

MEDICARE PAYMENT ADVISORY COMMISSION

ONLINE MEETING  
VIA GO-TO-MEETING

Thursday, April 2, 2020  
12:36 p.m.

COMMISSIONERS PRESENT:

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P R O C E E D I N G S

[12:36 p.m.]

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DR. CROSSON: Okay. Eric, you have the  
microphone.

5

MR. ROLLINS: Great. Thank you.

6

Good afternoon, or good morning, for some of you.  
For the first session today, we're going to talk about  
MedPAC's vision for payment and delivery reform in the  
Medicare program. The Commission has discussed this issue  
on a number of occasions over the last 12 to 18 months,  
using an outline that was developed by the Chairman. What  
we've tried to do here is synthesize the views that  
Commissioners expressed during those discussions and flesh  
them out some. The material from this session will form  
the basis for the opening chapter of the June report. Our  
goal today is to get your reactions to the draft chapter  
that was included in the mailing materials and your  
suggestions for any additional changes.

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Next slide.

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All of you are well aware that the growth in  
Medicare spending poses a significant challenge for the  
federal government. We discussed this spending growth in

1 the context chapter in our March report, and the mailing  
2 materials highlighted some key points from that work.  
3 Between 2018 and 2027, Medicare spending as a share of GDP  
4 is expected to increase from 3.6 percent to 4.7 percent.  
5 About 70 percent of this growth is due to higher per capita  
6 spending, which is driven more by growth in payment rates  
7 than by growth in service use. At the same time, the aging  
8 of the population is making it more difficult to finance  
9 the program.

10           The Commission contends that policymakers will  
11 need to address this unsustainable trend by developing new  
12 payment and delivery models. Given the size of the  
13 financial challenge that Medicare faces, these models will  
14 need to produce substantial savings if they are going to  
15 have a meaningful effect on the program's financial  
16 situation. A common element for these new models should be  
17 the use of value-based payment, or VBP, which is a term  
18 used to describe methods of paying for health care services  
19 that provide stronger incentives to control costs than fee-  
20 for-service while maintaining or improving quality.

21           Next slide.

22           Commissioners have expressed interest in a

1 multiyear effort to strengthen and expand the use of VBP in  
2 Medicare. Our work on this issue will be guided by the  
3 same fundamental principles that serve as the foundation  
4 for all of our policy development: ensuring that  
5 beneficiaries have access to high-quality care in an  
6 appropriate setting, paying providers equitably and giving  
7 them incentives to supply efficient and appropriate care,  
8 and assuring the best use of the taxpayer dollars that  
9 finance most of Medicare's spending. In particular, the  
10 Commission will seek to identify policy changes that  
11 encourage more providers to accept accountability for both  
12 the cost and overall health of a group of beneficiaries.  
13 This accountability would include attention to the quality  
14 of care, the provision of preventive services, the  
15 avoidance of waste, and the delivery of care at the most  
16 appropriate and cost-effective site of service.

17           Commissioners have indicated that the Medicare  
18 Advantage and ACO programs could provide a foundation for  
19 the broader use of VBP. These payment models currently  
20 cover almost two-thirds of beneficiaries who have both Part  
21 A and B, and they have stronger incentives to manage  
22 overall spending than traditional fee-for-service.

1 However, both programs need to be improved before they can  
2 realize their potential. For example, MA has always been  
3 more expensive than fee-for-service due to the way that  
4 Medicare sets plan payment rates, and the savings from ACOs  
5 have been fairly modest. If these programs are going to  
6 have a meaningful effect on Medicare's financial  
7 sustainability, they will need to produce much larger  
8 savings than they do now. The MA and ACO programs have  
9 already been a priority for the Commission and have been  
10 the focus of multiple presentations during this meeting  
11 cycle. Later today, you'll vote on draft recommendations  
12 that would create a new MA Value Incentive Program and  
13 modify how ACO benchmarks in the Medicare Shared Savings  
14 Program are calculated.

15           The Commission plans to conduct more work in the  
16 future to identify specific policy changes that improve the  
17 MA and ACO models. For example, in MA, we may examine  
18 issues such as the benchmarks that help determine plan  
19 payment rates and the risk adjustment system. For ACOs,  
20 Commissioners have discussed ways to make beneficiaries  
21 more engaged, whether there needs to be better integration  
22 between ACOs and other new models such as bundled payments

1 for episodes of care, and whether ACOs should have  
2 incentives to manage the use of outpatient prescription  
3 drugs.

4           This work may also include issues that are  
5 outside of the scope of the current ACO and MA programs.  
6 For example, we may consider whether Medicare should pay  
7 hospitals using global budgets that cover all of their  
8 inpatient and outpatient services.

9           Some Commissioners have said that the development  
10 of new payment and delivery models needs to accelerate.  
11 The traditional fee-for-service approach has an inherent  
12 incentive for providers to deliver more services and thus  
13 receive more payments; there is significant variation in  
14 quality and outcomes; and coverage for activities that are  
15 not directly related to a service, such as care  
16 coordination, has often been limited. However, fee-for-  
17 service has had some success at constraining spending  
18 growth through its use of administered prices, and efforts  
19 to broaden the use of VBP should be careful to avoid  
20 undermining this feature.

21           Medicare has taken numerous steps to reduce the  
22 basic fee-for-service incentive to provide more services

1 through initiatives such as the creation of bundled payment  
2 rates such as DRGs for hospitals, the use of capitated  
3 payments for health plans, and the development of ACOs.  
4 There have also been numerous efforts in recent years by  
5 the Congress, CMS (most notably through the Center for  
6 Medicare and Medicaid Innovation), and the private sector  
7 to develop new payment and delivery models, but these  
8 efforts have had relatively little impact on the average  
9 beneficiary. For example, we discussed last fall how  
10 evaluations for most of CMMI's models either have not been  
11 completed or have found that the model did not have a  
12 significant impact on cost or quality. So far, only two  
13 CMMI models have met the criteria for expansion.

14 Medicare has used a fee-for-service model to pay  
15 for services throughout its history, and it still plays a  
16 central role today, even in the MA and ACO programs. For  
17 example, MA benchmarks equal a percentage of fee-for-  
18 service spending and plans use fee-for-service rates to pay  
19 out-of-network providers. ACO benchmarks are also tied to  
20 fee-for-service spending and the vast majority of ACO  
21 providers are paid on a fee-for-service basis.

22 Nevertheless, based on your discussions, it's our

1 sense that the Commission contends that, to the degree  
2 feasible, Medicare should transition from paying providers  
3 using fee-for-service to paying providers through  
4 "accountable entities" that have incentives to control  
5 overall costs and improve quality while still providing  
6 appropriate care. The development of these entities could  
7 also facilitate other beneficial changes in the health care  
8 delivery system, such as better care coordination among  
9 providers, efforts to address the non-medical needs of  
10 beneficiaries, and the use of new technologies. Both  
11 beneficiaries and providers should have incentives to  
12 participate in these entities. These entities should also  
13 pay individual providers in ways that support value-based  
14 payment, such as the use of upside and downside financial  
15 risk.

16           That brings us to the discussion. In this  
17 presentation, we have tried to synthesize your views on the  
18 Commission's work on payment and delivery reform, building  
19 on the outline that the Chairman developed and that you  
20 have discussed multiple times. We'd now like to get your  
21 feedback on the draft chapter and your suggestions for any  
22 revisions to the text. In particular, we'd like to know if

1 there are any additional topics or areas that you think the  
2 Commission should consider in the future as it works to  
3 realize its strategic vision.

4 Thank you.

5 DR. CROSSON: Thank you so much, Eric, not just  
6 for the presentation but for all the work that you've done  
7 over the last number of months to get this draft chapter  
8 put together and, as you've mentioned, reflective in  
9 general of the comments, discussions, and in many cases  
10 desires of Commissioners as expressed over the last year or  
11 so.

12 Now we'll turn to one round of discussion. We're  
13 not going to have a Q&A discussion per se, but, of course,  
14 if you do have a question, you can incorporate that into  
15 your comments. And as Dana mentioned before, when you want  
16 to comment, send her a note in the chat box, and now, Dana,  
17 you can start from the top and we'll have a discussion.

18 DANA KELLEY: Okay. Kathy, you're up first.

19 MS. BUTO: Thank you. And, Eric, thank you so  
20 much for putting this chapter together. I think it's  
21 really important. I think it describes really well the  
22 work that the Commission has done to date and some

1 aspirations about further improvements.

2 I'd like to see or suggest that we look at, going  
3 forward, the bigger picture of are we aiming to make not  
4 just fee-for-service evolve more to an accountable system,  
5 but really put the existing payment systems -- fee-for-  
6 service, ACOs, and MA -- on a comparable footing so that we  
7 can -- beneficiaries even as we transition toward more  
8 accountable systems -- have a way to compare them within  
9 their area. So something that's a little more proactive  
10 about moving in that direction.

11 I think the Commission has already done a lot.  
12 For example, we have consistently worked on improving the  
13 population-based quality measures of value across all  
14 settings. We've also done some work -- it's been a number  
15 of years now -- comparing how fee-for-service, ACOs, and MA  
16 perform in different geographies around the country.

17 I think that it would be good to have a section  
18 that talks about what's next to how do we go beyond that to  
19 potentially getting away from a legislated MA rate-setting  
20 and benchmarking system to something that's more  
21 competitively bid or priced alongside fee-for-service and  
22 ACOs, maybe some opportunities for more beneficiary skin in

1 the game. There may be areas -- I think we've already  
2 identified home health, but there are other areas where  
3 beneficiary skin in the game is really important. And  
4 we've also touched on over the years the role of Medigap in  
5 fee-for-service.

6           So I think I'd just go the next step of  
7 suggesting some other areas that could sort of break this  
8 open a bit more. And then I would really love to see at  
9 least a challenge out there about continued innovation in  
10 Medicare. For example, service delivery differs so much  
11 from area to area. At times Medicare has sort of toyed  
12 with the idea of letting area health delivery systems get  
13 together and manage, whether it's all-payer or with  
14 Medicaid or employer-based, a broader set of sort of health  
15 system changes that would improve health across the board  
16 from the time somebody's employed or even childhood all the  
17 way through Medicare. So I think some notion of that next,  
18 you know, horizon of innovation.

19           The other thing I just want to mention is there  
20 are so many root cause conditions in Medicare like  
21 diabetes, mental health issues, that drive costs, and we've  
22 never done a good job in Medicare of developing models to

1 really focus more, target more, better management of those  
2 conditions, and they are longstanding in Medicare. So,  
3 again, some degree of innovation or experimentation that  
4 would advance that kind of work is something I think  
5 Medicare can do more aggressively, not just focus on  
6 payment but focus on the beneficiary and improving overall  
7 care.

8           And then the last thing I'll mention I was going  
9 to mention in executive session -- and I don't know that it  
10 belongs here, but it's something I hope people will discuss  
11 going forward -- is I think Medicare needs an investment  
12 fund. We need a fund that will fund research, whether it's  
13 on those kinds of conditions I just mentioned or whether  
14 it's to help contribute to a better system of developing  
15 flu vaccines going forward. Flu is obviously something  
16 that affects our population to a greater extent in many  
17 cases than the rest of the population. So something that's  
18 a little more proactive in the research area or in the area  
19 of service delivery would be really, I think, a  
20 breakthrough for Medicare, where Medicare takes some  
21 responsibility for whether it's partnering with NIH or CDC  
22 or even FDA to advance treatments in a way that really will

1 serve the population.

2 Thank you.

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

4 Brian, you'll need to turn your mic on. There  
5 you go.

6 DR. DeBUSK: Can you hear me now?

7 MS. KELLEY: Yes, we can.

8 DR. DeBUSK: Okay, great. First of all, Kathy,  
9 thank you for your remarks. I categorically agree with  
10 what you said. So many of the things that you mentioned I  
11 wanted to touch on.

12 Eric, wonderful chapter. I was really, really  
13 excited to read the chapter, and I think you really touched  
14 on so many things that we can build on going forward.

15 Just a couple things that I do want to mention.  
16 Kathy, I really appreciate what you were talking about,  
17 trying to bring more of a competitive element into this,  
18 and I think that would be important as we try to decouple  
19 from fee-for-service, at least partially decouple, because  
20 I do think fee-for-service will be around as a way to  
21 measure productivity. But I'm really excited about the  
22 idea of moving away from fee-for-service as a way to

1 determine the aggregate level of payment.

2           So, again, really exciting, and one thing I would  
3 propose -- and I don't know that it's ready for this  
4 chapter, but there are elements that we may want to bring  
5 to ACOs. For example, would you want an ACO benchmark to  
6 be developed by some type of competitively bid mechanism?  
7 I know it sort of has the specter of premium support and  
8 some of the things we've talked about before, but there may  
9 be some technical things that we could do with ACOs to help  
10 them, for example, with their attribution. You know, maybe  
11 prospective attribution isn't the answer. Maybe we need to  
12 go straight to attestation and incorporate some of that --  
13 whether they attest or not and which ACO they attest to,  
14 the Part B premium, or go back and revisit Medigap. I  
15 don't think there's a wrong answer there, but I think as  
16 long as we bring MA and ACOs -- as we harmonize them and  
17 build them out as vehicles to maintain health, not as  
18 vehicles to just deliver services, I think it's really,  
19 really exciting. Again, I love this chapter.

20           The other thing that I do want to mention, I  
21 really like the way we touched on engaging on how providers  
22 are paid. I really think that that's going to be an

1 important element of this, too. I think there are some  
2 more progressive methods out there for paying providers,  
3 and I also think there's some very regressive methods. And  
4 I think a lot of that's going to be tied back to how  
5 dependent they are on the fee schedule.

6 So wonderful chapter, wonderful vision. I cannot  
7 wait for the retreat at this point. Just a fantastic  
8 chapter. Eric, extremely well done. Thank you.

9 DR. CROSSON: Thank you, Brian, and thank you,  
10 Kathy.

11 Let me just pick up on this because I'm already  
12 detecting kind of two strains in the discussion here. One  
13 has to do with, you know, in this particular chapter I have  
14 a comment about -- and here a substitute comment about we  
15 ought to do it this way or a little differently. The  
16 second part, which is equally or perhaps more important, is  
17 as we continue to evolve this work, as both Kathy and Brian  
18 have mentioned, you know, here are issues that we need to  
19 take on that are perhaps not fully baked into this chapter  
20 yet, but definitely serve as priorities for future  
21 Commission work.

22 So to the extent that in your comments you can

1 try to distinguish between those two things, I think that  
2 would be helpful.

3 MS. KELLEY: Okay. I have Marge, Bruce, David,  
4 Dana, Amol, Jon Perlin, Larry, and Jaewon. Let me know if  
5 somebody else wants to jump in. Go ahead, Marge.

6 MS. MARJORIE GINSBURG: Okay. I just unmuted.  
7 So I'm in the category Jay was just referring to where I'm  
8 talking specifically about this chapter and the promise of  
9 value-based payment. So, anyway, like the others, I was  
10 very energized by reading this and very excited about it.

11 I have several different questions, and I think  
12 what I'm going to do -- questions or comments. I'm just  
13 going to -- there aren't that many -- lay them out and then  
14 maybe get some response afterwards.

15 So the first one is on page 3, the first  
16 paragraph. It says, "Our first step is to improve existing  
17 ACO models." So I want to really go out on a limb -- and I  
18 may be the only one to propose this, but I think our first  
19 step would actually be to fulfill the expectation of MA  
20 plans, that they deliver higher-quality care at lower cost  
21 to taxpayers and beneficiaries. So I just talking with we  
22 really haven't gone far enough. We've gotten great steps

1 moving forward to undo the wrongs that I think are  
2 currently baked into how MA is paid and evaluated. But I  
3 think we haven't gone far enough. And the future, in my  
4 mind, is with MA, and we need to get in front of that, get  
5 ahead of that. So that was my first comment.

6           The second one is really a question, a possible  
7 research. I know that was one of the areas of interest.  
8 So the essence of fee-for-service is that beneficiaries can  
9 go to any provider they want at any time. This is what  
10 sells people to original Medicare more than anything else.  
11 Do we know or can we find out how often beneficiaries  
12 actually use this privilege and the extent to which this  
13 increases costs to the program? I know with ACOs we're  
14 trying to corral that instinct to go outside, but just  
15 looking at the data we have or don't have, how big an issue  
16 is that? And does it represent a significant financial  
17 problem?

18           One other possible research area is to what  
19 extent does minimal beneficiary cost sharing affect overuse  
20 in services? So we all know that those with Medigap have  
21 virtually no cost sharing if they purchase, you know, the  
22 whole kettle of fish. Now, effective this year for people

1 who are new, who are 65 this year, Medigap will no longer  
2 cover Part B deductibles. But, you know, that's just one.  
3 But the fact is for most people they really can get  
4 anything they want.

5           Can we assess the use of services of  
6 beneficiaries, those with and without a gap plan? Because  
7 I think the extent to which we understand how much  
8 beneficiary cost sharing influences their decision to  
9 adhere to the highest-quality, most effective care could be  
10 meaningful.

11           And my last comment is on page 9, at the very  
12 end, and this may be too radical, but it's the bulleted  
13 list about the use of fee-for-service, just that it should  
14 be replaced over time and the degree feasible by systems  
15 that have incentives to, and then it lists all the bullets  
16 here. And I would add the bullet to reduce the financial  
17 burden on taxpayers and beneficiaries. For all the  
18 attention we give to the importance of corralling the cost  
19 of Medicare, I don't see we've done that much in focusing  
20 on the burden on individual beneficiaries. So that sort of  
21 sums up my major points on this. Very exciting start, and  
22 I look forward to moving ahead.

1 Thank you.

2 DR. CROSSON: Thank you, Marge. That is pretty  
3 radical, but I think we can incorporate it.

4 MS. KELLEY: Okay. Bruce.

5 DR. MATHEWS: Dana, can I get in here? Marge, on  
6 your second point, there's actually fairly extensive health  
7 services research literature on the relationship between  
8 cost sharing and service use, and we've done a good bit of  
9 that ourselves. I want to say back in 2013 or thereabouts  
10 we actually made a recommendation that there be an  
11 additional charge imposed on beneficiaries with high  
12 coverage Medigap plans because of the inductive effect of,  
13 you know, reduce cost sharing on service use.

