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

FROM THE JANUARY 14-15, 2021 VIRTUAL MEDPAC MEETING

PREPARED BY HART HEALTH STRATEGIES, INC.

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Assessing payment adequacy and updating payments: Hospital inpatient and outpatient services; and Mandated report: Expanding the post-acute transfer policy to hospice

Alison Binkowski, Jeff Stensland, Dan Zabinski, Ledia Tabor, Carolyn San Soucie, Kim Neuman

Presentation

Overview

As they did in December, staff reviewed MedPAC's payment adequacy framework for hospitals used to update the commission's recommendation for inpatient prospective payment system (IPPS) and outpatient prospective payment system (OPPS) base rates. Staff again noted that temporary or highly variable coronavirus effects are best addressed through targeted, short-term funding policies rather than permanent changes to all providers' payment rates in 2022 and future years.

Overall, staff noted that current payment adequacy indicators for hospitals are generally positive as noted in the table below:

Beneficiaries' access to care	Quality of care	Hospitals' access to capital	Medicare payments and hospitals' costs
• Occupancy stable in 2019 • Positive marginal profit • Fewer closures in 2020 • Continued shift to outpatient	• Risk-adjusted mortality and readmissions improved modestly • Patient experience stable	• All-payer margin at record high • Construction, bonds, acquisitions, and employment all strong	• Medicare margin still negative but improved • Efficient provider margin near zero • Projected margin to improve in 2021
Generally positive	Positive	Positive	Mixed

Staff also noted that, since the December meeting, CMS reduced its forecast of 2022 updates to hospital rates under current law and the suspension of sequestration was extended, which affects the Commission's projections of hospitals' Medicare margin in 2021. ***Staff estimate that IPPS hospitals' overall Medicare margins will increase from -8.7 percent in 2019 to -6 percent in 2021.***

Pursuant to a statutory mandate, staff also provided analysis of the effect of expanding the hospital transfer policy to include transfers to hospice. Staff explained that the post-acute care (PAC) transfer policy reduces IPPS payments for short stays followed by a transfer to PAC, and that hospice was added to the list of PAC settings to which the policy applies. The result of the expanded policy is savings to the Medicare program (about $300M in FY 2019) with no evidence of discernable changes in timely access to hospice care.

Commissioners reviewed the findings and voted on the draft payment update recommendation.

Chairman's Recommendation

By **unanimous consent**, the Commission voted in **support** of the following recommendation:

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For fiscal year 2022, the Congress should update the 2021 Medicare base payment rates for acute care hospitals by 2 percent.

Implications:

- Spending:
    - Annual update:
        - Inpatient: 2% update + 0.5% statutory increase = 2.5%
        - Outpatient: 2% update
    - Plus standing HVIP recommendation and removal of penalty-only programs
        - Inpatient + 0.8% = 3.3% (above current law)
        - Outpatient + 0.0% = (unaffected by HVIP) = 2% (below current law)
- Beneficiary and provider: Should not affect beneficiaries' access to and care or providers' willingness and ability to furnish care

Commission Comments

Commissioner Riley expressed concern about the impact on the pandemic on hospital finances as they related to safety net hospitals and staffing, particularly nurses.

Commissioner Pyenson is hopeful that MedPAC's recommendation for a hospital value incentive program (HVIP) will be implemented, but generally concerned there is an upside that was not the intent of the Commission.

Commissioner Perlin suggested the pandemic will forever change healthcare and that the durable effects will leave providers wounded. He noted concerns, including the garnishment of hospitals due to the accelerated payments.

Assessing payment adequacy and updating payments: Physician and other health professional services

Ariel Winter, Rachel Burton, Geoff Gerhardt, Ledia Tabor

Presentation

Overview

As they did in December, staff reviewed MedPAC's payment adequacy indicators for Medicare clinicians paid under the Medicare physician fee schedule, noting that current law provides no update to base payment rates. However, they highlighted clinicians ability to earn incentive payments under the Quality Payment Program (QPP) (i.e., MIPS and APMs).

Following up on Commissioner questions during the December meeting, staff provided an analysis of access-to-care broken out by age cohorts, nothing that older beneficiaries (80s or older) are less likely to be dissatisfied with care, have difficulty finding a new primary care provider, or forego care during the pandemic. Staff also noted that, after dropping sharply in the spring, volume of primary care visits and other services largely recovered in the summer and remained steady through November. They also noted that clinicians' revenues for privately insured were above last year's levels in July-October.

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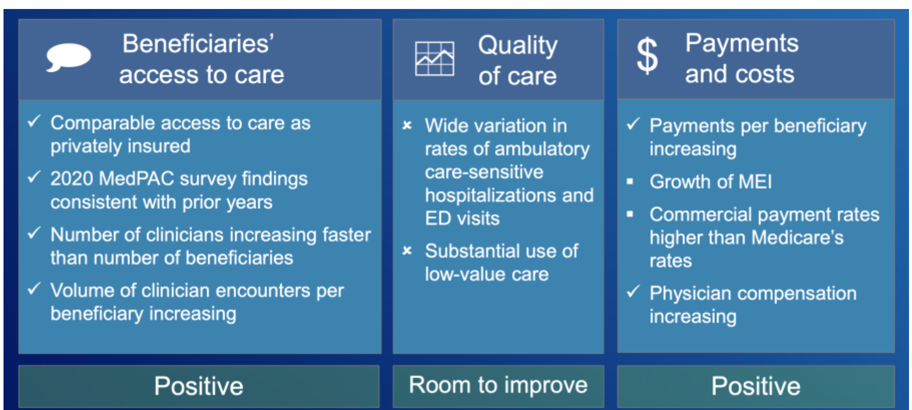
Staff then highlighted prior recommendations and work associated with primary care issues and site-neutral payments.

In sum, staff noted that current payment adequacy indicators are generally positive as noted in the table below.



Chairman's Recommendation

By **unanimous consent**, the Commission voted in **support** of the following recommendation:

> ***For calendar year 2022, the Congress should update the 2021 Medicare payment rates for physician and other health professional services by the amounts determined under current law.***

Implications:

- Spending: No change compared with current law
- Beneficiary and provider: Should not affect beneficiaries' access to and care or providers' willingness and ability to furnish care

Commission Discussion

Commissioner Rambur said physicians coming out of their training are not looking toward primary care. Instead, she said advanced practicing nurses (APRNs) provide the majority of primary care. She noted that 89.7% of nurses are trained in primary care, but only 69.7% deliver primary care. She noted that some are working in specialties that are more lucrative, but also that many are in hospice. She urged more focus on those delivering primary care, to include removing incident-to billing "so we know who is delivering the care."

Commissioner Casalino emphasized the optics of not recommending an update, noting that it won't sit well with the physician labor force and advanced practitioners. He remains concerned that the recommendation reliance on the MIPS is not good, particularly since "nobody thinks the MIPS program is good." He suggested looking at site-neutrality again when the lawsuits are over.

Commissioner Navanthe agreed that ongoing work should consider MIPS, and specifically, ways to remove MIPS. He suggested the program for physicians should be more like the Commission's recommendation for the HVIP for hospitals. He also asked, if MIPS were to stop, how would the PFS be updated.

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Chairman Chernew explained that, using the historic metrics for payment adequacy, things are "okay" for clinicians, but that doesn't mean we shouldn't think about workforce, MIPS and other issues that were raised.

