at that, but I do think
16 this is really important and worthy of further discussion.
17 Again, I think it would take a lot for me to believe that
18 it would be a good idea to pay them both equally.
19 The second thing I wanted to comment on, I can
20 comment on very briefly, is the issue of audio-only versus
21 -- payment for audio-only versus video visits. Jonathan
22 discussed that briefly.

1 I can see reasons to pay a bit more for video
2 visits. There may be a somewhat higher up-front cost and
3 maybe even in an ongoing way somewhat higher cost for video
4 visits, but if there's a big difference in the payments, I
5 think this would discriminate against beneficiaries who are
6 blind, for example. But more commonly, there's so many
7 beneficiaries who for many kind of a multitude of reasons
8 may have trouble doing video visits. We hate to
9 discriminate against them by having a big differential
10 between audio and video visits, and I'm sure other people
11 will probably want to comment on that issue.
12 The third thing and last thing I'll mention is
13 this virtual check-in issue. I actually have a -- well, I
14 think I agree with endorsing virtual check-ins, although
15 it's a little complicated distinguishing them from a
16 regular E&M telehealth visit, I think. Let's just say
17 there's a role for them. CMS has required that they be
18 delivered to an established patient. That's fine, but as
19 is in the slide, I think, and also in the chapter, they
20 can't be delivered to someone who's had a related E&M
21 service within the previous seven days. And they can't
22 lead to an E&M service within the next 24 hours or sooner.

1 That to me reflects a profound misunderstanding of a very
2 important way in which physicians take care of patients.
3 If I see a patient for an acute care visit or
4 even a chronic care visit for diabetes or hypertension or
5 atrial fibrillation or whatever and I make a change in
6 their medication, potentially a change that could lead to
7 bad things or good things, I don't want to just say come
8 and see me in a month. I'd want to call them a few days
9 later, and if it's a chronic care visit, I want to see what
10 happened because of the change I made. If it's an acute
11 visit but something I was a little uneasy about, I want to
12 call them, sometimes the next day, but certainly sooner
13 than seven days and say, "Is the person getting better, or
14 are they getting worse?" This could be a patient with
15 COVID, for example, a little short of breath, but you don't
16 think they have to come to the emergency room. But you
17 want to see how they're doing 24 hours later.
18 So to me, to say you can't do that, that's
19 exactly like the main purpose for a virtual check-in. To
20 say you can't do that, we won't pay for it, we'll pay for
21 things if they're not related to the service you've just
22 given the patient in the previous seven days, to me, it's

1 like cutting the legs under out from one of the most
2 important things physicians can do.
3 Now, good physicians do this anyway and haven't
4 been paid for it over the years, but God knows if we're
5 going to pay for other kind of virtual check-ins, to me,
6 these would be first on the list to pay for.
7 I know this was CMS's idea, not yours, but I
8 would strongly recommend that we -- I'll be interested to
9 hear what other people have to say, but my feeling now is I
10 strongly recommend that we actually go against that CMS
11 rule as it stands now.
12 Just to finish up, then, you know, that phone
13 call, that virtual visit is very likely to eliminate the
14 need for another office or ED visit, or it may lead to a
15 very appropriate office or ED visit that may not have
16 happened otherwise. So I see the concern for
17 overutilization, but I think you have to deal that through
18 a cost-sharing and outlier perspective rather than not
19 letting physicians do this, I think, very important
20 service.
21 And that's it.
22 DR. CHERNEW: Okay. Larry, thank you.

1 I made a mistake in missing Wayne. So, Wayne,
2 you are now up.
3 DR. RILEY: Great. Well, let me just react to
4 Larry's scenario. As an internist, I can't tell you how
5 many times I recall calling a patient to check in, and
6 either they degraded a little bit and I said, "No. You got
7 to come back," or I tell them, "No. You got to go to the
8 emergency room." So I have some concerns about the
9 delimiting of how you can use the virtual visit, telehealth
10 visit, whether it's virtual or telephonic. So I second
11 Larry's concern. As a physician, we do this all the time,
12 you know, the quick check-in. Good clinicians, good
13 nurses, good NPs, good PAs develop a sixth sense when their
14 patient doesn't look good, even over video or that they're
15 doing just fine. Right, Larry? So I'd worry about that
16 delimiting.
17 The other issue is the cost-sharing discussion.
18 I do have some concern about that and I believe we talked
19 about in November. Obviously, we don't want to encourage
20 fraud, waste, and abuse, and I thought we had mentioned
21 something about maybe limiting a number of telehealth
22 visits per beneficiary a year.

1 Ledia, Ariel, do you recall that? Did you guys
2 chew on that issue a little bit?
3 MR. WINTER: Yeah. And we supported that idea,
4 and there was a lot of concerns raised by Commissioners,
5 which I mentioned, some of which I mentioned in my
6 presentation that it would be kind of arbitrary to set up
7 flat limits and would it apply -- it might pose a burden on
8 both clinicians and beneficiaries, and it might be unfair.
9 So we would place that with the notion of applying
10 additional scrutiny to outlier clinicians. You're not
11 saying everything you -- you're not setting an arbitrary
12 cap. You're saying if you meet certain thresholds, we're
13 going to apply additional scrutiny to you, but we're not
14 going to deny your claims unless they're appropriate.
15 DR. RILEY: Okay. I missed that nuance. Thank
16 you, then.
17 The last point is in terms of -- I'll have to
18 defer to Brian on this. Again, a common thing that we do
19 as internists, I may call a patient, a new diabetic, and
20 they're worried about their blood sugar. I say, "Okay.
21 I'll send you a prescription or call in a prescription for
22 a home glucometer or ambulatory blood pressure

1 measurement." I don't think that kind of primary care-
2 based equipment should necessarily trigger a revisit with
3 me. So is there some consideration about the threshold of
4 cost of DME equipment?
5 Brian, this is -- Brian is the expert on DME. So
6 I'll defer to him if those two, sphygmomanometer and a
7 glucometer meet the technological definition of DME. I
8 don't recall.
9 Wheelchairs is another one, I know that once upon
10 a time, I did order over the phone. So was there any
11 discussion about that? And, Brian, you weigh in also,
12 please.
13 DR. DeBUSK: Wayne, a great point on the primary
14 care items.
15 You know, I really don't know that space like the
16 glucometers and that space that well. So I'll have to be a
17 little deferential on that.
18 On the bracing, it can really get out of control
19 quickly. I mean, I would recommend at least for items that
20 are discretionary, spine braces, knee braces, particularly
21 functional knee braces, I really do support the measure of
22 requiring some type of in-person visit. Again, it's just a

1 little bit out of my field to get into diabetes and blood
2 sugar management.
3 Thank you.
4 DR. CHERNEW: Paul, did you want to make a
5 comment just on this point? Because I put you at the end
6 of the queue, and in doing so, that would make Dana Safran
7 next.
8 DR. PAUL GINSBURG: Yeah. You can go to Dana.
9 I'm still formulating my thoughts.
10 DR. CHERNEW: Okay. Then, Dana, you're next, and
11 you're going to be followed by Marge.
12 DR. SAFRAN: Great. Thanks. I'll be very brief.
13 I really appreciate this work and how it's
14 evolved over the last couple of months.
15 My only questions really have to do with the
16 recommendations around payment rates and specifically the
17 lower rate for audio, audio only. I had some concerns
18 about that just because it seemed like it could drive
19 disparities in access, you know, if providers feel like
20 it's not worth it to bother with audio calls for the
21 populations that are going to be disproportionately poor,
22 but who don't have access to broadband for video. That was

1 a concern to me.

2 I wondered if instead we could make certain

3 services, services where Medicare only pays if video is

4 used and based on, then, clinical necessity for that

5 service, where you have to be able to lay eyes on the

6 patient.

7 Similarly, I do have some concerns. I know we

8 have a lot of mixed feelings about what the payment rate

9 for telehealth should be post public health emergency. I

10 do worry about having it be lower than in person because I

11 think we could expect a shift away from telehealth right at

12 a time where it's really helping to drive some innovation

13 that, I think patients probably appreciate greatly.

14 At the same time, I know we've worried -- and

15 I've worried a lot -- about the inflationary effect of

16 telehealth, if it sits there as yet another service for

17 fee-for-service providers.

18 So I don't have a great answer to that. I just

19 wanted to reflect my concern that we will kind of undercut

20 this technology and the way it's evolving, its important

21 role that's taking shape in the delivery system if we, post

22 emergency, say you get paid less for it.

1 Finally, I really agree with Larry's point around
2 really being careful around differentiating providers who
3 are telehealth only. We really don't want to promote this
4 discontinuities of care. So I think we really have to
5 delineate those providers as different.
6 That will get really tricky really fast as to,
7 you know, as soon as we make that differentiation. Then
8 what do they do to be able to have a facility or do
9 whatever the requirements are to meet the criteria to be an
10 established provider? So I think that's a gnarly problem,
11 but I think it's one we really have to take on because we
12 know the importance of continuity, both for quality and for
13 costs.
14 So thank you. That's all I have.
15 DR. CHERNEW: So before we jump to Mark, I want
16 to say one thing because, Dana, you raised a lot of
17 important issues.
18 The tension here which seems to come up
19 repeatedly is we really do want to promote access, and we
20 understand we want to promote access. We're very worried
21 about things like disparities, and so we want to make sure
22 that the entire population gets access to these type of

1 services. But in the same breath, we're worried that, for
2 example, if we pay too much for something like audio-only,
3 all of a sudden, not just the appropriate people will get
4 the call after the service, but everybody will get the
5 call. And they'll get a call two days after that. It's
6 not what the right sense is.
7 One way to think through that as we go through
8 this is to include some aspect of these changes being made
9 temporary or understand that we're going to have to make
10 changes. I realize there's some need to give organizations
11 who have to invest in telehealth some direction, which way
12 to go, but my personal view, I guess, is I see enough
13 uncertainty about the potential for abuse and what's going
14 to happen that we wanted to make sure we don't put
15 something in permanent status without a full review.
16 So I don't know what people think about that. So
17 I'll be quiet, and we'll go on with Marge. Marge?
18 MS. MARJORIE GINSBURG: Thank you, Mike. Your
19 comments actually were a perfect lead-in to my comments.
20 Some of you may remember I have been an outlier
21 on this topic since it first came up, and nothing has
22 changed in terms of my being a curmudgeon, if you will.

1 So our endorsement of the plan to embrace it with
2 what I see as so few restrictions post the pandemic really
3 concerns me, and I want to reflect back to page 37 of the
4 report. And I want to refresh your memory by reading the
5 short part.
6 If you recall, the Commission did look at
7 telehealth back in 2018, before the pandemic, to see
8 whether we should be covered or expanded. Let me just read
9 this. This report did not make -- the report that we did -
10 - did not make recommendations about specific telehealth
11 services. Instead, the Commission recommended the
12 policymakers should cautiously expand coverage of
13 telehealth services by evaluating whether individual
14 telehealth services balance the principles of cost, access,
15 and quality. In cases where evidence exists that these
16 services balance these principles, policymakers should
17 consider adopting them more broadly under Medicare.
18 However, when such evidence is lacking, policymakers should
19 consider pilot testing these services before adoption.
20 I don't think what we've done with the pandemic
21 can be considered pilot testing. So I think a lot of this
22 is likely to go forward, on matter what we do, because the

1 gate has been opened, and I think it's going to be very
2 hard to close it. But my recommendation is that we take
3 out permanence and we make this a pilot test, and whether
4 it takes one year or two years to decide whether we're
5 getting the cost and the quality benefit that we expect,
6 then they can talk about permanent later.
7 But, oh, my gosh. I see this just exploding into
8 more fraud and abuse than we can even begin imagining. So
9 thank you.
10 DR. JAFFERY: Mike, we can't hear you.
11 DR. CHERNEW: I was just looking at Larry and he
12 wasn't reacting. I thought I pissed him off.
13 Larry, I think you wanted to make a point on
14 this, a comment on this point, so jump in quickly.
15 Larry, now you're muted. You're passionate but
16 you're muted.
17 DR. CASALINO: Passionate and eloquent, but
18 muted. Okay. That's the story of my life.
19 The report comes down pretty hard in several
20 places on CMS should use its usual review process. It even
21 talks a little bit about what that would involve before
22 making something permanent. But then if you really read

1 it, it kind of sounds like, I'm not sure if this is what
2 was meant, but that by the end of 2021 or by the end of the
3 pandemic we'd have enough evidence to make a decision about
4 making things permanent or temporary. And I agree with
5 Marge, who is shaking her head there. That's likely to be
6 true, I suspect, for almost nothing.
7 So I think that we should maybe be more along the
8 lines of recommending that things be done temporarily,
9 while CMS is gathering evidence and making a decision,
10 rather than say -- well, we don't really say, except we
11 kind of act like that can be done by the end of the
12 pandemic, and I don't think that's true. So that's an easy
13 change to make, I think, and it probably makes sense.
14 DR. CHERNEW: Okay. Larry, thank you. Next up
15 is Jonathan and then Bruce.
16 DR. JAFFERY: Thanks, Mike. So I'll be brief on
17 two points. The first one has to do with, again, the
18 differential between audio visits and video visits, and
19 Larry spoke to some of this, and Dana, quite eloquently. I
20 am just also going to voice my concerns about some of the
21 potential unintended consequences of having a payment
22 differential, and wonder, you know, over time, I don't know

1 if there are other options, you know, if we think about the
2 difference in investment that is required that kind of
3 prompted that idea, and if there's an opportunity to
4 require providers to provide both, and then there's sort of
5 something analogous to a site-neutral payment approach that
6 might get adjusted over time.
7 Maybe related to this, and particularly this
8 conversation about testing things and them not being
9 permanent, and going back to a point that Amol made about
10 advanced APMs, I understand -- or APMs, in general -- I
11 understand how, you guys explained well, how we got to this
12 point in this discussion. But I do think we have this
13 threat of APMs being -- sort of this being a carrot for
14 APMs, to go into an APM, and have the opportunity to use
15 this technology. At the same time, particularly if there
16 is an APM with downside risk, that helps mitigate some of
17 our concerns about overutilization of these activities in a
18 fee-for-service model.
19 So I am concerned that we completely lose the
20 thread of the opportunity for telehealth within APMs, and
21 recognize that maybe there are some other flexibilities or
22 reasons why those haven't been taken up very much, because

1 I think the report mentions that only four Next Gens took
2 advantage of the opportunity to use the telehealth waiver.
3 So I just want to put that out there, that I would hate to
4 lose that, and again, it may tie back to some of these
5 concerns about opening up Pandora's box. Thank you.
6 DR. CHERNEW: Thank you, and just to emphasize,
7 we're about to move on to Bruce, but, of course, APMs or
8 any provider can do whatever they want. This is just what
9 they get paid for, in a very particular way. And the
10 challenge for some APMs, as I mentioned before, is
11 operationally it's very tricky. If you're a physician-only
12 MSSP, even if you're taking downside risk, and a patient of
13 yours gets a surgery, does the surgeon who might not be in
14 your ACO get to do whatever telehealth they want, that then
15 you're on the hook for, for example. So it's very tricky
16 when you have a fragmented system, who gets to apply what
17 to which patients, particularly when the assignment might
18 be retrospective.
19 But nevertheless, I do want to move through now,
20 so let's go to Bruce, and then we're going to have Jon
21 Perlin and Paul Ginsburg. We hope we will have some time
22 to come back and continue that part of the discussion.

1 Bruce?

2 MR. PYENSON: I want to echo others in thanking
3 Ariel and Ledia for just wonderful work here, and I agree
4 with Marge and others that anything that we do has to have
5 a time limit of perhaps two years, because the telehealth
6 services are moving just so fast with IT companies, and in
7 areas that we're not even discussing here. On one hand
8 it's very exciting, but on the other hand there's enormous
9 potential for taking away resources from things that we
10 really need.

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

17 Other challenges that come up with the IT
18 approach are how to do the regional adjustments. IT
19 companies are likely to base their physicians based on
20 optimizing net revenue, financial gain. That might mean
21 low-cost, low-wage areas. It might mean high-wage areas,
22 and that might move around, depending on how wage indexes

1 change. So there's a whole series of issues around that,
2 that, in my mind, mean that the current framework and
3 infrastructure we have for physician services don't even
4 work very well.
5 Looking ahead to where the technology might be
6 going, I could envision a set of services that may be
7 covered under a Medicare Part E, that are put out to bid
8 for companies, that any beneficiary can call up and get a
9 certain set of services, and maybe that's on a bid basis on
10 a capitated basis. So that could be where we end up in a
11 few years that would solve some of these other problems.
12 But I don't think we're going to decide that now,
13 so I think putting a short time limit on extension of the
14 telehealth would really be important. Thank you.
15 DR. CHERNEW: Bruce, thank you. We're going to
16 go Jon Perlin, then Paul Ginsburg.
17 DR. PERLIN: Yeah. Thanks to the staff for a
18 really thoughtful chapter, and also deeply thoughtful
19 discussion.
20 I want to really make three comments, one of
21 which was triggered by Bruce's comment. But let me start
22 somewhere else, this notion of trying to delineate what is

1 a direct-to-consumer telehealth entity. Dana described
2 that as a really gnarly problem, at best as a really gnarly
3 problem. At worst, it's beyond that.
4 We've already received overtures about things
5 that you'd think are offering direct-to-consumer being the
6 infrastructure or the intel inside of practices or health
7 systems, et cetera. And so it's not only not projectable
8 that there will be circumventions if there are a set of
9 rules that try to determine outside-inside, but that's
10 already part of the infrastructure today. So it's kind of
11 akin to a staffing company. So I think that's going to be
12 extraordinarily problematic to determine utilization on the
13 basis of this sort of corporate structure of the entity and
14 its relationship to a practice, because the nature of
15 practices is changing.
16 Which gets to the second point. I think -- and
17 this is in response to Bruce -- I appreciate where you're
18 going with that. However, I would also project that if you
19 actually pulled that away from a linkage to licensing
20 practitioners, providers with authority, et cetera, then
21 the ultimate extension of that is that it becomes offshore
22 and becomes something that's even more commoditized. Now

1 if that's what we want, that's fine, but what we're really
2 talking about, I believe, are ways to both increase the
3 quality and access to care as well as ultimately reduce the
4 cost. So that leads to the third point, that we really do
5 have to figure out what's waste and what's value.
6 And, you know, when I think about this, we are
7 accumulating a lot of data with respect to the pandemic,
8 but to Marge's point, it's not organized, it wasn't
9 structured in terms of trials or determination of value,
10 and where that comes up in other places, you know, CMS
11 embraces coverage with evidence determination. Again, I
12 think it would be retrogressive to say, okay, let's take
13 all the stuff done and throw it out. I wonder if there
14 really isn't an opportunity to recommend a technical
15 advisory panel that looks at the 160 or so additionally
16 approved telehealth interactions and determines which ones
17 actually are offering the greater utility and the others
18 that, in fact, need that greater evidence determination.
19 Because these technologies are such a part of the
20 environment of commerce and personal interaction at this
21 point that I fear that it would be not only anachronistic
22 not to accept the reality that they're part of that

1 environment, but counterproductive to the broader notions.
2 I think we can find controls. Last time we had
3 some discussion about it, the linkage of number of virtual
4 visits to in-person visits, some sorts of ratios there, may
5 be the sorts of checks that supersede whether that entity
6 is a staffing solution that's embedded or whether it's the
7 primary care provider themselves who is offering the
8 service.
9 Thanks so much.
10 DR. CHERNEW: Jon, thank you. Paul?
11 DR. PAUL GINSBURG: Yeah. Two things. First,
12 I'm really glad that Marge brought up the point that we're
13 not ready for permanent telehealth policy once the public
14 health emergency ends. And I would think that the next
15 stage should be a, say, two-year pilot, which reflects all
16 of the policies we're talking about today, and it only
17 continues for two years unless it's extended, and would be
18 advised at that point.
19 I've also been thinking a lot about Larry's point
20 about obviously Teladoc companies do have lower costs than
21 a bricks-and-mortar practice that does a proportion of his
22 time on video visits or audio and the rest on in-person

1 visits. And I think if we see -- I don't particularly see
2 value in continuing the brick-and-mortar practice of
3 continuity of care fragmentation, you know, where the same
4 physicians would be seeing the patient in person as opposed
5 to on a video call.
6 So I think there are ways of making the
7 distinction, particularly using the Medicare claims data,
8 that volume of in-person visits that go on. So I think
9 normally the economist would say pay everything at marginal
10 cost, but if you have an entity that's not going to be
11 competitive with 100 percent televisit company, you've got
12 to do something to allow them to continue, which would be
13 at higher rates, or if you think the rate may be high
14 enough already, a lower rate for the Teladoc company.
15 DR. CHERNEW: Great. Okay, Paul. So now we have
16 Karen and then Pat.
17 DR. DeSALVO: Thanks. I just wanted to start by
18 saying how much I appreciate the work that the staff is
19 doing on this seemingly simple but very complicated topic,
20 to thread the needle of improving access, drive equity, but
21 also prevent fraud and abuse, and just complete disruption
22 of continuity of care. So I just want to say thank you. I

1 think the iterations make a lot of sense, especially some
2 of the things that relate to trying to prevent the fraud
3 and abuse side.
4 But I just have a general comment to say, which
5 is I think what we saw in the last year is that given the
6 option there's a lot of pull for leveraging technology and
7 virtual services, digital services. That's going to be a
8 continued push for health systems in the existing framework
9 to have a digital front door, but for consumers to want to
10 look for other pathways that don't require them to take off
11 work or school or find a sitter or someone for their parent
12 and take transportation to go park and then go to the
13 doctor's office at the doctor's convenience.
14 And so I think we got a little taste of the pull,
15 is what I want to say, and this is, I think, the beginning
16 of what could be a super complex journey if we try to build
17 all of that payment for technology on the fee-for-service
18 chassis. And I know we can't shift overnight and we need
19 to solve for this, so I think we're on a good pathway for
20 it. But it's going to happen sooner than we know, that the
21 digital signals world or the internet of things, you know,
22 the ways that we're tracking and monitoring people with

