

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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P R O C E E D I N G S

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[9:45 a.m.]

3

4 begin.

5

I would like to welcome our guests to the opening session of the MedPAC November meeting. We have two topics on the table for this morning. The first one will be the first part of a body of work that the Commission staff has been doing in response to a request from Congress, specifically to answer a set of questions regarding hospital consolidation. And we have got Stephanie, Dan, and Jeff here. Stephanie is going to begin. You have the microphone.

14

MS. CAMERON: Thank you. Good morning. Today we are here to discuss a congressional request on health care provider consolidation. Before I begin, I would like to thank Carolyn San Soucie, Brian O'Donnell, and Alison Binkowski for their contributions to this work. This was a team effort.

20

In August 2018, the Chairman of the Committee on Energy and Commerce asked MedPAC to study the effects of hospital consolidation and physician-hospital integration.

21

22

1 Specifically, the Chairman asked the Commission to address
2 five specific questions related to consolidation in the
3 health care sector. The first three questions focused on
4 hospital consolidation, including trends over time, the
5 resulting effects on commercial prices, and the costs of
6 providing the services.

7 The fourth question included an examination of
8 physician-hospital integration and its effect on Medicare
9 payments and beneficiary coinsurance on drugs, treatments,
10 and services. The fifth and final question addressed the
11 extent to which the 340B program contributed to hospitals'
12 use of more expensive drugs, which we will discuss in a
13 subsequent session in January.

14 To provide a quick background, when we talk about
15 consolidation in health care we refer to two concepts,
16 horizontal consolidation and vertical integration. Some
17 examples of horizontal consolidation include hospitals or
18 hospital systems merging with or acquiring other hospitals
19 or hospital systems, or physician practices merging with
20 other physician practices. Vertical integration can
21 include hospitals acquiring physician practices or the
22 hiring of individual physicians from the community, as

1 examples.

2 Now with that background, let's start with the
3 first question regarding the trends in hospital
4 consolidation. Hospitals have been consolidating for
5 decades, and as you can see, by 2017, a majority of markets
6 are classified as "super concentrated" using the
7 Herfindahl-Hirschman index, a measure of market
8 concentration.

9 In 2003, 47 percent of urban CBSAs had a
10 Herfindahl-Hirschman index exceeding 5,000, indicating a
11 super-high level of market concentration. However, by
12 2017, this increased to 57 percent of markets. Once a
13 market becomes super concentrated, new competitors rarely
14 enter. Indeed, over this time period, not a single urban
15 CBSA experienced a material increase in consolidation --
16 excuse me, a material increase in competition.

17 In terms of the effect Federal policy might have
18 on health care consolidation, we look to changes in anti-
19 trust policy as enforced by the Federal Trade Commission.
20 We find that over the past 35 years there has been little
21 change in both anti-trust policy and the emphasis
22 researchers place on FTC challenges of hospital mergers and

1 acquisitions.

2 Although the FTC won several challenges of
3 hospital consolidation in the early 2010s, only 2 to 3
4 percent of hospital mergers are challenged in year.
5 Medicare generally pays a prospectively determined amount
6 to hospitals for inpatient services regardless of the level
7 of consolidation in the market. Therefore, increasing
8 hospital market share through horizontal consolidation does
9 not affect hospital payments.

10 In terms of vertical integration, however,
11 Medicare pays differential rates for care provided in a
12 physician office compared with that under a hospital
13 outpatient department. This differential may create an
14 incentive for hospitals and physicians to integrate, and we
15 will discuss this later in our presentation. However,
16 given the decades-long trend of greater horizontal
17 consolidation and the FTCs anti-trust policy, it does not
18 appear to be driven by changes in federal policy including,
19 for example, the introduction of accountable care
20 organizations.

21 Now moving to our second question of what
22 hospital consolidation means for the price commercial

1 insurers pay for hospital services, the preponderance of
2 the research over the past decade suggests that hospital
3 consolidation leads to higher prices for commercially
4 insured patients. However, a recent study funded by the
5 American Hospital Association disputes this finding. These
6 researchers found that after being acquired by another
7 hospital system, the acquired hospitals' revenue and cost
8 per discharge fell.

9 This study did not use actual commercial prices
10 via claims but a price proxy which could be affected by
11 payer mix, service mix, coding practices, and actual
12 commercial prices. Other recent studies that used
13 commercial payer claims data from the Health Care Cost
14 Institute found higher prices in monopoly markets, with an
15 increase in prices occurring when hospitals in the same
16 markets merged.

17 It is important to remember that hospital market
18 power is just one factor that affects the prices. Research
19 suggests that insurer consolidation also plays a role in
20 determining the level of commercial pricing.

21 Now we are going to address the question of
22 implications of consolidation and the cost of hospital

1 services. Theoretical arguments have been offered of both
2 sides of whether hospital consolidation will increase or
3 lower costs. On the one hand, greater hospital market
4 power could result in greater leverage over insurers,
5 resulting in higher commercial prices. This could result
6 in higher non-Medicare profits, looser budget constraints,
7 and ultimately less financial pressure to constrain costs.
8 We would expect to see these changes to occur over the long
9 term.

10 On the other hand, hospital mergers could produce
11 some efficiencies that could result in lower hospital
12 costs, including greater leverage with suppliers and the
13 labor force. Economies of scale through managerial
14 efficiencies, and lower costs of capital could also reduce
15 hospital costs. We would expect these reductions to occur
16 within a few years after consolidation. In sum, hospital
17 consolidation can create mechanisms that both increase and
18 lower costs.

19 The Commission has found that greater market
20 share is positively correlated with higher non-Medicare
21 profit margins, meaning that as a hospital's market share
22 or consolidation increases, non-Medicare profit margins

1 also increase. The Commission also found that higher non-
2 Medicare profit margins are positively correlated with
3 higher standardized costs per discharge. And while we
4 found a positive correlation between hospital market share
5 and cost per discharge, the correlation was not
6 statistically significant.

7 One potential reason for this lack of statistical
8 significance could be that our measures of market power are
9 imprecise and measured at the CBSA level, potentially
10 introducing a large amount of noise to the results. We
11 expect hospital unique factors to also affect prices
12 received, including a hospital's location within a CBSA and
13 the reputation of that hospital. Nevertheless, on the next
14 slide we show costs per discharge by hospital and insurer
15 concentration.

16 When we show the standardized cost per discharge
17 by hospital and insurer concentration, as you can see the
18 median standardized cost per discharge is higher in super-
19 concentrated hospital markets with a less consolidated
20 insurer market. For example, in the top row, in green,
21 hospitals in markets with lower levels of hospital
22 consolidation have a median standardized cost per discharge

1 of \$12,058 compared with \$12,457 in super-concentrated
2 markets.

3 In contrast to comparisons across different
4 levels of hospital consolidation, when we compare costs by
5 insurer concentration, here we are comparing the green row
6 to the blue row, you see that costs tend to be lower where
7 the insurer market is super concentrated. However, as a
8 reminder, these differences were not statistically
9 significant.

10 And with that, Dan will discuss vertical
11 integration and its effect on prices.

12 DR. ZABINSKI: Now we'll examine the question,
13 has the vertical integration of physicians and hospitals
14 affected Medicare payments for physician services.

15 One thing we know is that because of vertical
16 integration, the movement of physicians from physician-
17 owned practices to hospitals has been substantial. For
18 example, the Physician Advocacy Institute found that the
19 share of physicians that are employed by hospitals
20 increased from 26 percent in 2012 to 44 percent in 2018.

21 Research indicates that vertical integration
22 increases physician prices paid by patients and by third-

1 party payers, and three specific factors lead to these
2 higher prices. One is that if a hospital already has one
3 or more physician practices, adding another leads to
4 horizontal integration of the physicians, which gives the
5 hospital systems bargaining power for physician services.

6 A second factor is that physicians employed by
7 hospitals have more bargaining power with commercial
8 insurers when they have hospital support.

9 Then third, there is a site-of-service
10 differential, which means that when a hospital acquires a
11 physician practice, the hospital can convert that practice
12 to an HOPD, and this increases prices for Medicare because
13 in the Medicare program prices are typically higher in an
14 HOPD than in an office for the same service.

15 These higher prices could be offset if the
16 vertical integration also reduced volume through
17 efficiency, but research indicates that vertical
18 integration does not substantially reduce volume.
19 Therefore, vertical integration increases Medicare program
20 spending and beneficiary cost sharing.

21 One effect of vertical integration is that, in
22 general, the billing of services have shifted from

1 physician offices to HOPDs. On this table, we show four
2 service categories that have had especially large shifts
3 from 2012 to 2018: chemo administration, echocardiography,
4 cardiac imaging, and office visits.

5 We have found that from 2012 through 2018, volume
6 in all four of these categories decreased in physician
7 offices, but in contrast, cardiac imaging stayed about the
8 same and the other three categories substantially increased
9 in HOPDs.

10 In addition to affecting prices and spending,
11 vertical integration has other effects. One is that
12 vertically integrated physicians refer more patients to
13 hospital-based facilities, which suggests that referrals
14 are a motivating factor for hospitals to acquire physician
15 practices. One result of this pattern of referrals is that
16 patients' travel time may increase without an improvement
17 in their quality of care.

18 Second, the effect on quality is ambiguous. On
19 the one hand, some believe vertical integration can improve
20 quality through care coordination, but on the other hand,
21 the literature generally does not find material
22 improvements in quality from vertical integration.

1 A summary of the effect of consolidation on
2 Medicare beneficiaries includes (1) horizontal
3 consolidation of hospitals does not affect beneficiaries'
4 cost-sharing because Medicare sets prices. That is, the
5 effect that consolidation has on commercial prices does not
6 affect Medicare prices.

7 In contrast, vertical integration does affect
8 beneficiaries, because it causes services to shift from
9 offices to higher priced HOPDs, resulting in higher cost-
10 sharing. An exception to these higher HOPD prices is
11 drugs, because CMS has reduced the payment rates for drugs
12 provided in HOPDs of 340B hospitals, which decreases
13 beneficiaries' cost sharing for drugs. At the same time,
14 however, the price for drug administration is higher in
15 HOPDs than in offices, which offsets some of the lower
16 cost-sharing from lower drug prices in 340B hospitals.

17 A summary of the important results we presented
18 today include, first, hospital consolidation is associated
19 with higher commercial prices. However, federal policy is
20 not driving the consolidation of hospital, and also, it is
21 not clear what effect consolidation has on hospital costs
22 and quality. Finally, even though consolidation is

1 associated with higher commercial prices, Medicare
2 beneficiary cost-sharing is largely unaffected because
3 Medicare sets its prices.

4 A second important result is that vertical
5 integration leads to higher prices to both Medicare and
6 commercial insurers. Because Medicare typically has higher
7 payment rates for a service if it is provided in a hospital
8 rather than a physician office, Medicare policy encourages
9 this integration. Moreover, this integration increases
10 beneficiary cost-sharing.

11 Currently Medicare payment policy encourages
12 vertical integration regardless if the merger results in
13 improvements in quality or efficiency. However, if we had
14 site-neutral payments between HOPDs and offices, mergers
15 would occur when improvement in quality or reductions in
16 cost are expected. Conversely, when quality and cost
17 improvements would not occur, these mergers are less likely
18 to occur as well.

19 Finally, we want to say again that at the January
20 2020 meeting, MedPAC staff will present an analysis of the
21 question of whether participation in the 340B Drug Pricing
22 Program results in hospitals using more high-cost drugs.

1 So for your discussion today, we will address the
2 questions you have on our presentation, and we also look
3 forward to guidance on the content of the paper to meet our
4 March 2020 deadline.

5 I turn things back to Jay for questions and
6 discussion.

7 DR. CROSSON: Okay. Thank you, Dan, Jeff, and
8 Stephanie. We are now open for clarifying questions.
9 Larry. No. Okay, you're not Larry. Okay, Paul.

10 DR. PAUL GINSBURG: Yeah, actually, first I want
11 to make a comment that, you know, when hospitals acquire
12 physician practices we call it vertical integration but
13 it's really a hybrid between horizontal and vertical,
14 because typically hospitals already employ many physicians,
15 or have acquired groups, and by acquiring more they are, in
16 a sense, increasing consolidation in the physician services
17 market. And I think FTC so far has been using horizontal
18 consolidation to challenge vertical cases, perhaps waiting
19 for more research to develop.

20 I had a question about any thoughts, you know, on
21 the facility fee, which drives up what Medicare spends when
22 hospitals acquire physician practices, and I take it that

1 private insurers often pay these facility fees as well.
2 Any sense of if Medicare changed its policy how that would
3 affect private insurers' payment of facility fees?

4 DR. STENSLAND: I think from what we have heard
5 some do and some don't, and if Medicare changed its policy,
6 I don't know how that would change, but there's a lot of
7 following Medicare, so I would expect there would be more
8 shifting to the don't. There are already even some MA
9 plans that don't pay the facility fee.

10 DR. CROSSON: Okay. Marge and then David and
11 Warner.

12 MS. MARJORIE GINSBURG: I have a question about
13 the corporate practice of medicine, which I recall, back in
14 the day, where I thought that hospitals were not allowed to
15 purchase medical groups, because that was a violation of
16 the corporate practice of medicine.

17 So have I misunderstood that completely or did
18 things really change a number of years ago, that allowed
19 these consolidations to take place?

20 DR. PAUL GINSBURG: Marge, that's a California
21 law, and perhaps some other states. But having a lot of
22 experience in California, it is still in effect.

1 MS. MARJORIE GINSBURG: So that means that there
2 are no hospitals that own physician groups in California?

3 DR. PAUL GINSBURG: There are other ways that
4 they can own them.

5 [Laughter.]

6 DR. CROSSON: I mean, much of that has taken
7 place in California through the construction of various
8 foundation models that get around the law.

9 DR. CASALINO: Yeah, there are virtually no large
10 medical groups in California now that are independent, so
11 despite the corporate practice of medicine law and
12 foundation models, there are ways of getting that, that
13 actually just make everything more expensive, but they
14 don't really prevent the growth of medicine. It's good for
15 lawyers.

16 DR. CROSSON: David.

17 DR. GRABOWSKI: Great, thanks. First, I'm really
18 excited that we're doing this work. I wanted to ask you
19 about the first bullet on Slide 14. I don't disagree with
20 anything that's written there. I just wanted to push you a
21 little bit. This idea, I totally agree Medicare's a price
22 setter, yet are there any sort of ways in which -- you

1 know, Medicare doesn't set prices in a vacuum, and this
2 idea of kind of rising costs and we look at all-payer
3 margins, certain policymakers do, and just I wanted to kind
4 of push you a little bit on that. Is it truly that
5 Medicare's looking at this in a very siloed fashion?

6 DR. STENSLAND: Yes.

7 DR. ZABINSKI: And I agree.

8 DR. STENSLAND: We're saying there's no direct
9 affect, but there certainly is these indirect effects and
10 indirect pressure to increase rates when the gap between
11 private and Medicare increases.

12 DR. GRABOWSKI: Yeah, say more, Jeff, about that,
13 or any of the three of you, about that indirect pathway.

14 DR. STENSLAND: I don't have any great insights
15 here, but there's a couple of ways it might happen. One
16 way that we discuss here, which is not perfectly clear, is
17 to the extent that they have higher private revenues, there
18 could be higher costs. That makes the Medicare margins
19 look worse. That could add pressure for us to have higher
20 payment rates.

21 The other thing that you might see even more in
22 the physician side, maybe even in the hospital side where

1 your hospitals are dominated by nonprofits who have more
2 pressure to take everybody, but to the extent that private
3 rates for physicians keep on going up and up, there might
4 be some physicians who are saying, "I'm going to limit my
5 panels of who I'm going to take," or there's a certain
6 number of slots for Medicare -- you know, our data says
7 they still generally have pretty good access now, but
8 that's still a concern. And if you look at the big, broad
9 discussion, we talk about some of the big concerns with
10 sustainability of Medicare with the long term, this growing
11 gap between Medicare and private is just problematic in
12 many different ways.

13 DR. ZABINSKI: And I'll add one thing to that.
14 You know, the rate setting on the outpatient side, you
15 know, it's very cost-based, and as you get consolidation,
16 perhaps there's less discipline on keeping costs down.
17 That can just drive up Medicare prices because hospital
18 costs go up.

19 DR. CROSSON: Okay. I've got Warner and then
20 Jon, Bruce, Karen.

21 MR. THOMAS: Yeah, just a couple of questions.
22 So the data is pretty much focused on inpatient. Did you

1 do any -- or is there any ability to look at outpatient
2 data for hospitals and look at things that happened outside
3 of the hospital, you know, kind of nontraditional or, you
4 know, freestanding entities and kind of what that market
5 concentration looks like?

6 DR. STENSLAND: Concentration of physician
7 offices or --

8 MR. THOMAS: No. For outpatient services,
9 imaging, ambulatory surgery centers, you know, just --
10 because we're more focused on inpatient, and, you know,
11 more and more that's 50 percent or less of what happens in
12 a hospital. So I don't know if we've looked at the
13 outpatient component of what's happening in hospitals.

14 DR. STENSLAND: We had another chapter. It's not
15 the outpatient component necessarily. We did a chapter on
16 physician offices a little while ago, and we saw that, you
17 know, that's also consolidating. And you tend to get
18 better prices if you're the only urology practice in the
19 MSA than if you have lots of competitors.

20 MR. THOMAS: But I'm thinking about hospital
21 outpatient services. I mean, we see more and more kind of
22 moving outside of the hospital for things like imaging,

1 things like ambulatory surgery, things that -- you know,
2 and it doesn't appear that that's considered in this
3 analysis around consolidation.

4 DR. STENSLAND: We haven't looked at that, and we
5 haven't -- it's kind of a complex question of how much of
6 it is outside the hospital. But when it's outside the
7 hospital, how much of it is still owned by the hospital?
8 And we haven't done that analysis.

9 MR. THOMAS: And I guess what I'm saying is
10 looking at the whole market, I mean, you have to -- the
11 point being is that there's a lot less concentration in
12 that component of services that have been traditional
13 hospital services, and many of them are going outside of
14 the hospital. So it might be interesting to think about
15 that as you comment on concentration, you're really just
16 focusing on the inpatient, you're not focusing on
17 outpatient hospital services. So that's just a question.

18 The second question I had was: Have you looked
19 at the consolidation of hospitals and any correlation or
20 not in with how it correlates with insurer consolidation?

21 MS. CAMERON: We did look at that, and we did
22 find that there was a positive correlation between the

1 concentration of hospitals and the concentration of
2 insurers. That was positive and statistically significant.

3 MR. THOMAS: Okay. Also, did -- and I think it's
4 good to go down and look at the insurance piece of this in
5 conjunction with the hospitals. Did we or do you think it
6 would make any sense to look at consolidation in other
7 components of the industry just kind of in comparison --
8 GPOs, pharma companies, PBMs, things like that -- just to
9 kind of have an understanding of a comparator? Do we have
10 that information or --

11 MS. CAMERON: We did not include that information
12 as part of this analysis, and we don't have it at our
13 fingertips. I think it would take some thinking through on
14 how we would get that information. I'm not sure that we
15 would be able to understand market share of a GPO at a CBSA
16 level. I don't know if that data actually exists, but we
17 would need to do some thinking about that.

18 MR. THOMAS: Or even if you looked at it on an
19 aggregate level, on a national level. And I guess that
20 would be another question I would have: Have we looked at
21 consolidation of, you know, this component of the industry
22 versus the other components of the industry on a national

1 level? Because it would appear to me that the national
2 insurers have a lot more -- appear. I mean, I don't know
3 the numbers, but you may have a lot more consolidation
4 versus if you look at, you know, health systems or
5 hospitals. It appears that there's a lot more
6 fragmentation in hospitals than there are in insurers,
7 especially if you look at it on a national basis. I don't
8 know if we've made that point or comment. It's just a
9 question of whether you even have the data.

10 DR. STENSLAND: We do do the insurer part in the
11 paper, looking at the insurer concentration at the CBSAs,
12 and we did look a little bit about how that changes over
13 time. And there's actually a little bit more movement
14 towards in some markets creating more competition amongst
15 insurer than there is amongst hospitals. And I think part
16 of that is that if you have -- part of it is big health
17 care systems deciding they're going to have their own
18 insurer or they'll partner with another insurer. And it's
19 just easier if you're a big health care system in a state
20 to say, "Okay, I'm going to set up my own insurance
21 company."

22 MR. THOMAS: Sure.

1 DR. STENSLAND: Or to say, "I'm going to partner
2 with this other insurance company in another state, and
3 then I can have my own product." That's easier than an
4 insurance company saying, "I'm going to go set up my whole
5 new hospital and my whole new physician practice in the
6 state."

7 MR. THOMAS: Sure. I just didn't know if we had
8 national information comparing the insurance industry
9 and/or these other industries like GPO and what-not to the
10 hospital industry. I don't know if that's available.

11 DR. CROSSON: Jon.

12 DR. PERLIN: Thanks. Before I get to my
13 question, I believe I am correct that 80 percent of
14 commercial covered lives are concentrated in the five major
15 insurers. You know, so that is there.

16 The other interesting phenomenon is we talked
17 previously about physician consolidation into megagroups,
18 but insurers with very large footprints in terms of their -
19 - and, Paul, I'll need your economic guidance. If that's
20 totally vertical, then integration with the -- when the
21 insurers acquire the physicians, but clearly there has been
22 a lot of movement in that direction.

1 DR. PAUL GINSBURG: Yeah, I guess that also has a
2 mix in a sense. If an insurer for the first time acquires
3 a physician practice, that's purely vertical. But once
4 they acquire other practices, then it starts being
5 horizontal in the physician markets.

6 DR. PERLIN: Thanks. So my question is really --
7 you know, when I think about consolidation or the dynamics
8 in the market -- maybe it's because I grew up in the sort
9 of academic context. I think of hospital referral regions,
10 the conventions Dartmouth Health Atlas uses. Here we use
11 core-based statistical areas, which are much smaller.
12 Could you explain why we didn't use hospital referral
13 regions, which seem to be the basis of, you know, really
14 more of the evaluation of market dynamics or why we chose
15 CBSAs?

16 DR. STENSLAND: The HRRs can be really big, like
17 hundreds of miles. I don't think anybody in the antitrust
18 industry uses anything that large or I don't think -- if I
19 was picking an insurance product and they told me I'm in
20 southern Minnesota and your local hospital is not in your
21 network, but your referral hospital 100 miles away is in
22 your network, I would think that's not the product I want

1 to buy.

2 DR. PERLIN: Well, the HRRs are large in the
3 rural areas. They're more concentrated, obviously, in the
4 urban areas. The reason I ask this is that one can imagine
5 the math would be very different in terms of the HHI and
6 the outcomes there. The second is that, you know, I can't
7 help but think about my own organization. We're a fairly
8 large organization. We are nowhere near 50 percent. I
9 mean, you know, 25 to 30 percent of the market. So when I
10 think of a CBSA, in contrast, you know, when you have 50
11 percent, I can only think then of a two-hospital town. In
12 fact, in a one-hospital town, it's probably 100 percent for
13 that matter. Would my math be correct in that assumption?

14 DR. STENSLAND: You could have one hospital with
15 60 percent and four with 10 percent, or something like
16 that, of admissions. And it's not hospitals we're talking
17 about. It's hospital systems. So maybe you have two
18 hospitals in one system and another hospital in a separate
19 system.

20 DR. PERLIN: That was my next question. How did
21 we formally define the nature of "system" in this context?

22 MS. CAMERON: We relied on the AHA data and

1 systems within that. It's a self-identified process, but
2 it is, I think, the gold standard right now in terms of the
3 data available on defining a hospital system.

4 DR. PERLIN: Yeah, okay. So I know this data and
5 the system can really be a hospital or a hospital plus a
6 little bit around it.

7 Let me switch to a different thread, which is,
8 did you look at all at state overview of consolidation or
9 mergers? Obviously, FTC is not the only party with
10 interest in that. But it would seem actually that perhaps
11 even a greater degree of scrutiny or at least equivalent
12 would be from state regulators?

13 DR. STENSLAND: We didn't do anything systematic,
14 just anecdotal looks at different states and what they were
15 discussing when it came to how they were going to regulate
16 or accommodate mergers.

17 DR. PERLIN: Thanks.

18 DR. ZABINSKI: One more comment on the use of
19 HRRs versus the CBSAs. One issue I always had about the
20 HRRs is that, going from one to the next, there's some
21 degree of inconsistency. And I think a real good example
22 is comparing Miami to the St. Paul HRR. You know, Miami is

1 just Miami. It's strictly urban. While the one for St.
2 Paul stretches from -- it goes clear from the southern
3 border of Minnesota clear to Canada. And there's that
4 discontinuity of, you know, what each of them defines that
5 I've always had a little bit of a problem with.

6 DR. PERLIN: The challenge or the reason that
7 Dartmouth adopted the HRR convention is that the patients
8 in that area of Minnesota, you know, are predominantly in -
9 - or may come from very rural areas. In Miami, obviously,
10 the care -- the population concentration is very different.
11 But, I mean, the challenge I have is trying to interpret
12 these CBSAs, which are both geographically small, limited
13 obviously in terms of population, and, therefore, limited
14 in terms of the number of providers that are apt to exist
15 within a CBSA in contrast to an HRR. Thanks.

16 DR. CROSSON: On this note?

17 DR. GRABOWSKI: On the other issue that Jon
18 raised around sort of the AHA hospital system indicator.
19 There's the pay codes data now, and I don't know if that's
20 something that you've thought about here, but detailed sort
21 of ownership and investor information. That might be a way
22 to construct these hospital systems as well.

1 DR. CROSSON: Pat, are you on this or --

2 MS. WANG: No.

3 DR. CROSSON: Okay. All right. Next we've got
4 Karen.

5 DR. DESALVO: Thank you, guys. I loved this
6 chapter. It's frankly, you know, kind of getting to some
7 of the important issues about the through line from the
8 decisions that we make into what happens on the ground.

9 I just had a question about how you define
10 federal policies because it seems like much of what you
11 write about, at least in the chapter, is payment policy.
12 And I had two other big categories, one that was pretty
13 disruptive to the health care environment, which was those
14 that came out of HITECH, the meaningful use program. And
15 one of the things that we heard a lot when I was national
16 coordinator and I still hear some is that the cost and the
17 technical needs of adopting and maintaining and upgrading
18 EHRs is one of the drivers that causes hospitals to form
19 systems and for there to be acquisition. So I was
20 interested to know if you all had considered that as one of
21 the federal policies that might have been driving
22 consolidation either horizontally or vertically.

1 DR. CROSSON: Thank you --

2 DR. STENSLAND: We didn't formally look at that.

3 DR. DeSALVO: Okay. And then the second one I
4 had was -- and I don't know, by the way, the meaningful
5 use, I don't know if it had a material impact. I was just
6 interested to know if you all had considered it because it
7 was mostly anecdotal that we had heard.

8 The other one I also don't know if it would have
9 material impact, but graduate medical education policy, and
10 related to that, DSH and Medicaid reimbursement. So
11 teaching hospitals get higher reimbursement in some of
12 those areas or added funding, and something that I have
13 seen is hospitals acquiring smaller hospitals within a
14 certain radius that allows them to bill at a higher rate
15 for that hospital and call it a teaching hospital. And so
16 there are additional ways that they can improve the revenue
17 from a smaller hospital beyond just some of the payment
18 policies that you mentioned. I was just interested to know
19 if that had been in your basket of things you thought
20 about.

21 DR. STENSLAND: We thought about that a little
22 bit more in the IME discussion that we had a month or two

1 ago, and that's a little harder to do because it's all
2 based on a resident-to-bed ratio. So maybe if you bring
3 some other beds in, but then your resident-to-bed ratio
4 goes down. So it's not as clean of a -- it's not a real
5 clean way to really necessarily bring up your total
6 revenue. You might benefit more if you said, well, we
7 acquired this hospital, but now we're shifting some of
8 those cases to the teaching hospital, rather than keeping
9 those surgeries in the smaller hospital. That actually
10 would increase your payment.

11 DR. DeSALVO: Yeah. It may vary state by state,
12 so this is something I'm not expert in, but in Louisiana,
13 there is a material increase in reimbursement for the
14 Medicaid program, and it allows you to be more of a DSH
15 hospital, even if at the new site, if it can fall under the
16 tax ID, and it has to meet certain geographic requirements,
17 that may be state-by-state policy and not materially affect
18 other states.

19 MS. CAMERON: And I did want to add, Karen, that
20 we looked over time on an annual basis, and we didn't find
21 any major shocks, whether it was after HITECH or any other
22 major policy changes. If we had seen a shock, I think we

1 would have gone back and looked and said, you know, what
2 could have been driving this? But we didn't come across
3 that. So although we didn't specifically look kind of for
4 the two issues you mentioned, I think the overall trend was
5 this kind of steady increase and uptick in concentration.

6 DR. CROSSON: All right. Thank you, Karen.
7 Bruce.

8 MR. PYENSON: Well, thank you very much for a
9 really interesting chapter. I wanted to pick up on
10 Warner's point about looking at other sectors and, in
11 particular, the consolidation and evolution of health care
12 might have analogs in the utility industry where both on a
13 state and a federal level there were various concepts of
14 rate regulation and the use -- the control of what was
15 perhaps considered a useful monopoly. So it seems to me as
16 though there's analogs in that history in the way that both
17 states and the federal government regulated. I'm not sure
18 what to do with that, but it just seems like a perhaps
19 useful analog, and I wonder if you looked -- sorry. That's
20 a phase two question, perhaps. But I'm wondering if you
21 had thoughts about that.

22 DR. STENSLAND: That was a little bit outside the

1 scope of what they specifically asked us to look into, so
2 we didn't look into that.

3 DR. CROSSON: It's worked out well in California.

4 [Laughter.]

5 DR. CROSSON: Pat.

6 MS. WANG: If you mentioned this in the paper and
7 I missed it, I apologize. But going back to, you know,
8 what's on Slide 14 and the effect of consolidation of
9 beneficiaries, did you look or is it possible to know
10 whether there's a correlation between horizontal, I guess,
11 hospital mergers and the acquisition of physician
12 practices? Are they related to each other, that either
13 physicians are more likely to sell when hospitals in a
14 market are consolidating into a small number of systems?
15 Are hospitals more interested in acquiring the practices?
16 Is there any kind of relationship there?

17 DR. STENSLAND: Good question. We didn't look at
18 it. It would take some time to do that, I think.

19 DR. CROSSON: Dana.

20 DR. SAFRAN: Thanks. This is a little bit of a
21 follow-on to Karen's line of questioning around graduate
22 medical education, but taking a slightly different lens.

1 Where you see horizontal integration, understanding that
2 apart from the graduate medical education implications,
3 that Medicare payments don't create a big price
4 differential for those facilities, there still, I think,
5 would be a reason for the hospitals to begin moving
6 patients to the lower-cost facilities because their margin
7 will be better, right? The input costs at those community-
8 based hospitals are less than the input costs for the same
9 admission at the teaching hospital or tertiary facility.

10 So I'm curious as to whether -- and I know that
11 in the commercial space we have seen evidence that that
12 happens. When you introduce global budget payments,
13 hospitals then look to own a bigger share and then move
14 business out to the community.

15 So I'm just curious on the Medicare side whether
16 you've looked at the data to see any evidence that that
17 horizontal integration leads to moving Medicare beneficiary
18 admissions out to the community more.

19 DR. STENSLAND: I mean, we haven't looked at that
20 and haven't -- even anecdotally, haven't seen it. The
21 closest thing I can think of -- you know, because even on
22 the Medicare side, if you do move them into the teaching

1 hospital, Medicare is going to pay you more. Maybe your
2 costs are more. I'm not sure how it all balances out.

3 The closest thing we've seen is in Maryland,
4 where -- in the other states, you tend to see services
5 gravitating into the hospital, where they get the facility
6 fee.

7 DR. SAFRAN: Mm-hmm.

8 DR. STENSLAND: In Maryland, you see them more
9 going out of the hospital, and it's because there is still
10 the global budget. But Maryland doesn't pay you any more
11 if it's in the hospital or outside of the hospital. So I
12 think that idea of now the payment differential isn't
13 there, just the cost differential is there, so we're going
14 to move things out of the hospital.

15 DR. SAFRAN: That's very interesting.

16 My other question is whether you see any evidence
17 of disintegration meaning, Are there places where you see
18 physician practices because of the Medicare program and the
19 ACO opportunities actually moving away from hospitals?

20 I know you've done some interviews with some
21 organizations out there in the ACO world, some of whom are
22 working to support smaller practices. So I'm curious if

1 you see any evidence of that happening.

2 DR. STENSLAND: I haven't heard of any of that
3 since the 1990s. It doesn't mean it's not happening. It's
4 just we're not aware.

5 DR. SAFRAN: Thanks.

6 DR. CROSSON: Jaewon?

7 DR. RYU: I just had a couple questions. The
8 first one is in markets where you have the most rapid rise
9 as a percent share of the population in Medicare, so the
10 most rapidly aging market, let's say, I don't know if
11 there's any analysis that looks at what consolidation
12 dynamics -- do you see more or less consolidation in those
13 markets?

14 The reason I'm asking is it seems like that would
15 suggest that the more shifting into Medicare payment model
16 that there is, you'd see -- if there is a correlation, that
17 might explain it, and it might actually be driving some of
18 this consolidation activity. So I don't know if that's
19 been looked at or if that's something we can look at.

20 MS. CAMERON: I was going to say we haven't look
21 at it from kind of the beneficiary aging perspective. I
22 think that is an interesting question. I think it would

1 require some thought about how we would gauge that, but we
2 can think about it. But I don't have an answer for you
3 today.

4 DR. RYU: And then the other question I had --
5 Warner touched on it earlier -- the insurance market and
6 consolidation, I think you have that pretty -- it feels
7 like there's robust kind of look into that.

8 On the standalone physician -- and I think Jon
9 mentioned a lot of these groups that are now getting
10 acquired by other large insurance companies, but even some
11 groups, multispecialty groups, are just purely standalone.
12 They're not part of any hospital system. They're not part
13 of any insurance company, but they themselves are
14 consolidating.

15 So I think it would be good to take a look there
16 as well, and the reason for that is it almost then creates
17 a need for more of the horizontal consolidation as well. I
18 think these things are sort of intertwined, and so to the
19 extent that there is that analysis or, again, can it be
20 done, I think that might be informative as well.

21 DR. CROSSON: On this point?

22 DR. NAVATHE: Yeah.

1 I think there's also interesting variability
2 there. Some of it may be somewhat endogenous, but, for
3 example, in cardiac services, there's a lot more of that
4 type of consolidation than there are in other specialties.
5 There might be some variation there that could be
6 exploited.

7 DR. CROSSON: Okay. Seeing no further questions,
8 I think we will move on to the discussion period. We have
9 an opportunity here to help the staff improve the chapter,
10 so if we have ideas of that nature.

11 Brian?

12 DR. DeBUSK: First of all, I really enjoyed the
13 chapter. I think I would compliment Congress on an
14 excellent set of questions. I think they were pretty
15 insightful. They got to the heart of several matters.

16 But I also want to compliment the staff. I think
17 you guys are off to a great start for answering those
18 questions, and I realize that for the publication, we may
19 want to answer these questions somewhat narrowly, as we
20 have done historically.

21 But I couldn't help but read that chapter and
22 think about our context chapter and also think about the

1 payment adequacy framework and how all these pieces fit
2 together. So I'm going to digress for a minute, but, Jeff,
3 be ready to pounce on my line of logic, you specifically,
4 because I appreciate the feedback. But I'm ready to be
5 criticized. How's that? But bear with me.

6 We know on pages 13 through 15 that hospital
7 consolidation does lead to higher commercial rates. Got
8 that.

9 We know on page 20 that when nonprofits have
10 higher margins that they tend to spend that money. That's
11 page 20 of the reading materials.

12 I want to take a moment, and this is feedback
13 specifically on the chapter. I hope the chapter doesn't
14 read like, "Oh, gosh. The moment they get this money, it
15 turns a hole in their pocket, and they go spend it." I
16 think there's multiple things going on in a hospital right
17 now, and our operators may want to comment on it.

18 But you've got constant physician demands. I
19 mean, they want surgical robots. They want hybrid ORs.
20 They want multiple rooms so they can balance cases, and you
21 also have a consumer who considers in the absence of
22 meaningful quality measures, they really could seem

1 infrastructure as a proxy for quality.

2 I mean, I don't know that anyone is itching to
3 have a huge brass and glass lobby or to put a fountain out
4 near the patient drop-off area, but I do think that a lot
5 of consumers see the hospital's infrastructure as a proxy
6 for the quality of care they deliver. So that's just in
7 their defense. I hope the writing doesn't just make it
8 sound like the moment a not-for-profit hospital improves
9 their margin, they just spend that money.

10 But, anyway, when I think about the context
11 chapter, we always see that graph that shows that the
12 Medicare rates or the Medicare premiums and the commercial
13 PPO or HMO premiums are diverging. One way to look at that
14 is, well, it's a testament to Medicare's ability to
15 constrain rates, and it's sort of a testament to the rate-
16 setting function that Medicare does.

17 But then I also think about the payment adequacy
18 framework that we use. You know, this idea that we don't
19 have to cover a hospital's fully loaded cost, but that we
20 really -- as long as we're -- as long as we exceed -- or
21 payments exceed their variable costs, then we're --
22 basically, they'll continue to take our money.

1 Here's what I'm interested in, though. I think
2 it comes down to what is their variable cost. I mean, as
3 best I can tell, we pay 87 to 91 cents or so on the dollar
4 of a hospital's fully loaded cost. If you buy into the
5 idea that 80 percent of their costs are variable, I mean, I
6 think that's sort of one upper bound -- and, Jeff, you and
7 I have talked about this in the past -- and you consider
8 that commercial -- that hospital consolidation is paving
9 away for higher commercial rates and higher commercial
10 rates improve, increase hospital costs, we're only a few
11 years away. If it's an 80 percent variable cost and we're
12 covering 87 cents on the dollar, there's only about 7
13 percent there that's going toward covering hospital
14 overhead, covering fixed cost.

15 So we would be two or three mediocre Medicare
16 updates away from basically not being able to cover that
17 spread. In theory, they shouldn't want to take our money
18 anymore.

19 Now, I subscribe to the other school that
20 variable costs are more like 40, 50 percent, something like
21 that. If that school is right, then this whole concept of
22 shared savings doesn't work. Why would you give up an

1 admission or an ED visit, shed 50 percent of your variable
2 costs, for the chance to get 50 percent shared savings?

3 But I look at this, and it's sort of an untenable
4 situation, and I think that's part of what these questions
5 -- and I realize, this is much bigger than the chapter
6 reads. But it really -- it illustrates it doesn't really
7 matter what you believe. If you think it's 80 percent,
8 then we're a few updates away from not covering their
9 variable costs. If you believe it's 40 or 50 percent, then
10 the whole shared savings idea doesn't work.

11 The one takeaway that I get is we have to change
12 the way hospitals are paid, and again, I realize I've
13 gotten a lot bigger than the specific questions that
14 Congress is asking. But I don't see another solution other
15 than changing the way hospitals are paid. What's your
16 alternative? Are you going to undo a thousand mergers?
17 Are you going to try to do commercial rate setting? I
18 mean, I don't see a Plan B, but I do think this chapter,
19 there's a great set of questions and I think a great set of
20 research on your part. But I think it leads us down a path
21 that we need to recognize because this isn't being done in
22 a vacuum.

1 I mean, we have to also consider our context
2 chapter and our payment adequacy framework itself.

3 Thank you.

4 DR. CROSSON: Warner?

5 MR. THOMAS: Just to maybe add on a little bit to
6 Brian's point and maybe to Jaewon's question earlier, to
7 me, I think you do need to step back and take a broader
8 perspective on what's driving this situation. I think it's
9 11- or 12,000 people every day age into Medicare. So with
10 that acceleration into Medicare and given Brian's comments
11 on the payment accuracy, especially around inpatient
12 Medicare, which we look at, I mean, that creates tremendous
13 pressure on hospitals every day when someone converts from
14 commercial or traditional insurance into Medicare. So I
15 think that context of a macroeconomic issue in the industry
16 needs to be kind of in consideration when you think about
17 what are the things that are happening here and what's
18 driving it.

19 And I think Jaewon's question about where do you
20 see acceleration of Medicare recipients, is that driving
21 some of the consolidation and is it a correlation, I think,
22 is a really interesting question and one that should be

1 looked at and/or commented on in the report.

2 I think the second piece is I do think stepping
3 back and taking a national view of what does the industry
4 look like, not just looking at hospitals, but looking at it
5 in the context of insurers from a national perspective and
6 PBMs and GPOs on a national perspective and then look at
7 hospitals on a national perspective.

8 I absolutely get looking at the metropolitan
9 areas, but I do think taking a national perspective is
10 important, and in that, commenting on the fact that we do
11 see insurers looking at vertical integration -- and I
12 actually think the largest employer physician stay is
13 actually Optum, not a traditional provider, if you will.
14 That might be something to take a look at.

15 In my questions before, I also made a comment
16 about looking at outpatient because most of the comments in
17 here around consolidation are focused on inpatient, and
18 especially in areas where you don't have CON in markets
19 where you don't have a significant need, you see a
20 tremendous growth of nonhospital-owned ambulatory
21 facilities, which that's fine. It's a great competition,
22 but I do think it would be helpful to look at outpatient as

1 well as just inpatient services, seeing that we see a
2 continuous -- and we will likely see a continuous trend of
3 patients moving to outpatient or ambulatory versus being on
4 an inpatient. I think the more we look at consolidation on
5 inpatient only, I am not sure it is giving us the right
6 view of really what's happening in the industry.

7 So those are just some comments, but I do think
8 that setting this macro view of like what are some of the
9 things that are driving this, I think, are important. It's
10 not that consolidation just happening. I think it's the
11 macroeconomic policies and especially the acceleration of
12 Medicare recipients and what the pricing structures in
13 Medicare that is creating this economic pressure and
14 driving some of this consolidation.

15 DR. CROSSON: Thank you, Warner.

16 Larry?

17 DR. CASALINO: Great, really clearly written
18 chapter. To me, this is one of the most important issues
19 in U.S. health care right now, so I'm really glad to see
20 you addressing it.