Assessing payment adequacy and updating payments: Ambulatory surgical center services; Outpatient dialysis services; Hospice services

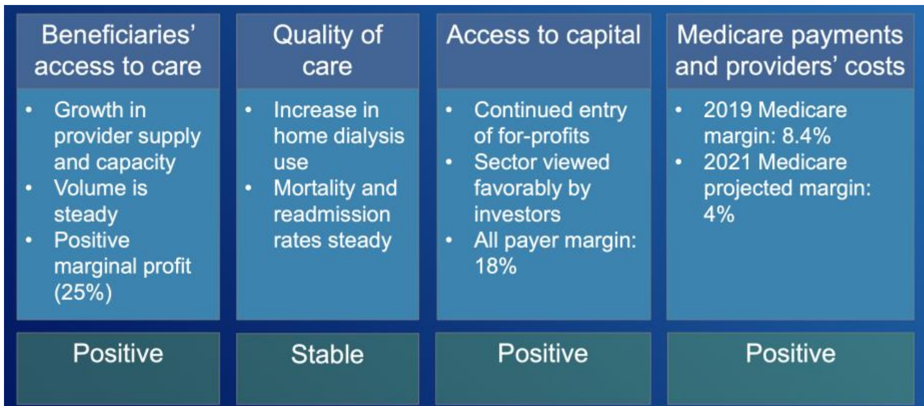
Dan Zabinski, Nancy Ray, Andy Johnson, Kim Neuman

Presentation

Overview

Ambulatory Surgical Centers: Consistent with their December findings, staff noted that measures of access remain strong for ambulatory surgical centers (ASCs), with access to ASC services and payments per beneficiary increasing based on 2019 data. They also noted that access to capital remained adequate and quality was largely unchanged. Staff reminded Commissioner's about the lack of cost data and its prior recommendation that ASCs be required to submit cost data.

Outpatient Dialysis Services: Staff noted that current payment adequacy indicators for hospitals are generally positive as noted in the table below:



Beneficiaries' access to care	Quality of care	Access to capital	Medicare payments and providers' costs
• Growth in provider supply and capacity • Volume is steady • Positive marginal profit (25%)	• Increase in home dialysis use • Mortality and readmission rates steady	• Continued entry of for-profits • Sector viewed favorably by investors • All payer margin: 18%	• 2019 Medicare margin: 8.4% • 2021 Medicare projected margin: 4%
Positive	Stable	Positive	Positive

Hospice Services: Staff noted that current payment adequacy indicators for hospitals are generally positive as noted in the table below:

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Beneficiaries' access to care	Quality of care	Hospices' access to capital	Medicare payments and hospices' costs
• Growth in provider supply • Growth in volume (use rates, ALOS) • Positive marginal profits (16%)	• Process measures topped out • Visits at end-of-life up slightly • CAHPS stable • OIG identified subgroup of poor performers	• Continued entry of for-profits • Sector viewed favorably by investors • Provider-based have access via parent provider	• 2018 Medicare margin: 12.4% • 2021 projected margin: 13%
Positive	Mostly positive; limited measures	Positive	Positive

Chairman's Recommendations

By **unanimous consent**, the Commission voted in **support** of the following recommendations:

Ambulatory Surgical Centers

For calendar year 2022, the Congress should eliminate the update to the 2021 conversion factor for ambulatory surgical centers.

Implications:

- Spending: Decrease relative to current law by $50 million to $250 million over 1 year and less than $1 billion over 5 years
- Beneficiary and provider: Not expected to diminish beneficiary access to services or ASCs' willingness/ability to furnish services

The Secretary should require ambulatory surgical centers to report cost data.

Implications:

- Spending: No direct effect
- Beneficiary and provider: Not expected to diminish beneficiary access to services or ASCs' willingness/ability to furnish services. May add some administrative costs for ASCs.

Outpatient Dialysis Services

Change from December: *For calendar year 2022, the Congress should eliminate the update to the 2021 Medicare end-stage renal disease prospective payment system base rate.*

Implications:

- Spending: Decrease relative to current law of $50 to $250 million over 1 year and $1B to $5B over 5 years
- Beneficiary and provider:
  - Beneficiaries expected to continue to have good access to outpatient dialysis care
  - Continued provider willingness and ability to care for Medicare beneficiaries

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Hospice Services

The Congress should:

- ***For fiscal year 2022, eliminate the update to the 2021 Medicare base payment rates for hospice, and***
- ***Wage adjust and reduce the hospice aggregate cap by 20 percent.***

Implications:

- Spending: Decrease relative to current law of $750M to $2B over 1 year and $5B to $10B over five years.
- Beneficiary and provider:
  - We expect beneficiaries to continue to have good access to hospice care
  - Continued provider willingness and ability to care for Medicare beneficiaries

Commission Discussion

Commissioner DeBusk urged future study of the growth in ASCs, which he noted is "alarmingly slow." He said there is 46% savings as a result of moving to ASCs, which is 10-20 times the savings.

Commissioner Wang noted that, for vertically integrated organizations, the Medicare cost report is not giving us the right view. She said more context is needed going forward to better understand the total picture and the impact on finances. ***Chairman Chernew*** said this is something that keeps folks up at night and that we need to figure this out.

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, Evan Christman, Jamila Torain, Kathryn Linehan

Presentation

Overview

Skilled Nursing Facilities: As noted in December, Skilled Nursing Facility (SNF) payment adequacy indicators are positive, as outlined in the table below:

Beneficiaries' access to care	Quality of care	SNFs' access to capital	Medicare payments and SNFs' costs
• Stable supply • Volume declines do not reflect adequacy of payments • High marginal profit (~20%)	• Small improvements in the rates of successful discharge to community and hospitalization	• Adequate access to capital • Low total margins (0.6%) reflect lower payments from other payers	• 2019 Medicare margin was 11.3% • Efficient provider margin in 2019 was 19.2% • Projected 2021 margin: 10%
Positive	Positive	Positive	Positive

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Home Health Agencies: Staff noted that current payment adequacy indicators for home health are positive as noted in the table below:

Beneficiaries' access to care	Quality of care	Access to capital	Medicare payments and HHA costs
➢ 99 percent live in a ZIP code with at least one HHA available ➢ Episode volume decreased; unrelated to payment ➢ Positive marginal profit (18%)	➢ Rates of successful discharge increased ➢ Small decline in hospitalizations	➢ Positive all-payer profit margin (5.9%) ➢ Large for-profits continue to have access to capital	➢ 15.8% Medicare margin in 2019 (efficient provider over 23%) ➢ Projected margin estimated to equal 14% in 2021
Positive	Positive	Positive	Positive

Inpatient Rehabilitation Facilities: Staff noted that current payment adequacy indicators for inpatient rehabilitation facilities (IRF) are positive as noted in the table below:

Beneficiaries' access to care	Quality of care	IRFs' access to capital	Medicare payments and IRFs' costs
➢ Capacity appears adequate ➢ Increase in volume ➢ High marginal profit ➢ FS: 40% ➢ HB: 19%	➢ Risk-adjusted outcome measures relatively stable since 2015	➢ IRFs maintain good access to capital markets ➢ The all-payer margin for freestanding IRFs is a robust 10.4%	➢ In 2019, the aggregate Medicare margin was 14.3% ➢ We project a margin of 16% in 2021
Positive	Positive	Positive	Positive

Long-Term Care Hospitals: Staff noted that current payment adequacy indicators for long-term care hospitals (LTCHs) are as expected in light of payment changes (see table below):

Beneficiaries' access to care	Quality of care	Access to capital	Medicare payments and costs
➢ Occupancy rate steady ➢ Share of cases meeting criteria increased ➢ Supply decreased ➢ Marginal profits adequate	➢ Stable mortality rates (unadjusted) ➢ Stable hospitalizations, slight decline in discharge to community (risk-adjusted)	➢ Industry contraction reduced the need for capital ➢ All-payer margin declined slightly from 2018	➢ Medicare margin for LTCHs with a high share of cases meeting the LTCH PPS criteria: 2.9 percent ➢ Projected 2021 margin: 2 percent
As expected, given changes in payment system	Mixed	As expected, given changes in payment system	Positive

Chairman's Recommendations

By **unanimous consent**, the Commission voted in **support** of the following recommendations:

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Skilled Nursing Facilities

For calendar year 2022, the Congress should eliminate the update to the 2021 Medicare base payment rates for skilled nursing facilities.