1 their consent in their home environments, and just the wave
2 of ambient computing incenting that's on the horizon will
3 make it quite difficult to figure out what's the fee
4 schedule and how to mitigate against it.
5 I think there's this other pathway the Commission
6 has been on about thinking about global budgeting and sort
7 of packing all that into what is the way that we hold
8 systems or providers accountable for the total cost of care
9 and outcomes for individuals will become increasingly
10 important as more of these technologies come on the market,
11 because they're just going to add cost and be confusing.
12 And this is the beginning of what I think will be a pretty
13 busy journey for the next few years.
14 So that's just my caution for all of us as we're
15 setting a foundation here. This is the backbone that a lot
16 of that stuff will get built on.
17 DR. CHERNEW: Karen, thank you. And I agree with
18 you. I think the challenge here is some of these services
19 provide really tremendous value, particularly to certain
20 populations, and we need to find a way to provide access.
21 But if we're not careful we will be in some huge cat-and-
22 mouse game, where we'll open the door to all of the good

1 things that we really, really want, and what will flood
2 through will be a bunch of things that we don't want and
3 don't want to pay for, and we're really struggling with how
4 to create the boundaries. Payment, of course, is only one
5 way. There's a bunch of other things, if you look at some
6 of the fraud cases, on ordering things. Those things may
7 have happened without even paying for the telehealth visit,
8 because the business model involved services that went back
9 to the telehealth amount.
10 So I guess part of the complexity here is why
11 we're not going to specific recommendations, and for those
12 of you that feel like we have a lot more of this mountain
13 to climb, that's absolutely true. And so I expect you'll
14 see more of this continuing in future cycles as well. It
15 is intellectually, I think, a real challenge. So I
16 appreciate your comments.
17 Let's go to Pat.
18 MS. WANG: Thanks very much. I also echo the
19 appreciate for the work and really for the discussion. I
20 think my sentiments are very much the same as what's been
21 articulated by a lot of the Commissioners.
22 I am torn between excitement at innovation,

1 technology. We all crossed the digital divide in the last
2 year. My personal opinion is it won't be the same again.
3 I don't know what it's going to be like, but it's not going
4 to be the same. And so the potential for a completely
5 different health care experience is tremendously exciting.
6 On the other hand, my fear is that this candidly
7 just becomes like urgent care again, where you have
8 duplicative, fragmented services that folks are paying for
9 in addition to, not instead of. So I appreciate all of the
10 sort of safeguards that folks have tried to build in, but
11 that's the fear.
12 So I guess, at a minimum, in the chapter as it's
13 written, I think it would be great to articulate the
14 sentiment that I think has been expressed by the other
15 Commissioners, that this is kind of what we see. This is
16 the immediate question in front of folks. What should we
17 extend? What should we pay for, but that we do anticipate
18 that this is going to be -- this is a completely new
19 modality in health care? I mean, will there be folks who
20 decide to get their health care entirely in a virtual
21 world?
22 What are the implications of that? So it's just

1 sort of -- I think it would be good to frame that we think
2 it's quite important to examine. I mean, payment policy is
3 almost the last thing. It's like what is the role of
4 telehealth in the Medicare system, and then how do we pay
5 for it?
6 I think that some of the considerations there
7 include, I mean, what commissioners traditionally talk
8 about. How do we encourage care coordination by PCP, or we
9 should do a care coordination fee? There was that
10 temporary thing that got put in place by the ACA. What
11 happens to something like that? I think that telehealth
12 companies are moving from what used to be kind of like a
13 really convenient, kind of urgent care model of calling
14 somebody, "Oh, I've got a rash. I'm home. I don't know
15 what to do," to kind of provide primary care. We'll
16 arrange for lots of things. We'll take care of your
17 chronic condition. It's kind of moving to a different
18 world, and as I said, that might be a really good thing if
19 that's what beneficiaries want or produces quality, but it
20 then gets -- another thing to think through is, so how does
21 that connect back into the ability to manage the total care
22 of a person? Are telehealth companies going to be subject

1 to interoperability rules? Is there an obligation to plug
2 back into the information highway so that someone's
3 information, if they get hospitalized in emergency, that
4 the information that comes up is not just what happened at
5 a traditional health care provider but also what happened
6 within telehealth? I think those things need to be thought
7 through a little bit.
8 I worry that -- at the same time of feeling like
9 this might be a great thing for beneficiaries, I really
10 worry about disturbing the primary care physician
11 relationship. I feel like these are services that people
12 will avail themselves of without understanding that their
13 PCP actually has no idea who they're talking to and the
14 advice that they've given because there is no feedback
15 loop. It's like urgent care. You walk in. You get what
16 you need, and your PCP never knows you went there. How
17 much more is that going to happen when it's so convenient
18 when people are pushing to sign up for this and you can
19 call this telehealth doctor anytime you have a problem?
20 I don't know what the answer is. I think it
21 would be good to be very conscious of this is the first
22 step, and I think the whole world of how digital health,

1 telehealth fits into the future of the Medicare health care
2 system, it's going to be things are going to change.
3 Thanks.
4 DR. CHERNEW: Great. So, Pat, I think you may
5 have had the last comment in Round 2. Others may be on the
6 sidelines. So I'm going to pause to see if anyone comes
7 off the sidelines.
8 DR. CASALINO: Mike?
9 DR. CHERNEW: Okay.
10 DR. CASALINO: I know I'm talking a lot this
11 session, but if I could just build a little bit on what Pat
12 said, since we have a little time yet? I'll just --
13 DR. CHERNEW: I'm hoping you would, Larry.
14 DR. CASALINO: Thank you.
15 DR. CHERNEW: We have some time, and that's why I
16 paused. Go on.
17 DR. CASALINO: Thank you.
18 Now, Pat's comments were great, I thought. I
19 think this is tricky. I don't think we want to -- I think
20 a lot of us have concerns about fragmentation and about the
21 quality of care that would be delivered by telehealth, but
22 I don't think we want to prejudge that or tell somebody who

1 feels that the convenience is so high that they want to use
2 that service. So I think it would be worthwhile to talk
3 about the issues maybe a little more than we do with
4 quality fragmentation and say we need more data on that,
5 because obviously Medicare doesn't want to pay for things
6 that have no value. But I don't think it's going to be the
7 case. I think the quality somewhere probably might be
8 okay.

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

19 Now, if the market makes that happen, that's the
20 way it is. It wouldn't be very good, in my opinion, but
21 that's the way it is. But if Medicare makes it happen by
22 paying one provider way, way above their costs, their

1 marginal costs, than another provider, then I think that's
2 a problem. I'll just leave it at that.
3 All day long, we talk about we don't want to pay
4 hospices or ASCs or whoever way, way above the cost them to
5 provide service. Why would we want to pay telehealth
6 companies way above what it takes to provide a service? So
7 that's what we'll do if we pay them at the same rate as we
8 would pay a bricks-and-mortar company for telehealth.
9 Jonathan raises a good problem that the
10 complexity of separating bricks-and-mortar from telehealth
11 companies is relatively easy now, but it could get harder.
12 But I think that's a problem that can be dealt with, and I
13 think it's going to have to be dealt with or we're going to
14 have problems, in my opinion.
15 DR. CHERNEW: I'm waiting for reactions.
16 DR. RAMBUR: If there's time --
17 DR. CHERNEW: So I agree with --
18 DR. RAMBUR: Go ahead.
19 DR. CHERNEW: Someone said something. I didn't
20 hear.
21 DR. RAMBUR: Go ahead. I was just going to say
22 if there's time, I'll comment, but go ahead, Michael.

1 DR. CHERNEW: There is time. Comment.
2 DR. RAMBUR: So I really appreciate this very
3 rich discussion, and just a few comments from my
4 perspective. There was a really interesting article
5 written by a primary care provider about mourning the lack
6 of or the reduction in face-to-face visits, and all of us,
7 I think, who are clinicians have in that model.
8 But I'm not so convinced that people will miss it
9 so much, and if you think about the enormous disruption for
10 people to do certain kinds of things -- taking off work,
11 taking elders, something I've just been through, a lot of
12 complexity -- and there's so many, I think, very exciting
13 things happenings that we should be learning, natural
14 language processing, more remote monitoring. So I really
15 like the idea of a two-year or some period of trial,
16 because I think there's going to be an explosion in things
17 that I personally can't even begin to think about.
18 And Bruce said something about physician or
19 robust or whatever, but there's also very simple things
20 like registered nurses, not nurse practitioners, not
21 physicians, not PAs, giving virtual support for families
22 who are doing chronic condition management. Unless there's

1 a certain global budget, those kinds of things are easily
2 reimbursed. So I think there's really a lot of
3 opportunities.
4 So I continue to feel that the audio-only has
5 value because of the number of people who are sort of out
6 of the picture without it. I'm very, very concerned about
7 the dialing for dollars and the potential for fraud, so the
8 enormous amount of scrutiny, that that needs to happen.
9 So that's my thoughts for now. Thanks.
10 DR. CHERNEW: Thank you, Betty.
11 Let me just try and summarize as we're coming
12 towards the end here. This is going to sound a little
13 hypocritical. We're really supportive of telehealth
14 broadly, and we very much understand that these
15 technologies are coming. And in many ways, they're the way
16 of the future and offer great value. With great value
17 comes great potential for abuse, and we're struggling with
18 how to deal with that in equilibrium.
19 We have a few things in the safeguard portion
20 there. I think there's some broad things we may be able to
21 say going forward. One of them, as several people have
22 mentioned, is we could keep this temporary as evidence

1 develops. We can experiment with different safeguards in a
2 whole variety of ways. I think there's a bigger issue
3 about how to separate out types of providers. That's much
4 more difficult. There's some operational issues about how
5 to build into APM.

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

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

1 what we're going to do.

2 I want to give the last word actually to Ledia or

3 Ariel, if you have any reactions to any of this. It's been

4 a far-reaching conversation, and you're the two most

5 important people here.

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

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

8 Ledia, go ahead.

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

10 rich discussion.

11 DR. CHERNEW: So we got the thumbs-up from Jim, a

12 whole bunch of thanks. We've all had a wonderful day.

13 I will say to the staff for all of the topics,

14 but certainly this one and the others, you guys put a ton

15 of work in. This is a really, really, really difficult nut

16 to crack, and I'll add my appreciation for all the work

17 you've done and all the information you've provided.

18 I'd like to thank the Commissioners for

19 navigating this sort of really good but kind of worrisome

20 kind of topic.

21 So we will go from there. Stay tuned, and again,

22 thank you.

1 In absence of any other comments, we are at the
2 end of our day. We'll be starting tomorrow at 9:30. I
3 think we're going to kick things off. Other than that,
4 I'll pause for a second to see if anyone wants to say
5 anything else. I will thank the people here and very much
6 thank the audience.
7 I want to add one other point while people ponder
8 if they want to say anything else. To the audience, we
9 very much want to hear your feedback. There's many ways to
10 provide feedback. Reach out to the staff. Send messages.
11 There's a website where you can contact us. So in a normal
12 public meeting, we would have time for folks to talk here.
13 Please do reach out and give us feedback. You should know
14 that at the beginning of every meeting, we get some summary
15 of what the feedback was, and we do take it quite
16 seriously.
17 So, again, thank you to the public for joining
18 us. Thank you for the Commissioners' comments, and thank
19 you to the staff for all of their work.
20 Jim, anything else?
21 DR. MATHEWS: No. All good.
22 DR. CHERNEW: All right. Thank you, everybody.

1 We'll see you tomorrow morning.
2 [Whereupon, at 4:45 p.m., the meeting recessed,
3 to reconvene at 9:30 a.m., Friday, January 15, 2021.]
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Virtual Meeting
Via
GoToWebinar

Friday, January 15, 2021
9:31 a.m.

COMMISSIONERS PRESENT:

MICHAEL CHERNEW, PhD, Chair
PAUL GINSBURG, PhD, Vice Chair
LAWRENCE P. CASALINO, MD, PhD
BRIAN DeBUSK, PhD
KAREN B. DeSALVO, MD, MPH, Msc
MARJORIE E. GINSBURG, BSN, MPH
DAVID GRABOWSKI, PhD
JONATHAN B. JAFFERY, MD, MS, MMM
AMOL S. NAVATHE, MD, PhD
JONATHAN PERLIN, MD, PhD, MSHA
BRUCE PYENSON, FSA, MAAA
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

AGENDA PAGE

The Medicare prescription drug program (Part D):
Status report
- Shinobu Suzuki, Rachel Schmidt, Eric Rollins.........3

Mandated report on the skilled nursing facility
value-based purchasing program and proposed replacement
- Carol Carter, Ledia Tabor, Sam Bickel-Barlow........64

Medicare’s vaccine coverage and payment policies
- Kim Neuman, Nancy Ray, Ledia Tabor.................118

Adjourn..141

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

2 [9:31 a.m.]

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

10 DR. SCHMIDT: Okay. Thanks. Good morning.
11 Today Shinobu and I will present a status report on Part D,
12 Medicare's outpatient drug benefit. This material will be
13 a chapter in the Commission's upcoming March report. We
14 would like to thank Eric Rollins for his contributions to
15 this work. As a reminder to the audience, a PDF of the
16 slides for this session is available at the right-hand side
17 of your screen.

18 Part D is complex, so we're going to spend part
19 of our time providing a high-level overview of the
20 program's approach and the role of manufacturer rebates.
21 We'll describe the effects of COVID-19 on Part D, then
22 provide a snapshot of the program and key trends. We'll

1 look at growth in drug prices and in the number of
2 enrollees with catastrophic spending. Finally, we'll
3 review the Commission's recommendations from last year and
4 open things up for your questions and discussion.
5 Prescription drugs are a critically important
6 part of patient care, and policymakers created Part D to
7 expand beneficiaries' access to drug coverage. Part D uses
8 a market-based approach: private plans compete for
9 enrollees based on the drugs they cover, premiums, cost
10 sharing, and pharmacy networks. The program was intended
11 to have plan sponsors bear risk for enrollee spending so
12 sponsors would have financial incentive to manage benefits.
13 Sponsors use the same management tools in Medicare as they
14 use for commercial clients, including formularies with
15 tiered cost sharing. However, CMS must approve Part D
16 formularies, and CMS requires certain beneficiary
17 protections. For enrollees with low income and assets,
18 Medicare subsidizes most cost sharing and premiums.
19 Separately, Medicare subsidizes about 75 percent of
20 premiums for basic benefits for nearly all enrollees. Part
21 D has other features that encourage broad participation of
22 plans and enrollees.

1 Some of the reasons for Part D's complexity are
2 that there are thousands of drug products and multiple
3 actors with key roles in providing drug benefits. Drug
4 manufacturers develop, produce, and market medicines. Plan
5 sponsors provide some insurance protection, enroll
6 beneficiaries, and administer benefits with the services of
7 a pharmacy benefits manager. The PBM operates the plan's
8 formulary, negotiates with manufacturers and pharmacies,
9 and adjudicates pharmacy claims. Pharmacies take physical
10 possession of inventories of drugs and dispense them to
11 beneficiaries, so plan sponsors and PBMs develop pharmacy
12 networks. When a beneficiary picks up her prescription,
13 the PBM pays the pharmacy an agreed upon amount. For some
14 brand-name drugs, the PBM later receives a rebate from the
15 manufacturer.
16 Private plan sponsors must be licensed to bear
17 insurance risk for their enrollees' spending. Most large
18 sponsors are vertically integrated and own their PBM, but
19 smaller sponsors contract for PBM services. Plan sponsors
20 and their PBMs take part in a couple of sets of
21 negotiations. One is with pharmacies, to set up networks
22 and agree on payment rates for prescriptions and post-sale

1 fees. The other negotiation is with manufacturers of
2 brand-name drugs over formulary placement and rebates.
3 Under Part D law, the Secretary is prohibited from
4 interfering in these negotiations, from requiring plans to
5 use a specific formulary, or from setting up a specific
6 price structure.
7 To focus on rebates for a moment, again, these
8 are payments from brand manufacturers to plans and PBMs
9 after the beneficiary has filled her prescription. They
10 aren't paid for every drug. It's generally when there are
11 competing drugs in a class and when plans can exclude some
12 drugs from their formularies. Manufacturers use rebates to
13 price discriminate -- to charge higher prices to some plans
14 over others. Plans that can help the manufacturer achieve
15 a larger share of the market over competing drugs pay a
16 lower net price. In Part D, plans generally use rebates to
17 keep their premiums lower than they otherwise would be.
18 This benefits the plans' enrollees and, because Medicare
19 subsidizes the premium, the Medicare program.
20 Rebate amounts are proprietary. Plans and
21 manufacturers don't want competitors to know what rebates
22 they've negotiated because it would affect the deals

1 they've struck. So this system allows some plans to get
2 steeper discounts than others, but it also means that
3 prices are not transparent. Over time, rebates have grown
4 faster than prices at the pharmacy, and there's been an
5 expanding gap between pharmacy prices and net-of-rebate
6 prices. When plans design their cost sharing as
7 coinsurance, it is based on a percentage of the higher
8 pharmacy price. As a result, beneficiaries can end up
9 paying a higher share of their prescription costs. This is
10 one reason behind calls to reform rebates. In November
11 2020, the Department of Health and Human Services Office of
12 Inspector General finalized a rule that would prohibit
13 rebates in Medicare Part D as they are used today. The
14 rule would withdraw rebates' exemption from the Anti-
15 Kickback Statute effective January 1, 2022, but would
16 permit rebates if they were used to reduce drug prices at
17 the point of sale. We can provide further detail about
18 this if you have questions.
19 So Part D is complex because there are multiple
20 actors because of the use of rebates, but also because it
21 has a complicated benefit design. Actually, there are two
22 distinct standard designs: one for enrollees without low-

1 income subsidies, such as shown on the left, and another
2 for those with the LIS, which is shown on the right. Last
3 year, the Commission recommended changes to these
4 structures for several reasons.
5 First, note that plan sponsors bear risk on the
6 sections in blue. For either type of beneficiary, plans
7 don't bear much risk at all in the coverage gap -- 5
8 percent on the left and zero on the right -- or in the
9 catastrophic phase where Medicare pays 80 percent of costs
10 and plans bear 15 percent. Rebates on some drugs can be
11 larger than the plans' liability. This structure
12 undermines plans' incentives for managing spending.
13 Second, beneficiaries without the LIS receive a
14 70 percent manufacturer discount on brand-name
15 prescriptions in the coverage gap, which is shown in
16 yellow. That discount makes brand-name drugs look
17 artificially cheaper relative to generics, and the discount
18 gets counted as though it were the beneficiaries' own out-
19 of-pocket spending towards reaching the catastrophic phase.
20 Third, note on the left-hand side that there's
21 unlimited cost sharing for enrollees without the low-income
22 subsidy who have very high drug spending, 5 percent.

1 Switching now to the status of the program,
2 obviously 2020 was an extraordinary year because of the
3 COVID-19 pandemic. Relative to the effects of the pandemic
4 on use of other medical services, Medicare beneficiaries'
5 access to prescription medicines had comparatively less
6 disruption. When state and local jurisdictions put
7 restrictions in place, pharmacies and grocery stores were
8 often permitted to remain open. Initially last March,
9 beneficiaries stockpiled medicines with 90-day supplies and
10 filled more prescriptions at mail-order pharmacies. CMS
11 encouraged Part D plans to loosen some management tools to
12 make those supplies available. After drawing down those
13 stocks, peoples' patterns of filling prescriptions returned
14 closer to those of the previous year. Unlike providers who
15 rely on billing Medicare for their revenues, throughout
16 2020, Medicare paid monthly payments to Part D plans based
17 on bids the plans had submitted in June 2019. If a plan's
18 actual benefit spending was lower than what they had
19 anticipated in the bid, Part D's risk corridors would help
20 the Medicare program to recoup a portion of the profits
21 that the plan would otherwise keep.
22 Let me quickly go over the current snapshot of

1 the program. In 2020, among 63 million Medicare
2 beneficiaries, nearly 75 percent were enrolled in Part D
3 plans. Nearly 2 percent got drug benefits through the
4 retiree drug subsidy, in which employers provided primary
5 drug coverage to their retirees in return for Medicare
6 subsidies. The remaining 23.5 percent was divided fairly
7 equally between those with other sources of drug coverage
8 as generous as Part D and those with no coverage or less
9 generous coverage.
10 Medicare program spending for Part D totaled over
11 $88 billion in 2019, predominantly for payments to private
12 plans, with less than $1 billion for the retiree drug
13 subsidy.
14 In addition, Part D enrollees directly paid
15 nearly $14 billion in premiums, as well as additional
16 amounts for cost sharing and supplemental coverage. More
17 than nine in ten enrollees say they are satisfied with the
18 program and with their plans.
19 And now Shinobu will take you through key trends
20 we've seen in Part D.
21 MS. SUZUKI: Part D enrollment has grown by about
22 5 percent per year, faster than the overall growth in

1 Medicare beneficiaries. As a result, today a higher share
2 of Medicare beneficiaries is in Part D than at the start of
3 the program.
4 In 2020, nearly half of the enrollees were in MA-
5 PDs, a shift from earlier years when most enrollees were in
6 stand-alone PDPs; 27 percent received the low-income
7 subsidy compared with 39 percent in 2007.
8 More beneficiaries are in employer-group waiver
9 plans as many employers switched from receiving RDS to
10 operating Part D plans, and today about 15 percent are in
11 these employer-group plans.
12 In 2020, monthly premiums averaged about $27, a 7
13 percent drop from the prior year. Average premium has
14 remained stable at around $30 since 2010, but there's a lot
15 of variation around that average.
16 For 2021, the number of plans offered are up,
17 providing broad choice of plans. A lot of that growth is
18 in enhanced plan offerings, including the new model run by
19 Centers for Medicare and Medicaid Innovation, which I'll
20 talk about next.
21 The number of PDPs that are premium-free to LIS
22 enrollees increased by 6 percent, and all regions have at

1 least five such plans.