14 MS. MARJORIE GINSBURG: So maybe we can dust that  
15 off and find a way to incorporate it into this plan as  
16 well. Thank you.

17 MR. PYENSON: I also want to compliment the  
18 chapter and point out that I think the Chairman's piece is  
19 prevailing despite the criticism that I and others had for  
20 it last summer. So I think compliments to Jay that that  
21 piece was perhaps more going in the right direction than  
22 many of us had given him credit for last summer.

1           I have a couple of big-picture items and small-  
2 picture items. One is I think we have an opportunity to  
3 look at the profound structural changes in the health care  
4 system and recognize those in our work. So much of our  
5 inadequacy is focused on the system as it had existed 20  
6 years ago or more with individual physician practices and  
7 community hospitals. Today we are far from that kind of  
8 structure, and consolidations are not reversing. So I  
9 think as we look down this road of a future of Medicare and  
10 accountability, a utilities model comes to mind, that we  
11 actually have a health care system in many regions that  
12 would best be thought about as a utility like the electric  
13 company. And what does that mean in terms of  
14 accountability and payment?

15           There's a variety of models in existence for  
16 treating utilities. Some are more successful than others.  
17 But I think that's really the kind of financial head that  
18 we ought to be looking at and kind of models as opposed to  
19 a fee-for-service approach or a system based on fee-for-  
20 service. So I think the utility model of payment and  
21 regulation is something we ought to look at because  
22 consolidation is not going to get reversed.

1           On a big-picture item, I think we should use the  
2 deflation word for health care spending. I think that's  
3 what we're all talking about, so I think we should get it  
4 out there and not mince words. We're talking about people  
5 getting -- organizations in the health care system in the  
6 future getting paid less than they're paid today, and  
7 that's our expectation. And I don't think there's a  
8 credible case to be made that we're going to be able to pay  
9 people more because they become so much more efficient.  
10 Hopefully that will happen, but I think we have to pay  
11 people less.

12           And, finally, I want to pick up on the large --  
13 and Kathy had talked about Medigap, and I think looking  
14 forward a tax on Medigap is something that ought to be on  
15 the table, and that has to have an impact on how the  
16 benchmarks are set for MA plans, that the induced  
17 utilization of Medigap ought to be taken out of the  
18 benchmarks for MA plans to level the playing field. I  
19 think that gets to perhaps some of Marge's accountability  
20 for MA.

21           But, again, back to the beginning, I think Jay  
22 laid this out about not quite a year and a half ago, and I

1 think he was more prescient that I had given him credit  
2 for.

3 Thank you.

4 DR. CROSSON: All right. Well, thank you, Bruce.  
5 Appreciate it.

6 MS. KELLEY: David?

7 DR. GRABOWSKI: Great, thanks. I also want to  
8 echo the other Commissioners and pass along my thanks to  
9 Eric. This is an excellent chapter and I think really lays  
10 out a nice agenda.

11 Jay, I think these comments would probably be in  
12 the bucket of largely edits to this chapter, although I do  
13 think they could influence our larger agenda here. I  
14 really like the part of the chapter that we're very direct  
15 about the problems with fee-for-service, and I think we  
16 sort of put ACOs as being necessarily better. And ACOs can  
17 be many things to many people, and so I wondered if we  
18 might be a little bit more explicit in the chapter around  
19 what we think is an ideal ACO. And we even talk about some  
20 of the changes that ACOs might undergo in the future, the  
21 inclusion of Part D, better engagement of beneficiaries.  
22 That sounds great to me. I wondered if we could even go

1 further in sort of outlining what are some key principles.  
2 I know we probably have done that in a chapter in prior  
3 years. Jim will probably remind me of exactly the year and  
4 the report that we did that in. But I think we're turning  
5 to that and saying these are the sets of principles and  
6 what else might need to change, and just to flag a couple,  
7 how we're setting the benchmarks with historical and  
8 regional components is problematic. The risk adjustment  
9 that we're currently using is problematic. And so there's  
10 a series of changes that we might think about such that  
11 we're not just saying ACOs are better but, rather, this is  
12 the ACO type model and value-based model that we have in  
13 mind.

14 I think that's really important here, and as a  
15 final comment, I think the ACO program has obviously  
16 undergone a lot of changes. We're going to talk more about  
17 that later this afternoon, or late morning for some of you.  
18 But I think we need to think about kind of what is that  
19 core principle around an ACO?

20 So I'll stop there, and, once again, Eric, this  
21 was a great chapter, and I'm really happy we're going down  
22 this path. Thanks.

1 DR. CROSSON: Thanks, David.

2 MS. KELLEY: Dana?

3 DR. SAFRAN: Thank you. I'll be brief. I echo  
4 many of the comments that have been made by other  
5 Commissioners, including kudos to you, Eric, for really  
6 excellent work.

7 The only two things I would chime in on are one I  
8 chimed in on before, that I think would be good to  
9 incorporate here, and that is a reference in the future  
10 work section to the importance of models that encompass the  
11 hospital and that really transform payment and payment  
12 incentives for hospitals. We really haven't, I don't  
13 think, addressed that, and we've talked many times over the  
14 past two years within the Commission about how without that  
15 we've really got one foot nailed to the floor as we try to  
16 move away from fee-for-service. So I'd like to see us  
17 mention that.

18 The other thing is -- and maybe this is not  
19 possible given the late date on the calendar relative to  
20 when this gets published, but, you know, we did have an  
21 interesting set of comments about telehealth in the crisis  
22 and how long-lasting that might be. And it seems to me

1 that in the future work section it might be worth a mention  
2 of, you know, the -- I hate to call it this but exciting  
3 response in the industry to the crisis and making mobile  
4 care available to people and the importance with which that  
5 will compel payment reform requirements once we are on the  
6 other side of this.

7           And then, lastly, just to underscore the point --  
8 now I'm trying to remember who raised it; it might have  
9 been Brian? Or somebody -- sorry, I'm forgetting who. But  
10 somebody raised the importance of getting to physician or  
11 front-line clinician level payments and that, you know, we  
12 have to address that piece, too, in order to hope for the  
13 success. We can't keep rewarding folks on an RVU basis and  
14 hoping that these models work. And, you know, I am mindful  
15 that CMS still has this framework -- I believe they do --  
16 around sort of the different typology of payment reform  
17 with a kind of most evolved view in their model is, you  
18 know, where there's actually capitated payments. And, you  
19 know, I think the question is: How do you within the Stage  
20 3 in their framework get to more effective programs? And I  
21 think part of that we might want to underscore that even  
22 when it's all sitting on top of the fee-for-service

1 infrastructure, if we address the issue of the incentives  
2 for individual clinicians in particular and to move away  
3 from RVU-based payments, maybe even as one of the measures  
4 of performance or criteria for participation at some level  
5 of having payment based on other things, that that can  
6 really strengthen our ability for success in that third  
7 level of the typology.

8           So those are my comments. Thanks very much.

9           DR. CROSSON: Thank you, Dana.

10          MS. KELLEY: Amol?

11          DR. NAVATHE: Hi, everyone. So, Eric, great job.

12 I think I'll echo many of the comments that other  
13 Commissioners have made supporting the work, supporting the  
14 direction, supporting I think many of the ambitious types  
15 of goals around future work and future state that have been  
16 articulated here.

17           I wanted to pause on a couple of things. So one  
18 point I thought that was important is I like the fact -- I  
19 think David said this, and I would repeat it, which is I  
20 like the fact that there's an explicit statement about fee-  
21 for-service being a very problematic chassis to which  
22 everything seems to be connected. So I think, you know,

1 you made the point in the chapter about Medicare Advantage  
2 payments being calibrated effectively to fee-for-service.  
3 Obviously, the MSSP or ACO type programs are calibrated to  
4 or based on fee-for-service. And so I think the idea of  
5 shifting away from there is very powerful.

6           The one piece that I thought we need to probably  
7 explicitly acknowledge is that that's not -- one, that's  
8 not trivial, and right now we don't have a lot of great  
9 examples out there of how to do it another way. And I  
10 think if you kind of sync that up with one of Dana's  
11 points, one of the examples that was offered, perhaps the  
12 main example that was offered was the Maryland hospital  
13 capitated budget type of model. And the evidence for that  
14 model, at least to date, is not resoundingly positive, and  
15 there's perhaps an issue of centrality of the hospital and  
16 some other models.

17           And so I think that to me highlights kind of two  
18 things. One, we need to harken back to Kathy's point  
19 about, you know, we need more innovation, we need to think  
20 more carefully about how we could catalyze the type of  
21 change that we need. What is the core system that ends up  
22 replacing fee-for-service? I feel a strong tension

1 between, on the one hand, saying that we need to, you know,  
2 partner or, as Dana was saying, make a requirement that you  
3 don't pay through RVUs or don't pay through fee-for-  
4 service, but, on the one hand, that's sort of very heavy  
5 handed from a regulatory perspective. At the same time,  
6 the question is, well, then what's the alternative? How  
7 are we actually basing productivity, how are we basing our  
8 ability to actually collect data?

9           So another important aspect, this one probably  
10 more concretely I think we can include as either a bullet  
11 point or a sentence or something in this chapter to  
12 acknowledge that what the fee-for-service system has given  
13 us is an ability to actually record what happens in a very  
14 effective way, albeit not specifically for research or  
15 measurement purposes, still has been the way predominantly  
16 that we've been able to do things like measure cost,  
17 measure utilization, measure productivity, to this point at  
18 least measure value, however we're doing it. And so we  
19 need -- there are elements of fee-for-service that we also  
20 need to preserve that are not related to the financial  
21 incentives but that are related to the ancillary ways in  
22 which we're able to make our system function and the way in

1 which we're able to actually measure and then try to  
2 improve our system. And I think it's important that we  
3 don't lose that point. Otherwise, it feels like perhaps  
4 we're chasing an ideal without really recognizing what we  
5 have in place at this point that could be potentially very  
6 problematic if we were to lose it.

7           The second point that I wanted to make is related  
8 to Dana's point around the shift -- and others, you know,  
9 we made in executive session as well around the idea that  
10 in this COVID crisis we've seen this dramatic shift toward  
11 telehealth. And I think one of the things -- when I took a  
12 step back and reflected upon this, obviously this is not a  
13 positive situation in which we've had to do this, you know,  
14 we've seen CMMI and CMS and Congress try to put out, you  
15 know, guidance and legislation and models and, what have  
16 you, regulation, to try to get our system to perform  
17 differently. And, largely speaking, we've said, well,  
18 there's small, modest effects. And here I think what we  
19 have seen -- in the context of a crisis, mind you -- the  
20 ability for the system to shift in a very dramatic way. I  
21 mean, this is kind of shocking, in a positive way, how much  
22 the system has changed in the matter of a month.

1           And so I think we should -- I don't know that we  
2 need to bring up COVID specifically, but I think we should  
3 point out that there is evidence that the system can shift  
4 in a pretty dramatic way, and what we need to be thinking  
5 about as MedPAC and as a nation is: How do we create the  
6 right environment in which to shift the system in a way  
7 that now we have a sense that it can shift much more  
8 dramatically? It doesn't have to be 1 percent, 2 percent.  
9 You know, there are actually ways to shift the system in a  
10 more dramatic way. So those are the two points.

11           I had one question perhaps for Eric, but I'm  
12 happy, of course, for others to respond to it as well.  
13 There was a comment in the chapter that basically said we  
14 have to be careful -- I can actually read it because I  
15 think it might be easier than my trying to paraphrase it.  
16 It's on page 6, about middle of the page or maybe a third  
17 from the bottom: "Since Medicare is on a financial  
18 unsustainable trajectory, efforts to broaden the use of  
19 value-based payment, which focused largely on changing  
20 patterns in service use, should be careful to ensure they  
21 do not inadvertently undermine the program's control over  
22 prices." And so I wanted to cue this up. I think I maybe

1 understand exactly what we mean, but I'm not sure, and I  
2 thought it might be worth asking Eric perhaps to clarify  
3 what was intended there and then in the chapter making sure  
4 that we're clear about that, because in some sense that  
5 feels like it could be ambiguous and it could be  
6 misinterpreted.

7           MR. ROLLINS: So in terms of that passage, Amol,  
8 I think that what we were trying to communicate there is  
9 historically Medicare has had maybe not perfect but at  
10 least a decent degree of control over the price of the  
11 individual service and less control over the volume side of  
12 the equation. And value-based payment is really looking to  
13 sort of put more attention on sort of what does the volume  
14 side look like, but we just wanted to underscore that, you  
15 know, one reason that cost growth in Medicare has been a  
16 lot lower than the commercial sector is this control over  
17 prices. And so when you're designing new models, just sort  
18 of, you know, be cognizant that that is an element of one  
19 thing that Medicare has done relatively well compared to  
20 the commercial sector and don't sort of inadvertently  
21 weaken it. So I think that was sort of, you know, what we  
22 were trying to communicate.

1 DR. NAVATHE: Got it. Okay. So there wasn't any  
2 particular concrete example or particular scenario that  
3 we're concerned about here? It was more of a guiding  
4 principle?

5 MR. ROLLINS: Yes, that's right. I don't think  
6 we had a specific, you know, people are considering X and  
7 this would cause all sorts of problems. It was more sort  
8 of a general caution.

9 DR. NAVATHE: Okay. Got it. Thanks, Eric.

10 DR. CROSSON: Thank you, Amol.

11 MS. KELLEY: Jon Perlin?

12 DR. PERLIN: Let me add to the thanks for a  
13 terrific chapter, and let me also strongly associate with  
14 Amol's first two points. I think they're right on target  
15 in terms of understanding what the replacements are.

16 With respect to that, I'm just trying to think of  
17 the reality of this chapter, which I realize should be  
18 transcendent, transcending current events like COVID with  
19 the reality of COVID. To the best of my mind, everybody  
20 I've been speaking with -- I mean, I think we have a peak,  
21 you know, last eight weeks, we'll have simmering activity  
22 for eight months, rinse and repeat in the fall, hopefully

1 there's a vaccine, but we're talking about 18 months of  
2 dislocation. And I want to just give you a view from the  
3 front. I'm sorry Warner's not on because I think he could  
4 speak pretty eloquently to New Orleans. We operate Tulane  
5 University Medical Center there and a number of other  
6 hospitals. You know, health care providers of all stripes  
7 are going to come out severely wounded. You know, surgeons  
8 have got no revenue. And I'm not asking for sympathy for  
9 surgeons. What I'm noting is that their offices are not  
10 paying their staff. Their staff will not reconstitute, and  
11 things will not look like what they did. Practices of non-  
12 proceduralists are decidedly limited. I want to absolutely  
13 associate with the notion that many have brought up, that  
14 telehealth is a boon and it is quite remarkable, Amol, that  
15 the adaptation and the adoption of that has been so rapid.  
16 In fact, one of my predictions that it would sort of merge  
17 with electronic records is really being borne out. And,  
18 you know, that's terrific that we're able to make some of  
19 those adaptations. But the human infrastructure is not  
20 going to be quite as adapted, and, you know, I don't know  
21 how we should think about some of what our transcendent  
22 principles have been a la Kathy Buto's point about really

1 building some resiliency into the system. I mean, we're  
2 struggling across the country because the system is not  
3 resilient. It is sounding like just-in-time inventory as  
4 one example, bed capacity as one example. It's not  
5 resilient. And I realize that's directly antithetical to  
6 the notion of trying to pull out additional efficiencies.  
7 So it takes us back to things where we have adapted, like  
8 with telehealth and finding a need to actually recommend  
9 perhaps a more adaptive policy, legislation that permits  
10 that policy, et cetera.

11           Switching gears from, you know, painting a  
12 picture that things will look very different as we emerge  
13 from this in an economy that is also distressed, I want to  
14 associate with Dana's comments. Some colleagues engaged in  
15 this. How will ACOs weather this? Looking at Sue, head  
16 nodding, I'd be interested in your comments. What are the  
17 permutations in terms of the benchmark attribution? How  
18 does that play in terms of a year that's been disruptive,  
19 and for next year as well? And how will we account for  
20 current events in evaluation of ACOs?

21           You know, to Bruce's point on deflation, you  
22 know, fine, I get that we need to take money out, but you

1 can't do that absent the regulatory and legislative  
2 adaptations to make things like telehealth durable, make  
3 things like licensure reciprocity among states durable,  
4 that make scope of practice more durable.

5 I remember back to my VA days; life was a lot  
6 simpler. It was completely capitated, just -- it was a  
7 different country in our country. But at the same time, I  
8 can't tell you that we were totally devoid of fee-for-  
9 service because you had to have a mechanism to reward  
10 effort from non-effort. And, you know, I think we're going  
11 to have to sharpen in future iterations our thinking about  
12 even if populations are capitated, what are the mechanisms  
13 that simultaneously balance the need to differentiate  
14 between effort and non-effort in a way that also supports a  
15 coherent philosophy about the maximum utility of the  
16 dollar.

17 Thanks.

18 DR. CROSSON: Thank you, Jon.

19 MS. KELLEY: Larry?

20 DR. NAVATHE: Is it possible for me to respond to  
21 Jon's points really quickly? Apologies to Larry.

22 DR. CROSSON: On this point, Amol?

1 DR. NAVATHE: On this point. So, Jon, I think  
2 there's one thing that you -- well, there's several things  
3 that you said that I think were really important and  
4 resonated, but one in particular that I thought would be  
5 great to add onto rather than really respond to even, you  
6 pointed out that as part of this telemedicine/telehealth  
7 shift, this has been done in rapid form in a way that  
8 perhaps we never could have truly predicted or really  
9 realized how fast it could happen, but there's also this  
10 collateral impact on the human elements and the human  
11 capital of health care. And I think that's a really  
12 important point because one thing to recognize is I think  
13 there is a really positive story here around how fast the  
14 health care delivery system has shifted, but we do need to  
15 recognize that it hasn't really shifted in a systematic,  
16 reasoned, and well-thought-out way in terms of how to  
17 maximize the positive impacts while minimizing the negative  
18 impacts.

19 And so as we think about the sort of ideation of  
20 the future system, I think we do want to capture and  
21 harness and retain some of that really positive element of  
22 how much the delivery system has shifted. But we need to

1 also counterbalance that with a systematic approach so  
2 we're not chasing system change without really recognizing  
3 what the countervailing effects might be.