Implications:

- Spending: Relative to current law, spending would decrease between $750 million and $2 billion for FY 2022 and between $1 billion and $5 billion over five years.
- Beneficiary and provider: Given the high level of Medicare's payments, we do not expect adverse impacts on beneficiaries. Providers should continue to be willing and able to treat beneficiaries.

Home Health Agencies

For calendar year 2022, the Congress should reduce the 2021 Medicare base payment rate for home health agencies by 5 percent.

Implications:

- Spending: Decrease relative to current law by $750 million to $2 billion in 2022 and over $10 billion over 5 years.
- Beneficiary and provider: We expect access to care will remain adequate; should not affect the willingness of providers to serve beneficiaries; but may increase cost pressure for some providers.

Inpatient Rehabilitation Facilities

For fiscal year 2022, the Congress should reduce the 2021 Medicare base payment rate for inpatient rehabilitation facilities by 5 percent.

Implications:

- Spending: Relative to current law, spending would decrease by between $750 million and $2 billion in 2022; and by between $5 billion and $10 billion over five years.
- Beneficiary and provider: No adverse effect on Medicare beneficiaries' access to care. May increase financial pressure on some providers.

Long-Term Care Hospitals

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

Implications:

- Spending: Relative to current law, Medicare spending would decrease by less than $50 million in 2022 and by less than $1 billion over five years.
- Beneficiary and provider: No adverse effect on Medicare beneficiary access to care. Not expected to affect provider willingness and ability to care for Medicare beneficiaries who meet the criteria.

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Commission Discussion

Commissioner Grabowski expressed concern about pandemic's lasting impact on SNFs and their providers, particularly given his observation of a significant shift to home health. He urged the Commission to monitor the change and the implications.

Commissioner Wang asked about IRF update, noting the impact of case mix. She noted that, in modeling PAC PPS, hospital and non-profit would go up given mix of patients and away from rehab-only patients. She said this underscores the need for broader payment reform in the PAC PPS. ***Executive Director Mathews*** noted that efforts to minimize differences by case type in IRF was implemented by CMS this year, and that we may see some mitigation over time.

CMMI's development and implementation of alternative payment models (APMs)

Geoff Gerhardt, Rachel Burton

Presentation

Overview

Staff provided an overview of the Center for Medicare and Medicaid Innovation (CMMI), including information on model impacts and barriers to model success. To begin, CMMI was established by the Affordable Care Act of 2010 to test innovative payment and delivery models that will reduce program spending and/or improve quality. CMMI received $10 billion in funding every 10 years into perpetuity. Most models run 3 – 5 years, but they may be expanded if the model is expected to decrease spending without decreasing quality of care or to increase quality without increasing spending. Staff then discussed the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which created a 5 percent bonus for clinicians who significantly participate in advanced APMs (A-APM). MACRA also established the Physician-Focused Payment Model Technical Advisory Committee (PTAC), which assesses models submitted by the public and recommends whether to implement the models to the HHS Secretary; CMS has not implemented any PTAC-recommended models to date.

To elaborate on CMS' strategic goals for alternative payment models (APMs), staff noted that CMMI funds the Healthcare Payment Learning & Action Network (the LAN) to encourage broad adoption of APMs. Over the years, the LAN has promoted specific goals for APMs and APM adoption, including pushing towards two-sided risk and partial and full capitation models. HHS also has three stated objectives for CMMI's APMs, that is that they be:

- Transparent – empowering consumers to drive value through choice
- Simple – focusing on measuring factors that matter rather than "check the box" requirements
- Accountable – encouraging risk and accountability to align incentives and drive behavior change.

CMS also considers the 20 factors listed on slide 7, including a model's potential for cost savings and quality improvement, strength of evidence base, extent of clinical transformation, overlap with current and anticipated models, feasibility of evaluating, and scalability.

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CMS has used the goals, objectives, and factors noted above to develop dozens of payment models over its first 10 years. In 2020, CMMI was actively operating 24 payment and delivery models, only 7 of which were designated as A-APMs. And historically, only four models have been certified as meeting the criteria for model expansion, and only one was an A-APM (Pioneer ACOs). The largest A-APM (the Medicare Shared Savings Program) is a permanent program, not operated by CMMI.

Staff reviewed the most recent evaluation reports for each of the 7 A-APMs and their predecessor models (15 models in total). Nine of the models generated gross savings; five also generated net savings; and seven models generated improvements on quality measures.

Staff discussed potential barriers that may be preventing models from having greater impact, including the following:

- Providers in APMs may continue to have incentives to maximize utilization
- Models' incentives can be hard for providers to understand
- Clinicians' employment arrangements may shield them from models' incentives
- Lack of alignment and integration between models
- Voluntary models may be subject to selection bias
- Beneficiaries' incentives may not align with models' goals

To increase the impact of CMS models, staff raised three policy options related to CMMI's management of models for consideration, and identified pros and cons listed below:

- Option 1: Implement a smaller suite of coordinated models designed to support a clear set of strategic goals
    - Pros: This would encourage CMMI to create a system of models that actively support one another, instead of separate one-off models and could reduce unintended interactions between models
    - Cons: This option would decrease the diversity of models being tested (decreasing the chances of finding models that work), and it could constrain CMMI's ability to implement models tailored to subgroups
- Option 2: Only develop second-generation models when specified criteria demonstrating promise have been met. Could include clear evidence-based metrics, including around spending and outcome measures.
    - Pros: This option would make CMMI's decisions about model relaunches more transparent and objective and would discourage CMMI from relaunching versions of models that have consistently failed to meet performance criteria.
    - Cons: This could create incentive for CMMI to focus on models that will meet continuation criteria and divert attention away from statutory criteria for expansion, and it might not provide CMMI with sufficient time or flexibility to fully test potential promising approaches.
- Option 3: Reduce or eliminate changes to models' features once they are in the field. This could include completely freezing models' features once they are in the field; only making minor technical fixes to models once they are in the field; or launching updated versions of models in subsequent provider cohorts.
    - Pros: This option would reduce provider administrative burden involved in keeping track of changes to models and adjusting plans accordingly and could encourage providers to make investments in care transformation infrastructure.
    - Cons: Under this option, more providers might exit models if flaws discovered during

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implementation are not fixed (leading to reduced participation); and this option might increase spending or other negative effects if problems with models cannot be fixed.

Staff requested input on the three policy options listed above. Any policy options of interest will be presented for further consideration this spring.

Commission Discussion

Overall Strategic Approach.