21 I have a few comments, one just very briefly. I
22 think it would be worth calling out -- it would only take a

1 couple of paragraphs -- that integration means ownership,
2 and it doesn't mean clinical integration or real
3 integration. There's some literature. I know Steve
4 Shortell has written a lot about that. I think it's worth
5 at least saying because naive readers may think integration
6 means they're really integrated, which would lend some
7 weight to the argument that integration can reduce cost and
8 increase quality. I think the evidence is pretty strong
9 that most integrated systems are not very integrated in a
10 sense that would improve care.

11 I do want to comment a little bit on insurer
12 consolidation. I think that it is important to look at
13 that. It affects provider consolidation through two paths.
14 One is the big provider organizations want to get bigger,
15 so there's kind of an arms race between the insurers and
16 the big provider organizations. And you addressed that and
17 the effects of that a little bit in Richard Scheffler's
18 research on what that does to consumer cost. So I think
19 that's good.

20 But there's another way that might be mentioned
21 that insurer consolidation can affect provider
22 consolidation, which is that the insurers in a big hospital

1 system and employs lots of physicians may have a standoff
2 about prices, and basically, they both do pretty well, and
3 the consumers and employers lose.

4 But if you're a physician in a small practice or
5 even a medium-size practice, there's no negotiations there.
6 If there's a dominant insurer, you just take what they
7 dictate to you about prices, about prior authorization,
8 about whatever. So, therefore, you give up, and you say,
9 "Okay. Why should I be getting paid 90 percent of
10 Medicare? I can get -- you know, sell my practice to a
11 hospital system, and I get paid 170, 200 percent of
12 Medicare." So that's driving consolidation. Insurer
13 consolidation is driving provider consolidation in that way
14 as well.

15 It has been mentioned that insurers are buying
16 practices, and Optum now claims to be the biggest employer
17 of physician practices in the country. So I don't know
18 where that fits in the chapter, but it's not something that
19 I think is a relevant phenomenon that should be overlooked.

20 And one thing that -- this is more of a
21 historical point that I think is worth making. When a
22 regional insurer is acquired by a national insurer, that

1 can really harm provider and insurer risk contracting.

2 So, in California, particularly, there were very
3 good relationships in many cases between the large
4 independent California medical groups and insurers, state
5 insurers like PacifiCare, where they had very, very good
6 risk-sharing arrangements that had a lot of cost savings
7 and benefits. As soon as PacifiCare was acquired by
8 United, to something national, all that went away. And
9 I've heard some anecdotes that that still kind of happens,
10 although that horse may be out of the barn.

11 So in terms of hospitals not being affected by
12 federal policy, I'm glad that Karen asked the questions
13 that she did because that did kind of stop me cold when I
14 read it. I actually have been so focused on vertical
15 integration in federal policy. I hadn't thought it that
16 much.

17 But, still, I think to see that bold statement
18 unreferenced or without citations might be a little much,
19 and I would really encourage you to look harder at what
20 federal policies might affect horizontal consolidation,
21 really to the point of going and doing some interviews with
22 people from varying viewpoints, varying relevant sectors.

1 I'll bet you if you go around and ask knowledgeable people,
2 like Karen and others, well, what federal policies might be
3 affecting horizontal integration, you would get some
4 answers that, yes, it is. And so I wouldn't want to just
5 give federal policy a complete pass on that without more
6 investigation.

7 Antitrust is a form of federal policy, and
8 clearly, that's affected horizontal and vertical
9 integration, usually. The antitrust authorities were very
10 leery about bring horizontal hospital cases after losing
11 the cases. You alluded to that. Now they're getting a
12 little bolder.

13 Then in terms of vertical integration, I think
14 there's still a strong segment within the antitrust
15 agencies. They're very kind of -- very Chicago School of
16 Economics, let's just say, that maintains that vertical
17 integration cannot increase prices or cannot increase
18 negotiating leverage. And I've had conversations with
19 Chicago School of Economics and people within the agencies
20 who say that.

21 Now, I've never heard a hospital executive off
22 the record or a health insurer, insurance executive, or a

1 physician group executive who doesn't think that vertical
2 integration increases prices a lot, and you've shown it.
3 So I think that that might be -- you know, that's a concern
4 about what -- the direction of the antitrust agencies.

5 One thing that you didn't mention -- I'm not
6 going to go on forever, Jay.

7 [Laughter.]

8 DR. CASALINO: This will be, I hope, my longest
9 speech of the day because I really do care about this.

10 You didn't mention a cross-market mergers and
11 acquisitions, and Leemore Dafny has looked into that a
12 little bit. Again, the theory would be if you're not
13 developing high market share as a provider organization in
14 a local market, you're not going to get more negotiating
15 leverage. But I think Leemore questions that assumption
16 and might be worth looking at that.

17 And then I guess there are other question about
18 antitrust. Could the antitrust agencies be doing more? If
19 so, how? This may be going beyond the scope of the chapter
20 and also -- perhaps beyond the scope of the chapter, but
21 for the Commission to think about, if not antitrust, then
22 what to kind of deal with this?

1 And then just two more areas, two more points, I
2 think that the relationship of hospital systems, both
3 horizontal consolidation among hospitals, but also
4 acquisition of physician practices has real effects on risk
5 contracting. So I think, actually, in California, for
6 example, when the wave of mergers started in the '90s, it
7 wasn't even so much to try to increase prices paid by
8 health insurers. It was to stop risk contracting because
9 the large independent medical groups basically were doing
10 very, very well, taking huge amounts of risk, and the
11 reason they could do that is they weren't tied to any
12 particular hospital. And they could play hospitals off
13 against each other, both on what the groups were willing to
14 pay out of their global budgets for hospital services but
15 also on the hospital's willingness to cooperate with them,
16 like telling them when their patients are in the emergency
17 room, for example.

18 So if you were in a market where there were
19 multiple hospitals, you could play them off against each
20 other, the groups did very well, and I think it was good
21 for patients.

22 When the hospitals consolidated, then they could

1 say, "Well, screw you," and that's one of the things that
2 really hurt the groups. Now those groups are all owned by
3 hospitals.

4 So I think that to an earlier point, we hear
5 large hospital systems around the country, vertically
6 integrated systems, saying, "Oh, we can't take more risk.
7 We can't take downside risk for 2 percent of our Medicare
8 payments. It's too much. We're moving too fast." Well,
9 again, in California, groups with 100, 200 physicians were
10 taking huge amounts of risk and doing well with it because
11 they weren't tied to the hospital system.

12 This is not just about commercial prices, but
13 Medicare beneficiaries are going to be affected by the
14 unwillingness of these large hospital systems to take risk
15 and saying, "Oh, maybe in 10 years, we can take 5 percent
16 risk, downside risk."

17 One more point, I would just say -- and this is a
18 quick one -- there is a question, and this will affect
19 Medicare beneficiaries, not just commercial prices. What
20 is the proper size for a provider organization, or do we
21 have a system in which organizations will -- in which the
22 organizations that win and out-compete other ones will be

1 the ones that are the best size to improve quality and
2 control costs? To me, the answer is absolutely not.

3 The way to out-compete your rivals right now is
4 to get as big as possible. You can make much more money
5 from getting higher commercial rates than you can from
6 getting any kind of shared savings for Medicare or from
7 commercial plans.

8 So being really large is the name of the game, by
9 far, even if you're not actually as good an organization,
10 and the way that that can -- just to finish with this, the
11 way that that can affected Medicare beneficiaries is not
12 just the ways I've been mentioning, but also if you win by
13 being really big, not by being better, that will be true
14 not just for commercial patients, but also true for
15 Medicare patients. And there may be people, organizations
16 that would take better care of Medicare patients. They
17 won't exist because they'll lose out because of the large
18 systems getting higher commercial prices.

19 DR. CROSSON: Thank you, Larry. Very rich. So
20 let me see where we are. We've got Jaewon, Dana, and
21 Bruce, Amol, and David, and then I think we have exhausted
22 our time.

1 DR. RYU: Thanks, Jay. I wanted to thank you
2 all, because I thought this is a very nuanced area, and I
3 think the complexity of just the multifactorial nature, I
4 think you all captured it pretty well.

5 But that being said, there are two places where I
6 thought it would be good to just capture a little bit more
7 of the nuance, because it felt a little too binary or
8 dichotomous there, where, you know, maybe it was one or the
9 other, and I don't think it as black and white.

10 And so one of those areas was around just the
11 statements around vertical integration, and it's kind of
12 fitting Larry's comments earlier. But I worry about the
13 take-home message to a casual reader on this. And I think
14 we see it on Slide 15, we see it on page 29 and 31 in the
15 readings, but this notion that vertical integration, in and
16 of itself, is what leads to the higher prices.

17 I think, really, to me, it feels like it's not
18 just vertical integration as the model that leads to higher
19 prices but it's vertical integration combined with the
20 hospital outpatient billing dynamic that leads to the
21 higher prices.

22 And so I think that's a good nuance to call out,

1 because vertical integration, in and of itself, if you
2 didn't have the HOP billing dynamic, might actually be a
3 very good thing. I mean, you have got clinical integration
4 that gets powered off of physicians and hospitals working
5 together. You also have, I think, a better aptitude to be
6 able to come up with accountable and value-based care
7 models when you have the two working together.

8 And so rather than paint vertical integration in
9 and of itself as the culprit, I think it's really important
10 to call out that really it's the HOP billing. If you
11 address the HOP billing, vertical integration wouldn't be
12 as much of an issue, I think. So that was point one.

13 The second area is in sort of the binary price
14 discrimination versus cost shift dynamic. And I was doing
15 the wrestling in my own mind on this one--it feels like it's
16 a little bit of both. And I think some of the reading
17 suggested that it's a lot more of the price discrimination
18 and a lot of less of the cost shift, and I don't know which
19 is more or which is less. But if I imagine a world where
20 Medicare payment rates would go up, you would still have
21 health systems trying to extract as much as possible from
22 commercial payers. I get that and I think, you know, the

1 dynamic of no one is going to leave money on the table,
2 that makes sense. That would speak towards price
3 discrimination being the dynamic.

4 But if you also imagined a world Medicare
5 payments went down, I do think you'd have even more
6 aggressiveness trying to maintain or grow commercial rates.
7 And I think that kind of speaks towards cost shifting still
8 playing a key role in that dynamic. So it feels like it's
9 more both than it is one or the other, was just some of my
10 takeaway observation as I was reading the chapter.

11 DR. CROSSON: Jaewon, just let me come back to
12 you for a second. I am not quite sure I understood the
13 term you were using -- HOP billing?

14 DR. RYU: Hospital outpatient.

15 DR. CROSSON: Oh, oh. I'm sorry. Thanks.
16 Thanks.

17 Dana?

18 DR. SAFRAN: Yeah, thanks. Just a couple of
19 comments. So I want to just double down on Warner's
20 comment about trying to bring a macro view in here, because
21 as I'm listening to this conversation, one of the things
22 that, you know, I wasn't getting out of the chapter, and

1 that is really surfacing here, is the importance of tying
2 this whole phenomenon to how it's going to relate to the
3 goals of the program around payment reform and accountable
4 care organizations.

5 So I think we really need to put this set of
6 dynamics in that context, both from the perspective of how
7 will it limit the success but also how will the program
8 goals of creating accountable care organizations
9 potentially continue to drive this dynamic. So it's a kind
10 of feedback loop that I think we have to pay attention to.

11 And I'd say two other things about that. On the
12 horizontal, you know, your answer to my question on round
13 one was interesting, that, you know, we don't see evidence
14 in Medicare of moving business out to the community, and I
15 shared that in commercial we definitely do. And you --
16 your response about Maryland, I think it is something that
17 belongs in the chapter, as, you know, why don't we? In
18 fact, even without, you know, an accountable care framework
19 on those horizontally integrated institutions, they should,
20 just based on margin, want to have the lower-acuity cases
21 moving out to the community. If we don't see that
22 happening, why don't we, and what is it about the Maryland

1 policy where we see more of that? So I think that could
2 use some work.

3 And then on the vertical piece, you know, I think
4 Larry's comments about the history in California are
5 extremely important, and I can just share from my own
6 experience, you know, at Blue Cross, that, you know, we saw
7 that very same dynamic in the early years. There were some
8 large, independent physician groups that were able to sort
9 of pit hospitals within a market against each other, and it
10 was good for probably everyone except possibly the
11 hospitals. And that virtually has disappeared because of
12 the absorption of physician groups into hospitals.

13 So I do think we have to -- and we have, you
14 know, written about the fact that we see physician-led ACOs
15 performing more favorably than hospital-led ACOs, so I feel
16 like this chapter needs to connect the dots on those things
17 and pay attention to that vertical integration issue in
18 that context. Thanks.

19 DR. CROSSON: Thank you, Dana. Bruce.

20 MR. PYENSON: Thank you again. I would ask for a
21 clarification of the role of commercial rates with respect
22 to Medicare rates. And I noted that you've emphasized that

1 Medicare sets rates and, therefore, there is no impact of
2 commercial rates on commercial reimbursement on Medicare.
3 But I think there is perhaps ways that that is reflected,
4 and others have raised some of those concerns.

5 And, in particular, I think we have a counter-
6 example in the DME world, where the fact of lower
7 commercial reimbursement for DME has enabled Medicare to
8 reduce its rates. And if we lived in a world where
9 hospitals charged commercial payers less than what Medicare
10 was paying, that would probably lead to lower Medicare
11 reimbursement.

12 So I would just ask for clarification of those
13 kinds of issues or a bit more detail on that.

14 DR. PAUL GINSBURG: Excuse me. Bruce, on that
15 point, in DME lower commercial rates did not lower Medicare
16 rates until Medicare went to competitive bidding. So it's
17 not just the existence of lower rates that will make a
18 difference. Medicare has to establish a competitive
19 arrangement, because otherwise, you know, the lobbying will
20 keep the Medicare rate high.

21 MR. PYENSON: Right. Good point.

22 DR. DeBUSK: On that point, outside of code

1 reviews, I mean, they still were doing code reviews on DME
2 products prior to competitive bid too. So, yes, a lower
3 commercial rate could trigger a code review. So, Bruce,
4 I'm agreeing with you.

5 MR. PYENSON: I was agreeing with Paul.

6 DR. CROSSON: Warner, on this point?

7 MR. THOMAS: No.

8 DR. CROSSON: Sorry. So we've got Amol, David,
9 and Warner, and then we have to stop.

10 DR. NAVATHE: So I think this is a big topic and
11 you guys did a nice job of summarizing a lot of evidence to
12 date, so thank you for that.

13 A couple of points. I think picking up on a
14 couple of the themes that other Commissioners have
15 commented on. So one piece is I would echo the support, I
16 think, Karen and Larry mentioned around looking at other
17 Federal policies, and the class here that I will mention is
18 Federal policies that also enable states to change their
19 policies, is kind of one other area that is worth looking
20 at.

21 The other piece is, I think we heard a little bit
22 from Jon and David about trying to really understand

1 system-ness, the hospital definitions of what are hospitals
2 and hospital systems. I think the same should actually
3 apply to the insurer side. One question was whether you
4 guys were looking across lines of business, for example,
5 across commercial Medicare-managed Medicaid, in trying to
6 define what is an insurer.

7 The reason is while obviously on the Medicare
8 side and on the Medicaid side, the rate structure may be a
9 little bit more constrained for various reasons. There are
10 still other things that insurers can do to use their market
11 power across those different lines of business, and so I
12 think it's worth looking at that, because that could still
13 impact the commercial rate side.

14 The other piece there is, and Jaewon kind of made
15 reference to this, but there are also partnerships between
16 insurers and health systems. You guys made some reference
17 to that, actually, in the paper, as well, as a way to enter
18 markets, but that also potentially changes the dynamic, to
19 some extent, and can have some market power effects for the
20 insurer.

21 And the last point is most of our discussion has
22 not focused on this notion of price discrimination versus

1 cost shifting. Jaewon made reference to it. I think,
2 generally speaking, I agree with the way that you guys have
3 synthesized the literature, which is more evidence for
4 price discrimination. There is a relatively recent new
5 study that is an NBER working paper by Darden and
6 colleagues and I'm happy to share it, that looked at
7 Federal policies like HRP, that showed commercial insurers
8 did bear about 70 percent of the burden through a cost-
9 shifting-like mechanism. And so it may be worth including
10 some data points on the other side of the sort of argument,
11 so to speak. I am happy to follow up and share that with
12 you guys.

13 DR. CROSSON: David.

14 DR. GRABOWSKI: Great. Thanks. I am once again
15 thrilled that we are talking about this issue. I think
16 provider consolidation is really the elephant in the room
17 in a lot of the topics that we discuss on this Commission,
18 especially around value-based payment.

19 Several other Commissioners have already made
20 this point so I promise to be brief. But I think what was
21 kind of lost in the chapter was just the role Medicare, and
22 I think you were very narrow on kind of Medicare and

1 Federal policy, how that has impacted consolidation, and
2 then how both horizontal and vertical integration or
3 consolidation has impacted Medicare beneficiaries. And so
4 I pushed you on round one about some of those indirect
5 effects, and I would love to see that come out more in the
6 chapter. And whether it's a text box or maybe as Dana and
7 Warner were describing, like more of just a complete kind
8 of macro framing at the start of the chapter.

9 But I think we need to focus more on kind of
10 Medicare's role here. And it's been said several times,
11 and I even said it, but Medicare doesn't operate in a
12 vacuum, and just thinking about Medicare's role, vis-à-vis
13 other payers, I don't want that to get lost here. So any
14 way we can draw that out I think would be an improvement.
15 Thanks.

16 DR. CROSSON: On this point, Marge?

17 MS. MARJORIE GINSBURG: Yes, I think so. One
18 point of clarification. This is a report that's being
19 asked of us by Congress, so this is completely separate
20 from the things we produce in March and June, right? This
21 is a separate -- this has nothing to do -- is that right?

22 DR. CROSSON: Well, it is a specific request from

1 Congress, but it is not separate from our report.

2 MS. MARJORIE GINSBURG: So it will be
3 incorporated.

4 DR. CROSSON: Yes. We have multiple inputs, of
5 course, into the two reports we do each year. Some of
6 those are a direct request from Congress and some are
7 generated here.

8 MS. MARJORIE GINSBURG: I see. Okay, well then
9 forget my comment. Thank you.

10 DR. CROSSON: Okay. Warner, last comment, and we
11 need to move on.

12 MR. THOMAS: Just being a little more specific, I
13 mean, in the chapter, on page 6, and then at the top of
14 page 7, where you say, you know, "recent trends in hospital
15 consolidation, what degree of recent policy is
16 accelerated," and it said, you know, Federal policies do
17 not appear to be driving mergers. I guess the only thing I
18 would say is I really just don't think that's correct,
19 because the policy of having inpatient Medicare rates have
20 a negative margin is a big factor in driving consolidation
21 across the country. And I do think in the report it would
22 be helpful to just really be clear about that, that that is

1 a huge issue, and the escalation of people into Medicare is
2 a huge issue.

3 It may also even be helpful to identify -- I know
4 we have this is our annual chapter of kind of the overview
5 of what's happened in the program, but to identify
6 inpatient margin versus the other components, you know,
7 home health and post-acute and those types of things, to
8 just show the inpatient margin versus the other components
9 of the program, because that is a major factor that I
10 believe is driving this. It is not the only one. There
11 are a lot of things that are happening. But we indicate
12 that, you know, the outpatient rates are driving physician
13 consolidation to hospitals, but, I mean, this is a big,
14 fundamental issue of why you see a lot of this change
15 happening and why you see more pressure on commercial
16 insurers to cost shift some of this, because Medicare
17 inpatient rates continue to lag.

18 So I think it's a -- I just thought -- I don't
19 think those specific lines in the report are really
20 accurate, personally.

21 DR. PERLIN: On this point, Jay?

22 DR. CROSSON: On that point, and then Paul, as

1 well.

2 DR. PERLIN: To those who are actually in the
3 fray, it defies face validity for other reasons Warner
4 mentioned. I think just the fact, that if I'm correct in
5 this, CMS releases about 300,000 pages of new regulation
6 every year affecting hospitals, and for unaffiliated
7 hospitals to independently synthesize that is a very
8 difficult feat. Karen mentioned, you know, EHR, and EHR1
9 is far less efficient than larger.

10 You know, as to, you know, the great point that
11 was made about the alignment and difference between
12 alignment and ownership, that Larry made, you know, the
13 fact that hospitals and physicians are actually scored
14 differently on quality metrics and paid different under
15 different programs actually is a feature that actually
16 leads to a lack of alignment. And so there are a number of
17 structural issues that lead to consolidation, both
18 vertically and horizontally, and so that blanket statement,
19 I think, is one that will elicit a fairly strong reaction.
20 Thanks.

21 DR. CROSSON: Thank you. Paul.

22 DR. PAUL GINSBURG: Yeah, the issue that Warner

1 raised is something I've often thought about, and I guess
2 the way I'd characterize it is that if the hospital feels
3 under more pressure on Medicare or Medicaid rates, it's
4 perhaps willing to pursue a merger, to increase its
5 leverage, that it would not have been willing to pursue
6 otherwise. I don't know that there is a way for research
7 to get at that, so in a sense it becomes a logical
8 possibility, but I don't know that we'll ever have a
9 definitive answer.

10 MR. THOMAS: Or maybe it's just sustainability.

11 DR. CROSSON: Or an alternative is economy of
12 scale, to reduce costs in the face of reduced Medicare
13 payments.

14 MR. THOMAS: I'm not sure if it's Paul's point or
15 if it's just sustainability and fiscal stability to be --
16 to exist. I think there is a lot of -- I mean, there are a
17 lot of organizations doing well. There are a lot of
18 organizations that are literally on the edge. And so I
19 think sustainability is a real issue for many organizations
20 in the field today.

21 DR. CROSSON: Okay. Rich discussion. Plenty of
22 stuff for you guys, Dan and Jeff and Stephanie. Thanks so

1 much.

2 Okay. I think we can move on to the second
3 presentation. We have had a continuing dialogue for a
4 number of years now about our concern that fewer and fewer
5 physicians are seeking to practice in adult primary care
6 and a long-term concern as a consequence that we may be
7 moving towards a situation where Medicare beneficiaries who
8 wish to receive their primary care services from physicians
9 will not be able to do that in the future. And this
10 Commission has made a number of recommendations over the
11 years, and we are going to come at this again.

12 So in order to do that, we've had some field work
13 done by Rachel Burton and Ariel, who are here to give us
14 some feedback about what the players, if you will, out
15 there who are dealing with this question actually think and
16 made some suggestions to us as to where we might put our
17 energy. Ariel. I'm sorry. Rachel.

18 MS. BURTON: All right. Back in March,
19 Commissioners considered the idea of a new loan repayment
20 program to attract more physicians to primary care. At
21 that meeting, many of you encouraged us to identify other
22 possible policy options through interviews we were planning

1 to do with medical schools and by interviewing other types
2 of stakeholders.

3 Since that time, we have completed 25 interviews
4 and are now ready to share some of our key findings with
5 you. The paper we mailed out has additional information
6 not covered today.

7 We'd like to thank colleagues who helped us with
8 this paper, including Sam Bickel-Barlow, Alison Binkowski,
9 Brian O'Donnell, Carolyn San Soucie, and Ledia Tabor.

10 So why are we concerned about the primary care
11 pipeline?

12 Partly it's because studies have found that the
13 supply of primary care physicians is associated with many
14 benefits, including a higher likelihood of receiving
15 effective care, better patient experience, lower total
16 spending, and longer life expectancy. But as the next few
17 graphs will show, growth in the number of physicians
18 choosing primary care is slowing.

19 As Brian noted last month, the number of primary
20 care physicians billing Medicare has plateaued in recent
21 years (once hospitalists are excluded from our counts)
22 while the number of specialists continues to grow.

1 Although this has not yet caused primary care access
2 problems for beneficiaries, Commissioners have expressed
3 interest in preserving the supply of primary care
4 physicians.

5 One reason to believe the supply of primary care
6 physicians may not improve is the fact that declining
7 shares of internal medicine residents are planning to
8 practice general internal medicine, which is a type of
9 primary care.

10 Instead, more than half are pursuing additional
11 training to become specialists and one in five plans to
12 work as a hospitalist.

13 Perhaps even more relevant for the Medicare
14 program, the number of physicians training to become
15 geriatricians is very low and has been declining. At
16 present, only half the geriatric training positions in the
17 U.S. are even filled.

18 In addition, less than 2,000 geriatricians now
19 treat Medicare fee-for-service beneficiaries -- making up
20 about 1 percent of the primary care physicians who treat
21 this group.

22 To better understand how to attract more

1 physicians to primary care, and geriatrics specifically, we
2 did 25 interviews this summer.

3 Eight of our interviews were with medical
4 schools, half of which were allopathic and half of which
5 were osteopathic. All but one of these schools graduated
6 high shares of students who went on to pursue primary care.

7 We also interviewed 17 other stakeholders,
8 including leaders of primary care residency and geriatric
9 fellowship programs, national organizations involved in the
10 training of physicians, and researchers studying the
11 primary care pipeline. I will summarize interviewees'
12 thoughts about why a declining share of physicians are
13 pursuing primary care. Then Ariel will summarize
14 interviewees' suggested ways to reverse this trend. I'll
15 also note that interviewees' comments do not necessarily
16 reflect the Commission's views.

17 Our interviewees identified three main factors
18 that are dissuading physicians from pursuing primary care.

19 First, interviewees often cited primary care
20 physicians' low pay relative to specialists' as driving
21 physicians' career decisions. Over a lifetime of earnings,
22 specialists now make several million dollars more than

1 primary care physicians.

2 Second, interviewees often felt that medical
3 students and residents don't see primary care done well,
4 which makes them not want to pursue primary care as a
5 career. In particular, interviewees said residents are
6 turned off by the high number of visits primary care
7 physicians feel compelled to complete per day and the high
8 proportion of primary care physicians' time consumed by
9 administrative work, especially in practices that haven't
10 adopted a team-based approach to care.

11 Interviewees usually felt that residency programs
12 are too grounded in the hospital since only a third of
13 internal medicine residents' time is required to be in
14 outpatient settings.

15 The outpatient experiences they do get tend to be
16 in hospital-based clinics that are not representative of
17 community-based, ambulatory practices.

18 In these hospital-based clinics, interviewees
19 said faculty are there one day and out the next, and
20 residents might only spend a half-day in the clinic per
21 week, which makes it harder to develop long-term
22 relationships with staff and patients.

1 Interviewees also told us that primary care
2 residency programs rarely have geriatric rotations, which
3 they felt was a missed opportunity since geriatricians have
4 very high job satisfaction and exposure to geriatric
5 clinical experiences increases interest in pursuing
6 geriatrics as a career.

7 Finally, a third major factor identified by
8 interviewees was a perceived anti-primary care bias in
9 medical schools and residency programs. For example, one
10 interviewee told us he did exit interviews at one medical
11 school with grads going into primary care. All of them
12 said that faculty had recommended against going into
13 primary care and had encouraged them to specialize instead.

14 MR. WINTER: Next, we'll look at ideas suggested
15 by our interviewees for attracting more physicians to
16 primary care.

17 There are many entities in the health care system
18 that influence physicians' career choices. For example,
19 there are a number of programs and organizations that
20 finance graduate medical education, including Medicare,
21 state Medicaid programs, HRSA, the VA, DOD, and hospitals.
22 Thus, improving the primary care pipeline requires action

1 from actors, including Medicare.

2 The people we interviewed identified a number of
3 key factors to focus on, some of which touch on Medicare
4 and some of which do not.

5 One important issue is medical school. Medical
6 schools that graduate a high share of primary care
7 physicians told us that their recruitment efforts target
8 students who are likely to practice primary care; they also
9 stress the importance of role models who are primary care
10 physicians; and their students do clinical rotations in
11 community settings, which helps students envision
12 themselves outside of a large medical center.

13 However, medical schools are not an area where
14 Medicare has direct influence. On the other hand, Medicare
15 plays an important role with regards to residency programs
16 and physician payment. In the next few slides, we will
17 focus on policies that Medicare can implement.

18 Interviewees suggested several ideas related to
19 increasing the exposure of residents to geriatric care
20 settings and high-functioning primary care practices.

21 Some interviewees said that Medicare should pay
22 performance bonuses to residency programs based on the

1 share of their graduates who practice primary care.

2 Another idea is for Medicare to encourage
3 residency programs to train residents at high-functioning
4 practices, such as CPC+ or Primary Care First practices.
5 This would enable residents to experience a team-based
6 primary care environment.

7 Interviewees also suggested that Medicare require
8 residents to spend a greater share of their clinical time
9 in outpatient settings and require internal medicine and
10 family medicine residents to do geriatric rotations.

11 They also told us that Medicare could provide
12 more support for rural residency programs, which generally
13 have more of an outpatient focus.

14 This could include offering technical assistance
15 to rural community hospitals that want to set up their own
16 residency programs or expanding existing programs that
17 promote rural training.

18 For example, the Teaching Health Center Graduate
19 Medical Education program funds residency programs in
20 community-based, outpatient settings, over half of which
21 are in underserved areas. But this program only funds
22 about 800 residents a year, and the level of financing for

1 the program has been uneven.

2 Interviewees had several ideas to reduce the
3 compensation gap between primary care physicians and
4 specialists.

5 First, Medicare could increase payments for PCPs.
6 For example, Medicare could increase payment rates for
7 evaluation and management services, as CMS has recently
8 announced it will do starting in 2021.

9 Medicare could also expand payment models that
10 support team-based care, such as CPC+ or the new Primary
11 Care First model.

12 Second, the geriatricians we interviewed said
13 that Medicare should increase payments for geriatricians by
14 creating new billing codes for services such as
15 comprehensive geriatric assessments or use a higher
16 conversion factor for fee schedule services provided by
17 geriatricians.

18 Third, Medicare could establish and fund a loan
19 repayment program for primary care physicians. There were
20 mixed views about this idea. Some people thought that such
21 a program would attract more physicians to primary care,
22 but others disagreed because they felt it would not have a

1 major impact on income disparities between specialties.

2 We also asked about a Medicare loan repayment
3 program targeted only to geriatricians. According to a
4 geriatrician we spoke to, even if such a program attracted
5 only a small number of new physicians to geriatrics, the
6 field is so small that bringing in another 50 to 60 people
7 would make a difference.

8 So for next steps, please let us know if there's
9 any additional information that would be helpful and which,
10 if any, of these ideas for increasing the number of primary
11 care physicians you would like us to explore further.

12 This concludes our presentation. We'd be happy
13 to take any questions.

14 DR. PAUL GINSBURG: Thank you, Rachel and Ariel.
15 Open for clarifying questions. Kathy.

16 MS. BUTO: I wonder if you could tell us if we
17 know that there's an impending shortage of any of the
18 specialties, and I'm thinking particularly of
19 endocrinologists, nephrologists, physician subspecialties
20 that the Medicare population will really depend on. Do we
21 have any sense of that?

22 MR. WINTER: We've heard concerns that there are

1 -- about specialties that bill a lot of E&M services, like
2 rheumatology and neurology and endocrinology in particular.
3 In terms of whether there are shortages forecast for these
4 specific specialties, I'll have to look into that and get
5 back to you.

6 DR. DeSALVO: Kathy -- oh, I'm sorry.

7 MS. BUTO: Go ahead.

8 DR. DeSALVO: On this point, the fee schedule
9 rebalance rule that CMS put out Friday rebalances not only
10 to support primary care but the cognitive specialties,
11 including rheumatology and endocrinology.

12 MR. WINTER: And the impacts on those two
13 specialties in particular would be very large.

14 DR. PAUL GINSBURG: Yeah, if I could say, you
15 know, this pattern of shortages is for the most part
16 reflecting specialties or subspecialties that only do
17 visits are under stress. Those that do mostly procedures
18 are doing well, and, you know, as Karen pointed out, this
19 very substantial rebalancing of the fee schedule could
20 change that whole thing.

21 MS. BUTO: Yeah, I just think -- well, we can get
22 to that in Round 2, but just to keep in mind it isn't just

1 family practice and internal medicine practices that are in
2 danger.

3 DR. PAUL GINSBURG: That's right.

4 MS. BUTO: And I wondered, secondly, whether
5 there's a way to bring in a consideration of the growth in
6 the area of nurse practitioners and PAs because that's sort
7 of the other side of the coin, if you will, in terms of the
8 availability of primary care to beneficiaries. Did we
9 think about that or do we have a way to bring in -- because
10 I know we've done the analysis.

11 MR. WINTER: So in our June chapter from this
12 year, the chapter on primary care issues, we had a section
13 on primary care physicians and the pipeline and looking at
14 loan repayment programs. There was also a large section on
15 NPs and PAs and looking at incident-to billing. But we
16 also looked at the two areas in combination, and we charted
17 the decline in E&M visits billed to Medicare provided by
18 primary care physicians alongside of a very large increase
19 in the number of E&M services billed by NPs and PAs. And
20 so there does seem to be some substitution.

21 On the other hand, we also noted a growing trend
22 of NPs and PAs practicing in specialty areas, like some of

1 the specialties you just mentioned, and also procedural
2 specialties. And so, you know, we can't -- I don't think
3 it would make sense -- I'm not sure we should be counting
4 on NPs and PAs to fill all the gaps that could be left --
5 all the gaps that are left by a decline in primary care
6 physicians that we might see in the future.

7 MS. BUTO: Right. My point is just that as we
8 look at incentives for physicians to stay in primary care,
9 primary care, we might also want to think about that in
10 relation to NPs and PAs.

11 DR. PAUL GINSBURG: Marge.

12 MS. MARJORIE GINSBURG: Yes, I'm curious about
13 the geriatricians, and since there are so few of them, do
14 we know much about where they practice and how they
15 practice? I have a hard time envisioning very many
16 geriatrics setting up an independent office and expecting
17 anybody to come to their door. So are they usually
18 consolidated with other large PCP groups? Are they often
19 in systems that are salaried? So sort of what do we know
20 about where they are?

21 MS. BURTON: That's certainly an area that we can
22 look into. I will say that the interviewees all mentioned

1 that geriatricians tend to do longer visits, and they tend
2 to mainly serve people with Medicare and Medicaid and not a
3 lot of commercially insured. So they mentioned that as
4 like a differentiating feature. But I can look into the
5 question you are raising.

6 DR. PAUL GINSBURG: Yes, Amol.

7 DR. NAVATHE: Just with respect to the loan
8 repayment option, I was curious if you guys have any data
9 on the distribution of debt associated with medical school
10 for medical students and how that plays out across
11 geographics and how that ends up playing out across
12 specialty selection as well. It might be helpful to have
13 some of that fact base to be able to evaluate what the
14 benefit of such a program could be.

15 MR. WINTER: Yeah, so we will look into whether
16 there are data on debt by specialty -- I'm not aware of
17 any, but we'll look into that -- and whether there's any
18 data by geographic areas. In our June report, the chapter
19 on primary care, we did review the literature on the
20 various factors that affect specialty choice, and we
21 drilled down into the literature on particularly debt. And
22 the evidence there is mixed. There are some studies which

1 show that debt does play a significant influence on
2 specialty choice and other studies which find no effect and
3 other studies which find a mixed effect that, for example,
4 for physicians coming out of medical school with no medical
5 education debt, they're more likely to go into specialties,
6 higher-paying specialties; and physicians coming out with
7 higher debt are more likely to go into primary care, but
8 only up to a certain level. Above \$100,000, there's a
9 declining relationship.

10 So, you know, the evidence is kind of all over
11 the board, but we'll look into evidence regarding your
12 first two questions.

13 DR. PAUL GINSBURG: Sue and then Bruce.

14 MS. THOMPSON: Thank you, Paul, and thank you for
15 the chapter and our ongoing discussion.

16 In your interviewing, did you get a sense, of
17 those you interviewed, of their understanding of models
18 like patient-centered medical home, or team-based care, or
19 what the appetite was among students to be attracted to
20 that kind of a model, or how much education is happening to
21 inform them of that opportunity? That would be my first
22 question.

1 MS. BURTON: I think they had wide awareness of
2 those models. Interviewees often mentioned CPC+ and
3 Primary Care First and feeling like that was a good model
4 that they wanted more residents to be exposed to, and they
5 felt that residents, if they were exposed to those types of
6 practices, they would be more likely to pursue primary care
7 careers.

8 MS. THOMPSON: And then secondly, did any of them
9 mention, or did you query about their appetite for
10 technology -- telemedicine, managing, you know, a
11 population of beneficiaries from a, you know -- yeah, I'll
12 let you talk about that.

13 MS. BURTON: It is not a line that we pursued in
14 our interviews.

15 DR. CROSSON: Bruce.

16 MR. PYENSON: Thank you for the chapter. It
17 seemed like most of the comments coming from the
18 interviewees were along the lines of supply side, how to
19 increase supply. Were there any suggestions that would --
20 from a demand side, that is, create more demand for primary
21 care or geriatricians?

22 MR. WINTER: Demand by patients and

1 beneficiaries?

2 MR. PYENSON: Or payers or hospitals or others
3 that could fund?

4 MR. WINTER: Yeah. We focused mainly on the
5 supply side. We will go back and look -- I will go back
6 and look at my notes and see if there were -- if people
7 talked about the demand side in terms of employers and
8 payers.

9 DR. CROSSON: Well, we certainly hear comments
10 from time to time from ACOs, medical groups, and others who
11 were engaged in accepting risk for cost and quality that
12 integral to that is access to a good supply of adult
13 primary care physicians. And where there are shortages it
14 is a problem for those types of organizations.

15 MR. WINTER: And one thing I just remembered from
16 our interviews was talking to a leader of an osteopathic
17 medical school who talked about issues getting their
18 students clinical preceptors, placed into rotations with
19 primary care physicians. And he said it's generally
20 difficult, but in their market there are a lot of health
21 care systems that see -- they really want to attract and be
22 involved in developing a primary care workforce, and they

1 see opportunities to host these students at their systems
2 for their rotations, so that they can hopefully get them to
3 come back to do their residencies there and keep them on
4 staff. So we saw that as an opportunity to, you know, link
5 up with demand by health care systems for PCPs.

6 MR. PYENSON: Thanks. I recall, I think that was
7 in the reading material, description of that. So was there
8 any sense that that -- whether that demand was having any -
9 - could help solve this, the issue?

10 MR. WINTER: We didn't get -- we didn't pursue
11 that line of thought, but that is something certainly to
12 think about, whether higher demand will stimulate medical
13 schools to kind of change the way they approach things, to
14 kind of meet that demand. And certainly this was an issue
15 that a lot of schools that we're thinking about in the
16 context of rural and underserved areas, where they saw a
17 real shortage of PCPs, or where they were really targeting
18 their efforts to increase the PCP workforce in those
19 markets.

20 DR. CROSSON: Karen.

21 DR. DeSALVO: I'm not sure where the non sequitur
22 happened for me but it prompted something to ask you about,

1 which is last weekend I was at a Society of General
2 Internal Medicine meeting and an abstract was presented, so
3 not peer-reviewed yet but some early data from some
4 residents in the Boston system. And they looked at the
5 clinical and social complexity of the patients that their
6 residents saw, primarily, in primary care, compared with
7 the faculty clinic patients, and they saw pretty
8 significant difference in both the clinical and the social
9 complexity.

10 And it just sort of gets to the issue of it is
11 not only the practice environment but also the kinds of
12 patients that are directed to be seen by the residents,
13 predominantly, in those clinical, in the training clinics,
14 compared with faculty clinics.

15 I can't tell you how -- I would tell you, well,
16 let me say, experientially, I actually -- it has a lot of
17 face validity for me, that that is the way these things
18 work. And I just don't know if it's possible for -- can we
19 tell, in data, whether a patient is seen by a training
20 clinic compared with a faculty clinic, and try to tease out
21 if that's a national issue? Because it gets to this
22 question of, do they have the right resources even in a

1 resident training clinic of primary care to address the
2 clinical and social complexity of the individuals they are
3 serving.

4 MR. WINTER: Yeah, I don't think in our claims
5 data we can distinguish that, but maybe there is literature
6 out there that have looked at clinic in real -- you know,
7 case studies, for example, of clinics that are staffed by
8 residents versus faculty. So we can look at the
9 literature, but I don't think we can get at that with
10 Medicare claims data.

11 DR. CROSSON: Okay. Seeing no further questions
12 we will proceed to the discussion, and I think, Brian, you
13 are going to lead off.

14 DR. DeBUSK: First of all, I am really excited to
15 see you guys working on this. I think this is a very
16 important topic and it's great to see the Commission take
17 this up.

18 Full disclosure, I spend about 25 percent of my
19 time with a high-PCP medical school. We produce about 80
20 percent, or above 80 percent primary care physicians. And
21 I do think that your interviews were really, really
22 accurate. I think you guys did an excellent job of

1 ferreting out the information. And it was exciting reading
2 this because I felt like I was reading, you know, kind of
3 what I do for a living, so I liked that.

4 I love the term "high PCP." We are going to be
5 incorporating that into our marketing material shortly. We
6 are not going to give you credit for it, but it's a nice
7 term. We are going to use it.

8 One of the things I liked seeing in the chapter
9 emerge is, is this understanding that high-PCP schools and
10 traditional medical schools are fundamentally different. I
11 mean, we really do -- we recruit differently. I mean,
12 almost everything we do -- what we are looking for, the way
13 we interview, the questions, the mentoring process -- it's
14 just fundamentally different. And I'm hoping that from the
15 interviews you guys are gleaning that, that it's apples and
16 oranges.

17 It is also nice to see that, at least my belief,
18 that the loan forgiveness programs have limited
19 effectiveness. I mean, it's well-intended but I don't
20 think it's going to get you there. And, I mean, I've
21 talked about that in the past. It is not going to be the
22 silver bullet.

1 What I do want to mention, though, and I think
2 that the reading hinted to this, if you look at high-PCP
3 schools and traditional schools, medical schools, there's a
4 ton of friction out there right now. And the friction is
5 at the clinical rotation level and it's at the loan
6 forgiveness level -- oh, no, I'm sorry -- clinical rotation
7 level and the residency spot level.

8 And, you know, internally, we joke about it.
9 It's almost like the cattle-and-sheep wars. You know, we
10 use the resources differently, we want -- you know, in some
11 ways the traditional schools are always trying to box us
12 out of their clinical rotation spots and out of their
13 residency programs.

14 But I want to walk through, and try to get --
15 instead of complaining about that, what I want to do is
16 walk through some ideas that we could use. And what I
17 wanted to focus on first was on the clinical rotation
18 spots, because the high-PCP schools need more clinical
19 rotations. DCOM was one of the first, back in 2010 to
20 2015, to begin paying for clinical rotation spots.