2 Last year, CMMI introduced a new voluntary model

3 called Part D senior savings model that would cap

4 beneficiary cost sharing for insulins.

5 Participating plans must offer at least one of

6 each type of insulins at cost sharing of no more than $35

7 per one-month supply.

8 The model is limited to non-LIS beneficiaries who

9 enroll in participating enhanced plans. About 1,600 plans

10 are participating this year.

11 The model allows plans to offer enhanced benefits

12 for insulins without losing manufacturer discounts in the

13 coverage gap.

14 By ensuring cost sharing of no more than $35, the

15 model could improve access and adherence to insulins. But

16 it does not address high insulin prices, and enrollees in

17 participating plans may face higher supplemental premiums.

18 This table shows indexes measuring prices at the

19 pharmacy before post-sale rebates and discounts. The first

20 two columns show price indexes for 2018 and 2019 relative

21 to prices in January 2006. The last two columns show

22 growth rates.

1 As shown in the top row, overall prices grew more
2 slowly in 2019, growing by 2.6 percent compared with an
3 average annual growth of 5.3 percent in prior years. This
4 slowdown is also seen for brand-name drugs, shown in the
5 second row. But the growth rates for brand-name drugs are
6 much higher than for all drugs and biologics.
7 When generic substitution was taken into account,
8 prices decreased by 2.1 percent, reversing the inflationary
9 trend before 2019.
10 But the change in price indexes varied widely
11 across therapeutic classes. Prices decreased for classes
12 with new or increased generic competition such as
13 anticonvulsants, while prices continued to rise for
14 therapeutic classes dominated by brand-name drugs or
15 biologics such as anti-inflammatory drugs.
16 And these high-priced specialty drugs and
17 biologics are one of the main factors driving Medicare's
18 reinsurance spending, which we'll turn to next.
19 This table shows Medicare's spending on Part D.
20 It includes Medicare's payments to plans, including the
21 low-income subsidy that pays premiums and cost sharing for
22 LIS enrollees and less than $1 billion for RDS.

1 I want to focus on the top two rows: the direct
2 subsidy, which is a monthly capitated payment and
3 reinsurance, which is a cost-based reimbursement that
4 covers most of the catastrophic costs.
5 In 2019, reinsurance grew to just over $46
6 billion, up from $40.6 billion in 2018 while the direct
7 subsidy declined from $13.5 billion to $11.6 billion.
8 This pattern has persisted over the years.
9 Between 2007 and 2019, reinsurance grew by an annual
10 average of nearly 16 percent compared with a 3.4 percent
11 decrease for the direct subsidy.
12 This rapid growth in cost-based reimbursement
13 means that a disproportionate share of risk is borne by
14 Medicare and, therefore, taxpayers. The contrast between
15 2007 and 2019 highlights the diminished role of the
16 capitated direct subsidy payments that was supposed to
17 provide market-based incentives.
18 Total Part D spending at the bottom shows an
19 increase of about $5 billion between 2018 and 2019. That
20 increase is almost entirely driven by the growth in
21 Medicare's payments for reinsurance.
22 As you saw earlier, Medicare's reinsurance picks

1 up 80 percent of the cost once an individual reaches the
2 catastrophic threshold. 2019 saw the largest ever increase
3 in these high-cost beneficiaries, with 4.3 million, or
4 about 9 percent of all Part D enrollees, reaching the
5 catastrophic phase of the benefit.
6 That's a 12 percent increase from 2018, and most
7 of that increase was among non-LIS enrollees shown in blue.
8 The surge in high-cost, non-LIS enrollees was
9 driven primarily by two factors.
10 First, the recent law change that increased the
11 manufacturers' coverage gap discount from 50 percent to 70
12 percent. That meant many people reached the catastrophic
13 threshold with lower spending than in 2018.
14 Second, the use of prescriptions for which a
15 single claim is sufficient to reach the catastrophic phase
16 continued to grow, with more than 480,000 enrollees filling
17 such claims in 2019 -- this is up by more than 100,000 in 2
18 years, from 380,000 in 2017 and just 33,000 in 2010.
19 At the same time, general indicators of access
20 show improvements in formulary and coverage decisions, and
21 more than 80 percent of the surveyed beneficiaries report
22 high satisfaction, saying that their plans provide good

1 value with reasonable cost sharing.

2 So the trend reflects dichotomy among

3 beneficiaries without the low-income subsidy. For them,

4 access depends on their medication needs.

5 For those taking generic drugs for common

6 conditions, Part D provides good coverage and access.

7 But for those who need many brand-name drugs or

8 high-priced specialty drugs, high cost-sharing requirements

9 may pose barriers to access.

10 These trends in program cost and access highlight

11 two main issues in Part D: the decline in plan's insurance

12 risk that undermine their incentives to manage spending and

13 the increasing role of drugs with very high prices.

14 Last year, the Commission recommended changes to

15 restructure Part D.

16 To address distortions in plan incentives created

17 by rebates and discounts that increase Medicare's

18 reinsurance costs, the Commission recommended eliminating

19 the coverage gap discount and increasing plan liability in

20 the coverage gap and the catastrophic phase of the benefit.

21 To address high prices and high-cost sharing, the

22 Commission recommended creating a new manufacturer discount

1 and providing a complete insurance protection in the
2 catastrophic phase.
3 The recommendations included other provisions to
4 restore market-oriented incentives while providing greater
5 flexibility to manage benefits.
6 Here's a list of items for your discussion.
7 Based on your feedbacks from the fall presentations, we
8 plan to continue our work on Part D's risk adjusters and
9 LIS benchmarks. We also plan to focus on Part D's for all
10 in long-term care settings.
11 We're also excited to report that the recently
12 passed Consolidated Appropriations Act included a provision
13 to provide MedPAC with access to Part D rebate data. We're
14 hoping to begin exploratory analysis as soon as we have the
15 data in-house and update you on the progress during the
16 next cycle.
17 We're interested in your feedback regarding the
18 mailing materials and our future work plan.
19 With that, we'll turn it over to Mike.
20 DR. CHERNEW: Great. Thank you all.
21 I will just emphasize how excited we are about
22 getting the rebate data. I won't take more of your time to

1 emphasize that.

2 But Dana is going to manage the list. I know

3 there's some people on it. So, Dana, you should call folks

4 out.

5 MS. KELLEY: Okay. I have Brian first with a

6 Round 1 question.

7 DR. DeBUSK: Yes. First of all, thank you for a

8 great report, a really, really good read.

9 I had three questions, and they're all tied to

10 this rebate rule, the November rebate rule. Just to

11 clarify, if a manufacturer is offering, let's say, a 20

12 percent discount and that discount is reflected at the

13 counter when the beneficiary purchases the drug, is there

14 any way that even with this new rebate rule -- is there any

15 way that that process could run afoul of this new rule?

16 Would it still stay in the safe harbor?

17 DR. SCHMIDT: I think the intention is for yes.

18 That would be within --

19 DR. DeBUSK: Okay. There is. Okay. I just

20 wanted to make sure I wasn't missing.

21 Now, similarly, let's say that same 20 percent

22 was tied to some year-end purchasing goal. Let's say as

1 long as you don't put drugs on there to compete against me,
2 then you get the 20 percent. Well, you wouldn't know if
3 you had it or not at the time of the purchase. Is there
4 any way a rebate structure like that should make it through
5 the rebate rule, this new rule, and enjoy safe harbor?
6 DR. SCHMIDT: I think that's the crux of it.
7 There is a wide variety of estimates that affects this
8 rule, and I think that's getting towards the crux of the
9 reason there is a wide range of estimates. The key
10 question is --
11 DR. DeBUSK: Based on your -- I'm sorry.
12 DR. SCHMIDT: I'm sorry.
13 DR. DeBUSK: No. Please, please go ahead.
14 DR. SCHMIDT: Just a key question is would, for
15 example, the Office of the Actuary argue that because the
16 manufacturers would no longer be able to look at what was
17 attained in terms of market share of your product. They
18 would not offer as large rebates, and so in order to
19 structure and negotiate a rebate, sort of the structure
20 that would provide as much of a discount as they've been
21 getting under the current setting, how rebates are used.
22 But the flip side of that is that other people

1 are arguing, well, plans, if they're not receiving these
2 rebates, if they're going to the beneficiary of the point
3 of sale and maybe they'll have different kind of formulary
4 incentives, you know, with the weird benefit structure that
5 Part D has, sometimes those rebates are larger.
6 That's kind of the two sides of the coin, and
7 there's just a lot of uncertainty about what the behavioral
8 response is.
9 DR. DeBUSK: Thank you.
10 I have one last question, and I share Michael's
11 view on the excitement over getting the rebate data. Will
12 we have any insight into how those rebates are structured?
13 For example, that 20 percent rebate, when they share that
14 data, will we know if that's a proportional rebate or some
15 type of punitive rebate?
16 DR. SCHMIDT: I don't know that we'll know, and
17 we've never --
18 DR. DeBUSK: We'll say the 20 percent.
19 MS. SUZUKI: My -- or our general sense is we'll
20 know the amount, and usually that would be reported at the
21 drug level. However, I don't think we would have insight
22 into exactly how the contract was structured.

1 DR. DeBUSK: Okay. Well, thank you, and thank
2 you again for a great report. That answered my questions.
3 DR. PAUL GINSBURG: I'd like to come in with a
4 follow-up to Brian's first question. Given the rebate rule
5 along with the Most Favored Nation rule for Part B drugs
6 were kind of a series of last-minute rules issued by the
7 Trump administration, all of which have been sued to block,
8 and I think many of the lawsuits are going to prevent them
9 because often the administrative procedures were violated.
10 So we shouldn't assume if that is part of the permanent
11 landscape.
12 I think now that we have the rebate data and we
13 can identify some issues to work on in rebates, we should
14 probably assume clean slates, though we may come up with a
15 much better idea for dealing with the problem that
16 beneficiaries that use highly rebated drugs pay a lot for
17 them, other than the rebate rule. And when we get down the
18 road, I have my own ideas, which I've published on.
19 Thanks.
20 DR. SCHMIDT: I understand people are having a
21 little difficulty hearing me. Is this any better? Okay.
22 Yes, Paul. You're absolutely right. I think there's

1 already been a legal challenge to this rebate rule on the
2 administrative procedures aspect but also because part of
3 the rule said that it would only be implemented if it
4 wouldn't increase program spending or beneficiary premiums.
5 The Secretary of Health and Human Services says
6 that that will be the case. It won't increase spending,
7 but prior estimates of the effects of this by both the
8 Congressional Budget Office and the Office of the Actuary
9 said that it would increase both beneficiary premiums and
10 program spending. So we shouldn't necessarily assume it
11 will be implemented.
12 In our comment letters, we've also argued that
13 our fundamental restructuring of the beneficiary structure,
14 the benefit design of Part D would go far away towards
15 providing better formulary incentives and might overcome
16 some that choose with rebates.
17 DR. PAUL GINSBURG: Thanks, Rachel.
18 MS. KELLEY: Okay. I have Bruce next.
19 MR. PYENSON: Thank you very much. This is a
20 terrific chapter.
21 As you've indicated, the industry is highly
22 concentrated. I'm wondering if you have thoughts on

1 justifying a three-year phase-in for some of the biggest
2 corporations in America that dominate Part D. Do we have
3 support for that? I know that's part of our
4 recommendation, but I wonder if you could discuss a little
5 bit on the thinking of the need for that, given how
6 consolidated the industry is.
7 DR. MATHEWS: So, Bruce, that was, indeed, part
8 of the Commission's recommendation last year. I would be
9 hesitant to start to second guess that or reopen that
10 recommendation on the basis of this one element.
11 DR. CHERNEW: And just to jump in, so for people
12 listening, we are not -- I was not part of the Commission
13 when that recommendation was made, for people who don't
14 follow all the MedPAC goings-on, but nevertheless, I think
15 we're not relitigating that recommendation for now for
16 focus. I mean, that recommendation stands, just to make
17 that point. We'll see where it goes.
18 Obviously, it hasn't been taken up yet, but I
19 think there's a lot there that was outstanding work. But
20 back to you, Dana.
21 MS. KELLEY: Sue?
22 DR. CHERNEW: Dana Kelley. I think she's going

1 to call the next person.

2 MS. THOMPSON: Yes, she did. Thank you, Dana.

3 And, Rachel and Shinobu, it's so nice to see your

4 faces, so good morning. Again, thank you for all of your

5 good work in this arena, and again, it was great to see

6 your chapter.

7 I'm going to go back to a comment that's within

8 your chapter that we haven't seen much benefit as it

9 relates to medication therapy management programs. I'll

10 prepare you. My question is on how did you assess it. How

11 are we assessing that? How many programs have we looked

12 at?

13 My strong belief here is that the root of this

14 big problem around drugs is we're prescribing way too many

15 drugs, and we've got a whole lot of beneficiaries out there

16 that are overmedicated, and so talk a little bit about,

17 again, your assessment of the MTM programs that exist.

18 MS. SUZUKI: I can start. I think one of the

19 things we reported is on the enhanced MTM program, which

20 gave certain plans more flexibility than are available to

21 them under current law. Under those enhanced MTMs, there

22 was a requirement for CMS to do an evaluation. In our

1 paper, what we discussed is some of the results of
2 evaluation reports that come out.
3 The intent of enhanced MTM, in addition to
4 looking at medication used, is to see whether there were
5 effects on health outcomes as measured by Parts A and B
6 spending, and overall they did not see effects on Parts A
7 and B spending from investing more in these MTM services.
8 It's hard to discuss how the other, current law,
9 MTM programs are working. There's not a lot of data that
10 measures what those programs are doing. We know that plans
11 are required to provided MTM services. They do try to
12 reach out to eligible beneficiaries who are taking multiple
13 medications or meet certain condition requirements, and
14 there are some take-up of medication reviews. It's just
15 not clear whether that's resulting in health outcomes.
16 DR. CHERNEW: I think --
17 MS. THOMPSON: One follow-up question, Mike.
18 Is it clear about the extent of their investment
19 in MTM?
20 DR. SCHMIDT: I think there's a variety of
21 different approaches that plans are using. Some are more
22 invested than others. It's not entirely clear. Some are

1 using mail, phone calls, that sort of thing. Others are
2 getting the pharmacist more directly involved. It's just a
3 wide variety of approaches. So we don't know the extent to
4 which any of those are successful or some are more
5 successful than others.
6 I think we generally share your concern about
7 polypharmacy which we've written about in the past with the
8 Medicare population. So we've raised this as a problem.
9 MS. THOMPSON: Thank you both.
10 DR. CHERNEW: Yeah. So let me just jump in and
11 say two things, and this is just building on what Rachel
12 said. The screen is so small, I can't see people's
13 reactions. So I'm going to watch you, Rachel and Shinobu,
14 who I actually don't see on my screen.
15 In any case, there's a few things. The first one
16 is all of the analysis -- and this is more than just this
17 Part D chapter or medication therapy management services.
18 Our conclusions are based on averages. So in no way does
19 that mean there aren't potentially successful programs that
20 are working very well. When we say they don't work of
21 something is not giving us savings, for example, that's
22 really more comments on averages. That's the way research

1 works in general.
2 The second point is I think there's a lot of
3 things where we've realized there's a problem, and we're
4 not quite as successful at solving the problem, even though
5 we've put in place policies where we would hope we would be
6 able to address the problem. And then after the fact upon
7 the evaluations, we aren't as impressed with the results as
8 we might have been going on. Sometimes that's an execution
9 issue.
10 I'm not sure exactly what's going on here, but
11 you should interpret the findings as an assessment of where
12 we are in the literature, not a belief that polypharmacy is
13 not a concern, because I think in many ways it is.
14 MS. KELLEY: All right. Then, Amol, you're next.
15 DR. NAVATHE: Thank you for a great chapter.
16 My questions, hopefully, is a simple one. In the
17 LIS, in the policy option recommendation, where I'm trying
18 to make the LIS part more -- there was a suggestion to
19 allocate the auto-assign, randomly assigned beneficiaries
20 proportionately based on the premium. What I was curious
21 about is what -- where is there variation, if at all, in
22 the benchmark plans based on their premium variations and

1 knowing that they do vary, obviously, in their premiums?
2 Are there any other factors around coverage or benefit
3 design or anything else that actually does have variations
4 that may be correlated with their premiums?
5 DR. SCHMIDT: You can feel free to jump in here
6 too.
7 So they're all basic plans -- basic benefits.
8 They're not plans, but not hardly any at all use the
9 standard benefit design. So there is variation. Whether
10 they're charging the copays, exact copays they're charging,
11 they all have to be actuarially equivalent to the basic
12 benefit. But the formularies and the cost-sharing
13 structure can differ from plan to plan, as long as they
14 have that same average value.
15 So I'm not sure if that's addressing the
16 question.
17 DR. NAVATHE: I think that is addressing the
18 question because I think, in part, because -- I expected
19 you to say there was some variation there around those
20 factors. That's what I guessed, and if that's the case,
21 then I wonder a little bit about the wisdom of auto-
22 assigning proportionately, because we could actually have

1 some more -- "generosity" may not be the right exact word,
2 but there could be differences around how chronic condition
3 medications are on the formulary or what have you. It
4 might behoove us to look a little bit more deeply at that
5 to ensure that there's not any unintended effect like heard
6 in LIS bene.
7 DR. SCHMIDT: That's a good point, I would say,
8 but I would also just remind everyone that there is a
9 review of the formularies that CMS does to try and ensure
10 that there's pretty broad coverage, and in fact, in an
11 evaluation that CMS does, they found that most of the drugs
12 needed by LIS beneficiaries tend to be widely available
13 across, among the plans.
14 DR. NAVATHE: Thanks, Rachel.
15 MS. KELLEY: Dana?
16 DR. SAFRAN: Thank you.
17 I have two questions. One is I didn't see
18 anything in the chapter about quality measurement, and I
19 know that Medicare Advantage plans have prescription drug
20 measures that they're accountable for through stars, and
21 I'm curious whether we have similar measures that are
22 applied for Part D plans, and regardless of whether we do

1 or we don't, what we know about the comparability of
2 quality and member experience in the MA plans with Part D
3 versus the Part D plans for members in original Medicare.
4 That's my first question.
5 My second question is a kind of bigger, broader
6 one, and that is as we think about the fact that this is
7 the newest part of the Medicare program and looking at the
8 spending trends, thinking back to the rationale for
9 introducing Part D and the importance of access to drugs
10 for seniors particularly as medications were starting to
11 and continue to play such a larger and larger role in
12 managing health and health conditions, I'm curious whether
13 there have been any analyses by MedPAC staff or otherwise
14 that really try to stand back and look at the value that
15 has been brought by having Part D. For example, in
16 commercial, we think all the time about the value of
17 managing chronic conditions to avoid the complications and
18 longer-term effects that can land people in hospitals and
19 with very serious health complications of chronic illness.
20 And I'm curious because I don't think I've ever
21 seen it in my years on MedPAC whether there have been
22 analyses that really stand back and look at sort of the

1 value of Part D, both from a financial perspective for the
2 program and for kind of health and avoided health
3 complications for beneficiaries.
4 Thank you.
5 MS. SUZUKI: I'll start with the quality
6 measures. We did discuss the star rating that's comparable
7 to what's in MA-PDs but measure somewhat different items.
8 It used to be focused on adherence, with most weights
9 coming from adherence to, say, statins or hypertensive
10 drugs. I think in recent years they've switched to more
11 beneficiary experience measures, so the weights on those
12 measures have gone up.
13 So there are 14 metrics, a much smaller number
14 than for MA-PDs. For MA-PDs they have combined MA measures
15 plus the 14 metrics for Part D. It's hard to compare PDPs
16 versus MA-PDs directly, but typically there are substantive
17 plans that are doing well, in terms of star rating. It's
18 hard to know what that really means in terms of quality of
19 the plans. Some of it measures, are the prices listed on
20 Plan Finder accurate, or how's the -- adherence continues
21 to be some of the measures. And I think patient access and
22 process and that sort of thing is also measured. That's

1 based on CAHPS survey results.

2 So we haven't put a lot of work into trying to
3 figure out whether those measures correlate with anything
4 in the Part D program. Part of it is it's hard to measure
5 how the outcomes and the relationship between what Part D
6 is doing -- so a couple of years back we tried to look at,
7 for example, adherence and outcomes, and we found that
8 figuring out what outcome, measured by, say, Parts A and B
9 spending, is really affected by better or worse adherence
10 to certain medications, even when we limit it to certain
11 beneficiaries with same conditions.

12 So this is an area where we've tried, but the
13 health outcomes is a difficult thing to measure, especially
14 in a population where they're aging and adherence seems to
15 drop off when there's some health even that's unrelated to
16 the adherence happens. So that's one.