- ***Chair Chernew*** noted that the discussion would focus on traditional Medicare, and is likely to contribute a multi-cycle undertaking.
- ***Commissioner Navathe*** expressed general support for "expanding the aperture" for viewing APMs. He noted that this work is broader than CMMI and addresses Medicare payment reform more broadly, also noting that many programs, notably MSSP, are not under CMMI. He also expressed the need to revisit the Commission's principles for value-based payment, and to develop a strategic plan for CMMI. He noted that while he is supportive of the three policy options, there is much more underlying how the policy options would play out and that there are many factors that need to be considered (e.g. risk adjustment, mandatory participation, etc.). ***Commissioner Jaffery*** likewise noted challenges around setting benchmarks, which has an impact on measuring savings. ***Commissioner Navathe*** also suggested developing criteria that CMMI could use to develop and cancel models.
- ***Commissioner Navathe*** noted his belief that the Commission is missing equity as a focus of APMs. The Commission could recommend adding language to the statute focused on health equity, which has an impact on health quality. Equity is an important focus that should not be left behind. ***Chair Chernew, Vice Chair Ginsburg, and Commissioner Wang*** voiced support the inclusion of an equity goal. Commissioner Wang suggested evaluating models for their equity impacts.
- ***Commissioner Jaffery*** expressed concern that there is not an overall vision for CMMI. ***Commissioner Pyenson*** also suggested that CMS needs a clear set of strategic goals, and MedPAC can help to develop those. He noted that the quality of thinking that has come out of CMMI is much better than what private payers demonstrate, but CMMI also has about a billion dollars a year to do its work. Strategic goals are needed to optimize CMMI's work.
- ***Commissioner Pyenson*** noted that the three policy options may not be the right ones. ***Executive Director Mathews*** noted that these three policy options had support among Commissioners during the October meeting, so was surprised to hear ***Commissioner Pyenson's*** comment. ***Commissioner Pyenson*** responded that these three options generated additional thinking and noted interest in developing strategic goals.
- ***Chair Chernew*** noted that he was hearing from the discussion that the Commission needs a system of payment models that will help achieve cost and quality goals and move away from the current "test, test, test" posture. The strategic goals will likely align with the Commission's overarching goals regarding cost, access, and quality. ***Commissioner Casalino*** noted that the paradigm of "launch, test, launch, test" is promoted by the incentive structure for CMMI employees.
- ***Commissioner Wang*** noted that, if the goal is delivery system reform, there are not consistent signals to the delivery system, for example to states for payment reforms conducted through Medicaid 1115 waivers. She suggested that the Commission should consider recommending that signals to the delivery system are consistent and intentional across all CMMI models, and that the

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Medicaid side of CMS should also have these in mind. If quality metrics were the same, and if the end expectations were the same, it would go a long way for moving the needle for the entire delivery system. ***Commissioner Pyenson*** also suggested that strategic thinking should also incorporate the non-Medicare population.
- *Chair Chernew* noted his hope that this cycle, the Commission can get to a paradigm shift recommendation, and after that there will be more strategic concrete recommendations in future cycles.

CMS Accomplishments.
- *Commissioner Safran* noted that APMs represent a significant accomplishment that should not be undersold. She contrasted APMs against Medicare Advantage (MA), which still has not produced savings. In addition, she noted that there has always been controversy around gross versus net savings, but noted that when there are gross savings, behavior is changing. She noted that other interventions are not changing behavior. Gross savings suggest that APMs are pointing in the right direction. ***Commissioner Casalino*** agreed.
- *Commissioner Casalino* noted that CMMI has "organized an atmosphere" to make it clear that change is coming and has supported development of infrastructure to lead to better results.

Policy Option 1: implementing a Smaller Suite of Coordinated Models
- Many Commissioners supported this policy option *(**Jaffery, DeBusk, Rambur, Ryu, Casalino, Safran**)*.
- *Chair Chernew* noted that CMS needs to innovate, but that overlap may create significant challenges. The Commission needs to think about this in the context of policy option 1. *Commissioner Thompson* also agreed that clarity around overlap was needed.
- *Vice Chair Ginsburg* noted that he sees this policy option as a strategy, while the other two are tactics that should not get as much attention.
- *Commissioner Jaffery* noted concern about the number of models, but also mentioned that PTAC may contribute to increasing the number of models and may complicate things.
- *Commissioner Jaffery* noted that additional work is needed to harmonize models, noting that 20 percent of Medicare FFS beneficiaries are in MSSP. He also noted challenges in understanding overlap across models. Several other Commissioners also supported model harmonization (Grabowski, Ryu, Safran). ***Commissioner Safran*** also recommended bringing in Medicare Advantage, e.g. to harmonize on risk adjustment and benchmarks and quality measurement.
- *Commissioner DeBusk* agreed that fewer models are needed, but everyone will likely think that their model should not be cut. He suggested that standardizing aspects (e.g. waivers) so they will not vary from model to model could be helpful. Additionally, he suggested that there could be three categories of models – episode-based models, accountable care models, and primary care or chronic care; if a new model is launched in one of those buckets, but with standardization, that could help create certainty.
- *Commissioner Rambur* supported a smaller set of models paired with "unrelenting momentum" towards mandatory models with substantial risk sharing.
- *Commissioner Thompson* expressed some conflict since CMMI was intended to come up with a number of models. She noted that 6 percent of ideas come to fruition. Limiting the number of models could create potential challenges with innovation. She expressed a need to be thoughtful.

Policy Option 2: Limiting development of second-generation models
- *Commissioner Jaffery* noted complications around thinking of models as second-generation

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models versus new models, and *Commissioner DeBusk* generally agreed.
- ***Commissioner Wang*** hoped that the second and third models become less volatile.
- ***Commissioner Safran*** expressed mixed support for this option.
- Commissioner Casalino expressed reservations about putting constraints on CMMI under this option. He would prefer to give CMMI cover and ideas for strategic direction, more than narrow constraints.

Policy Option 3: Reducing or eliminating changes to models' features
- ***Commissioner Jaffery*** agreed that changes to models increase complexity and burden.
- ***Commissioner Jaffery*** suggested the need to flesh out how to think about reducing changes to models, but agreed that model changes lead to disruption participants. Sometimes significant changes are required in very short timeframes.
- ***Commissioner DeBusk*** proposed adopting practices similar to Part D mid-year formulary changes, which allows for beneficial changes but not negative changes. If a model needs significant changes to maintain solvency, perhaps models should just be cancelled.
- ***Commissioner Grabowski*** also suggested that CMS should be more deliberate around any changes made to models.
- ***Commissioner Ryu*** noted that there is a need to be nimble, so a balance is needed to course correct as the models proceed.
- ***Commissioner Wang*** noted some reservations with this option since course corrections may be needed, but also expressed hope that the need for such changes would be reduced if policy option 1 is successful. ***Commissioner Thompson*** also expressed caution in supporting this option.
- ***Commissioner Safran*** noted that some changes are needed at times, including to mitigate struggles for participants, but they should not be planned at the outset. She also noted support for limiting substantial changes within cohorts and implementing changes on a cohort basis.

Barriers to Model Success.
- ***Commissioner Safran*** noted that many organizations have mixed incentives, and there has also been more and more consolidation, so volume incentives continue to apply. These mixed incentives need to be addressed.
- ***Commissioner Safran*** noted that there has been a lot considered about different features of models and what does and does not work. She highlighted the need to be able to synthesize lessons learned across models: 1-sided versus 2-sided risk; physician versus hospital led; single versus multi-payer; total cost of care versus episodes. Getting this analysis will help address barriers to success.
- ***Commissioner Pyenson*** noted that there has not been much work on scale and scalability. Specifically, what size organization is needed to have the resources to succeed, including dedicated leadership and time and expertise? The GEO Direct Contracting model may be more successful since it requires significant scale.