21 One of the problems -- and I think the material
22 alluded to this, that you guys should focus on -- in 2010

1 to 2012, \$600 to \$800 per student per month bought me a
2 clinical rotation spot. That wasn't a problem. Now, even
3 \$1,200 to \$1,500 a month sometimes can't get those spots
4 established. And there are non-U.S. schools that will come
5 in and pay a multiple of that.

6 So one of the things, just to get specific, you
7 guys may want to explore a cap on clinical rotation spots.
8 And the reason I say that is not because we just don't want
9 to pay whatever the market rate is. It's just that every
10 time that number bumps up, we have to increase our tuition.
11 So what you're really doing is you're increasing student
12 debt, and you would be doing it -- I mean, obviously a
13 disproportionate number of these clinical rotation spots
14 would be blocked by high-PCP schools, so you're actually
15 disproportionately increasing primary care physician debt,
16 say, over the traditional school debt. So just watch out.
17 I think a cap there would be great.

18 I think funding the clinical sites, if Medicare
19 had some way to provide for funds for, say, a program
20 director or a site director or something, to help these --
21 the clinical rotation sites in the outpatient clinics --
22 let me qualify that -- I think having more quality

1 outpatient clinical rotation sites would be key, and I
2 think it wouldn't take a tremendous amount of money to help
3 fund those sites.

4 Typically, when we move in, we'll do a core of 12
5 students, and again I already told you our going rate is
6 about \$1,200 per student per month. But then we typically
7 will also have to fill that clinical director spot.
8 Sometimes that's \$40,000 a year. Sometimes that's \$200,000
9 a year. But that's another thing to consider. I think
10 there's some infrastructure that maybe Medicare or someone
11 else could help offset, that would avoid having these
12 monies be wrapped up in tuition. So caps and funding of
13 clinical sites.

14 The other thing, which would be a little
15 controversial, is I do think you need to eliminate
16 exclusivity arrangements. What you will see -- and we run
17 into this all the time -- we will run into a hospital
18 system, say a large, not-for-profit system, that has a
19 private practice physician who wants to take on one of our
20 students. Let's say it is in an outpatient clinic, they
21 want to take one of our students, everything is lined up.
22 We love them; they love us. But the medical center may be

1 under an exclusivity arrangement from a medical school, and
2 even though that medical school isn't particularly
3 interested in putting a student in that clinic, and the
4 physician that is involved in doing the precepting isn't a
5 member of the university faculty -- because that's
6 different.

7 I mean, if the physician was part of the faculty,
8 of the teaching school, practicing at the medical center, I
9 completely understand. That makes sense. But if they
10 aren't, having an agreement that forbid someone else from
11 coming in and doing preceptor work, simply because they're
12 -- and I think there's precedent there. I mean, hospitals
13 can't sign exclusivity arrangements with DMEs. They can't
14 sign exclusivity arrangements with nursing homes. I'm not
15 sure why they could even sign if they are going to accept
16 Federal funds, an exclusivity arrangement with a medical
17 school involving a professor that isn't on their payroll.

18 But those are the three things I would do to try
19 to free up some of the clinical rotation resources.

20 Next you get into residency funding. I think
21 there are a lot of ideas there. What I would do -- and
22 this is -- the thing you have to watch out, any time you

1 try to raise the cap or introduce more money into the
2 residency pool, the problem is you've got probably \$1
3 billion worth of unfunded residency positions out there
4 already, you know, where institutions have gone over their
5 cap. Well, those residency slots are very fungible. So
6 your problem there is that if I put more money into primary
7 care, they can also shift spots, move spots around, and it
8 would be difficult to make sure that money actually hit
9 primary care.

10 One idea -- and this may draw a lot of criticism
11 -- would be to split the pools of GME funding. Have a pool
12 of specialty funding. And I'm not suggesting cutting
13 anyone. I'm not suggesting -- you know, basically if you
14 split the pools out you could let the specialties operate
15 under the old GME rules, which would involve caps and, you
16 know, what you would have to do for new hospitals. But if
17 primary care GME funding was split out, you would at least
18 have the option to say raise the cap, or temporarily
19 eliminate the cap for a certain period of time.

20 The other thing you could do, getting these
21 hospitals that are uncapped, that don't have residency
22 programs -- you know, because now you can start a problem

1 from scratch, and over five years you build up your number.
2 The reason that hospitals are a little hesitant to do that
3 is because you go for about two years. You know, there's a
4 lag between when you incur all these costs and these
5 payments. And it can cost \$1 to \$3 million worth of what's
6 really permanently lost revenue, because by the time the
7 lag occurs you never truly get that money back. I mean,
8 that becomes an investment, even though it's money you're
9 going to get.

10 You know, as we speak, I mean, but for this
11 meeting I would be in Tupelo, Mississippi, right now, for a
12 1:00 meeting, where we are going to bring some cash to try
13 to convince a medical center to start a residency program.
14 And that was the other thing I wanted to mention. I think
15 being able to do some targeted money there would be
16 beneficial to these high-PCP schools, because what you are
17 seeing us do -- and it's not just DCOM that's doing this --
18 we are starting to fund those programs.

19 Well, when we fund those programs, that's coming
20 from tuition too. If you look at what's happening to the
21 high-PCP schools, in clinical rotations and in residencies,
22 every time we try to fix this solution with cash, what it

1 translates into is a higher tuition, which translates into
2 more medical debt. And I think these primary care doctors
3 are the last people that we want to have higher debt,
4 because they are the ones that are most poorly equipped to
5 pay it off.

6 So those are -- back to the residency idea, I do
7 think splitting the pool, I think exploring and expanding
8 the cap, and I think doing a program for limited start-up
9 capital. You might even want to do it as matching funds,
10 where the high-PCP school brings some of the money to the
11 table and then, say, Medicare would match it. The only
12 problem is we're going to ask for something. We're going
13 to want some exclusivity or some form of comfort ourselves.
14 So, you know, there is benefit to Medicare doing it and
15 leaving it open to all.

16 And then the final thing I want to mention -- and
17 sorry this has gone a little longer than I'd hoped -- the
18 final thing you guys ought to look at, the ACGME
19 requirements for things like family medicine, they were
20 designed in a hospital-based context.

21 So, for example, some of the requirements, that
22 you have 1,650 visits, not a problem at all. But some of

1 the requirements, for example, they want to deliver a
2 certain number of babies. Well, that can complete with the
3 hospital's OB services. Or, for example, they have
4 inpatient pediatrics. Well, you know, for a rural family
5 practice, if you're trying to set up a residency program
6 that involves a lot of rural family medicine, you're
7 probably not going to meet the ACGME requirements and see
8 that many inpatient peds.

9 So we probably need to just revisit those. I
10 wouldn't call them onerous. I just don't know that they
11 were developed with the outpatient setting in mind. So I
12 think that's the other thing that you could do to encourage
13 some of these primary care residencies.

14 And with that I'm done.

15 MR. WINTER: Just along the lines of one of your
16 ideas for residency funding, I just want to note that in
17 our paper we mentioned briefly that there is a HRSA grant
18 program for the states that want to establish new rural
19 residency programs.

20 DR. DeBUSK: But that isn't guaranteed money.
21 What happens is they have to apply for it, and then in any
22 given year that money could go away.

1 MR. WINTER: Yeah.

2 DR. DeBUSK: If you could figure out how to make
3 that money permanent, or at least consistent, I think
4 you're off to a good start. I just think you would need
5 more -- I can just tell you, to get a residency program off
6 the ground, we usually can get people interested for \$1 to
7 \$3 million. That's sort of the ballpark number.

8 DR. CROSSON: Larry, Karen, Jonathan.

9 DR. CASALINO: I have very brief comments. One
10 is your brief has already had one positive effect on the
11 world, I would say, or at least on me. It's made me feel
12 less alone.

13 I was very glad to see that your interviews, your
14 comments about faculty telling students, "You're too smart
15 to go into primary care," my experience is a little
16 different. The faculty that liked me said that, basically,
17 "You're too smart to go into primary care," but the faculty
18 that didn't think that well of me made very clear that,
19 "Yeah, that's about right for someone like you, to go into
20 primary care."

21 [Laughter.]

22 DR. CASALINO: So thank you. All these years

1 I've had to carry that, and now I have this.

2 But there are two substantive points I want to
3 make, very quickly. One is in terms of the demand side
4 comment that Bruce made. I think the thing about the
5 demand side is good. Again, something that was very clear
6 in the '90s, and has been almost, not completely forgotten
7 but you don't see much of it anymore, is that organizations
8 that are taking global cap, or some semblance thereof,
9 really do want primary care physicians, and that would
10 usually increase the demand for primary care if, in fact,
11 we saw provider organizations that were accountable for a
12 higher percentage of costs.

13 There's another way that moving in the direction
14 of global cap, though, I think, would not increase the
15 demand of primary care physicians but maybe the supply, and
16 would make primary care a better job, is the whole field of
17 telemedicine. So, you know, right now primary care
18 physicians, in my experience, at least, hate telemedicine,
19 because it's not a substitute for work they already do.
20 It's just a complete add-on, because they're in fee-for-
21 service environments.

22 In my institution, for example, 100 percent

1 value-based payments, 1 percent revenue from value-based
2 payments. The primary care physicians, therefore, have to
3 see just as many patients in person as they did before,
4 because they have to keep generating the fee-for-service
5 revenue at that level. But they are still expected to
6 communicate with patients, many, many patients, through
7 various things of what I'll just call telemed.

8 And actually, you know, my primary care physician
9 has expressly told me he is thinking of retiring. He is a
10 great physician, very dedicated, but he said, "You know, I
11 spend a hours a day on this. I communicate offline and I
12 don't get paid anything for it. It just means I do two
13 hours of that work a day."

14 So I think that paying for telemedicine is a
15 short-term stop gap for that, but better would be, in a
16 globally capitated environment, that would become an
17 integral part of primary care physician work, not just an
18 add-on.

19 And the only other thing I wanted to say, in
20 terms of training, I think the points you make about the
21 limitations of primary care training for medical students
22 and residents are all very good. I would just emphasize

1 one that I don't think you quite said flat out. It's not
2 just being in a high-quality primary care environment. In
3 my 20 years of full-time primary care, one of the most
4 satisfying things was the longitudinal relationships I had
5 with patients and their families, often three generations
6 of the same family. That was intensely satisfying, and
7 being there for them every day, pretty much.

8 So it's very hard to build that into -- you can't
9 build it into a medical student experience, and it is not
10 easy to build it into a primary care resident experience.
11 I think there are people in this room -- you know, Brian
12 and probably many others -- who understand better what it
13 would take to change the way primary care residents are
14 trained, but essentially they would have to have a lot more
15 time out of the hospital and doing outpatient care.

16 But not just doing outpatient care, but have it
17 set up in such a way that from year one through year three
18 you're really seeing the same patients, again and again.
19 Otherwise, there's no reason to do primary care ever,
20 really. There really is very little need now, with
21 hospital medicine, hospitalists becoming such a big part of
22 the workforce, very little need for primary care physicians

1 to have the inpatient skills that we all spent a lot of
2 time learning before.

3 MR. WINTER: Larry, there are some medical
4 schools that have these longitudinal care models for
5 primary care, and we note that in the chapter, in the
6 paper, so we can have --

7 DR. CASALINO: One thing to think about -- and I
8 don't have really an answer to this -- is this too micro
9 for federal policy? Does it really have to be school-
10 specific, or is there anything that federal or state policy
11 could do that would encourage them?

12 DR. CROSSON: Well, I think, you know, thinking
13 back to some of the work we did on GME funding, IME funding
14 specifically, some years ago, there was a fundamental issue
15 on the table, which is still there, which is, If Medicare
16 is the primary payer for graduate medical education, does
17 the Medicare program have the right or the responsibility
18 to require some specific output from the expenditure of
19 those dollars? And I think the answer is yes.

20 We spent some time some years ago talking about
21 the nature of the education that residents receive. Are
22 they prepared for the world that they are going to enter

1 and practice in the next 30 years?

2 But I think, legitimately, the question of who is
3 being trained and with what specific patient experience is
4 definitely at play here, and so one could conceive, if the
5 Commission wants to move in this direction eventually, that
6 we could make a recommendation for some direction in terms
7 of the nature of the experience that residents receive, and
8 that the type of experience you are describing be increased
9 in order for facilities to receive the payments.

10 DR. CASALINO: If I may, just for one, 30
11 seconds. I think that could be emphasized a lot more
12 because I think other aspects of their experience and
13 training are more emphasized than that, and to me, this is
14 the primary reason to be a primary care physician, to have
15 a longitudinal relationship with things. If you don't have
16 that, you might as well not do it, really.

17 So more, if it is appropriate to talk about
18 federal policy, GME, having some expectations about that,
19 that would be great, I think.

20 DR. CROSSON: Thank you, Larry.

21 Okay. Karen.

22 DR. DeSALVO: Terrific. Well, favorite topic of

1 mine.

2 But following on what you just said, Jay, I do
3 think it's the responsibility of the Commission and of the
4 Medicare program to direct and drive the output of the
5 dollars that we spend on training the physician workforce.

6 On the other hand, I think you have to be really
7 careful about it because if you -- just checking a box that
8 you had experience in your outpatient setting, it may be
9 such a terrible experience for a variety of reasons that
10 you would absolutely never want to go into primary care.

11 So I think that per other conversations about GME
12 and partnering with others, we have to be really thoughtful
13 about how to drive and direct it.

14 I do think that supporting the environment where
15 the training happens, including making sure there's
16 appropriate resources for clinical teachers, but also for
17 the preceptors themselves makes a lot of sense.

18 I wanted to make two comments. One is about
19 supply and demand. I do believe that -- of course, Kathy
20 is right; she's always right -- that there's more than just
21 primary care at hand here, that there are an array of
22 specialists that we need to keep our eye on who partner

1 with primary care and thinking about this in the context of
2 what are the other choices that clinicians are making.
3 That's also, by the way, how a blunt instrument like
4 requiring a certain amount of primary care could get us in
5 trouble if we needed more other specialties.

6 But I had shared with you a paper from the
7 Journal of General Internal Medicine that seemed to show
8 from some large national databases that there seems to be
9 less demand for primary care for whatever reason. They
10 offer some options. Some of that could be just other --
11 telehealth or better coordinated care or maybe just a
12 changing way that people are asking for service delivery.
13 So we should keep our eye on what is it the beneficiaries
14 want and need, and we've talked about this also. It's not
15 just the access to care, so supply and demand important.

16 But I just have a suggestion about a pathway for
17 increasing supply that doesn't have to do with the longer
18 pipeline that we've been thinking more about, and it's just
19 a notion around midcareer physicians who want to make a
20 switch, whether they've been either out of the workforce
21 for some reason or applying your skills in another way in
22 the workforce and would like to go back into practicing

1 primary care if they've been maybe in a subspecialty like
2 pulmonary or something like emergency medicine and they
3 wanted to switch to primary care.

4 To my knowledge, there's not really any programs
5 that support physicians relearning primary care in
6 midcareer. To be more specific, I think, Jonathan, the way
7 I'd want to do it is have it happen at the VA because I
8 think you could easily have a lot of sites nationally that
9 could take on someone for a few months to retrain in
10 primary care and one of the best models there is in the
11 country, in my opinion, with a lot of good data backbone,
12 to look for competency-based improvement, not just time in.
13 So maybe we should think a little bit about -- where I'm
14 going with this idea is that we don't have to necessarily
15 wait for the pipeline to develop over time.

16 There may be physicians or clinicians -- I'll say
17 physicians in particular because that's what we're talking
18 about -- who would want to get back in the workforce, but
19 there's not a pathway for them to do that or to switch
20 somewhere later in their career.

21 DR. CROSSON: Thank you, Karen.

22 Jonathan?

1 DR. JAFFERY: Yeah. Thanks. To follow up on
2 what Karen just said, I think that's a really interesting
3 idea, and I thought there was some program maybe in San
4 Diego or something. But it's pretty limited, and I do
5 think would be an interesting thing to develop.

6 So I entered my internal medicine residency in a
7 primary care program, and as you know, I'm a specialist.
8 There's a number of factors for that. I don't think
9 compensation was one of them or certainly not the major
10 driving one.

11 So when I reflect on it, I really do think about
12 a lot of this team-based care and the experience, at least
13 that I had in training, with excellent preceptors, who I
14 still stay in contact with and think are just fantastic
15 doctors.

16 But the experience that I was seeing was not the
17 supportive environment that I could picture myself spending
18 my career practicing in.

19 As I think about the chapter in that context,
20 there are kind of two main things, comments I wanted to
21 make. One is around the teaching health centers.
22 Actually, I think it is on Slide 13. You referenced

1 something about rural programs. So just keep in mind that
2 I think the teaching health centers don't
3 have to be just rural, so there's that.

4 And this is woven throughout the discussion today
5 and your presentation and the chapter, but a big set of
6 barriers is around that that funding is separate. It's
7 primary driven through HRSA, if I am not correct, THC
8 funding?

9 MR. WINTER: Yeah, that's all HRSA.

10 DR. JAFFERY: It's all HRSA, and it's not as
11 stable as we think about GME. If we could not have it be
12 such a separate piece and give folks that stability, they
13 might be much more inclined to set up those programs,
14 again, in not only rural setting but maybe urban settings
15 or whatnot.

16 The second part may be related. It goes back to
17 this team-based care model. I thought it was really
18 interesting that you had a number of -- your interviews
19 mentioned things like CPC and the primary care plus. I
20 wouldn't have guessed that based on the types of folks you
21 interviewed. In my experience, at least in Madison, those
22 folks are not really thinking about these kinds of care

1 models. So I was actually glad to hear that they thought
2 about it.

3 There's, to me, a lot of uncertainty still around
4 how those would create those team-based care models. I
5 think that's a really crucial piece to try and encourage
6 that, but maybe there's also work that could be done about
7 how do we flesh out what that really means.

8 So those are my comments. Thank you.

9 DR. CROSSON: Thank you, Jonathan.
10 Kathy?

11 MS. BUTO: So thanks for this work. I think it
12 continues to be really interesting and stimulating.

13 I was struck by in the reading materials on page
14 12. I know it was one interview with the residency
15 director who said about compensation. It's a relative
16 thing rather than an enough money thing, and that he didn't
17 actually -- or she didn't -- that most people don't
18 complain about the amount of income, just relative to their
19 specialty colleagues.

20 And it's been my belief, based on the feedback
21 over the years I've heard from primary care physician
22 groups as well, that it really is more about the relative.

1 So I'm a fan of increasing E&M payments, but I
2 don't think that's really the answer to this issue if we
3 think this is central to maintaining the supply or
4 increasing the supply of primary care physicians.

5 I would like to see something that is maybe more
6 like a beefed-up primary-care per-beneficiary amount that
7 we talked about way back a couple years ago, and that would
8 be an add-on. And I wouldn't do it by service because I
9 don't think we want to stimulate utilization, especially
10 unnecessary utilization, of course, but really almost a
11 per-member per-month kind of arrangement. And maybe CPC+
12 or using the AAPM approach -- in other words, you would
13 only be entitled to this if you were part of an AAPM or
14 engaged in something like CPC+, so that everybody wouldn't
15 just gratuitously get an added fee.

16 But it strikes me that that's, in my view, a
17 better way to even up or at least to begin to address the
18 income disparity, while recognizing the unique role that
19 primary care physicians play, rather than just paying them
20 more for every service that they provide.

21 So, on that note, I really liked a lot of the
22 suggestions, but not the one coming that came from, I

1 think, the geriatrician group, that there be a separate
2 conversion factor. So, again, I would address that by some
3 sort of an add-on payment or a bonus payment in relation to
4 whatever the structure is we think makes sense to stimulate
5 more geriatric practices, but do it as a flat amount rather
6 than do it as a conversion factor to services. Again, I
7 think that just stimulates more utilization or encourages
8 more utilization.

9 Then, as I said earlier in the earlier session, I
10 think it would be helpful to somehow down the road at least
11 acknowledge that whatever approaches we think makes sense,
12 increasing the physician pipeline for primary care, that we
13 look at how those same incentives would apply to nurse
14 practitioners. Again, if we think they're specializing or
15 having the same problem, let's look at having something
16 that's basically very congruent with whatever we think
17 makes sense for primary care physicians.

18 DR. CROSSON: Thank you, Kathy.

19 Jon is next. Jon and then Bruce.

20 DR. PERLIN: Great. Well, let me thank you for a
21 terrific chapter. I thought it was very thoughtful.

22 As an aside, before I get to my comment, let me

1 just thank Karen for calling out the VA model because I
2 think it's really special. Currently, the model is called
3 Patient Aligned Care Teams. By nature, it's very patient-
4 centric. VA's population is disproportionately congruent
5 with them, Medicare beneficiaries, and it sort of includes
6 a really team-based care approach. But it is, candidly, a
7 lot of fun to practice, and it's why I continued on the
8 primary care track and ultimately affiliated with VA, that
9 longitudinal experience that Larry mentioned that's
10 incredibly powerful in terms of overcoming some of the
11 adverse marketing that steers people away from primary
12 care.

13 I just had a couple notions, one building a
14 little bit on Kathy's point. When you think of what a
15 primary care provider does, they have sort of two distinct
16 roles. One is the care of the individual patient. Again,
17 the fun part is, obviously, that longitudinal relationship,
18 but in another sense, they are also caring for a panel of
19 patients.

20 When you think about our considerations in terms
21 of the evolution of Medicare payment, I know we have been
22 thinking about these sort of grand sort of machinations,

1 but I would hope we would also think about some things that
2 may actually be better suited to CMMI tests where primary
3 care providers might be rewarded for the successful care of
4 a panel of patients, the specifics of that to be
5 determined. But one can envision that it's really the
6 convergence to those two factors, knowing that you've cared
7 well for an individual and family with whom you've
8 established a relationship and, two, that you've cared well
9 for a group of patients that you consider your patients
10 that are invested in. I think bring that together with a
11 compensation model.

12 It gets beyond what Kathy essential described,
13 what in the HR literature is known as the hygiene factors,
14 enough money to make needs, but the rest of it is really
15 about the meaning of work.

16 Just coming beyond that, I think there is one
17 very practical piece of advice, I think, I have for you on
18 this chapter, which is that on pages 18 and 19, you've
19 quite rightly interviewed those high-PCP environments and
20 gotten their insights. I think just for the uptick of this
21 chapter and perhaps to see if there aren't some other ideas
22 as well, go to some of the low-PCP environments and ask

1 them what their ideas are. I think you might find that
2 there are some mechanisms that converge.

3 As I say, I also think, just in terms of the
4 impact of the chapter and its uptake, it's apt to fall more
5 favorably.

6 Thanks.

7 DR. CROSSON: Thank you, Jon.

8 Bruce?

9 MR. WINTER: Just to point out we did look at --
10 we did talk to one school, a medical school that we
11 selected, specifically because it was a low, low PCP
12 school, and used that as a contrasting site for the high-
13 PCP schools.

14 What they were doing was they acknowledged that
15 most of their students go on to specialties, but they were
16 starting a special training track, a leadership track for
17 students who wanted to go into primary care. And they had
18 kind of a special admissions process. So they were trying
19 to do their own thing at a smaller level.

20 DR. CROSSON: Bruce?

21 MR. PYENSON: I can't help but think that there
22 might be ways through the conditions of participation or

1 other means that Medicare has to influence the provider,
2 large providers to encourage roles of geriatrics or primary
3 care, either training or access to specialties or
4 geriatrics or primary care. Of course, we've seen how
5 effective that was with electronic medical records and the
6 promotion of that.

7 So I would ask almost as a forward-looking
8 whether creating, balancing the demand for specialty, which
9 is evidently much bigger than the demand for primary care,
10 could be somehow balanced through other means,
11 participation in Medicare.

12 DR. CROSSON: Thank you, Bruce.

13 Warner?

14 MR. THOMAS: Yeah, just briefly. I think this
15 idea of either increasing or having -- I think going to
16 Brian's point, having shared investment, I mean, we've had
17 these hard caps on GME for a long time, and I think the
18 idea if organizations wanted to target investment in this
19 area that there be some federal opportunity to do that and
20 do it in a shared fashion.

21 The thing about incentives or says that we could
22 create incentives in that area, I think, would be really

1 interesting, and I think the challenge is -- I think E&M
2 change, which we talked about earlier today, is a really
3 positive move for primary care, but it's got a long delayed
4 kind of impact that's just going to take time. And I think
5 if there was something more immediate, you may see the
6 training program open up and just do things in a broader
7 fashion.

8 As an aside -- and this is off the topic, but I
9 do think at some point, we could talk about just workforce
10 in general. I think that's one of the biggest issues
11 facing the industry today, and there are a lot of barriers
12 to training and educating lots of different components of
13 the workforce, physical therapy, pharmacy, nursing, and I
14 think those are really gating items and serious issues for
15 the industry going forward. It may be interesting to at
16 least have a conversation about that topic in a broader
17 fashion.

18 Obviously, primary care is a huge issue, but
19 these other disciplines are really important. And there's
20 a really big need and shortage in many of those areas.

21 DR. CROSSON: Thank you, Warner. David.

22 DR. GRABOWSKI: Great. Thanks, Jay. I think if

1 we all asked our colleagues and friends what percentage of
2 Medicare beneficiaries are receiving primary care from a
3 geriatrician, I don't think many of us would say the answer
4 was 1 percent there. That really struck me in the chapter.
5 I see a lot of surprising numbers in MedPAC reports.
6 Usually they have a dollar figure in front of them, and
7 they're really big numbers. But that can only -- you know,
8 that less than 2,000 geriatricians treated fee-for-service
9 beneficiaries in 2017 is just staggering, and it really
10 makes me wonder. It's almost -- I wanted to say, you know,
11 geriatricians are like primary care physicians only more
12 so, but I think it's actually -- there's a whole other
13 level of a problem here. It's probably much more nuanced.

14 And so I wonder if -- it's great that we're
15 taking it on in this chapter, but if this is a direction we
16 want to go -- and that's obviously up for debate. I think
17 there are many in our field who believe, you know,
18 geriatricians, through their specialized training and these
19 longer visits, and much of what they provide do a better
20 job. There are others that debate that, but we can
21 certainly consider if we want to grow this group that
22 there's a lot of work here to be done, and maybe that's

1 deserving of a longer treatment by MedPAC, if that's
2 something that we as a Commission think needs to be
3 encouraged. So I just wanted to say that.

4 DR. CROSSON: Yeah, and I actually was going to
5 make a similar comment, that I hadn't heard very much about
6 geriatricians in this discussion, so I was starting to
7 wonder why. And I think maybe it has something to do with
8 what you said, which is this is really -- it's connected to
9 the supply problem, but on the one hand, it's different.
10 You know, it's really about what role these individuals
11 should be playing. They have a specific expertise. But
12 whether, you know, somebody mentioned the fact that one of
13 the comments that you had received was, gee, if we could
14 increase the number of geriatricians by 50 -- right? --
15 that would make a difference. It would make a difference
16 in something, but I don't think it would make much of a
17 difference in the problem that we're talking about, which
18 is the long-term supply of primary care physicians to treat
19 Medicare patients. But there may be, as you say, something
20 there that is a separate issue that needs to be undertaken.
21 Now, whether it's fodder for this Commission or not, I
22 think that's a good point.

1 Jon, do you want to comment on that?

2 DR. PERLIN: On this point, thank you. You know,
3 I think too often the model, incorrectly, is that the
4 geriatrician sees the patient after there's been some
5 failing of care in whatever those sort of mainstream set of
6 services are. It's not to diminish the expertise anywhere.
7 And, in fact, you know, a much healthier model and one of
8 the things, again, alluding to VA, for example, the
9 Geriatric Research and Education Centers, or the GRECCs,
10 are a program that imbue the system, you know, really with
11 a precursor to what became the Age-Friendly Health System
12 concept, you know, 4Ms of the Age-Friendly Health System:
13 mentation, mobility, medication, and what matters to the
14 patient.

15 The reason they call these things out is that,
16 again, when we think about the sustainability of the care,
17 one of the first maneuvers of the geriatrician is really
18 focusing on what matters and the medications. And,
19 oftentimes, deconflicting both of those actually leads to a
20 much better clinical course, one that's much more
21 compatible with the desires of the patient, and oh, by the
22 way, much less intense in terms of resource utilization.

1 Thanks.

2 DR. CROSSON: Good point. Pat.

3 MS. WANG: On this point, you know, I think it's
4 a very important question to raise about geriatricians, and
5 the comments have been made earlier and your findings in
6 the interviews that, you know, the longitudinal experience
7 is very important to encourage people to pursue a career in
8 primary care. The thing in my very small sample size of
9 friends and family who are devoted geriatricians, like two
10 of them, actually, who are partners --

11 [Laughter.]

12 MS. WANG: -- is that geriatricians also like old
13 people, and they will tell you that, that they really like
14 old people, and they have been influenced by their own
15 family experiences. That is a very special thing that
16 perhaps we could take that lesson into our thinking about
17 primary care for the Medicare population generally so that,
18 in addition to building in, you know, really quality
19 experiences that are longitudinal, that there also be an
20 emphasis on quality longitudinal experiences with an
21 elderly population. I think that some geriatricians are
22 surprised to find that people kind of look down on their

1 profession because they feel like they take care of the
2 most complex patients in the system, so how could anybody
3 think that they should be paid less or what have you.

4 So I would just -- so, you know, on Slide 14,
5 this idea of increasing payments for geriatricians, billing
6 codes, higher fee schedule conversion factor, if there were
7 a way to expand that notion to also any primary care
8 physician who's taking care of a certain type of elderly
9 patient so that, you know, the production of geriatricians
10 I think is a very important focus because that's their
11 specialty. But, you know, a general internist can
12 certainly take care of older people, too, but they also
13 need this treatment about recognition that it takes more
14 time to do an office visit, higher payment and recognition
15 of that. So maybe there could be some blending of the
16 experiences of what does it take to get more people to
17 actually be specializing in geriatric medicine, and how do
18 you take some of those, you know, insights and spread them
19 to other PCP tracks.

20 DR. CROSSON: Thank you, Pat. Jaewon.

21 DR. RYU: Just a quick comment or thought, and
22 maybe it's a little bit a question just on this topic of

1 geriatrician. I think it would be worth drilling into this
2 a little bit because there are a couple things that seem
3 like conundrums in this geriatric space. One is I think
4 it's one of the few specialties where you get additional
5 training and the earning potential goes down and not up.

6 [Laughter.]

7 DR. RYU: So that's, I think, an issue that needs
8 to be addressed.

9 I think the second is if you think about the
10 input into a geriatric practice, it's a little bit
11 challenged to begin with because adults that are 64 or 63,
12 they already have an established primary care physician,
13 and generally people don't like changing their primary care
14 physician. And so at a certain age threshold, whenever
15 geriatrics kicks in, really the only folks that land in
16 that practice are the folks who are so complex and sort of
17 get referred by their primary care physician because there
18 are so many chronic diseases, because at that point in
19 their lives, there's a good chance they've already had an
20 established relationship with a PCP.

21 So I think there are a lot of dynamics feeding
22 into the geriatrics question that probably, you know, if we

1 want to go there, I think it requires a deeper level of
2 inquiry.

3 DR. CROSSON: Thank you, Jaewon, and I'd just
4 make a point that we will not be addressing the question of
5 when geriatrics kicks in.

6 [Laughter.]

7 DR. CROSSON: Karen.

8 DR. DeSALVO: Well, I don't even -- I think it
9 might be helpful to get some more insights from the
10 geriatrics profession or community or specialty to
11 understand how they perceived themselves in the array. I
12 ran a section of general internal medicine and geriatrics,
13 and our geriatricians thought of themselves as specialists
14 because they were, and they taught and supported the
15 primary care internists as part of that, but wouldn't have
16 been the front line primary care for less complex, younger
17 patients, even irrespective of age. And so I'm just a
18 little uncomfortable calling them "primary care." I think
19 of them more as a specialist, but it would be helpful to
20 know their point of view on that.

21 DR. CROSSON: And, of course, the number of them
22 suggests that they are specialists, almost by definition,

1 right? Huh?

2 DR. CASALINO: Yeah, on this topic. I think it
3 would be -- this is, I think, building on what the last few
4 people have just said. I think it would be very important
5 to know who these 2,000 people are. I don't know much
6 about this, but my impression is that probably a pretty
7 high percentage of the 2,000 geriatricians work not just in
8 hospital employment but in academic medical centers --
9 which is not a bad thing, necessarily, especially if
10 they're serving as teachers and kind of super-specialists
11 in a way. But I think if we do want to think more about
12 the question of geriatricians, should there be more, what
13 should they do, how should they be paid, it would be -- a
14 starting place would be to know where do they practice and
15 how many of those 2,000 actually see patients full-time or
16 what.

17 DR. CROSSON: Okay. Sue.

18 MS. THOMPSON: Well, at the risk of stating the
19 obvious, and just thinking about all the different points
20 that have been made and connecting dots here, you know, we
21 find ourselves in this situation of an inadequate supply of
22 primary care physicians and an inadequate number of medical

1 students that are thinking about moving into primary care
2 because we have a broken system. And it just strikes me in
3 this chapter we need to apply context once again to the
4 discussion, because what we're attempting to do is fix this
5 problem in an existing broken system. And while I'm not
6 suggesting we go into that context in a broad way, but we
7 are here because it's a broken system.

8 I mean, yes, I agree, Larry, primary care
9 physicians do want to have longitudinal relationships with
10 families over generations. That's the beauty. That's the
11 richness of being a primary care provider. But when you
12 have to see 50 patients a day in order to make the same
13 amount of income you made last year, you're not
14 establishing -- you're not maintaining longitudinal
15 relationships. So this is broken. And until we come to
16 grips with that, I don't think we're going to solve the
17 issue.

18 So, again, it's a context statement that needs to
19 be made to acknowledge we're not going to attract providers
20 to this work until we make the work meaningful again.

21 DR. CROSSON: Thank you for that, and that's a
22 good way to end what was a very rich discussion.

1 So now we have an opportunity for a public
2 comment period. If there any of our guests who wish to
3 make a comment about the issues before the Commission this
4 morning, please come to the microphone so we can see who
5 you are.

6 [No response.]

7 DR. CROSSON: Seeing none, we will adjourn until
8 1:45.

9 [Whereupon, at 12:18 p.m., the meeting was
10 recessed, to reconvene at 1:45 p.m. this same day.]

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1 high-quality care, we do not currently have the tools to
2 judge the quality of care MA plans provide or how one MA
3 plan compares to another on quality metrics.

4 Although a key concept in having a private health
5 plan program in Medicare is to offer beneficiaries a choice
6 of how to receive their care, whether MA or fee-for-
7 service, and which MA plan might be the best fit for them,
8 the current system does not provide adequate information on
9 plan quality in a given area, and we are far from being
10 able to compare MA quality with fee-for-service quality in
11 each geographic area.

12 Since 1999, that is, over the past 20 years, the
13 Commission has supported the use of financial incentives to
14 promote quality in MA, with Medicare payments redistributed
15 among plans to reward high quality. However, the quality
16 bonus program instituted in 2012 is unlike any other
17 quality incentive program in Medicare. Those other
18 programs are either budget-neutral or result in program
19 savings. The MA bonus program, on the other hand, is
20 financed with added program dollars, costing the Medicare
21 program \$6 billion per year.

22 In response to a congressional mandate, in 2010,

1 the Commission published an extensive review of the MA
2 quality program and made a number of recommendations for
3 improving the program. Many of those recommendations have
4 yet to be implemented.

5 In this session, we will review why reform of the
6 system continues to be necessary. We will describe an
7 alternative approach that addresses the flaws of the
8 current system but which is financed in a budget-neutral
9 manner, as the Commission has recommended over the years.

10 This table provides a very brief summary of the
11 issues we have identified over the years with the MA
12 quality bonus program. One is that the program is
13 overbuilt, with too many measures, including process and
14 administrative measures. There have also been issues with
15 the manner in which the program has been implemented, which
16 I will talk about in greater detail on the next slide.

17 Another flaw of the current system is that it
18 creates uncertainty among plans; for example, knowing
19 whether they are eligible for bonuses, given that there is
20 a cliff effect whereby only star ratings of 4 or higher on
21 the 5-star scale result in bonus payments.

22 The star system that is the basis of bonus

1 payments also appears to be inequitable in that contracts
2 with high shares of low-income beneficiaries are less
3 likely to receive bonuses, even though CMS has a peer
4 grouping mechanisms to recognize differences in the
5 composition of enrollment among MA plans.

6 Finally, the program is very costly. It is not
7 financed in the budget-neutral manner, meaning that extra
8 program dollars are used to finance bonuses. The bonus
9 payments are not a trivial amount, and the MA quality bonus
10 program is all the more costly because the vast majority of
11 enrollees, 82 percent, are in contracts that are in bonus
12 status.

13 I will go into more detail on the financing issue
14 after discussing a major implementation issue, and Ledia
15 will walk you through what we have to say about the other
16 issues listed here.

17 One of the major reasons that we say that the
18 quality bonus program is not well implemented is that
19 information on plan quality is collected and reported at
20 the MA contract level.

21 The reporting unit that the Congress envisioned
22 in the Balanced Budget Act of 1997 and which MedPAC has

1 recommended is the local market area, not the contract.

2 For a number of reasons, an MA contract can
3 include any number of geographic areas, whether or not the
4 areas are contiguous. For example, one contract
5 configuration consisted of counties in Iowa combined with
6 counties in Hawaii.

7 In 2019, there are three multi-state contracts
8 with over 1 million enrollees each across non-contiguous
9 states.

10 Because CMS evaluates quality at the contract
11 level, a single measure result applies to the entire
12 contract across all its market areas. That single result,
13 in the case of many measures, is based on chart reviews of
14 a sample of 411 medical records.

15 Given what we know about regional variation in
16 quality and variation among population subgroups, contract-
17 level reporting does not give an accurate picture of
18 quality for these large contracts, and it is certainly the
19 case that information on plan quality that Medicare
20 beneficiaries can see at the medicare.gov website often
21 does not accurately represent the quality of care that the
22 plan offers in the beneficiary's geographic area.

1 Large multistate contracts exist in part because
2 of a policy of encouraging consolidation of contracts, a
3 policy of predating the introduction of the bonus program.
4 However, a policy decision made with regard to
5 consolidations provided a financial incentive for increased
6 consolidation activity. This is because, until recently,
7 if a company consolidated contracts, it could choose which
8 contract would be the surviving contracts, and that
9 contract's star rating would apply to all the absorbed
10 contracts.

11 So companies used bonus-level contracts to
12 subsume non-bonus contracts so that all enrollees of the
13 surviving contract were in bonus status. Over a five-year
14 period, this strategy was used to move 4 million enrollees
15 to bonus status from non-bonus status and obtain
16 unwarranted bonus payments.

17 A recent legislative change that followed the
18 MedPAC recommendation to prevent unwarranted bonuses has
19 been effective in that there was no consolidation activity
20 for 2020 that resulted in unwarranted bonus. However, the
21 strategy can still be used under certain circumstances, and
22 the effect of creating large contracts continues to be a

1 problem under the current method of evaluating quality at
2 the contract level.

3 The Commission position on budget neutrality for
4 the MA quality incentive program has a long history. In
5 1999, the Commission encouraged Medicare to institute a
6 program involving rewards and penalties. The 2004
7 recommendation specifically called for a system of
8 withholds that would finance a budget-neutral system for
9 moving money among plans based on their quality. This
10 position was reiterated in 2005 and again in 2009, with
11 some additional features, including a statement that if
12 plan quality was better than fee-for-service quality, plans
13 could be paid more than fee-for-service.

14 One concern that stakeholders have expressed
15 about moving to budget-neutral financing of the bonus
16 program is that the reduced payments to plans would result
17 in reduced extra benefits to MA enrollees. Currently, MA
18 enrollees enjoy a very high level of extra benefits
19 financed by rebate dollars when plan bids are below
20 Medicare's payment benchmarks. In 2019, the average value
21 of extra benefits for MA enrollees was \$107 per month, up
22 from \$95 in the preceding year.

1 The evidence does not indicate if the bonus
2 program moved to budget-neutral financing that there would
3 be a dollar-for-dollar reduction in extra benefits. For
4 example, predictions that ACA payment reductions would
5 result in major upheaval in the MA market and a reduction
6 in extra benefits were off the mark. Plans were able to
7 deal with the financial pressured imposed by the ACA
8 changes.

9 Some stakeholders have also maintained that plans
10 are required to use all bonus dollars to finance extra
11 benefits, but there is no such requirement. On the
12 contrary, our analysis has shown that when a plan newly
13 achieves bonus status, the extra money is often retained as
14 profit or used for payments to providers, and when plans
15 lose bonus status, they find ways to continue providing
16 extra benefits to enrollees.

17 I mentioned that the cost of the quality bonus
18 program is not a trivial amount. Making the program
19 budget-neutral would produce significant savings for the
20 Medicare program.

21 In a 2018 budget options document, the
22 Congressional Budget Office estimated that financing an MA

1 quality bonus program on a budget-neutral basis, that is,
2 doing away with the 5 percent bonus as the source of
3 financing, would save the program \$94 billion over 10
4 years. Such a level of savings would mean that the Part A
5 Trust Fund could be strengthened, saving Part A about \$40
6 billion over the 10 years.

7 The Part B share of savings would be about \$54
8 billion, meaning that the taxpayers who fund the general
9 revenues that finance 75 percent of Part B would save about
10 \$40 billion.

11 Medicare beneficiaries, who finance 25 percent of
12 costs, along with states paying premiums for Medicaid
13 beneficiaries, would save about \$13 billion over the 10
14 years.

15 Ledia will now discuss the features of the
16 proposed redesign of a quality incentive program for MA to
17 replace the current system and address its flaws.

18 MS. TABOR: As Carlos just discussed and as laid
19 out on the left-hand side of the slide, the QBP, as
20 currently implemented, is flawed and makes it difficult to
21 evaluate quality in MA.

22 With about one-third of the Medicare population

1 in MA, it is essential that the Medicare program be able to
2 accurately evaluate MA plan performance and link payment to
3 the quality of care plans provide.

4 In the June 2019 report to the Congress, we laid
5 out a redesigned MA value incentive program, or MA-VIP,
6 that is consistent with the Commission's principles for
7 quality measurement.