4 DR. CROSSON: Go ahead, Dana.

5 MS. KELLEY: Larry?

6 DR. CASALINO: So I share the enthusiasm about  
7 how good the work on the chapter is, and also I agree with  
8 the direction and with the emphasis on finding ways to make  
9 the ACO and make programs better.

10 I do have five questions or reservations that are  
11 geared to the report, I think, but also toward the retreat.  
12 And then I have a quick bonus comment on telehealth based  
13 on the discussion so far. I think I can be very brief.

14 So the first point is on page 9 there's a  
15 sentence that says, "The entities" -- these are accountable  
16 provider organizations -- "would in turn be expected to pay  
17 individual providers using approaches that support value-  
18 based payment." Why would we want to reform micromanaging  
19 how accountable entities pay their individual providers?  
20 If their incentives are strong enough to improve the care  
21 they provide, quality and cost, then they'll find ways to  
22 compensate their providers that work best within their

1 organization. I think any attempt to tell entities how  
2 they're supposed to pay their physicians, for example,  
3 would be misguided at best. So I do have a reservation  
4 about that sentence.

5           Second point, should there be some mention of  
6 size somewhere in the chapter and also discussion of this  
7 at our retreat? Clearly, the current crisis is going to  
8 lead to more consolidation, both on the physician and on  
9 the hospital level. And the directions that will be  
10 proposed by the ACOs, for example, probably will lead to  
11 even more consolidation, which hurts the private sector,  
12 but even for Medicare, with administered prices, if  
13 competition is reduced in a geographic area, that can hurt  
14 beneficiaries. So this is obviously not the focus of the  
15 chapter, and I don't think it should be, but I hate to see  
16 the chapter not make any mention of the risk of  
17 consolidation and maybe possibly a comment or two about,  
18 you know, things that might be important in that respect,  
19 like antitrust enforcement.

20           Then the second thing I think about consolidation  
21 and size, I think we might want to mention -- we might want  
22 to think about this at the retreat more extensively -- that

1 the programs as they develop probably should include ways  
2 for smaller practices to participate in accountable  
3 entities without being owned by accountable entities  
4 necessarily. I know there have been efforts like that in  
5 ACO programs, for example, but this chapter makes no  
6 mention of that, and I think it would be good to call it  
7 out. There are still a lot of physicians in small and  
8 medium-size practices that are independent, although  
9 obviously the number is shrinking.

10 Third point, should the government be picking  
11 winners and losers in terms of categories of organizations?  
12 And what I mean by that, if you look at the statement on  
13 page 4, which, I think if you read it carefully, it's  
14 actually ambiguous what it means, the statement is: "As  
15 models improve, we would support Medicare increasing  
16 incentives for providers to participate in and improve  
17 delivery of care." So the ambiguity there to me is the  
18 meaning of "increasing incentives." It could mean, on the  
19 one hand, making very strong -- you know, very large  
20 potential rewards masked in some way, say large potential  
21 risks/penalties for providers that want to be accountable  
22 entities, making the incentives larger than they are now.

1 So increasing incentives could mean that. And/or it could  
2 mean just giving provider organizations or accountable  
3 entities money for participating as an advanced alternative  
4 payment model, even if they don't perform better. So that  
5 would be, for example, the 5 percent bonus that's been  
6 given for five years to advanced APMs.

7           To put it another way, one way to proceed is just  
8 to make increases of payment in a fee-for-service system  
9 very small or none, as has been done again in MACRA, and  
10 then make the rewards and risks much larger for  
11 organizations that want to take accountability, so you can  
12 choose to stay out of those accountable organizations, but  
13 you then get very little pay increases. Or you can join  
14 them, and you have potential big bonuses but potential big  
15 penalties. So that's one way to do it. Another way is to  
16 do that or maybe not do that as extensively, but then just  
17 give money to organizations just for being an A-APM, and  
18 that to me it is being done, it does smack a little bit of  
19 government picking winners and losers, maybe we want them  
20 to pick winners and losers. But I just raise this as a  
21 question. I don't mean it as a rhetorical question or take  
22 a position on it, but I think it's important to explicitly

1 consider it.

2           Fourth point, we've talked a lot about fee-for-  
3 service today. I think some mention that it's not likely  
4 to disappear completely and soon, and that it might be  
5 worth spending some energy on finding ways to make it work  
6 better insofar as it does exist, for instance, getting the  
7 prices better, and there have been various suggestions  
8 about how to do that.

9           Then the fifth point, Dana emphasized that it's  
10 important to give hospitals some significant incentives to  
11 reduce costs and increase quality. I agree with that. And  
12 I also agree that MedPAC studying global budgets for  
13 hospitals is worthwhile. It almost sounds too positive the  
14 way it comes down in the chapter as it's phrased now, at  
15 least to me. I mean, it would take some real convincing  
16 for me to think we should give hospitals control of the  
17 delivery system and just kind of hand it to them, which is  
18 what global budgets for hospitals that can include  
19 outpatient care does, I think. They haven't done very well  
20 as ACOs, and I wouldn't expect them to do much better with  
21 these global budgets necessarily. So I think we would  
22 really want to think before we come out to that.

1           And then just this thing about telehealth, I  
2 thought that telehealth was great before when there were  
3 only telephones, no video, and the more, the better. I'm  
4 delighted to see so much -- and Cornell has done outpatient  
5 care and NY Presbyterian pretty much to virtually 100  
6 percent for all outpatient care. Very, very little is  
7 being done in person now, and that happened in just two  
8 weeks, as people have said. And I don't think -- well,  
9 that's going to retreat some after all this is over, but I  
10 agree that telehealth is going to be around, and I think  
11 that's great.

12           I think some thought needs to be given -- this  
13 doesn't have to be in the report, but I'll just flag the  
14 issue here. Obviously, what has made telehealth happen  
15 more is partly the contagious problem but partly the fact  
16 that now all of a sudden, it's going to be paid for pretty  
17 well. It is being paid for at fee-for-service, and I think  
18 we'll want to give some thought going forward, if not in  
19 the report, to think about probably in the short run it  
20 does have to happen that telehealth get paid at fee-for-  
21 service, but that could have all kinds of unintended  
22 consequences. In our ideal system, I think, the incentives

1 to be efficient would be so strong that you would do  
2 telehealth -- you in accountable care entities -- you would  
3 do telehealth because it's the best way to provide care,  
4 quality, and cost, not because you get paid every time you  
5 do a telehealth visit in fee-for-service. So that's it.

6 DR. CROSSON: Thank you, Larry. I'd just make  
7 one comment in terms of your third point, which is the  
8 issue of whether or not a 5 percent bonus should be paid or  
9 not. And I think our position, which we made a couple of  
10 years ago, anyway, after MACRA, was that that should not be  
11 the case, that the 5 percent bonus should be paid -- and it  
12 is paid through these entities, but it should be paid to  
13 entities for distribution who are, in fact, being  
14 successful as opposed to just being in existence.

15 DR. CASALINO: Is that the MedPAC position? I  
16 didn't realize that, actually. I think that's terrific.

17 DR. CROSSON: Yes, it is.

18 DR. CASALINO: Good.

19 DR. JAFFERY: Jay, on that point?

20 DR. CROSSON: Yes.

21 DR. JAFFERY: I'm aware that that's been the  
22 position, and I think that -- because that was a couple

1 years ago, so that discussion about that predated my time  
2 on the Commission. I think that it's worth at some point  
3 maybe thinking about why we think that, again, or  
4 clarifying what we think the purpose of the advanced APM  
5 is, because in some ways there is a sense of that being not  
6 quite a cash flow issue, but a way that systems that aren't  
7 able to necessarily be confident that they can weather  
8 certain losses as they're ramping up, know that they've got  
9 some sort of backstop, and that may or may not be the right  
10 thing, but I think that is a perspective that a lot of  
11 folks have as they're entering into some of these models,  
12 especially if it's a physician group that may not have the  
13 financial backing of a hospital system.

14           Again, I wasn't part of that conversation a  
15 couple years ago, but I do think that there is some  
16 perspective of that.

17           DR. CROSSON: It can certainly be re-thought. I  
18 was simply noting that that is our current position.

19           MS. KELLEY: I think Bruce has a question for  
20 Larry.

21           MR. PYENSON: Larry, you brought up, as you often  
22 do, some really important items and questions. I wanted to

1 support examination of whether MedPAC -- whether we should  
2 tell Medicare how providers pay their expenses. And I've  
3 been in favor of that, pointing to the vertical  
4 consolidation of organizations where what used to be  
5 distinct entities are now in effect self-dealing  
6 organizations.

7           There is, of course, another side to that, which  
8 is as long as the providers can get efficient, why do we  
9 care? But I think there's two sides to that, and I think  
10 that deserves to be on our agenda. We see that in some  
11 profound ways in the supply chain where organizations are  
12 getting paid by Medicare, own part of their own expense  
13 determinations, which is potentially a big distortion in  
14 the Medicare cost reports as well as probably being a bad  
15 thing. So, Larry, I think that issue is something we need  
16 to look at. I might have a different take on it than you  
17 do, but I'm glad you raised it.

18           DR. CROSSON: Thank you, Bruce.

19           MS. KELLEY: Jaewon?

20           DR. RYU: Can you all hear me? Hello? Yeah,  
21 okay. I have a couple comments. I also want to thank Eric  
22 for a great chapter. I like that it was short but sweet,

1 but I did have a couple comments, and I think this goes  
2 into both of your categories, Jay, as far as things that  
3 should be, I think, incorporated into the chapter but also  
4 could inform future work for the Commission.

5           The first was I like the mention of both Medigap  
6 and the Part D plans as really the way it's framed it seems  
7 like impediments to the advancement of the ACO work, and I  
8 think that sounds about right. But I think we may want to  
9 have a section in the chapter that looks at other big  
10 impediments. Think of them as oak trees that sort of need  
11 to be moved out of the path if we're to move out of fee-  
12 for-service and into more value-based payment. And I think  
13 Medigap is a great, almost a poster child illustration of  
14 one of them. But I imagine there are others as well, so I  
15 think it would be helpful from a contextual standpoint to  
16 lay out a little bit of what's the kind of work that would  
17 need to happen to take ground on this. And then, second,  
18 it would, I think, demonstrate the magnitude of tackling  
19 this because some of these things are big programs that  
20 would need to be addressed in order to make progress. So I  
21 think that was my first comment.

22           The second comment goes to the discussion we were

1 having around the downstream payments, so to speak, so MA  
2 plans and how they pay downstream providers, and if it's  
3 still on a fee-for-service chassis, I think that is an  
4 impediment itself. And how do we create incentives to have  
5 plans paying downstream providers or even systems in a way  
6 that's more conducive to value? I actually think from a  
7 payment standpoint maybe it doesn't make that much  
8 difference because, you know, the program has already paid  
9 the MA plan, what do we care what the plan does to the  
10 provider? But I think outside of payment, if you're really  
11 looking at how do you spark delivery system change and  
12 reform, I think that's really where that downstream payment  
13 becomes very relevant.

14           So I would suggest maybe incorporating some  
15 acknowledgment of that in the chapter as well, that that's  
16 why we would care about those downstream payments, is  
17 because this isn't just about payment reform and moving  
18 from fee-for-service to value, but it's also about taking  
19 that change and sparking or catalyzing change in the  
20 delivery system as well.

21           DR. CROSSON: Thank you, Jaewon.

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

1 DR. MATHEWS: Just for my benefit and Eric's  
2 benefit, as we come back and start to finalize the chapter  
3 in light of this discussion. So the back-and-forth that  
4 we've just had -- let's begin with Larry's commentary --  
5 does highlight a certain difference of opinion that I want  
6 to make sure I can successfully adjudicate.

7 On the one hand, there seems to be a camp that  
8 says we should not care how one provider pays for its  
9 affiliates or acquires its requisite services if we set  
10 very strong performance targets with respect to cost and  
11 quality, and those are the things against which the entity  
12 that is receiving a payment from Medicare is judged. This  
13 was Larry's point. Why should we care? And to the extent  
14 we're saying you can't pay fee-for-service, what would we  
15 suggest?

16 The other camp seems to, you know, fall into the  
17 category of, no, as long as any fee-for-service exists in  
18 the payment stream, it is going to bring all of the adverse  
19 effects of that mechanism of payment, and so we do need to  
20 care about how things are paid throughout the system. And  
21 if an MA plan is paying its providers on a fee-for-service  
22 basis, that is of concern.

1           So could folks say a little bit more to try and  
2 help me, at least, figure out what to put --

3           DR. CROSSON: Let me jump in here because I'm not  
4 sure -- because I want to make sure everybody gets a chance  
5 to comment on the chapter, and we're closing in on 15  
6 minutes to go here.

7           The difference of opinion that you just mentioned  
8 and that we heard has been present really for a long time.  
9 I think it was probably earlier in the fall when I brought  
10 up this question with respect to MA, which is kind of along  
11 the lines that Jaewon say: Should we care or should we not  
12 care? And, you know, a few people raised their hands on  
13 both sides, and just looking at the Commission, I got the  
14 sense that there was maybe some difference of opinion, but  
15 more than that, people needed to think about it, so I --  
16 because I think they're god points. The first person to  
17 raise their hand when I brought that up said, well, why  
18 would we care? Because, you know, we're transferring the  
19 risk in this case to MA plans, and as Larry said, they have  
20 incentives to manage cost and quality. So why not? Or why  
21 get in the middle of that?

22           And I think another commenter said, yeah, but

1 they're not doing it. I mean, they seem to be agnostic to  
2 the value of trying to encourage some sort of value-based  
3 payment. Personally, I think the reason that they have not  
4 done it is it's just hard, it's difficult. As many people  
5 have said, it requires, you know, substantive change in  
6 mind-set and in mechanisms and the rest of those things.

7           On the other hand, I think the point that Jaewon  
8 made, I wouldn't say, you know, personally, now we should  
9 just say that we want to expunge fee-for-service payment as  
10 a matter of principle. But I do think that the point that  
11 Jaewon made that if we think, you know, with one half of  
12 our brain that movement towards value-based payment is  
13 valuable per se -- and we're talking about that, you know,  
14 in the context of ACOs and MA and even in fee-for-service -  
15 - then you know maybe -- and I think in the language you've  
16 got here, Eric, you just basically said some consideration  
17 should be given to thinking about whether or not CMS should  
18 encourage, not even incent but just encourage holders of  
19 risk MAs and ACOs, to think about how they pay. I think  
20 that's -- you know...

21           So my guess here, Jim, would be maybe we expand  
22 that a little bit to bring in both points of view here,

1 which is kind of a pro and con, well, here's the arguments  
2 for not interfering in that relationship, but then there  
3 are arguments for why it might be done, and I think we  
4 could get to a point -- and remembering we will have a  
5 chance to review this, the wording of this, one more time.  
6 But I think by framing it as pros and cons, which is just  
7 simply reflective of the discussion that we've had, we can  
8 get through that. At least that's my thought.

9 Is there disagreement with that approach?

10 MS. KELLEY: Larry, your mic?

11 DR. CASALINO: Yeah. So, no, Jay, I think it's  
12 always good to say pros and cons. I'd be happy with that.  
13 You know, I would just add -- and I won't take more than 30  
14 seconds for this. In what other industry would government  
15 even think about telling the companies, say telling Delta  
16 Airlines how to pay its employees? If you just step back,  
17 it's a very radical suggestion and real kind of  
18 micromanagement. And I would say it's kind of an admission  
19 of failure that we don't have the incentives right. If we  
20 had the incentives right, we wouldn't be trying to tell  
21 people how to pay their employees. So I'll just end with  
22 that. But I think putting in pros and cons would be great.

1 MS. BUTO: Jay, it's Kathy.

2 DR. CROSSON: Yes, Kathy.

3 MS. BUTO: On the same point, I agree with Larry.  
4 I think I was one of the first to say I don't see why we'd  
5 do this. Actually, the main reason is we don't get fee-  
6 for-service right; I don't see how we're going to get  
7 payment from an MA plan to providers within the plan right.  
8 I think there is a danger of overreach by sort of the  
9 several levels, because it's easy one-stop shopping. We  
10 think we know best. But I'm not convinced that some of the  
11 approaches that we're talking about are better than fee-  
12 for-service. So I really -- until we have a better sense  
13 of that -- and I'd be interested to know what MA plans  
14 think of having the government come and suggest, well, we  
15 really need to move in this direction or that direction.

16 Back to my original point, I think that sometimes  
17 plans really do know best, and if we really want to hold  
18 them accountable, let's do it through quality measures and  
19 not try to tell them how to pay their providers.

20 DR. CROSSON: Okay, Kathy. Well, I think that  
21 thing would be one we would incorporate in the cons.

22 DR. DeSALVO: I actually agree with that,

1 although there is a situation where in MACRA there is an  
2 implicit expectation that providers are going to move to a  
3 different -- to a non-fee-for-service model over time. So  
4 there's some precedent for that bit of overreach. But I  
5 like the way that you all are shaping it. I do think that  
6 holding some kind of accountable entity accountable for  
7 outcomes and not for a certain type of payment would be the  
8 preferred direction that we should be recommending.

9 DR. DeBUSK: On that point, if I could make one  
10 comment. Maybe we don't go as far as to say this is how  
11 they're to be paid, but there may be some merit in saying  
12 these are the types of transactions we don't like. And,  
13 you know, I would go back to sort of the villain of the MA  
14 plan that just chose high and paid low. I mean, could we  
15 create incentives to at least not engage in certain  
16 behaviors and then let them decide what a global payment --  
17 you know, what this new payment needs to look like, and  
18 maybe just discourage these very granular fee-for-service  
19 transactions. Is there a point -- is there a choice, I  
20 guess is what I'm asking?

21 DR. SAFRAN: Can I just add one comment? I think  
22 it's a new point here.

1 DR. CROSSON: Yes.

2 DR. SAFRAN: So I'm listening to this, and I  
3 think part of the disconnect here in some ways relates to  
4 this issue of hospitals and hospital participation. What I  
5 mean by that is if we think of an ACO that is strictly a  
6 large enough primary care group, then I totally think  
7 Larry's and others' point is correct, that we have created  
8 an accountability model, their population is their primary  
9 care base, that is their ACO, and they're accountable and  
10 everything lines up.