Mandatory Models.
- ***Commissioner Jaffery*** noted support for expanding mandatory models.
- ***Chair Chernew*** suggested that the Commission is not ready to discussion mandatory models yet, since more analysis and better information are needed on what should be mandated.

Additional Topics.

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- *Vice Chair Ginsburg* asked whether CMMI authorizing statute is restrictive on CMS' ability to move a model to a more successful iteration. Staff noted that the authorizing legislation gives CMS great leeway for testing models and does not include many parameters around how CMS designs and implements models. The restrictions occur with respect to expanding models, requiring certification by the Office of the Actuary.
- ***Commissioner Ginsburg*** asked about the extent to which physicians are both in FFS Medicare and MA. If physicians are under both, what they do under MA may influence what they do under FFS. This could influence the potential success of the models. ***Chair Chernew*** offered that most physicians are in both FFS and MA, with a few exceptions such as Kaiser. There is also spillover in physician practice patterns, so what MA does will spillover to FFS and vice versa.
- ***Commissioner Casalino*** asked whether CMMI has the authority to make a model permanent and mandatory for all eligible providers. Staff noted that models can be expanded on a mandatory basis and provided the Home Health Value-based Purchasing Program as an example.
- ***Commissioner Thompson*** asked how many providers have participated in models over the years and what we know about their characteristics. She noted that, as there is effort to move to value, information on growth in participation is needed. Staff noted that we know how many providers are in each model, and usually evaluation reports provide some descriptive statistics. However, we do not know how many providers have ever been in any model, since participation is typically not tracked across models.
- ***Commissioner Jaffery*** noted that stakeholders may have concerns about participating in the PTAC process when models are not implemented.
- ***Commissioner Casalino*** asked if is possible for a researcher to study models independently from CMS, based on information that CMS makes publicly available (e.g. NPI-level data). Staff noted that for many programs, CMS does post participation lists, but not always (e.g. the Comprehensive Primary Care Plus model). In such cases, it is very difficult to get access to such data. ***Chairman Chernew*** noted that he has done his own independent research, noting that population-based models tend to save money, on net; episode-based models can achieve some savings for certain types of episodes; and advanced primary care models are a more challenging area.
- ***Commissioner Grabowski*** noted that some of the changes to MSSP have not been beneficial or always clear.
- ***Commissioner Ryu*** noted that better visibility into how MA plans work with providers would be beneficial.
- ***Commissioner Safran*** noted the importance of the next generation of quality measures. She noted broad support for moving towards a more outcomes-oriented system, but noted that there has not been much progress on outcome measures.
- ***Commissioner Safran*** differentiated between global budgets and global payment. While capitated payment aligns incentives, it minimizes access to claims data, so something needs to be done to continue to get that data.
- ***Commissioner Casalino*** noted that CMS' goal for transparency is something that requires attention. Models are not transparent. The size of incentives are not large, and there are conflicting incentives.
- ***Commissioner Pyenson*** suggested that models should consider benefits to providers, beyond just shared savings. Providers may gain benefit from changing behaviors and expanding their markets. Assessments by CMMI should consider these types of benefits.

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Telehealth in Medicare after the public health emergency

Ariel Winter, Ledia Tabor

Presentation

Overview

Staff provided information on the current public health emergency (PHE), and how Medicare has rapidly expanded telehealth in response, leading to rapid adoption. Advocates assert that telehealth expands access to care and can reduce costs. Others contend that telehealth has the potential to increase use and spending. In addition, telehealth has recently been implicated in several large fraud cases related to the ordering of durable medical equipment (DME) and cancer genetic tests. Moreover, current evidence on how telehealth services impact quality of care is limited and mixed. A key issue is how to achieve the benefits of telehealth while limiting the risks.

Staff presented policy options for expanding telehealth that were intended to reflect Commissioners' views from previous discussions and sought confirmation from Commissioners on their support, for inclusion in the March Report to Congress. Overall the policy options presented seek to balance beneficiary choice and access with protecting program integrity. They also assume that policymakers will continue to gather more information about telehealth during the PHE. Staff also noted that CMS has authority to offer waivers to clinicians participating in A-APMs, which staff assumed CMS will continue to exercise. The policy options are detailed below.

Policy Option. Cover certain telehealth services provided to all beneficiaries and to beneficiaries at home. This reflects interest in expanded access, particularly with beneficiaries with chronic conditions. Staff noted that direct-to-consumer telehealth companies would be able to bill for telehealth services for new and established patients, which could improve access but would also raise concerns about care fragmentation.

Policy Option. Cover additional telehealth services when they meet CMS' criteria for an allowable telehealth service. This option would revert to CMS' standard review process for adding services to the list of Medicare telehealth services. Staff suggested that CMS criteria could be modified to explicitly consider how adding the service to the list affects program spending.

Policy Option. Cover certain telehealth services when provided by audio-only interaction if they offer clinical benefit. Audio-only interaction would be allowable for certain telehealth services if CMS determines it offers clinical benefit. CMS should use a process similar to the one it uses to determine whether to pay for a telehealth service.

Policy Option. Cover audio-only evaluation and management (E/M) visits or virtual check-ins for established patients. These services should not be covered if they originate from a related E/M service provided within the previous 7 days or lead to a new E/M visit. These services would not need to go through CMS' review process under this option.

Policy Option. Pay lower rates for telehealth services than for in-person services. Payments should also be lower for audio-only services than for telehealth services. This is because costs are likely lower for telehealth services than in-office services. In the short term, this could be based on facility rates, but in the long-term, CMS should collect data on costs. Audio-only services do not require video technology.

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Policy Option. Require beneficiary cost sharing for telehealth services. The same cost sharing for in-person services should apply. This would reduce the possibility of overuse, but staff also noted that clinicians would not need to bill patients with Medigap.

Policy Option. Include other safeguards to protect Medicare and beneficiaries from unnecessary spending and potential fraud, including the following:

- Apply additional scrutiny to outlier clinicians who bill many more telehealth services than other clinicians. This could include a targeted review of claims to ensure claims meet billing rules.
- Require clinicians to provide an in-person visit before they order high-cost durable medical equipment (DME) and high-cost clinical lab tests.
- Prohibit "incident to" billing for telehealth services provided by any clinician who can bill Medicare directly. This builds on the Commission's 2019 recommendation on "incident to" services and would give CMS more information about clinicians who furnish services via telehealth.
- Require clinicians who bill "incident to" services to provide direct supervision in person instead of virtually. Virtual supervision could lead to safety and cost concerns.

Staff sought input from Commissioners on these options. ***Chair Chernew***, however, noted today's discussion would not lead to draft recommendations. Rather, Commissioners' input will be important for understanding where the Commission is and incorporating into the March Report to Congress. He noted hope that over the next several months, the Commission could reach a rough consensus on its position for the purposes of engaging with the Hill and other policymakers. ***Executive Director Mathews*** agreed with this characterization.

Commission Discussion

General Comments.