17 DR. SCHMIDT: On your question about the overall
18 benefits of Part D, I don't think there are a lot of
19 studies, and I don't know that they've focused particularly
20 on Part D. I've seen studies, for example, that just talk
21 about broader availability of medicines that treat cardiac
22 conditions and the broad benefits associated with those,

1 especially since so many of those medicines right now are
2 available on a generic basis and so the costs are way low,
3 so there's usually large social benefits associated with
4 that. And given our population [inaudible] a benefit
5 associated with that. But I'm not very familiar with
6 studies that have looked at the social value of Part D per
7 se. I haven't been looking for it, but we can probably do
8 that.
9 DR. SAFRAN: Thank you both.
10 MS. KELLEY: Jaewon?
11 DR. RYU: Yeah. I had a question that's a little
12 related to that topic and maybe the MTM topic as well, and
13 it gets to the interrelatedness between standalone PDP and
14 APM models. And I was just curious if there is any
15 analysis along those lines, meaning could it be that bigger
16 uptake in APM models has enhanced medication adherence and
17 driven up standalone PDP cost, and the benefit is sitting
18 over on the A and B side? I think the MA-PD, it's a lot
19 cleaner because all of it is bundled together into a single
20 program, but I wonder -- and I'm curious if we have any
21 information that ties, in a standalone PDP, with the
22 activity of APMs.

1 And the other question that's kind of related is
2 I think to the extent programs have, like in bundles where
3 they've put drug costs in together, I believe it's mostly
4 just on the Part B, as in boy, side, but I was curious if
5 there's any interrelatedness or interface, interaction
6 between the two programs.
7 DR. SCHMIDT: I'm sorry. I'm not -- oh, I'm
8 sorry. Go ahead, Shinobu.
9 MS. SUZUKI: Go ahead, Rachel.
10 DR. SCHMIDT: I was going to say, I'm not
11 familiar with studies that have looked particularly at the
12 intersection between PDPs and APMs, but a few generally
13 thinking about -- we had some discussion within the
14 Commission in past years about ACOs and PDPs, and the fact
15 that there are some plan sponsors of PDPs that have
16 actually tried to establish some relationship with ACOs.
17 But it's always been on an informal basis. But I'm not
18 aware of studies of that per se.
19 DR. RYU: Thank you.
20 MS. KELLEY: All right. I think we are ready to
21 move to Round 2, and I have Brian first, unless you want to
22 start off, Mike, with anything? We can't hear you, Mike.

1 DR. CHERNEW: That's all right, because I wasn't
2 saying anything of consequence. I think we should jump
3 right into the Round 2 comments and then we'll see where
4 that takes us, and I'll make comments at the end, depending
5 on how long they go.
6 MS. KELLEY: Okay. Brian then.
7 DR. DeBUSK: Thank you, and first of all, Rachel
8 and Shinobu, thank you again for a wonderful chapter.
9 Still, I want to compliment the work on the restructuring
10 of the reinsurance benefit. I mean, that literally
11 predated my time even on MedPAC. I think that was a 2016
12 work, analysis, but it was very, very impressive work. And
13 I also want to compliment you on your work on the LIS last
14 year. I think last year's work, taking on LIS in the Part
15 D drug benefit was also very, very impressive work.
16 I want to encourage everyone, both of you but the
17 whole staff, to keep digging into this rebates issue. I've
18 been hung up on rebates for a very long time and I just
19 want to take a moment and point something out. These
20 aren't 2 and 3 and 5 percent discounts that we're talking
21 about here. To give you a feel for the scope, according to
22 my math, you've got about $14 billion a year in premiums

1 coming into Part D. You've got about $17 billion in cost
2 sharing. Now consider that against the backdrop of $28
3 billion in rebates. When you consider that cost sharing
4 presumably is to influence beneficiary behavior, and we
5 feel that $17 billion in play is enough to influence
6 beneficiary behavior, well, how much influence does $28
7 billion buy? I mean, the money that's changing hands
8 behind the scenes is almost double what we spend in cost
9 sharing.
10 So I would hope that we continue to dig into
11 rebates. I do think that the current rule -- and Paul, I
12 agree with you; I think there are a number of legal
13 challenges and some issues with the current rule as it
14 stands -- but I think this idea, directionally, this idea
15 of cleverly dissecting beneficial rebates, pure discounts,
16 dissecting those from these more punitive and predatory
17 rebates I think is very, very important work. And I think
18 there's a clear distinction between the two. And I think
19 lumping all rebates into one bucket is very flawed.
20 And so again, any work that we can do to try to
21 define what is a beneficial rebate, what is a punitive
22 rebate, and then dissect those from the policy so that we

1 keep the good and we shun the bad. I really hope we'll
2 continue to do work there, and again, Rachel and Shinobu,
3 fantastic work. I always enjoy reading your work. Thank
4 you.
5 MS. KELLEY: Bruce?
6 DR. CHERNEW: Can I step in for one second first,
7 before Bruce? Brian, I'm sorry. I was muted again. First
8 of all, our excitement about the rebate data is not because
9 we wanted the data to work and we can work with the data.
10 It was because we wanted the data and we will work with the
11 data. So you don't have to worry about us digging into
12 some of the rebate activities. We certainly will.
13 I might add, there are a lot of other
14 institutional things that are related to discounts that
15 aren't necessarily considered rebates. A good example
16 would be 340B and what's going on in 340B where there's a
17 serious of other discounts that are given, and I imagine
18 Bruce would know something about 340B. But the point is
19 this discrepancy between the amount that's paid to the
20 companies, the amount that's charged to patients, how the
21 money is flowing in complex ways is an important topic.
22 And so to the extent that your comment was we should

1 continue to dig into that, the answer is yes.
2 MR. PYENSON: And I also agree with that,
3 Michael, and I want to echo Brian's compliments for the
4 team on this work.
5 My comments are about the future work. I think
6 that we should examine the consolidation of the industry in
7 a bit more detail. It's difficult because of the vertical
8 and horizontal consolidation of the PBM and Part D industry
9 and drugstores and other elements there. But I think
10 that's a critical element of understanding what's happening
11 in Part D. In particular, I think a look at this would
12 identify where the risk issues are and where the role
13 rebates and other kinds of transfers perhaps related
14 parties.
15 So I think I would put that onto the work issue.
16 I don't think we can come close to understanding Part D if
17 we really don't do that. Only part of that is the rebate
18 issue. As you know, an important part of direct and
19 indirect reimbursement are the fees that are paid by
20 drugstores to Part D plans or PBMs, which weren't affected
21 by the change in the interpretation of the Anti-Kickback
22 Statute.

1 So to put that as a bullet point, I think,
2 looking at the industry structure and the consolidation of
3 the industry I think would be an idea I have for future
4 work. Thank you.
5 MS. KELLEY: Paul?
6 DR. PAUL GINSBURG: Thanks. You know, on the
7 slide in front of me, Questions and Discussion, the first
8 one, feedback on the draft chapter, really outstanding
9 chapter and presentation. I'm just really, really pleased
10 with it. And I'll endorse Brian's statement about the past
11 work in this area has been very strong.
12 I have two ideas for future work. One which has
13 already been brought up by Brian is rebates. I think this
14 is an area we haven't worked on. Now that we have better
15 tools we can do better work. I think that the immediate
16 problem is solving the issue for the beneficiaries who
17 happen to unfortunate enough to be using, or need to use,
18 for their illness, the highly rebated drugs and wind up
19 basically subsidizing their colleagues in the benefit pool
20 in Part D.
21 There are some simple solutions that Medicare
22 could consider such as what UnitedHealthcare is doing in

1 its commercial plans, which is providing at the point of
2 service an approximate amount of rebates, which still
3 shields the secrecy, which I think does have value. And,
4 of course, there's a premium increase when that happens,
5 but it's a legitimate premium increase because basically
6 the benefits are hollowed out as rebates grow along with
7 list prices, and it's really a way of restoring. And
8 that's really happened in Medicare. That's why, as you've
9 shown in your presentation, you have what the beneficiary
10 pays has been roughly unchanged for a decade now. It's not
11 that this insurance is doing great. It's just that it's
12 being hollowed out.
13 My second ideas is I'd like us to look into
14 various approaches to provider limits on prices for brand-
15 name drugs that don't have competitors. There's been a lot
16 of policy discussion and activity in the Congress and in
17 the administration about these limits. I think the initial
18 movement towards taking prices to those in other countries
19 is not the best way to proceed. I think a much better way
20 to proceed would be to set up expert panels to opine on
21 value and set payments according to value.
22 And so I think the Commission has the potential

1 to look at what some of the other countries who use this
2 approach have done, and also look into the unexpected
3 consequences, shortcomings, of pegging prices to prices in
4 other countries rather than having the United States come
5 up with its own judgments as to what prices would be
6 appropriate. Thanks.
7 MS. KELLEY: Larry?
8 DR. CASALINO: Yeah, two quick things and a
9 question. First of all, I'd like to second Bruce's thought
10 about looking more at concentration, and especially
11 concentration and its relationship to rebates and whether
12 the rebate rules are making there be more concentration.
13 Secondly, I think it might be good to know more
14 about the relationship between plan sponsors and PBMs.
15 You've written some about that already, but it seems like
16 such an important relationship, and the role of PBMs more
17 generally seems so important, and it might bear more
18 scrutiny. And that's, I know, a very general comment but
19 that's the best I can do.
20 And then question I wanted to ask is, we did talk
21 about influencing beneficiary behavior, in this context as
22 well as others. And I wonder, in Part D, how important

1 that is. I know we had some discussion, quite a bit, and
2 some recommendations even, about influencing the behavior
3 of beneficiaries with a low-income subsidy, possibly very
4 small changes in their copayments, for example.
5 So again, it's a question of whether -- well,
6 I'll just put that aside for a second. For everybody else,
7 though, what are we trying to influence exactly? I think
8 the generic prescribing rate is quite high, if I understand
9 correctly, for the non-LIS beneficiaries, and maybe the LIS
10 as well. So if we already have a high rate of generics,
11 then there are the really high-cost drugs, but it's not
12 really a beneficiary choice to say, okay, I want a drug
13 that costs $200,000 a year, or whatever. I mean,
14 presumably they really need it, and I'm sure it's the
15 prescriber, the physician's decision.
16 So I think when we talk about influencing
17 beneficiary behavior in Part D we need to think a little
18 bit more, not just take that for granted, think about what
19 are we actually trying to influence, how much effect we
20 would have, and is the game worth the candle, so to speak.
21 That sounds like a rhetorical question but I actually mean
22 it as a real question. You know, what are we trying to

1 influence? What should we try to influence?
2 DR. SCHMIDT: So you are right that generic
3 dispensing rates are quite high, but I wouldn't say it's
4 uniform. I think there's still room to improve on that.
5 Preparing for last year's recommendations we did a series
6 of stakeholder interviews, including with some plans that
7 have a lot of LIS enrollees. The reason that we had that
8 part of our recommendation of having somewhat higher cost
9 sharing for LIS enrollees was because we heard that there's
10 still room for change along those lines. So that's one
11 area that I think we still want to continue is trying to
12 affect beneficiary behavior.
13 DR. CASALINO: And Rachel, for the non-LIS
14 beneficiaries, does it make sense -- again, not a
15 rhetorical question. I'm really asking this -- how big an
16 issue is it for the non-LIS beneficiaries to influence
17 their behavior?
18 DR. SCHMIDT: Again, generic dispensing rates are
19 high, but I would say it's probably not uniform. There are
20 still people who are going to want a brand name and when,
21 you know, it's not necessarily much better when there are
22 perfectly viable alternatives. I think that maybe there is

1 room for more generic use, especially higher with the LIS
2 population than the non-LIS. And you're right, with
3 respect to the high-cost drugs, many beneficiaries don't
4 feel they have much choice. So I think we'll have to keep
5 looking at this issue. It may be that the mood for
6 effecting behavior is changing, but I don't think it's
7 absent entirely as you might be saying. I'm not sure.
8 DR. CASALINO: Okay. I would like to second also
9 Paul's comment, I think it was, about can we look more
10 closely at the really high-cost drugs. There's obviously a
11 lot of people, a lot of opinion pieces written about this,
12 a lot of people thinking about what to do with really high-
13 cost drugs that don't have a substitute. I guess my
14 question here would be: Is there a role for -- does MedPAC
15 have something to contribute to that discussion? Which is
16 pretty wide-ranging right now.
17 DR. SCHMIDT: One other issue --
18 DR. CASALINO: I would ask that question -- I
19 would deliberately ask that question, asking that the staff
20 and leadership try to decide is there a role for MedPAC in
21 that or not; and if so, you know, what is it? Because it
22 is a pretty urgent issue.

1 DR. CHERNEW: Can I -- I'm sorry. Let me -- so
2 two related things, Larry. The first one is Part D, unlike
3 the other parts of Medicare -- well, unlike Part A and B,
4 anyway, is structured on the back of private plans, which
5 means a lot of the activities that are done to influence
6 patient behavior, use of generics, a whole bunch of things,
7 are actually not made by Medicare. They're made by the
8 private plans.
9 As was noted by you all, not me, in the Part D
10 chapter from last year, the structure of the program could
11 be better in terms of encouraging the plans to do certain
12 things, particularly, for example, around reinsurance. And
13 a lot of the recommendations that were made by MedPAC were
14 to address that type of behavior.
15 The other role that we clearly have, of course,
16 is as CMS publishes various types of rules, including, for
17 example, the international pricing rule, we make comments
18 on those. So everything you see that MedPAC does isn't
19 limited to what you see in a MedPAC chapter or, for that
20 matter, in a MedPAC recommendation. So I think we do have
21 a clear role to think about how the Part D program is
22 structured. It is a slightly different role than we might

1 expect in Parts A and B because of the role of private
2 plans and what goes on. But I think with the rebate data
3 more broadly, in the spirit of, I think, of what Bruce
4 said, the more we can shine a light on what's happening,
5 identify where there's inefficiencies, identify where
6 changes in Medicare policy might encourage private actors
7 to behave in a way that we think would be better for the
8 beneficiaries in the program, I think that's absolutely in
9 our role, and we will continue to do that.
10 And your point -- Paul, you may be in this
11 category -- that many have written on things to do about
12 this is well taken. This is not an area that people have
13 shied away from, and I think certainly think we will try to
14 contribute, when we can constructively, about that.
15 Jim, do you want to add something? I'm sorry. I
16 want to see if Jim wants to add anything about the MedPAC
17 role that I may have missed in that response to Larry.
18 That's a no, so thank you for moving on.
19 MS. KELLEY: Bruce, did you have something on
20 this point?
21 MR. PYENSON: Yes, and I'm very sympathetic to
22 Larry's point of not blaming the patient or putting

1 pressure on the patient, but I think overall Rachel is
2 right about the opportunity. This is tied up with the
3 rebate issue often, and although the particular issues, the
4 particular drugs where this happens are perhaps relatively
5 few, they may account for lots of dollars where particular
6 brands that pay rebates can be preferred over generics.
7 Likewise, I think on future work on biosimilars and what
8 can be done to make sure that the value of biosimilars are
9 realized for the Medicare program and for beneficiaries
10 would be important.
11 So my personal view, as others may recall, is
12 that our expectation for prices should be deflation because
13 of the commodity nature of the industry -- the industries
14 that we're working with here. So I would just like to see
15 that as incorporated in future work as the expectation.
16 MS. KELLEY: I have David next.
17 DR. GRABOWSKI: Great. Thanks, Dana.
18 DR. CHERNEW: David, can I respond to Bruce?
19 Again, just very quickly. So I understand your comment,
20 Bruce. I think one of the things that hasn't come up
21 enough in this discussion makes it complicated to figure
22 out what to do, and I understand all of the concerns and

1 all of the dysfunctions in this sector, they're enormous.
2 But I think we would be remiss if we didn't acknowledge the
3 core difference in that innovation is fundamental here, and
4 so there's a tension between how we plan our policy for a
5 given set of drugs once they've been launched and how we
6 think about the incentives to innovate.
7 This whole area, again, and the whole area of
8 drug policy is going to be quite bigger than Medicare, and
9 we'll have to think through that. So back to what I
10 answered to Larry, we absolutely have a role, but it is
11 going to be a role that is going to be complicated by
12 balancing a bunch of things, and we'll try and pick our
13 places where we can make the system work more efficiently,
14 recognizing that we'll be balancing a bunch of market
15 dysfunction with a core desire to support innovation. I
16 think there's no time like this year to understand the
17 importance of drug innovation. But I'll leave it there.
18 MR. PYENSON: Mike, did you just imply that the
19 rest of the health care system is not so interested in
20 innovation?
21 DR. CHERNEW: No, not in the least, but I do
22 think there is a fundamental difference in innovation

1 across the sectors. We could have a broader debate about
2 that, but I think the role of innovation, patent policy and
3 new products, and a bunch in the drug sector I think is
4 qualitatively different.
5 Again, I'm happy to allow you to disabuse me of
6 that notion, Bruce, but that's kind of what I think is
7 partly what makes -- I guess I can't use the word "unique"
8 now, although I'm an economist and no one expects me to use
9 words correctly, but special, different, qualitatively at
10 least. And I think we will have to sort through how that
11 influences what our recommendations are. And, frankly, I
12 think what bedevils a lot of policymakers because there's a
13 ton of dysfunction. And I should say one more thing if
14 people are listening. I believe strongly that it's
15 important for us to support innovation. I believe strongly
16 that does not mean that the drug sector should get a blank
17 check to do whatever they want, and as soon as you use the
18 word "innovation" you're given a pass for all other types
19 of behavior.
20 I think it is just one consideration that weighs
21 here more heavily than it does in our debates about many of
22 the other sectors.

1 MR. PYENSON: I agree.
2 DR. GRABOWSKI: Okay. Part 2 or Take 2, I guess.
3 So, first, great work, Shinobu and Rachel. I really
4 appreciated the chapter and the data you presented today in
5 the presentation. I have kind of three quick thoughts.
6 First, I share others' enthusiasm for the rebate
7 data and what we can do with those data. I was taken by
8 Bruce's earlier comment about concentration, and there's
9 probably other kind of interesting analyses there. So I'm
10 super excited about being able to unpack some of what we
11 haven't been able to unpack in the past.
12 My second comment, I'm always struck by just this
13 shift in terms of spending with the reinsurance, almost 500
14 percent increase since 2007. We made the recommendation in
15 the June 2020 report about the catastrophic phase. We saw
16 since that report, you know, a $6 billion increase, I think
17 in the most recent year, if I read that correctly. This
18 problem isn't going anywhere, and so I just wanted to
19 emphasize again just the importance of that recommendation
20 and the work that we've done there, and anything we can do
21 to continue to kind of keep the pressure on there would be
22 great.

1 A final comment involves the future work here,
2 and I'm incredibly pleased to see long-term care pharmacy
3 on the list. This has been a long interest of mine. Long-
4 term care recipients, Medicare beneficiaries in these
5 settings, are different. They're higher users, so it's
6 certainly important. But there's also some other
7 interesting kind of market dynamics here in terms of
8 competition. It's a highly concentrated market. It
9 actually intersects with Part A given, you know, all of our
10 drugs for those -- those SNF patients are bundled in their
11 Part A, and you have these long-stay residents who are
12 under Part D. And so there's some really interesting
13 dynamics there as well. So I look forward to work there
14 and kind of examining a lot of those issues. Thanks.
15 MS. KELLEY: Pat.
16 MS. WANG: Okay, thank you. So also tremendous
17 compliments to the MedPAC staff. Rachel and Shinobu, it's
18 a great chapter and it's great work.
19 This topic of Part D is complicated enough,
20 plenty complicated, so I don't mean to muddy the waters
21 here by just raising an observation, I guess, that the next
22 thing that we're going to discuss in our meeting is payment

1 for vaccines, because the same vaccine -- or some vaccines
2 are paid by Part B only, some by Part D only, and some by
3 both. And so there's going to be an effort very soon to
4 try to figure out what the best approach is to pay for
5 vaccines.
6 I kind of think that it would be at a minimum
7 useful -- and I don't mean to burden you with more work.
8 The relationship between Part D and Part B is not so clear-
9 cut anymore. As the pharmaceutical world does innovate and
10 evolve, for example, there are chemo agents that are taken
11 orally now as opposed to infused, but the disease condition
12 is -- they may wind up getting paid -- there are different
13 generations of drugs that I think some are expected to be
14 paid under B, some under D. I think that there is some
15 pushing back and forth. So I don't really know if that's
16 true. It's just that -- or how big an issue that is. It's
17 just something that has been -- I've heard comments to that
18 effect in my own work: Well, that used to be B, now it's
19 D, now it's both.
20 To the extent that when we're talking about drugs
21 that are sort of prescribed or given to treat conditions
22 and it's a gigantic balloon of cost and efficacy that we

1 keep squeezing, which we kind of did when we talked about
2 Part B restructuring. In my mind is, you know, how do we
3 squeeze the balloon? All the cost is in there. How do we
4 squeeze the balloon differently? There might be another
5 balloon that is connected here, which is Part B, which is
6 paid completely differently, obviously, has many other
7 dynamics going on.
8 I just wanted to raise it because I understand
9 that the structure of the programs appears to give a very
10 clear dividing line, but I just wonder -- it's part a
11 question and I guess part a comment. I just wonder whether
12 you see some permeability in that line that is of interest.
13 Thanks.
14 DR. SCHMIDT: I'm not sure if you're looking for
15 a response now or not, but that's definitely an area of our
16 work, and, yes, there is permeability. There are some
17 therapeutic alternatives that are [inaudible] and so
18 certainly some issues around [inaudible].
19 MS. WANG: I guess the question is, does it make
20 -- can you hear me? Does it make sense to at least keep
21 that in the peripheral vision of the future work around
22 Part D?