11 I think, Larry, what doesn't line up is where you  
12 have an institution that some of its population, they're  
13 accountable, and some they are seeing the population on a  
14 referral basis and still very much in fee-for-service mode.  
15 And I think in that situation our minds go to, gee, how do  
16 we stop such an organization from just churning, and so we  
17 think about the front-line incentives around volume versus  
18 outcome. So I think we have to give a little bit more  
19 thought to this issue because it's actually, I think, as  
20 I'm thinking it through in this conversation, it's not  
21 really the clinicians in service of the ACO patients that  
22 we're concerned about, because I think we're assuming or

1 striving at least to have the right incentives for the ACO  
2 that that all lines up. It's the fact that oftentimes the  
3 ACO is an organization that is caring for Medicare patients  
4 from somebody else's ACO and they have the wrong  
5 incentives. So I hope that is a helpful point, even if it  
6 doesn't give us a clear direction.

7 DR. CROSSON: Okay. Thank you, Dana.

8 Dana Kelley, where are we in terms of the queue  
9 at the moment?

10 MS. KELLEY: I think Larry wanted to make a one-  
11 sentence clarification on this point, and then we have Sue,  
12 Pat, Paul, Kathy, and Warner.

13 MS. BUTO: I don't need to make my comment  
14 anymore.

15 DR. CROSSON: Okay. So I think that will be the  
16 queue. Larry, do you have another point?

17 DR. CASALINO: No, it's just a point of  
18 clarification. I think we have different -- I think we  
19 read the text differently, and we have different mental  
20 models in mind, and that would make you think that if it's  
21 published as is, there are other reasonable ones, too. So  
22 some of us seem to be thinking of MA plans and how they pay

1 provider entities, and others -- and I'm in the latter  
2 group -- had a mental model of, again, we were telling, you  
3 know, Geisinger how to pay its physicians. And it seems  
4 like some people only have one model and some people have  
5 others. So I'm just saying I think if we keep this in  
6 there at all, I think we need to be really clear about  
7 that, because those are quite different situations, I would  
8 say.

9 DR. RYU: Yeah, and I would comment on that  
10 point. I think that's the distinction because I would feel  
11 differently about those two scenarios. What I would be in  
12 favor of is MA plans and how they pay downstream providers.  
13 I do think there's a role for CMS to play there. But as  
14 far as systems and how they pay their employees, I think  
15 that feels like a bridge too far, and I don't know that  
16 that's as productive.

17 DR. CROSSON: I think that distinction could be  
18 made.

19 DR. NAVATHE: On that point, there are MA plans  
20 that also employ clinicians directly. So I think it does -  
21 - there's a little bit of ambiguity and potential gray area  
22 that could be problematic there. I think we should -- you

1 know, I'm generally in favor of your approach, Jay, of  
2 there's pros and cons, and clearly, I think there's a lot  
3 of complexity. We need to think more about this.

4 DR. CROSSON: That point could be included as  
5 well. Thank you.

6 Let's continue with the queue.

7 MS. KELLEY: Okay. Sue is up next.

8 MS. THOMPSON: Can you hear me?

9 MS. KELLEY: Yes, we can.

10 MS. THOMPSON: Good. Thank you. I will be as  
11 brief as I can be here. I agree with the conversation  
12 about payment to physicians and what was just said. I  
13 agree with Larry's point. I just want to go on record  
14 expressing support for Larry's position.

15 I do think the point made by David about a need  
16 to define ACOs is important, and I think that would help  
17 inform the discussion as well about how payment to  
18 physicians are made.

19 I also want to go on record in support of the  
20 comments that Brian made about the need for us to spend  
21 some time thinking more about blending some of the MA  
22 attributes to ACOs. But, again, it goes back then to us

1 having a clear definition of when we say ACO, what are we  
2 saying? Because ACOs mean very different things to those  
3 of us who are in different kinds of ACOs. And I think  
4 there's a need at some point -- and this may be in our work  
5 this summer, not necessarily for this chapter, but some  
6 acknowledgment that we are now having to reconcile to all  
7 kinds of new programming coming from CMMI around direct  
8 contracting and other alternative payment models or  
9 advanced alternative payment model participants like  
10 NextGen, which, again, contributes to, I think, a great  
11 deal of our internal confusion when we get into these  
12 discussions about the generic term of ACO.

13           Having said that about the comments made to date,  
14 in relation to the chapter, Eric, I think it's excellent.  
15 I enjoyed reading it. I found it to be very clear. But I  
16 had a hard time compartmentalizing my life today with  
17 imagining that we're ever going to be able to get back to  
18 something that looks like this world again without  
19 modifications from what we're learning in this COVID  
20 crisis.

21           I want to go on record: We're in Iowa. We are  
22 way behind the curve in terms of when the surge will hit.

1 But we have been entertaining all of these release and  
2 regulations that have been coming forward on nearly a daily  
3 basis, and the changes in regulations to our front-line  
4 workers are profound. And we are transforming health care  
5 as we speak in this crisis. Telemed is but one.

6           The three-day waiver, I mean, suddenly we had  
7 expansive three-day waiver going on across the state. The  
8 release of regulations around home care that just appeared  
9 on Monday this week, important for us as MedPAC to  
10 understand and know what those changes are going to mean to  
11 letting the horse out of the barn, if you will.

12           I mean, I am having a hard time imagining how  
13 we're ever going to go back to looking like anything that  
14 we looked like before. And I don't intend to suggest we do  
15 a lot in this chapter on what we're seeing in this short  
16 period of time, which feels like an eternity. But I think  
17 without some commentary in this chapter, recognizing  
18 there's such an opportunity to learn when we come out of  
19 this into whatever our new normal will be, and we do need  
20 to understand a lot of what we have been working on in  
21 MedPAC, we have seen regulations just evaporate.

22           I spoke with one of the front-line physicians

1 this morning who said, again, we've had the advantage in  
2 Iowa to have more weeks to prepare than those on the east  
3 coast. But our front-line physicians are saying, "I feel  
4 such freedom." And I think the impact on our workforce and  
5 their expectations going forward is profound. And whether  
6 that's some footnote to this chapter or certainly a comment  
7 for our summer work, we have a lot of great learning and a  
8 lot of transformation that's going to come forward from  
9 whatever this is and however long it will last that I just  
10 can't help but make comment on it as we're thinking about a  
11 world that we used to know that I think is going to be  
12 unrecognizable in the future.

13 DR. CROSSON: Thank you, Sue.

14 MS. KELLEY: Okay. Pat.

15 MS. WANG: Thank you. I will try to be brief.

16 Just to pick up on that, Sue, it doesn't seem like an  
17 eternity. It really is an eternity.

18 You know, a comment on the conversation that was  
19 happening on the point that Larry brought up about how  
20 downstream providers get paid, Jaewon, too. My personal  
21 view is that it is very difficult to ask a federal agency  
22 in Washington to issue meaningful guidance on how

1 downstream providers should be paid, whether it's through  
2 an MA plan -- and I do agree with Jaewon's points on this  
3 and how we would like things to happen, but I'm a little  
4 bit more skeptical about the feasibility of CMS ever really  
5 coming up with anything that people could really implement.

6           Among other things, it takes two to tango. An MA  
7 plan could say, "I want to do all of this groovy stuff with  
8 all of this payment," and the provider could say, "Thank  
9 you very much, but I'm really not interested in that." So  
10 it's complex. It's complex by region, et cetera.

11           But there is an underlying point here which has  
12 to do with the flaws of the fee-for-service system, because  
13 a lot of the barrier to enter into value-based payment  
14 arrangements with providers is that there's something  
15 better on the other side. So as a comparison, could I do  
16 better with what fee-for-service would give me versus what  
17 you're giving me? Being at risk for something is a heck of  
18 a lot more work. Why don't I just bill, you know?

19           And so I think that the importance of the fee-  
20 for-service system is what Eric said. Medicare controls  
21 prices. It doesn't control utilization, but it controls  
22 prices such that the baseline of spending per beneficiary

1 is lower than it would be in a comparable commercial  
2 population. And I wouldn't want to kind of completely let  
3 go of that, but I think the important thing for fee-for-  
4 service reform is to shift fee-for-service to support  
5 models, whether they're ACOs or MA, to sort of make it more  
6 explicit that people get rewarded, not just that they're  
7 incentivized, the list on Slide 9, the bulleted list. I'd  
8 like to see that stated a little bit more forcefully, that  
9 not only should there be incentives to do the right thing  
10 kind of, but that there be actual -- the folks who will be  
11 rewarded in a future fee-for-service system that is  
12 migrating to an ACO/MA world, is that people who do the  
13 right thing about managing chronic conditions, keeping  
14 people out of the hospital, using telehealth, community-  
15 based organizations, and other things to achieve the  
16 outcomes that actually lower unnecessary utilization,  
17 inappropriate utilization, and thereby lower costs that we  
18 need to have a bigger emphasis on that.

19           On the point of telehealth, I agree with what  
20 everybody has said about how incredible it is. I mean, we  
21 have crossed the digital divide in this crisis, and there  
22 is no going back. My caution on this, though, is that if

1 what we have built with telehealth simply mimics what  
2 exists in the fee-for-service system, that's not so good.

3           For example, if somebody has built an entire  
4 telehealth system that makes open access to super-  
5 specialists available because that was the model that they  
6 used to practice, you know, in the face-to-face world, that  
7 to me is not progress. And so I think that we have to be  
8 mindful when hopefully this thing is over sooner than later  
9 and we see how people adjust the way that they get care,  
10 that we keep in mind that telehealth could simply just be  
11 additive to people having face-to-face care. And the only  
12 way -- my own experience with urgent care, which we put in  
13 place to try to divert people from the emergency room, what  
14 we have said is they're going to urgent care or they're  
15 going to the emergency room. So, you know, it's just a  
16 cautionary tale. I am hugely supportive of telehealth, but  
17 at least from my perspective, we're trying to be very  
18 intentional about the network that we are making available  
19 and building for our members, making sure that their  
20 community primary care providers are in it so that we don't  
21 sever those relationships as opposed to just kind of, God  
22 bless them, pushing everybody to the hospitals because

1 their telehealth capabilities are much more mature, much  
2 more stood up, et cetera.

3           So that would be my only point about whether it's  
4 telehealth or other modalities, it just underscores the  
5 importance of it being part of a budget so that you don't  
6 have, you know, just more modalities to do more fee-for-  
7 service specialty billing. And so that's really all I want  
8 to say. Thank you.

9           DR. CROSSON: Well, thank you, Pat, and I think  
10 you've underscored a point I heard Dana make a while ago,  
11 which is perhaps not surprising, but that I think we're  
12 beginning to realize looking forward that there's going to  
13 be a relationship between the expansion of telehealth and  
14 payment reform.

15           DR. DeSALVO: On this point, maybe some of the  
16 way we could message this in the chapter is that by moving  
17 to this vision of accountable entities having longitudinal  
18 responsibility for the cost and health outcomes in  
19 partnership with beneficiaries would allow more innovation  
20 not only in payment and we would hope better outcomes and  
21 cost savings, but also more innovation in modalities of  
22 delivery like telehealth. So, in other words, instead of

1 calling out -- we could call out telehealth, but I think  
2 the whole point of this is that let the beneficiaries and  
3 the delivery system and the financial accountable entity  
4 partner to achieve the outcomes that make the most sense  
5 based upon the tools and capabilities that are available in  
6 the environment and the health needs of the population that  
7 is being served.

8 MS. WANG: I think that's helpful. Let me, if I  
9 could, just mention one other thing. I will be perfectly  
10 honest with you. Whoever said it before, the hospitals are  
11 getting decimated financially by what's going on,  
12 emotionally, you know, in their souls and financially  
13 decimated. If I have any concern, it's that when people  
14 start to come out the other side, anything that they were  
15 doing in value-based payment, which is very much harder  
16 than the old fee-for-service tried and true, is going to  
17 get put to the side; and that, if anything, people are  
18 going to be more intense on the tried and true, you know,  
19 jacking up fee-for-service and really anything that's  
20 medically necessary, fighting every opinion about whether  
21 an admission could have been avoided, whether a readmission  
22 was really appropriate, things of that nature, it's much

1 harder to deliver health care that way than just, you know,  
2 like pay me for every service. I mean, I get it, but, you  
3 know, that's why this chapter's very important, and I  
4 realize that it's not COVID-specific, but I do think that  
5 it is a reality coming out the other end that all this will  
6 be good stuff that we've been discussing, is at least  
7 something that's very much on my radar screen, because I  
8 kind of see it happening with the anxiety.

9 DR. CASALINO: Jay, if I can, on the point that  
10 Karen and Pat just made, you know, I think the chapter does  
11 -- is very negative about fee-for-service, and that's fine.  
12 But I think it may miss -- if we're going to talk  
13 negatively about fee-for-service, I think the chapter may  
14 be missing an important opportunity. It's not news that  
15 fee-for-service leads to more service and, therefore, more  
16 costs, generally speaking. And certainly we want to say  
17 that, but that won't really surprise anyone. But equally  
18 bad about fee-for-service, and maybe really worse in the  
19 big picture, is that you have to decide what services to  
20 pay for, right? So you pay for telehealth fee-for-service  
21 or you don't pay for telehealth fee-for-service. You pay  
22 for getting someone an air conditioner, and you pay for

1 transportation, and there's endless things you could pay  
2 for. This really gets back to Karen's point. You really  
3 would like provider organizations to deliver the mix of  
4 services, the types of services and who provides them and  
5 where they're provided that they think is going to work  
6 best to take care of their patients at a reasonable cost.  
7 And fee-for-service inherently, you know, is opposed to  
8 that because you're saying we'll pay for this, this, this,  
9 and this, but these other things we won't pay for.

10           And so part of the reason for moving away from  
11 fee-for-service and for more global payment is individual  
12 organizations can figure out the best mix of services. And  
13 I think if we're going to criticize fee-for-service, we  
14 should give that equal billing with also that everybody  
15 knows that it increases costs because it increases the  
16 volume of services.

17           DR. CROSSON: Okay. Thanks, Larry.

18           Dana Kelley, could you give me a sense now of the  
19 queue? Because I think we're going to have to begin to end  
20 the discussion.

21           MS. KELLEY: Yes, just Paul and Warner left.

22           DR. CROSSON: Okay. Terrific. Paul and Warner,

1 go for it.

2 DR. PAUL GINSBURG: I'll be brief because it came  
3 up with this thought very early in the discussion and  
4 probably much of it is encouraged, but just the need in  
5 this chapter to perhaps add a paragraph just acknowledging  
6 how much change we're seeing because of many regulations  
7 that were put in place to protect us as payers in a fee-  
8 for-service system have been, temporarily at least, thrown  
9 away because of the need to respond to the epidemic and  
10 assure that a lot of medical care continues to be safe for  
11 patients and providers.

12 I would point to the fact that, you know, once we  
13 get some experience, we're going to have to proceed very  
14 cautiously in telemedicine, in the three-day  
15 hospitalization requirements, and now we're going to have  
16 to rethink some of these things, hopefully in the context  
17 of getting more value out of responsible changes. And it's  
18 just like putting a marker up there, that this is going to  
19 have to be part of our agenda as well as what we're  
20 describing so well in the chapter.

21 The other point I was going to make is that when  
22 we have this discussion particularly about MA plans that

1 use a lot of fee-for-service, my perspective is that over  
2 the last ten years MA plans have been doing a lot more to  
3 facilitate value. And I think a key reason for that is  
4 that their payment rates have been squeezed. Many of their  
5 payment rates are still very good, their margins are very  
6 high. But this relationship between how well you pay in  
7 the aggregate and how much organizations are willing to  
8 invest to get to a better payment structure in fee-for-  
9 service will always be with it. It's particularly complex  
10 in the ACO world because that's still volatile and, you  
11 know, ACOs are not doing that well. You know, we don't  
12 really have -- and, actually, ACOs are very restricted as  
13 to their role in payments. And this maybe brings up the  
14 notion of how I would like to see ACOs having more  
15 authority over how to pay the providers that are part of  
16 the ACO.

17 I'll stop now.

18 DR. CROSSON: Thank you, Paul.

19 Warner, I don't know how you ended up at the  
20 virtual end of the table again. This is your customary  
21 spot, but take us home.

22 MR. THOMAS: Here we go. Just a couple of

1 thoughts on the chapter. I think one thing that would be  
2 important here and I think it's going to be important as we  
3 move to global payment is the assignment of primary care  
4 physicians. I know it's a sensitive topic because people  
5 want choice, but the attribution model doesn't work. The  
6 idea that someone doesn't know who their primary care  
7 physician is or their personal care physician, I just think  
8 that's something that ought to be referenced or identified  
9 in the chapter.

10           The second thing is that I think it's important  
11 to indicate that even if we move to global payments, we  
12 still have to have fee-for-service as an interim  
13 reimbursement for essentially, you know, referral care that  
14 moves back and forth between global payment organizations,  
15 and that model will have to stay in place even if there's a  
16 global payment of an ACO or whatever you want, determine  
17 the name of it. So I just, you know, get the sense of,  
18 well, we're just going to do away with fee-for-service just  
19 doesn't work because how are you going to do interim  
20 reimbursement between entities?

21           The last thing would just be on global payments.  
22 You know, if there isn't alignment of incentives, then I

1 think the test point -- you know, hospital systems,  
2 physicians, physician-owned entities, whatever, they'll  
3 figure out ways to generate additional revenue. And so I  
4 think there has to be an upside to the global payment. It  
5 can't just be, well, you're going to be fee-for-service  
6 minus 3 percent or 5 percent. It has to be looked at as a  
7 long-term way to basically bend the curve. We're talking a  
8 lot about bending the curve on COVID-19. We need to bend  
9 the curve on Medicare costs that have been going up, you  
10 know, 3, 4 percent forever. You know, if we don't change  
11 the payment mechanism, maybe it doesn't show any benefit  
12 for multiple years. But the question is over a three- to  
13 five-year period, can you start to bend the curve by  
14 getting alignment of the economics? So I just think in the  
15 chapter, referencing that this may take time, that, you  
16 know, having alignment of economics from an incentive  
17 perspective is important. I think there are just pieces  
18 that need to be referenced a little more clearly.