- *Commissioner Perlin* noted the need to figure out what is waste and what is value and suggested that it would be retrogressive to throw out all the progress made. There may be an opportunity for an advisory panel to determine which services are of benefit. He noted that many of the technologies are part of the environment and part of personal interaction at this time. He suggested that there may be some sort of ratio of in-person versus virtual visits and contemplated whether there was a staffing solution that a provider could incorporate.
- *Commissioner DeSalvo* noted that there is a lot of interest in leveraging technology and virtual services, but also that that it will be difficult to move forward on a FFS chassis. She suggested that thinking about global budgeting and holding providers accountable for total cost of care will be increasingly important as these technologies come on the market.
- *Chair Chernew* agreed that telehealth services could provide tremendous value, but noted that opening the door could lead to a lot of undesirable things flooding through. Part of the complexity here is why the Commission will not make recommendations. As such, he noted that more of this work will continue into future cycles.
- *Commissioner Wang* noted tension between excitement about innovation and technology, but also concern about the potential for fraud and abuse. This may become like urgent care again, where there is payment for duplicative, fragmented services, rather than increased coordinated care. She suggested that it would be good to frame the role of telehealth in the Medicare system and then how we pay for it. She worried about disturbing the primary care physician relationship

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and breaking the feedback loop to primary care providers when patients receive care through telehealth companies. She noted the need to be careful about how to move forward.
- *Commissioner Casalino* agreed with Commissioner Wang. Many of the Commissioners have concerns about fragmentation, but he did not want to prejudge the value that that telehealth services may give. He also agreed with all the policy options except the second incident to recommendation, which he believes requires additional discussion.

Payment Differentials.
- *Commissioner Jaffery* asked about payment for visits that start with video but then convert to audio-only. Staff indicated their expectation that such payments would receive the lower audio-only level of payment.
- *Commissioner Casalino* agreed that higher payments might be appropriate for video visits relative to audio-only visits, but if there are higher costs, it could discriminate against beneficiaries who are blind, or beneficiaries who may have trouble with video visits.
- *Commissioner Safran* raised also concerns about lower rates for audio-only services as it could lead to disparities in care for patients who do not have access to broadband. Instead, she suggested that there could be differences in payment for services that require or do not require visual inspection.
- *Commissioner Jaffery* also raised concerns about the payment differential between video and audio-only telehealth. He suggested perhaps requiring both and offering a site-neutral payment.
- *Commissioner Safran* expressed concern with lower payment rates for telehealth relative to in-person services, which could drive a shift away from telehealth at a critical time when patients are becoming more accustomed to the use of telehealth. She agreed that there were also risks with increased spending, so this would be difficult to address.

Direct-to-Consumer Practices
- *Commissioner Casalino* expressed concerns with paying direct-to-consumer providers the same as other types of providers. He indicated that without brick-and-mortar care, these providers' expenses are significantly lower, and they will drive brick-and-mortar offices out of business. *Commissioner Safran* also expressed concern around direct-to-consumer arrangements and the potential negative impact it could have on continuity of care. She therefore believed the Commission would need to differentiate those providers from others.
- *Commissioner Perlin* noted that there could be circumventions about whether services are considered outside or inside of brick-and-mortar entity since the nature of practice is changing. *Commissioner Casalino* agreed with this concern.
- *Vice Chair Ginsburg* noted that if there is value in continuing brick-and-mortar practice, there are ways of making the distinction (including use of claims data) to determine use of telehealth. As such, a lower rate for the virtual-only practice may be appropriate.

Telehealth in the Context of APMs.
- *Commissioner Navathe* asked whether A-APM flexibility was deliberately set aside or not. Staff indicated that AAPM flexibilities were set aside for now based on guidance from Commissioners in the September meeting. Additionally, CMMI already has flexibility to provide waivers to APMs, so it did not seem necessary to focus on A-APMs. ***Chair Chernew*** also noted that there were also questions about whether the flexibility was for just the APM provider, the APM patient, or the APM provider furnishing services to the APM patient, all of which created some complexity. This, paired with CMMI authority, led the staff to focus on recommendations for Original Medicare.

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- *Commissioner Jaffery* noted that expanded use of telehealth has been a carrot for APMs. It may be useful to understand why APMs have not taken greater advantage. ***Chair Chernew*** noted that APMs can do what they want, but they may not get paid for all the services they furnish. He noted that it is tricky when you have a fragmented system and providers outside the ACO may have access to the flexibilities.

Implementation of Policies on a Temporary Basis.

- *Chair Chernew* agreed with concerns about the potential for abuse and suggested that policies should be put into place on a temporary basis until there is a full review.
- *Commissioner Ginsburg* noted that the Commission looked at telehealth in 2018 to see if it should be expanded. The report at the time did not make recommendations about specific telehealth services. Instead, it said that policymakers should cautiously expand telehealth, balancing cost, access, and quality, and that when evidence is lacking, policy makers should consider pilot testing these services before adoption. She did not believe the PHE counted as pilot testing. She recommended that the changes be offered on a pilot testing basis, rather than as a permanent change. Telehealth could explode into substantial fraud and abuse.
- Several Commissioners (*Casalino, Pyenson, Vice Chair Ginsburg, Rambur*) agreed with providing greater flexibility on a temporary basis, rather than permanent basis, with some suggesting a two-year limit.

Additional Topics.

- *Commissioner Casalino* noted that while there is a role for virtual check-ins, the limits on prior or follow-up visits suggests a profound misunderstanding of how care is delivered. He noted that quick follow-up care is appropriate and high quality, and for virtual visits to prohibit follow-up care within the following 7 days of a visit is. He noted that "good physicians" conduct follow-up in this manner and have not been paid for it for years. He also noted that such a follow-up phone call may eliminate the need for a follow-up visit, or may lead to a necessary visit that would otherwise not have happened. He therefore expressed opposition against that CMS restriction for virtual check-ins. *Commissioner Riley* supported these comments.
- *Commissioner Riley* asked about including potential limits on the number of telehealth visits, which the Commission discussed during the last telehealth discussion. Staff noted that many Commissioners expressed concerns with such an approach, so staff replaced that requirement with the recommendation for additional scrutiny.
- *Commissioner Riley* asked about the threshold for cost of DME that would require an in-person visit, including low-cost items like glucometers. *Commissioner DeBusk* noted that he was not familiar with items like glucometers, but that there can be abuse with discretional items like braces, and that he supported the policy option to require in-person visits.
- *Commissioner Pyenson* noted that technology is changing. He also suggested that some services should not be considered telehealth services. He suggested that the current framework that we have for paying for physician services may not work well, particularly when considering how technology will change the delivery of services. He contemplated a "Medicare Part E" that is paid on a capitated or bid-basis. *Commissioner Perlin* suggested that the ultimate extension use of technology in care delivery without the use of licensed practitioners would be offshore and more commoditized. He noted that the ultimate goal is to improve access to care and quality.
- *Commissioner Rambur* noted did not think patients would miss face-to-face visits given significant benefits of virtual care to patients. She also noted benefits that might further accrue, e.g. RNs supporting families with chronic condition management.

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Summary.

- *Chair Chernew* summarized that while the Commission is supportive of telehealth, it is struggling with how to address potential for fraud and abuse. A couple of ways might be to keep the flexibilities temporary, incorporate some safeguards, and separate different types of providers. Going forward, he noted that the Commission will take this discussion and will try to strike a balance in the chapter.