8 Andy and I will go through elements of the
9 redesigned MA-VIP, shown on the right-hand column, and our
10 modeling plan.

11 I want to highlight the long discussed goal of
12 the Commission is to compare MA and fee-for-service quality
13 in local geographic areas. Consistent with this goal, we
14 are designing the MA-VIP with the anticipation that we can
15 compare across MA, fee-for-service, and ACOs in the future
16 as we continue to work through data limitations.

17 Consistent with the Commission's principles for
18 quality measurement, the MA-VIP will score a small set of
19 population-based outcome and patient experience measures
20 that are patient-oriented, encourage coordination across
21 the delivery system, and promote change in the delivery
22 system.

1 Plans and providers can use process measures for
2 their own quality improvement activities. The measures
3 should not be unduly burdensome for providers and plans.
4 So they should largely be calculated or administered by
5 CMS, preferably with data already being reported.

6 We are limited in the measures that we can
7 currently include in the initial MA-VIP because of the lack
8 of complete MA encounter data, in particular, for physician
9 and outpatient services.

10 Also, like fee-for-service claims data, MA
11 encounter data does not include detailed clinical
12 information such as tests performed during medical visits,
13 discharge plans, and lab results, which could allow us to
14 measure preventative care and clinical outcomes.

15 Measuring these topics would require sampling of
16 medical records which can be burdensome, and EHR data is
17 not yet available for Medicare use.

18 The MA-VIP measure set should continue to evolve
19 as better data becomes available.

20 One thing to note is that the MA-VIP level of
21 measurement or reporting unit is the MA organization within
22 a local market area, instead of the contract level.

1 Comparing the quality of care within market areas allows us
2 to evolve to eventually compare the quality of MA and fee-
3 for-service.

4 This table summarizes the initial MA-VIP measure
5 domains for which we calculated results to score in the MA-
6 VIP. These domains include existing quality measures that
7 the Commission has discussed in the past as a basis for
8 comparing MA and fee-for-service. They cover many aspects
9 of quality, including access and coordination across the
10 delivery system, overall patient health status improvement,
11 and patient experiences with the plan and the care that
12 they receive.

13 The first domain measures access and coordination
14 of care across the ambulatory care system to keep patients
15 from being hospitalized. The Commission discussed this
16 measure of risk-standardized ambulatory care-sensitive
17 hospitalizations per 1,000 enrollees last month.

18 The second measure, readmissions, measures how
19 effective the MA plan is at making sure beneficiaries have
20 the discharge information they need and that their care is
21 coordinated so they do not return to the hospital.

22 For both of these measure calculations, we used

1 MA encounter data supplemented with MedPAR inpatient data.
2 The Commission's previous analysis of the encounter data
3 showed that we needed to use both data sources to have the
4 most complete data for hospitalizations.

5 The third and fourth measure domain calculations
6 used beneficiary-level survey data. To capture patient-
7 reported outcomes, we calculated improvement or maintenance
8 of physical and mental health status using health outcome
9 survey, or HOS, data.

10 For the patient experience domain, we used
11 beneficiary-level CAHPS survey results to calculate a
12 composite for the seven core measures of enrollee
13 experience, which includes getting needed care and care
14 coordination.

15 In the hospital value incentive program, the
16 Commission modeled last cycle, we distributed rewards and
17 penalties on a national level, because we did not believe
18 geography itself should be a factor in the quality of care
19 that hospitals provide.

20 However in MA, it may make more sense to create
21 peer groups within local market areas. Plans often leave
22 or enter new market areas or do not operate in certain

1 markets. In a sense, they choose their own patient
2 populations.

3 Also, beneficiaries can and often do switch plans
4 within their market areas.

5 So the MA-VIP will distribute penalties or
6 rewards to each parent organization in a market area based
7 on their performance on the four measure domains.
8 Distributing rewards within each market area avoids the
9 possibility that MA plans operating in market area with
10 persistently low levels of quality consistently receive
11 penalties, and plans operating in markets with persistently
12 high levels of quality consistently receive rewards.

13 Consistent with the Commission's principles, we
14 did not include social risk factors in the risk-adjustment
15 models for the outcomes measures. The MA-VIP would
16 consider differences in the social risk factors of plan
17 populations, by incorporating the method of stratifying
18 enrollment into peer groups in which quality-based payments
19 are distributed to plans in a market area based on their
20 quality performance and payment tied to covering fully
21 dual-eligible beneficiaries, Peer Group 1, and non-fully
22 dual-eligible beneficiaries, Peer Group 2.

1 We anticipate that peer groups with more social
2 risk factor will receive a greater reward per point
3 increase in quality. Also, grouping different populations
4 a plan serves within a local area will likely make payment
5 adjustments more equitable compared with the existing QBP.

6 To be included in the MA-VIP, each reporting unit
7 and peer group would need to meet minimum sample size
8 requirements for the measure domains. To implement the MA-
9 VIP, we believe three parent organizations are necessary in
10 a market area to ensure adequate comparison and
11 distribution of rewards and penalties in the market area.
12 As part of future modeling analysis, we will review the
13 effects of the MA-VIP in market areas with fewer than three
14 parent organizations.

15 To estimate the number of market areas with
16 sufficient parent organization enrollment to be included in
17 the MA-VIP, we applied a minimum sample of 600, based on
18 CMS' current requirement that any contract with at least
19 600 enrollees must collect CAHPS results. Applying this
20 requirement to each reporting unit would likely increase
21 the total number of surveys required, compared to the
22 current number.

1 We found that approximately 96 percent of MA
2 enrollment is in the 721 MedPAC market areas with at least
3 3 parent organizations that meet a minimum sample of 600
4 enrollees.

5 I will now turn it over to Andy.

6 DR. JOHNSON: I'm going to briefly mention the
7 remaining steps in implementing an MA Value Incentive
8 Program. The value incentive program will use a continuous
9 performance to points scale to convert a parent
10 organization's performance within each market to a number
11 of points. National distributions of performance will be
12 used to create one scale for each measure domain. Each
13 parent organization will receive a separate score for their
14 full dual and non-full dual peer groups in each market
15 area, based on the performance for each peer group.

16 Next, there will be separate reward pool for each
17 peer group. For example, in our modeling, the reward pool
18 for full duals will be funded with 2 percent of Medicare
19 payments for fully dual eligible enrollees, and the same
20 for the non-fully-dual reward pool.

21 Finally, we will distribute each peer group's
22 reward pool to parent organizations so that each reward is

1 proportionate to the total points achieved and all withheld
2 payments are distributed within the market area and peer
3 group.

4 Your mailing materials provide information about
5 the modeling of the value incentive program that we have
6 completed to date. I would like to note that due the
7 limited availability of CAHPS and HOS survey data, which
8 are currently collected at the contract level, we have
9 sufficient data to model only a subset of all parent
10 organizations and market areas.

11 Our modeling is based on 65 market areas and 87
12 unique parent organizations for a total of 284 units of
13 analysis. Forty-one percent of all MA enrollment is
14 represented in these data.

15 In January, we will present the full results of
16 our modeling, which will include performance to points
17 scales for all measure domains, market-level information
18 about the distribution of points and reward amounts, and
19 information about the types of plans that received rewards
20 or penalties.

21 As Carlos discussed at the start of the
22 presentation, we are currently unable to assess MA quality

1 in a meaningful way, and beneficiaries lack good
2 information about MA quality in their market area. Yet,
3 the quality bonus program generates an additional \$6
4 billion in Medicare spending annually, above the cost of
5 providing the basic Medicare benefit plus extra benefits.

6 For your discussion, we would like your feedback
7 on the aspects of the MA value incentive program that we
8 presented today as well as considerations for our continued
9 work to model the program. Thank you, and now I will turn
10 it back to Jay.

11 DR. CROSSON: Thank you very much. We are now
12 open for clarifying questions. I see Marge and Brian and
13 Karen and Jon and Pat and Dana and Bruce.

14 DR. PAUL GINSBURG: I got the first two.
15 [Laughter.]

16 DR. CROSSON: Okay. Hands again.

17 MS. MARJORIE GINSBURG: Oh, hands are still --

18 DR. CROSSON: I will get the order screwed up.
19 Marge and then I saw Brian and Karen, and then I saw Jon
20 and Pat and Bruce and then Dana and Larry.

21 DR. CASALINO: Good. These are short speeches to
22 start his question.

1 [Laughter.]

2 DR. CROSSON: You're learning quick. You're
3 learning quick.

4 MS. MARJORIE GINSBURG: I have a quick question,
5 though. First, I want to say this is so exciting. I mean,
6 I can't -- speaking for myself, I am so delighted to see us
7 taking on the challenge Medicare Advantage quality with
8 such commitment. So, anyway, fabulous work, and this is
9 just the beginning.

10 Quick question. So I know we discussed it
11 before. You refer to those with fully dual eligible and
12 not with fully dual eligible. You can have programs with 1
13 percent full dual eligible, up to 50 percent. So it seems
14 to me at some point we did lay that out, about the numbers,
15 the percent of enrollment that fall into those categories.
16 In probably limited time you didn't include that here, but
17 I wonder if you could briefly summarize what you see, how
18 the evaluation will take place, based on the percent of
19 beneficiaries who fall into those two categories.

20 DR. JOHNSON: So we would treat the fully dual
21 eligible population separate from those that are not fully
22 dual eligible within each parent organization. So if there

1 are differences within a market, one parent organization is
2 mostly full duals and one is only few duals, the quality of
3 those two organizations would, for their full duals, would
4 be compared. And we would treat almost a separate system
5 of funding the rewards based on the quality of those two
6 incentive programs. So as long as a parent organization
7 has the sufficient number of dual eligible enrollees and
8 not fully dual eligible enrollees to meet the data
9 requirements and have sufficient and accurate results for
10 each measure, they will participate in the program.

11 DR. CROSSON: Okay. Brian.

12 DR. DeBUSK: Great report. Great subject. I had
13 three questions, actually.

14 First of all, how does a tournament model produce
15 82 percent of the people in the bonus? Is this like an
16 everybody-gets-a-trophy league?

17 MR. ZARABOZO: So, you know, there are currently
18 45 measures, is the one that was dropped, so each of those
19 measures is evaluated on the tournament model to assign the
20 star-level rating. So it's the average across all those
21 measures. So you could get to an average of four stars or
22 high, based on a number of ways. As we pointed out I think

1 in March of last year, some plans, for example, have done
2 it solely on the basis of process measures, some plans
3 solely on the basis of sometimes administrative measures.
4 So because it's such a large mix of measures, and each is
5 done at a tournament level, so the relatives measure by
6 measure, and then you average --

7 DR. DeBUSK: So it's a series of tournaments, and
8 the results of each tournament get added up. But what I'm
9 really hearing is that there is a bias in the result of the
10 tournament model so that you can't have more than 50
11 percent winners.

12 MR. ZARABOZO: Right. And you can see like the
13 average star rating for each measure is very variable
14 across the ratings. So the administrative measures, people
15 do really well. I think the current average of the star
16 ratings for that administrative measure is 4.7 out of 5.

17 DR. DeBUSK: Okay. So the categories are
18 tournaments but the sum of the categories isn't a
19 tournament.

20 MR. ZARABOZO: [Off microphone.]

21 DR. DeBUSK: Got it. Totally there.

22 DR. CROSSON: Let me just make one clarification

1 here. It is 82 percent of beneficiaries, not 82 percent of
2 plans.

3 DR. DeBUSK: Okay.

4 MR. ZARABOZO: Yeah, 82 percent of beneficiaries.

5 DR. CROSSON: And it's like 45 percent of plans?

6 MR. ZARABOZO: Right. It's about half of plans.

7 Right. So if you look at the contract level --

8 DR. DeBUSK: Gotcha. Gotcha. Okay. That helped
9 a lot.

10 Can you also elaborate, because I've always
11 thought that rebate dollars had to be spent on extra
12 benefits. Is it just the bonus dollars that are exempt
13 from that, or are all rebate dollars exempt from that?

14 MR. ZARABOZO: If you have rebate dollars they
15 are to be used for extra benefits. Whether you have rebate
16 dollars is a matter of where is your bid in relation to the
17 benchmark. If the benchmark goes up because of quality of
18 adding 5 percent to the benchmark, your bid can change in
19 relation to that benchmark.

20 So, for example, if 5 percent is added to the
21 benchmark, you may decide, well, I will add 5 percent to my
22 bid.

1 DR. DeBUSK: That's how they do it. So it's not
2 -- so it is the way I thought. I mean, true rebate dollars
3 are supposed to go to --

4 MR. ZARABOZO: Yeah. Rebate dollars go to extra
5 benefits.

6 DR. DeBUSK: -- extra benefits or --

7 MR. ZARABOZO: Certain percentage is based on the
8 quality --

9 DR. DeBUSK: Okay. So it's the fact that they
10 get to basically have the option, at least, to rebid their
11 bid if their bonus dollars --

12 MR. ZARABOZO: Right. That was the point that
13 we're raising is --

14 DR. DeBUSK: Okay.

15 MR. ZARABOZO: -- some people say you must use
16 all the bonus dollars for extra benefits. No, that's not
17 correct. You must use all rebate dollars for extra
18 benefits. How you arrive at rebate dollars is --

19 DR. DeBUSK: Gotcha. So that's how the bonuses
20 work.

21 Now the third question is, just one time, for
22 clarification, let's say I'm a parent organization -- name

1 an insurance company -- and I'm in a specific market, a
2 CBSA, that doesn't span a state line, so it's a MedPAC
3 unit. If I've got a regular MA plan, I've got a C-SNP, and
4 I've got a D-SNP, what you're proposing is you're going to
5 take all the people I have enrolled in all three plans, put
6 one group into the non-dual eligible peer group, into the
7 dual eligible, so three plans are going to get turned into
8 two peer groups under one parent organization, irrespective
9 of how those people were contributed into peer group one
10 and peer group two?

11 MS. TABOR: That's correct.

12 MR. ZARABOZO: Strictly based on their status.

13 DR. DeBUSK: Strictly based on their dual status.

14 So you're going to see through the plan itself.

15 MR. ZARABOZO: Correct.

16 DR. DeBUSK: Okay. Now quick question with that.

17 Wouldn't that mean, though, that you could have

18 dramatically different outcomes? I mean, if I'm in a C-SNP

19 because I have a very specific chronic condition, I might

20 do a lot better than if I'm in the regular MA plan and

21 don't have some of the special features of that C-SNP.

22 MR. ZARABOZO: Which is sort of one of the

1 reasons why we would be doing this. So, for example, if
2 the D-SNPs were, in fact, better at providing care to full
3 duals, better than others in the community --

4 DR. DeBUSK: It would incentivize this for me to
5 get them out of my MA plan and into the D-SNP.

6 MR. ZARABOZO: Or, you know, do the strategies
7 that specialist plans do for these populations.

8 DR. DeBUSK: Wow. You guys really thought about
9 this.

10 [Laughter.]

11 DR. DeBUSK: Nice. Thank you.

12 DR. CROSSON: Karen.

13 DR. DeSALVO: Thank you, guys, so much. I had --
14 first of all, I'm just delighted to see the patient-
15 reported outcomes component to it, and I am, like Marge,
16 really excited that we're moving in a direction to be able
17 to compare across types of payment systems, so that's
18 helpful.

19 But I had a question about the patient-reported
20 outcomes. If this is going to be a comparator opportunity,
21 have you all started thinking about where you would collect
22 the data on patient-reported outcomes from the non-MA

1 enrollees, like in fee-for-service or ACOs?

2 MR. ZARABOZO: So that's one of our
3 recommendations from 2010, that we want HOS reporting for
4 the fee-for-service sector, in addition to reporting for
5 MA. And I would think, also, that what happens in MA is
6 you survey them in one year and then two years later, the
7 same plan, that's how you would evaluate it. I would think
8 we would also want to say, actually everybody needs to be
9 evaluated because during that time period somebody is
10 responsible for your care. So that is the kind of
11 information we would like to have also.

12 DR. DeSALVO: Well, it would be great, and the
13 thing is that the reported outcomes like healthy days or
14 the ones in the health outcome studies are correlated with
15 some of these health care measures also, so I'll let you
16 all work out the methodology there. But they're nice
17 global indicators of future utilization of health services
18 and morbidity and mortality, even as a single item.

19 I had a second question, which is about the
20 social risk adjuster or stratifier. So I think I stepped
21 into the peer grouping thing. We've already sort of
22 decided that's a pathway that we want to take, but it feels

1 so unsatisfactory to me, I guess, just because, as I think
2 we've talked about before, being dually eligible, you know,
3 or partial, is very different depending on state and also
4 depending on how you got there, financially and otherwise.

5 So I just wondered if you all are thinking
6 already about other social risk stratifiers that we might
7 be able to use in the next gen?

8 MS. TABOR: Yes, we have. So based on the
9 feedback we received from the Commission, I know the area
10 of deprivation and disease is some of that we are planning
11 on looking into, but we want to kind of keep moving forward
12 with this as we investigate it further. And then we could
13 also think about disability as another factor, not just
14 dual eligibility. So we are thinking about that, and plan
15 to come back to you.

16 DR. DeSALVO: Great.

17 DR. CROSSON: Thank you, Karen. Jon.

18 DR. PERLIN: Let me join in the chorus of thanks
19 for terrific work in this area. By way of clarification
20 let me just understand. In terms of the areas, we have got
21 three parent organizations. You are calibrating for best
22 performance in that region, which would inform the

1 beneficiary of what the best choice is, potentially, on the
2 basis of the performance indicators in that area.

3 Is it feasible that you could actually have a
4 high performer in the lowest-performing area being rewarded
5 more than a lower performer in a high-performing area, who
6 is actually performing on an absolute scale better? So the
7 low performer in a high-performing area does better than a
8 lower performing, high performer in a low-performing area.

9 [Laughter.]

10 MR. ZARABOZO: On first base or third base?

11 [Laughter.]

12 DR. JOHNSON: Yes, that is possible, and I think
13 we considered this situation where we're just looking at
14 comparing MA plans to MA plans, to keep it at the market
15 area so that if it was on a national scale, like the HVIP
16 is, then that high-performing area might attract a lot of
17 parent organizations who want to use that pool of providers
18 and be able to get a nationally high score, to the extent
19 that influences their score.

20 DR. PERLIN: Yeah. So I totally grant, you know,
21 that idiosyncrasy, but putting that aside for a second, one
22 might -- in your evaluation, part of the rationale for

1 looking at demographics of proportionate dual eligibles was
2 to reward on the basis of potential disparities, resources,
3 social determinants, et cetera. So on that basis, is it
4 feasible then that it could actually structurally reinforce
5 the disparity and clinical performance? If a low performer
6 -- if the highest of low performers is doing better than
7 the lowest of the high performers, and there is a
8 correlation between the low-performing area with adversity,
9 then I'm worried -- it would seem logical, if I'm thinking
10 about this correctly, that it could actually reinforce the
11 resources brought to bear on that more adversely
12 accentuated area.

13 DR. JOHNSON: So I think the incentives under a
14 market competition versus a national competition would
15 still both involve the parent organization seeking to
16 improve their quality, to get a higher share of the reward
17 dollars. I think what would better address the question
18 you're asking is a future phase down the road when we have
19 quality information for fee-for-service, and we could bring
20 fee-for-service in as a benchmark and say, if those MA
21 plans in low-performing areas are still high performance in
22 that area, if they're beating the fee-for-service level of

1 quality, that is at least an improvement that the Medicare
2 Advantage plans are offering improvement over the existing
3 system.

4 DR. PERLIN: Okay. The second question is, set
5 of questions, is when we go to a small area to be able to
6 inform beneficiaries towards making best possible choices,
7 so those areas may have modally a small number of parent
8 organizations. And how have you contemplated, particularly
9 as some of the performance metrics in the reading materials
10 indicated they would be collected over a three-year period,
11 likely consolidation that would occur over that time
12 period. Is there a set of rules of engagement that would
13 mitigate against the issue that we're trying to address, in
14 terms of national, kind of Iowa-Hawaii type problems?

15 MS. TABOR: I can take that. So we used the
16 three years of data for the modeling, really, because we
17 needed to get more CAHPS and HOS data, since it's collected
18 at the contract level. And we could talk about this more
19 in the chapter, but I think we even kind of present that
20 perhaps three years is not the right amount of data,
21 because there is so much movement amongst the markets. So
22 it could be one year of data is the right amount when the

1 MA-VIP is actually implemented.

2 DR. PERLIN: Okay. And this is perhaps in the
3 next round, but I'm worried about multi-years of data
4 because it tends to lock in performance and makes it
5 difficult to overcome the tail. And if when in terms of
6 informing consumers we note that there is little
7 correlation on a predictive level when you have an
8 indicator that's, you know, very low frequency, you know,
9 just to get the shortest comparability over a period of
10 years, it then does not extend from that that it predicts
11 likelihood of good or bad in that sort of short period,
12 going forward.

13 So we'll come back to that issue. But I
14 understand the complexity of low frequency events, and I
15 wanted to just identify with Karen's point on more robust
16 collection of data that are perhaps more prevalent.
17 Thanks.

18 DR. CROSSON: Pat.

19 MS. WANG: Thank you. Just for clarification,
20 when you say parent organization, is that the same thing as
21 H number, or is it a new definition? No. Okay.

22 MR. ZARABOZO: Parent organization is, for

1 example, United is a parent organization. You are a parent
2 organization.

3 MS. WANG: But if the parent organization has
4 three H numbers that do a C-SNP, I-SNP, and D-SNP, are you
5 --

6 MR. ZARABOZO: If it's in the same geographic
7 area that's one unit, as far as we are concerned.

8 MS. WANG: Okay. And you're still going to group
9 dual versus non-dual together.

10 MR. ZARABOZO: Right.

11 MS. WANG: Okay. Got it. Thank you.

12 Just for point of clarification, the statistic
13 about, whatever, 80 percent of beneficiaries are in bonus
14 out of 6 million, that's in 2019?

15 MR. ZARABOZO: That's the 2020 number.

16 MS. WANG: The 2020 number?

17 MR. ZARABOZO: Eight-two percent of enrollees --

18 MS. WANG: Okay. So the 2020 number, which is
19 based on 2019 stars, which is based on 2017 dates of
20 service.

21 MR. ZARABOZO: Well, no. We're using 2019
22 enrollment with the 2020 stars, as they're called --

1 MS. WANG: Okay.

2 MR. ZARABOZO: -- which were just released.

3 MS. WANG: Okay. But the 2020 stars represent
4 something from a few years ago.

5 MR. ZARABOZO: Right, from 2018.

6 MS. WANG: So what proportion -- I mean, the
7 figure in here says 4 million people are in bonus status
8 because of contract consolidations. Is that 25 percent of
9 the total? I mean, rough math, because there's 22 million
10 and 80 percent are in bonus status --

11 MR. ZARABOZO: It would be a little under 20
12 percent of the total.

13 MS. WANG: Twenty percent of the total?

14 MR. ZARABOZO: Now, it isn't necessary 4 million.
15 I mean, we would have to kind of look back and see who
16 arrived in that position, in that manner.

17 MS. WANG: So would you expect, with the changes
18 in the legislation around contract consolidations, which
19 were passed in 2018, I guess, effect 2019, that the number
20 of lives in bonus status and the dollars associated with it
21 would decrease because these contract consolidations kind
22 of stop -- the music stops and you can't keep doing,

1 perpetuate that thing?

2 MR. ZARABOZO: Yes. Our initial look at what
3 happens in 2020 is that nobody did this kind of
4 consolidation activity.

5 MS. WANG: Right.

6 MR. ZARABOZO: As we pointed out, because of this
7 averaging method, if you, as a company, can come up with
8 two contracts where you are pretty sure that the averaging
9 method will result in a bonus for the combined thing, where
10 previously it was one bonus, one not bonus, there's still
11 an opportunity for consolidation.

12 MS. WANG: Okay. And the number that has been
13 cited about average supplemental benefits of around 100-
14 something dollars does represent this current situation
15 with the number or proportion of contracts that are in
16 bonus status, because of contract consolidations. The only
17 point I'm trying to make is it takes a while for that
18 contract consolidation thing to work its way out of the
19 system. So I just want to be careful when we are using
20 numbers like there's \$6 billion in bonus payments.

21 Look, I hate that thing, the contract
22 consolidation. I think the work that you guys did on it

1 was amazing and very, very impactful. But I just don't
2 want to mix apples and oranges with sort of saying there's
3 \$6 billion in bonus payments, and we should take that all
4 back and it would save so much money, when the changes that
5 Congress made in 2018 are likely to have an impact on
6 shrinking that. What's your opinion on that, if no other
7 change?

8 MR. ZARABOZO: Well, I would say because of --
9 the 82 percent number is based on the 2020 stars, and there
10 was no consolidation activity in that time period. I'm not
11 sure that it would shrink all that much as a percentage of
12 enrollees who are in bonus status.

13 MS. WANG: But 2020 stars is based on the 2017
14 program year.

15 MR. ZARABOZO: Right, but the payments for 2020 --
16 what I'm saying, that 82 percent figure pertains to a
17 future payment year because the current payment -- payments
18 into 2020 are based on the stars that were available in
19 June 2019, which is the preceding year's stars, which were
20 all the -- a lot of consolidation activity. The 82 percent
21 is sort of post-consolidation.

22 MS. WANG: Okay. So your -- I don't know how --

1 MR. ZARABOZO: It might be a little bit of
2 reduction from 82, but there's --

3 MS. WANG: So you believe that the 82 percent
4 represents no contract consolidations. That's just pure
5 new rules.

6 MR. ZARABOZO: Correct. In the 2020, we did not
7 see any contract consolidation.

8 MS. WANG: I understand what -- I don't know how
9 it rolls, though, Carlos, is what I'm saying.

10 MR. ZARABOZO: 82, there still would be some
11 after-effects of contract consolidation that would be --
12 would yield a different number, yes.

13 MS. WANG: Okay. I think it's important to just
14 sort of put a little highlight on that because I think, all
15 things being equal, the \$6 billion would be a different
16 number, the 107 would be a different number, whatever.
17 Okay.

18 There was a statement in the paper around no real
19 difference in CAHPS scores between dual and non-dual. Did
20 you look at whether or not there were differences on the
21 individual questions? Because I think when people have
22 looked at the individual questions, they have found

1 distinctions.

2 MS. TABOR: We haven't looked at that, but we can
3 look at it.

4 MS. WANG: Okay. I think that would be
5 interesting.

6 MS. TABOR: And by individual questions, you mean
7 individual measures, right? You mean the individual CAHPS
8 measures, like the --

9 MS. WANG: The individual -- yeah, exactly.

10 MS. TABOR: We haven't.

11 MS. WANG: As opposed to the rolled-up score.

12 I'm glad that Karen raised the question about
13 social determinants and so this is like Round 1.5, like
14 strong encouragement to do that, because -- and I know you
15 know this -- two groups, dual and non-dual, dual is very
16 tight in terms of their characteristics, and even within
17 that, as Karen mentioned, people get there by spend-down,
18 people get there because they've been poor their whole
19 lives, so heterogeneity there. But in the non-dual,
20 there's a ton of heterogeneity, so you have people who are
21 making \$10 more in income a month so they're not dual, but
22 they live in those neighborhoods and they have the same

1 barriers to access. And then you have people on the Upper
2 East Side of Manhattan who are in an MA plan, and those,
3 one thing is not like the other. So I think it's great
4 that you're looking at things like area deprivation index
5 because it's a great opportunity to refine that further.
6 I'm sorry. I slipped into Round 2.

7 A question on the targets. Would they be
8 nationally set? And if so, based on what?

9 MS. TABOR: The way that we're modeling it, yes,
10 they would be national, just because although we understand
11 there are differences within the markets as far as like
12 plans that can leave and go, we wanted to also just assess
13 the fact that this is a national program, so we wanted to
14 have national standards. And we propose to set the targets
15 the same way we've done in the HVIP, so to kind of model
16 Dana's beta binomial distribution, we said -- we took
17 performance for all the plans and said the 2nd to 98th
18 percentile. The 2nd percentile is zero points; ten points
19 is the 98th percentile. So basically everybody will have
20 an opportunity to earn points except for the extreme
21 outliers.

22 MS. WANG: Okay. So the targets are national,

1 and a local market is comparing themselves to the national
2 targets?

3 MS. TABOR: Correct.

4 DR. DeBUSK: I'm confused on that. The targets
5 are nationally set, but I could be in one market where
6 eight points is phenomenal, and I could be in another
7 market where eight points is terrible because each market,
8 to Pat, I think that was the question you were asking. In
9 some markets -- the markets aren't going to be on an
10 absolute scale. The national calibration for earning the
11 points will be, but the number of points you receive in any
12 given market will be relative.

13 MS. TABOR: It'll really be the dollar amounts
14 that you get will be relative. The dollar amounts that you
15 can get tied to your performance.

16 DR. DeBUSK: Eight points in one market might
17 earn you a lot of money. Eight points in another market
18 might earn you none of your holdback back.

19 MS. TABOR: Correct. And these are the types of
20 things that we plan to explore in the modeling to see kind
21 of how this plays out.

22 MS. WANG: But in that situation, is it a

1 principle that whatever money is withheld in a market will
2 be distributed?

3 MS. TABOR: Correct.

4 MS. WANG: Okay, so it would --

5 MS. TABOR: It is contained within the --

6 MS. WANG: -- scale, I guess.

7 MS. TABOR: Yeah.

8 MS. WANG: Okay. Just a final question. Right
9 now there's such a big lag between the sort of performance
10 year and the actual stars year. It's like two to three
11 years. Is there anything in your proposal that would speed
12 that up potentially?

13 MS. TABOR: So we actually talked about this
14 after we turned in the paper, and we can kind of play this
15 out for you in the next version. I think there's two
16 things that would still kind of allow for a lag right now,
17 and that is the fact that there's an encounter data lag.
18 So it's about 13 months -- right, Andy? -- before CMS gets
19 encounter data, which creates one issue. And the second is
20 if we're following our principles to have prospectively set
21 targets, we'd want plans to know their targets at least a
22 year in advance, so to have that happen, the targets

1 themselves would at least have to be based on some old
2 data.

3 MS. WANG: So let me ask you a question that
4 maybe is a Round 2 or something like that as well. So the
5 idea of getting rid of the tournament model seemed to make
6 a lot of sense when we were talking about a national
7 competition, so the South Bronx competing with, you know,
8 Puget Sound on these measures. But when you get to a local
9 market area, did you consider whether it was necessary that
10 -- maybe the tournament model, since you are in a local
11 market area so you eliminate some of those extreme, maybe
12 strange competition, that in a local market area a
13 tournament model could actually stimulate additional
14 improvement? Does it change the perspective on the
15 tournament model.

16 DR. JOHNSON: I don't know that we considered the
17 extent to which additional improvement would be stimulated
18 under a local versus national model. But I think the other
19 aspect here that adds some tension is trying to keep the
20 system budget neutral so that if you're having a withhold
21 and you're going to then determine how many points are
22 equated to the performance that is achieved that year that

1 you distribute that money so that it is roughly budget
2 neutral requires some balancing after the fact.

3 MS. WANG: You could always scale whatever there
4 is, though, whatever the performance is into the available
5 funds.

6 DR. CROSSON: Okay. Bruce.

7 MR. PYENSON: Well, thank you very much. I have
8 two questions. The first is a content scope question, and
9 it's -- obviously we wanted to simplify the current stars
10 system. And had we agreed as a Commission to abandon
11 things like the HEDIS-like metrics for preventive care,
12 immunization, and that sort of thing? Is there a role for
13 that in this structure?

14 MS. TABOR: So we did consider that. I think we
15 looked at those HEDIS measures, like the annual flu
16 vaccine, breast cancer screening, colorectal cancer
17 screening, as measures that are process measures that plans
18 should continue to report and perhaps even CMS should
19 continue to collect and report for just overall monitoring,
20 but consistent with the principles, focusing payment on
21 outcome and patient experience measures. But I guess I
22 would also ask that back to the Commission, if we should be

1 including those process measures in the payment system.

2 And I would also note that there's still some
3 limitations on what we could do with encounter data, so
4 like right now we could calculate annual flu vaccine
5 because it's collected through the CAHPS data. We could do
6 breast cancer screening because it's a purely
7 administrative measure. We couldn't do colorectal cancer
8 screening because it requires medical record review, like
9 an eight-year lookback. So there are still limitations on
10 what we could do.

11 MR. PYENSON: Okay. A second question is on the
12 population categories. You're using two populations, non-
13 duals and all other. And I think there's other potentially
14 important populations that are identifiable. There's a
15 fully dual, a partial dual. There's individuals enrolled
16 through an EGWP plan versus individual insurance. I wonder
17 if that's a technical detail to work out or if you've
18 looked at that.

19 DR. JOHNSON: We haven't looked at that yet, in
20 part because we have been limited in the modeling sample
21 because of the CAHPS and HOS data. But as we have started
22 to present some results that Ledia talked about, about what

1 an MA-VIP program would look like if the CAHPS and HOS
2 requirements were adjusted to fit the MA-VIP program,
3 whether or not additional peer groups like partial duals
4 and EGWPs could be included there. That might be something
5 we could look into.

6 DR. CROSSON: Thank you. David. No? Oh, Dana.
7 I'm sorry.

8 DR. SAFRAN: Thanks.

9 DR. CROSSON: I confused the two of you.

10 DR. SAFRAN: Thank you. I'm really tremendously
11 excited about this work, so thank you very much. A few
12 questions from me.

13 One is about the budget-neutral methodology. So
14 I think that while the measures that are in the stars
15 program today have been criticized, for good reason, and
16 your approach and new measure set I think is really an
17 important change, it is true, I think, that the current
18 measures and approach to setting the targets, even though
19 it's a tournament model and people don't know exactly where
20 is the stars benchmark going to land, it's extremely
21 motivating to plans, and they work to get every last gap
22 filled, et cetera. So they are -- even though we

1 collectively have said tournament models, one of their
2 downsides is they can be de-motivating because you don't
3 know where the benchmark's going to land, in this model you
4 know.

5 And so I don't really understand well enough in
6 what you've described here how making this budget neutral
7 will or won't sort of change that drive that the plans
8 currently have to keep working on these measures, because
9 these ones are going to be harder, and so my worry would be
10 that people just give up.

11 MS. TABOR: I guess I think -- a question I would
12 kind of pose back would be perhaps it's the size of the
13 withhold, like how much -- even though it's budget neutral,
14 how much are we going to withhold from plans and have
15 available back for penalties and rewards, which I think if
16 the right amount is that, it could motivate behavior even
17 though we're kind of taking away the unknown targets.

18 DR. SAFRAN: Okay.

19 MS. TABOR: I mean, that's just a thought.

20 DR. SAFRAN: Yeah, and it may be something for
21 the discussion round. But we should think through if that
22 backfired and folks said, like, throwing up my hands, not

1 going to work on this, in fact, maybe don't want to be in
2 this program anymore, then, you know, they're back to fee-
3 for-service. And then maybe, you know, they're into the
4 ACO program where they've got the same measure set coming
5 at them at some point soon, I think, based on what your
6 vision is. So we just have to, I think, think that
7 through.

8 Second question, you did mention a beta binomial.
9 I could have missed it, but I didn't see it in the written
10 materials. I only saw reference to 2nd percentile, 98th.
11 Are you using or planning to use the beta binomial for
12 setting that?

13 MS. TABOR: So maybe we can talk about it
14 offline.

15 DR. SAFRAN: Okay.

16 MS. TABOR: Because I think we thought that the
17 2nd to 98th was kind of using a form of the beta binomial.

18 DR. SAFRAN: Okay.

19 MS. TABOR: But we can talk, yeah.

20 DR. SAFRAN: Okay. No problem.

21 Then two more questions. One is you say -- you
22 have on the slide and in the paper 96 percent of members,

1 but it looks like 59 percent of market areas would be
2 included with your target of three measures. I'm a little
3 concerned about whether the local market is the right unit
4 of analysis, especially given national benchmarks. I'm
5 just wondering whether there's a way to have a larger unit
6 of analysis so that you have larger sample sizes, more
7 robust measurement, and so I'm just trying to understand
8 that local unit choice and also this, like you've really
9 only got 59 percent of market areas included, if I
10 understand correctly. Is that right?

11 DR. JOHNSON: That's correct. I think there are
12 a number of markets areas where there were -- there were
13 some market areas with zero parent organizations that had
14 sufficient numbers of enrollees to participate. Many had
15 just one, and those wouldn't offer any competition. So
16 with 96 percent of the MA enrollment, it's hard to imagine
17 without -- some of the things we mention in the paper could
18 be in those other areas, hard to imagine ways to include
19 them except maybe combining those areas where there are
20 insufficient numbers of enrollees. I think we're trying to
21 balance that with what the Commission has stated for a long
22 time as being in a local market area so that the

1 beneficiary is looking at quality among their plan options
2 and among fee-for-service's and trying to keep that
3 relatively tight.

4 DR. PERLIN: On this point?

5 DR. CROSSON: Yeah.

6 DR. PERLIN: Just following up on Dana's point, I
7 don't understand. If I'm a beneficiary in a market and I'm
8 still -- I see three parent organization plans in my
9 market, and relative to a national benchmark, they
10 ordinally rank one, two, and three, why would that
11 information be any different than, you know, how they rank
12 in the market alone? Wouldn't it actually be richer
13 because it includes not only the ordinal rank in the
14 market, but also the relative performance vis-a-vis the
15 national?

16 DR. JOHNSON: I'm not sure if this is what you
17 said, but we would have in each market a ranking of those
18 three parent organizations, if there was only three, and
19 that ranking might change market by market. And it would
20 be based on each parent organization's enrollment in that
21 market.

22 DR. SAFRAN: But the benchmarks are -- the table

1 you have in the paper -- I don't think it was in the
2 slides; I forget -- that shows the zero to ten scoring, and
3 I think what you've said is that's going to be the same
4 nationally.

5 DR. JOHNSON: Yes.

6 DR. SAFRAN: So help us understand. Where does
7 the local unit of analysis come into play if you have
8 nationally set benchmarks?

9 DR. JOHNSON: So that scale is set nationally
10 determining what results from the measures will get you
11 what number of points. And then in each market, if there
12 are three parent organizations and collectively they
13 achieve 15 points, that might be ten, three, and two as
14 their total points, numbers. The reward pool will be
15 distributed accordingly to the ten, three, and two. It
16 would be proportional to the number of points they achieve
17 in the local market area.

18 MS. TABOR: So the payment multiply you get per
19 point will be national.

20 DR. SAFRAN: Okay -- well --

21 MS. TABOR: Sorry, will be local. Will be local.

22 DR. SAFRAN: We don't have to get bogged down in

1 this, but I think that having the local unit as the unit of
2 analysis is something we should revisit, especially since
3 we may need larger sample sizes to get to measure some of
4 this. But I'll hold that for the discussion round.

5 The last question I had was: There's a lot to be
6 said for using the measures that you're using because the
7 data already exists. But it does row against the direction
8 where the measurement field is trying to go, including
9 where CMS has been trying to go, with using data from the
10 clinical record because of provider desire for that as the
11 source.

12 So I'm just curious whether you've thought about,
13 or if you haven't, maybe you can incorporate into the paper
14 at least a vision, like a road map of how we can use some
15 of the changes that are being made through ONC and HHS to
16 make clinical data more available, so, like, to have a
17 vision for how we'll get from using administrative data to
18 using, you know, clinical data.

19 MS. TABOR: We haven't given it much thought, so,
20 again, I'll kind of turn it back to the Commission, if this
21 is something that, you know, everybody decides this is a
22 good thing for us to work on. We can do that.

1 DR. CROSSON: One sec. You have --

2 DR. MATHEWS: Yeah, so there's always some risk
3 when I enter the conversation here, but let me see if I can
4 clarify a couple of rudimentary points that might help get
5 us to a shared understanding of what the proposal is on the
6 table here.

7 I think we've established that there would be a
8 national performance standard for any given measure across
9 the country, but that the performance of plans would be
10 assessed at the market level. And so on the points to --
11 or performance-to-points scale, the target might be, let's
12 say, nine out of ten. So your target is nine. You might
13 have higher-performing areas, markets, where the average
14 performance is, let's say, eight and you might have lower-
15 performing markets where the average is four, and you've
16 got some distribution around four and you've got some
17 distribution around eight.

18 So then given that distribution, though, you've
19 still got a withhold of dollars that is contained within
20 the market area, and so a lower number of points in the
21 lower-performing areas, even if it doesn't meet the
22 national standard, is still going to result in some

1 redistribution of dollars within that market. And so if
2 what I've said is, one, correct and, two, understandable,
3 there is still sort of a miniature tournament model
4 operating within each market that does give incentives for
5 plans, even in lower-performing areas, to continue to
6 improve.

7 How much of what I said is --

8 DR. SAFRAN: Yeah, and I --

9 DR. MATHEWS: All right.

10 DR. SAFRAN: So I'll hold it for the discussion
11 round, but I'd say we have a good debate to have about why
12 you want to have national benchmarks, but then reward poor
13 performance in certain markets, unless you really believe
14 there's something about that market that is, you know, out
15 of their control that leads to poor performance.

16 DR. MATHEWS: Yeah. We could have that
17 conversation, and we had this conversation among at the
18 staff level last week. But it was on the basis of the
19 Commission discussion at the April meeting this year, where
20 there was some consensus around this notion of containing
21 the dollars that are redistributed at the local level.

22 DR. CROSSON: Okay.

1 DR. JOHNSON: If I could add one point about the
2 local versus national to it, I think part of our thinking
3 about keeping it local is to try and give a signal to the
4 beneficiaries to choose the best option in their area,
5 where if you have a national scale that is -- some plans in
6 some part of the country have very high quality, and
7 there's lower quality in area, that there's less of an
8 incentive to say this plan should be operating. And I
9 think that whole decision gets a little bit more clear once
10 we're able to evaluate relative to fee-for-service too, so
11 that there is truly an improvement among the options
12 between MA and fee-for-service.

13 DR. CROSSON: Okay. So Brian and Karen on this
14 point, and then we have Larry. And then I want to move on
15 to the discussion period.

16 DR. DeBUSK: This was on Dana's question, though,
17 just to try to clarify because I think I'm like 95 percent
18 there, but I want to make sure, because it sounds like we
19 have a nomenclature issue.