19           Those are my comments.

20           DR. CROSSON: Okay. Thank you, Warner. And  
21 thank you, everyone. This has been a very valuable  
22 discussion, not just for the chapter but, as many of you

1 have noted, for the work that is to come.

2 We will now take about a ten-minute break. Let's  
3 say we'll reconvene at 25 minutes past the hour.

4 [Recess.]

5 DR. CROSSON: I see David now. Okay. We don't  
6 exactly have everybody back, but I think we should start  
7 the process here.

8 Just to remind everybody, we're going to have a  
9 brief presentation, which in many ways will be a summary of  
10 what was presented in March, and then there will be some  
11 changes as requested by Commissioners, in one case to the  
12 recommendation.

13 Then I'm going to ask Dana to call the roll and  
14 have everybody express their position, support for the  
15 recommendation, lack of support, if so, why not. That will  
16 not constitute the vote, but will give everybody an  
17 opportunity to express and record their point of view.

18 When that's completed, then we'll go back and  
19 have another roll call vote, which will be the official  
20 vote, and I'll ask for either support, no vote, or an  
21 abstention. That will be the process.

22 Okay. So I still see one. Someone is missing,

1 but why don't we proceed. I see Jeff and David. Who's  
2 going to begin the presentation? David?

3 MR. GLASS: Luis. Luis is.

4 DR. CROSSON: Luis. Oh, I don't see -- where is  
5 Luis? I can't find him. Oh, there you are. Sorry, Luis.  
6 Go ahead.

7 MR. SERNA: That's okay.

8 Good afternoon. Today we are going to talk about  
9 challenges in maintaining and increasing savings from  
10 accountable care organizations.

11 I will provide a brief background on ACOs. Then  
12 I will present our concerns with patient selection and one  
13 method of addressing some of those concerns, using National  
14 Provider Identifier, NPI-based benchmarks. We will then  
15 present the draft recommendation on requiring NPI-based  
16 benchmarks.

17 During the discussion in March, you expressed  
18 interest in knowing more about ACOs' documented reasons for  
19 conducting annual wellness visits and which ACO NPIs would  
20 be used for assignment under NPI-based benchmarks.

21 We have provided that information in your reading  
22 material and can take any questions later during the

1 discussion.

2           The recommendation will be included in a June  
3 chapter. In addition to the topic presented today, the  
4 chapter will include other areas of Commissioner interest  
5 such as specialist involvement in ACOs, beneficiary  
6 engagement, ACO integration with Part D, and hospital  
7 incentives. The chapter will also include other ACO  
8 analyses presented in this cycle on PAC savings and the  
9 spending of beneficiaries who are switched out of and into  
10 ACOs. In future analytic cycles, we will continue to  
11 consider other aspects of MSSP such as regional  
12 benchmarking and risk adjustment.

13           For review, ACOs are collections of providers  
14 willing to take accountability for the spending and quality  
15 of care for an assigned patient population.

16           Actual spending is compared to a benchmark. If  
17 spending is under the benchmark, the difference or savings  
18 is shared between Medicare and the ACO. If spending is  
19 over the benchmark, there are two cases. If the ACO model  
20 is one-sided, then Medicare absorbs any spending above the  
21 benchmark. If the ACO model is shared risk also known as  
22 two-sided risk, the ACO may have to pay CMS for some of the

1 spending above the benchmark.

2 Today we are going to concentrate on the Medicare  
3 Shared Savings Program, MSSP, which is by far the largest  
4 ACO program in Medicare and the only one set in statute.

5 In 2020, there are 517 MSSP ACOs and 11.2 million  
6 beneficiaries assigned to those ACOs.

7 MSSP benchmarks are a blend of two types of  
8 spending. First, benchmarks include spending for  
9 beneficiaries who would have been assigned to the ACO in  
10 the baseline years; that is, the three years prior to an  
11 ACO's agreement period. And second, benchmarks include  
12 fee-for-service spending in the ACO's region, which  
13 includes spending on beneficiaries in ACOs.

14 To understand if an ACO model as a whole is  
15 saving money for Medicare, a counterfactual is necessary;  
16 that is, understanding what spending would have been in the  
17 absence of the ACO model.

18 Relative to a counterfactual for MSSP, we found  
19 slower spending growth for beneficiaries assigned to an ACO  
20 in 2013, about 1 or 2 percent savings through 2016. That  
21 estimate does not include shared savings payments, which  
22 would have decreased estimated savings.

1           The point is savings are relatively small but  
2 still more than most care coordination models, and they  
3 need to be protected. If shared savings payments are  
4 unwarranted, they could put Medicare savings at risk and  
5 shift MSSP from small savings to program losses.

6           The modest savings achieved in MSSP thus far  
7 could be vulnerable if ACOs can engage in patient selection  
8 that is not reflected in their benchmarks and leads to  
9 unwarranted shared savings payments.

10           Selection is problematic because it can  
11 inaccurately improve an ACOs performance year spending  
12 relative to its baseline years.

13           Selection can occur by adding clinicians that  
14 disproportionately have low-cost patients or by removing  
15 clinicians that disproportionately have high-cost patients.

16           Selection can also occur via beneficiary  
17 assignment to ACO clinicians by keeping low-cost patients  
18 and losing high-cost patients.

19           We do not believe selection in MSSP has been  
20 occurring on a widespread basis, but under current rules,  
21 Medicare is vulnerable to such manipulation.

22           We provide one way of addressing the

1 vulnerabilities of patient selection: the use of NPI-based  
2 assignment for benchmarks. I will go over how patient  
3 selection may be exacerbated through assignment to an ACO's  
4 Taxpayer Identification Numbers, or TIN, to create  
5 benchmarks. Recall that each clinician has a unique NPI,  
6 and an NPI can bill under one or more TINs. MSSP  
7 identifies an ACO as a collection of one or more TINs.  
8 This determines beneficiary assignment because  
9 beneficiaries are assigned to ACOs based on the TINs under  
10 which their claims are billed.

11 Spending for those assigned beneficiaries is then  
12 used to construct ACOs' benchmarks. However, the use of  
13 TINs to identify an ACO's clinicians weakens the utility of  
14 historical assignment and benchmarks, potentially creating  
15 unwarranted shared savings.

16 When individual clinicians leave or join a TIN,  
17 the beneficiaries historically assigned to that TIN do not  
18 change, and the ACO's benchmark is also unchanged. We have  
19 seen anomalies where this has occurred. The figure in this  
20 slide illustrates how changes in clinicians who make up a  
21 TIN could lead to unwarranted shared savings.

22 In the benchmark year, the TIN is comprised of

1 Clinician A and Clinician B. If Clinician A's  
2 beneficiaries are high-cost and Clinician A is removed from  
3 beneficiary assignment for the performance year, these  
4 high-cost beneficiaries remain in the ACO's benchmark.

5 Further, if the ACO adds Clinician C, who has  
6 historically low spending to its TIN, the ACO's benchmark  
7 would not reflect the low cost of this provider's  
8 beneficiaries, but performance year spending would. The  
9 mismatch between the benchmark and performance year  
10 clinicians raises potential concerns about the accuracy of  
11 baseline spending used for benchmarks.

12 CMS annually recalculates an ACO's benchmark  
13 based on its updated list of TINs. However, CMS does not  
14 recalculate benchmarks based on changes in the NPIs billing  
15 under the TINs. What this means is changes in how NPIs  
16 bill through TINs are not reflected in the benchmark  
17 calculation

18 As we discussed in January and March, rather than  
19 basing historical benchmarks on TIN, NPI-based benchmarks  
20 would most accurately capture the ACO's historical  
21 spending. Any changes in an ACO's performance year  
22 clinicians would correspond with changes in the clinicians

1 used for historical benchmarks. If an NPI bills under a  
2 TIN participating in an ACO, CMS could use all primary care  
3 visits from that NPI, regardless of what TIN they are  
4 billed under, to assign beneficiaries to that ACO.

5 Using NPIs to compute benchmarks and performance  
6 year spending would reduce selection from, first, removing  
7 high-cost clinicians from ACO TINs; second, adding low-cost  
8 clinicians to ACO TINs; and third, billing high-cost  
9 beneficiaries outside of ACO TINs.

10 It is important to understand that redefining ACO  
11 assignment on the basis of clinicians' NPIs would not  
12 require any changes to the structure of the ACO, its  
13 clinicians, or the specialists clinicians recommend for  
14 beneficiaries. The only difference is that the rather than  
15 the ACO's assignment being computed based on a collection  
16 of TINs, the ACO assignment is now computed based on a  
17 collection of clinician NPIs. The set of NPIs used to  
18 compute performance year assignment are now used to compute  
19 assignment in the base years. This means that all claims  
20 billed by the ACO's clinicians are now used for both  
21 benchmark and performance year assignment.

22 In summary, ACO savings have been modest.

1 Unwarranted shared savings payments to ACOs could result in  
2 costs that exceed MSSP savings.

3           To avoid putting MSSP at risk of being a net cost  
4 to Medicare, CMS needs to reduce vulnerabilities that can  
5 result from patient selection, even if the selection is not  
6 intentional.

7           To help limit program vulnerabilities, the  
8 Commission could recommend that MSSP baseline and  
9 performance year spending use NPIs rather than TINs.

10           The integrity of using historical benchmarks  
11 requires reliably matching the ACO's performance year  
12 clinicians with the ACO's historical primary care visits.  
13 Calculating benchmarks based on a collection of NPIs would  
14 better ensure that performance year clinicians are captured  
15 in benchmarks.

16           Allowing ACOs to benefit from changing NPI  
17 participation in TINs creates the potential for patient  
18 selection and unwarranted shared savings.

19           That brings us to the draft recommendation, which  
20 reads "The Secretary should use the same set of National  
21 Provider Identifiers to compute both performance year and  
22 baseline assignment for accountable care organizations in

1 the Medicare Shared Savings Program."

2           Three corollaries would need to be included when  
3 implementing this recommendation. First, if an NPI bills  
4 under a TIN participating in an ACO during the performance  
5 year assignment period, CMS should use all primary care  
6 visits in the ACO's market from that NPI, regardless of  
7 what TIN they are billed under. This would prevent the ACO  
8 from allocating high-spending patients to a TIN not in the  
9 ACO. Thus, it would partially address selection against  
10 high-spending patients.

11           Second, claims occurring outside the ACO's  
12 current market should be removed from assignment  
13 calculations. This would prevent claims from other areas  
14 from being considered in the case of clinicians who either  
15 join the ACO after moving from a different market or leave  
16 the ACO midway through the performance assignment period  
17 and move into a different market.

18           Third, clinicians' claims would only be used for  
19 assignment to a single ACO. This would be needed in the  
20 case of a clinician billing under multiple TINs to prevent  
21 selection among that clinician's patients.

22           This recommendation will result in a decrease in

1 spending of less than \$50 million over one year and under  
2 \$1 billion over 5 years compared with current policy.

3 The recommendation would not have any effect on  
4 beneficiary access to care.

5 The impact on providers would likely be small.  
6 Some providers may receive smaller shared savings.

7 With that, we look forward to your discussion,  
8 and I turn it back to Jay.

9 DR. CROSSON: Thank you, Luis. Could you put the  
10 recommendation back up? Thank you.

11 So Dana is going to ask for Commissioner  
12 positions on the recommendation. She will do this as well  
13 in the voting process and in the subsequent treaty  
14 presentations and discussions that we have, but she'll use  
15 a different order. So you don't have to always think that  
16 you're going to be at the beginning or the end or even in  
17 the middle.

18 Dana?

19 MS. KELLEY: Okay. Kathy?

20 MS. THOMPSON: I support the recommendation.

21 MS. KELLEY: Larry?

22 DR. CASALINO: I support.

1 MS. KELLEY: Brian?  
2 DR. DeBUSK: I support the recommendation.  
3 MS. KELLEY: Karen?  
4 DR. DeSALVO: I support the recommendation.  
5 MS. KELLEY: Marge?  
6 MS. MARJORIE GINSBURG: Support.  
7 MS. KELLEY: Paul?  
8 DR. PAUL GINSBURG: Support.  
9 MS. KELLEY: David?  
10 DR. GRABOWSKI: Support.  
11 MS. KELLEY: Jonathan Jaffery?  
12 DR. JAFFERY: I support the recommendation.  
13 MS. KELLEY: Amol?  
14 DR. NAVATHE: I support.  
15 MS. KELLEY: Jon Perlin?  
16 DR. PERLIN: Support.  
17 MS. KELLEY: Bruce?  
18 [No response.]  
19 MS. KELLEY: Microphone? Say again, Bruce?  
20 MR. PYENSON: Support.  
21 MS. KELLEY: Jaewon?  
22 DR. RYU: Support.

1 MS. KELLEY: Dana?

2 DR. SAFRAN: Support.

3 MS. KELLEY: I don't think Warner is with us.  
4 I'll give him a second in case he is.

5 [No response.]

6 MS. KELLEY: Sue?

7 MS. THOMPSON: Support.

8 MS. KELLEY: And Pat?

9 MS. WANG: Support.

10 MS. KELLEY: Okay. Jay, that's everyone.

11 DR. CROSSON: Okay. Dana, now we'll take a vote,  
12 and we'd ask Commissioners to vote aye, no, or abstain.

13 MS. KELLEY: All right. Just to make sure the  
14 transcriptionist gets everything; I am going to use last  
15 names.

16 Casalino?

17 DR. CASALINO: Aye.

18 MS. KELLEY: DeBusk?

19 DR. DeBUSK: Aye. Yes.

20 MS. KELLEY: DeSalvo?

21 DR. DeSALVO: Aye.

22 MS. KELLEY: Ginsburg, Marjorie Ginsburg?

1 MS. MARJORIE GINSBURG: Aye.  
2 MS. KELLEY: Paul Ginsburg?  
3 DR. PAUL GINSBURG: Aye.  
4 MS. KELLEY: Grabowski?  
5 DR. GRABOWSKI: Aye.  
6 MS. KELLEY: Jaffery?  
7 DR. JAFFERY: Aye.  
8 MS. KELLEY: Navathe?  
9 DR. NAVATHE: Aye.  
10 MS. KELLEY: Perlin?  
11 DR. PERLIN: Aye.  
12 MS. KELLEY: Pyenson?  
13 MR. PYENSON: Aye.  
14 MS. KELLEY: Ryu?  
15 DR. RYU: Aye.  
16 MS. KELLEY: Safran?  
17 DR. SAFRAN: Aye.  
18 MS. KELLEY: Thomas is not here.  
19 Thompson?  
20 MS. THOMPSON: Aye.  
21 MS. KELLEY: Wang?  
22 MS. WANG: Aye.

1 MS. KELLEY: Jay Crosson?

2 DR. CROSSON: Aye.

3 MS. KELLEY: And Buto?

4 MS. BUTO: Aye.

5 MS. KELLEY: That's everyone, Jay.

6 DR. CROSSON: I believe we heard 16 affirmatives,  
7 no negatives, no abstentions, and one Commissioner, Warner  
8 Thomas, not present.

9 MS. KELLEY: Correct.

10 DR. CROSSON: Okay. Thank you so much.

11 We'll now move on to the second presentation.

12 Okay. I see Shinobu, Rachel, and Eric. Shinobu,  
13 it looks like you're going to begin.

14 MS. SUZUKI: Yes.

15 DR. CROSSON: Go ahead.

16 MS. SUZUKI: Good afternoon. Today we're here to  
17 discuss draft recommendations to realign incentives in  
18 Medicare Part D. They reflect the Commission's work over  
19 the past year, including our June 2019 report to the  
20 Congress and the Commissioners' discussions during the four  
21 meetings we've had this cycle.

22 Next slide.

1 Trends in Medicare's payments to plans suggest  
2 that Part D needs to be restructured. Cost-based  
3 reimbursements for reinsurance and for low-income cost-  
4 sharing subsidies have grown, while risk-based capitated  
5 payments have declined. Those trends are counter to the  
6 original intent for the program, and cost-based payments  
7 undermine plans' incentives to manage benefits.

8 Part D's benefit design also results in  
9 misaligned incentives. Brand manufacturer discounts in the  
10 coverage gap lower brand prices artificially relative to  
11 generics. And because of the coverage gap and Medicare's  
12 generous reinsurance, plans do not bear much insurance  
13 risk. This structure may also affect manufacturers'  
14 pricing decisions because manufacturers may be able to gain  
15 market share by setting prices high and providing larger  
16 rebates. Those situations result in high cost sharing for  
17 some beneficiaries and higher program spending.

18 You've seen this slide several times, so I'll go  
19 through it quickly. The benefit for enrollees without the  
20 low-income subsidy is on the left and the benefit for LIS  
21 enrollees is on the right.

22 Here is the coverage gap. The figures show how

1 the coverage gap looks for brand-name drugs and biologics.  
2 The blue sections show plan liability, which is small for  
3 both types of beneficiaries in the coverage gap and in the  
4 catastrophic phase. By comparison, rebates for some brand-  
5 name products can exceed plans' liability in these parts of  
6 the benefit.

7 For non-LIS enrollees, in the coverage gap, there is 70  
8 percent brand discount, which distorts prices, because  
9 plans and enrollees don't get this discount for generics.  
10 What this shows is that the current structure doesn't give  
11 plans strong incentives to push back on high drug prices or  
12 to manage spending.

13 This table summarizes the key elements of the  
14 current benefit on the left and compares it with the  
15 restructured benefit on the right. Under these changes,  
16 the annual out-of-pocket threshold would roughly equal the  
17 amount that beneficiaries now pay under current law.

18 At the top, under the restructured benefit, the  
19 coverage gap would be eliminated for all enrollees and the  
20 coverage-gap discount would be discontinued. Plans would  
21 become responsible for 75 percent of spending between the  
22 deductible and the out-of-pocket threshold.

1           At the bottom, you can see the changes to the  
2 catastrophic phase. Enrollee cost-sharing would be  
3 eliminated and Medicare's reinsurance would be lowered from  
4 80 percent to 20 percent, as in our 2016 recommendations.  
5 There would be a new manufacturer discount of at least 30  
6 percent for brands and high-priced generics. The remaining  
7 costs -- 50 percent for brands and high-priced generics,  
8 and 80 percent for all other drugs -- would be plan  
9 liability.