The Medicare prescription drug program (Part D): Status report

Shinobu Suzuki, Rachel Schmidt, and Eric Rollins

Presentation

Overview

Staff reviewed the goals and the market-based approach of Part D. There are multiple actors in pharmacy benefits: brand drug manufacturers, plan sponsors, pharmacy benefit managers (PBMs), pharmacies, and beneficiaries. Plan sponsors accept insurance risk and own or contract for services of a PBM. Sponsors and PBMs negotiate with pharmacies over payments for prescriptions filled, post-sale fees; and with pharmaceutical manufacturers for rebates on brand-name drugs. By law, the Secretary may not interfere with negotiations among drug manufacturers, pharmacies, and plan sponsors, require a particular formulary, or institute a price structure. Post-sale payments to plans/PBMs from brand manufacturers are made when there are competing therapies and drugs can be excluded from formulary and are used by manufacturers to tailor prices depending on the plan's ability to expand market share. They are generally used by plans to lower premiums. Rebate amounts are highly proprietary; final drug prices are not transparent. There is a growing gap between prices at the pharmacy and net-of-rebate prices. When plans use coinsurance, it is based on pharmacy price. A recent rule from U.S. Department of Health and Human Services (HHS) Office of the Inspector General (OIG) would no longer exempt rebates from the antikickback statute in Part D as of January 1, 2022, but would permit rebates at the point of sale.

Staff reviewed the two distinct defined benefit structures for enrollees with and without the low-income subsidy (LIS).

There has been comparatively less disruption of access to medicines as a result of COVID-19 than to other types of health care. Grocery stores, community, and mail-order pharmacies often remained open during restrictions. Enrollees initially stockpiled supplies, and returned closer to patterns from the previous year by late summer. Medicare's monthly payments to plans during 2020 were based on bids submitted in June 2019.

Staff provided a snapshot of the Part D program: among the 63 million Medicare beneficiaries in 2020, 47 million enrolled in Part D plans; another 1 million received retiree drug subsidy (RDS). Program spending totaled $88.4 billion in 2019. Plan enrollees plaid $13.9 billion in basic premiums and $16.7 billion in cost sharing. Most continue to say they are satisfied with their plan. Enrollment has grown 5 percent per year through 2020. Among all Part D enrollees, average monthly premiums decreased from $30 to $27 in 2020, and there was an increased number of plan offerings for 2021.

Staff reviewed the Center for Medicare and Medicaid Innovation's (CMMI) new Part D Senior Savings model for 2021, which will provide coverage of certain insulins at cost sharing of now more than $35 per one-

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month supply. It is limited to non-LIS beneficiaries who enroll in participating enhanced plans, and allows plans to offer enhanced benefits for insulins without losing manufacturer discounts in the coverage gap. It could improve access and adherence to insulins, but does not address high insulin prices. Enrollees may face higher supplemental premiums.

Overall Part D prices grew more slowly in 2019. Changes in price indexes between 2018 and 2019 varied widely. Prices decreased for classes with new/increased generic competition. Prices continued to rise for therapeutic classes dominated by brand-name drugs or biologics. Medicare's reinsurance continues to be fastest growing part of program spending. 2019 saw the largest ever increase in non-LIS beneficiaries reaching the catastrophic phase.

General program-wide indicators of access show improvements in formulary and coverage decisions. More than 80 percent report their plans provide good value with reasonable cost sharing. However, for beneficiaries without the LIS, access depends on their medication needs.

Staff reviewed the Commission's 2020 recommendations to improve Part D. Future work could include examining rebates and risk adjustment, low-income premium benchmarks, and long-term care pharmacies.

Commission Discussion

Anticipation of Rebate Data

Across the board, commissioners were enthusiastic about examining the issue of rebates in more depth. ***Chairman Chernew*** emphasized how excited he and other commissioners are for MedPAC to look in the rebate data. ***Commissioner DeBusk*** also encouraged staff to continue to dig into the rebate issue – rebates total $28 billion. Rebates influence beneficiary behavior. How much influence does $28 billion buy? This is almost double what is spent on cost-sharing. There are a number of legal challenges to the current rule as it stands, but he supports the idea of dissecting beneficial rebates from punitive rebates – there is a clear distinction between the two, and policy should keep the good while shunning the bad. ***Vice Chairman Ginsburg*** echoed the idea of looking at rebates for future work. ***Commissioner Grabowski*** shares the enthusiasm for getting the rebate data.

Chairman Chernew added that there are a lot of institutional issues related to discounts that are not related to rebates – like 340B. The discrepancy between the price paid to companies and the price charged to patients is an important topic, and MedPAC should continue to dig into this.

Role of Consolidation

Commissioner Pyenson believes that MedPAC should examine the consolidation of the industry in more detail. This is difficult because of both vertical and consolidation in the PBM and Part D industry. Looking at this area could identify where the risk issues are. ***Commissioner Casalino*** agreed with the idea of looking more at concentration, as well as its relationship to rebates (whether the rebate rule would increase concentration). He would also like to learn more about the relationship between plan sponsors and PBMs. ***Commissioner Grabowski*** is also excited to unpack the issue of consolidation.

Other Areas of Interest

Commissioner Grabowski was struck by the shift in spending toward reinsurance. The long-term care pharmacy issue has also been of interest to him for a long time – it is a highly concentrated market and intersects with Part A with really interesting dynamics.

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Commissioner Safran noted that there are not any good measures of the value being produced in this area of coverage. How do we know if the market is working? It could send a good signal if the Centers for Medicare and Medicaid Services (CMS) started to do pilots with more innovative PBMs. There also needs to be a better way to compare what beneficiaries are getting from MA-PD compared to PDPs.

Commissioner Navathe also echoed support for looking at issues of particularly obvious value, including the use of biosimilars and the interaction between plan and beneficiary.

Chairman Chernew noted that innovation is fundamental in this space. MedPAC needs to pick its places to address market disfunction while acknowledging the importance of drug innovation. The role of innovation in the drug sector is qualitatively different. There is a ton of disfunction, and he believes strongly that the drug sector should not just be given a blank check. But the importance of innovation weighs heavily here. MedPAC will continue to work on topics that some might view as smaller technical adjustments (reinsurance, rebates, etc.). The way policymakers engage must be cognizant of the institutional differences in this space, compared to other spaces.

Mandated Report on the Skilled Nursing Facility Value-based Purchasing Program and Proposed Replacement

Carol Carter, Ledia Tabor, Sam Bickel-Barlow
Presentation

Background

In the *Medicare Act of 2014*, Congress mandated that MedPAC issue a report on the Medicare Skilled Nursing Facility (SNF) Value-based Purchasing Program (VBP). This discussion is a follow-up to work conducted in late 2020 to review the SNF VBP and to make recommendations on how to improve the program.

Staff noted that very few SNFs earned back the entire 2 percent program withhold and fewer earned the maximum bonus amount. Staff opined that part of the reason for this is that the payments were not sufficiently large to motivate improvement. They also noted that performance by providers was inconsistent over the 2 years that staff reviewed.

Already as part of MedPAC's review, the Commission was able to identify several design flaws in the SNF VBP:

- *Performance gauged with a single measure (readmissions) yet quality is multi-dimensional*
- *Minimum count does not ensure reliable results for low-volume providers*
- *Performance scoring does not encourage all providers to improve*
- *Does not account for social risk factors of the beneficiaries treated by a SNF*
- *Amounts withheld are not fully paid out as incentive payments*

Notably, when Congress passed the *Consolidated Appropriations Act, 2021* in December, Congress made changes to the SNF VBP and the changes were consistent with some of what the Commission had already addressed in its public discussions:

- Statute now allows the use of up to 10 measures (and requires data validation)

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- Statute now states that the program cannot apply to providers that do not meet a minimum count for each measure.

In response to a question from ***Commissioner Perlin***, staff clarified that the policy options and potential recommendation are designed to align with MedPAC's position and statutory requirements for the Unified Post-Acute Care (PAC) Prospective Payment System (PPS).