20 Like in HVIP, we have national scale, national
21 data, 10 peer groups. In this, what we could call a peer
22 group in HVIP is really what we would sort of call a

1 market-area peer-group combination, because what we're
2 calling a peer group here is really more like a cohort. So
3 if I look at like --

4 MS. TABOR: Like stratification.

5 DR. DeBUSK: Yeah. I'm really stratifying by
6 market in the MA-VIP, and in the HVIP, I'm stratifying by
7 peer group nationally. So I've got 10 peer groups in HVIP,
8 and in this MA-VIP, I've got how many?

9 MS. TABOR: Two for every parent organization in
10 a market area.

11 DR. DeBUSK: But they're stratified by -- I mean,
12 they're really contained by market. I mean, the market is
13 sort of the peer group in the MA-VIP, and each market is
14 broken into two cohorts, full duals and non-duals.

15 MS. TABOR: Exactly, exactly.

16 DR. DeBUSK: So it's almost like -- I think part
17 of the rub here is what you're calling a peer group in HVIP
18 is what you're almost calling a market in MA-VIP, and I
19 think that's maybe where my confusion at least came from.

20 Yes? No?

21 MS. TABOR: It is defined -- the peer groups are
22 differently defined, are defined different.

1 DR. DeBUSK: Okay.

2 MS. TABOR: And the way you explained it is
3 correct.

4 DR. CROSSON: Larry?

5 DR. CASALINO: Yeah. I don't have any speeches,
6 just questions.

7 [Laughter.]

8 DR. CASALINO: But just a very basic one. You
9 said in several points that the encounter data is not fully
10 available IN MA. I don't know that much -- have much
11 current information about this, but my understanding has
12 been that historically, capitated physicians would not
13 necessarily submit claims under MA. But I'm not sure
14 that's what you mean now. Are you saying that there are
15 claims for outpatient visits, for example, that are not
16 completely submitted as they are in Medicare fee-for-
17 service? Is that what you mean?

18 DR. JOHNSON: In general, we think that is the
19 case. Now, outpatient services and physician services are
20 two of the areas -- let me back up. In the July 2019
21 chapter, we had a comparison of the encounter data to all
22 of the available sources of MA utilization we could think

1 of and use, and there weren't many good sources for
2 physician outpatient services. But for inpatient hospital
3 stays, we compared to MedPAR data, and we compared SNF
4 encounter data to MDS and home health to OASIS as a
5 dialysis indicator.

6 So when we found evidence of MA utilization in
7 those other sources, we found some examples where there was
8 not a corroborating encounter record.

9 DR. CASALINO: Okay. I suppose it would be
10 possible to make a federal requirement that even within MA
11 plans, providers should have to file claims, even if
12 they're capitated.

13 DR. JOHNSON: Yes. And that is the current
14 requirement.

15 DR. CASALINO: A second thing that hasn't really
16 come up, and maybe it hasn't come up because I don't
17 understand it properly, but what is the purpose of paying -
18 - basically having separate pools for duals and non-duals
19 or however you want to measure social risk as opposed to
20 having multiple categories, multiple peer groups, as in the
21 hospital value incentive plan based on kind of a continuous
22 scale? So 10 percent, 20 percent, whatever, making peer

1 groups as in other recommendations we've made, so multiple
2 peer groups based on a social risk factor, not two
3 completely separate pools. I'm not sure what the
4 advantages and disadvantages are.

5 DR. JOHNSON: I think the decision was mostly
6 limited by the decision to work within market areas, and so
7 where the HVIP is national and has groups, hospitals, into
8 10 peer groups, the MA-VIP would look at the number of
9 parent organizations in that market area. And often there
10 are -- we've used a number of market areas with at least
11 three parent organizations, but I think the average number
12 was about five. So creating peer groups out of whole plans
13 would be difficult, and that's why, in part, we went with
14 the stratification of each.

15 DR. CASALINO: Okay. It seems like there might
16 be people in the room who this will add fuel to the
17 conversation about national versus local market area
18 comparisons.

19 That is, I think, my last question. Kind of
20 building on what Jonathan and Dana and Brian have
21 questions, what is special about Medicare Advantage that
22 would make us want to distribute rewards based on comparing

1 performance in a market between relatively small number of
2 plans as opposed to nationally? I mean, I think we all
3 understand there are advantages and disadvantages to local
4 versus national payment rewards and also public reporting.

5 DR. JOHNSON: Sure.

6 DR. CASALINO: So I'm not really asking
7 necessarily for a recap of those advantages and
8 disadvantages, but what's different about Medicare
9 Advantage that would make us do it differently there than
10 like for the hospital incentive program?

11 DR. JOHNSON: It's the ability of plans to change
12 their service area each year, so that if one service area
13 became unprofitable for a plan, they could get up a leave.
14 And the extent to which a consistent negative quality
15 reward would result in less profitable plans be going in
16 those lower-quality areas, we'd want to avoid that.

17 DR. CASALINO: So, basically, the idea is it's
18 easier for plans to move around than it would be for a
19 hospital to move around.

20 DR. JOHNSON: Correct.

21 DR. CASALINO: Okay.

22 DR. JOHNSON: And I think the other point that

1 Carlos made is that so that the beneficiaries have
2 information about their plan choices and not what happens
3 nationally.

4 DR. CASALINO: But that doesn't -- I think this
5 is echoing Jonathan. I'm not sure I buy that. If I'm a
6 beneficiary and I see that there's three plans in my market
7 and one ranks 20th in the country and one ranks 50th and
8 one is 100th, I can compare that just as well as I can
9 compare 1, 2, 3 in my market, right? But then I also have
10 the additional information of where they stand nationally.
11 So am I misunderstanding that?

12 MS. TABOR: Well, I guess I would also encourage
13 us to kind of think about we really focused the discussion
14 on payment and how do we kind of fairly reward and penalize
15 the performance, and then the issue of how do we publicly
16 report it to consumers would be a different question --

17 DR. CASALINO: Right.

18 MS. TABOR: -- that we weren't planning to
19 discuss today. But we can at another time.

20 DR. CROSSON: Okay. Marge?

21 MS. MARJORIE GINSBURG: Two questions. On page
22 36 of the report, where you have the modeling, the point

1 system, zero to 10, I just was curious whether this was
2 completely fictitious numbers that you put in for
3 illustration, but the points are distributed unevenly
4 across these various numbers.

5 So, for example, on the first column, it's about
6 6 points between the zero point and 2 point reward, but 15
7 points between 4 and 6. So you can see that sometimes the
8 pattern is consistent and sometimes it's not, and I just
9 wondered if you could explain how you -- that's the first
10 question.

11 My second question is if we know we're going to
12 do a tournament model, then that assumes we really are
13 going to distribute the bonus money completely. Is there
14 any discussion about doing the model so that we might, in
15 fact -- if there's a lot of low performers, that we might
16 actually save money? Do we have to distribute all the
17 bonus money? Is this being set up that way to do that?

18 So those are the two questions.

19 MS. TABOR: So I'll go with the second question
20 first. So I think that would be, again, something for the
21 Commission to discuss.

22 I think we have been thinking about this as a

1 budget-neutral program. Traditionally, in fee-for-service,
2 the withhold is entirely given back. The one exception for
3 that is the SNF VBP does keep some of the withhold, but
4 that's the only example of that. Usually, it is budget-
5 neutral, and the withholds are completely distributed.

6 On Table 4 in your notes, in your reading
7 materials, these are real numbers. We did calculate these
8 based on the MA plans in our model, and it really is just
9 purely based on distribution. So we took the second
10 percentile of distribution -- the second percentile of
11 performance when you rank all MA plan performance in our
12 model, rank order them. That person gets zero points, and
13 then the plan at the 98th percentile gets 10 and then just
14 do a continuous scale in between that zero to 10.

15 MS. MARJORIE GINSBURG: [Speaking off
16 microphone.]

17 MS. TABOR: Right. And I think that's because we
18 generally -- and this is true also in the HVIP. We found
19 this, that there is not much variation on the patient
20 experience measures. So you are kind of limited on how
21 much difference you're going to see. Whereas for
22 hospitalizations and probably for readmissions too, we're

1 going to see more variation. Yeah.

2 DR. CROSSON: Okay. Sue, let me ask you to come
3 in, in the next round. We've used up the majority of our
4 time on the questions here.

5 We have a very complex proposal here, and my
6 guess is that it's not going to be resolved in the next 15
7 minutes. I'm willing to extend it for another 15 minutes,
8 so we'll have a half-hour discussion. I'll shut up in a
9 second.

10 But just to reiterate, we've got four elements
11 here on the table. One is the proposal to change from
12 contracts to markets. The second one is to change the
13 measures from the existing, primarily, process measures to
14 the MA-VIP. The third one is to change from added bonus to
15 budget neutral, and the fourth one is to do redistribution
16 or whatever you want to call it, locally versus nationally.
17 So those are the four elements. They are somewhat
18 separate, but they are interrelated in terms of how it's
19 under consideration at the moment.

20 So, obviously, with the four elements and 17
21 Commissioners, we're going to have a hard time getting to
22 resolution here, but I would like to start the discussion,

1 see where we're going. I'd ask you to be concise. I'd ask
2 you to be as direct as possible towards these four elements
3 as you can, and Amol is going to start.

4 DR. NAVATHE: Thank you.

5 So, actually, I wanted to just ask a quick
6 clarifying question before I jump to the comments, Ledia,
7 if it's possible.

8 Is this a MedPAC record for the clarifying
9 questions length of discussion?

10 DR. CROSSON: No, unfortunately.

11 DR. NAVATHE: Okay. I'm the newbie here,
12 obviously.

13 So you mentioned for the clinical measures -- so,
14 in the star set, there's a bunch of these HEDIS measures
15 that require clinical data, like blood pressure and such,
16 and you mentioned that we could do this for breast cancer
17 and other administrative measures. So I was curious if you
18 mean we can do this in terms of our modeling or in terms of
19 what is a "choice set" here, quote/unquote, to include in
20 the MA-VIP?

21 MS. TABOR: I think we mean for our modeling and
22 also consistent with our principles, so consistent with the

1 Commission's principles and measure set that would be
2 available based on kind of administrative data, and as that
3 exists now, we are limited.

4 DR. NAVATHE: Okay. Thank you for the
5 clarification.

6 So, in terms of comments, I will try to be
7 relatively punchy here.

8 To your point, Jay, I think there are some
9 interactions between these pieces. So my comments do touch
10 on the interactions.

11 Overall, I thought this is a super-complicated
12 topic, very supportive of the direction, the idea. I think
13 there is probably several pieces that are worth doing some
14 additional investigation, and so I'll kind of direct my
15 comments primarily focused around those pieces.

16 I think, generally speaking, the idea, of course,
17 of being consistent with MedPAC measurement goals is good.

18 I think, largely, also, I would say fairly
19 consistent with what we might call behavioral common
20 principles, but I think there are some places that we might
21 want to think about the deviation from that or where they
22 apply or they don't.

1 So, in general, I think the idea that we're --
2 this first point of contract versus market, I think, the
3 potential, in some sense, for gaming the idea of the
4 beneficiary focus makes a lot of sense, and I think very
5 strongly supportive about that. I have a couple of layers
6 points later about that, but I generally support it.

7 In terms of the measure set itself, I think,
8 generally, the idea of having a smaller set of measures is
9 appealing in a broad sense and I think also consistent with
10 this sort of behavioral principles of choice overload or
11 peanuts effect or something.

12 That being said, a couple of comments. So one
13 thing is I do agree with Dana's concern that many of the
14 clinical measures -- those measures in the star set that
15 are HEDIS that do include clinical data are one of the few
16 areas that we do have where clinical data enters our
17 measurement, and that actually can be quite powerful. And
18 the fact that plans are caring about that is maybe
19 something that we don't want to necessarily give up right
20 away.

21 I would actually be fairly cautious in thinking
22 about that, recognizing your point about we could still

1 collect the data, but at the end of the day, payment is
2 really what's going to motivate the action against it.

3 And some of these outcomes, while they may, in
4 part, reflect those measures, they may imperfectly reflect
5 a lot of those processes that we know are high value in a
6 broad sense, and I am thinking about vaccination measures.
7 I'm thinking about the sub-measures in diabetes, some of
8 which are intermediate outcomes like Alc. I think those
9 are actually very valuable, and so I hesitate to get rid of
10 them, in some sense.

11 While simplicity is important, at least from a
12 behavioral economic sense, that would really be much more
13 important at the level of an individual clinician, not
14 necessarily at the level of an individual plan, which has a
15 lot more infrastructure to be able to deploy.

16 So I think the simplicity of measurement,
17 notwithstanding, I think there may be something that we
18 would be losing that's significant, worth thinking about.

19 Another point is around the measures. The
20 readmission measure, generally speaking, supportive of the
21 concept, I think one piece here is that it's effectively
22 double-counting readmissions because readmissions show up

1 in the cost performance piece too, and so are readmissions
2 so important that we really want to double down on them?
3 It's already a part of the cost incentive, and that we also
4 want to double-count it on the quality side. Ideally, our
5 quality set would reflect purely quality and not be related
6 necessarily to cost. So it's something to think about.
7 The other measures, I thought were very good.

8 The peer group piece, I think we've heard a lot
9 about. I'll just echo the points that we might want to
10 think about, more peer groups in terms of the continuity of
11 the different types of socioeconomic disadvantaged-ness, et
12 cetera, recognizing that we have this challenge of sample
13 size. So it's hard to slice and dice one market into so
14 many different layers and then still achieve sample size
15 requirements.

16 One thought I had is, Would there be a way to
17 create a peer set of markets that have similar
18 characteristics that would allow us to group and get more
19 sample size, a little bit more fidelity on that matching,
20 in some sense, of the peer groups?

21 And that would also have another potential
22 benefit to think about, which is -- one thing I am worried

1 about when I look at the scaling is if you have the
2 scenarios that Jonathan was sort of playing out, multiple,
3 quote/unquote, low-quality or low-performing plans in one
4 market, we might find a lot of clustering around the same
5 numbers, which we may then allocate dollars relatively
6 imperfectly, because there's actually not a lot of
7 variation there that we're able to measure when from a
8 beneficiary perspective, it actually could be quite
9 meaningful.

10 And so if we're able to stratify a little bit
11 more by grouping peer markets, quote/unquote, "peer
12 markets," that might give us a little bit more variation
13 there that would be closer to the reflecting truth. So
14 it's something to think about that could perhaps integrate
15 many of the comments that folks have mentioned.

16 Let me also help, to some extent, with the small
17 areas that we have, where we have less than three plans.
18 So we could also combine kind of based on like markets.

19 The budget-neutral concept, I think I'm very
20 supportive of, particularly the consistency across MA and
21 fee-for-service and the other programs that we've been
22 talking about, and I think it's very important, I think,

1 from an economic perspective to highlight that if what
2 we're really seeking out of the kind of rebate concept of
3 supplemental benefits, if what we're really seeking is to
4 transfer to the beneficiary, we should find a directly way
5 to transfer to the beneficiary. Using a bonus/rebate
6 indirect mechanism is intrinsically going to be inefficient
7 to do that. So if we want to reward beneficiaries for it,
8 we should just go straight out and do that, would be the --
9 at least economic view on it.

10 And definitely, I also echo Karen's point about
11 applauding the -- including the patient-reported outcomes
12 in this. I think while there may not as much variation
13 here, I think if we can figure out some of these sample
14 size issues, it could all become particularly important and
15 be a right step in the long-term direction.

16 So I will stop my comments there. Thank you.

17 DR. CROSSON: Thank you, Amol. Comments? I see
18 Jaewon, Dana, Bruce, Brian, Pat, Jon.

19 DR. RYU: Thanks, Jay. So I'll rifle through
20 just some thoughts here. Migrating from contract-based to
21 market-based, I think that's exactly right. Process-
22 oriented measures, migrating to MA-VIP, I think that makes

1 a lot of sense.

2 On the budget neutrality, I do pause there, and
3 the reason why is I know that the readings talked quite a
4 bit about plans when they've lost bonus status, they've
5 still maintained their benefits. I think that's isolated
6 plans here and there. I do wonder what happens when the
7 entire program loses a whole swatch of dollars. What
8 happens to those benefits?

9 I think when an isolated plan loses the bonus
10 status, they still have to compete and maintain a certain
11 benefit offering versus when an entire industry loses a
12 certain pool of dollars, I do think benefits would come
13 out. So that gives me a little pause.

14 On the local versus national, I actually do like
15 the local, and maybe this is a little bit of my bias based
16 on the geography that I'm coming from. But I think there
17 is something that's different for each market area and, in
18 particular, I think rural. And maybe it is just a rural
19 phenomenon, but I think about, you know, a few things that
20 are very different about rural that I think wouldn't be
21 equitable if you compared it on a national level. You
22 know, transportation is one. Wide distances. There's no

1 train, there's no public bus, there's no Uber. It's a very
2 different set of circumstances to hit on various quality
3 measures.

4 Second is literacy level and education level, and
5 I think those are very different in rural environments
6 versus, you know, urban or suburban areas.

7 I think the third is structural, you know,
8 largely around the delivery system itself, just the
9 prevalence of things like primary care, which may be in a
10 heavily urban area every couple blocks; in a suburban area
11 every couple miles, in a rural area every couple hours.
12 And so I think there is something to looking at the market
13 level.

14 And then the last point I wanted to make was just
15 around Pat's comment earlier around heterogeneity.
16 Specifically when you get to states that have very
17 stringent Medicaid criteria, if you had non-duals, non-dual
18 eligible in those populations, I think the heterogeneity is
19 potentially huge. And so I don't know if there's another
20 gradation that you add there somehow, another pool of
21 cohorts. And I guess the other question I would have is,
22 you know, the market areas, are there any market areas that

1 span state borders? Because -- okay. But, yeah, those are
2 the comments.

3 DR. CROSSON: Thank you, Jaewon. Dana.

4 DR. SAFRAN: Thanks. Okay, so, number one, I
5 think that the measure set that you've defined is really
6 superb. It's parsimonious but really stands for true
7 value. So I really like it a lot. I'm really thrilled
8 with the addition of the health outcome measures, patient-
9 reported outcome measures.

10 There was something I saw in the paper that said
11 something about a sample size of 30 is enough in CMS' mind.
12 I just sent you an article while we were talking on that
13 topic, but it's not. But that's okay because plans will
14 have sufficient membership to be able to measure this, and
15 all the better that we will be incentivizing that you need
16 a robust way to collect this information across your
17 population and track it. So I think it's great.

18 I like the readmission measures. You know, when
19 I was doing this for a living in the commercial sector, I
20 did face that hard choice of did I want to double down on
21 something that's already on the cost side. And there were
22 a couple places, and readmissions is one of them where it's

1 both big enough quality issue, safety issue, cost issue,
2 and actionable that I think it's a good thing to do.

3 The second point is that these are hard, these
4 are going to be hard measures to perform well on. I sort
5 of indicated this in one of my questions at the beginning,
6 so I do think we have to think really carefully about how
7 we structure the benchmarks, who you're measured against,
8 the incentives, and everything else, because we don't want
9 to demoralize folks and have them throw up their hands.

10 However, that said, you know, I land in a
11 different place from Jaewon on the local versus larger, for
12 a couple reasons. One is it's hard for us to face certain
13 markets and just say we have a lower standard of care for
14 you. You know, your providers are really not nearly as
15 good as these other ones, but we pay them handsomely for
16 whatever they can do. And I think we want to push folks to
17 innovate. You know, this is Medicare Advantage where they
18 can use telehealth; they can be creative in solving some of
19 the problems that Jaewon rightly points us to. And I think
20 we want to encourage them to do that.

21 So for that reason, plus the sample size and
22 other issues, I'd just like us to take another look. And

1 that doesn't stop us, by the way, from reporting locally,
2 right? So we can measure, you know, to benchmarks
3 nationally, compare peer groups nationally, but still give
4 people information about their local plan in terms of
5 performance.

6 Two last things. One is that -- I think Marge
7 was commenting on this as I had to step out. There is a
8 difference in how much variation you have from the 2nd to
9 the 98th percentile across these measures. That's okay. I
10 think for now there's enough to work with. But you have to
11 plan for the fact that as improvement happens, especially
12 in the patient experience, you may have too narrow a range
13 to split it ten ways, and you ought to be thinking ahead to
14 that scenario.

15 And last is, as has been mentioned, I'd love to
16 see us come up with another methodology for the social risk
17 stratification that isn't just tied to duals. Thanks.

18 DR. CROSSON: Thank you, Dana. Bruce.

19 MR. PYENSON: I support all four structural
20 changes. I think they're important and a big improvement.

21 I would like to see a fifth domain in the measure
22 set, which is a small group of what we're calling "process

1 measures" that can be obtained through claims. And I think
2 many of those, although they're process measures, have a
3 very solid evidence base supporting them -- vaccinations,
4 cancer screenings, a handful of others. And some of those
5 measures, some of the current measures, I believe, could be
6 changed to get more of them from claims than currently.

7 So that's the only change I'd like to see. Thank
8 you.

9 DR. CROSSON: Thank you, Bruce. Brian.

10 DR. DeBUSK: First of all, yes to moving from
11 contracts to markets. I think that's great.

12 Yes to narrowing the measures down with the
13 caveat, to Bruce's point, which I do think if there's some
14 claims -- you know, not all process measures are the same.
15 You know, some are truly useless and some may have some
16 merit. And if we can preserve some of the claims-based
17 ones and create a fifth domain, I think that would work.

18 As far as is it budget neutral or is a cut? I
19 think the cut is a separate conversation. I would love to
20 see us have the discussion about the cut, but, you know,
21 it's quality, it's benchmarks, it's coding adjustments. MA
22 has so many different facets to how you would adjust that

1 overall payment that I would love to see that as a separate
2 discussion.

3 The final point, a number of people talked about
4 -- pointed out the limitations of confining everything to a
5 market area. But I think the point that one of you two
6 made right at the very end really outweighs a lot of those
7 limitations, which is any redistribution we do that goes
8 beyond the local market area, you know, national or
9 whatever, you're going to run the risk of creating these MA
10 deserts where in any given area, if there's poor health
11 care overall, these plans are so fluid they're just going
12 to simply move out of that area. And you're going to
13 create these areas that the plans just can't afford to move
14 into.

15 So it is somewhat unsavory to have to keep
16 everything at a market level and in theory reward people
17 who have mediocre performance just because they're, you
18 know, the best mediocre performed among the mediocre. I
19 mean, that's distasteful, but, you know, the alternative I
20 think is worse, which is the idea of an MA desert where no
21 one wants to -- a geography where no one wants to go.

22 So thank you, and great work. I hope you keep it

1 going.

2 DR. CROSSON: Thank you, Brian. Pat.

3 MS. WANG: I'm in favor of the local markets and
4 hopefully that -- I really think that it's very
5 appropriate, and I hope that the issues that people have
6 raised with, you know, not enough plan sponsors, not enough
7 -- can be dealt with by doing some expansions, because
8 right now it sounds like the vast majority of people are in
9 what you're defining as local market, and I do think that
10 quality is local, so it's very important to measure and
11 reward that way.

12 On the measure set, I appreciate the effort to
13 reduce the number of measures and to make them all capable
14 of reporting through administrative data. But I don't
15 actually think that they are the right universe. Fifty
16 percent of the measures have to do with avoidable
17 admissions; 50 percent of the measures have to do with, you
18 know, patient satisfaction, self-reported outcomes. So
19 those have a place in any quality measurement system, but I
20 think that we're missing a lot by restricting to that.

21 I kind of agree with Amol about readmissions, and
22 there's noise in the measure, too. It can be addressed,

1 but how do you deal with observation stays? How do you
2 deal with payment denial? Did it happen? Did it not
3 happen? It's a display measure now in stars because the
4 specifications keep changing to try to get at some of this
5 squishiness. So I actually -- I also think that with the
6 emphasis on moving care outside of the hospitals, there
7 needs to be -- to capture things that I think are very,
8 very important to many more people than an avoidable
9 readmission, which, you know, medication adherence, they're
10 terrible difficult measures, but I really believe that
11 they're important, some of the control measures, blood
12 pressure controlled, blood sugar controlled, the cancer
13 screenings, and some of these are hybrid measures. They
14 require medical records review. But plans are doing it
15 today, and providers are supplying that information today.
16 It's not a new burden.

17 I think that, you know, pulling back on the
18 administrative functions and those kinds of things, as you
19 had suggested will relieve a lot from people's plates, but
20 I think that including impactful HEDIS measures is really
21 quite important, whether they're claims-based or medical
22 records review-based.

1 People talked about the peer groups. I totally
2 endorse like really kind of doing a deeper dive in trying
3 to do much better than this binary you're a dual/you're not
4 a dual.

5 On the tournament model, I actually think that --
6 and I'm just speaking from my own perspective. It
7 stimulates more competition and more initiative on the part
8 of plans and their providers when they don't know exactly
9 where they need to get. Like you can eke out some
10 incremental improvements in quality that I think are really
11 important.

12 As far as the budget neutrality or the savings is
13 concerned, I am -- I think that Jaewon's comment and
14 Brian's comments are good in terms of using this as a
15 vehicle to do a cut to the MA program. I would really try
16 to separate those two things. We have an upcoming
17 discussion about benchmarks, so this is all -- those things
18 are sort of tied together. Budget neutrality sounds really
19 good in principle, but budget neutrality based on what?
20 You know, what's the underlying payment system that you're
21 taking money out of and giving back.

22 The final thing that I would say is the aggregate

1 observations about what plans do and don't do when they go
2 into bonus status, they come out of bonus status, I was
3 really surprised by the observation that plans don't make
4 any changes in extra benefits when they don't have the
5 bonus. Again, this is just local experience. That doesn't
6 even seem possible to me, and I think that there are some
7 plans -- just so that people appreciate how important the
8 bonus programs are to focus -- so some plans take quite a
9 bit of that money and turn them into provider quality
10 incentive programs that are quite focused at specific
11 activities and really hitting and trying to do better and
12 better and better. The power of that reward is bigger than
13 the underlying payment and contract because it's like
14 you're doing the right thing for the member, the person's
15 patient, what have you, and I just think it's just a really
16 critical program to maintain as something special.

17 DR. CROSSON: Okay. Sue, remember, I cut you
18 off. Do you want to come in at this point.

19 MS. THOMPSON: The comment's been made [off
20 microphone].

21 DR. CROSSON: Comment made. I'm sorry. Okay.
22 So I've got Jon, Paul, and Larry, and Kathy and Warner.

1 And then that's it. Sorry. Only because we're not done
2 with this, right? Okay, Jon.

3 DR. PERLIN: Thank you. There's clearly an
4 interplay between these four structural elements, so I
5 think it's hard to think of them entirely separately. I'll
6 come back to why I say that.

7 But to the first question, should the consumer be
8 able to have insight into the performance of a plan that's
9 going to affect them in their local area? Absolutely.

10 Where I get into a little trouble and see a bit
11 of the interplay is that I think you may need a larger
12 sample size for a variety of reasons. It gets to this
13 question of simplify the measures, I think is the wrong
14 question. Improve the measures is, I think, the better
15 question there.

16 The reason I want to get to improve the measures
17 as opposed to simply simplify the measures is that there
18 could be some very unintended consequences. You want the
19 measures to actually predict the performance the
20 beneficiary is apt to receive from the plan in the market.

21 What do I mean by that? You know, I'm going to
22 use readmissions as the example. If you have either by a

1 low-frequently event or a limited sample size or a limited
2 sampling frame, an inadequate number of events in the
3 particular year, say 2019, but instead say, okay, I'm going
4 to look back 2014 to 2017, that creates a number of
5 derivative effects.

6 First, a consumer, a beneficiary is trying to
7 make a prediction about what will happen to me in 2020
8 based on the performance report I read in 2019. But here's
9 the problem: It's not 2019 that's predicting 2020, which
10 is the extrapolation they make. You actually have a three-
11 year sampling frame, 2014 to 2017, that probably has more
12 predictive value for 2015 through 2018 than the year-to-
13 year. The math just doesn't work, otherwise, and Rich
14 Blatt and others have written on that, so it's got two
15 structural flaws.

16 That suggests two things. One, you know, go to a
17 larger area that's part of the same plan, but also go to
18 higher-frequency events or find a way to get higher-
19 frequency data. Process measures are really good in that
20 regard.

21 Patient experience is a wonderful indicator, but
22 when you have 26 percent, as the HCAHPS does -- and I don't

1 know what the CAHPS analog is here -- you don't have a
2 representative sample. What if you actually included a
3 general member satisfaction question or two in every annual
4 enrollment period based on their last? You'd have 100
5 percent response actually and data that actually predicts
6 the next year.

7 So I think this balanced approach is absolutely
8 terrific but would really encourage that we have data to
9 predict, you know, prospectively for the period that the
10 beneficiary is going to enroll for.

11 The point came up earlier as to why a frustrated
12 plan might exit the market. It's not just that they can't
13 get the dollars. It's that they can't control the
14 variables that are the key to the dollars. What do I mean
15 by that? It gets back to that readmissions as the example.
16 If you have a 12-month trailing average that's in arrears
17 by at least a year, they can't overcome the tail of that
18 for a long period of time. They've got to actually focus
19 in on other measures.

20 That obviously identifies the second issue, that
21 if you have a balance sheet and scorecard of measures and
22 you can't do anything about one of the measures, you're

1 going to write that measure off regardless so it's actually
2 no longer viable as a performance improvement opportunity.

3 Then, finally, let me come to this notion of
4 conflation, as Brian pointed out, between, you know, the
5 dollars and the structure here. If we do go to this model,
6 I would encourage that we consider building the equivalent
7 of the excess into the first year so it's not a hit. Why
8 do I say that? For all the reasons that have been
9 mentioned, but one thing that hasn't come up is that
10 there's also a downstream effect on the providers there,
11 and I think you want to make sure, particularly in markets
12 that may be more challenged, that the assets are there.
13 And why is that important in turn?

14 You know, one thing we never talk about here --
15 and I don't know if the data are available or I don't know
16 the data, but we've talked about the average losses on
17 Medicare beneficiaries in hospitals, for example. But I
18 would bet you that there's a difference between the MA
19 losses per beneficiary and the fee-for-service losses per
20 beneficiary. And if, in fact, MA is propping up fee-for-
21 service, then you're going to actually impair access for a
22 variety of other reasons.

1 So for all those reasons, I think we're
2 absolutely on the right track here, but I would suggest
3 these amendments, particularly this last one. We need to
4 think about the downstream impacts in its linkage to the
5 benchmark setting as well. But the intent of this,
6 allowing consumers to be able to have visibility into what
7 their likely experience is absolutely right.

8 And, finally, you know, I don't think it's an
9 either/or, either I can reference my local market
10 performance between different competitors, or I can
11 reference it with respect to a national. It's really
12 both/and. Let me give you a concrete example of that. If
13 I am buying a car, I might think about the national -- or
14 the performance of the vehicles overall, and that's one
15 factor. The second is what is the service in my
16 environment, and I think the consumers can make that sort
17 of determination when presented with data that ordinarily
18 ranks within a market and simultaneously gives them the
19 understanding of how that compares against a broader
20 reference rank.

21 Thanks.

22 DR. CROSSON: Thank you, Jon. Paul.

1 DR. PAUL GINSBURG: Okay. Yes, like others I
2 certainly think moving from contracts to markets is the way
3 to go.

4 I had a couple of thoughts about new measures.
5 We have a lot of interesting thoughts about how perhaps we
6 need to be more nuanced, new measures we need to draw,
7 selected careful, process measures. But, you know, we need
8 to think about, you know, it's one thing to need to choose
9 the measures to model, but on the other hand we don't want
10 to attract Congress to come up with 40 measures or 20
11 measures when it writes legislation. So it's really
12 important to talk about, you know, directions, examples,
13 illustrations, but not actually get tied up in exactly what
14 should the measures be.

15 As far as budget neutrality, I think that -- and,
16 of course, this could be phased in, Pat, but I think that
17 we are overpaying for quality, in the sense we have, you
18 know, a case of everyone succeeding and we're giving
19 everyone a bonus. And, you know, where still Medicare MA
20 payments are above fee-for-service, and that's an unhealthy
21 thing. So I don't think there's really any justification
22 for continuing this quality stars as an add-on.

1 Final thought is that I was glad to hear some of
2 the concerns about, you know, the MedPAC has been against
3 tournament models ever since I've been on the Commission.
4 I've never been convinced. I like the arguments about how
5 tournament models keep everyone focusing, rather than
6 saying, "Oh, we already achieved that. I don't have to
7 work this year, because I know I can do it."

8 DR. CROSSON: Thank you, Paul. Larry.

9 DR. CASALINO: I'm just going to comment on the
10 local versus national as a place for comparison and reward.
11 I think we've heard really compelling arguments for both
12 sides, early on from several people for national and then
13 Jaewon, it's pretty had to refute what he said for local.
14 So I don't know what to do about that. There might be an
15 opportunity to reconcile things by thinking more deeply
16 about peer groups.

17 We have had surprisingly little discussion, or
18 none, really, about the concept of having these two
19 separate pools, one for non-dual eligible, one for dual
20 eligible, or whatever social risk factor you want to use,
21 or a combination of factors. The fact we haven't had much
22 discussion about that worries me a little -- this is an

1 aside -- because God knows what unintended consequences
2 could come out of that. So I think more thinking needs to
3 probably be done about that.

4 But let's suppose we could create peer groups
5 that would be national but would help take care of some of
6 the concerns, for example, like the rural concern that
7 Jaewon mentioned. So, for example, what if a peer group --
8 and I'm not suggesting this as a best example but just for
9 conceptually a way of thinking about it -- what if the peer
10 groups were based on rural plus some social risk factor --
11 dual eligible or whatever -- and you could have however
12 many categories you wanted based on that.

13 It seems to me if those peer groups could be well
14 designed that way, first of all we get away from having to
15 do something that we're not doing anywhere else, I don't
16 think, in Medicare, these two separate pools of payment for
17 dual eligible and non-duals. But secondly, we could do
18 national tournament, if you want to call it that, but still
19 hopefully be addressing the concerns about what happens if
20 you ignore local market conditions. So again, rural dual
21 would be a kind of crude first cut at that.

22 DR. CROSSON: Thank you, Larry. Kathy.

1 MS. BUTO: So I want to support moving from
2 contract to area. I want to also add my voice to others
3 who have said the measure set looks really good but it
4 would be, from a perspective of a beneficiary, I think it's
5 missing a big piece of what kind of care am I going to get
6 through this organization. So I think if we can add some
7 process measures that are aimed at some of the highest-cost
8 conditions, I think that would be a place, and we ought to
9 have some criteria around the measures that we think ought
10 to be added so that Congress doesn't come along and willy-
11 nilly add 30 more.

12 I feel strongly that we should go to budget
13 neutrality, but I liked Jon's suggestion that you add the
14 \$6 billion into the base and then go from there, as opposed
15 to approaching it as a \$6 billion cut or something like
16 that. I think it's fair to put quality dollars in, but I
17 also think it's fair to look at it not being sort of a one-
18 sided reward system, if you will.

19 So other than that I think this is terrific work,
20 and I think -- oh, the other one is national versus local.
21 I don't have a strong opinion on that, although my gut
22 tells me we tend to want to do everything nationally in

1 Medicare, and I just -- as long as I worked in Medicare at
2 the national level I found there are so many flaws in
3 trying to impose a one size fits all on each area.
4 Delivery systems are different. MA plans are going to be
5 structured differently. Challenges are different. And we
6 ought to find a way to accommodate that, and I don't know
7 if it's the new care grouping that you were suggesting,
8 Larry. But I fear that going total national doesn't make a
9 lot of sense, and it's hard to explain. People don't
10 understand why they're being compared to plans in
11 California if they're in rural Pennsylvania. So I just
12 think we need to think more about that.

13 DR. CROSSON: Kathy, let me just ask you one
14 clarification. So when you said the highest cost issues, I
15 heard that in two ways, focused on the highest-cost
16 patients or in the case of --

17 MS. BUTO: Conditions, highest-cost --

18 DR. CROSSON: -- cancer prevention, there's a
19 difference in the level of investment required. So, for
20 example, I can't think of it -- like, for example,
21 colorectal cancer screening requires a high level of
22 investment in order to get to a significant portion. So

1 when you were using the term "cost," which way were you
2 using it -- highest-cost patients or highest-cost
3 investment, which is a little different?

4 MS. BUTO: Highest cost --

5 DR. CROSSON: Because one is up front --

6 MS. BUTO: -- if something isn't done, the
7 highest cost to the system, in terms of generating high-
8 cost care.

9 DR. CROSSON: Okay. So that -- anyway.

10 MS. BUTO: So this could be uncontrolled
11 diabetes, it could be -- I don't know.

12 DR. CROSSON: Yeah. So that's downstream and the
13 other is upstream.

14 MS. BUTO: I would look at that.

15 DR. CROSSON: Yeah. Thanks. Okay. Warner.

16 MR. THOMAS: I will be brief. Just two comments.
17 I agree with Pat, and I think Bruce made a comment as well.
18 I mean, the process, your screening measures, I think are
19 really important, and just going to Kathy's point, I mean,
20 I think whether it is hypertension or diabetes or major
21 cancer screenings, I think those are really important and
22 need to be included in this as a significant part of what

1 we do.

2 And the last piece, I know we're trying to --
3 there's been a lot of discussion on national versus local
4 and whatnot. I come back to I'd like to make sure we have
5 alignment between these quality measures and what we're
6 trying to do in the ACO world that we're in, you know, the
7 fee-for-service world. We've got to make sure that those
8 are aligned. I didn't see a lot about that in here. I
9 know that's probably the intent, but I'm a little concerned
10 that we're so concerned about the tournament model and
11 national versus local that, you know, to me it's like are
12 the measures the same across the population, which
13 ultimately, if we want to do a good job taking care of
14 people we've got to have that consistency.

15 DR. CROSSON: Okay. Rich discussion. Almost,
16 not the end.

17 DR. SAFRAN: Very, very fast, but I think this is
18 important. I think we're conflating the use of the term
19 "tournament" with the idea of having absolute versus
20 relative performance targets. And so I just wanted to say
21 that. Like I think there is a tournament -- when you have
22 absolute performance targets, I think the value is

1 providers know what they are trying to accomplish, and we
2 aren't stuck rewarding mediocrity just because that's --
3 you know, that's the best anybody has been able to do.

4 So I think having absolute performance target and
5 then letting folks have at it, competing to achieve those,
6 is language maybe we can work on. But we're not against
7 tournaments. We're against setting benchmarks in a way
8 where they're relative and so you don't really know what
9 good is. Thanks.

10 DR. CROSSON: Yeah. So there's -- well, I'm
11 going to violate my own rule here.

12 Good discussion. More to come. That's the good
13 news and the bad news. Thanks Carlos, Ledia, and Andrew.

14 [Pause.]

15 DR. CROSSON: Okay. I assume more of the other
16 Commissioners will be back soon, but I think we do need to
17 get going. For our guests, we have now had one issue for
18 the afternoon, which went a little longer than we thought,
19 related to Medicare Advantage, and we're going to have a
20 second presentation on Medicare Advantage here, the issue
21 ore forming the system that creates the payment benchmarks.
22 And Scott Harrison is here for this.

1 DR. HARRISON: Good afternoon. Today, I will
2 describe the current MA payment system and present some
3 alternatives for you to consider.

4 The MA program gives Medicare beneficiaries the
5 option of receiving benefits from private plans rather than
6 from the traditional fee-for-service Medicare program. The
7 Commission strongly supports the inclusion of private plans
8 in the Medicare program -- beneficiaries should be able to
9 choose between the traditional fee-for-service Medicare
10 program and alternative delivery systems that private plans
11 can offer. Because Medicare pays private plans a risk-
12 adjusted per person rate rather than a per service rate,
13 plans have greater incentives than fee-for-service
14 providers to innovate and use care-management techniques to
15 deliver more efficient care.

16 Unfortunately, much of the growth in MA
17 enrollment over the past 20 years has been subsidized by
18 high payments, payments well in excess of what it would
19 have cost the Medicare fee-for-service program.

20 Recent legislation, namely the ACA, has lowered
21 MA payments relative to fee-for-service Medicare. There are
22 still a couple of percentage points worth of risk-coding

1 that is not accounted for, but other than that payments
2 have reached rough parity over the past few years.

3 But there are opportunities for further
4 reductions that will allow the Medicare program to achieve
5 savings to help the long-term sustainability of the
6 Medicare program. Plans bid an overall average 89 percent
7 of fee-for-service, yet because of the still-too-high
8 benchmarks, the Medicare program realizes no overall
9 savings from the MA program.

10 The Commission has emphasized the importance of
11 imposing fiscal pressure on all providers of care to
12 improve efficiency and reduce Medicare program costs and
13 beneficiary premiums. For MA, the Commission previously
14 recommended that payments be brought down.

15 Over the past few years, plan bids and payments
16 have come down in relation to fee-for-service spending
17 while MA enrollment continued to grow. The pressure of
18 lower benchmarks has led to improved efficiencies and more
19 competitive bids that enable MA plans to continue to
20 increase enrollment by offering benefits that beneficiaries
21 find attractive.

22 If we expect that MA plans will become a more and

1 more important part of the overall Medicare program, it is
2 essential that plans contribute more and more savings to
3 sustain the program.

4 Back in the 1980s, Medicare managed care plans
5 were paid at a set rate of 95 percent of the county risk-
6 adjusted average per capita fee-for-service spending. The 5
7 percent differential recognized the presumed greater
8 efficiency of private plans through their ability to reduce
9 program expenditures using tools such as closed provider
10 networks, prior authorization, and value-based cost-sharing
11 that the fee-for-service system generally cannot use.

12 A series of legislation beginning in 1997,
13 running through the MMA in 2003, established the MA program
14 and expanded the role of private plans in Medicare. The MA
15 payment system we have today, based on plan bids and county
16 benchmarks, became effective in 2006.

17 MA enrollment and payments increased throughout
18 this period. By 2009, benchmarks averaged 118 percent of
19 fee-for-service spending and payments averaged 114 percent.

20 In response to the excessive payments, the ACA
21 changed and reduced the benchmarks substantially. The ACA
22 also introduced the quartile system, which I will describe

1 shortly, and quality bonuses, which you just heard about in
2 the last presentation. The changes were designed to save
3 the Medicare program over \$100 billion dollars over a 10-
4 year period, by reducing the average MA benchmark to about
5 102 to 103 percent of fee-for-service spending by the end
6 of a seven-year transition.