10           Next slide.

11           MR. ROLLINS: Here's how the restructured benefit  
12 would look. There's a single benefit structure for all  
13 enrollees. The coverage gap has been eliminated, discounts  
14 have been shifted from the coverage gap to the catastrophic  
15 phase, and plans have more liability than they do now.  
16 Medicare would still cover 74.5 percent of the costs of the  
17 basic Part D benefit, but more of its subsidies would be  
18 provided through capitated payments instead of cost-based  
19 reinsurance. Medicare's LIS would continue to cover most  
20 or all out-of-pocket costs for low-income enrollees.

21           Some related policy changes would help make the  
22 transition to a restructured benefit successful. One set

1 of changes relates to the implementation of the new benefit  
2 structure. We think that the increase in plan liability in  
3 the catastrophic portion of the benefit should be phased in  
4 gradually, that CMS should recalibrate the Part D risk-  
5 adjustment model to ensure that payments to plans are  
6 adequately adjusted for differences in enrollees' health  
7 status, and that policymakers should make Part D's risk  
8 corridors more generous during the transition period to  
9 protect plans against unexpected financial losses.

10           The second set of changes would help Part D plans  
11 control drug spending and manage the additional risk they  
12 would bear. We think that LIS enrollees should be required  
13 to pay somewhat higher cost-sharing for non-preferred and  
14 non-formulary drugs, that plans should be allowed to use  
15 separate preferred and non-preferred tiers for high-cost  
16 specialty drugs, and that plans should have greater  
17 flexibility to manage spending in the protected drug  
18 classes.

19           This brings us to the three draft  
20 recommendations. The first restructures the Part D benefit  
21 and the other two make concurrent changes that give plans  
22 more tools and flexibility to manage spending and provide

1 greater financial protection during the transition to the  
2 new benefit. We've grouped the concurrent changes into two  
3 separate recommendations because some changes fall under  
4 the purview of the Congress while the Secretary of HHS  
5 would have responsibility for others.

6           The three recommendations should be viewed as an  
7 interrelated package of policy changes that balance the  
8 goals of ensuring Medicare's financial sustainability and  
9 providing beneficiaries with good access to prescription  
10 drugs.

11           The first draft recommendation reads:

12           The Congress should make the following changes to  
13 the Part D prescription drug benefit: Below the out-of-  
14 pocket threshold, eliminate the initial coverage limit;  
15 eliminate the coverage-gap discount program. Above the  
16 out-of-pocket threshold, eliminate enrollee cost sharing;  
17 transition Medicare's reinsurance subsidy from 80 percent  
18 to 20 percent; require pharmaceutical manufacturers to  
19 provide a discount equal to no less than 30 percent of the  
20 negotiated price for brand drugs, biologics, biosimilars,  
21 and high-cost generic drugs.

22           The second draft recommendation reads:

1 Concurrent with our recommended changes to the benefit  
2 design, the Congress should establish a higher copayment  
3 amount under the low-income subsidy for non-preferred and  
4 non-formulary drugs; give plan sponsors greater flexibility  
5 to manage the use of drugs in the protected classes; modify  
6 the program's risk corridors to reduce plans' aggregate  
7 risk during the transition to the new benefit structure.

8           The third draft recommendation reads:

9 Concurrent with our recommended changes to the benefit  
10 design, the Secretary should allow plans to establish  
11 preferred and non-preferred tiers for specialty-tier drugs;  
12 recalibrate Part D's risk adjusters to reflect the higher  
13 benefit liability that plans bear under the new benefit  
14 structure.

15           The Congressional Budget Office estimates that  
16 the three draft recommendations, taken together, would  
17 reduce federal Medicare spending by more than \$2 billion  
18 over one year and by more than \$10 billion over five years.  
19 CBO's estimates do not break out the effects of each  
20 component of the draft recommendations.

21           DR. SCHMIDT: For beneficiaries, the key  
22 advantage of the package of recommendations is that it

1 would eliminate cost sharing in the catastrophic phase.  
2 Beneficiaries would gain more complete financial  
3 protection. As a result, beneficiaries would have  
4 increased access to drug therapies, some of which are  
5 appropriate but also some that may be less appropriate or  
6 inappropriate.

7 LIS enrollees who use preferred drugs would not be affected  
8 by setting a higher LIS copayment for drugs on non-  
9 preferred tiers. Likewise, beneficiaries who use drugs on  
10 a preferred specialty tier would either see no change or  
11 lower out-of-pocket spending.

12 However, LIS enrollees who fill prescriptions for drugs on  
13 non-preferred tiers or non-formulary drugs and  
14 beneficiaries who use non-preferred specialty-tier drugs  
15 would need to switch medications, pay higher cost sharing,  
16 or seek tiering exceptions.

17           The effects of restructuring on beneficiary  
18 premiums would depend on a number of factors. The  
19 manufacturer discount rate could increase over time if  
20 catastrophic spending increases rapidly, which could  
21 moderate changes in premiums. Other factors would affect  
22 premiums too, such as how effectively plans manage

1 benefits.

2 Under the restructured benefit, more of  
3 Medicare's payments to plan sponsors would be capitated,  
4 which would give plan sponsors stronger incentives to  
5 manage spending and lower the financial benefit of placing  
6 high-price, highly rebated drugs on plan formularies.

7 Because there would be no cost-sharing once an  
8 enrollee reaches the out-of-pocket threshold, plan sponsors  
9 may find it more challenging to manage catastrophic  
10 spending. However, other new tools would help plans better  
11 manage spending and give sponsors more leverage in  
12 negotiations for rebates on some drugs.

13 Plans with larger numbers of LIS enrollees will  
14 see larger increases in plan liability. However, CMS would  
15 recalibrate its risk adjusters and make Medicare payments  
16 that, on average, compensate sponsors for the higher plan  
17 liability. Modified risk corridors would provide greater  
18 financial protection to plan sponsors, particularly smaller  
19 ones that may have less capacity to absorb unexpected costs  
20 of new therapies.

21 Today, employer group waiver plans receive a  
22 disproportionate share of manufacturer discounts because

1 those plans provide richer coverage and, under Part D's  
2 true out-of-pocket provision, their enrollees don't tend to  
3 reach the catastrophic phase. After restructuring, EGWPs  
4 would receive fewer discounts, but they should have some  
5 lead time to modify their benefit packages.

6           The effects on manufacturers would vary by  
7 company. Eliminating the coverage-gap discount and  
8 replacing it with a discount in the catastrophic phase  
9 would shift much of the discount liability from  
10 manufacturers of brand products with lower prices to  
11 manufacturers of high-price products. We anticipate that  
12 the policy changes would affect manufacturers' pricing  
13 behavior, but exactly how depends on factors such as  
14 Medicare's market share for each product and how much  
15 competition a product faces within its therapeutic class.

16           Because plans would have stronger incentives to  
17 manage spending and new tools to do so, some manufacturers  
18 may see lower Part D revenues or have less ability to raise  
19 prices. At the same time, other manufacturers may launch  
20 at higher prices. Going forward, different outcomes across  
21 manufacturers may affect the mixture of future research and  
22 development projects.

1           Next slide.

2           This slide summarizes the draft recommendations.  
3 Together, they make up an interrelated package that's  
4 designed to strengthen plan incentives and tools under Part  
5 D's market-based approach. We think these changes would  
6 restore the risk-based capitated approach envisioned in  
7 Part D's original design, and eliminate program features  
8 that distort market incentives and create inflationary  
9 pricing pressure and higher program costs.

10           Thank you for your attention.

11           DR. CROSSON: Thank you, Shinobu and Rachel. I  
12 want to make just one suggestion here on how to proceed. I  
13 think we can take the discussion part, if we want to call  
14 it that, of support, et cetera, as one body. We will need  
15 to vote separately on each of the recommendations, however.

16           In terms of this phase, I would like to make  
17 slight change, particularly given the complexity of this,  
18 which would be to offer Commissioners to express either  
19 support, general support with following reservations, and  
20 then lack of support, because I think there may be some  
21 Commissioners who generally support this but have a  
22 particular perspective that they would like to add.

1           So Dana, with that, you can begin.

2           MS. KELLEY: Okay. Why don't we start with Paul  
3 Ginsburg?

4           DR. PAUL GINSBURG: Yeah. I fully support.

5           MS. KELLEY: Jon Perlin?

6           DR. PERLIN: Support. Thank you.

7           MS. KELLEY: Dana Safran?

8           DR. SAFRAN: Support.

9           MS. KELLEY: Brian DeBusk?

10          DR. DeBUSK: I fully support it.

11          MS. KELLEY: David?

12          DR. GRABOWSKI: Support.

13          MS. KELLEY: Bruce?

14          MR. PYENSON: I generally support. However, I  
15 strongly oppose the transition for the period for the  
16 catastrophic for three reasons. I am very strongly in  
17 support of the change, and especially given the discussion  
18 we just had about the dramatic transitions in the health  
19 care system today in response to COVID. It seems silly to  
20 extend, over multiple years, in an environment where we  
21 have exquisite data, foresight over new products coming in,  
22 and increased protection through risk corridors.

1           I think the paper and the staff has done an  
2 extraordinary job of identifying the pathology of the  
3 current structure, and I see no reason to prolong that. So  
4 the first objection is that a transition will be a  
5 hindrance to new market entrants because new market  
6 entrants will not be successful playing the pathological  
7 game that staff has identified.

8           I had mentioned the risk corridor protection, but  
9 let's recognize that part of the protection is that moving  
10 from a 20 percent to a 30 percent manufacturer  
11 recommendation also diminishes the plan liability from 60  
12 percent to 50 percent in that period.

13           My third reason is that a transition would  
14 require separate risk adjustments for each year of  
15 transition, and it is hard enough to get risk adjustment  
16 right, and the transition requires that over a course of  
17 three years.

18           So I am enthusiastically supporting the new  
19 structure and the work behind it. I just think transition  
20 is the wrong way to go, and I see no evidence from anybody,  
21 including staff, that the financial risks are such that we  
22 should support it.

1 DR. CROSSON: Bruce, I think I will weigh in  
2 here. I do remember, and I think the rest of the  
3 Commissioners remember the points that you made in March,  
4 quite similar to this point of view. We did, at the time,  
5 entertain the possibility of doing some further analysis to  
6 support your position, for example, an analysis of the  
7 potential for a hybrid model where new entrants would have  
8 a different ability to come, and the second one was the  
9 notion of trying to understand the relative impact of  
10 existing plans on having no transition.

11 As I mentioned in the March meeting, and given  
12 the time frame that was required, to say nothing about what  
13 has happened subsequently, it has not been possible to do  
14 those analyses, unfortunately.

15 I do, however, recognize that the point you've  
16 made here, which is that the transition could potentially  
17 inhibit the entrance of as-yet to be described new entrants  
18 into the market, was not mentioned at all in the material,  
19 and I do believe, and I think I've taken a look at where  
20 that could be inserted, simply to say that the point has  
21 been made that this is a possibility. So I just wanted to  
22 let you know that.

1 Dana, you can proceed.

2 MS. KELLEY: Okay. Karen?

3 DR. DeSALVO: I support.

4 MS. KELLEY: Amol?

5 DR. NAVATHE: Support.

6 MS. KELLEY: Jaewon?

7 DR. RYU: Support.

8 MS. KELLEY: Sue?

9 MS. THOMPSON: Support.

10 MS. KELLEY: Larry?

11 DR. CASALINO: A quick question. Is this on  
12 draft recommendation 1 or all three?

13 DR. CROSSON: It's all three, Larry.

14 DR. CASALINO: Can I just see number 2 for a  
15 second? So I realize we don't want to count micro in the  
16 recommendations, but the first bullet point there,  
17 establish a higher copayment amount, blah-blah-blah, for  
18 low-income subsidy beneficiaries. Is there any reason for  
19 concern that Congress could say a higher copayment amount?  
20 We had in our materials, I think, looked at very low  
21 copayment increases, or copayments. Is there any concern  
22 that that's not the way Congress would see it, and is there

1 any reason to worry, you know, establish a slightly higher  
2 copayment amount, or something like that?

3 DR. CROSSON: So let me ask Jim or the staff to  
4 comment on whether -- because I don't have it in front of  
5 me right now -- whether the language in the text would make  
6 it clearer to what our intent is here.

7 MR. ROLLINS: There is additional detail in the  
8 text on this point. For example, we have a table in the  
9 chapter that sort of lays out here's the cost-sharing  
10 structure that LIS beneficiaries face now, here's what they  
11 would face under this higher co-payment that kind of lays  
12 out we're talking about these sets of drugs, about other  
13 sets of drugs and sort of we can be careful to make sure  
14 that we're talking -- you know, that the magnitude we have  
15 in mind is sort of, you know, relatively modest. We didn't  
16 want to get into obviously specific dollar amounts, but I  
17 think the surrounding text sort of makes all of those  
18 points.

19 DR. CASALINO: I know that the text is there, and  
20 I think it's great. My question is just: Will the text  
21 have that much influence compared to the recommendation?  
22 And should there just be an adjective in front of "higher"?

1 And I don't know, so I'll shut up, but that's my question.  
2 I support the recommendations. I'm just asking if we  
3 should have an adjective in front of "higher" there. That  
4 would perhaps make it less likely that someone in Congress  
5 would jump on this and say, oh, great, you know, let's make  
6 it \$30.

7 DR. CROSSON: Okay. So in terms of altering the  
8 recommendation, Larry, do you have a specific word that  
9 you're suggesting?

10 DR. CASALINO: Again, I don't have the experience  
11 to know whether it matters or not, and I really would defer  
12 to Jim and the staff and others who are knowledgeable.  
13 But, you know, when I read this, I thought I'd feel more  
14 comfortable if it said "slightly," "modestly," something  
15 like that. But, again, I may be splitting hairs here that  
16 don't need to be split, so I'd defer to what others think.

17 DR. MATHEWS: So I would suggest leaving it as  
18 is. If we do get into the process of advising Congress on  
19 specific legislative language, we can convey this and point  
20 them to, you know, the surrounding text here. But  
21 including a term that says "modestly" or "slightly" or  
22 "nominally" or something like that, those are sufficiently

1 subjective that while they might convey we're talking about  
2 magnitudes of, you know, \$10 and not \$100, it still isn't  
3 specific enough to constrain, you know, the kind of  
4 reaction that you might be anticipating. My recommendation  
5 would be to leave the language as is.

6 DR. CASALINO: All right. And I would support it  
7 as is.

8 DR. CROSSON: Okay. Thank you, Larry.  
9 Dana, proceed.

10 MS. KELLEY: Pat.

11 MS. WANG: So I think -- you know, my  
12 appreciation to Jim and the team for producing what I think  
13 is the most comprehensive and thoughtful and well-  
14 researched implementation, you know, sort of road map for  
15 the original proposal that had its roots I guess in the  
16 2017-ish recommendation of MedPAC to shift the risk in  
17 reinsurance where it's magnificent. The chapter is  
18 incredibly comprehensive. I truly appreciate all of the  
19 extra work that has been done and the sensitivity to the  
20 LIS population, to regional plans.

21 My dilemma is that in the current environment, it  
22 has made me sort of sit back and sort of try to visualize

1 if this structure were in place today, what would that  
2 actually mean to my plan or to a plan that is like mine.  
3 Hopefully, God willing, it will be seen sooner than later.  
4 No idea how much it's going to cost. Forty million seniors  
5 are going to be running out to get it. There may be other  
6 treatment modalities. There may be treatment modalities  
7 that exist today that will spike in cost. It's just hard  
8 to know. And it's not specific to this crisis because this  
9 is extraordinary, what we're going through, but what it has  
10 made me kind of visualize is how do you do a bid when there  
11 are new drugs coming in, you have no idea what utilization  
12 and cost is going to be. And so I think, you know,  
13 Congress is going to go forward with this thing. This is  
14 the best possible road map they could have to do it.

15 I wasn't here in 2017 when the original MedPAC  
16 recommendation was made to shift the liability, and so I am  
17 going to abstain.

18 DR. CROSSON: Thank you, Pat. I would point out  
19 that it is our hope -- no guarantee at all -- that as this  
20 plays out, and it may well play out as you describe, there  
21 will be consideration in terms of the bidding process,  
22 because I think there's already recognition of the point

1 that you're making.

2 Go ahead, Dana.

3 MS. KELLEY: Kathy.

4 MS. BUTO: So I strongly support the  
5 recommendations. I really think the restructuring is a  
6 brilliant stroke. I'm excited to see the coverage gap go  
7 away. I think you're aligning the incentives in the right  
8 direction.

9 I agree with Bruce on one level, not so much his  
10 point of no transition, but I think the transition needs to  
11 be more clearly explained because saying four years, it  
12 wasn't clear to me in reading the chapter how it was going  
13 to work. I assumed the coverage gap would go away right  
14 away and manufacturers would shift to the catastrophic area  
15 with their discounts. And I assumed what you were talking  
16 about for transition were the risk corridors, percentages  
17 that plans and manufacturers and the federal government  
18 would have to bear -- in other words, above the cap. I  
19 assumed you're wanting to be sensitive to plans having to  
20 shift to a large chunk of risk. We might want to either  
21 keep manufacturers at 30 or go to 20 and then ramp up to 30  
22 when you go to fully phase in. But you'd want the federal

1 government to absorb more of the risk during the  
2 transition, I assume. But I didn't see that clearly  
3 spelled out or I missed it if it was there.

4           So I would urge you to be clearer on that, and I  
5 would actually suggest we might want to consider a shorter  
6 transition. Four years just seems like a lot to me. I  
7 think PPS was only three years. Jim, maybe it was four.  
8 But the whole inpatient DRG system didn't take, I don't  
9 believe, four years.

10           DR. CROSSON: It actually was four years, Kathy.

11           MS. BUTO: It was? Okay. The whole DRG system,  
12 the whole hospital system. So all I'm saying is I think  
13 that's being super generous, and I'm not sure that we need  
14 the extra year.

15           Lastly, to Pat's point -- and I think she's  
16 pointed something out that's really important -- with MA  
17 plans, when a new technology comes along that hasn't been  
18 anticipated, there is the ability to provide an add-on  
19 payment, and I think there ought to be some acknowledgment  
20 that for extraordinary circumstances there ought to be some  
21 process for plans to come in and make their case, and maybe  
22 you use sort of the adjudication process that we talked

1 about earlier to really assess whether or not there ought  
2 to be an extra payment. In other words, it shouldn't be  
3 automatic. We don't want to create another TDAPA. But  
4 there should be a way, when there's extraordinary  
5 circumstances totally out plans' control and the timing is  
6 not right to anticipate it, for there to be some redress  
7 for those circumstances.