1 DR. MATHEWS: Yeah, Pat, obviously we would do
2 that, and, you know, to the extent we have been concerned
3 about drugs landing in both components of the program, in
4 recent years we have made specific recommendations to
5 address spending growth in Part B, most recently in 2017.
6 And, you know, we anticipate doing some additional work in
7 Part B over the next cycle. But your point about, you
8 know, the lines between the two programs not necessarily
9 being as clear as they once were is something, of course,
10 we will keep in mind as we continue to do work in both
11 parts of the program.
12 DR. CHERNEW: Yeah, so let me -- there's been
13 several comments around the table, and obviously it's
14 because the plan of this presentation is think about our
15 future directions, and so there's been a lot of discussions
16 about possible future directions. So let me make a big-
17 picture comment.
18 We will continue to work on topics that some
19 might view as small technical fixes in this state. A good
20 example could be risk adjustment and rebates and how that
21 matters. That's a topic we've dealt with. There's a range
22 of things in Part B. We've been worried about biosimilars

1 and biologics, how they're bundled. And there's a slew of
2 other things one might think are smaller. Frankly, in the
3 Part D discussion which we're having now, there was an
4 enormous amount of work done last cycle, and I think that
5 was terrific. And there's some cause that -- that's one
6 reason we haven't really gone after it strong in this cycle
7 is to see how that recommendation sort of moved along and
8 let it sit a little bit.
9 But we will continue not only to think about
10 areas where there are sort of what I would call, for lack
11 of a better phrase, smaller -- that doesn't mean small --
12 relatively smaller technical fixes. In addition, now that
13 we have the data, we will try and shed light on where some
14 of the dysfunction is. There's obviously a lot here. And
15 then the last point, building on, I think, where Paul and
16 Larry and others were, so I apologize to those of you that
17 I'm not lumping in this group, there's some really big
18 directional things about how much we pay for drugs and
19 particularly how much beneficiaries, therefore, have to pay
20 and a whole -- what I would call much bigger things, like
21 the topics that we're taking on last cycle, and we won't
22 shy away from them when we find constructive places to

1 engage.

2 I don't think we're going to have as

3 comprehensive of a Part D summary in the next cycle, for

4 example, just because we had one last cycle, and I think

5 that will have to wait. But that doesn't mean we don't

6 look at some of the issues here, and certainly there's

7 going to be a lot of effort around rebates and other types

8 of discounts and the impact on beneficiaries of some of

9 what I would call dysfunctions that are going on in the

10 market. And there will obviously be some connection

11 between the B and D and the Part B plan and the MA-PD plan;

12 those types of issues are always on our radar, as I think

13 they should be and will continue to be.

14 I hope that was a comprehensive enough answer.

15 MS. WANG: It is, and just to put a period at the

16 end of the sentence, my sentence, as between D and B the

17 goal is to pay for the drug in the most efficient

18 setting/way. That's all. That's where I was trying to go.

19 DR. CHERNEW: Yes, that's true. As I said, I

20 think in response to another comment, one of the

21 challenges, of course, is that B and D are structured

22 fundamentally differently. It's not quite the same as

1 site-neutral might be and we're thinking about different
2 services in Part A or in Part B. They're just structured
3 fundamentally differently because of the role of the
4 private plans, and for that matter the role of the MA-PD
5 plans, which obviously you know well. So the way we have
6 to engage has to be cognizant of the institutional
7 differences in this space relative to other spaces, but
8 your main point, Pat, I agree with you completely. And
9 we're going to continue to work in those types of areas.
10 MS. KELLEY: Okay. I have Dana next.
11 DR. SAFRAN: Thank you.
12 Adding my compliments to Rachel and Shinobu, this
13 is ever complicated, extremely important, and you do such a
14 good job of distilling it and making it as clear as it can
15 be.
16 My comments go back or build on the question I
17 was asking earlier about value, and I guess, first, to
18 point out the obvious, what's so different about this
19 sector from the other sectors is Medicare doesn't get to
20 set the rates, that we're relying on the market to set the
21 rates here. So this wasn't part of our annual percentage
22 increase, and so we see the increases just going and going

1 in this sector.
2 And what's more, as you were saying in your
3 response to my question, we don't really have any good
4 measures of the value being produced out of this really
5 important and costly area of coverage that's been added.
6 So it's very unclear how we know if the market is working
7 in the ways that we've asked it to.
8 So that really causes me to think about the work
9 I've been involved with in the private sector, where in the
10 private sector, self-insured employers are looking to take
11 back control of the full end-to-end value chain from the
12 PBMs, and they're looking to do that because analyses have
13 shown that at every point along that continuum, there are
14 profit pools being called by the PBMs that purchasers are
15 purchasers are frankly just fed up with and they want to
16 take back control of their money.
17 And they're doing that in part by beginning to
18 work with new innovator PBMs who are willing to just be
19 claims processors, which is how the PBM industry started,
20 to do fully passthrough pricing without rebates, and it
21 does cause me to wonder whether Medicare could begin to
22 experiment in a similar way.

1 Now, these platforms are small, and there's no
2 way they could accommodate significant volume from
3 Medicare, I think, my knowledge of them at this point, but
4 it certainly would send an interesting new signal to the
5 market if Medicare started to do some pilots with those
6 innovative PBMs. So I offer that for consideration.
7 Then also, just to build no my other question
8 from earlier, I do think it's important that we begin to
9 have a better ability to compare what we're getting from
10 the PDP and the MA-PD. What MA-PD brings that PDP doesn't
11 is the total cost of care accountability that those plans
12 have, and so, in theory, we should be seeing not just
13 smarter purchasing but also better uses of medications to
14 deliver better control and outcomes because those plans are
15 accountable for that, so really thinking about how to begin
16 to accomplish the same thing on the PDP side, leveraging
17 our ACO programs, but also just an ability to compare the
18 value that we're getting in PDP and MA-PD, not just based
19 on adherence but also based on actual outcomes.
20 So those are my thoughts. Thank you.
21 MS. KELLEY: Betty?
22 DR. RAMBUR: Thank you so much.

1 So, as a person who hasn't been on MedPAC until
2 this year and who has not had responsibility for thinking
3 about Part D until now, I just want to thank the staff for
4 an absolutely brilliant chapter. It was very eye-opening
5 to me, and I really appreciate the illuminating comments
6 from my fellow Commissioners.
7 A few thoughts from me, in terms of international
8 comparisons, it seems to me that that's sort of you're
9 looking at a quadrant, but I really did resonate with what
10 Paul said about value and also Dana's and other comments
11 about value, really looking what's the outcome of this huge
12 expenditure.
13 I tend to resonate with Bruce's comment on
14 deflation, understanding, of course, the need for
15 innovation as well, but I tend to resonate with that.
16 Certainly support the comments about long-term
17 care pharmacy that is in the recommendation and that David
18 brought up.
19 Then there's other pieces of homework that I need
20 to do. For example, I don't understand how the reinsurance
21 attachment point was initially set and if there's any
22 opportunity there, but that's something I'll study offline.

1 So thank you very much. I'm very enthusiastic.
2 I appreciate the hard work.
3 MS. KELLEY: And I think the last comment I have
4 is from Amol.
5 DR. NAVATHE: I just want to echo comments from
6 the Commissioners about the great work here, Rachel and
7 Shinobu. Very complicated. You guys always somehow pull
8 off making it quite understandable. So thank you for that.
9 I just wanted to amplify a couple of comments
10 that the Commissioners have made, so I think just
11 recapping, I think, pulling you here. The chapter did a
12 nice job of discussing the RxHCC risk adjustment model and
13 the impact that the rebates, presumably getting access.
14 The rebates data could give us a better understanding of
15 how many distortions we get because of that.
16 I think even the sort of sample analysis that you
17 guys did was very provocative. It's almost definitely true
18 that there is a whole variety of different distortions that
19 we're actually seeing in terms of how the risk adjustment
20 system works and, therefore, the way that premiums are
21 determined.
22 So I think that part is fundamentally really

1 important. So I think that was tucked in a couple of
2 Commissioners' comments, but I think didn't perhaps receive
3 its own singling out, if you will. So I wanted to make
4 sure that we do that.
5 I also wanted to just say I, of course, support
6 the general work around competition here. I had a question
7 earlier about the competition for the LIS side. I think
8 looking at the distribution that you guys showed, it's
9 pretty compelling that the more competition that we can
10 produce under the LIS side also is important and could save
11 the program a considerable amount of dollars in terms of
12 efficiency.
13 Lastly, I just wanted to also echo support for
14 not only the general pieces, but there do seem to be some
15 pockets of just particularly obvious value that we should
16 be focusing on, such as the use of biosimilars and why that
17 hasn't taken off. That suggests, I think, an interaction
18 between some of the points that Larry has brought out and
19 others have brought out between the kind of interaction
20 between plan and beneficiary.
21 So thank you for a great chapter, and I really
22 look forward to pursuing this work further.

1 DR. CHERNEW: So we're just about at time. Thank
2 you all for your comments. There was actually, I think, a
3 lot of enthusiasm and a lot of consensus about where we
4 will go. We will review all of the comments, and I've made
5 some of my summary comments at various points along the way
6 so I won't make them again. But it's certainly an area
7 that is, A, very important, B, increasingly important, C,
8 really important for the care that beneficiaries get and
9 the quality of care that they get. So I don't think you
10 have to worry that we will not be spending time looking at
11 this. I think as I may have said to some others of you,
12 the challenge is always going to be matching our tools to
13 our aspirations, what we would like to have happen with
14 tools, that we have to try and make that happen, and we
15 will continue to do that both for smaller and bigger
16 issues.
17 So, again, thank you, and I think if there's
18 nothing else that Jim or Rachel or Shinobu want to add,
19 we're going to move on.
20 [No response.]
21 DR. CHERNEW: Once, twice, sold.
22 I think we are now going to talk about the SNF

1 value-based purchasing program and some work that we've
2 done on our proposed replacement.
3 Carol, are you leading off? Sam or Ledia?
4 DR. CARTER: I am. This is Carol.
5 DR. CHERNEW: Okay. Carol, take it away.
6 DR. CARTER: I will. Good morning, everyone.
7 Before I get started, I want to note that the
8 audience can download a PDF version of these slides in the
9 handout section of the control panel on the right-hand of
10 the screen.
11 Today we're going to continue our conversation
12 about MedPAC's mandated report on the SNF value-based
13 purchasing program. The Protecting Access to Medicare Act
14 of 2014 requires MedPAC to review the program's progress,
15 assess the impacts of beneficiaries' socioeconomic status
16 on provider performance, consider any unintended
17 consequences, and make any recommendations as appropriate.
18 Our report is due June 30th of 2021. We plan to
19 include it as a chapter in the June report.
20 To meet this due date, we have been working on
21 the following time table. Last September, we reviewed the
22 current program's design and summarized the results for the

1 first two years of the program. You discussed the
2 shortcomings of the design and concluded that the program
3 should be eliminated.
4 In October, we outlined an alternative design,
5 estimated its potential impacts, and compared the impacts
6 of the current and alternative designs.
7 Based on these discussions, we've outlined policy
8 options for your consideration.
9 Based on your discussion today, we expect that
10 the Chair will draft recommendations for you to consider at
11 the March meeting and to vote on in April.
12 So to quickly review the results of the program,
13 in each of the first two payment years of the program that
14 was fiscal year 2019 and 2020, the majority of providers
15 had their payments lowered by the program, 73 percent in
16 2019 and 77 percent in 2020. We will add the third-year
17 results once we have completed our analysis of them.
18 Many SNFs earned back essentially none of the
19 amount that was withheld, the 2 percent -- 21 percent of
20 SNFs in 2019 and 39 percent in 2020.
21 Few SNFs received the maximum increase. In 2019,
22 3 per of SNFs earned the maximum, which was 1.6 percent.

1 In 2020, fewer SNFs earned the maximum, but the maximum was
2 larger, 3.1 percent.
3 The trade press has observed that these incentive
4 payments may not have been sufficiently large to motivate
5 improvement.
6 We also found that incentive payments were
7 generally higher for larger providers, for providers whose
8 patients had lower risk scores, and for providers that
9 treated fewer patients at high social risk, as measured by
10 share of fully eligible dual beneficiaries.
11 We also found that providers' performances were
12 fairly inconsistent across the two years. These patterns
13 suggest a couple of revisions to the program. First,
14 social risk factors should be considered in making the
15 payment adjustments. This would counteract the fact that
16 it is harder for providers that treat a high share of
17 patients at high social risk to have good quality outcomes.
18 Second, raising the minimum counts would help ensure that
19 the results are more reliable and less variable from year
20 to year. Third, expanding the measure set would also help
21 smooth out inconsistencies in performance that is gauged
22 using a single measure.

1 In considering how the program might be
2 restructured, we looked at the current flaws of the program
3 and the ways to correct them, and in the next two slides,
4 I'll be comparing the current flaws and the design features
5 of a proposed value incentive program.
6 First, instead of a single measure, the
7 alternative design uses a small set of measures tied to
8 outcomes and resource use.
9 Second, raising the minimum count to meet a
10 widely accepted reliability standard will help ensure that
11 the measure results are reliable, especially for low-volume
12 providers.
13 Third, the value incentive program establishes a
14 system for distributing rewards without the cliff effects.
15 The scoring encourages all providers to improve.
16 Social risk factors should be considered in
17 assessing performance because it is harder for providers
18 that treat a high share of patients at high social risk to
19 have good outcomes.
20 While the current VBP does not consider the
21 social risk factors of a provider's patients, the proposed
22 design does. The alternative design would account for

1 differences in patients' social factors, risk factors, when
2 tying performance to their incentive payments.
3 Finally, the alternative design with SNF VBP
4 would distribute all funds back to providers as rewards and
5 penalties.
6 As we were working on the design to address the
7 shortcomings of the current program, in late December the
8 Congress made changes to the SNF VBP.
9 The Consolidated Appropriations Act made changes
10 that are consistent with what we've talked about. It gave
11 the Secretary of Health and Human Services the authority to
12 expand the measure set and requires that the data are
13 validated. This would apply to the provider-reported
14 measures.
15 It also bars the program from applying to
16 providers that do not meet a minimum volume for each
17 measure. Depending on how this measure is implemented,
18 that is, if the current minimum volume remains the same,
19 the results may still be unreliable.
20 The legislated changes do not address three
21 design flaws: the scoring cliffs, the lack of
22 consideration of social risk factors, and the fact that the

1 program retains a portion of the incentive pool as savings.
2 So while the changes are a positive development, there is
3 more that needs to be done to improve the program.
4 And now I'll turn it over to Ledia to review the
5 VIP design in more detail.
6 MS. TABOR: The first key element of the SNF VIP
7 is that it scores a small set of measures. The Commission
8 has stated that value incentive programs should use
9 measures of outcomes, patient experience, and resource use
10 to gauge provider performance.
11 The design we modeled used three claims-based
12 measures: hospitalizations during the SNF stay, successful
13 discharge to the community, and Medicare spending per
14 beneficiary.
15 In October, we talked about the need for patient
16 experience measures. Measures and surveys to collect this
17 information have been developed but not finalized for
18 implementation. These measures need to be finalized and
19 used in public reporting and included in a value incentive
20 program.
21 Second, the VIP incorporates strategies to ensure
22 reliable results. The proposed design uses a higher

1 reliability standard to set the minimum stay counts. For
2 the measures we modeled, 60 stays are required, which
3 translates to a .7 reliability, compared to the .4 percent
4 the VBP uses. By using a higher reliability standard, a
5 provider's results are more likely to reflect actual
6 performance and not random variation and will be less
7 likely to vary from year to year.
8 To include as many providers as possible in the
9 program, the performance period could span multiple years.
10 Although there are pros and cons to this approach, as
11 discussed in this paper. In our modeling, the performance
12 period spans three years.
13 Third, the proposed design establishes a system
14 for distributing rewards without cliff effects.
15 Performance on a measure is assessed against the national
16 performance-to-point scale. In the SNF VIP modeling, we
17 set the scale using a distribution of all SNFs'
18 performance.
19 By applying a continuous performance-to-point
20 scale, every achievement is recognized by earning
21 performance points. There are no cutoffs, no minimum
22 thresholds to meet to earn performance points, and no

1 topping out for the best performers.

2 Fourth, the VIP accounts for differences in

3 provider patient populations. The Commission has said that

4 Medicare should take into account differences in provider

5 populations through peer grouping. Like other MedPAC VIP

6 programs, in our modeling, we set peer groups based on a

7 provider's share of fully dual-eligible beneficiaries.

8 Within each peer group, incentive payments are

9 distributed to each provider based on its performance

10 relative to its peers. The peer grouping is a way to

11 compare the performance of providers with similar mixes of

12 patients at high social risk. As the share of fully dual-

13 eligible beneficiaries increases, providers have the

14 potential to earn larger rewards for better performance.

15 With this approach, performance rates remain intact, while

16 payments are adjusted.

17 Finally, the design would distribute entire

18 provider-funded incentive pools as rewards and penalties

19 and would not be used to achieve program savings. The

20 Congress has other policy levers, such as updates to

21 payment rates, to lower the level of payments, if

22 warranted.

1 Each year, the payment adjustments tying
2 performance points to payments would be calculated to fully
3 spend out the incentive pool of dollars.
4 We compared the performance of the current
5 program with the illustrative value incentive program.
6 Here, we look at impact on providers with different shares
7 of patients at social risk.
8 On the left are the payment adjustments under the
9 current program. We show five peer groups, with low shares
10 of fully dual-eligible beneficiaries in yellow and high
11 shares in red. On the left, the incentive payment
12 adjustments get more negative under the current program as
13 the share of dual-eligible beneficiaries increases.
14 In contrast, on the right are the adjustments
15 under the VIP. Under this design, the average adjustments
16 are much smaller, and they are more equitable across peer
17 groups. This would counteract the disadvantage these
18 providers have in obtaining good outcomes and would dampen
19 the incentive to avoid patients with more social risk
20 factors.
21 Now we look at how the alternative design would
22 affect payment adjustments for providers treating patients

1 with different average medical complexity.

2 On the left are the results of the current

3 program and on the right are the results of the

4 illustrative design. Under the current program, on the

5 left, providers with low average risk scores have positive

6 payment adjustments, on average, while providers with high

7 average risk scores have negative payment adjustments.

8 This could result in patient selection, where providers

9 avoid admitting medically complex patients.

10 In contrast, under the alternative design, on the

11 right, the average payment adjustments were not related to

12 medical complexity of the patients. As a result, providers

13 would have less incentive to avoid medically complex

14 patients.

15 The paper includes other results by provider

16 groups. Most notably, nonprofits and hospital-based

17 providers would have higher payment adjustments than other

18 SNFs.

19 In summary, the SNF VBP is flawed. The VIP

20 design addresses these flaws. Compared to the VBP, the VIP

21 design better motivates providers to improve their quality

22 and dampens the incentive to avoid beneficiaries with more

1 social risk factors and that are more medically complex.
2 The recent legislation corrected some flaws of the program
3 but there is more opportunity to improve.
4 Here is the policy option for your discussion
5 today. The Commission's feedback will shape the
6 development of potential Chair's draft recommendations that
7 would be presented at the March meeting. First, eliminate
8 the current SNF VBP. Second, establish a SNF Value
9 Incentive Program that would meet the design elements we
10 have previously discussed. Third, finalize development and
11 begin to report patient experience measures. The first two
12 portions of this option would be directed to the Congress
13 with a third to the Secretary of Health and Human Services.
14 I will now turn it back to Michael and look
15 forward to the discussion.
16 DR. CHERNEW: Great. We're going to jump into
17 Round 1 in a second. I just want to clarify, for those
18 that are listening. Unlike the telehealth discussion we
19 had yesterday, where we discussed policy options that
20 weren't envisioning moving to recommendations and a vote,
21 this is actually the step that precedes draft
22 recommendations and then we'll proceed on a vote. The vote

1 will probably be -- the schedule now is in the April
2 meeting. We'll have draft recommendations in March. So to
3 give you some idea, that's the direction we're going. This
4 is not the first time we have seen the SNF VBP discussed,
5 but that's sort of the track where we're going, so
6 comments, observations, if people are comfortable with that
7 track are super important.

8 So with that we should start with clarifying
9 questions.

10 MS. KELLEY: Okay. Larry, I have you first.

11 DR. CASALINO: Thanks, Dana. Nice presentation,
12 as always, guys. Could you show the slide again, the first
13 modeling slide in the incentives that would be paid out, by
14 peer group? Yeah, that one. So am I reading this
15 correctly, to say that in the MedPAC recommended model the
16 payment adjustments, or the incentive payments, let's call
17 them, would be very small? Is that right, or is that a bad
18 interpretation?

19 MS. TABOR: Yes. In our modelings they would be
20 small. I will say these are average net payments so there
21 is still a range. We use the 5 percent withhold in the
22 modeling so it could go up to 5 percent, or it could go

1 higher than 5 percent but not lose -- the penalty couldn't
2 be more than 5 percent.
3 DR. MATHEWS: Can I ask for a clarification on
4 your answer to Larry's question? So on the right-hand side
5 of Slide 14 here, what this is showing is not necessarily
6 that the payment adjustments themselves would be small,
7 because with a 5 percent withhold they could be plus or
8 minus 5 percent. What this slide is showing is that the
9 amount or the magnitude of the withhold does not vary
10 systematically, under our construct, as a function of the
11 share of full dual eligibles the way it does under the
12 current SNF VBP, where the larger your share of full dual
13 eligibles, the larger your negative adjustments.
14 Ledia, is any of that correct? I'm keeping my
15 fingers crossed that it is.
16 MS. TABOR: That is all correct.
17 DR. CASALINO: So I think I'm not understanding
18 that. So if we look at the red bar on the SNF VIP
19 modeling, which is about 0.2, what exactly does that 0.2
20 state? What is that?
21 MS. TABOR: That is the average net payment
22 adjustment for the providers in that peer group.