7 There was a lot of concern about reducing the
8 benchmarks that much and CBO and CMS forecast that those
9 lower benchmarks would lead to a substantial decrease in MA
10 enrollment.

11 While the benchmarks did decline as expected, the
12 fiscal pressure did not lead to decreased MA enrollment.
13 Instead, MA plans were able to find efficiencies and lower
14 their bids in response to the benchmark reductions. By
15 2019, the average MA bid was down to 89 percent of fee-for-
16 service, down from 100 percent in 2010.

17 Those lower bids allowed plans to offer generous
18 benefits, which have been increasing, and in 2019 were a
19 record high of \$107 per month. These benefits are funded
20 by rebates, which are a feature of the bidding process I
21 will explain shortly. Amendment these extra benefits
22 encouraged enrollment, which has doubled since 2010.

1 Now let's look at how the ACA sets benchmarks
2 using quartiles of fee-for-service spending. Under the
3 ACA, each county's benchmark, excluding quality bonuses, is
4 a certain percentage of the average per capita spending for
5 the county's fee-for-service Medicare beneficiaries. Each
6 county's benchmark percentage is determined by organizing
7 the counties into quartiles based on their fee-for-service
8 spending.

9 Counties are ranked by average fee-for-service
10 spending. The lowest-spending quartile of counties has
11 benchmarks set at 115 percent of local fee-for-service
12 spending. The next lowest-spending quartile is set at 107.5
13 percent, followed by the third-lowest, or second-highest on
14 here, set at 100 percent, and the highest-spending quartile
15 has benchmarks set at 95 percent of fee-for-service.

16 Low fee-for-service spending counties have
17 benchmarks higher than fee-for-service to help attract
18 plans and high fee-for-service spending counties have
19 benchmarks lower than fee-for-service to generate Medicare
20 savings.

21 I'll note here that the benchmarks are adjusted
22 higher for plans that were deemed high quality, but we are

1 assuming that plan quality payments will be made outside
2 the benchmark structure, and for the remainder of this
3 session, all references to the benchmarks will be to the
4 base benchmarks; that is, benchmarks that do not include
5 any quality bonuses.

6 Now let's step back and look at the mechanics of
7 how the bids and benchmarks work. Medicare payments to MA
8 plans are determined by the plan bid, which represents the
9 dollar amount that the plane estimates will cover the Part
10 A and Part B benefits for beneficiary and the benchmark for
11 the county in which the beneficiary resides.

12 The benchmark is a bidding target that is based
13 on the average expected fee-for-service spending in a
14 county.

15 If a plan's bid is below the benchmark, as is the
16 case for almost all plans, its payment rate is its bid plus
17 a share -- and that's between 50 percent and 70 percent,
18 depending on a plan's quality ratings -- of the difference
19 between the plan's bid and the benchmark.

20 The added payment based on the difference between
21 the bid and the benchmark is referred to as the rebate.
22 Plans must use the rebate to provide additional benefits to

1 enrollees in the form of lower cost sharing, lower
2 premiums, or supplemental benefits. Plans can devote some
3 of the rebate to administrative costs and margins.

4 In the rare event that a plan's bid is above the
5 benchmark, Medicare pays the plan its benchmark, and the
6 enrollees have to pay a premium equal to the difference.

7 Returning to the benchmarks, we see a couple of
8 problems with the quartile system.

9 One problem is that the quartile structure
10 creates discontinuities, or cliffs, at the three borders or
11 cut-points between the quartiles. The differences in the
12 quartile factors are large enough to make the cliffs
13 significant.

14 For example, assume County A has average fee-for-
15 service spending of \$741 and County B has average spending
16 of \$1 more or \$742. Further, assume that the cut-point
17 between the two lowest spending quartiles is just under
18 \$742 so that County A is in the 115 percent quartile and
19 County B is in the 107.5 percent quartile.

20 County A's benchmark would be set at 115 percent
21 of \$741, or \$852, and County B's benchmark would be set at
22 107.5 percent of \$742, yielding a benchmark of \$798.

1 So the \$1 difference in fee-for-service spending
2 would produce a negative \$54 difference in benchmarks.

3 There are two other cliffs, one between the
4 second and third quartiles and one between the third and
5 fourth quartiles, and each of the drops off these cliffs
6 are also in the \$50 neighborhood.

7 Another fundamental problem with the system is
8 that the benchmarks are simply too high on average for the
9 Medicare program to realize any savings. The primary
10 argument for setting benchmarks above fee-for-service is to
11 promote plan availability in low fee-for-service areas.

12 When the quartile structure began in 2012, there
13 was concern that low fee-for-service spending areas would
14 have trouble attracting MA enrollment if plans were not
15 paid more than fee-for-service.

16 The goal of this policy was to promote wide
17 access to managed care plans in Medicare, so the ACA
18 included the quartile system that set higher benchmarks in
19 low-spending areas. The relatively high benchmarks made it
20 easier for plans in those areas to offer relatively
21 generous benefits to attract enrollment.

22 This strategy has been very successful, and

1 currently 37 percent of beneficiaries living in low-
2 spending areas have enrolled in MA plans. That 37 percent
3 penetration rate is higher than the national average of 34
4 percent. Unfortunately, the Medicare program pays 11
5 percent more for MA enrollment than for fee-for-service
6 enrollment in those areas.

7 This means that, currently, MA enrollment from
8 areas in the lowest-spending quartile -- and to a lesser
9 extent in the second lowest-spending quartile -- increases
10 the cost for the Medicare program which both weakens the
11 Hospital Insurance Trust Fund and produces taxpayer, state,
12 and beneficiary costs in the Part B program, which is
13 financed by general revenues and Part B premiums.

14 More generally, the ACA benchmarks have been
15 fully phased in and stable for the last three years, and if
16 we ignore the excess MA risk coding, the aggregate payments
17 to MA plans have been about the same as fee-for-service in
18 each of the last three years.

19 This equilibrium suggests it is unlikely that MA
20 plans will ever provide any meaningful savings to the
21 Medicare program, absent changes in the benchmarks.
22 However, the Commission believes that the Medicare program

1 should share in the efficiencies currently being enjoyed
2 only by the plans and their enrollees.

3 The Commission has seen that plans can provide
4 extra benefits more efficiently than fee-for-service
5 Medicare, and again, they are currently bidding 89 percent
6 of fee-for-service on average. We believe that the
7 increased fiscal pressure would prod plans to find
8 additional efficiencies and lower their bids further.
9 Thus, we consider potential alternatives to the current
10 benchmark system.

11 So we have a few issues with the current
12 benchmarks. First is the cliffs. They introduce an almost
13 random factor in the determination of the county
14 benchmarks.

15 Second is that the Medicare program is not
16 realizing any savings from the MA program because of the
17 level of the benchmarks.

18 And lastly, there is a tradeoff between treating
19 all areas of the country the same relative to their local
20 fee-for-service spending, which for this session, we will
21 "geographic equity," and the desire to promote or subsidize
22 plan participation in low fee-for-service spending areas.

1 I will present three alternatives for the current
2 benchmarks and examine how they address the three issues
3 above.

4 All three alternatives have been designed to realize
5 savings by lowering the average benchmark to 98 percent of
6 fee-for-service.

7 We chose 98 percent of fee-for-service for the
8 average benchmarks in order to claim a modest share of plan
9 efficiencies for the program and to match the shared
10 savings threshold in some of the Medicare ACO models. In
11 some of those models, ACOs are paid shared savings only
12 after they meet a 2 percent savings threshold.

13 There could be many other alternatives, including
14 some more comprehensive approaches that could include
15 competitive bidding. These three, however, were chosen as
16 relatively simple approaches that could be implemented
17 almost immediately after legislation was passed. Also,
18 these alternatives would not preclude Congress from working
19 on more comprehensive approaches that may take more time to
20 implement.

21 Alternative 1 would set all benchmarks at 98
22 percent of local fee-for-service spending. There would be

1 no cliffs, as all areas would have the same relationship
2 between their fee-for-service spending and their MA
3 benchmark. The relationship also means that this
4 alternative would be geographically equitable.

5 Alternative 1 would not promote plan
6 participation in the low fee-for-service areas, but that
7 does not mean that all the plans would necessarily leave
8 those areas.

9 In 2019, plans bid an average of 99 percent of
10 fee-for-service in low-spending areas. Modest bid
11 improvement might allow wide plan availability even under
12 Alternative 1.

13 Alternative 2 would reduce each of the four
14 quartile factors by 3 percentage points. The four factors
15 would change to 112 percent, 104.5 percent, 97 percent, and
16 92 percent. These would increase fiscal pressure across
17 all plans and areas of the country. The increase in
18 pressure would be uniform across the country and would be
19 likely to cause little disruption as all the areas would
20 see a relatively small decrease in benchmarks.

21 It is likely under this alternative that plans
22 serving areas in the three highest-spending quartiles could

1 contribute savings to the Medicare program. In 2019, we
2 estimate that savings generally came from just the two
3 highest-spending quartiles.

4 Under Alternative 2, the quartile structure
5 remains, so there would still be cliffs, and high spending
6 areas are treated differently than low-spending areas
7 relative to local fee-for-service. The 112 percent for
8 low-spending areas should be more than adequate to support
9 plan participation in those areas.

10 Alternative 3 is a hybrid that combines some
11 concepts from the other alternatives. The hybrid would set
12 benchmarks above fee-for-service in low fee-for-service
13 spending areas to promote plan availability. It would also
14 set a benchmark limit, or ceiling, for the highest-spending
15 areas to avoid paying excessive rates in those areas. Most
16 areas would lie between the low-spending areas and the
17 ceiling. As the fee-for-service spending in these areas
18 increases, so would the benchmarks but at a much slower
19 rate, about 40 cents on the dollar, if you were to follow
20 the line-up.

21 Alternative 3 was designed without any cliffs.
22 The benchmarks would range from 112 percent for the lowest

1 half of the lowest-spending quartile to promote plan
2 participation in those areas, and it would decrease by the
3 time you got to the very highest-spending counties, to
4 about 8 percent of fee-for-service.

5 This alternative does not treat all areas equally
6 and does promote plan participation in low-spending areas.

7 All of the alternatives were calibrated to
8 produce the same average benchmark equal to 98 percent of
9 fee-for-service, so they would all produce an increase in
10 fiscal pressure and should yield savings for the Medicare
11 program.

12 Both the 98 percent of fee-for-service in all
13 areas, alternative and the hybrid, eliminate cliffs while
14 the lower quartiles alternative keeps them. Only the 98
15 percent of fee-for-service alternative produces benchmarks
16 where all areas are treated equally compared with local
17 fee-for-service spending.

18 The quartile and hybrid alternatives promote plan
19 participation by subsidizing low-spending areas.

20 An ideal benchmark system should try to support
21 several principles: promote financial neutrality between
22 MA and fee-for-service Medicare, while applying fiscal

1 pressure on MA plans; support payment fairness across
2 geographic areas; and support wide availability of plans
3 without paying excessive rates. These principles will
4 usually involve tradeoffs, but I hope that this chart can
5 help start a discussion about the Commission's preferences
6 for a revised benchmark system.

7 In summary, there is an urgent need to reform the
8 MA benchmarks. Medicare is not realizing savings from MA
9 plan efficiency, nor is it likely to without reform.

10 I look forward to your discussion, where you may
11 begin to prioritize potential reforms to the benchmarks. I
12 just presented three alternatives, but I'm sure you may
13 think of others that we can examine in the coming months.

14 Staff will build out any alternatives which
15 interest you. At the January meeting, we aim to present
16 payment simulations stemming from your guidance during this
17 meeting.

18 DR. CROSSON: Thank you, Scott.

19 We will now take clarifying questions. I saw
20 Jonathan, Sue, Marge, talking slowly, Dana, Bruce, and
21 Brian.

22 MS. WANG: And Pat.

1 DR. CROSSON: Oh, I missed you.

2 DR. JAFFERY: So, Scott, great chapter. Thanks.
3 I absolutely agree that this is an important area to
4 explore.

5 Two questions. First, did I hear you say that MA
6 plans can provide extra benefits more efficiently than fee-
7 for-service? And if that's what you said --

8 DR. HARRISON: So they can provide the regular
9 benefit package more efficiently, which then allows them to
10 include extra benefits in their package.

11 DR. JAFFERY: Okay. That's what I was trying to
12 clarify.

13 DR. HARRISON: Sorry. I misspoke.

14 DR. JAFFERY: Others can't provide extra benefits
15 at all, right?

16 DR. HARRISON: Right.

17 DR. JAFFERY: Okay. And then a separate
18 question, do we know how ACO availability is distributed
19 across the low- and high-spend areas?

20 DR. HARRISON: My sense is that they're more
21 prevalent in the high-spend areas.

22 I'm looking for help. A little bit.

1 DR. JAFFERY: So there is some. There are some.

2 DR. HARRISON: My sense was they were more
3 successful in the high-spend areas. Excuse me. High
4 utilization.

5 DR. JAFFERY: Okay. Right. So we've seen that a
6 bunch of times.

7 Okay. I'll come back in Round 2. Thanks.

8 DR. CROSSON: Sue?

9 MS. THOMPSON: Thanks, Jay, and thank you, Scott.
10 What can you tell us about the four quartiles,
11 characteristics of them? Urban, rural, or anything else
12 that kind of differentiates them?

13 DR. HARRISON: So you might have thought -- and
14 maybe in the beginning, they were more rural. They're not
15 anymore -- oh, I'm sorry. The low-spending area is.

16 There are some counties that don't have any plans
17 now. They're not in the 115 quartile. They're in the 95
18 quartile, more likely to be in the 95 than the 100 and the
19 115. So it's like Alaska doesn't have -- yes, they're
20 rural, but they're also high-spending.

21 The other thing we've seen is that higher-
22 population counties have started to spend less, and lower-

1 population counties have started to spend more. So you've
2 had some crossing, just by population, not by necessarily
3 MA penetration, but you've seen some crossing.

4 We've seen an increase in the population of the
5 115 counties, I would say.

6 DR. CROSSON: Marge?

7 MS. MARJORIE GINSBURG: I have two questions.
8 Let me state them, and then you can answer them.

9 The first one is very general. It says in the
10 opening statement of what we were sent that it's consistent
11 with the Commission's support of equity between the two
12 programs. We've always talked a lot about maintaining
13 equity. Do we assume, then, that that meant that we were
14 obligated -- the Commission was committed to equality in
15 what they are paid? That's the first question.

16 And the second is very specific. In reading
17 about MA plans and how they -- I was under the assumption
18 that the only time an MA plan could have a monthly premium
19 for their enrollees was if they had bid over the benchmark.
20 Then they were justified, and all I see in Sacramento
21 County is -- with one or two exceptions, are MA plans with
22 not small monthly premiums.

1 So I wonder if you could clarify that.

2 DR. HARRISON: Yeah. So there's a monthly
3 premium that would only be paid for the Medicare benefit,
4 Part A and Part B benefit. That's only if you bid above
5 the benchmark.

6 So if you bid below the benchmark, you're going
7 to have enough so that you can offer a zero premium plan if
8 you want to, but you may be offering extra benefits in that
9 package that you -- so you submitted a bid, and it includes
10 not just the A and B benefit. It includes extra benefits.

11 So you're going to end up getting some money back
12 from Medicare to provide some of them, but maybe you're
13 providing even more than that in your benefit package, and
14 so there's a premium. But that's mostly for extra
15 benefits.

16 DR. CROSSON: Pat?

17 MS. MARJORIE GINSBURG: Could you answer the
18 other one, please?

19 DR. HARRISON: Oh. We've had a longstanding
20 principle where we've tried to maintain what we call
21 "financial neutrality" between the two programs. One of
22 them is so that the beneficiaries have the right incentives

1 and they're not trying to pick one or the other that's
2 going to have different costs for the Medicare program, and
3 the other reason is a sense of fairness.

4 MS. MARJORIE GINSBURG: So then this really might
5 suggest that we'll drop that language?

6 DR. HARRISON: We'll have to see, yeah.

7 DR. CROSSON: Pat?

8 MS. WANG: So going back to the average bid, it
9 is now 89 percent of fee-for-service. Do you know what it
10 is in the different quartiles? Does it differ much?

11 DR. HARRISON: It does, and it's in our reports
12 each year. The average bid in the 115 quartile was 99
13 percent, and by the time you get to the 95 percent
14 quartile, it's maybe 80, maybe in the 70s. So, yes, it
15 changes quite a bit.

16 MS. WANG: Okay. And, again, I'm confused. This
17 came up in the last discussion. The average \$107
18 supplemental benefit, does that include the quality bonus?
19 It must, right? It has to because that would --

20 DR. HARRISON: Yes, the quality benchmarks are in
21 there. Yes.

22 MS. WANG: Okay. So that elevates the benchmark,

1 and then there's more money available.

2 DR. HARRISON: Right.

3 MS. WANG: Okay. Final, just small question, is
4 there any correlation between plans that charge a premium
5 and what quartile they're doing -- what quartile they're in
6 for those products?

7 DR. HARRISON: That's not something we've looked
8 at.

9 MS. WANG: Okay.

10 DR. HARRISON: But the rebates are of different
11 sizes, right? So, in the 115 quartile, I think the rebate
12 was around \$69, and in the 95 percent quartile, it was like
13 150.

14 MS. WANG: How many people live in the 115
15 quartile? I know that they're split by numbers of
16 counties.

17 DR. HARRISON: It's getting fairly close to
18 evenly distributed.

19 MS. WANG: Okay.

20 DR. HARRISON: Between the four quartiles.

21 MS. WANG: Thanks.

22 DR. HARRISON: It's not exactly there, but --

1 DR. CROSSON: Dana?

2 DR. SAFRAN: Thanks.

3 Sue asked my main question, but my other two
4 questions are -- number one, have you got any analysis of
5 the financial impact to MA plans of these three different
6 alternatives?

7 DR. HARRISON: So that's what I would come back
8 in January with.

9 DR. SAFRAN: Got it. Okay. And then do we know
10 -- these quartiles are based on the fee-for-service
11 spending so I'm trying to get a handle on just how big is
12 the MA population in the low fee-for-service spending
13 quartile, and how big is the number of MA plans?

14 DR. HARRISON: All right. So you are not talking
15 about the penetration rate. You want to know where the
16 people are coming from?

17 DR. SAFRAN: Yeah, for the plans.

18 DR. HARRISON: Yeah. So it was almost an even
19 split, again. It wasn't exactly there, but you're talking
20 at least in the 20s for each of the four quartiles. It may
21 not all be 25 but they're in that range. And I can get it
22 for you.

1 DR. SAFRAN: Okay. Thanks.

2 DR. CROSSON: Bruce.

3 MR. PYENSON: Thank you very much, Scott. I'm
4 wondering if we could include information on Medigap in the
5 four quartiles when we consider the impact on
6 beneficiaries. It strikes me that for the non-duals that
7 Medicare Advantage is competing against fee-for-service
8 plus Medigap, and a fair comparison from the standpoint of
9 beneficiaries would look at that perhaps.

10 DR. HARRISON: So the quick datasets that we have
11 area all Medigap by state. To do it at an individual level
12 would take a little while. There is some data that we
13 think is trustworthy, but it's a challenge to work with.
14 So maybe by January we could at least do a run and see
15 that.

16 MR. PYENSON: Or an approximation. I mean, pick
17 an average age or something for states that are age rated.
18 I mean, it gets complicated, of course.

19 DR. HARRISON: Let's talk, yeah. I think we can
20 come up with something.

21 MR. PYENSON: A different question. I know in
22 the past I think three years ago, maybe two years ago,

1 MedPAC recommended that it would be fairer if the benchmark
2 were based on people who had both A and B, not everybody.
3 And I don't recall if that made sense from a perhaps equity
4 or fairness basis. Was that also a statutory -- was there
5 some legal basis for that?

6 DR. HARRISON: I think that probably CMS could do
7 that without it. There might be some debate -- I'm not a
8 lawyer, but, yeah, it's possible that that might be done
9 just through CMS.

10 MR. PYENSON: And likewise from a benchmark
11 standpoint, since the presence of Medigap inflates, through
12 induced utilization, inflates the benchmark, would it be
13 feasible to unwind that impact from the benchmark?

14 DR. HARRISON: I'm not sure. It's possible but
15 I'm not sure. I think that would be -- and I'm not sure --
16 again, not being a lawyer, I'm not sure what the statute
17 would say about that. It might be that CMS could do that.

18 MR. PYENSON: Okay. What are your thoughts on
19 MedPAC, the staff calculating that, in fact?

20 DR. HARRISON: So we did sponsor a study a few
21 years ago where we said what the gross impact was. It was
22 coordinated with our work on redesigning the fee-for-

1 service benefit package back -- I have a hard time with
2 time -- six, seven years ago. And there we found quite a
3 significant increase due to Medigap. People who had
4 Medigap spent a lot more money in fee-for-service.

5 DR. CROSSON: Thank you, Bruce. Brian?

6 DR. DeBUSK: Great report. Great topic. What I
7 wanted to clarify, and you're not the only person I've
8 heard say this, but when they talk about rebates being paid
9 back, people will always say, "And these rebates have to be
10 spent on extra benefits," and then under their breath they
11 say, "And a portion of the proceeds can be applied toward
12 administrative costs and plan profits." And then they just
13 keep going. So can you help me --

14 DR. HARRISON: All right. So this is like fully
15 loaded -- they have to spend it on fully loaded -- the
16 benefits can be fully loaded. So how you value those
17 benefits can include profit and administrative costs.

18 DR. DeBUSK: Okay. So you can build -- because
19 we know about the bonus thing where you can reprice your --
20 you know, we talked about that in the last session.

21 DR. HARRISON: The bonus is different --

22 DR. DeBUSK: It's different.

1 DR. HARRISON: -- where you don't actually know.

2 DR. DeBUSK: You get to reprice your bids, sort
3 of.

4 DR. HARRISON: You don't know what --

5 DR. DeBUSK: You get to reprice your bid. I got
6 that one. That one's clever, and I did not know that until
7 the last session. So what you're saying is when you guys
8 are saying administrative and plan profits, what they're
9 saying is you get to load administrative cost and plan
10 profits onto the extra benefits.

11 DR. HARRISON: Right, just as you do onto the
12 basic.

13 DR. DeBUSK: You don't get to just -- okay.
14 Good, good, good. I just wanted to make sure there wasn't
15 some back door where they could just generate profit out of
16 thin air rebate dollars.

17 DR. HARRISON: No.

18 DR. DeBUSK: Okay. Good, good, good.

19 The second thing -- at first this is going to
20 sound like a Round 2. I promise it isn't. It's Round 1.
21 It's legit. If I look at this rebate -- you know, hand me
22 the rebate. You know, Bruce alluded to this -- a portion

1 of my rebate is going to go toward really just achieving
2 parity with Medigap, you know, toward --

3 DR. HARRISON: Buying down the cost-sharing.

4 DR. DeBUSK: -- buying down the cost-sharing.

5 DR. HARRISON: Mm-hmm.

6 DR. DeBUSK: And then I would think that there's
7 this tranche of probably decent benefits, you know, of
8 transportation services and telemedicine, which now can be
9 built into the bid. But anyway, it was a good example up
10 until a year ago. But sort of the genuine, the bona fide
11 benefits.

12 But then I would think that there's this tranche
13 of things where the plans are just looking to dump the
14 money somewhere. I mean, it's the lower-value benefits.
15 And this is my question: Has anyone explored trying to
16 gauge how much of that are low-value benefits? Do the
17 plans really want to spend the money in the first place?
18 Could we just split the money and give half of it to CMS
19 and let them keep half of it and profit?

20 [Laughter.]

21 DR. DeBUSK: I mean, is there -- again, I get it.
22 Medigap tranche, good tranche, but I keep being left with

1 this impression that there's some noise out there that I
2 don't think anybody really wants.

3 DR. HARRISON: So most of the rebate has been
4 used to lower cost-sharing. Another big chunk goes to pay
5 down the Part D premium, and then they also supplement Part
6 D. So that's where the bulk of the money is, but then
7 there are other extra benefits. I think dental and vision
8 and hearing aids are becoming more popular, so those are,
9 you know, real supplemental benefits that they would
10 provide. And then, you know, some of these other things --
11 gym memberships, et cetera -- I don't know how much money
12 is going for those.

13 DR. DeBUSK: So we don't, and again, to be a
14 Round 1 question we don't really have a feel, even if it's
15 a qualitative feel, for sort of how that money -- how those
16 rebate dollars are being distributed into those three broad
17 categories.

18 DR. HARRISON: Once you're in the supplemental
19 benefits, no, I don't think we know that much about what's
20 in there.

21 DR. DeBUSK: Okay. Thanks.

22 DR. CROSSON: Okay. I've got Kathy, Amol,

1 Warner.

2 MS. BUTO: I have four I hope kind of quick
3 questions. So one of them is, do you know, Scott, whether
4 the bids tend to cluster around the benchmarks, or do they
5 tend to cluster around each other? I'm just curious if we
6 know that.

7 DR. HARRISON: So when we've looked in the past,
8 what we've found is that the bids do not tend to track fee-
9 for-service spending. Instead, they track the benchmarks.
10 And so I think that, for instance, the rebate percentage,
11 what percent of your bid is rebate, is similar in all four
12 quartiles.

13 MS. BUTO: Okay.

14 DR. HARRISON: The thought here is that, you
15 know, MA plans have a different production function, so to
16 speak, than fee-for-service, and so their production
17 function might look pretty similar across the country, and
18 so they're a little immune to fee-for-service changes. But
19 they track the benchmark because that's what they need to -
20 - that's what they're competing on.

21 MS. BUTO: Right. What I'm trying to do is
22 understand -- and you can also help me with this second

1 question, which is, is our alternative one similar to the
2 old competitive pricing approach that CMS was trying to
3 experiment with, where essentially the only benchmark, if
4 you will, was fee-for-service spending, and then plans were
5 competing with each other against what the A and B benefits
6 were worth or were valued at? Do you know that your
7 alternative one and that approach are similar? I know
8 their benefits were constructed at a local level, depending
9 on what they considered the standard benefit in the area.

10 DR. HARRISON: By happenstance, it used to be
11 that you get 95 percent of fee-for-service and there were
12 proposals to add a 3 percent package as a supplement to bid
13 on. So I guess it does kind of look like that.

14 MS. BUTO: Yeah. I was actually talking about
15 the competitive bidding demonstration, where, you know, we
16 only know a little bit about how much would have been saved
17 when plans were allowed to compete for what the cost would
18 be and what they would charge to provide the Part A and B
19 benefits, with a small drug benefit.

20 DR. HARRISON: I don't necessarily -- well, I
21 guess we had been thinking about this more as like going
22 back in time when it was 95 percent --

1 MS. BUTO: Oh.

2 DR. HARRISON: -- and we were just going to have
3 98 percent.

4 MS. BUTO: Okay. All right. And we know very
5 little about what that result would have been, because they
6 were never allowed to actually get underway.

7 My third question is about the extra benefits. I
8 know that plans are required to provide them under the
9 statute. I cannot remember whether that includes a cash
10 rebate to the beneficiary or even reductions in the Part B
11 premium.

12 DR. HARRISON: It definitely --

13 MS. BUTO: Are those allowed?

14 DR. HARRISON: Yeah, so you can definitely reduce
15 the Part B premium, and it seems like more plans have been
16 doing that. I haven't seen the latest bids but you may
17 find out next month.

18 Now one thing about giving back the Part B
19 premium is you don't get to load that. That's straight
20 cash, so that's probably a little less popular among plans.

21 MS. BUTO: Right. Okay. Thank you.

22 DR. CROSSON: Amol.

1 DR. NAVATHE: Thanks, Scott. So I have one
2 question, which is I think perhaps a redux of Marge's
3 question. But on page 3 of the writeup -- so her, I guess,
4 second question which you answered first, which was about
5 the premiums -- so it says, "If a plan's bid is above the
6 benchmark, Medicare pays the plan's benchmark amount for
7 each enrollee, and enrollees have to pay a premium." And
8 then in parentheses it says, "In addition to the usual Part
9 B premium," close parenthesis, "equals the difference."
10 Can you explain that part?

11 DR. HARRISON: So it's even a separate thing.

12 DR. NAVATHE: Okay.

13 DR. HARRISON: To be eligible to join an MA plan
14 you have to be enrolled in Part A and Part B. The Part B
15 premium you have to pay, so that's one premium. There
16 could be another premium if the plan bids below the
17 benchmark. That usually doesn't happen but, you know, once
18 in a while maybe. But normally the premium you are paying,
19 you're paying your Part B premium unless it's rebated to
20 you, but you're paying that plus you're paying a premium if
21 the plan provides a package and they ask for a premium, and
22 that would include generally a good bid of extra benefits.

1 DR. NAVATHE: Correct. Got it. Okay. So when
2 we say zero premium we are referring specifically to the MA
3 portion, and we're not saying that the rebate is offsetting
4 the Part B premium.

5 DR. HARRISON: Correct. That's right.

6 DR. NAVATHE: It may, in part, do that, but not
7 fully. Okay. Got it. So that was question one.

8 Question two is, does this -- does the fee-for-
9 service, the percentages under rates apply similarly to
10 SNPs?

11 DR. HARRISON: SNPs are paid just like --

12 DR. NAVATHE: Same thing, so the benchmarks are
13 just for those specific populations than the fee-for-
14 service.

15 DR. HARRISON: Right.

16 DR. NAVATHE: Got it. Okay. And then the last
17 question I have is, so it seems like the cliffs that we're
18 observing are at the county level.

19 DR. HARRISON: Correct.

20 DR. NAVATHE: So are we seeing plans respond to
21 those cliffs? Because you would see potentially that they
22 should be looking at where they can offer plans and,

1 quote/unquote, "gaming that" or at least responding to that
2 incentive.

3 DR. HARRISON: So --

4 DR. NAVATHE: It sounded like you were saying
5 that the distribution is actually pretty even across.

6 DR. HARRISON: Yeah. So plans -- I don't know if
7 I want to say rarely, but they usually are serving more
8 than one county, and so their benchmark is going to be a
9 mashup of the different counties. Well, the weird thing is
10 that you would think that a county would complain that
11 their rate, you know, fell off a cliff, but we haven't
12 heard from any, so I don't know what to say about that.
13 Yeah, I don't know how much of a reaction there is to the
14 cliffs. It could be that the plans are -- it all comes out
15 in the wash to the plans.

16 DR. NAVATHE: So last question is -- sorry. Last
17 question is on Slide 4 you say in 2019, the average plan
18 bid was 89 percent of fee-for-service, which is
19 substantially lower than the fee-for-service markup in each
20 of those tiers. But then we also said that the rebate is
21 pretty similar across the different --

22 DR. HARRISON: Right. So, well, it averages 89

1 but it varies from 99 to maybe 80, depending on the
2 quartile.

3 DR. NAVATHE: Okay. So the margin is still
4 pretty constant.

5 DR. HARRISON: It seems like the margin is fairly
6 constant, yeah.

7 DR. CROSSON: Okay, Kathy.

8 MS. BUTO: Very quick. Scott, are there low-
9 spending counties that have high penetration?

10 DR. HARRISON: Yes. And in general they have
11 high --

12 MS. BUTO: So they're getting sort of, if you
13 will, overpaid, because the idea behind paying more than
14 fee-for-service was to encourage more participation in MA,
15 right?

16 DR. HARRISON: I would agree with that, yeah.

17 DR. CROSSON: Warner.

18 MR. THOMAS: Two questions. How often do
19 counties, or do counties move between the various --

20 DR. HARRISON: They move a good bit. Now if you
21 are a county and you move across a threshold, you actually
22 will get the average factor for the following year. So

1 let's say in 2015, you were 115, and then you moved to --
2 oh, math is tougher. Let's do you move from 107 ½ to 100
3 in '15 and '16. In '17, you would get 103 ½ percent.

4 MR. THOMAS: For that county.

5 DR. HARRISON: For that county, yeah.

6 MR. THOMAS: And do you see any differential in,
7 or do you have information for medical trend by county? Is
8 there any major difference based upon low- or high-cost
9 areas, on trend?

10 DR. HARRISON: I do not have that.

11 MR. THOMAS: Okay.

12 DR. CROSSON: Okay. Seeing no questions we will
13 come to the discussion period. Let's put up Slide 13,
14 which are the alternatives on the table, and we're going to
15 go to Paul to begin.

16 DR. PAUL GINSBURG: Thanks, Jay. Scott, you've
17 done a really good job in the presentation and you answered
18 the questions so efficiently that we're talking at 4:30
19 instead of 5:30, as far as the discussion.

20 [Laughter.]

21 DR. PAUL GINSBURG: So, yeah, I have two thoughts
22 to share with the Commission. I have never been a fan of

1 the quartile approach that I guess came into the Affordable
2 Care Act. My sense is if the origin of Medicare Advantage,
3 or its predecessors really, was that, you know, there was
4 more potential in some areas for, you know, private plans
5 to deliver better value to the beneficiaries and the
6 program, and so, you know, the penetration was much
7 greater, particularly in the areas that were fairly
8 expensive and fee-for-service. And I guess South Florida
9 stood out as the extreme.

10 Then I think when Congress was then the Balanced
11 Budget Act of 1997, cut the payments a lot, I think,
12 anyway, there was real concern in Congress about Medicare
13 Advantage or predecessors not being viable. So there were
14 floors put in, and ultimately, in a sense, the payments, as
15 you noted from the paper, got much higher than fee-for-
16 service Medicare.

17 And in Congress it started to be perceived as
18 "This is a wonderful thing. I want to make sure my
19 constituents get their share," and I think that led to the
20 quartile as things are being squeezed down in the
21 Affordable Care Act.

22 I think it makes more sense to say that where a

1 private plan can, you know, serve a beneficiary more
2 efficiently and perhaps with better quality, that's where
3 the reward should be greatest rather than seeing this
4 spread around everybody. So I'm that one of your options
5 is, you know, a 98 percent without quartiles.

6 The other point I want to make is that, you know,
7 there's been a lot of thinking in a group at Brookings and
8 other organizations that I was part of, did a paper last
9 year on competitive bidding for Medicare Advantage, not
10 premium support because this bidding would be only within
11 Medicare Advantage. I think others have written on it, and
12 I'd like to be able to consider that as one of the
13 alternatives to the three that you've put up on the table.
14 It has the virtue of the structure of what the benchmark is
15 in various areas, is market-based rather than policy
16 decision. And so I'll just stop there.

17 DR. CASALINO: Just describe what the alternative
18 would be [off microphone].

19 DR. PAUL GINSBURG: Okay. The alternative would
20 be that each plan makes a bid as to what -- the benchmark
21 it would require or, you know, what I can do Medicare
22 Advantage for in an area, which would be larger than a

1 county, presumably MedPAC areas or something, it would be -
2 - an average or some other measure would be taken of the
3 bids, and that would determine the Medicare -- the
4 benchmark. So in a sense, it's a way of exploring the
5 potential for, you know, could Medicare pay less and still
6 do well, still have participation? And I think that's the
7 essence of it.

8 DR. CASALINO: So do rebates go away then? Or
9 you get your rebate?

10 DR. PAUL GINSBURG: No, there's still rebates,
11 because if you're really a low-cost plan, your bid is
12 likely to be under the benchmark for your area.

13 DR. CASALINO: Just one shot at it.

14 DR. PAUL GINSBURG: Well, you do set a bid, and
15 you have to stick to the bid.

16 MS. MARJORIE GINSBURG: A clarifying question
17 about this. So from my previous question, you might tell
18 that I'm a little annoyed by what I think are high monthly
19 premiums that so many MA-PDs are applying to this.

20 With your model, if they submit the bid and they
21 win the contract, does that mean that they can no longer
22 then attach another \$98 a month as premium in order to make

1 up for extra benefits or, in fact, to basically improve the
2 bottom line?

3 DR. PAUL GINSBURG: Well, if the plan believes
4 that there's a demand in the area for Part D and other
5 benefits like buying down the cost sharing, just like
6 today, it would set a premium for this enhanced plan at
7 higher than the benchmark. So in a sense, it wouldn't be -
8 - to the degree that people are demanding richer plans, in
9 many cases they don't have to pay a premium for that.

10 DR. NAVATHE: Would they be required to offer the
11 base plan, though, as the bid?

12 DR. PAUL GINSBURG: Yes. Actually, one of the
13 other aspects of it is that we thought it was valuable to
14 have some standardization, so every plan would submit a bid
15 for the base plan. There would be an enhanced plan that
16 would be also standardized, and they would set a bid for
17 that. And then they could come up with their own further
18 enhanced version and set a bid for that.

19 MS. BUTO: Paul, a question about the extra
20 benefits, though. If the plan is below the benchmark, can
21 the plan offer whatever extra benefits it wants to for no
22 additional cost? That would still be in play, right?

1 DR. PAUL GINSBURG: I think so. Now, I'm not
2 sure if --

3 MS. BUTO: And when you say standardization extra
4 benefits, I start to think, well, there's go the innovation
5 opportunity.

6 DR. PAUL GINSBURG: Oh, yeah. Actually, it
7 depends on how you describe it. What I would prefer is
8 standardizing it as an actuarial value. So say it's 105
9 percent of the basic Medicare benefit would be that second
10 level. And then the third level of further enhanced would
11 be whatever the plan wants to do.

12 DR. CROSSON: So let me just suggest here that
13 perhaps the paper that you wrote, participated in writing,
14 or some other summary of this proposal would be available
15 to the Commissioners.

16 DR. PAUL GINSBURG: Oh, certainly, yes.

17 DR. CROSSON: Okay. So let's go on with further
18 discussion. We're going to start over this side. Brian,
19 Dana, Pat, David. Who did I miss? Bruce, Pat, Kathy,
20 David, Jonathan. Brian.

21 DR. DeBUSK: Scott, again, great paper, great
22 work. I do think anything that linearizes the benchmark I

1 think is a good thing. So the hybrid, I like the hybrid,
2 but, you know, the specifics of that aren't as important to
3 me as the fact that you do avoid the cliffs.

4 You know, as per the previous discussion, the
5 overall idea of do you do it, do you build the cut into
6 this, or do you make it budget neutral, I do think that's a
7 completely separate discussion on what do we want to do
8 with MA. And I would hate, again, to see good technical
9 work get caught up with, you know, the policy decision over
10 is MA paid adequately, overpaid, underpaid, whatever. So,
11 again, separate discussions, but I do like the
12 linearization.

13 One thing that I've always been suspicious of
14 when I first learned about MA is this idea that you get a
15 rebate back and tell somebody, "You have to spend this
16 money." And I wish there was some way to discover how much
17 of that money -- you know, sort of a thought experiment
18 here. If I give them a \$120 rebate, if the plan could just
19 pocket the money and not, say, buy down and, you know,
20 basically effectively compete with Medigap, they'd probably
21 have what could be a wildly profitable that nobody wants.
22 You know, great margins on zero sales are still zero.

1 At the same time, you have to wonder, if there
2 was a mechanism -- because we're trying to think about how
3 -- you know, the problem we're trying to solve is not cut,
4 cut, cut. It's how do you generate genuine savings to the
5 Medicare program. Has anyone explored -- and I'd love to
6 see us explore -- when that rebate comes back, giving the
7 plan some flexibility to say, okay, you can use a portion
8 of this rebate for administrative costs and profit, but
9 you're going to do it at, say a 1:1 or a 2:1 ratio. You're
10 going to return some of that money to CMS as well.

11 I wonder if, given the option, you know, there's
12 \$100 in their plan, let's say they've got to spend \$50 of
13 it to get parity with Medigap. If you took that \$50 that
14 was left over and said, okay, you can go buy a gym
15 membership, you know, 20 miles from the patient's house
16 that's never going to get used, or you can take that \$40,
17 let's split it 50/50. You return \$20 of it to Medicare,
18 \$25 of it to Medicare; you can keep -- and it doesn't have
19 to be 1:1.

20 I'm just wondering if we could somehow discover
21 what that rebate dollar is really worth to the plan because
22 right now we don't know. We just hand them a crisp \$100

1 bill and tell them they have to go spend it. Let's figure
2 out how much of that they'd really spend and how much of
3 that they could genuinely return to Medicare.

4 Anyway, that was just my thought.

5 DR. CROSSON: Great. Dana -- sorry, I missed
6 Bruce. I missed you twice.

7 MR. PYENSON: I agree with Paul's sentiment,
8 though I'm thinking there's a multiphase goal here. One is
9 to look at something that could be implemented very
10 quickly, and I think, Scott, you mentioned that as a goal
11 at the beginning. And if we agree with that, I think the
12 three alternatives on the table are -- or some variations
13 of that is what we have to do. But I think longer term the
14 issue that Paul raised and the question of Medigap is going
15 to be really essential to get this to the right place.

16 I'd suggest a hybrid of the hybrid approach would
17 be compelling because the idea of paying more than fee-for-
18 service in some areas is of questionable merit from the
19 standpoint of the Medicare program. So I hate to ask for a
20 fourth option on the short-term proposals, but I think the
21 graph -- I think it was Figure 5 in your presentation, in
22 the writeup, that was a particularly good illustration of

1 the different options. And that might be --

2 DR. HARRISON: So are you suggesting like maybe
3 100 percent of fee-for-service at the low end and then some
4 savings at the high end?

5 MR. PYENSON: Something like that. I don't have
6 an opinion on the precise numbers.

7 DR. HARRISON: But you're not concerned too much
8 about attracting plans in the low end with extra money?

9 MR. PYENSON: Correct, for the reasons that Paul
10 mentioned.

11 DR. HARRISON: Okay.

12 DR. CROSSON: Dana.

13 DR. SAFRAN: Thanks. Thanks for this work,
14 Scott.

15 I'm not concerned based on what you've told us
16 about attracting plans in the lower spending area. It
17 sounds like that might have been a worthwhile goal before,
18 but that it might have outlived its useful purpose. But in
19 any case, I would say that I don't fully want to cast a
20 vote until we see the impact analysis that you're bringing
21 us in January. But without seeing that, I do find
22 Alternative 1 really attractive. The only thing that

1 concerns me about it is -- well, two things concern me
2 about it. One is that you've got the high-spending folks -
3 - or the folks in the highest-spending market get a raise
4 out of the deal --

5 DR. HARRISON: Suggest something else [off
6 microphone].

7 DR. SAFRAN: Yeah, so -- but I do like just
8 having it be the same regardless of geography, and so we
9 may have to just deal with that pain point one time and get
10 over it.