8 So I would suggest those points.

9 DR. CROSSON: Thank you, Kathy.

10 Dana, you can proceed.

11 MR. PYENSON: Just on that point, Jay.

12 DR. CROSSON: Yes.

13 MR. PYENSON: There's currently a process where  
14 PD plans don't have to put new drugs on their formulary  
15 right away. Now, there might be extraordinary issues like  
16 a new vaccine comes along and that gets required. But  
17 there's currently a delay process to allow for medical  
18 review and appropriateness and contracting and everything  
19 else. So that exists today. And it's not like plans don't  
20 know what's coming. There's PIPLA (phonetic). There's  
21 sources of pipeline information, expected dates of FDA  
22 approval indications that are readily available to the

1 plans.

2 MS. BUTO: But they don't know what the prices  
3 are going to be, Bruce, even while they're --

4 MR. PYENSON: Actually they do pretty well. I  
5 mean, there's sort of benchmarks for different prices  
6 depending on what the market has borne for other  
7 conditions. So what I've seen is that there's an  
8 expectation that, for example, any new MS drug is going to  
9 be around \$100,000. A rare ultra-orphan gene therapy  
10 curative is going to be in the, you know, million-dollar  
11 range. Not that many of those are used for Medicare  
12 patients. CAR-T therapy was kind of known in advance.

13 But the bigger issue for Part D isn't the new  
14 drugs. It's the existing drugs, right? If you look at the  
15 driver of trend -- and MedPAC has reported on this -- it's  
16 not the new technology. It's the price rise in existing  
17 specialty drugs. I'd ask staff to confirm that or not.

18 DR. CROSSON: Okay. I'm going to interrupt  
19 because I think we're getting a little far afield. I  
20 appreciate the discussion, but I'd like to proceed with  
21 positioning, and then we have three votes to go through.

22 MS. KELLEY: Okay. Marge?

1 MS. MARJORIE GINSBURG: Support.

2 MS. KELLEY: Jonathan?

3 DR. JAFFERY: Support.

4 MS. KELLEY: And Warner is not present, so I  
5 think we're done. Oh, wait, I'm sorry, he is here.

6 MR. THOMAS: Support.

7 MS. KELLEY: Okay. That's all, Jay.

8 DR. CROSSON: And I support as well. Okay. So I  
9 suppose we could do them all together, but I think to be  
10 consistent with how we've done work in the past on the  
11 Commission, we'll take each recommendation in turn,  
12 starting with Recommendation Number 1.

13 MS. KELLEY: Okay. The recommendation is up  
14 there on the screen, and I'll run through and ask for a  
15 yes, no, or abstain. Kathy?

16 MS. BUTO: Support, yes.

17 MS. KELLEY: Larry?

18 DR. CASALINO: Support.

19 MS. KELLEY: Brian?

20 DR. DeBUSK: Yes.

21 MS. KELLEY: Karen?

22 DR. DeSALVO: Yes.

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

1 MS. KELLEY: And Pat?

2 MS. WANG: I abstain.

3 DR. CROSSON: And Jay says yes.

4 MS. KELLEY: And Jay.

5 DR. CROSSON: I believe we have 16 votes yes and  
6 one abstention. Is that correct?

7 MS. KELLEY: Correct.

8 Now to Recommendation 2. The recommendation is  
9 up on the screen. Pat?

10 MS. WANG: Abstain.

11 MS. KELLEY: Sue?

12 MS. THOMPSON: Yes.

13 MS. KELLEY: Warner?

14 MR. THOMAS: Yes.

15 MS. KELLEY: Dana?

16 DR. SAFRAN: Sorry, I was muted. Yes.

17 MS. KELLEY: Jaewon?

18 DR. RYU: Yes.

19 MS. KELLEY: Bruce?

20 MR. PYENSON: Yes.

21 MS. KELLEY: Jon Perlin?

22 DR. PERLIN: Yes.

1 MS. KELLEY: Amol?  
2 DR. NAVANTHE: Yes.  
3 MS. KELLEY: Jonathan Jaffery?  
4 DR. JAFFERY: Yes.  
5 MS. KELLEY: David?  
6 DR. GRABOWSKI: Yes.  
7 MS. KELLEY: Paul?  
8 DR. PAUL GINSBURG: Yes?  
9 MS. KELLEY: Marge?  
10 MS. MARJORIE GINSBURG: Yes.  
11 MS. KELLEY: Karen?  
12 DR. DeSALVO: Yes.  
13 MS. KELLEY: Brian?  
14 DR. DeBUSK: Yes.  
15 MS. KELLEY: Larry?  
16 DR. CASALINO: Yes.  
17 MS. KELLEY: Kathy?  
18 MS. BUTO: Yes.  
19 MS. KELLEY: Jay?  
20 DR. CROSSON: Yes. I believe we have 16 yes and  
21 1 abstention.  
22 MS. KELLEY: Yes. And now Recommendation 3. The

1 recommendation is up on the screen. Paul?

2 DR. PAUL GINSBURG: Yes.

3 MS. KELLEY: Karen?

4 DR. DeSALVO: Yes.

5 MS. KELLEY: Jonathan Jaffery?

6 DR. JAFFERY: Yes.

7 MS. KELLEY: Larry?

8 DR. CASALINO: Yes.

9 MS. KELLEY: Jon Perlin?

10 DR. PERLIN: Yes.

11 MS. KELLEY: Kathy?

12 MS. BUTO: Yes.

13 MS. KELLEY: Dana?

14 DR. SAFRAN: Yes.

15 MS. KELLEY: Brian?

16 DR. DeBUSK: Yes.

17 MS. KELLEY: Jaewon?

18 DR. RYU: Yes.

19 MS. KELLEY: Marge?

20 MS. MARJORIE GINSBURG: Yes.

21 MS. KELLEY: Pat?

22 MS. WANG: I abstain.

1 MS. KELLEY: Amol?  
2 DR. NAVANTHE: Yes.  
3 MS. KELLEY: Warner?  
4 MR. THOMAS: Yes.  
5 MS. KELLEY: David?  
6 DR. GRABOWSKI: Yes.  
7 MS. KELLEY: Bruce?  
8 MR. PYENSON: Yes.  
9 MS. KELLEY: Sue?  
10 MS. THOMPSON: Yes.  
11 MS. KELLEY: And Jay  
12 DR. CROSSON: Yes. I believe we have 16 yes and  
13 1 abstention.  
14 MS. KELLEY: Yes, that's correct.  
15 DR. PAUL GINSBURG: Is it possible to give Warner  
16 a chance to vote on the ACO recommendation now that he's  
17 here?  
18 DR. CROSSON: You know, there is precedent for  
19 that. As much as I would like to do that, the Commission  
20 precedent is we do not go back and revisit votes.  
21 Okay. Let's proceed to the third of the  
22 recommendations.

1 MS. KELLEY: Jay, I think we've gone through all  
2 the Part D recommendations, and we're ready to move to the  
3 next --

4 DR. CROSSON: I'm sorry. I meant the next item  
5 of business.

6 MS. KELLEY: Okay.

7 DR. CROSSON: Okay. Ready to begin. We've got  
8 Andy, Carlos, and Sam on as well? I see Carlos.

9 MS. TABOR: And Ledia.

10 DR. CROSSON: Oh, and Ledia? Okay.

11 So it looks like, Andy, you've got your  
12 microphone on you. It looks like you're going to be it.  
13 Go ahead.

14 DR. JOHNSON: Good afternoon. I'll be presenting  
15 on behalf of our team, including Ledia, Carlos, and Sam.

16 We are here to discuss the draft recommendation  
17 to implement a redesigned value incentive program for MA.  
18 The design of the value incentive program was initially  
19 published in our June 2019 report to the Congress and  
20 discussed at several Commission meetings over the past  
21 year.

22 During the discussion at the March meeting, the

1 Commission made clear that although today's recommendation  
2 would produce savings for the Medicare program and its  
3 beneficiaries, the Commission is not rendering a judgement  
4 on the appropriate level of payments to MA plans overall.

5           Reforming the quality bonus program is a matter  
6 of urgency. One-third of Medicare beneficiaries are now  
7 enrolled in Medicare Advantage, and that number is growing.  
8 MA plans have the potential to be more efficient than fee-  
9 for-service Medicare while providing high-quality care.  
10 However, the Medicare program does not have the tools to  
11 judge the quality of care MA plans provide, and  
12 beneficiaries do not receive accurate information about  
13 plan options.

14           The current QBP uses broad contract-level quality  
15 results that have spurred contract consolidation and led to  
16 unwarranted bonus payments.

17           The QBP ineffectively accounts for social risk  
18 factors of plan populations, and plans that serve high-  
19 needs population are less likely to be classified as high-  
20 quality plans.

21           Also, the QBP adds \$6 billion per year in program  
22 costs, unlike nearly all fee-for-service quality incentive

1 programs, which are budget-neutral or produce program  
2 savings.

3 Over the course of the quality bonus program,  
4 many companies consolidated contracts to boost star ratings  
5 and obtain unwarranted bonuses.

6 As of 2020, the majority of MA enrollees are in  
7 plans that have some level of consolidation.

8 Although recent legislation has limited plans'  
9 ability to use the consolidation strategy to obtain  
10 unwarranted bonuses, the legacy of past consolidation  
11 continues to result in increased program expenditures,  
12 inaccurate consumer information on quality, and quality  
13 data that is not representative of performance in a local  
14 area.

15 In addition, past consolidations have given some  
16 companies an unfair competitive advantage in certain  
17 markets.

18 Over the next several slides, I will walk through  
19 the key design features of the MA value incentive program.

20 First, the value incentive program scores a small  
21 set of population-based measures that focus on patient  
22 outcomes and experience.

1           This table displays an illustrative measure set  
2 that incorporates the Commission's discussion. It is not a  
3 definitive list of measures. CMS should develop a complete  
4 measure set through a public review and input process that  
5 could evolve as better data, including encounter data,  
6 become available.

7           In our illustrative modeling, we scored the six  
8 measures noted with an asterisk, which are the only  
9 measures with sufficient beneficiary-level encounter or  
10 survey data.

11           The value incentive program evaluates quality at  
12 the local market level, meaning it scores a plan's  
13 performance for the enrollees in each local market area as  
14 opposed to the contract.

15           Using market-level measure results provides a  
16 more accurate picture of quality, both for beneficiaries to  
17 select a plan in their market and for the Medicare program  
18 to understand plan performance.

19           In our illustrative modeling, we used a parent  
20 organization within a local area as the reporting unit and  
21 limited our analysis to markets with sufficient enrollment  
22 to reliably calculate measure results.

1 Medicare should take into account, as necessary,  
2 differences in enrollee populations, including social risk  
3 factors.

4 One way to do this is to stratify plan enrollment  
5 into groups of beneficiaries with similar social risk  
6 factors to determine payment adjustments. Comparing  
7 beneficiary groups with similar compositions accounts for  
8 social risk factors without masking disparities in plan  
9 performance, which occurs when measure results are adjusted  
10 directly.

11 In our illustrative modeling, we stratified each  
12 parent organization's enrollment into two peer groups and  
13 then calculated measure results for each of the groups. We  
14 used eligibility for full Medicaid benefits because it is  
15 readily available in our data sources and capture the  
16 characteristic that may affect a plan's ability to serve  
17 its enrollees. Policymakers could explore other factors  
18 for potential peer grouping.

19 The value incentive program uses a performance-  
20 to-points scale for each measure to convert a plan's  
21 performance to a score which determines the rewards and  
22 penalties the plan receives. There are two key features of

1 this scoring mechanism.

2 First, plans know that performance improvements  
3 can impact their rewards, which can drive quality  
4 improvement.

5 Second, the scale is continuous, meaning that  
6 every change in performance will affect the number of  
7 points achieved and the size of any reward or penalty.  
8 Unlike the current QBP, there are no performance cliffs in  
9 the scoring.

10 In our illustrative modeling, we set each  
11 measure's scale based on a beta distribution of current  
12 national performance.

13 Rewards in the value incentive program would be  
14 financed through a pool of dollars that is funded by a  
15 share of plan payments.

16 A key change from the current quality bonus  
17 program is that quality bonuses would not increase plan  
18 benchmarks. Instead, the value incentive program would  
19 redistribute plan payments based on quality performance.

20 Reward pools would be distributed within each  
21 local market based on local performance, resulting in some  
22 parent organizations receiving rewards and others receiving

1 penalties. Local distribution controls for varying market  
2 conditions, including differences in safety net programs,  
3 like Medicaid and food assistance, that could cause a plan  
4 applying the same quality strategy to have different  
5 results across markets.

6 Based on the Commission's discussion during the  
7 March meeting, we revised the chapter to reflect the  
8 Commission's support for distributing rewards and penalties  
9 at a local market level as opposed to a national or blended  
10 approach.

11 Your mailing materials contain information about  
12 our illustrative modeling of the MA value incentive  
13 program, but here are the main points.

14 First, local distribution of reward pools  
15 guaranteed that some parent organizations received rewards  
16 and other received penalties and controlled for varying  
17 market level conditions. We think that the market-specific  
18 conditions contributed to differences in average market  
19 performance, which varied from 3.5 to 7.5 points out of 10.

20 Second, fully dual-eligible enrollee peer groups  
21 tended to have lower quality scores than the all-other  
22 enrollee peer group. This result highlights the need for

1 stratifying enrollees into peer groups to account for  
2 differences in social risk factors through the distribution  
3 of rewards and penalties within those populations.

4           Finally, payment adjustments tended to be small  
5 in our modeling. When implemented, payment adjustments  
6 could be scaled appropriately by adjusting the performance  
7 to points scale or the share of plan payments used to  
8 finance the program.

9           Finally, I will note that there are differences  
10 in how plans fare in the value incentive program as  
11 compared to the current QBP. The three most important  
12 differences are, first, plans enrolling large shares of  
13 fully dual eligible beneficiaries are treated more fairly  
14 under the value incentive program. Second, large  
15 organizations that had an undue advantage in the QBP system  
16 have less of an advantage in the value incentive program,  
17 and third, the value incentive program would better target  
18 positive financial results. Some plans that are not in  
19 bonus status would perform better under the value incentive  
20 program. These plans tend to be smaller and operate in  
21 single markets or limited geographic areas.

22           That brings us to the draft recommendation, which

1 reads "The Congress should replace the current Medicare  
2 Advantage quality bonus program with a new value incentive  
3 program that scores a small set of population-based  
4 measures, evaluates quality at the local market level, uses  
5 a peer grouping mechanism to account for differences in  
6 enrollees' social risk factors, establishes a system for  
7 distributing rewards with no cliff effects, and distributes  
8 plan-financed rewards and penalties at a local market  
9 level."

10 Next slide, please. We should be on Slide 12.

11 MS. KELLEY: Is that it?

12 DR. JOHNSON: Thank you.

13 We seem to have a slightly different slide than  
14 we have in our deck. That looks like the Part B slide.

15 MS. KELLEY: Hang on. Let me make a switch.

16 Just one second.

17 DR. JOHNSON: That's the one. All right. Back  
18 on Slide 12.

19 The rationale for the draft recommendation is  
20 that the QBP is flawed and does not provide a basis for  
21 evaluating MA quality in meaningful way. Plans have also  
22 received unwarranted bonus under the QBP system.

1           The QBP increases Medicare program spending. A  
2 plan-financed value incentive program that does not involve  
3 additional dollars would put the MA quality incentive  
4 program on par with nearly all fee-for-service quality  
5 incentive programs, which are budget-neutral or produce  
6 program savings.

7           Compared to the QBP, the value incentive program  
8 will provide the Medicare program and its beneficiaries  
9 with more accurate information on MA quality and will  
10 produce a fairer distribution of incentive payments across  
11 market areas and across MA enrollees.

12           The implication on spending is that the draft  
13 recommendation would reduce program spending relative to  
14 current law by more than \$2 billion over one year and by  
15 more than \$10 billion over five years. The chapter clearly  
16 states that in making the recommendation, the Commission is  
17 not rendering a judgement on the appropriate level of  
18 overall payments to MA plans.

19           The recommendation is not expected to affect  
20 beneficiaries' access to plans or plan participation in MA.

21           Depending on how plans respond to the lower  
22 benchmarks that some plans would face, extra benefits may

1 be reduced, plans may choose to reduce profits, or plans  
2 may lower their cost of providing the Medicare benefit.

3 Plans serving high-needs populations would be  
4 treated more equitably, putting those plans on more even  
5 footing in competing with other plans in their area and  
6 possibly improving the level of extra benefits for their  
7 enrollees.

8 Finally, beneficiaries will have better  
9 information on the quality of plans in their area, but some  
10 plans will have higher administrative costs due to the  
11 additional surveys required to produce quality information  
12 in each local market area.

13 That concludes the presentation, and now we'll  
14 turn back to the draft recommendation for your discussion.

15 DR. CROSSON: Okay. Thank you, Andy.

16 So we will proceed, and again, I would suggest  
17 that Commissioners either respond by support, generally  
18 support with a comment, or do not support.

19 Dana, you can begin.

20 MS. KELLEY: Okay. Amol?

21 DR. NAVATHE: Support.

22 MS. KELLEY: Bruce?

1 MR. PYENSON: Support.

2 MS. KELLEY: Dana?

3 DR. SAFRAN: Support.

4 MS. KELLEY: Sue?

5 MS. THOMPSON: Support.

6 MS. KELLEY: Pat?

7 MS. WANG: I support, and I think you guys did a  
8 fabulous job.

9 I just would note I still think that like nothing  
10 on Part D -- somebody is going to have to do like part two  
11 of this to figure out what should happen with the Part D  
12 quality measures. But I support.

13 MS. KELLEY: Warner?

14 MR. THOMAS: Support.

15 MS. KELLEY: Kathy?

16 MS. BUTO: Support.

17 MS. KELLEY: Paul?

18 DR. PAUL GINSBURG: Support.

19 MS. KELLEY: Jonathan Jaffery?

20 DR. JAFFERY: Support.

21 MS. KELLEY: Jaewon?

22 DR. RYU: Support.

1 MS. KELLEY: Jon Perlin?

2 DR. PERLIN: Generally support with two comments.

3 First, I'm worried about the effects of unintended  
4 consequences of -- even though I totally agree that this  
5 should be -- operate just like all of the other value-  
6 incentive programs, where it's out of the corpus, as  
7 opposed to an add-on. I do worry that it will have some  
8 downstream effect on providers, particularly coming out of  
9 COVID.