1 DR. CASALINO: So is that 0.2 percent or 2
2 percent?
3 MS. TABOR: 0.2 percent of payment.
4 DR. CASALINO: So, Jim, I must not be
5 understanding still what you said. So that looks to me
6 like a very small incentive, but I must be interpreting it
7 incorrectly.
8 DR. MATHEWS: Let me make another run at the
9 explanation here. This is when you array the percent
10 adjustments by peer group category, and what this is
11 showing is that in contrast to the current system, where
12 the higher your share of duals the more disadvantaged you
13 are, that here the SES of your population, at least as
14 measured by full duals as a proxy, isn't going to
15 systematically influence your performance. However, if you
16 took SNFs performance and just arrayed it on an ordinal
17 basis, best to worst, you would have a very different-
18 looking histogram here. Again, Ledia, is that correct?
19 DR. CASALINO: Okay, I think I understand now.
20 So I did understand, at first, looking at these slides,
21 that this shows that you won't be penalized anymore for
22 having lots of dual eligible patients, so that I get. But

1 the 0.2 there is the average incentive payout that we're
2 modeling for SNFs in that peer group. Individual SNFs can
3 earn much more or much less.
4 DR. MATHEWS: That is exactly right.
5 MS. TABOR: And I would refer to -- this is an
6 average, and I would refer to Table 11 in the paper. That
7 shows the range within each peer group, that you could earn
8 up to a 15 percent reward or a 5 percent penalty.
9 DR. CASALINO: Yeah, I should have gotten that
10 point from the paper. Okay, thank you.
11 MS. KELLEY: Okay, I have Jon Perlin next.
12 DR. PERLIN: Good morning, and thanks, Ledia and
13 Carol, as always, for an excellent report.
14 I assume the answer to this is yes because of the
15 nature of the metrics that are being introduced into this
16 new value-based payment program. But it always strikes me
17 that as we address one more circumscribed policy issue, are
18 we setting the trail toward our ultimate destination? I
19 was wondering if you could comment on how this builds
20 forward to our current concept of unified PAC PPS. Thanks.
21 DR. CARTER: It is okay if I start? Yeah, so we
22 think this is a really good building block because it would

1 create a model that a broader program, that spans the four
2 settings, could emulate, and it would give at least this
3 sector some experience under that model.
4 We purposely selected these measures because they
5 are uniform across the four settings, so they would be
6 ready to use across the four settings. But the whole
7 approach of peer grouping and risk adjustment -- the risk
8 adjustment is uniform, but I think it was yesterday it was
9 mentioned that we now have a mandated report on PAC VBP,
10 and we'll be looking at how this could be rolled out across
11 the four settings in that.
12 DR. PERLIN: Maybe just a brief follow-up. Maybe
13 a paragraph of context to that trajectory, how the pieces
14 come together, would really clue in the industry. Thank
15 you so much.
16 MS. KELLEY: So that's all I have for Round 1
17 clarifying questions. Should we move to Round 2, Mike?
18 DR. CHERNEW: Absolutely. I guess if someone has
19 a Round 1 question you now must build it into your Round 2
20 question. So I happen to know that David, you're up first,
21 but I'm turning it back to you, Dana, to call on David.
22 MS. KELLEY: Go ahead, David.

1 DR. GRABOWSKI: Great. Thanks, Mike, and thanks,
2 Dana. And first, Carole and Ledia, great work. I'm really
3 excited about the way this chapter and this set of
4 recommendations is shaping up.
5 First, I was pleased to see that the Congress
6 addressed the SNF VBP with some legislative changes. I do
7 believe this is a step in the right direction. However,
8 the program is better but still not well, and that's why I
9 think the SNF VIP is an opportunity to really fix the full
10 sort of set of problems that you've identified with the SNF
11 VBP.
12 As the program currently stands, even with the
13 legislative changes, I still don't believe it's equitable
14 or effective at directing payments to the highest-
15 performing facilities. Though SNF VIP would be much more
16 equitable, obviously by accounting for social risk factors,
17 per Larry's comments and questions just a few minutes ago,
18 while also expanding the measure set here to better
19 approximate quality.
20 So let me list out what see are the real sort of
21 positives of the program and then highlight a few concerns.
22 Things I really like here, I have always been troubled by

1 the reliance on just a single measure, the readmissions
2 measures, so expanding the set of measures is really
3 important. I like that we're using a higher minimum state
4 threshold for greater reliability. You mentioned the
5 elimination of the "cliff" effects. I think that's really
6 important. The peer grouping by duals is a great step.
7 The improvement in the risk adjustment is also incredibly
8 important.
9 And then finally, I don't know why we have had
10 this holdback and not paid out all the dollars in this
11 program. The idea that this was a budget saving program
12 never made any sense to me. So I'm really pleased about
13 all of those elements.
14 Let me now tick off just a few kind of concerns,
15 and I know these are already on your radar screen, Ledia
16 and Carol, but at least I will talk a little bit about
17 them. The first, and you didn't raise this during the
18 presentation or I missed it, but in the chapter you talked
19 about incorporating a satisfaction measure, and that came
20 up, obviously, during our last discussion.
21 You did reach out to CMS. I didn't find the
22 agency's response very compelling on this issue. Their

1 response was this is hard and yes, I agree with that, but I
2 really think this is an important part of the program, that
3 we have these three claims-based measures right now. How
4 do we get a measure of satisfaction? And I think really
5 pushing them on development of such a measure, that would
6 really kind of round out the measure set here.
7 Second comment or concern was really about how
8 best to maximize the number of participants in the program.
9 This minimum state threshold is really important towards
10 improving reliability. You mentioned, in the chapter, and
11 you touched on it during your presentation, this tradeoff
12 between kind of a higher minimum state threshold in the
13 most recent year versus kind of using multiple years of
14 data, and maybe weighting the more recent year with kind of
15 an integrator amount.
16 I like using multiple years with weighting in the
17 most recent year in order to increase the number of
18 participants in the program. I feel like with a minimum
19 state threshold we might lose some smaller SNFs. And so if
20 there's a way to kind of maximize the number of
21 participants, I realize then we're using data from two or
22 three years back and that's suboptimal, but maybe by

1 weighting the most recent year a little bit more we could
2 get around that issue to some degree.
3 There was a text box in the chapter around kind
4 of how do we sort of match the information that is being
5 provided in this program to quality reporting. One of my
6 other kind of policy hats, in addition to MedPAC, is I
7 serve on the CMS technical expert panel for the Nursing
8 Home Compare website. That's the CMS nursing home report
9 card where they produce a lot of quality information.
10 These measures we're discussing today are totally different
11 than the measures that are presented on that website, and I
12 can say as just a broader comment, MedPAC's philosophy
13 around quality reporting is very different than CMS's,
14 based on my experience. Just two very different views
15 where if you were to go on Nursing Home Compare there's 30-
16 plus measures and lots of details, whereas MedPAC prefers a
17 smaller set.
18 And I'm just wondering a couple of things there.
19 I love the idea that was raised of trying to better align
20 the information that's being used. I think that will be
21 more straightforward for consumers but also for providers
22 in terms of producing the information and actually

1 responding to these measures.

2 The one kind of final element that's really

3 emphasized in the CMS Nursing Home Compare website is

4 staffing. That's not something we've taken on here. I

5 realize it's very different than your typical MedPAC

6 measure but the staffing data that's now used in nursing

7 homes has improved a lot with the Payroll Based Journal

8 data. I don't know that I'm advocating we include it but

9 only kind of think about this alignment. It's a really

10 important measure to a lot of consumers. It's a really

11 important measure in the nursing home space. I realize

12 this blurs the kind of post-acute and long-stay

13 populations, but it's really important to think about how

14 we're thinking about quality on that side versus this

15 program.

16 So just to sum it up, I'm really excited about

17 where we're going, Carol and Ledia, with this, and some

18 ideas that maybe to further improve our recommendations.

19 I'll stop there and say thanks.

20 MS. KELLEY: Okay. Marge, you're next.

21 MS. MARJORIE GINSBURG: Well, notwithstanding

22 David's comments about additional work we have ahead within

1 this, what I wanted to comment on was the fact that how
2 much we reinforce the idea that this is urgent. And, in
3 fact, it said on page 1 the Commission concluded in October
4 that the SNF VBP should be immediately eliminated. That
5 sense of urgency is written throughout this, so my comment
6 is, do we really have to wait until June if we can actually
7 ever work it all out that we're all happy? The idea that
8 this is a mandated report, which means we don't really have
9 to wait to include it in the policy report in June, and
10 would it not have, in fact, perhaps more impact, get more
11 attention, raise more flags if we sent it out separately?
12 So my recommendation is let's not wait until
13 June. At least let's consider this. Let's clean it up and
14 maybe send it out in April. But to send it out like in the
15 June report. Thank you.
16 DR. CHERNEW: So, yeah, let me jump in on that.
17 A few things. We'll see how the rest of this discussion
18 goes, and again, this is not our first discussion on this
19 point. But unfortunately, the process by which we get to
20 actual recommendations, which involves a vote, and we need
21 to stick to that process. What we don't, and that's
22 certainly clear in telemedicine, is in our engagements with

1 the Hill and what happens, all the directions we're going
2 can inform those discussions and they inform any comment
3 letters we may make.
4 But I think in this particular case, because
5 we're going to have to get the draft recommendation, and
6 because we're going to have to get to a vote, and because
7 we will do that by June, our ability to do anything much
8 before June I think is really severely limited. I was
9 going to say a little more about that but I'm going to
10 defer to you before I do. Jim?
11 DR. MATHEWS: Yes. So we do indeed, as Mike
12 said, have a process, and we have a two-times rule when it
13 comes to formal recommendations -- here's the draft and
14 here's the one you're going to vote on. I also agree that
15 just by virtue of having these discussions in public and
16 the technical assistance that we provide the Congress
17 between meetings, we are sending a clear signal of where we
18 think the SNF VIP work should go, and that is not missed by
19 any of the intended audience.
20 And then lastly, from a production point of view,
21 even putting together our March and June reports along with
22 everything else that we do is just exquisitely, tightly

1 wired. And if my production manager is watching these
2 proceedings she is no doubt on the floor of her den having
3 a heart attack right now. So we'll call an ambulance.
4 We'll make sure she's okay. But we've got to be cognizant
5 of just the logistics as well.
6 So the message is being heard.
7 DR. CHERNEW: So the last thing I'll say is even
8 though we are in a transition of administrations and the
9 change in the leadership of CMMI and all the things related
10 to that, I actually think that there's not a lot of
11 pressure to come out with this a lot sooner, particularly
12 now. I think telehealth is one where it's really been a
13 staff-at-night issue trying to figure out how to deal with
14 the timing because of the pace with which telehealth stuff
15 has been going and the complexity of that issue.
16 In this particular case, I actually think our
17 timing will probably be okay given the timing that I
18 perceive and what CMS would be able to do, particularly
19 since they have moved a little bit in this direction, and
20 I'm not going to quantify how much. They have moved
21 somewhat in this direction anyway, so I don't think we are
22 missing a big vote. In fact, I think we should be happy --

1 I think David expressed that we were -- that, in fact, some
2 of the concerns that were raised have been moving into the
3 broader policy discussion. So that's where we are.
4 MS. KELLEY: Okay. I have Jonathan Jaffery with
5 a comment.
6 DR. JAFFERY: Great, thank you, and I won't
7 belabor it. Of course, it's always hard to follow David
8 talking about some of these things. This is really -- I
9 echo really his comments, and thanks, Carol, Ledia, and
10 others. I think it's wonderful to see a chapter that not
11 only gives some concrete things about advancing specific
12 policies here, but as you laid out in the beginning, it
13 really lays the foundation for some of our broader work
14 around post-acute care.
15 The only thing I would -- I'm fully in support of
16 all these pieces for all the reasons David mentioned and
17 that you brought out. The only thing I want to emphasize
18 even I guess a little bit more that maybe we can -- when we
19 talk about the peer grouping, it sort of ties in some of
20 the conversation we had yesterday that we recognize that
21 this is where we are now and it's really helpful for us,
22 but it's not -- we recognize that it's not sufficient, that

1 it doesn't capture everything. And, again, as I think
2 David said in the past, for example, Medicaid eligibility
3 varies by state. And so some of those shortcomings, just
4 acknowledging them and saying that -- recognizing that
5 we've got more work to do there and look forward to that.
6 Thank you.
7 MS. KELLEY: Brian.
8 DR. DeBUSK: First of all, Carol, Ledia, thank
9 you. Just absolutely fantastic work. I'm really, really
10 impressed with what you've done here with the VBP,
11 particularly the methodological consistency. Really,
12 really nice to see, you know, some of the same principles
13 that we're seeing in the hospital VIP and the MA-VIP and
14 all those other areas, very nice to see those uniformly
15 applied and to see these same things appearing again and
16 again.
17 I want to echo David's and Jonathan's comments as
18 well. I think your treatment using peer groups for dealing
19 with socioeconomic inequity or adjustments is outstanding.
20 So really great work, and I hope we continue to pursue
21 this.
22 MS. KELLEY: Dana.

1 DR. SAFRAN: Thank you. I'll just pile on. I
2 really just so appreciate how this work has continued to
3 evolve and take shape over the last couple of months. I
4 think it's really important and valuable. I love the
5 parsimony but breadth at the same time of the new measure
6 set, and so I really appreciate everything about it.
7 I in particular would just call out that I really
8 am glad that you've incorporated the work around
9 reliability calculations and that we will propose even
10 though past CMS policy has suggested that they might not
11 incorporate the idea of waiting across three years. I'm
12 really glad that you're proposing that and incorporating
13 the important information about reliability, because
14 without stable, reliable information, you know, we're just
15 kidding ourselves if we think we're rewarding performance
16 based on, you know, small, noisy pieces of data.
17 I love that you're removing cliffs and improving
18 risk adjustment. I would just make two small comments
19 about the risk adjustment. One is I think we all
20 understand duals to be a quite inadequate indicator of
21 social risk, and so I dealing with really encourage that we
22 -- even as we use that in the beginning, continue to

1 explore how to make it better. And, in particular, I
2 really favor exploration of incorporating data from census
3 bloc group because I in my own work have found that gives
4 very rich information that's a quite good proxy for
5 individuals and much broader than what dual status can tell
6 us.
7 My final thing -- actually, final quick two
8 things. One is, as I previously highlighted -- and I
9 apologize if I missed it in the chapter. I just couldn't
10 quite tell whether the current approach that you're
11 suggesting for peer grouping holds different groups
12 accountable for different levels of performance or not.
13 And I should have asked this in Round 1, so I apologize.
14 But as you've heard me say before, I think it's a really
15 important principle for us to vary the reward for providers
16 who care for a more disadvantaged population but not the
17 performance standard. So we would want to see the same
18 level of performance rewarded regardless of the difficulty
19 of your population, but your reward is higher. So I just
20 didn't see that level of detail in the chapter, and I
21 apologize if I missed it, but I just wanted to understand
22 if that is, in fact, how it works from your perspective.

1 The last point is that, you know, I think COVID
2 has really shown us the extreme vulnerability of this
3 population, and I do wonder whether there are measures of
4 safety that we can ultimately incorporate here. Even as I
5 say that, you know, I debated with myself that perhaps the
6 first two measures related to hospitalizations and then
7 safe discharge or successful discharge to the community
8 might be kind of ultimate outcome measures of safety. But
9 I just wanted to make that point about whether there's any
10 indicators of definitely that we could incorporate.
11 Thank you.
12 DR. CHERNEW: So, Carol and Ledia, let me try and
13 address Dana's question about holding folks to different
14 standards. The phrasing of exactly what's meant being held
15 to different standards is a little complex, but I believe
16 we're doing what you would want us to do, so let me
17 describe that. And then I'll let -- I'm going to do a Jim
18 thing and say, once I'm done with the comment, I'm going to
19 ask Carol if I got it right.
20 But the gist here is the score for any
21 organization is based on the exact same scale. If you're a
22 41, you're a 41; if you're a 92, you're a 92; if you're an

1 88, you're an 88. The score is computed exactly the same.
2 What is changing in each peer group is how robust you get
3 rewarded for that score. That's what the adjustment is
4 doing. So, effectively, we are changing that relationship,
5 and as the slide that Larry was talking about earlier
6 shows, in the current model you can get penalized if you
7 are serving more disadvantaged populations, so we end up
8 penalizing those types of organizations in that peer group
9 collectively. There's obviously variation within each peer
10 group, but, collectively, those that are serving more
11 disadvantaged populations are penalized in the current
12 model. I believe I have that right. And what our model
13 does is it sort of adjusts on average, but within each peer
14 group, you still get rewarded if you do better.
15 So your score is what your score is, and it's
16 comparable across all the peer groups. The payment
17 changes. In each case if you do better, you do get paid
18 more, so there's always a benefit to doing better. But as
19 the chart that Larry was asking about before, I think,
20 demonstrates, there's no longer a systemic skewness against
21 organizations that are serving more disadvantaged people,
22 and that's accomplished not by changing what we hold them

1 to. It's accomplished by changing the penalty levels or
2 how we construct the penalties, some version of that.
3 Carol, do you want to set me straight? Ledia, do
4 you want to set me straight?
5 DR. CASALINO: So, Michael, can I just confirm
6 that I understand? And Carol and Ledia. So if you get a
7 41 in Group 2, it's a 41; if you get a 41 in Group 20, it's
8 a 41. But the average scores in Group 20 are going to be
9 lower and, therefore, you're being compared to your other
10 peers in that group, and so the 41 will get you a bigger
11 positive payment or a smaller penalty than it would in a
12 higher SES peer group. That's part of the --
13 DR. CHERNEW: Yeah, I believe the answer's yes,
14 and if this were Zoom, I'd give you a little thumbs up.
15 But that is -- you said that -- in fact, if this is getting
16 recorded or something, maybe we'll just write that in
17 there, because what you said was --
18 DR. CASALINO: Yeah, I mean, it's -- yeah, it's a
19 simple concept, but it's hard to -- simple but brilliant,
20 but it's hard to word it non-ambiguously, and so hopefully
21 that helps. But I guess my --
22 DR. CHERNEW: Well, you just worded it non-

1 ambiguously, I think. A 41's a 41.

2 DR. CASALINO: Desperation made me --

3 DR. CHERNEW: Yeah, okay, but a 41's a 41. It's

4 just the amount you get for a 41 depends on where you are

5 relative to your peer group.

6 DR. CASALINO: Right. But now I guess the

7 question I have is: Who will see who got a 41 and who got

8 a 75? Because we're not -- these results are not going to

9 be publicly reported, correct? This is not Nursing Home

10 Compare or whatever the new name for it is.

11 DR. CHERNEW: Yeah, I'm going to defer that

12 question to Carol. So my focus, Larry, has been on the

13 payment amount. The publication of the numbers I'm going

14 to defer to Ledia and Carol.

15 DR. CASALINO: And, again, I think the idea is we

16 don't want to risk-adjust this because we don't want to

17 obscure the absolute performance. But we don't want to

18 penalize people. We'll pay in the way we just discussed,

19 but ideally people -- everybody would still be able to see

20 who got a 41 and who got a 90. But is there any mechanism

21 for that as we -- as the proposal is now?

22 MS. TABOR: I think we consider payment different

1 than what we would do for public reporting because there's
2 a science to both, and we really just focused on the
3 payment side. My hope would be that, you know, results
4 would be publicly reported, but kind of how to best do that
5 is a separate question. We did try to kind of cull that
6 out in a text box in the chapter, but we can, you know,
7 kind of add more to it if you all would like.
8 DR. CHERNEW: But the key point is, Larry, at
9 least in my opinion, we would report your score. We could
10 report your score. We could report your score relative to
11 your peer group, but the point is we would report your --
12 the key point is we would report your score. We would
13 never do a subtraction and say you're plus three relative
14 to your peer group. You would get your score like 41, so
15 that would be -- so people would understand that's what
16 your score was, and they would have to interpret that in
17 the context of the peer group. I think that's what you're
18 advocating for.
19 DR. CASALINO: Well, I think I'm just not clear
20 about the reporting mechanism. If there's already a CMS
21 nursing home reporting mechanism, how does the 41 get
22 reported?