Policy Options

As discussed in previous meetings, the Commission is considering several policy options to address the Commission's identified shortcomings of the SNF VBP.

Policy Option 1: *Eliminate the current SNF VBP*

Policy Option 2: *Establish a SNF Value Incentive Program (SNF VIP).* In order to address the MedPAC-identified flaws in the SNF VBP, the SNF VIP would build in the following elements:

- Score a small set of performance measures. The SNF VIP would still keep the measure set small, with a likely recommendation to focus on the following measures:
    - *Hospitalizations During the SNF Stay*
    - *Successful Discharge to Community*
    - *Medicare Spending Per Beneficiary*

  Commissioners expressed general support for expanding the measures under the program (***Commissioner Grabowski***). Given the vulnerability of this patient population highlighted by the COVID-19 pandemic, there was also a suggestion that the Commission consider whether there needs to be a safety component added to the performance assessment (***Commissioner Gelb-Safran***). ***Commissioner Perlin*** highlighted the importance of outcome measures and stated that the Commission should acknowledge that there will be an evolution in quality measures and that they should be careful to not select measures or word this in way that would back the Commission or the program into a corner. ***Commissioner Wang*** stated that it is important to acknowledge there is an absence of really good risk adjustment of these measures, and there is no "purity" to these quality metrics. She added that it is acceptable that these approaches are an attempt to use the tools that are available but that it is important to note that these measures are not absolute.

  There was some also concern about the program operating independently (or contrary to) the public reporting available on CMS' Nursing Home Compare. One commissioner highlighted that staffing is a key component of Nursing Home Compare but not a part of the SNF VIP and that there has been a lack of transparency with the program (***Commissioner Grabowski***).

- Incorporate strategies to ensure reliable measure results. There was support for improving the reliability of results under the redesign (***Commissioner Grabowski***). However, there was some concern about excluding too many providers. Some expressed support for using multiple years of data (***Commissioner Grabowski***) with potential higher weighting for more recent years.

- Establish a system for distributing rewards with no "cliff" effects

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- Account for differences in patients' social risk factors using peer groups. This concept in its current iteration would be administered by using "share of fully dual-eligibles." The staff modeled the peer groups based on this to demonstrate that by accounting for share of fully dual-eligibles those providers that serve this community would not be systematically disadvantaged under the program as staff believes they have been under the SNF VBP. Staff believes this change provides less incentive to avoid medically complex patients. There was some commissioner suggestion that there needs to be additional work here on the reliability issue and the underlying premise of using dual-eligibles as the mechanisms for risk adjustment (***Commissioners Jaffrey, Gelb-Safran,*** and ***Wang***). ***Commissioner Navathe*** added that there is an incentive in the structure of the peer grouping that still encourages improvement because if you stay still and everyone else improves, you would fall behind. Chair Chernew added that they will develop recommendations based on the feedback but that the main goal is to ensure that they are not pulling resources away from the facilities that are treating the most disadvantaged.

- Distribute the entire provider-funded pool of dollars. As stated by staff, the full pool of funds should be distributed and the VIP should not be used as a mechanism to generate program savings. There was some concern that the payments would continue to be small (***Commissioner Casalino***), but general support for distributing the entire pool (***Commissioner Grabowski***).

Policy Option 3: *Finalize development and begin to report patient experience measures*. Many commissioners expressed support for the inclusion of a patient experience measure (***Commissioner Grabowski***).

Next Steps

There was general directional support from commissioners (***Commissioners Jaffrey***, ***DeBusk***). Staff and Chair Chernew outlined that draft recommendations will be provided to the committee at the March meeting with the final recommendations to be voted on at the April meeting. As the *Medicare Act of 2014* established a report deadline of June 31, 2021, the discussion and recommendations will be included in the MedPAC June 2021 Report to Congress. (***Commissioner Ginsburg*** raised the question of whether the recommendations and report could be issued more quickly than June, but ***Chair Chernew*** and ***Executive Director Mathews*** highlighted the established process for issuing formal recommendations that necessitates the recommendations will not be able to be issued prior to June.)

Medicare's Vaccine Coverage and Payment Policies

Kim Neuman, Nancy Ray, Ledia Tabor

Presentation

Overview

The staff presented on efforts to monitor vaccination rates and what the Commission might consider in the wake of the COVID-19 pandemic. The staff noted that the ability to conduct this is limited by current reporting requirements. Staff cited that vaccine-related quality measures vary across fee-for-service (FFS) providers. While some institution-level measurement requirements include vaccination measures, there are no vaccine measures for ambulatory surgery centers (ASCs), dialysis facilities (as of 2022), hospice providers, or skilled nursing facilities (SNFs). At the clinicians level, since you are allowed to pick your measures, there is no requirement to report on vaccinations. Staff also noted that while accountable care

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organizations (ACOs) are currently scored on flu vaccination rates, the new set for 2022 will not include the vaccine measure.

Staff outlined current coverage rules for Medicare Part B and Part D for vaccinations. Currently,

- Part B covers vaccines for seasonal flu, pneumococcal disease, hepatitis B for certain patients, COVID-19 (*per The CARES Act*), and others "used to treat injury or direct exposure" (e.g. tetanus or rabies). There is generally no cost-sharing (except for those "used to treat injury or direct exposure). These are administered in a variety of settings.
- Part D, on the other hand, covers all "commercially available vaccines not covered by Part B" (e.g. shingles or hepatitis A). Shingles is vast majority. Also cover administration. Cost-sharing varies by plan. This are largely administered in pharmacies.

The Commission discussed the following policy option for potential endorsement:

Policy Options

- **Policy Option (Coverage)**: *Coverage all appropriate preventive vaccines and their administration under Part B instead of Part D without cost-sharing.* Staff noted that in the MedPAC June 2007 Report to Congress, the Commission recommended coverage of vaccines under Part B rather than Part D. The Commission continues to believe that this would promote wider access as more people have B than D, Part B reaches a wider variety of settings, it could be less confusing to patients and no cost-sharing could be removed as a barrier. Staff noted that the 2007 recommendation was silent on cost-sharing.
    - "*Appropriate Preventive Vaccine"*: ***Commissioner Perlin*** inquired on the definition noting that it is viewed largely through an infectious disease lens, but there could be other clinical areas that need to be considered, such as in oncology with the HPV vaccine. Staff noted that it is a complicated issue, but in order to avoid making it more complicated, the policy option is anchored to the Advisory Committee on Immunization Practices (ACIP) and would expect any changes or expansions to be administered at that level.

- **Policy Option (Payment)**: *Modify Medicare's payment rate for Part B-covered preventive vaccines from 95% of average wholesale price (AWP) to 103% of wholesale acquisition cost (WAC), and require vaccine manufacturers to report average sales price (ASP) to CMS for analysis.* Staff observed that the current policy, 95% of AWP, results in a payment that is much higher than the WAC. Because this is more like paying on the sticker price, not a market-driven price, eventually moving to something based on ASP would get closer to market prices. However, to go that far, staff believes more data might be needed because they do not know what ASP is for current covered vaccines.

340B. During the discussion, ***Commissioner Wang*** asked if there would be any implications for the 340B program and discounts. Staff believed that the vaccines would not be subject to 340B discounts but that they would have to confirm.

Administration Fees. These would continue to apply and staff noted they will continue to do work on potential spending implications.

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The next MedPAC meeting is scheduled for March 4-5, 2021.

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