10 Second, while I totally agree in principle with  
11 the notion of redistributing the dollars to the local  
12 market, it strikes me that as a practical matter, those  
13 national organizations that operate in different markets  
14 will essentially redistribute on the basis of fungible  
15 dollars, not these dollars. So I think the intent is  
16 correct, but I'm somewhat skeptical of the operation it  
17 takes in a multimarket interest. Thanks.

18 DR. CROSSON: Dana, you can proceed.

19 MS. KELLEY: Okay. Marge?

20 MS. MARJORIE GINSBURG: Support.

21 MS. KELLEY: David?

22 DR. GRABOWSKI: Support.

1 MS. KELLEY: Brian?

2 DR. DeBUSK: Support and appreciative that we  
3 teased apart the level of payment from the mechanics of the  
4 QBP.

5 MS. KELLEY: Larry?

6 DR. CASALINO: I think this is excellent work,  
7 and I support it.

8 The only comment I would make -- and I think I  
9 made it before -- is that although I totally support  
10 providing incentives and presumably public reporting of  
11 quality at the local level, I think there also ought to be  
12 public reporting of quality at the national level so that a  
13 local plan can be rewarded for doing well compared to other  
14 local plans. But I still think that beneficiaries,  
15 business leaders, you name it, in a local area should see  
16 how their plans compare on a national level and not just to  
17 each other locally, even though the payments are all going  
18 to be the -- the rewards are only going to be distributed  
19 on the local level. I think that ought to be important.  
20 But I support things as they are.

21 MS. KELLEY: Okay. Karen?

22 DR. DeSALVO: Support.

1 MS. KELLEY: And Jay?

2 DR. CROSSON: Well, it's my recommendation. I  
3 kind of support it. Okay. You can proceed to the vote.

4 DR. SAFRAN: You're getting snarky towards the  
5 end of your term.

6 [Laughter.]

7 MS. KELLEY: All right. The draft recommendation  
8 is up on the screen. Yes, no, or abstain.

9 Kathy?

10 MS. BUTO: Yes.

11 MS. KELLEY: Karen?

12 DR. DeSALVO: Yes.

13 MS. KELLEY: Amol?

14 DR. NAVATHE: Yes.

15 MS. KELLEY: Jon Perlin?

16 DR. PERLIN: Yes.

17 MS. KELLEY: Brian?

18 DR. DeBUSK: Yes.

19 MS. KELLEY: David?

20 DR. GRABOWSKI: Yes.

21 MS. KELLEY: Dana?

22 DR. SAFRAN: Yes.

1 MS. KELLEY: Warner?  
2 MR. THOMAS: Yes.  
3 MS. KELLEY: Pat?  
4 MS. WANG: Yes.  
5 MS. KELLEY: Larry?  
6 DR. CASALINO: Yes.  
7 MS. KELLEY: Sue?  
8 MS. THOMPSON: Yes.  
9 MS. KELLEY: Marge?  
10 MS. MARJORIE GINSBURG: Yes.  
11 MS. KELLEY: Jonathan Jaffery?  
12 DR. JAFFERY: Yes.  
13 MS. KELLEY: Paul?  
14 DR. PAUL GINSBURG: Yes.  
15 MS. KELLEY: Bruce?  
16 MR. PYENSON: Yes.  
17 MS. KELLEY: Jaewon?  
18 DR. RYU: Yes.  
19 MS. KELLEY: And Jay?  
20 DR. CROSSON: Yes.  
21 I believe I heard 17 affirmative votes; is that  
22 correct?

1 MS. KELLEY: That is correct.

2 DR. CROSSON: Okay. Thank you. So we'll move on  
3 to the last item of business.

4 MS. RAY: Are we ready?

5 DR. CROSSON: Nancy, you're still there, and Andy  
6 is still there? Yeah, I see Andy. I don't see Nancy, but  
7 you must be somewhere off to the side here.

8 MS. KELLEY: Nancy, can you turn your -- there  
9 you are.

10 MS. RAY: Here I am.

11 DR. CROSSON: Okay. So Nancy, are you going to  
12 begin?

13 MS. RAY: Yes.

14 DR. CROSSON: Go right ahead.

15 MS. RAY: Thank you. Good afternoon. Andy and I  
16 will walk you through two draft recommendations aimed at  
17 improving Medicare's payments for dialysis services. We  
18 have discussed these issues for a couple of cycles and have  
19 developed the draft recommendations over the last several  
20 Commission meetings.

21 I will take you through the first policy option,  
22 eliminating the transitional drug add-on payment

1 adjustment, the TDAPA, for new drugs in an existing ESRD  
2 functional category. Andy will take you through the second  
3 option, to replace the low volume payment adjustment and  
4 rural adjustment with a single payment adjuster, what we  
5 call the low-volume and isolated adjustment.

6           Before beginning, a few housekeeping issues. The  
7 draft chapter has been revised to reflect your questions  
8 and comments from the March meeting. For example, Bruce, we  
9 have added text on dialysis organizations having long-term  
10 contracts with drug manufacturers. Warner, we have added a  
11 table that addresses your question, facilities receiving  
12 the low-volume payment adjustment are less likely to be  
13 associated with the two large dialysis organizations. And  
14 Brian, we have added a table showing that the adjusted cost  
15 per treatment for urban versus rural dialysis facilities is  
16 similar after adjusting for total treatment volume.

17           Recall that there are two TDAPA policies for new  
18 dialysis drugs. In the first, highlighted in the center  
19 column, the TDAPA applies to new drugs that are not in one  
20 of the 11 existing ESRD functional categories. Our draft  
21 recommendation does not change this policy. In the second,  
22 highlighted in the right column, the TDAPA applies to ESRD

1 drugs that are in an existing ESRD functional category.

2 This is the focus of our draft recommendation.

3 As of 2020, no ESRD drug has qualified for either  
4 policy.

5 Our policy option addresses two concerns  
6 associated with the current policy. First, current policy  
7 reduces the competition that would occur if all drugs with  
8 the same function were paid under a single rate, and it  
9 fails to provide an incentive for drug manufacturers to  
10 constrain drug prices. Second, the TDAPA payment is  
11 duplicative of the payment for drugs already included in  
12 the bundle. For patients prescribed the TDAPA drug,  
13 Medicare will pay the facility the full base rate plus the  
14 TDAPA payment.

15 Not only is the TDAPA duplicative, it creates a  
16 financial incentive to provide TDAPA-covered drugs over  
17 drugs in the bundle, and potentially promotes the overuse  
18 of TDAPA-covered drugs.

19 The policy option eliminates the TDAPA for new  
20 drugs in a functional category. Its goals are to maintain  
21 the structure of the ESRD prospective payment systems, and;  
22 and create pressure on drug manufacturers to constrain the

1 prices of new and existing ESRD drugs. Drugs entering the  
2 market would immediately be included in the ESRD bundle  
3 with no changes the base rate.

4           It will be important to monitor how Medicare's  
5 payments align with providers' costs and the need for  
6 future rebasing. The Commission's annual analysis on  
7 payment adequacy, ESRD drug use, and changes in patients'  
8 outcomes can help inform policymakers.

9           As I said up front, this policy option would not  
10 change the TDAPA for new drugs that do not fit into an ESRD  
11 functional category.

12           So that brings us to the draft recommendation  
13 that reads:

14           The Congress should direct the Secretary to  
15 eliminate the end-stage renal disease prospective payment  
16 system's transitional drug add-on payment adjustment for  
17 new drugs and an existing ESRD functional category.

18           This draft recommendation is estimated to  
19 decrease program spending by \$250 million to \$750 million  
20 over one year and by \$1 billion to \$5 billion over five  
21 years, relative to current policy.

22           In terms of beneficiary implications, we do not

1 anticipate any negative effects on access to care. This  
2 draft recommendation would generate savings for  
3 beneficiaries through lower cost-sharing. In terms of  
4 provider implications, this draft recommendation would  
5 reduce future payments to dialysis facilities. This draft  
6 recommendation is not expected to impact providers'  
7 willingness and ability to care for dialysis beneficiaries.

8 DR. JOHNSON: We are now going to discuss a  
9 replacement for the current low volume and rural payment  
10 adjustments.

11 The current low-volume payment adjustment, or  
12 LVPA, increases the base payment rate for all treatments in  
13 eligible dialysis facilities by 23.9 percent. To be  
14 eligible, facilities must furnish fewer than 4,000  
15 treatments in each of the three years prior to the payment  
16 year in question. The LVPA only considers facilities that  
17 are owned by the same parent organization if within five  
18 miles from one another. In 2017, about 5 percent of  
19 dialysis facilities received the LVPA.

20 We have three main concerns with the LVPA's  
21 design. First, the single volume threshold of 4,000  
22 treatments may encourage some facilities to limit services

1 or report inaccurate data to maintain eligibility. Second,  
2 the LVPA does not address the higher cost of facilities  
3 with volumes of between 4,000 and 6,000 treatments per  
4 year. Finally, the LVPA does not target isolated  
5 facilities. In 2017, 40 percent of LVPA facilities were  
6 located within five miles of another facility.

7 Now we turn to the rural payment adjustment. The  
8 rural adjustment increases the base payment rate by 0.8  
9 percent for all facilities located in rural areas,  
10 regardless of their treatment volume or proximity to  
11 another facility. In 2017, 18 percent of dialysis  
12 facilities received the rural adjustment.

13 Our main concern is the targeting of the rural  
14 adjuster. In 2017, about 30 percent of rural facilities  
15 were located within five miles of another facility, and  
16 about half of rural facilities had higher treatment  
17 volumes, furnishing more than 6,000 treatments per year.

18 Finally, I will note that an adjustment for low  
19 treatment volume is mandated by law, but a rural adjustment  
20 is not mandated. CMS introduced the rural adjustment in  
21 2016.

22 Now we are going to review the low-volume and

1 isolated, or LVI, policy option. The LVI is a single  
2 adjustment that would replace the current low-volume and  
3 rural payment adjustments and would be targeted to  
4 facilities that are both low-volume and isolated.

5 In modeling the LVI adjustment, we used  
6 illustrative distance and treatment volume parameters. We  
7 required facilities to be farther than five miles from any  
8 other facility, and to furnish fewer than 6,000 treatments  
9 during each of the preceding three years.

10 The low-volume criteria could be implemented with  
11 a continuous adjustment or set of categorical adjustments.  
12 Either approach would help mitigate the cliff effect of the  
13 current low volume adjustment, and would better account for  
14 the higher costs in relatively low volume facilities.

15 Your mailing material contains more information  
16 about both approaches and also includes the results of our  
17 LVI modeling.

18 That brings us to the second draft  
19 recommendation, which reads:

20 The Secretary should replace the current low-  
21 volume and rural payment adjustments in the end-stage renal  
22 disease prospective payment system with a single adjustment

1 for dialysis facilities that are isolated and consistently  
2 have low volume, where low volume criteria are empirically  
3 derived.

4           The draft recommendation has the following  
5 implications. For spending, the draft recommendation is  
6 estimated to be budget neutral with current policy.  
7 Beneficiaries' access to care would be enhanced at  
8 facilities that are critical for access to dialysis  
9 treatment. Providers' willingness and ability to serve  
10 Medicare beneficiaries would not be affected.

11           Our analysis shows that payments would increase  
12 or remain the same for low-volume, isolated providers that  
13 are necessary for maintaining access to dialysis treatment.  
14 Payments would decrease for low-volume and rural providers  
15 that are in close proximity to another provider and would  
16 decrease for high-volume rural providers.

17           That concludes our discussion of the TDAPA and  
18 low volume payment policies. The material covered in  
19 today's presentation will be included in a June 2020  
20 chapter on ESRD prospective payment system design issues.  
21 Both draft recommendations are listed on this slide.

22           Thank you, and we look forward to your

1 discussion.

2 DR. CROSSON: Okay. Thank you so much, Andy.

3 Once again, we will proceed forward by roll call, asking  
4 Commissioners for support of both recommendations, general  
5 support with a comment or lack of support.

6 And Dana, you can start calling the roll.

7 MS. KELLEY: All right. Bruce?

8 MR. PYENSON: Support.

9 MS. KELLEY: Jaewon?

10 DR. RYU: Support.

11 MS. KELLEY: Dana?

12 DR. SAFRAN: Support.

13 MS. KELLEY: Warner?

14 MR. THOMAS: Support.

15 MS. KELLEY: Sue?

16 MS. THOMPSON: Support.

17 MS. KELLEY: Pat?

18 MS. WANG: Support.

19 MS. KELLEY: Kathy?

20 MS. BUTO: Support, but I just wanted to point  
21 out I noticed for the first time in this material that a  
22 large percentage of hospital-based are not close to other

1 facilities, but I wondered -- I just raised the question in  
2 the report itself that we address whether there is any  
3 rationale for hospitals to have dialysis facilities if they  
4 are low volume but they are actually close to a  
5 freestanding facility. You don't have to answer it now. I  
6 just think it's important to know whether we think that is  
7 of any value beyond the report.

8 DR. CROSSON: Thank you, Kathy. Dana?

9 MS. KELLEY: Larry?

10 DR. CASALINO: Support.

11 MS. KELLEY: Brian?

12 DR. DeBUSK: Support.

13 MS. KELLEY: Karen?

14 DR. DeSALVO: Support.

15 MS. KELLEY: Marge?

16 MS. MARJORIE GINSBURG: Support.

17 MS. KELLEY: Paul?

18 DR. PAUL GINSBURG: Support.

19 MS. KELLEY: David?

20 DR. GRABOWSKI: Support.

21 MS. KELLEY: Jonathan Jaffery?

22 DR. JAFFERY: Support.

1 MS. KELLEY: Amol?

2 DR. NAVATHE: Generally support. I think my one  
3 comment on the LVI work was it may have been -- I guess I  
4 would have preferred, it would have been even more  
5 convincing if we had seen some sort of match between supply  
6 and the population of beneficiaries, ESRD beneficiaries  
7 needing dialysis. And right now the way we approach it is  
8 proximity to other facilities, for example, whereas I think  
9 from an access perspective what we really care about is  
10 matching the, quote, "supply and demand." But I generally  
11 support.

12 MS. KELLEY: Okay. And Jon Perlin?

13 DR. PERLIN: Support.

14 MS. KELLEY: Jay?

15 DR. CROSSON: I support. Okay. So we are going  
16 to vote on -- I know they're on one slide here -- we're  
17 going to vote on each of the recommendations separately.  
18 We will take the first recommendation. Dana?

19 MS. KELLEY: Okay. Pat?

20 DR. CROSSON: Either yes, no, or abstain. Pat?

21 MS. WANG: Sorry. Yes.

22 MS. KELLEY: I should have set this up better.

1 Molly, can you put Recommendation 1 up? There we go. The  
2 draft recommendation is on the screen, and I'm sorry, go  
3 ahead Pat.

4 MS. WANG: Yes.

5 MS. KELLEY: Okay. Sue?

6 MS. THOMPSON: Yes.

7 MS. KELLEY: Warner?

8 MR. THOMAS: Yes.

9 MS. KELLEY: Dana?

10 DR. SAFRAN: Yes.

11 MS. KELLEY: Jaewon?

12 DR. RYU: Yes.

13 MS. KELLEY: Bruce?

14 MR. PYENSON: Yes.

15 MS. KELLEY: Jon Perlin?

16 DR. PERLIN: Yes.

17 MS. KELLEY: Amol?

18 DR. NAVATHE: Yes. Did you hear me that time?

19 MS. KELLEY: Yes. Thank you. Jonathan Jaffery?

20 DR. JAFFERY: Yes.

21 MS. KELLEY: David?

22 DR. GRABOWSKI: Yes.

1 MS. KELLEY: Paul?  
2 DR. PAUL GINSBURG: Yes.  
3 MS. KELLEY: Marjorie?  
4 MS. MARJORIE GINSBURG: Yes.  
5 MS. KELLEY: Karen?  
6 DR. DeSALVO: Yes.  
7 MS. KELLEY: Brian?  
8 DR. DeBUSK: Yes.  
9 MS. KELLEY: Larry?  
10 DR. CASALINO: Yes.  
11 MS. KELLEY: Kathy?  
12 MS. BUTO: Yes.  
13 MS. KELLEY: Jay?  
14 DR. CROSSON: Yes.  
15 MS. KELLEY: Okay. And could we go to Draft  
16 Recommendation number 2? The recommendation is on the  
17 screen.  
18 Pat?  
19 MS. WANG: Yes.  
20 MS. KELLEY: Sue?  
21 MS. THOMPSON: Yes.  
22 MS. KELLEY: Warner?

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

1 DR. DeBUSK: Yes.

2 MS. KELLEY: Larry?

3 DR. CASALINO: Yes.

4 MS. KELLEY: Kathy?

5 MS. BUTO: Yes.

6 MS. KELLEY: And Jay?

7 DR. CROSSON: Yes. I heard unanimous support for  
8 both recommendations.

9 MS. KELLEY: Correct.

10 DR. CROSSON: Okay. So that ends this order of  
11 business. I just have a couple of comments I would like to  
12 make for the record. The first is to acknowledge the hard  
13 work of Jim Mathews, Dana Kelley, Stephanie Cameron, and  
14 the rest of the staff during this year, to get us to the  
15 point where we have arrived at the end of our cycle here.  
16 It has been extraordinary all year. It has been  
17 unbelievably extraordinary during the last month or so, I  
18 think as everybody understands.

19 Secondly, for the record, I would like to make it  
20 clear that the staff will make available time for public  
21 input, which we normally have at our in-person meetings.  
22 That will be approximately in the week or so after the

1 publication on the MedPAC website of the transcript of this  
2 meeting, so people will have had a chance to read it and  
3 provide public comments.

4           That, I believe, if there are no comments from  
5 anyone, would be the end of this meeting. So we will  
6 adjourn the meeting and the recording will cease at this  
7 point.

8           [Whereupon, at 3:57 p.m., the meeting concluded.]