1 DR. SAFRAN: If I could, I'll just say that I'm
2 not sure -- and I'm happy to take it offline because I
3 don't want to bog us down here. But I'm actually not sure,
4 based on what Michael has said, that we're accomplishing
5 what I hope we're accomplishing, because if what we're
6 saying is that for certain Medicare beneficiaries who are
7 more socially at risk, their providers will get rewarded
8 for lower performance, then I think we need to think hard
9 about that, because what I was hoping we were accomplishing
10 is good performance is good performance regardless of what
11 population you're serving, and poor performance is poor
12 performance. But if you're achieving good performance with
13 a harder population, you're getting a bigger reward for
14 that.
15 So if you tell me that's what we're
16 accomplishing, that's fantastic. But if we're saying that
17 actually a 41 will get rewarded in some peer groups but not
18 in others because in others that's low performance but in -
19 - you know, then I would say that means we're holding folks
20 to a different standard based on the population, and I'd be
21 concerned with that.
22 DR. CHERNEW: Dana, we will go back. We did an

1 exchange after the last time we discussed this about the
2 math, and we'll go back and revisit exactly where the
3 exchange is. I thought we had gotten to a place where we
4 sort of understood where we were, but we're not going to
5 now work through how the exact math works. So then you'll
6 see the way it works. There's certain things that have to
7 happen mathematically in this context, whether you count it
8 at -- it is the case, for example, that if you get a 41 and
9 you do it with a more disadvantaged population, in the SNF
10 model we're talking about, the SNF VIP, you would get a
11 higher payment for achieving that 41 than you would if you
12 did that with fewer disadvantaged people. I think that's -
13 - and, again, Carol, I think what I said was right, but I
14 believe, Dana, that is also a correct interpretation of the
15 words that you said, which is good performance/good
16 performance, you just get paid more for that if you're
17 serving a harder population. And I think that
18 mathematically leads to the property that I said. But,
19 again, I don't know if we're going to be able to sort
20 through all of the exact math here on the call, so we will
21 make sure to clarify that as we move through to the draft
22 recommendation to make sure we understand your concern and

1 really how to translate that into the actual mash.
2 DR. SAFRAN: That's great, thanks. I just want
3 to make sure that we don't have to face out to the Medicare
4 population and say we will reward low performance for some
5 beneficiaries and not for others -- but we won't reward low
6 performance for others. That's just -- the optics on that
7 and just the policy on that would be poor.
8 DR. CASALINO: If I may, though, Dana, I think
9 that is what this amounts to, and what -- I think that is
10 what this amounts to, for better or for worse. If that's
11 correct, that is one reason that it is important, I think,
12 to publish the scores so that people can see what the
13 absolute performance is. But I don't know how that would
14 work since CMS already has a public reporting program in
15 place.
16 DR. CHERNEW: The challenge, I think -- and,
17 again, we will go through this -- is if you go back to the
18 slide that Larry pulled out, the question is how people
19 feel -- pointed out, it was the one that had the red bar.
20 Larry was talking about the red bar on the left-most one.
21 So in the current model, it pushes money -- because
22 currently SNFs that have a lot of dual-eligible

1 beneficiaries, in this case the red, on average perform
2 worse, in the current model they get penalized. And when
3 you look at the SNF VIP we're proposing, they don't get
4 penalized, and the reason is not because their scores are
5 any different. The scores are exactly the same as the
6 scores in the other peer groups. It's just we don't take
7 the money away from those organizations the same way we do
8 in the existing current SNF VBP. And we can debate the
9 merits of the optics of that separately, but I think, Carol
10 and Ledia, I think I phrased that right, but if we do, I
11 think it's consistent very much with what Larry said and,
12 frankly, I personally advocate that because I don't want to
13 take money away from the peer groups that are serving
14 highly disadvantaged patients. I also don't want to make
15 it seem like they're performing well. So what we've done I
16 think is how I phrased it before, which is pretty much what
17 Larry summarized, which is your score is your score, but
18 how that gets translated into dollars depends on where you
19 are in the peer grouping. And, again, we can go through
20 exactly what the math looks like, but if you want to avoid
21 taking money away from the SNFs that are serving
22 disadvantaged populations, you're going to end up having

1 some version of the problem you raise, I think.
2 MS. KELLEY: Jonathan, did you have something on
3 this.
4 DR. JAFFERY: Yeah, please, just I'll try to be
5 brief. This has been actually a really important
6 discussion, I think, and I want to thank Dana for pushing
7 us on this.
8 I guess, you know, I've always viewed trying to
9 adjust things based on social risk factors and what-not as
10 a means to try and get additional resources to providers
11 who are taking care of a more disadvantaged population,
12 recognizing that there may be things that they need to do
13 to invest in that care. And I guess as we -- I hadn't
14 thought about it as much as I have in the last couple
15 minutes, but I guess for me, what I'm starting to think
16 about is that maybe we're doing it at the back end instead
17 of the front end here, and that's creating some of this
18 problem, that we're trying to say we're going to give
19 people more payment if -- you know, associated with quality
20 and outcomes that then gets inherently linked to some
21 differentials in what the expectations are, as opposed to
22 trying to somehow adjust that on the front end and actually

1 provide more resources via payments based on whether or not
2 you're caring for a population that is on average more --
3 has higher social risk factors.
4 So I don't have -- I think that's starting to
5 open up a whole can of worms now, so I don't mean to bog us
6 down on that, but it does become a fundamentally different
7 approach, and so maybe it's worth us thinking about that
8 more at future discussions.
9 DR. CASALINO: May I comment again, or is there
10 someone else in the queue?
11 MS. KELLEY: I have David in the queue, but I
12 think he may have had a point on a different topic. So go
13 ahead, Larry.
14 DR. CASALINO: Well, I'll just say I think, you
15 know, the point Dana's raising is one that is important
16 and, you know, people have been debating for some years
17 now, and there obviously is no perfect solution. But I do
18 think if there's no published reporting of the 41, then a
19 SNF in a high dual-eligible group could just say, okay, I'm
20 getting paid for these 41's, I can just kind of go on as I
21 am, really. This is Dana's concern about apparently
22 rewarding poor performance -- well, apparently rewarding

1 lower scores because the population is low SES, and they
2 need to give some motivation to keep improving your score
3 even if you're in a low SES peer group.
4 So one way to do that is to pay for improvement
5 as well as absolute score, but another way to put at least
6 some pressure on a provider organization, whether it's a
7 SNF or whatever else, to keep improving and not be
8 satisfied with a low score but good incentive because
9 they're in a high SES peer group, is to publish the scores
10 so that everybody can see that there's a 41 or two stars or
11 whatever.
12 So there's really two -- there's three tools, I
13 think, to try to motivate. One is the incentive payment;
14 one is the published reporting of the absolute score; a
15 third would be to pay for improvement. But, you know, that
16 can be quite complicated.
17 DR. SAFRAN: I'll just comment that, Larry, I
18 think the model here already does pay for improvement and
19 absolute performance. That's the beauty of getting rid of
20 "cliffs" is that for every increment of improvement,
21 there's more reward. So that's a model that I incorporate
22 into my work at Blue Cross that we found very motivating to

1 providers because you're rewarding both performance and
2 improvement by having a continuum across which there is
3 increasing reward.
4 I'm just looking for that continuum to be the
5 same, regardless of what population you're serving, so that
6 we say, like, here's the beginning of good performance,
7 here's exceptional performance, and whoever you serve, you
8 get rewarded for that. But you get rewarded more at every
9 point on the continuum if you have a higher degree of
10 difficulty based on who you're serving.
11 MS. KELLEY: Amol, did you have something on this
12 point?
13 DR. NAVATHE: Yes. Just really quickly, I think,
14 Dana, that was a nice description. That being said, I
15 think any time we decide to reward more based on the
16 population, I think we end up in this challenging situation
17 of potentially end up sort of setting different standards
18 concept.
19 That begin said, I fully support the idea of
20 incorporating a piece on transparency here around the
21 absolute performance, as, Larry, I think you started to
22 push us toward, which I think is great.

1 The other part that I think that's important to
2 remember is because the allocation is done within peer
3 group, the incentive to improve certainly exists for every
4 organization because if you don't improve and your peers
5 improve, then staying stable means that your bonus goes
6 down. That competition around quality itself is also, I
7 think, fundamentally important.
8 We have to strike a balance between ensuring that
9 we're recognizing the challenges that some SNFs may have in
10 socially disadvantages areas versus others. I don't think
11 that the peer group being by structure is absolutely
12 problematic in that domain because of the incentives to
13 improve, regardless. I think, again, the transparency part
14 is a really good addition.
15 MS. KELLEY: Brian?
16 DR. DeBUSK: I just wanted to comment on the
17 discussion about the peer grouping and rewards and
18 penalties. I think it's important to separate out the
19 measure of performance and making that data -- Amol, you
20 touched on that as well -- making that data publicly
21 available; for example, knowing where someone scores in the
22 discharge-to-community rate on the relative scale. I think

1 making that -- publishing that in absolute terms and making
2 that information available is different than categorizing
3 these providers into different peer groups and handing out
4 rewards and penalties, because, again, a discharge-to-
5 community rate for Peer Group 1 which has the lowest share
6 of fully eligible duals, the average discharge-to-community
7 rate in Peer Group 1 might make you a 95th percent
8 performer in Peer Group 20.
9 So I think we need to untangle the issues of
10 absolute performance, which should be transparent, which
11 should be published, versus how we hand out rewards and
12 penalties, which then can be compartmentalized by peer
13 group, just to ensure that we aren't penalizing the lower
14 socioeconomic groups simply because they are lower SES.
15 Thank you.
16 DR. CHERNEW: So I'm not sure how many people
17 want to jump in on this more. I think we might want to
18 bring this part of the discussion to a close.
19 Dana, I think I understand what you're saying.
20 The challenge in many ways is to get the math of what
21 you're saying right. To some extent -- and, again, I've
22 been sitting here pondering if I should use these words in

1 a public meeting -- this is a little bit about an intercept
2 versus a slope, and we could discuss exactly what you mean
3 there. But the point is if you give a different value,
4 whether you shift the intercept or the slope, when you get
5 to a point, there will be different rewards for people
6 based on the population that they serve.
7 You can't not have that happen. There is no way
8 it will not happen. You might think there's some level of
9 performance below which no one should get anything, that if
10 you move down the performance gradient, it shouldn't matter
11 what your score is -- I'm sorry. If you move down the
12 performance gradient, it shouldn't matter what your SES is.
13 You shouldn't get rewarded, that you to have and look and
14 see where that is, but the fact of the matter is if you
15 plot out the actual performance and how it relates to the
16 SES amount, if you don't adjust the payment by SES, you end
17 up pooling a lot of the money away from the organizations
18 that serve low SES people, and that's what I think is
19 fundamentally problematic.
20 You could solve that problem by shifting a slope.
21 You could solve it by shifting an intercept. We can look
22 how that plays out in the math, and I think you can go

1 offline to see where that goes. But there is going to be
2 some point in which -- maybe I shouldn't have picked 41, my
3 example. If you get a 92 and you have a very advantaged
4 population, should that organization get the same amount of
5 money as an organization of 92 in a disadvantaged
6 population? And then you can move down the 92 to say,
7 okay, well, what about 82? What about 70? And I can work
8 that back, and at some point, those are going to have to
9 stay separate, or our methodology has a particular
10 functional form we can discuss. And we will work through
11 the math, I think, offline. But this is really, I think,
12 about that principle.
13 I don't know. I can --
14 DR. SAFRAN: Absolutely, I agree. I think we all
15 agree that we want a picture that looks more like the
16 right-hand side of the slide that's up where we are not
17 disadvantaging SNFs that take care of disadvantaged
18 populations, but I'm also looking to be sure we're not
19 disadvantaging the populations themselves by settling for
20 and rewarding low performance, because my own experience
21 says that if you set the performance bar the same,
22 regardless of the population served, those who serve lower

1 SES populations will rise to the challenge to deliver
2 better care.
3 DR. CHERNEW: Yes.
4 DR. SAFRAN: And that's what I hope to
5 accomplish.
6 DR. CHERNEW: Yes. So maybe there's a discussion
7 about level versus change, and I think, Amol, you may have
8 said something like this. But I will try to iterate this
9 point.
10 My view is in order to prevent people from
11 settling for low performance, what you need to do is set
12 the price for better performance high, and so there's
13 nowhere in the existing SNF VIP that anyone gets to rest on
14 their laurels and say, "Oh, it's not worth it for us to do
15 better." Everyone, no matter what they serve, no matter
16 what -- this is set up that no matter what peer group
17 they're in, there is an incentive to do better for those
18 individuals.
19 So if he question is what is the incentive for
20 you to improve, that -- in fact, I think the way it might
21 work -- and I'd have to look. It might actually be higher.
22 It's complicated for me to know exactly what the slope is

1 across the different groups, but the point remains no one
2 gets to say, "Oh, I did fine. I can now stop." There's
3 always a benefit for getting better in the way this is set
4 up. So everyone has an incentive to get better across the
5 board. There's never a point where we say, "Oh, you hit
6 41, but given your SES profile, that's fine." That's not
7 the way this works.
8 You're always better if you're at 41 to get to
9 42, as you're always better if you're an 81 to get to 82.
10 It's just the amount that you get increases. It's harder
11 to get if you have a different SES profile. That's
12 basically the way that this works.
13 So we've tried to maintain exactly that.
14 Basically, we're trying to get a picture that looks like
15 the right-hand side of this as opposed to the left-hand
16 side but do it in a way that gives every organization
17 incentive to move to better performance, and I think the
18 current formulary does that.
19 Carol? Ledia?
20 MS. KELLEY: Jon Perlin.
21 DR. PERLIN: I was actually going to weigh in,
22 but I'll share what I was thinking, which is I remember

1 facing this problem in managing the VA system. This is a
2 little bit off the direct path here. But this is
3 fundamentally a utility of process measures.
4 I realize there are limitations categorically
5 with certain process measures, as there are with outcome
6 measures, but those few that have to be tightly linked with
7 outcome are measures that we can use across different risk
8 populations, so just to think, as we're thinking about our
9 evolution here, as there will be certain metrics that don't
10 back us into a corner of unintended consequences. Thanks.
11 MS. KELLEY: Okay. I have no one left in the
12 queue on this particular issue -- oh, I'm sorry. Wait.
13 Pat. I do have Pat. Go right ahead, Pat.
14 MS. WANG: Thank you.
15 Just really quickly, this has been a really
16 important conversation. I just wanted to weigh in that I
17 think what we're looking at is sort of we're judging sort
18 of fairness to institutions based on distribution of the
19 award, but I think underlying this -- and I really
20 appreciate Dana kind of raising it. This is my personal
21 view. In the absence of really good risk adjustment of the
22 measures themselves, there is no purity to these quality

1 metrics.

2 I view these approaches as an attempt, you know,
3 to use the tools that we have, to recognize that these
4 quality measures are not absolute.

5 Successful discharge to the community, if we deem
6 that 41 is bad and that 82 is good, and a facility that has
7 a high proportion of disadvantaged folks can only score a
8 50, that is not necessarily a reflection of what's good.
9 If they were to score 91, it would -- housing is great,
10 that social supports for that individual are great, that
11 there is -- you know, that the person lives maybe in an
12 elevator building with a doorman as opposed to stairs. You
13 can tell I live in an urban area. I just want to say I
14 don't -- and I'm not a quality expert. So I'll be the
15 first person to say that.

16 Some of the quality metrics to me are a little
17 bit -- they're not pure. It's not sort of like a
18 mathematical certainty that successful discharge to the
19 community is so absolute that we can't -- I view these as
20 sort of back-door ways of pulling together the tools that
21 we have to recognize that the measures themselves are not
22 perfect. So I don't view this so much as giving a break to

1 the institution as a recognition of the situation that is
2 real for people, that starts and extends way beyond what
3 happens inside of a facility.
4 I am all for rewarding improvement and better
5 performance and setting a high bar out there, but I just
6 wanted to offer that perspective. I don't see this as sort
7 of we're trying to be nice to these facilities. I think
8 that it is more recognition that the measures don't capture
9 the reality of a lot of beneficiaries. Thanks.
10 MS. KELLEY: Anyone else on this before I move to
11 David on a different topic or a different issue in this
12 topic?
13 [No response.]
14 MS. KELLEY: Okay. David?
15 DR. GRABOWSKI: Great. Thanks, Dana, and I can't
16 help myself, but now I've got to weigh in on this as well.
17 So I'll do it really quickly.
18 Larry raised a great point about transparency.
19 We've had a real lack of transparency, I think, with the
20 SNF VBP. If you want to lean who the winners or losers
21 are, you don't find that on Nursing Home Compare. You go
22 on the CMS website, and you download a flat file. And you

1 find the facility, and it's totally hidden somewhere on
2 Medicare.gov.
3 Larry, I love the idea of bringing these results
4 out and putting them on Nursing Home Compare, but as I said
5 earlier, Nursing Home Compare is built around a five-star
6 system with survey deficiencies, staffing, minimum dataset-
7 based measures, claims-based measures. We have a measure
8 here that's based totally on claims. It's just focused on
9 post-acute. So it's a very different measure, and just
10 harmonizing what we do or what CMS is doing on the payment
11 side with what they're doing on the quality reporting side,
12 there is a little bit of a -- not even a -- there's a lot
13 of disconnect across the two.
14 So I love the idea of transparency, but it
15 strikes me that it's easier said than done, just given the
16 different systems. That will be great, and I think Carol
17 and Ledia took some of this on in the chapter. Carol and
18 Ledia, maybe you want to talk about transparency as being
19 one of the goals of this program of getting these -- to get
20 the 41 or the 96 or whatever. That's public information,
21 and folks can see that as part of their report. That's a
22 really nice idea.

1 But as Carol and Ledia know well, that's totally
2 separate from what's currently reported with the -- you get
3 one to five stars, Larry, and that's a totally different
4 system.
5 I promised another comment. We spent a lot of
6 time on part of Dana's comment, but she also had this, I
7 think, really interesting point about are there safety-
8 based measures that might be included. The one that we
9 often point to, Dana, as you know well, are falls, and
10 that's been this kind of great measure.
11 But, Carol and Ledia, talk a little bit about
12 falls. Unfortunately, the minimum dataset, once again, is
13 facility-reported. There's been some great academic work
14 showing that if you compare sort of falls from the MDS
15 versus claims-based measures of falls, they don't match
16 very well. I think just a simple claims-based measure may
17 not be frequent enough, but I do think, Carol, Ledia, I
18 like where Dana is going with that, thinking about are
19 there claims-based adverse events that in terms of safety
20 that we could potentially leverage.
21 Maybe it's just a quick question. We haven't
22 really explored this. Is it a small number issue? There

1 just aren't enough of those kind of claims from a given
2 facility that it's really meaningful, but it is intriguing.
3 Thanks.
4 DR. CARTER: Yeah. Ledia and I talked about safe
5 measures yesterday, anticipating this question, and that
6 was the one we came up with and then sort of talked amongst
7 ourselves about the MDS versus claims-based measures the
8 problems within, so everything you just laid out. So
9 that's the dilemma.
10 MS. KELLEY: Okay. Mike, back to you.
11 [No response.]
12 MS. KELLEY: Mike, we can't hear you.
13 DR. CHERNEW: Yeah. You couldn't hear me talk
14 about how exhausted I've become.
15 So this is the policy option session. We will
16 come up with a recommendation when we go forward. We will
17 be very cognitive of this discussion. We will try and do
18 it in language that don't involve intercepts and slopes,
19 but the point remains I do think there's a mathematical
20 problem that has to be solved, which will give you a point
21 in the distribution where your SES population will
22 influence how much you get paid. By definition, that will

1 create different payments for groups serving -- you can't
2 mathematically make that not create different groups. So I
3 don't want to relitigate that.
4 Actually, I should have just stuck with thank you
5 for the very rich discussion. We have heard it all, and we
6 will revisit it, and I do appreciate -- I think the word
7 that someone may have used was "conundrum." I do
8 appreciate the conundrum, and we will try and find a way
9 out. But we're going to do so in a way that makes sure, in
10 my opinion, that we don't direct resources away from
11 organizations that are serving some of the most
12 disadvantaged individuals, without signaling that it's okay
13 that their performance isn't very good. That's the core of
14 the conundrum, and that's what we would like to do, and
15 obviously, transparency is a part of that.
16 But for now, we're going to move on to another
17 topic which is vaccines. This is something we've been
18 working on a long time before the current vaccine activity,
19 which is obviously crucially important, but I think, Nancy,
20 are you starting this off?
21 MS. RAY: I am starting. Thank you.
22 The audience can download a PDF of the slides on

1 the right-hand side of the screen.

2 Today we are going to continue our discussion

3 from the September meeting about Medicare coverage and

4 payment for vaccines. Many other people beside the three

5 of us listed here have contributed this work, including

6 Rachel Schmidt, Shinobu Suzuki, and Bhavya Sukhavasi.

7 During today's session, I will first summarize

8 Medicare's quality efforts to measure vaccination rates

9 across providers and plans. This is in response to

10 Commissioners' requests in September for such information.

11 Next, Kim will discuss two policy options on

12 vaccine coverage and payment based on your discussions at

13 the September meeting. The first relates to moving all

14 appropriate preventive vaccines under Part B, similar to

15 the Commission's 2007 recommendation. The second option is

16 in response to your request for alternatives to improve

17 Medicare's payment method for Part B vaccines.

18 It would be helpful to get your feedback on the

19 policy options and whether you would like us to work with

20 the Chair to develop them into draft recommendations.

21 In response to Commissioners' request, we found

22 that use of vaccine-related measures for public reporting

1 on medicare.gov and in the providers' quality reporting
2 programs varies across fee-for-service providers. For
3 example, for hospitals paid for under the inpatient
4 prospective payment system, cancer-exempt PPS hospitals,
5 long-term care hospitals, inpatient rehabilitation
6 facilities, measures assessing influenza vaccination of
7 healthcare personnel are used in each setting's quality
8 reporting program and are publicly available on
9 medicare.gov. By contrast, no measures are used for the
10 other provider types listed on the slide -- ASCs, dialysis
11 facilities as of payment year 2022, hospice providers, and
12 SNFs. Some clinician specialties have the option to be
13 scored on vaccination measures. Otherwise, vaccination
14 rates are not scored in any of the value-based payment
15 programs for fee-for-service providers as of payment year
16 2022.
17 ACOs are currently scored on flu vaccination
18 rates of their beneficiaries, but beginning in payment year
19 2022, ACOs will be scored on a smaller measure set which
20 does not include any vaccine measure. Flu vaccination of
21 beneficiaries is publicly reported and scored in quality
22 bonus program for MA plans.