11 The other, which kind of relates to my comment
12 about waiting until January, is until we really know how
13 much pain this inflicts on those in the lower-spending
14 areas who are going to take a bigger hit, it's a little
15 hard to know. But for now, that's the model that I prefer.
16 Thanks.

17 DR. CROSSON: Okay. Where are we? Pat.

18 MS. WANG: I'm also in favor of Alternative 1 or
19 something that groups much more tightly that way. I sort
20 of would -- I think Dana stated it well, that maybe it was
21 a good idea at the time, but at this point the idea of
22 paying that much more than fee-for-service seems --

1 especially since the counties like flow back and forth. I
2 don't know. Maybe it's not necessary anymore.

3 The one thing I just want to -- the way that this
4 is presented and, therefore, what frames the discussion,
5 you know, the way that you put it was there's an urgent
6 need for reform for increased efficiency and the
7 realization of savings. I would kind of try to maybe shift
8 the discussion to value as opposed to savings. There is a
9 statutorily mandated use of rebate dollars, which, Bruce,
10 they are already split with CMS. I don't know if that was
11 clear. But if you bid below the benchmark, if you're not
12 in star bonus, you're giving 70 percent of that delta back.
13 So there's a built-in savings in there. If you're in star,
14 you get to keep more of it, but, you know, I just wanted to
15 make sure, because you were doing that kind of at the end
16 like another split. There's a split at the front end.

17 But there's an explicit expectation, I guess,
18 that part of the thing for MA, even if they're being paid
19 at the equivalent of Medicare Advantage, is that they are
20 trying to deliver some extra value to beneficiaries by the
21 mandated use of the rebate. So I just want to be careful
22 about saying -- kind of getting into that by saying, no,

1 no, that money should instead be spent on savings.

2 So I think the value issue is important. I know
3 that there have always been concerns echoed, like, well,
4 how come only MA beneficiaries, enrollees, are getting the
5 dental, the hearing, the transportation, you know, the
6 eyeglasses, you know, for poorer folks, they're getting
7 other things that support their health care, and why
8 shouldn't that be available to the whole program? You
9 know, that's a more philosophical questions, I guess. But
10 somehow or other these market dynamics have made it
11 possible for MA plans to, in many, many cases, deliver, I
12 think, a superior-quality product to fee-for-service and
13 make room for valuable benefits that are meaningful to
14 beneficiaries.

15 Bruce, to your question, I would love to meet the
16 plan who says at the table when they are kind of looking at
17 their bid and how things are shaping up, "Oh, my gosh, we
18 have too much money to spend on supplemental benefits. We
19 should just give some" -- there's always --

20 DR. DeBUSK: But I'm back to -- sorry to
21 interrupt. But one thing, I still, when I learned, I saw a
22 paper once on the number of gym memberships that these

1 plans were buying, and there were like 10 and 20 and 30
2 miles from these people's homes. I won't go two miles to
3 get to a gym.

4 [Laughter.]

5 DR. DeBUSK: And I just -- again, I agree with
6 you. I don't think these people are swimming in dollars.
7 But I think if we look through the program, there's clearly
8 some money being spent on marginal activities.

9 MS. WANG: You know, it's an interesting question
10 and part of, I think, what plans go through, is this
11 actually being utilized? Because that gym membership is so
12 important to so many people. I just have to tell you, they
13 want it. And maybe they don't have any other options for
14 exercise, but the gym membership is -- there's certain
15 things, and that's what the market kind of does, is it
16 pushes towards meeting actual demand in the community as
17 opposed to something that somebody thinks is a good idea.
18 So it does, it flexes, you know, year by year, and
19 different populations want different things at different
20 stages of their lives. That's a very interesting feature,
21 I think, about MA, and it goes to the innovation.

22 So this idea of, like, with the reform it gets

1 savings out, we have to be kind of careful, I think is the
2 point that Kathy was making. I think the program is set up
3 with rebates being spent on supplemental benefits for a
4 reason. Maybe it's not savings, but it's value. So I'd
5 just be a little careful there.

6 But, otherwise, I'm also -- I feel like there
7 should be -- it's time to kind of look at -- there's a
8 simplicity to sort of saying everybody's getting paid at
9 the same percentage of fee-for-service and then it opens up
10 a better baseline discussion, for example, for how you pay
11 for a quality bonus.

12 DR. CROSSON: Are you on this point also, Marge?

13 MS. MARJORIE GINSBURG: Yes.

14 DR. CROSSON: All right. I saw Marge first, and
15 then, Bruce on this point.

16 MS. MARJORIE GINSBURG: My comment is relevant
17 because of the reference to the gym memberships, and I have
18 to tell you this whole topic area, I am wearing my taxpayer
19 advocate hat. And the gym membership one, particularly,
20 brings to mind a project that we did. I ran a nonprofit
21 that worked on health policy issues with the public.

22 We did 1,000-person phone survey. It was done by

1 whoever those big survey people are in California. They're
2 all Californians, and people responded to, I think, 20
3 different vignettes. And they were told to answer two
4 questions for each vignette. How important is insurance
5 covering this on a scale of 1 to 10, and should it be part
6 -- then a yes or no. Should it be part of a health plan?
7 And we had every interesting, you know, short two-sentence
8 scenario possible.

9 The lowest scoring was gym membership, and this
10 was 2009, and I don't know if anybody was actually paying
11 for it then, but somehow we included it.

12 I went and looked up the results in anticipation.
13 Twenty-six percent said, "yes, they'd cover it."

14 Now, they were told, in responding to this, "You
15 are answering these questions knowing that the more things
16 that are covered, the more that it costs you and others.
17 So you are wearing both your consumer hat and your taxpayer
18 hat."

19 I'll get off my soapbox, but I guess what
20 troubles me is that at the end of the day, it is the
21 taxpayer. It is the Medicare budget that's being impacted
22 every time new extra benefits are added. These are not

1 free. The health plans are not paying for them. The
2 taxpayers are paying for them.

3 That's all. Thank you.

4 DR. CROSSON: Bruce? Asked.

5 Okay. David?

6 DR. GRABOWSKI: Great. First, thanks, Scott.

7 I'm once again very excited that we're going down this
8 path, and I'm very supportive of reforming the benchmark.

9 I like how Bruce framed this. There's a two-
10 stage process here. First, we want to fix this, and I
11 think we have some good options on the table here. I think
12 if I had to choose among these options, I'd go with kind of
13 a flat 98 percent of fee-for-service spending.

14 I very much view that, hopefully, as a first part
15 to our agenda here, and I wanted to go down the same path
16 in a second stage that Paul took us. And that's to think
17 about competitive bidding here. There's a lot written on
18 this. We can share some of that, but it basically uses the
19 bids that all these different plans offer as a way of
20 helping shape the adjusted benchmark.

21 As Paul said, you have a geographic area, and
22 potentially, you take the mean kind of bid within that area

1 and use that as the new benchmark. Some of these plans put
2 an inflation factor on top of that, maybe a buffer, if you
3 will, 5 percent, just to make certain there's greater
4 rebates.

5 I really like this approach, and CBO costed it
6 out a couple of years ago, the 10-year window here with a 5
7 percent buffer, and they came up with savings of about \$77
8 billion. So it's a big number, and there's a lot of money
9 on the table. I really like going down this path.

10 I think the limitations -- and we can get more
11 into these downstream, but obviously, you're taking
12 benefits off the table. You're taking dollars off the
13 table, and there are strong incentives for selection as you
14 begin to kind of ratchet that down and finding certain
15 types of beneficiaries. I think you magnify some of the
16 incentives that are present in the current system. But I
17 really like that and hope we'll continue to talk about it.

18 Jim, I don't know how this fits in that current
19 chapter scope of work. Is that a text box? Is there sort
20 of a second part to this? You don't have to answer that.
21 But just as a way of sort of framing this, I really hope
22 we'll talk more about that and think more about it.

1 Thanks.

2 DR. CROSSON: On this point? Just on the list?

3 Sorry. Larry?

4 DR. PAUL GINSBURG: I think on this point.

5 DR. CROSSON: On this point? Oh, you're in line.

6 MS. BUTO: I think I'm in line.

7 DR. CROSSON: You are, yes.

8 Is there anybody who wants to talk on this point?

9 DR. NAVATHE: On this point.

10 DR. CROSSON: Okay.

11 DR. NAVATHE: I would strongly echo that. I
12 think the current system is actually pretty weird in the
13 sense that it's sort of a double regulatory system, where
14 we're regulating fee-for-service prices in the first place,
15 and then we're regulating on top of that. So there's kind
16 of a two-phase movement away from markets, and then we're
17 presumably doing it in the name of competition because we
18 think MAs -- the privatization or private option around
19 Medicare. I think that's very incongruous. It actually
20 doesn't make a lot of sense, except that we need to short
21 fix that. I would vote 1 here as well. Again, I think it
22 would help, per Dana's points, to see the actual program

1 impact.

2 I think there's a lot to be said for going to a
3 competitive bidding lottery-type system, and I think
4 there's probably a lot of options, David, that could work
5 because to deal with that 5 percent inflation factor, you
6 can find a portion of the bid, the top quartile or top
7 tertile or something and exclude them from even
8 participating as a way to constrain the inflation piece of
9 it,

10 There's a lot of subtlety to that as well, but I
11 think it's certainly worth -- I would strongly encourage
12 the Commission to continue exploring that as the long-run
13 view around MA benchmarks.

14 DR. CROSSON: On his point? On our point?

15 MS. WANG: Yeah, on this point, generally, about
16 competitive bidding.

17 So I'm really interested that so many
18 Commissioners are kind of really interested in pursuing
19 this. The one thing that I would ask is we do this, and
20 maybe it's in the paper and the literature, is whether -- I
21 mean, don't forget. An MA plan is delivering the benefit
22 through providers. So whatever happens at this level

1 trickles down into providers, is whether there's any
2 literature or studies on how to prevent sort of redlining
3 higher-cost providers. That might be academic medical
4 centers, and it's not a race to the bottom, because that's
5 always the fear with competitive bidding. So I'm sure that
6 people have thought about that. I would just personally
7 appreciate knowing more about that.

8 DR. PAUL GINSBURG: I just wanted to say one
9 thing. I think those are really good thoughts.

10 One thing we can't do is contemplate doing an
11 experiment because that was attempted in the 1980s and the
12 1990s, and Congress shut down the experiment each time. I
13 think this is an area where we're just going -- as we have
14 in a lot of other Medicare payment policies, just jump in,
15 like we did with DRGs, if we decide to go forward with
16 this.

17 DR. CASALINO: On this point, the competitive
18 bidding point, I realize that I'm not -- I'm confused about
19 what people -- I'm not sure we all are thinking about the
20 same thing when we say competitive bidding, or at least I
21 don't understand.

22 I don't think you used the phrase "competitive

1 bidding." To me, competitive bidding means you submit your
2 bids, and some people get contracts, and some don't. But
3 that's not what we're saying here, just to be clear.

4 DR. PAUL GINSBURG: Yeah. This is competitive
5 bidding in health care financing, which has always been
6 that nobody loses.

7 [Laughter.]

8 DR. PAUL GINSBURG: But some people get paid less
9 than they had hoped they would.

10 DR. CROSSON: It's competitive bidding to set the
11 benchmark.

12 Kathy:?

13 MS. BUTO: Yeah. Competitive pricing is what it
14 --

15 DR. CROSSON: Right.

16 MS. BUTO: I look back at Brian Dowd's article
17 trying to summarize the four or five demos that tried to
18 get started on this, and the last one, which I was involved
19 in, was killed in 1999. So we're at the 20-year mark, and
20 in 2000, Mark McClellan actually laid out a framework that
21 was under consideration on the Hill by Breaux and Thomas
22 and others, a bipartisan group looking at two different

1 ways to do competitive pricing for Medicare Advantage
2 plans.

3 So, to your point, Pat, yes, a lot of work has
4 been done, but a lot of it has been stymied, if you will,
5 because the experiments were never allowed to go forward.

6 So I think I just want to -- having said that as
7 a preamble, I think this is really a good idea and one to
8 pursue. Of the options that are laid out, Scott, in your
9 paper, I would choose the first one, but I know, without
10 any question, that it will overpay in a lot of areas. If
11 you set a rate at 98 percent of fee-for-service, that's
12 going to overpay, maybe in most areas.

13 So the appeal of the benchmark being set through
14 a competitive approach, I think it's the competitive
15 benchmark setting as much as anything else. It's that you
16 get some of the savings, just from the competition.

17 To Pat's point, I think one of the things that we
18 have to face -- and really Marge's point too -- face up to
19 is maybe we don't want to necessarily require that all or
20 most of the savings go back into extra benefits. We should
21 think about that. I mean, we haven't revisited that. That
22 was always the sweetener to make it more appealing, but

1 maybe there is a happy medium there, more flexibility for
2 the plans, you figure to be competitive with other plans.
3 Plans are going to offer additional benefits, either at a
4 supplemental premium or from whatever savings they can get
5 by bidding against the benchmark.

6 But I would let them keep a lot of the money if
7 they can bid under the benchmark that's competitively set
8 and not have to put all that back into extra benefit.

9 I mean, I just think there's a lot of stuff for
10 us to talk about, but to the benchmark issue itself, I
11 think I like Alternative 1, but I think it's going to badly
12 overpay. It's just a lot simpler to administer. There
13 won't be cliffs, but I think it's just a baby step.

14 DR. CROSSON: Okay. Good discussion.

15 Oh, Jonathan.

16 DR. JAFFERY: Sorry. I can do this in under 20
17 minutes, I premise.

18 [Laughter.]

19 DR. JAFFERY: I'll be quick. First of all, I am
20 also supportive. I think I like to see modeling. I think
21 that getting rid of cliffs is going to be beneficial and,
22 in general, feel like you don't need to encourage people to

1 participate in the way that maybe we did in the past.

2 I think the point I want to make that I don't
3 think we've talked about is one that actually is true. It
4 was true in the previous discussion as well, and I think
5 we're not just talking about things, changes or
6 recommendations that could impact the MA program anymore.
7 We're not just talking about MA versus everybody else in
8 traditional fee-for-service.

9 We're now in a situation where we've got ACOs,
10 and we're talking about a couple different models. And I
11 think we just -- whatever we're doing, I think we want to
12 be mindful that that's another part of the conversation,
13 and we shouldn't be totally thinking about all these
14 policies completely in isolation.

15 We've got high-cost or high-spend areas right now
16 where ACOs operate, and they're coming in below their
17 benchmark and getting a lot of money back, even though
18 maybe we're overspending in those areas, which are very
19 different from the low-spend areas.

20 So I just wanted to bring that piece into the
21 conversation we had, actually both conversations this
22 afternoon.

1 Thanks.

2 DR. CROSSON: Okay. Again, thank you. Good
3 discussion.

4 Scott, we'll be hearing from you again.

5 We now have time for a public comment period, if
6 there are any of our guests who would like to make a public
7 comment based on the material that has been discussed this
8 afternoon. Please come forward to the microphone.

9 [No response.]

10 DR. CROSSON: Seeing no one, we are adjourned
11 until 8:30 tomorrow morning.

12 [Whereupon, at 5:00 p.m., the meeting was
13 recessed, to reconvene at 8:30 a.m., Friday, November 8,
14 2019.]

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MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

The Horizon Ballroom
Ronald Reagan Building
International Trade Center
1300 Pennsylvania Avenue, NW
Washington, D.C. 20004

Friday, November 8, 2019
8:31 a.m.

COMMISSIONERS PRESENT:

FRANCIS J. CROSSON, MD, Chair
PAUL GINSBURG, PhD, Vice Chair
KATHY BUTO, MPA
LAWRENCE P. CASALINO, MD, PhD
BRIAN DeBUSK, PhD
KAREN B. DeSALVO, MD, MPH, Msc
MARJORIE E. GINSBURG, BSN, MPH
DAVID GRABOWSKI, PhD
JONATHAN B. JAFFERY, MD, MS, MMM
AMOL S. NAVATHE, MD, PhD
JONATHAN PERLIN, MD, PhD, MSHA
BRUCE PYENSON, FSA, MAAA
JAEWON RYU, MD, JD
WARNER THOMAS, MBA
SUSAN THOMPSON, MS, RN
PAT WANG, JD

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P R O C E E D I N G S

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[8:31 a.m.]

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DR. CROSSON: Okay. I think we can begin to get started here.

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I'd like to welcome our guests to the Friday morning session of the November MedPAC meeting. This morning we're going to be discussing two issues, the first of which is part of our continuing work on Medicare drug policy, specifically Medicare Part D, and the role of low-income beneficiaries, and Eric is here. I think Shinobu is riding shotgun. So, Eric, you can start.

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MR. ROLLINS: Thank you. Good morning.

At our meeting last month, Rachel and Shinobu spoke about the shortcomings of the Part D drug benefit and outlined some potential reforms that would give plans better incentives to manage drug costs. Today I'm going to continue our work on this topic by taking a closer look at the implications of restructuring Part D for plans that serve beneficiaries who receive the program's low-income subsidy, or LIS. We plan to make recommendations on Part D reform during this work cycle and include those recommendations in the Commission's June 2020 report.

1 Let me start by giving you a little bit of
2 background. The LIS was created to ensure that low-income
3 Medicare beneficiaries have access to Part D drug coverage
4 by helping them pay their premiums and out-of-pocket costs.
5 As of April 2019, almost 13 million beneficiaries receive
6 the LIS, and they account for 28 percent of overall Part D
7 enrollment. Most LIS beneficiaries qualify automatically
8 because they receive both Medicare and Medicaid benefits,
9 but the program also covers beneficiaries who have income
10 below 150 percent of the federal poverty level and limited
11 assets.

12 LIS beneficiaries tend to be in poorer health
13 than other Part D enrollees and have higher drug costs. As
14 you can see here, gross drug spending for LIS beneficiaries
15 is more than two times higher than spending for non-LIS
16 beneficiaries. The spending for LIS beneficiaries is
17 higher because they fill more prescriptions, and those
18 prescriptions are, on average, more expensive. Because of
19 their higher spending, you'll also notice that LIS
20 beneficiaries are much more likely to reach the
21 catastrophic phase of the Part D benefit. In 2017, 19
22 percent of LIS beneficiaries reached the catastrophic

1 phase, compared to only 3 percent of non-LIS beneficiaries.

2 As I mentioned earlier, the LIS covers both
3 premiums and cost sharing. For premiums, the LIS tries to
4 encourage beneficiaries to enroll in lower-cost plans by
5 putting a dollar limit on the amount it will cover, known
6 as the benchmark. As a result, the LIS covers the entire
7 premium for only about a quarter of the stand-alone Part D
8 plans, or PDPs, that are being offered this year.

9 For cost sharing, the LIS eliminates the
10 deductible and the coverage gap and limits the amount that
11 beneficiaries pay for prescriptions to nominal copayments.
12 The copayment amounts are set in law and updated annually.
13 This year, most LIS beneficiaries pay no more than \$3.40
14 for a generic and \$8.50 for a brand-name drug. If the
15 regular copayment for a drug is lower than those amounts,
16 LIS beneficiaries pay the regular copayment. In addition,
17 as we discuss in the mailing materials, the copayments for
18 many LIS beneficiaries are even lower. The LIS also covers
19 all cost sharing in the catastrophic phase for most
20 beneficiaries.

21 The LIS helps ensure access to coverage, but its
22 limits on cost sharing also weaken incentives for

1 beneficiaries to use lower-cost drugs. This table shows
2 how cost sharing in stand-alone Part D plans differs for
3 LIS and non-LIS beneficiaries. The cost sharing for non-
4 LIS beneficiaries varies depending on where a drug appears
5 on the plan's formulary. Almost all PDPs now use
6 formularies with five tiers: two tiers for generic drugs
7 and three tiers that are largely for brand-name drugs. In
8 contrast, the cost sharing for LIS beneficiaries varies
9 depending only on whether a drug is generic or brand. I'd
10 like to highlight two ways that cost sharing for these
11 groups differ.

12 First, non-LIS beneficiaries have strong
13 incentives to use generics. As you can see in the yellow
14 box on the left, the two generic tiers have significantly
15 lower cost sharing than the other tiers. A beneficiary who
16 uses a generic on Tier 2 instead of a brand drug on Tier 3
17 can save \$35. If you look at the yellow box on the right,
18 you'll see that LIS beneficiaries also pay less when they
19 use generics, but the savings are much smaller -- about \$5
20 at most.

21 Second, the cost sharing for brand drugs differs
22 significantly from tier to tier. It's a little hard to see

1 here because Tier 3 usually has copayments while Tiers 4
2 and 5 have coinsurance, but as we note in the mailing
3 materials, the coinsurance for Tier 4 can be as high as
4 \$100 and the 26 percent coinsurance for Tier 5 is at least
5 \$174. So a beneficiary who uses a preferred drug on Tier 3
6 can save as much as \$60 compared to a non-preferred drug on
7 Tier 4 and more than \$130 compared to a specialty drug on
8 Tier 5. Plans use this differential cost sharing as
9 leverage to negotiate rebates from manufacturers that want
10 their products placed on the preferred tier. However, LIS
11 beneficiaries pay the same amount for drugs on all three
12 tiers and thus have no financial incentive to use a
13 preferred drug.

14 The distinctive features of the LIS population
15 make it more difficult for plans to manage their drug
16 spending, but these challenges are magnified for plans that
17 have large numbers of LIS enrollees. Both Part D and
18 Medicare Advantage have features that encourage LIS
19 beneficiaries to cluster in certain types of plans. In
20 Part D, the LIS only covers the entire premium when
21 beneficiaries enroll in lower-cost benchmark plans, plus
22 Medicare automatically enrolls LIS beneficiaries in

1 benchmark plans when they do not pick a plan on their own.
2 In MA, many sponsors operate special needs plans for dual
3 eligibles, who all receive the LIS. As a result, LIS
4 beneficiaries account for a majority of the enrollees in
5 about a quarter of all Part D plans. These majority-LIS
6 plans together cover about 65 percent of the entire LIS
7 population.

8 Given the differences between LIS and non-LIS
9 beneficiaries, we interviewed several Part D sponsors to
10 learn about their experience with the LIS population.
11 These sponsors were a mix of large, for-profit companies
12 that operate both PDPs and MA-PDs and smaller, nonprofit
13 companies that operate regional MA-PDs. Each sponsor had
14 at least one plan where a majority of the enrollees are LIS
15 beneficiaries.

16 Every sponsor said it was more difficult to
17 manage drug costs for the LIS population, primarily because
18 their basic strategy for managing drug costs -- tiered
19 formularies and differential cost sharing -- is relatively
20 ineffective because the LIS covers most cost sharing. For
21 example, many sponsors pointed out that LIS beneficiaries
22 are less likely to use generics. Some sponsors said they

1 used somewhat narrower formularies for their majority-LIS
2 plans, but the differences from the formularies for their
3 other plans were not viewed as significant. Finally,
4 although sponsors said it was more difficult to manage drug
5 costs for the LIS population, they nonetheless felt that
6 Medicare's payment rates for these beneficiaries were
7 adequate because of the adjustments that CMS makes to
8 account for differences in beneficiaries' health status.
9 We'll return to this issue again later.

10 This brings us to our work on restructuring the
11 Part D drug benefit. As we discussed last month, the
12 Commission has been examining several changes to Part D
13 that would require plans to bear more risk and would give
14 them stronger incentives to manage drug costs.

15 First, we would equalize the benefit structure
16 for LIS and non-LIS enrollees by making plans responsible
17 for 75 percent of costs between the deductible and the
18 catastrophic phase. We would do this by expanding the
19 basic benefit to fill in the coverage gap for LIS
20 beneficiaries and eliminating the coverage gap discount
21 program for non-LIS beneficiaries.

22 Second, we would add an annual cap on beneficiary

1 out-of-pocket costs.

2 And, third, we would change the financing of the
3 catastrophic phase by reducing the use of Medicare
4 reinsurance, creating a new program of manufacturer
5 discounts on brand-name drugs, and increasing the share of
6 spending covered by capitated payments where plans bear
7 risk.

8 We wanted to demonstrate the effect that these
9 kinds of reforms would have on payments for LIS versus non-
10 LIS beneficiaries, so we put together an illustrative
11 example that makes the following changes. Under this
12 illustrative package, plans would cover 75 percent of costs
13 between the deductible and the catastrophic phase for all
14 beneficiaries. The catastrophic phase would start when a
15 beneficiary had about \$7,500 in total drug spending. We
16 chose \$7,500 because we used 2017 data for this exercise,
17 and that was roughly where the catastrophic threshold was
18 in that year. There would be no beneficiary cost sharing
19 in the catastrophic phase. Finally, in the catastrophic
20 phase, plans would pay for 50 to 60 percent of drug costs,
21 Medicare reinsurance would pay for 20 percent, and
22 manufacturer discounts would cover the remaining 20 to 30

1 percent.

2 This graphic shows the impact that this
3 illustrative package of reforms would have on payments for
4 LIS and non-LIS beneficiaries. The figures here show gross
5 drug spending in 2017 on a per enrollee per month basis.
6 The two columns on the left show spending for LIS
7 beneficiaries, while those on the right show spending for
8 non-LIS beneficiaries for comparison. The columns that
9 show spending under the illustrative package of reforms do
10 not incorporate any behavioral responses by plans or
11 beneficiaries.

12 Looking at the left-most column, you can see
13 that, for LIS beneficiaries, the capitated payments where
14 plans bear risk -- that's the red segment -- are \$139 per
15 month, which is less than 30 percent of total spending.
16 Most spending for LIS beneficiaries is financed by Medicare
17 reinsurance -- which is the orange segment -- and the LIS -
18 - which is the green segment -- which are both cost-based
19 forms of reimbursement. Out-of-pocket spending plays a
20 minimal role because the LIS covers most beneficiary cost
21 sharing.

22 Under our illustrative package of reforms,

1 capitated payments would play a much larger role,
2 increasing to \$314 per month, or about 60 percent of total
3 spending. The share of spending financed by Medicare
4 reinsurance and the LIS would decrease to about 25 percent
5 combined. You can also see that some costs would be
6 financed by manufacturer discounts, which isn't the case
7 now.

8 As we've noted already, you can see that the
9 average spending for non-LIS beneficiaries is much lower.
10 Here, too, the reforms would increase the role of capitated
11 payments and reduce the use of reinsurance.

12 Under our illustrative reforms, risk adjustment
13 would play an important role in ensuring that the capitated
14 payments are adjusted for differences in beneficiaries'
15 health status. As we showed on the previous slide,
16 capitated payments for LIS beneficiaries will need to be
17 much higher than the payments for non-LIS beneficiaries --
18 \$314 per month versus \$135 per month, on average. We
19 believe that CMS can recalibrate its risk adjustment model,
20 known as the RxHCC model, to provide an adequate overall
21 level of risk adjustment. One key feature of the model
22 that makes this possible is the use of separate risk

1 adjusters for LIS and non-LIS beneficiaries. CMS added
2 separate adjusters to the model in 2011, and the plan
3 sponsors and actuaries we interviewed said that this change
4 had made payments for LIS beneficiaries more accurate.

5 However, some sponsors expressed concern that the
6 recalibrated model might underestimate costs for certain
7 types of beneficiaries, such as those who use very high-
8 cost drugs. These high-cost outliers might pose a greater
9 risk for smaller, regional plans that have lower
10 enrollment, but the Part D risk corridors would provide
11 some protection against unexpected losses, and plans might
12 also be able to buy private reinsurance, as we discussed
13 last month.

14 The Commission has long believed that if Part D
15 plans are going to be required to bear more risk, there
16 should also be reforms that make it easier for them to
17 control drug spending and thus manage the added risk. With
18 respect to LIS beneficiaries, there was wide agreement
19 among the sponsors we interviewed that Part D could be
20 modified in ways that make it easier to manage drug costs
21 while still ensuring access to coverage.

22 One policy change that the Commission could

1 consider is requiring LIS beneficiaries to pay higher cost
2 sharing for non-preferred drugs. This would make it easier
3 for plans to manage costs by giving LIS beneficiaries
4 stronger incentives to use lower-cost brands and generics.
5 Under this approach, the cost sharing for preferred drugs
6 would not change. Since CMS requires plans to include at
7 least one drug in each therapeutic class on a preferred
8 tier, LIS beneficiaries would still have good access to
9 coverage. The sponsors we interviewed believed that the
10 cost sharing for non-preferred drugs would need to be \$10
11 to \$20 higher to encourage LIS beneficiaries to use a
12 preferred product.

13 Policymakers could also apply this approach to
14 high-cost specialty drugs by allowing plans to have
15 separate preferred and non-preferred tiers for these
16 products. CMS currently limits plans to one specialty
17 tier. This would be a broader change that would apply to
18 all Part D enrollees, not just those receiving the LIS.

19 This next slide provides an illustrative example
20 of how this policy might work. In this example, the plan
21 has added a preferred tier for specialty drugs, so its
22 formulary has six tiers instead of the five-tier structure

1 that is typically used now.

2 The first three tiers that we have listed here
3 would be the preferred tiers -- with one tier for generics,
4 a second for brands, and a third for specialty drugs. When
5 LIS beneficiaries used drugs on these formulary tiers, they
6 would have the same nominal copayments as they do now -- in
7 this example, \$3.40 for a generic and \$8.50 for a brand.

8 The last three tiers would be the non-preferred
9 tiers, and again you'd have one tier for generics, one for
10 brands, and one for specialty drugs. Under this policy,
11 when LIS beneficiaries used drugs on these tiers, their
12 copayments would be higher than they are now. These higher
13 copayments would give LIS beneficiaries a financial
14 incentive to use a preferred drug. Policymakers would need
15 to decide how much higher the copayments for non-preferred
16 drugs would be, but presumably the differential would be
17 smaller than what plans use for non-LIS beneficiaries.

18 One potential concern about this policy would be
19 its impact on out-of-pocket spending. As we discuss in the
20 mailing materials, the vast majority of LIS beneficiaries
21 now spend less than \$200 annually on Part D drugs. The
22 policy's impact on out-of-pocket spending would depend

1 heavily on how LIS beneficiaries respond to the higher
2 copayments. If beneficiaries switch to preferred drugs,
3 the impact on out-of-pocket spending would be minimal. If
4 beneficiaries continue to use non-preferred products, their
5 out-of-pocket spending would increase. However, it is
6 worth noting that beneficiaries would have access to a
7 preferred drug in every therapeutic class, and that any
8 increases in out-of-pocket spending would reflect
9 beneficiaries' choices about which drugs to use.
10 Policymakers could also limit any increase in out-of-pocket
11 spending by allowing beneficiaries to request exceptions
12 from the higher cost sharing if their physician believes
13 that a non-preferred drug is the more appropriate
14 treatment.

15 That brings us to the discussion portion of our
16 session. We'd like to get your feedback on whether LIS
17 beneficiaries should be required to pay somewhat higher
18 cost sharing when they choose non-preferred drugs. We'd
19 also like to know if there are other tools that you think
20 Part D plans should be able to use to manage drug costs for
21 LIS beneficiaries while preserving access for this
22 important population. For example, we touched briefly on a

1 few other possibilities in the mailing materials, such as
2 requiring LIS beneficiaries to pay higher cost sharing when
3 they use a non-preferred pharmacy and giving plans more
4 flexibility to manage drugs in Part D's six protected
5 classes.

6 Finally, in terms of next steps, we -- and by
7 "we" I mean Rachel and Shinobu -- will return to you in
8 January to give our annual Part D update and discuss the
9 parameters of a redesigned benefit.

10 That concludes my presentation. I will now be
11 happy to take your questions.

12 DR. CROSSON: Thank you, Eric.

13 We are now open for clarifying questions. Paul
14 and David and Bruce and Jonathan.

15 DR. PAUL GINSBURG: Sure. I've got two.

16 Eric, any comment about how well the exceptions
17 process works today for either LIS or non-LIS?

18 MR. ROLLINS: I think that's going to depend
19 partly on who you talk to. I think the beneficiary
20 advocates would say that the exceptions process does not
21 work terribly well, partly because a lot of beneficiaries
22 are not very aware that it exists.

1 MS. SUZUKI: But I also think we heard in
2 stakeholder interviews that when there are drugs that a
3 beneficiary wants and it is not on the formulary that the
4 plan ended up covering them through formulary exceptions,
5 and because they were not getting rebates on those drugs,
6 it ended up costing them. And so that makes us think that
7 exceptions processes do work in some cases.

8 DR. MATHEWS: Can I jump in?

9 Shinobu, a couple years back, we actually did an
10 evaluation of starting with the number of exceptions that
11 were actually initiated. We tracked in a given year how
12 many went through the first process, the second process.
13 Can you say a little bit more about that?

14 MS. SUZUKI: So I don't remember the exact
15 statistics on this, but there are very few drugs that
16 actually went through the exceptions process.

17 The one data point we don't have is the
18 denominator that people could have gone through the
19 exceptions process but did not and either went and got
20 another medication or did not fill that prescription. So
21 we don't have that information to say whether or not the
22 process is easy for beneficiaries and prescribers to

1 maneuver or not.

2 But we also think that we've heard from plans,
3 like I said, that the process has provided access to many
4 of the medications that are either not on the plan's
5 formulary or on higher tiers.

6 DR. CROSSON: Shinobu, remind me now, because I
7 remember going over this, particularly when Jack Hoadley
8 was on the Commission. What's the process to notify either
9 physicians or beneficiaries that the exception process
10 exists, or is there a process?

11 MS. SUZUKI: So the claim is rejected at the
12 pharmacy, and I believe the pharmacist will see that there
13 needs to be a process. And pharmacists may reach out to
14 the prescriber to get a different drug, or they may contact
15 the prescriber or beneficiary may contact the prescriber to
16 start the exceptions process, but I believe they find that
17 out usually at the pharmacy counter.

18 And we had talked about how a better system would
19 be if prescribers could have access to that information
20 prior to prescribing a medication.

21 DR. CROSSON: And that could be electronic, for
22 example?

1 MS. SUZUKI: Yes.

2 DR. CROSSON: Thank you.

3 Okay. David?

4 MR. ROLLINS: Paul, did you have -- you said you
5 had two questions.

6 DR. CROSSON: Oh, I'm sorry.

7 DR. PAUL GINSBURG: I am halfway withdrawn. The
8 second question was going to be about is there a literature
9 about the sensitivity to cost sharing of low-income people,
10 but I am suspecting there isn't because of the uniform
11 national benefit design for low-income people.

12 MR. ROLLINS: That is correct, yes. There have
13 been a number of studies done that look at how responsive
14 Part D beneficiaries are to sort of tiered cost sharing and
15 their incentives to move from a brand to a generic, for
16 example, but the studies I have seen routinely exclude the
17 LIS population because, as you say, there really just isn't
18 much variation in what they pay.

19 DR. CROSSON: David. I'm sorry. Kathy, on this
20 point?

21 MS. BUTO: Isn't there, Eric, some literature
22 analysis using Medicaid copay policies? In other words,

1 some states use more drug copays than others, and I
2 wondered if there was anything there or not. I thought
3 there was an effect on beneficiary access.

4 MR. ROLLINS: We can look into that, but again,
5 the Medicare copayments are very tightly constrained. They
6 are, in some way, lower than the limits we've been talking
7 about here. It's usually \$1 or \$2 or \$3.

8 I think even we can look at that literature, but
9 this specific policy that we're talking about, there's also
10 this element of how much do they move to the substitute
11 product, and I'm not sure that the research that's been
12 done will sort of focus on that question specifically. But
13 we can look.

14 DR. CROSSON: David?

15 DR. GRABOWSKI: Great. Thanks. I'm super
16 excited we're working on this.

17 Help me understand. I'm auto-assigned to a
18 benchmark plan. Am I totally indifferent as a beneficiary
19 as to which of those plans I'm assigned to? For example,
20 do they all have uniform formularies? I get the zero
21 premium part.

22 MR. ROLLINS: They do not have uniform

1 formularies, but all of the plans will meet CMS's
2 requirements for formularies. So, for example, they cover
3 two products in each therapeutic class. They cover all
4 drugs in the protected classes, things like that.

5 So it's possible that depending on the mix of
6 drugs that an individual beneficiary takes, you could
7 potentially be auto-enrolled in a plan, that one of your
8 drugs is on the formulary, is not on the formulary.

9 That being said, historically, the LIS population
10 was allowed to switch plans on a month-to-month basis. CMS
11 has tightened that recently. They can now switch once a
12 quarter, but there's also that option as well.

13 DR. GRABOWSKI: This will not surprise Amol, who
14 does a lot of behavior economics work, but very few people
15 switch is my understanding.

16 [Laughter.]

17 DR. GRABOWSKI: There's a real stickiness in the
18 program. So you're sort of stuck with what you're
19 initially assigned.

20 MR. ROLLINS: Most of them accept their initial
21 assignment, and as we discussed in the paper, CMS will
22 periodically reassign people to new plans if the premium

1 goes up. And in most of those cases, the people will
2 accept reassignment to a new plan.

3 DR. CROSSON: On this point?

4 DR. NAVATHE: So if there's multiple benchmark
5 plans, how do they get auto-enrolled? Do they get
6 distributed across them, the ones who auto-enroll? How
7 does it work?

8 MR. ROLLINS: So what CMS does is it will take
9 the lineup of benchmark plans in a particular region, and
10 then it divvies people up based at the parent organization
11 level. So, for example, if you've got three plans and
12 they're offered by three different parent organizations,
13 each of them is going to get a third of the auto-assigned
14 population, and you can get this right now, like what we
15 have now, with the mergers that have been going on.

16 If you had four benchmark plans in a region, but
17 there were still only three parents, one of the companies
18 had two products, each parent is still going to get a third
19 of the LIS assignment. But the one that has two plans, they
20 will be sort of split. Its third is going to be split
21 evenly across its two products.

22 DR. CROSSON: Warner.

1 Hold on one second.

2 Warner, were you on this point or just in the
3 queue?

4 MR. THOMAS: [Speaking off microphone.]

5 DR. CROSSON: Karen?

6 DR. DeSALVO: Just for the auto-assignment, so
7 there are beneficiaries auto-assigned without any risk
8 adjustment taken into account? Is it basically just one,
9 two, three, four, five, six assignment, or are they
10 stratified and then assigned in that way?

11 MR. ROLLINS: It's completely random.

12 DR. DeSALVO: Thank you.

13 DR. CROSSON: Okay. Bruce?

14 MR. PYENSON: Yeah. A couple of questions. I
15 think an important group of LIS patients are those who are
16 institutionalized, and they have other types of benefits
17 that are expensive; for example, transitional scripts and
18 dispense, mechanisms for dispensing drugs that also add
19 cost.

20 Have you been able to subset that group out or
21 have a sense of how much spending is associated with them
22 or some of the options for dealing with those?

1 MR. ROLLINS: We didn't do it specifically for
2 these mailing materials.

3 As we noted, roughly 20 percent of your LIS
4 population pays no copays at all because they receive long-
5 term services and supports. Now, that includes both people
6 who are in nursing homes and people who are receiving like
7 home- and community-based waiver services. The nursing
8 home population is a subset of that. We could look more to
9 see what their spending profile looks like, but I would
10 certainly expect it to be high.

11 MR. PYENSON: Another question. On Slide 10, the
12 assumption about behavioral change of the beneficiary as
13 well as the behavioral change of the plan, I think that, of
14 course, reflects lots of numbers here, that there's no
15 behavioral change on either part. How do you think
16 behavioral change would affect any of this; for example,
17 the top line numbers?

18 MR. ROLLINS: Well, I think certainly the hope
19 would be that by having plans have stronger incentives to
20 manage drug costs, the hope would be that the total drug
21 spending might be lower under the illustrative package that
22 it is now, but that's the policy goal. We don't know

1 exactly how that would play out, and to what degree it
2 would play out is not easy to know.

3 MR. PYENSON: That's the plan behavior. How
4 about the member behavior, beneficiary behavior?

5 MR. ROLLINS: I think the two would be sort of
6 interlinked. The plans would make different decisions
7 about which drugs they cover, how they structure their
8 formularies. The beneficiaries would face a different set
9 of decisions about what prices they're getting charged for
10 the drugs on the different tiers. So I think they would
11 sort of work in tandem.

12 DR. CROSSON: Kathy, are you on this point?

13 MS. BUTO: No.

14 DR. CROSSON: Okay. Jonathan?

15 DR. JAFFERY: Thanks, Jay.

16 Going back to Paul's question about literature on
17 the impact on low-income individuals or their behavior
18 based on these things, I know you said a couple times that
19 we don't have literature, but I wonder if there's any
20 literature in non-Medicare spending, just related to
21 behavioral change in low-income individuals based on taxes
22 of different things?

1 MR. ROLLINS: So to the extent that I'm aware of
2 it, it's sort of more general research on what's the effect
3 of cost sharing or co-insurance for health care services
4 generally, and the thing I had in my mind is that -- and I
5 think this kind of, sort of makes sense, an intuitive
6 sense, that if you charged, let's say, a fixed-dollar
7 amount, a \$20 copayment for a particular service, that a
8 lower-income population is going to be more responsive to
9 that than a middle-income or a higher-income population.

10 But, again, in this particular case, it's not
11 simply a matter of charging potentially somewhat higher
12 cost sharing for certain drugs. It's also the extent to
13 which you want them to move to another product as opposed
14 to some of the broader literature on sort of use of co-
15 insurance or cost sharing for health care which is sort of
16 to what extent do they just use fewer services generally.

17 So there's an element of substitution here that
18 I'm not sure we're getting.

19 DR. JAFFERY: Yeah. I was sort of thinking of
20 things that aren't even in the health insurance realm, but
21 I think you'd have the same issues where some of those
22 things, people just are choosing not to do, certain

1 behaviors.

2 My second question is around actually the
3 exceptions issue. Have you considered the feasibility or
4 the cost of an exception process that would grandfather
5 people into preferred drugs or specialty drugs that they
6 had?

7 MR. ROLLINS: That's not something that we've
8 considered. If that's the Commission's interest, that's
9 something we could look at.

10 Certainly, to the extent that you are
11 grandfathering in the medications that the current
12 beneficiaries are taking, the impact of the policy would
13 probably be substantially reduced, at least in the near
14 term.

15 DR. CROSSON: Thank you.

16 Warner?

17 MR. THOMAS: Just a couple of questions. On the
18 various tiers, do you have information on the spending in
19 the different tier levels, like the percentage of spending
20 between the tiers? And if it was in the report, I missed
21 it.