1 Now Kim will take you through the two policy
2 options for your consideration.
3 MS. NEUMAN: Good morning. So first we'll talk
4 about the policy option related to Medicare coverage of
5 vaccine. Medicare coverage of vaccines and their
6 administration is split between Part B and Part D. Part B
7 covers preventive vaccines that are specifically named in
8 statute, that is flu, pneumococcal, and for beneficiaries
9 at medium or high-risk hepatitis B. The CARES Act added
10 Part B coverage of COVID-19 vaccines in their
11 administration.
12 In limited circumstances, Part B also covers
13 certain other vaccines when used in response to an injury
14 or direct exposure, such as rabies or tetanus vaccines.
15 Part D covers all commercially available vaccines not
16 covered by Part B. Shingles accounts for the vast majority
17 of Part D vaccine doses.
18 When Part B or Part D cover the vaccine, they
19 also cover the administration.
20 A few differences between Part B and D coverage
21 of vaccines. Part B covered preventive vaccines are not
22 subject to cost-sharing whereas Part D plans are permitted

1 to charge cost-sharing for vaccines, and those amounts vary
2 by plan and benefit phase.
3 Part B vaccines are administered in a variety of
4 settings. Mass immunizers such as pharmacies and physician
5 offices are the most common sites of administration, but
6 hospitals, skilled nursing facilities, home health
7 agencies, and other providers also bill Part B for
8 vaccines. Part D vaccines are mostly administered in
9 pharmacies, but systems referred to as clearinghouses have
10 been developed so physicians can generally bill Part D for
11 vaccines.
12 In June 2007, the Commission recommended that all
13 Medicare vaccine coverage be moved to Part B. Some of the
14 rationale for that recommendation stemmed from concerns
15 that physicians would have difficulty billing Part D plans
16 for vaccines and concerns that patients would have to pay
17 for vaccines up front and seek reimbursement from plans
18 afterwards, potentially deterring access. Since then steps
19 have been taken to lessen these billing issues under Part
20 D. However, there continues to be strong rationale for
21 moving coverage of all preventive vaccines to Part B.
22 Moving all vaccine coverage to Part B would

1 promote wider access to vaccines. More beneficiaries have
2 Part B coverage than Part D coverage. Part B vaccines are
3 administered in a wider variety of settings than Part D
4 vaccines. It may also be less confusing to beneficiaries
5 and providers to have all vaccine coverage under one part,
6 instead of split across B and D. Also, coverage of
7 vaccines under Part B without cost-sharing would ensure
8 that cost-sharing is not a barrier to vaccine access for
9 beneficiaries.
10 For these reasons, the Commission could consider
11 a policy option to cover all appropriate preventive
12 vaccines under Part B instead of Part D without cost-
13 sharing. The language in this policy option is similar to
14 the Commission's 2007 recommendation, except that it
15 specifically states that there would be no cost-sharing for
16 preventive vaccines under Part B in the future, whereas the
17 previous recommendation had been silent on cost-sharing.
18 Adding this language on cost-sharing would ensure that
19 there is no cost-sharing for vaccines moved from Part D to
20 Part B and for new preventive vaccines developed and
21 covered under Part B in the future.
22 Next, we will turn to how Medicare pays for

1 vaccines. At the September meeting, we discussed how Part
2 B's payment approach for preventive vaccines was
3 inefficient, and Commissioners asked for additional
4 analysis about how Part B payment rates compare to other
5 pricing benchmarks and asked for alternative payment
6 approaches that could be considered.
7 So first, some background on how Medicare pays
8 for vaccines. Part B preventive vaccines are paid 95
9 percent of average wholesale price. AWP is akin to a
10 sticker price does not necessarily reflect market prices.
11 In limited circumstances, Part B covers a small number of
12 vaccines in response to an injury or direct exposure, like
13 a rabies shot after an animal bite. The payment rate in
14 that situation is the same as for other drugs and
15 biologicals, 106 percent of the average sales price. Part
16 D pays for vaccines based on a plan-negotiated rated with
17 pharmacies. Part D plans may also negotiate rebates with
18 manufacturers, although we don't have data to know whether
19 that occurs.
20 This next slide compares Medicare's payment rates
21 for vaccines under Part B and D to wholesale acquisition
22 costs. These payment rates are for the vaccine itself and

1 do not reflect the separate payment made for
2 administration. Note that some of the data in this chart,
3 in particular the middle column, has been revised from
4 what's in your paper.
5 In the first column on the left, we compared
6 Medicare's payment rate of 95 percent of AWP for flu,
7 pneumococcal, and hepatitis B vaccines to WAC. As
8 expected, 95 percent of AWP substantially exceeds WAC. For
9 example, for the flu vaccine, 95 percent of AWP is about 17
10 percent greater than WAC for the median product.
11 In the last column on the right, we compare Part
12 D's vaccine payment rates for ingredient cost to WAC. As
13 you see, the median Part D payment rate is typically a
14 couple percentage points above WAC.
15 A few of the vaccines covered by Part D are also
16 covered in limited circumstances by Part B at a rate of 106
17 percent of ASP. And we can see in the middle column of the
18 chart, that Medicare's payment at 106 percent of ASP is
19 substantially below WAC for the products we have data.
20 So Commissioners asked us to think about
21 alternatives to payment at 95 percent of AWP. One option
22 would be to pay based on WAC, for example, 103 percent of

1 WAC, similar to the rate Part B pays for new drugs and
2 biologics that lack ASP data. WAC is the price set by the
3 manufacturer and it reflects the price at which the
4 manufacturer sells to the wholesaler, and it does not
5 reflect discounts or rebates to the extent they are
6 available. But WAC is lower than AWP, and paying based on
7 WAC would moderately reduce payment rates.
8 Another option would be to pay based on the
9 average sales price. ASP is a market-based price, and
10 reflects the manufacturers average sales price to most
11 purchasers, net of rebates and discounts with some
12 exceptions. As we saw in the prior chart, for those
13 vaccines where we have data, ASP appears to be
14 substantially below WAC. So an argument could be made to
15 pay based ASP because it would reflect actual market prices
16 rather than an undiscounted wholesale price.
17 For a few reasons, it could be helpful to have
18 more data before considering an ASP-based payment amount.
19 We do not know what ASP is for the current Part B
20 covered vaccines that are paid 95 percent of AWP and how it
21 much using ASP as the basis for payment would change the
22 Medicare payment rates. Because ASP is an average, we do

1 not know how much vaccines acquisition prices vary across
2 purchasers such as physicians. Understanding that price
3 variation could help inform whether 106 percent of ASP or
4 an alternate add-on to ASP is appropriate.
5 With vaccines, there is also uncertainty about
6 how the two-quarter lag in ASP would affect Medicare's
7 payments. So for example, that could be an issue given the
8 seasonality of the influenza vaccine.
9 Given all this, an option that could be
10 considered is to modify Medicare's payment rate for Part B
11 covered preventive vaccines from 95 percent of AWP to 103
12 percent of WAC, and require vaccine manufacturers to report
13 ASP data to CMS for analysis. The intent of this option
14 would be to move away from inefficient AWP-based payment
15 while ensuring beneficiary access to vaccines.
16 As an initial step, this option would base
17 payment on WAC, which better approximates acquisition costs
18 than AWP. This would moderately reduce payment rates, but
19 to a level that should be accessible to providers.
20 Concurrently, this policy would require
21 manufacturers to report ASP data for vaccines to CMS, so
22 that the agency could study how payment rates would be

1 different if ASP were used as a basis of payment. As part
2 of this assessment, the Secretary could, potentially
3 through the Office of Inspector General, gather data on
4 immunizers' acquisition costs for vaccines to study how
5 prices vary across purchasers. The collection of ASP data
6 by CMS and acquisition cost data by the Secretary could
7 build the knowledge base to consider and potentially
8 develop a payment rate that better reflects market prices
9 in the future.

10 So this brings us to the end of our presentation.
11 We would be glad to answer any questions and look forward
12 to your discussion. It would be helpful to get your
13 feedback on the policy options and whether you would like
14 us, working with the Chair, to develop them into draft
15 recommendations.

16 So now we will turn it back to Mike.

17 DR. CHERNEW: I'm muted but I'm good. We had
18 some discussion so I'm going to turn it to you, Dana
19 Kelley, to manage any comments that people may have asked
20 to make.

21 MS. KELLEY: I think Pat has a Round 1 question.

22 MS. WANG: Thank you. Can you guys comment -- I

1 just wasn't clear. There's the cost of the vaccine and
2 then there's the cost of administration. Is there any
3 implication to how the proposal to shift everything to Part
4 B, is there any implication for the site of vaccine
5 administration, whatever the distribution right now is,
6 pharmacy versus physician office, et cetera, as well as the
7 cost of administration? I know that the paper talked about
8 the desired kind of look at the cost of administration, but
9 aside from the cost of the vaccine itself, do you think
10 that there are implications for moving vaccines to Part B?
11 And I guess tucked in there -- this is sort of an
12 ancillary question, I guess -- is are there implications
13 for 340B, if everything goes to Part B and ordering of the
14 drugs or what have you is perhaps more reliant on 340B? I
15 just wonder if there is some other threads of implications
16 running behind the transfer.
17 I can't hear you, Nancy.
18 MS. RAY: So I guess I'll take the first part of
19 the question. In terms of implications for the site of
20 care, I think that's something that we'd like to consider a
21 little bit more. But, you know, right now I wouldn't
22 expect that there would be. But I think we would like to

1 think about that a little bit more and get back to you on
2 that.
3 Kim?
4 MS. NEUMAN: I think we also should get back to
5 you on the 340B question as well, to confirm that these
6 products are not subject to 340B discounts. Let us double-
7 check that point and we'll get back to you.
8 MS. WANG: Okay. Thank you very much. Where I'm
9 going with this, I just want to understand if there are
10 implications for the cost of administration, because in a
11 pharmacy there really aren't, but in physician's office, to
12 the extent that it's accompanied by an E&M visit or
13 whatever, there just might be implications. Thank you.
14 MS. KELLEY: Jon Perlin.
15 DR. PERLIN: Thanks, Kim and Nancy, for a very
16 thoughtful chapter. You know, since the last time we
17 discussed this I think all of us have been thinking about
18 vaccines a whole lot more, and I certainly have been. I
19 guess it's led me to the question on this slide that's up
20 right now, 13, cover all appropriate preventive vaccines.
21 What constitutes, as we think forward, an appropriate
22 preventive vaccine? I know when we're contemplating the

1 context of that previously we were really thinking about
2 infectious disease. And I remember we had some discussion
3 about those things that span from infectious to, you know,
4 what we consider oncology or cancer, like HPV vaccine.
5 But as we think forward and project the changes
6 in technology, there may be anti-cancer vaccines,
7 immunological approaches. And, in fact, some of them may
8 not only be generalized, like the HPV vaccine, but, in
9 fact, could be tailor-made for a specific individual, based
10 on their genetic makeup.
11 And I just wondered whether we've contemplated
12 were we to limit our concept of vaccine, which I realize
13 this part is Part B, which I strongly endorse, with some
14 circumscription of things that are likely coming down the
15 pike that perhaps we're not ready to deal with yet.
16 Thanks.
17 MS. NEUMAN: So that does raise a number of
18 complicated issues. I think that we have some discussion
19 in the paper that talks about the definition of an
20 appropriate preventive vaccine as being a key piece of this
21 policy, and one of the things that we point to is
22 potentially using a group like ACIP and their

1 recommendations on what vaccines are recommended for adults
2 as a way to potentially define appropriate preventive
3 vaccines. But we could think more about that and other
4 alternatives.
5 The other thing I would note is that the
6 definition of vaccine, as you say, is complicated, and
7 there are some vaccines that prevent conditions, you know,
8 like flu and pneumococcal. There are also uses of vaccines
9 as treatments. There are certain cancers that are treated
10 with a vaccine once you already have the condition.
11 Currently Medicare treats those kinds of products as
12 treatments to cure an illness or injury, and as such
13 they're subject to the normal payment provisions for Part B
14 drugs and biologics.
15 DR. CHERNEW: I think that was useful. In fact,
16 in general, the one thing I realize is no matter what you
17 do, we run into semantic problems. So I appreciate that
18 comment, and of course, I also very much appreciate the
19 challenge and the focus CMS faced because they run into the
20 same semantic issue that they have to deal with.
21 I think as new things get developed and sort of
22 get in the gray area, there will have to be decisions, and

1 we will have to make comments on those as they arrive. So
2 I think now we're trying to get the system to work better
3 for where we are now, and we will approach things that
4 might stretch the gray area when the things that stretch
5 the gray area arise. That's my take on this. Others may
6 disagree.
7 MS. KELLEY: Larry?
8 DR. CASALINO: Thanks, Dana.
9 Could you show us Slide 9, please?
10 In terms of the payment rate or how Medicare pays
11 -- this makes my eyes cross, but looking at the note there,
12 some providers such as hospitals, SNFs are paid reasonable
13 cost. So hospitals and SNFs are not a trivial part of the
14 health system.
15 So I guess two related questions. What does
16 reasonable cost mean? Two, how, if at all, does the policy
17 option you suggest in terms of how Medicare pays for
18 vaccines -- does out policy action interact with this
19 reasonable cost thing for hospitals and SNFs or not, and if
20 not should we have something to say about this reasonable
21 cost way of paying hospitals and SNFs and home health
22 agencies and rural health clinics?

1 MS. NEUMAN: So reasonable cost for vaccines is
2 adjudicated at cost report settlement. We have not to date
3 looked at what Medicare is paying on the cost reports for
4 vaccines, but we're hoping we'll be able to come back to
5 you with some information on that at a future session.
6 As the policy option is currently structured,
7 it's focused on 95 percent of AWP, but we could consider
8 whether it should be expanded.
9 DR. CASALINO: As you were talking, I realized I
10 want to ask you a very basic question. Is the vaccine cost
11 for a hospital or a SNF built into the prospective payment
12 and not paid separately?
13 MS. NEUMAN: It is paid separately, and it's
14 still adjudicated later.
15 DR. CASALINO: Okay. So it is reasonable to
16 think that at some point, we might want to have a policy
17 option for how these providers in this footnote are paid.
18 I mean, hospitals and SNFs are not small, right, as part of
19 -- or home health agencies as part of the health care
20 system.
21 MS. NEUMAN: Right. As part of the whole health
22 care system, they are not small.

1 You can see on page 10 of the paper, we break out
2 the locations of vaccinations, and you can see that of
3 those settings, hospital is the biggest of the ones paid
4 reasonable cost. But it's a smallish, a much smaller share
5 of vaccines than it is of other kinds of services.
6 DR. CASALINO: Thanks.
7 MS. KELLEY: Okay. I have no more Round 1
8 questions, unless someone wants to raise their hand now.
9 So we'll go to Bruce on Round 2.
10 MR. PYENSON: Thank you.
11 I want to compliment Nancy and Kim on just
12 terrific work here, and the policy options that are
13 discussed seem pretty much on target.
14 I did want to have a comment for future
15 consideration that we're getting into public health issues
16 -- flu vaccine, COVID vaccine -- public health issues where
17 the acute care system in the physician fee schedule are
18 perhaps not the best way to meet the needs of Medicare
19 beneficiaries.
20 We obviously have to move ahead with what we have
21 in the structure we have, but I think as we look at the
22 public health aspects of vaccinations as well as perhaps

1 public health aspects of other kinds of services, to think
2 broadly about what's the best way that Medicare
3 beneficiaries can get these services, there's all sorts of
4 challenges, I think, for the beneficiaries and, frankly,
5 for physicians in considering these are part of physician
6 services.
7 But thank you. My compliments on this material.
8 I think it's really very, very well done.
9 MS. KELLEY: That's all I have for Round 2, Mike.
10 DR. CHERNEW: I don't have a lot more to add, to
11 be completely honest with you. I think this is a
12 tremendous body of work.
13 So Amol has something to add, I see. So I will
14 continue with my thank-you after Amol adds what will surely
15 start with his thank-you. Go ahead, Amol.
16 DR. NAVATHE: Sure. So, first off, thanks, Nancy
17 and Kim. Very good work. I think you very clearly laid
18 out nice options.
19 I just wanted to point out that you guys do make
20 the point in the paper itself that the Affordable Care Act
21 created a no cost-sharing policy for commercial health
22 plans, yet in Medicare, we don't have that situation. And

1 I just wanted to highlight that asymmetry, which we should
2 hopefully all find very disconcerting and uncomfortable
3 given that Medicare is always state government programs.
4 So as you guys have, you've laid out policy
5 options that addressees that. I think that's very
6 important that any policy option we pursue going forward
7 has this parity, if you will, between the requirements of
8 the Affordable Care Act for commercial plans and what we
9 might pursue as a Medicare policy option.
10 DR. CHERNEW: Amol, thank you. That's certainly
11 reasonable.
12 Jon Perlin. I'm sorry, Dana. People are raising
13 their hands. So go ahead, Jon.
14 DR. PERLIN: Yeah. Just very quickly, first
15 off, you made the point that this is a public health issue
16 at one level, but, you know, Mike's very -- and VA is such
17 a wonderful sort of test bed, its, you know, bias toward
18 older high concentrations of chronic illness. The
19 implementation of pneumococcal vaccination in VA -- and
20 this is correlative, not causal, we actually published,
21 actually decreased the rates of hospitalization.
22 So in thinking from a purely Medicare beneficiary

1 stewardship perspective, while there is a beneficial public
2 health aspect, there's also a beneficial return for
3 particular populations. In some instances, that return is
4 actually faster than others, in fact, in VA. Moving the
5 pneumococcal vaccination rate from about 24 percent up to
6 above 90 percent saved the taxpayers about $60 million
7 annually, so appreciate those distinctions. Thanks.
8 DR. CHERNEW: Paul?
9 DR. PAUL GINSBURG: Yeah. Thanks.
10 I'm glad Amol brought up the issue about Medicare
11 seemingly being forgotten about when the Affordable Care
12 Act required no cost sharing for vaccinations for both
13 employer-based plans and individual plans, and I definitely
14 support the first option.
15 On the second one, this probably should have been
16 a Round 1, but I think it's a good idea to move from 95
17 percent of AWP to 103 percent of WAC. But what's the
18 argument for not going to 106 percent of ASP, which we do
19 for all other physician-administered cost?
20 MS. NEUMAN: So we talk about in the paper that
21 there being some uncertainty about what the payment rates
22 would look like at using ASP and as well as not knowing the

1 variation around ASP for vaccines and whether 106 percent
2 would be the right add-on or some other add-on would be
3 appropriate.
4 And then there's something related to vaccines
5 that's a little bit different from other products in the
6 sense that -- the flu vaccine is a really good example.
7 It's a vaccine that has seasonality to it, and the ASP
8 payment rates, the way they're set up, it's based on a two-
9 quarter lag.
10 So in the fall of the year, the ASP payment rate
11 would be based on the prices from two quarters prior, and
12 so there's some uncertainty of how that lag might affect
13 the rates. And so there could be benefit for additional
14 study to look at that, get the data, and make a
15 determination.
16 DR. PAUL GINSBURG: Yeah. So actually to use ASP
17 might actually require changes in the way the data are
18 collected, which may be more burdensome than just not
19 pursuing the ASP and relying on WAC.
20 MS. NEUMAN: Yeah. I think we don't know at this
21 point. We don't know whether the ASP would be just fine or
22 whether these unique things to vaccines should be factored

1 in, in some way.
2 DR. PAUL GINSBURG: Yeah.
3 DR. CHERNEW: I would just as an aside, actually
4 it gets into what Dana was saying. We were having our
5 discussion about Part D earlier today. I still worry in
6 general with payment policies that are a percentage of
7 anything that someone set because I'm worried that that
8 basic formula is inflationary. This adds all this data
9 component to it, but again, this is a broader -- right now,
10 I think -- let me see if I can characterize this.
11 First of all, thank you all for your comments.
12 Second of all, I think the sort of main goal
13 here, at least for me, is to think about how to make sure
14 that we can get people access to vaccines in an efficient
15 manner. I personally think this moves us in the right
16 direction, and I hear some consensus around that, at least
17 broadly. We'll come back with actual recommendations.
18 There are some issues around pricing, for
19 example, that dovetail with other discussions we've had
20 about pharmaceutical pricing over time and how that works,
21 and I think those are the ones you're raising, Paul. And I
22 agree with that, and I do think there's some unique data

1 issues here.

2 But, anyway, I guess I'm pausing for a second to

3 see if anyone else wants to add. Kim or Nancy, do you want

4 to add anything else to this discussion? Do you think you

5 have what you need?

6 [No response.]

7 DR. CHERNEW: Jim?

8 DR. MATHEWS: I think we're good on vaccines.

9 DR. CHERNEW: I think we're good for the entire

10 January session. So let me call our a particularly hearty

11 thanks to all of the staff that did a lot of work, and I

12 said at the beginning of the meeting -- and I will close in

13 a moment -- particularly all the work they did over the

14 holiday season. It really is remarkable to see your

15 dedication and restores some of my faith in public service,

16 so a hearty thank you.

17 To the audience that has joined us, remember this

18 is a somewhat begrudging virtual meeting, and we would all

19 like to see each other and you in person. And hopefully,

20 we will be able to do that again. Notice how I dovetailed

21 that into the whole vaccine session?

22 Anyway, we hope to be able to do that again, but

1 in the interim, please feel free to reach out to us on the
2 website or other means. Reach out to the staff to give
3 your comments on our work. It is important that we do our
4 work in public, and we really do value that feedback that
5 we get.
6 So for many of these sessions, including
7 vaccines, but the others, we are going to be returning to
8 them in March. We draft recommendations after we debrief
9 from this whole discussion.
10 So I appreciate everybody's time. I hope that we
11 have what is a good long weekend. I think we all need a
12 long weekend to reflect on where we'll collectively end up
13 in this country, and we will do that. So, again, have a
14 terrific weekend, everybody, and thank you again for all
15 your contributions and for participating in the meeting.
16 MS. KELLEY: Thanks, everybody.
17 [Whereupon, at 12:44 p.m., the meeting was
18 concluded.]