22 MR. ROLLINS: It's not in the report. I don't

1 think we have that.

2 MR. THOMAS: Was there any discussion in your
3 interviews about the cost sharing on LIS just being zero
4 for lower tiers and the impact that may have on compliance?

5 MR. ROLLINS: There was some discussion of having
6 lower cost sharing particularly for generics, like should
7 there be generics where essentially they're free and
8 there's no cost sharing, and there have been some efforts
9 to sort of experiment with that, as you say, with the goal
10 of promoting it here for certain classes where we think
11 that it would be very beneficial.

12 But there wasn't any sort of structured, I think,
13 takeaway that we got from the sponsor in terms of Medicare
14 should really consider doing X or Y.

15 MR. THOMAS: Okay. On Slide 10, where you have
16 the manufacturer discounts, exactly how would you see that
17 working? Are there opportunities to do more in that area,
18 especially around LIS plans or beneficiaries?

19 MR. ROLLINS: So, again, the keyword on this
20 slide is "illustrative." What we have in the figures that
21 you --

22 MR. THOMAS: Not even fiction?

1 [Laughter.]

2 MR. ROLLINS: Illustrative in the sense of that
3 decision is going to be made by the 17 of you and not the 2
4 of us.

5 MR. THOMAS: Okay.

6 MR. ROLLINS: If the Commission is interested in
7 pursuing higher discounts, that's an option, or lower
8 discounts. That's going to be a decision that you all are
9 going to have to make.

10 MR. THOMAS: So, basically, it's a possibility
11 that some way it could be considered.

12 MR. ROLLINS: It's something that could be dialed
13 up or down, depending on the collective judgment.

14 MR. THOMAS: Okay. Thanks.

15 DR. CROSSON: Larry?

16 DR. CASALINO: Yeah. At the first pass, at
17 least, it's not the patient or the beneficiary who chooses
18 the medication. It's the physician, and the patient, in my
19 experience at least, gets involved when they get to the
20 pharmacy. They see what it's going to cost, and the
21 physician gets a call, "How come you prescribed this drug
22 that is going to cost me so much money?"

1 Did you have any information on what information
2 is readily available to physicians at the point of care
3 that would make it possible for them to be aware of what
4 the cost to the patient is going to be? If they're dealing
5 with beneficiaries who are in multiple Part D plans -- I
6 know this is already the case, but this would actually
7 potentially add to it and also make it less desirable to
8 take care of LIS patients because of more hassle in dealing
9 with the pharmacists.

10 Right now, how is it done? Is there any
11 systematic way that makes it easy for physicians at the
12 point of care to understand what copays their patients are
13 going to be paying?

14 MR. ROLLINS: I don't know that it rises to the
15 level of being systematic yet, but we did talk to some
16 sponsors that have developed systems that allow clinicians
17 sort of like Jay was referring to, sort of at the point
18 where they're getting ready to write a prescription, they
19 can consult and see sort of which for your patient's plan,
20 which drugs are the preferred drugs, what are sort of the
21 differences in cost sharing that he or she would pay.

22 DR. CASALINO: Software?

1 MR. ROLLINS: It's like an online portal they can
2 look at.

3 DR. CASALINO: Online portal for a particular
4 plan or for all the plans?

5 MR. ROLLINS: Well, it would be for that
6 beneficiary's particular plan, and they would have to
7 navigate more than one plan. But keep in mind at least for
8 the LIS population, they're often concentrated in only four
9 or five plans.

10 So I think one thing we heard is these systems
11 are very useful, but for an LIS beneficiary, all they show
12 is the two different cost sharing amounts -- the generic
13 amount and the brand amount -- and that for a non-preferred
14 drug, if you had the system, that would show the cost
15 sharing for one of those drugs would be somewhat higher.
16 That would be very helpful.

17 DR. CASALINO: Do you have a sense of how often a
18 particular plan makes changes in its formulary, which would
19 change the copay for beneficiaries?

20 MR. ROLLINS: Well, they are very limited in what
21 they can do during a plan year. They have more flexibility
22 from one plan year to the next.

1 DR. CROSSON: Kathy?

2 MS. BUTO: I know it is only illustrative here on
3 Slide 10, but have we thought about the increase in
4 premiums now that the capitated payments would go up in the
5 illustration? Have you looked at that at all? Because I
6 think that as we look at the policy, we'd want to consider
7 how big a jump in premiums we're going to be dialing up or
8 down.

9 MR. ROLLINS: We have not looked at that
10 specifically, but again, that's going to be a question that
11 you all have to wrestle with starting next month. There
12 are a lot of sort of moving pieces here that we're talking
13 about for the reforms. So holding all other things equal,
14 if you took the coverage gap for LIS beneficiaries, which
15 is now the LIS covers this drug spending there, if you move
16 that into the basic benefit, all other things being equal,
17 that would tend to increase premiums.

18 Similarly, again, all other things being equal,
19 if you had a beneficiary out-of-pocket cap roughly at where
20 it is now, plans would be covering spending that they're
21 not covering now, and that would also put upward pressure
22 on premiums.

1 But, again, where that out-of-pocket cap starts
2 is a decision you will need to make. What the level of
3 manufacturer discounts are, that's also a decision you will
4 need to make. So there's a lot of considerations that
5 would go into what's going to be the effect on the premium.

6 DR. CROSSON: Amol.

7 DR. NAVATHE: So picking up on Warner's first
8 question -- and I think this may have been, at least in
9 part, in a previous report that you guys have done -- do we
10 have a sense, so in addition to sort of spending by tier
11 for LIS beneficiaries, a dollar amount and a percent of
12 spend that is presumably modifiable? So this idea that we
13 could move from branded to generic or from non-preferred to
14 preferred, and what that sort of size of opportunity is
15 here that we're trying to affect, potentially?

16 MR. ROLLINS: In terms of a dollar figure I don't
17 think we have that. We touched at a couple places in the
18 mailing materials where we noted that even within
19 therapeutic classes where there are a lot of generics
20 available, you will see that the generic usage rate for the
21 LIS beneficiaries is a few points lower than for the non-
22 LIS, and that's been, at least across all drug classes,

1 that's been something we've seen for many years in Part D.
2 So that would at least give you a sense.

3 Specifically on the issue of brands and sort of
4 how much is potentially achievable on sort of taking a
5 preferred brand versus a non-preferred brand, that's not
6 something we've generated.

7 DR. CROSSON: Brian.

8 DR. DeBUSK: If I remember correctly, there is a
9 skew in the way DIR is allocated back to plans -- how much
10 of it goes to the capitated payments versus so much of it
11 goes back to reinsurance. And I just made a mental note
12 that if we ever got a chance we should fix that. Could you
13 guys speak to that misallocation, and does this move us a
14 step closer to having that misallocation fixed, or is there
15 an opportunity here to do something there as well?

16 MS. SUZUKI: So the issue we discussed a couple
17 of years back is that the way CMS currently allocates the
18 DIR is using the gross spending, and above the gross
19 spending 80 percent is Medicare's reinsurance. So they
20 figure out how much Medicare keeps for that portion of the
21 benefit, using the shared spending that's covered by
22 reinsurance, which means the plan portion is everything

1 else, including the rebates they receive during all the
2 phases, gap phase and LIS.

3 So in looking at how much the DIR offsets the
4 cost to the Medicare versus plans, it looked like offsets
5 for the plan costs are much higher than reinsurance offset.
6 This would move in a direction of fixing that issue,
7 primarily because plans would be responsible for all the
8 costs below the out-of-pocket threshold, all the benefit
9 costs below the out-of-pocket threshold. So they're not
10 keeping greater share than their benefit covers currently.

11 DR. DeBUSK: That was what I was thinking, is if
12 you go from the skew impacting 80 percent to saying we're
13 like 20 percent, you know, because some of the illustrative
14 things have had you at 20 percent. Is that correct?

15 MS. SUZUKI: Mm-hmm.

16 DR. DeBUSK: The other question I had, and this
17 touches on what Warner was asking about, I'm assuming at
18 some point then you guys are going to bring us, here's the
19 coverage gap discount program, you know, how much is paid
20 into that, here's what we would propose, go into, now the
21 reinsurance, basically transformed into reinsurance, and
22 then I would assume the Medicare payment, the catastrophic

1 phase, would still -- would be the difference, basically.
2 I mean, are we going to see a model like that at some
3 point?

4 MR. ROLLINS: I'm not going to commit to a model
5 per se, but in terms of like -- I think that's the right
6 way to think about the catastrophic phase is sort of three
7 buckets that are going to play a role in financing. One is
8 the Medicare reinsurance, one is manufactured discounts,
9 consistent with what you have discussed, and the remainder
10 would be sort of capitated payments for the plan's bare
11 risk, and sort of it's up to you all to decide what mix you
12 want those three to play.

13 DR. DeBUSK: Okay. So at some point in the
14 upcoming work you're going to have three buckets and fill
15 in the blank, basically.

16 MS. SUZUKI: The thing I'll caution is we may,
17 for example, prior to the meeting, we may try to think
18 about, in the static sense, what the current data shows.
19 That would be different from cost estimates that CBO would
20 provide. So for recommendations we usually come up with
21 parameters and have CBO provide us with cost estimates. So
22 if we chose 20 percent, they would provide one-year, five-

1 year estimate for that.

2 DR. CROSSON: On this point?

3 MR. PYENSON: Brian, correct me if I'm wrong. On
4 the percent retained by the plan of DIR rebates, as Federal
5 reinsurance shrinks, that percentage is going to go up,
6 assuming the total drug spend doesn't change, the Federal
7 reinsurance, which is the numerator, is going to go down
8 from 80 percent to something smaller. So the plan portion
9 of retained rebates goes up. However, the plan liability
10 for expensive drugs goes up also, from 15 percent to, say,
11 60 percent. So the incentives will turn so that it will be
12 hard for a rebate to meet -- harder for the rebate to meet
13 profitability.

14 DR. DeBUSK: That's what I was thinking, is that
15 the theoretical rebate you would need to still defeat the
16 system I think goes down by a factor of four, if you're
17 dropping from 80 percent to 20 percent. Because, you know,
18 in theory there's always a theoretical rebate that will
19 defeat the system.

20 MR. PYENSON: I think the rebate has to go up --

21 DR. DeBUSK: Yeah, that's what I'm saying. Yes,
22 I'm sorry. I said that backwards.

1 MR. PYENSON: Yeah.

2 DR. DeBUSK: It's going to get much harder to
3 find -- I mean, you're going to need a 90 percent rebate
4 instead of a 40 percent.

5 MR. PYENSON: It also depends on the other
6 corridors as well.

7 DR. DeBUSK: Okay.

8 DR. CROSSON: Okay. Karen.

9 DR. DeSALVO: I'll wait for them.

10 DR. CROSSON: Okay. Sorry. I have Jon.

11 DR. PERLIN: Thanks. On Chart 5, could you
12 roughly allocate where you see the proportions of the
13 dollars that potentially could be saved if we went from
14 generic to preferred generics from non-preferred to
15 preferred branded, and just extrapolating to the ultimate
16 six, your table, from preferred specialty to specialty? In
17 other words, I'm going to assume most of the money is at
18 the lower end of the table. Is that correct? In other
19 words, where do you get the bang for the buck in terms of
20 making changes here?

21 MR. ROLLINS: I think it's difficult to say
22 exactly how this would play out because it would depend on,

1 sort of, again, you would need to figure out what is the
2 differential in cost-sharing that we are going to use that
3 we don't have now. And as we've discussed, we don't have a
4 great research base in terms of sort of what effect that
5 would have on patient behavior.

6 DR. PERLIN: In a sense, you know what drugs are
7 prescribed and you know the behaviors of the non-LIS
8 population, and so there's a hypothesis that if the LIS
9 beneficiaries behaved more like the non-LIS beneficiaries
10 then there would be a better set of utilization of the
11 drugs and that would result in lower expenditures while
12 retaining the quality of care, because the drugs are
13 interchangeable.

14 MR. ROLLINS: Yes. I mean, the hope would be
15 that in response to the higher cost-sharing for the non-
16 preferred drugs you could have beneficiaries who, instead
17 of the non-preferred drugs switch to a preferred brand,
18 which would be less expensive for the program, or
19 potentially move all the way down to a generic.

20 DR. PERLIN: The reason I'm getting at this, I
21 wanted to clarify, where we think the dollars are, is that
22 really sensitive to Larry's issue, it's not the patient

1 that comes in and says, "Hey, this is the drug I need," and
2 it's the physician to make a choice. And the challenge for
3 the physician is this workflow issue, is that, you know,
4 you've got not only Medicare beneficiaries with different
5 plans but you've got all these commercial formularies.
6 What happens is it's impossible to go outside of your
7 workflow, go to a portal, look something up, and back to
8 your workflow. You know, it's Miller, not Budweiser --
9 please, a metaphor.

10 [Laughter.]

11 DR. PERLIN: It just doesn't happen, and that
12 means it gets arbitrated at the point of the pharmacist.
13 And in terms of not adding, you know, burden into the
14 process, if we know most precisely where we think the
15 savings are, that means that we can focus down on the
16 particular tier exchange where the dollars are, in a way
17 that's as efficient as possible. Because I think the piece
18 that I'm trying to understand is, you know, what can we do
19 most precisely that retains the benefit for the quality of
20 prescribing for the beneficiary while also not adding
21 inordinate additional work load to this sort of arbitration
22 process, which ultimately, you know, will exist at the back

1 end, from a patient who is concerned about the cost
2 interacting with the pharmacist and going back to the
3 physician's office.

4 MR. ROLLINS: Again, I don't think we have a
5 great sense of that because right now this is just kind of
6 a concept that we're putting in front of you. I think, you
7 know, your concerns about sort of the physician workflow,
8 they deal with this for the non-LIS population, and even if
9 you do this on a more targeted basis for the LIS
10 population, you're still going to have them deal with sort
11 of the same hassles.

12 DR. PERLIN: Thanks.

13 MS. SUZUKI: Can I just add one thing?

14 DR. CROSSON: Go ahead.

15 MS. SUZUKI: So I think we talked a little bit
16 about this at the last meeting, but EHR and real-time
17 benefit checks are things that are supposedly is going to
18 help the prescribers make this easier. And the other thing
19 to note is this policy layers on top of the current plan
20 structure, so the prescribers already do this for their
21 non-LIS beneficiaries. They have seen the same kind of
22 drug, and beneficiaries probably would ask for the cheaper

1 option, and they have had to do similar kind of
2 transactions.

3 DR. PERLIN: So, Shinobu, absolutely terrific
4 point. So whatever a policy option, it would seem fit the
5 degree to which that can be inserted into standard EHR
6 capacities would be the best approach. Thanks.

7 DR. CROSSON: Bruce, you had --

8 MR. PYENSON: But, Jonathan, on some of the
9 socioeconomic differences in populations are such that I've
10 seen lower adherence by LIS than non-LIS in a category of
11 drug. So there are things other than cost-sharing that
12 drive -- so the behavior of non-LIS is not always useful
13 completely. But a question on that process. I think the
14 state-level dispense has written laws and other things like
15 that that probably take precedence over Medicare rules, or
16 how does that, the mandatory substitution laws, how does
17 that interact with Part D?

18 MR. ROLLINS: They generally apply to Part D. So
19 a Part D beneficiary could also get a mandatory dispensing
20 of a generic product in a state that had that law.

21 MR. PYENSON: Or likewise, do we know if there is
22 a way for Federal rules to supersede state rules for Part

1 D? Is that a CMS rule or is that Federal?

2 MR. ROLLINS: To supersede what specifically?

3 MR. PYENSON: So, for example, the mandatory
4 generic substitution.

5 MR. ROLLINS: That can be overwritten if the
6 prescriber says "dispense as written" on the script.

7 MR. PYENSON: Only in certain states?

8 MR. ROLLINS: I think that's going to take
9 precedence everywhere. I don't know that. We can double-
10 check, but that's my guess.

11 MR. PYENSON: But does that seem like a viable
12 solution to the problem?

13 DR. PAUL GINSBURG: Bruce, I don't see how that
14 solves it at all, because if the pharmacist can add
15 substitutes then it just goes back to the beneficiary,
16 here's how much more you're left to pay, and then I guess
17 the beneficiary can get the doctor to change. So, in a
18 sense, it's really something about how smoothly the process
19 works rather than the ultimate outcome.

20 MR. PYENSON: Well, I'm thinking of circumstances
21 where manufacturers may have encouraged physicians to write
22 DAW, which is not in the interest of the Medicare program.

1 DR. CROSSON: Okay. All right. I think we're
2 done with that. Warren, you have a separate issue?

3 MR. THOMAS: Separate. On the chart here, I
4 assume that, is the total cost here illustrative as well,
5 or is that the actual cost?

6 MR. ROLLINS: So this is 2017 data and this is
7 actual for their gross drug spending. It doesn't include
8 manufacturer rebates and discounts, so it doesn't have sort
9 of the net. This is just sort of the gross payments at the
10 pharmacy counter.

11 MR. THOMAS: And do we have a handle on the --
12 that's a pretty substantial differential, and do we have a
13 good handle -- I know in Table 1 we had, you know, I guess
14 it's 19 percent of the LIS enrollees are above the
15 catastrophic versus 3 on the non-LIS. Do we have a decent
16 handle on the differential in that cost, like what's
17 driving -- is it all just the catastrophic or are there
18 other pieces that are driving that differential?

19 MR. ROLLINS: I think generally probably across
20 most -- I'm not going to go so far as to say every single
21 drug class, but generally speaking, across the board, the
22 LIS population is going to use more of a particular type of

1 medication. They are particularly likely to use certain
2 types of medications -- behavioral health medications,
3 things like that. But generally speaking they are going to
4 use more of just about everything.

5 DR. CROSSON: Okay, Sue, last question.

6 MS. THOMPSON: Well, I want to go back to the
7 interviews that were conducted. Can you talk just a little
8 more -- I mean, you talk about interviewing several Part D
9 plan sponsors. How many? What was their geography? How
10 many of the LIS beneficiaries lived in urban versus rural
11 communities? Can you just describe that complement of who
12 you interviewed?

13 MR. ROLLINS: We talked to, all told, I'm going
14 to say about a half dozen plan sponsors. Most of them were
15 national sponsors that are operating sort of across the
16 country, so we didn't get specifically into sort of urban
17 versus rural issues. But to the extent that they are
18 operating nationally they are in all of those areas. And
19 then we also talked to some regional sponsors that had MA-
20 PDs in like certain areas.

21 MS. THOMPSON: And did you visit with any
22 clinical pharmacists in terms of the impact from a clinical

1 perspective these policies might have, from their
2 viewpoint?

3 MR. ROLLINS: No, we did not.

4 MS. THOMPSON: And in relation to the idea of
5 preferred pharmacies, any thoughts about, or did the plans
6 have any thoughts about the impact to rural communities if
7 we moved towards preferred pharmacy?

8 MR. ROLLINS: They did not voice those concerns,
9 but I don't want to make it sound like it's something that
10 we probed deeply on. I think before sort of that policy
11 would be kind of ready for prime time, if you will, I think
12 we would want to dig a little bit more deeply and sort of
13 see what that means, because a lot of times the preferred
14 pharmacies are sort of the chain pharmacies or your grocery
15 stores or things like that, and we have heard some plans
16 say that the LIS population is much more likely to use
17 independent pharmacies, things like that.

18 So I think we would want to get a better picture
19 of sort of what's going on there before sort of really
20 moving forward with higher cost sharing for the non-
21 preferred pharmacies.

22 MS. THOMPSON: Thank you.

1 DR. CROSSON: Okay. So we will move forward to
2 the discussion. Could you put up Slide 15, the last slide?
3 We would like to focus the discussion on a fundamental
4 question, and that is, is there support for moving forward
5 with changing the benefit structure, payment structure for
6 LIS beneficiaries. Are there any thoughts about a
7 different way to go about reducing perhaps excess
8 expenditures by LIS beneficiaries?

9 And I would add, I think, you know, based on the
10 questions so far, if you have thoughts about the exception
11 process, because I'm going to suggest I think towards the
12 end that maybe if we go forward with this policy we may
13 want to bring back some of our former point about the
14 exception process, ease of use, et cetera, because I think
15 it goes together with this.

16 And so Paul is going to begin.

17 DR. PAUL GINSBURG: Thanks. Yeah, you did a
18 really comprehensive job on this question. You know, this
19 comes down to a basic concept behind Part D, which was that
20 rather than the Medicare program taking risk, as it does in
21 Parts A and B, it would have Part D plans take risk, and
22 the reason for shifting the risk would be because to engage

1 the plans in management activities, designing formularies,
2 negotiating formularies using other utilization management
3 techniques such as prior authorization. And what you're
4 pointing out here is that these techniques, at least the
5 formulary techniques, likely are much more effective with
6 the non-LIS population than the LIS population.

7 So now that we're contemplating moving to
8 shifting a lot of the risk that should have been on the
9 plans back to the plans through changing the reinsurance,
10 the question you posed is whether, in fact, the plans have
11 adequate tools to handle their very large, very expensive
12 LIS populations.

13 So I'm really glad that you conducted the
14 interviews. I find in so many MedPAC analyses the
15 interviews are very valuable, and it was very meaningful to
16 me.

17 I'm generally supportive of the proposal's next
18 steps you put up, and I was going to mention, before Jay
19 did, that I think work on making sure the -- improving the
20 exceptions process, making it more usable, more transparent
21 to the beneficiary, at least aware of their options, I
22 think would be a good thing. And I think some of the

1 things that we come up with for LIS would be suitable for
2 non-LIS, and we should add that in.

3 DR. CROSSON: Thank you, Paul. Further
4 discussion? Karen, Bruce, Amol, Pat. Karen -- and Warner.

5 DR. DeSALVO: Thank you, guys, so much for this
6 follow-up. You know, I don't want to be paternalistic but
7 just realistic that I think asking the beneficiaries to
8 drive the process and trying to use them even would seem
9 like small financial levers to get their behavior to change
10 is not the direction that I would feel comfortable going.
11 I think that the majority of these individuals are living
12 on the edge financially and also don't feel a sense of
13 agency in the conversation with their clinical teams. And
14 often they may have -- you know, folks who are trying to
15 help them navigate the systems, they might be prescribed,
16 you know, a psychotropic medication on a Friday afternoon
17 in clinic and then show up at the pharmacy, and it's not
18 the right pharmacy and it's not the right drug, and then
19 they have to go the next few days until the doctor is able
20 to answer the phone. And so they get caught up in a broken
21 system.

22 So I think that, harkening back to what Warner

1 said, I'd almost see, you know, asking them to pay zero,
2 but I'm not really in favor of leveraging them to drive
3 down costs.

4 On the other hand, I think this conversation that
5 we started having about the use of technology is ripening
6 for an opportunity to drive point-of-care behavior, and I
7 think that helps everybody involved. And I'm not very
8 familiar with how good the literature is that's driving the
9 market to build these kinds of tools, but there may be some
10 that you're familiar with. And, you know, as a couple of
11 examples, Humana and Epic announced a pathway to integrate
12 into the work flow point-of-care decisionmaking using that
13 as sort of a first step into how other electronic health
14 record companies could do this work, Epic having a huge
15 market share. Cerner, another major vendor, announced a
16 pathway partnering with Surescripts, which does most of the
17 trafficking -- the data trafficking, that is -- when you
18 say "trafficking" and "drug" in one sentence.

19 [Laughter.]

20 DR. DeSALVO: -- for the country. So those are
21 big moves, especially Epic, Cerner, and Surescripts, to try
22 to free up the marketplace, and there are others, CVS

1 Caremark from a pharmacy angle.

2 I think the policy issue -- the market can drive
3 some of that, but the policy issues are already in flow but
4 need to be finalized. So, you know, the 2015 edition of
5 the electronic health record requires open nonproprietary
6 API, which means a doorway to the data that allows easier
7 connectivity and pushing point-of-care decisionmaking about
8 real-time benefits check into the work flow for the
9 clinicians so there's not a separate portal to look at. So
10 the technology exists. The policy has been made. It has
11 to be continued to be acted on and the rules in play right
12 now that I guess are under review at OMB, the
13 interoperability rules from CMS and ONC are a part of that
14 puzzle to keep pushing a more open ecosystem and require
15 the use of a specific technology FHIR-based APIs, which is,
16 you know, not proprietary and inexpensive.

17 So that policy direction is less about payment
18 and more about keeping that train going that has been
19 around pushing the technology side, and I wouldn't want us
20 to lose sight of that as an opportunity to put some more
21 pressure on the point of care and not on the beneficiary.

22 Saying that, I think having some evidence about

1 whether that actually works and what are the results of it
2 for all types of patients and not just commercial patients,
3 but is it going to help particularly those that are low-
4 income, because, for example, my suspicion would be that
5 low-income beneficiaries are less likely to be cared for in
6 practice environments that are using Epic or Cerner, just -
7 - those are the two big first, probably more likely to be
8 smaller -- not smaller but relatively smaller technologies
9 like eClinicalWorks. So not to get too into the weeds
10 here, but I think just the broad policy -- it's not so much
11 about what the market decides to do independently. CMS has
12 a really important role to say the entire market needs to
13 move in this direction, and that sort of ties into all the
14 HIT policy that they already have underway but need to
15 complete.

16 DR. CROSSON: On this?

17 DR. CASALINO: Yeah. You know, I don't have
18 anything to contribute on the technology side of it, but I
19 do want to emphasize the issue, basically restating a
20 little bit more strongly what I said and Jonathan said a
21 few minutes ago. It's really -- to talk about the
22 beneficiary making a choice, it's not a trivial use of

1 language, and I think Karen's right. I think that a lot of
2 these beneficiaries are not in a good place to make a
3 choice. They're likely to wind up as a result paying more,
4 especially if they're seeing physicians who aren't well
5 equipped to even understand what the choices are.

6 But then I do want to talk about from the
7 physician side of things. Unless this can be done right
8 within the work flow, not having to go to a portal for
9 every different health plan to try to figure this out, it's
10 just very, you know, unfair to physicians and the patients.
11 And it does add cost to the system; it's just not visible
12 immediately to Medicare, because it's a huge cost in
13 physician and staff time and physician morale. Physician
14 morale at this point -- you know, I can't tell you how many
15 times in the last couple of years I've gone to a medical
16 group leader and asked him to ask their physicians to do X,
17 Y, or Z, take a three-minute survey or whatever. And they
18 said, "Larry, I'm sorry. I'd like to do that, but my
19 physicians tell me with gritted teeth, 'Not one more
20 thing.'" This is not a trivial thing, so requiring
21 physicians to go through different portals is analogous, or
22 maybe even worse, to the situation, when I left practice,

1 with pharmaceutical formularies, I had a desk drawer, a
2 large drawer that was full of formulary books from each
3 health plan, which changed each year, and were supplemented
4 by faxes that we'd get from the health plans. I'd get a
5 fax one day from Humana: "You may no longer use lisinopril
6 as your preferred" blah, blah, blah. And from a different
7 health plan the same day, "You must now use lisinopril as
8 your preferred" blah, blah, blah. So there's no rational
9 way for a physician to learn, okay, this is the best drug
10 at the best price for what I want. It takes enormous time,
11 and it's an enormous hassle and creates a lot of cynicism,
12 I think, among physicians and staff, and pharmacists, too.

13 I think you're going in the right direction, but
14 I do think that -- and this is something I don't understand
15 the technicalities. But insofar as Medicare can put
16 requirements on that would make this, so at the point of
17 care in your work flow you can see this, and physicians
18 will be, you know, happy to do what they can for their
19 patients. But, otherwise, it's just one more burden, and
20 not a trivial one, for physicians and one that will make
21 LIS patients less desirable to exactly the kind of
22 practices we might want to see them have access to.

1 DR. DeSALVO: Just to respond to that, Larry,
2 that's exactly what the product track is with this API, the
3 doorways to the data. They're not proprietary. They're
4 open source. Then it can allow those data feeds to come
5 right into the work flow and not have to go to a separate
6 portal. The pathway right now is the market's kind of
7 creating different portals, but that's where the more
8 progressive part of the market is and where federal policy,
9 is to make it directly into the work flow.

10 DR. CASALINO: But, Karen, there's no need for
11 any additional federal policy in relation to --

12 DR. DeSALVO: There needs to be finalization of
13 rules, but that's going to hopefully be in process now.

14 DR. CASALINO: But no need to put something into
15 this proposed program specific to that.

16 DR. DeSALVO: You know, I'm not sure that there
17 has to be anything additional, except unless we find
18 something in the literature that, in addition to just
19 having the information, maybe -- if only 40 percent of
20 clinicians act on information and make change, which is the
21 little bit of literature that I've seen, then that's not as
22 far as you'd want to get. There may be other policy

1 actions. But to me, starting with a point-of-care
2 decisionmaking that's in your work flow so that it's on the
3 burden of the clinician as the first step would be where I
4 would prefer to start instead of adding -- and let that
5 play out.

6 DR. CROSSON: I'm sorry. Brian, on this?

7 DR. DeBUSK: A question on this, and I'm going to
8 show naivete when I ask you both. There seems to be this
9 issue about the physician work flow that you guys were
10 talking about. And then, you know, Karen, you mentioned
11 the patient, you know, what if the patient -- can they deal
12 with the difficulties that may arise, like a non-LIS
13 patient? But I want to focus on the physician perspective.
14 When I'm a practicing physician in the office and I'm about
15 to prescribe something, do I even know if they're a LIS or
16 a non-LIS? I mean, I'm doing this regardless, aren't I?

17 DR. DeSALVO: Yeah, you may not know, but the
18 system will know. That's sort of the idea of having it
19 embedded into the electronic health record because it will
20 know the benefits of the person. And so when you're doing
21 a real-time benefits check, it's an automated process that
22 augments your decisionmaking at the point of care.

1 DR. DeBUSK: But I'm coming back to if there's a
2 drug I'm supposed to prescribe or not supposed to
3 prescribe, I mean, I'm doing that right now for the
4 majority of Medicare beneficiaries. I'm asking, by the
5 way. This isn't a lightning rod type question.

6 DR. DeSALVO: Yeah. Well, and others could
7 probably weigh in, obviously, but these systems exist for
8 formulary checks, but it's just that they tend to be
9 separate and apart from the work flow. And the idea is
10 that all that data lives or is connected to the electronic
11 health record, the formulary for that beneficiary of
12 whatever type, and it supports the decisionmaking. So if
13 you prescribe something, it'll redirect the clinician to
14 the best alternative.

15 DR. CROSSON: Okay. Let's -- I don't want to
16 spend the whole time just focusing on this, but Jaewon and
17 then Jon on this point.

18 DR. RYU: I just wanted to throw one other thing
19 that I think Jon raised earlier, which is how much of this
20 lands more appropriately in the pharmacy work flow at the
21 point of distribution. And I don't know, you know, what
22 should land on the physician work flow side, what should

1 land on the pharmacy side, and how much of these scenarios
2 are actually substitutable situations. But I think that
3 would be useful to know as well.

4 DR. CROSSON: Jon.

5 DR. PERLIN: And I think it's incredibly relevant
6 on this point, is that all other things being equal, you
7 want to use the most effective, least expensive medication
8 that's appropriate.

9 Second, you don't want to have the patient have
10 to be the one to reconcile the deficiencies in the system.

11 Third, the ideal would be to get it right at the
12 front end. Karen and others, Larry, suggest that the
13 technology be inserted into work flow.

14 And then, fourth, Jaewon says that ideally if it
15 can't be there, don't -- why burden the beneficiary,
16 especially financially? And I think Bruce's point, there
17 may be other reasons that beneficiaries may be at greater
18 risk for noncompliance and, therefore, worse outcomes. So
19 what can the pharmacist do to reconcile. That is, I think,
20 design principles, but I think it is worth reinforcing in
21 whatever sense of MedPAC, if not a specific statement, that
22 these are the technologies that would optimize both the

1 expenditure as well as, most importantly, the clinical
2 outcome.

3 DR. CROSSON: Yeah, this has been a good
4 discussion. I'd just like to point out, though, at least
5 from my point of view, this is anchored in the issue of
6 viability of the exception process, were we to move forward
7 with changing the incentives for LIS beneficiaries. I
8 think the exception process, which is already in place and
9 may or may not be functioning properly, needs to be thought
10 through and perhaps improved. And what we're talking about
11 here is one way to do that, but also perhaps a little bit
12 larger set of questions around work flow for doctors and
13 everything of that sort.

14 Okay. All right. So I've got Bruce next.

15 MR. PYENSON: Thank you very much. This has been
16 great work and a terrific discussion. I would recommend,
17 along the lines of the other tools, that we look at whether
18 NDC blocks are being used appropriately. There's certainly
19 instances where Part D plans block generics and require use
20 of brand and things of that sort, and vice versa with
21 respect to the impact of dispense as written and whether
22 that's in the public health -- in the public's interest and

1 the circumstances under which it is, which also gets to
2 Jay's point about the exception process for exceptions to
3 formularies.

4 You had suggestions for changing and MedPAC has
5 had suggestions for changing the protected classes, and I
6 think revisiting that would be important, and, again, to
7 Paul's point, not just for LIS but more broadly.

8 I would also urge us to look at the long-term-
9 care patients who are even more expensive than the regular
10 LIS and whether there's an opportunity to bring better
11 value to both those patients and the Part D program.

12 That's it. Thank you.

13 DR. CROSSON: Thank you, Bruce. Amol.

14 DR. NAVATHE: So thanks for taking this important
15 work on and putting out an illustrative scenario for us to
16 sink our teeth into.

17 I wanted to actually integrate several of the
18 different points here. First off, just expressing support
19 for the work that you guys are doing and the very general
20 direction that we're going.

21 I think my initial question in the Q&A phase, I
22 think Jon has done a nice job, I think, of also -- perhaps

1 said it better in terms of trying to quantify to some
2 extent the opportunity. And I think the reason we need
3 some level of specificity on what the opportunity is,
4 quote-unquote, and where the opportunity is, as Jon
5 described, is really important because it ties into Karen's
6 point, which is we want -- through this change we want to
7 use the design principles that Jon laid out around getting
8 the lowest-cost effective medication for these
9 beneficiaries. That's fundamentally important, but we have
10 to do it in a responsible way where we don't think that
11 we're putting beneficiaries at harm in the process.

12 And so if we can get a greater level of detail, I
13 think even some examples of where we have therapeutically
14 equivalent medications that are preferred, branded, versus
15 non-preferred and that substitution and what that cost
16 difference is, I think that would give us a greater level
17 of certainty and a sense that truly in the system we can
18 make cost-saving choices or cost-saving design changes to
19 the policy that would still be equivalent for the
20 beneficiary.

21 So I think that hopefully we can try to dive a
22 little bit deeper in future work to at least give some

1 illustrative scenarios and size the opportunity in some
2 level of granularity, I think that would actually be very
3 helpful, particularly because at some point we will want to
4 make recommendations on what those differences in cost
5 sharing, for example, would be, or copays would be, between
6 preferred and non-preferred. Right now they're very
7 abstract concepts, and so I think that piece is also
8 important.

9 The other piece I'd highlight is that the dollar
10 amount that we set for a difference between preferred and
11 non-preferred or brand and generic is also a choice, and so
12 it doesn't necessarily have to be a huge difference, and we
13 still may find that LIS beneficiaries are potentially
14 responsive to that. And I think that we have to
15 internalize that there is a possibility here, recognizing
16 some of the system problems that we have, that we can get
17 to this goal of still effective or equivalently effective
18 medication for an LIS beneficiary for lower cost.

19 DR. NAVATHE: And that is the goal. There are
20 system barriers, perhaps.

21 I think one thing to recognize is if we don't
22 have differences in cost sharing, it doesn't matter how

1 good the health IT is on real-time benefit checks because,
2 if there's no incentive to change, there's going to be on
3 incentive to change, and the real-time benefit check is not
4 going to do anything. So I think that's kind of one
5 important piece that's very broadly supportive of the
6 direction that we're going here, and I think it's
7 important.

8 I also think we should be reasonably cautious
9 about relying purely on the health IT solution soon. I've
10 had the opportunity to actually see them in practice,
11 actually look at data on engagement and, quote/unquote,
12 "practice change." It's still pretty low. Most people
13 still click around it. There's very few. I would say from
14 the data that I saw, less than a fifth of opportunities are
15 actually for -- therapeutically equivalent changes are
16 actually followed through upon. So we still have some work
17 to do there, and again, I think the policy pieces, design
18 pieces have to be in place.

19 And the last piece I'll say is I think preserving
20 ideas like "dispense as written" are actually really
21 fundamentally important for patient safety. I think we
22 know that there are cases in some endocrine drugs,

1 certainly in psychotropic medications and other mental
2 health-oriented medications where branded generic can
3 matter. When you have a patient on a stable dose of a
4 medication that's branded, it's much more predictable for a
5 patient with bipolar or some other mental health disease.
6 You really may not want to switch to a generic, even if it
7 seems cost saving, because of the fact it may be bad for
8 patients, and it may actually be anything but cost saving
9 in the long run.

10 I think we should certainly espouse the
11 principles around protecting these beneficiaries and
12 recognizing that there is a number of other barriers around
13 them, but if we don't set up the policy in the first place,
14 then the system is not going to adapt to try to drive the
15 right behaviors at the point of the physician, at the point
16 of the pharmacist, and then I think perhaps downstream at
17 the point of the beneficiary.

18 DR. CROSSON: Thank you, Amol.

19 Pat?

20 MS. WANG: Thanks.

21 Thank you, Eric, for doing this really important
22 work and focusing on this population.

1 Can you go back to Slide 10 for a second? This,
2 especially in color, is a very impactful slide. Where we
3 start, as you have noted, the beneficiary structure for LIS
4 today is different than it is for non-LIS. This re-
5 depiction follows the goals set out in the initial work of
6 standardizing the beneficiary design between LIS and non-
7 LIS.

8 But what this shows really is the magnitude of
9 the risk shift to plans from CMS. That's the goal.

10 In the non-LIS population on the right-hand side,
11 obviously the risk shift is smaller in dollars, and it's
12 also smaller proportionately from current to the plans,
13 like one and a half times.

14 If you go to the left and you look at the
15 magnitude of the risk shift from an LIS plan today, it's
16 two-plus times, and the magnitude of the dollars is much,
17 much bigger.

18 So I think that it's really important to just
19 stop and pause and stare at this because the title of this
20 paper was "Implications for Plans Serving LIS
21 Beneficiaries," and so this is the magnitude of the impact
22 on those plans. Let's just start there.

1 Here, I'm focused on really D-SNPs, MA-PDs, not
2 the freestanding drug plans. I don't know enough about
3 freestanding drug plans, but I know a little bit about D-
4 SNPs, who serve the population. Many of them are Medicaid
5 plans that have kind of gone into this serving duals who
6 have aged in or are from the same community as Medicaid
7 members. Those of the plans that are not-for-profit,
8 regional, provider-sponsored, what have you, I think are
9 very well suited to serving the population because this is
10 a population that is very local.

11 So hyper-local approaches, their physicians are
12 different. They're not practicing in big group practices
13 with Epic and all this kind of thing, as Karen pointed out.
14 They're onesie-twosies community doctors. Depending on the
15 community that they're in, they may be immigrants. They
16 may be -- because of cultural competence and the need for
17 language competence, it's a different population. It's a
18 different provider workforce. It's a different pharmacy,
19 dispensing pharmacy, community pharmacies, not the big drug
20 chains that are connected to the world through
21 sophisticated technology.

22 To the extent that those are the plans that are

1 serving this population today, I think it's very important
2 to understand the implications of the magnitude of the risk
3 shift. So that's number one.

4 Number two, if you go to Slide 13 -- and this was
5 also in Table 3 on page 9 of the paper -- just to stare at
6 this again, the illustrative middle column, these are six
7 tiers of varying cost-sharing implications for non-LIS
8 populations, and on the right for LIS beneficiaries, this
9 depicts the cost sharing for LIS Category 1, where one-
10 third of LIS beneficiaries fall into that category today.
11 This is their cost sharing.

12 There are four LIS categories, the third of
13 which, according to the payer, 19 percent of LIS
14 beneficiaries fall into this category. Zero cost sharing,
15 zero generics, zero brand, zero catastrophic. These are
16 duals who are using long-term supports and services. These
17 are the duals in the duals demos. These are the duals who
18 are in I-SNPs and PACE programs. Forty-four percent of the
19 LIS population is in the full-benefit dual population,
20 where the cost sharing is \$1.25 for generics and \$3.80 for
21 brand.

22 These are appropriate levels of cost sharing for

1 the population. This is not a population that has any
2 money. This is a population that is sicker, that has many,
3 many barriers to care, and so this is appropriate cost
4 sharing.

5 The other thing, I mean, Eric, I appreciate many
6 of the suggestions that you developed in the paper, but I
7 want people to appreciate what the rules around the LIS
8 formulary management is today. If there are six tiers here
9 shown here and those translate into five or so tiers in the
10 non-LIS Part D benefit, for the LIS population, current
11 rule is there's one tier. Every single one of those
12 generic, brand, preferred, non-preferred specialty is
13 required to be in one tier. The only thing that differs is
14 the cost sharing applicable to the beneficiary, which in
15 the case of 20 percent of the population is zero. All of
16 those things by law today are in one tier.

17 So if you go back to Slide 10 and just stare at
18 the magnitude of the risk shift, I would just suggest that
19 the points that people raised here today may explain why
20 the benefit structure in Part D is different today for LIS
21 than for non-LIS.

22 I really think that, Amol, the goal is to lower

1 the cost of drugs, the appropriate life-saving, safe drugs
2 for the LIS population. The question is, How do you get
3 there?

4 I think the suggestions on cost sharing are
5 appropriate. It's important to try to do what there is
6 where it's possible to, but then on the other hand, there's
7 a desire to make sure that there are good exceptions
8 processes.

9 There's an expectation that physicians will
10 somehow be able to say, "You don't have any cost sharing,
11 but I'm going to take the time to figure out which brand is
12 preferred and lower cost." I mean, I don't think that's
13 realistic. So you don't want to put the burden on the
14 physician.

15 The beneficiaries have got a lot going on in
16 their lives. The expectation that they are going to
17 understand, this is better to take a lower-cost brand
18 because it will save the Medicare program money, and that's
19 what they want me to do, even though I have no differential
20 cost sharing or zero cost sharing. It's not realistic
21 either.

22 So where are we? Where I think we are not, in my

1 view, without people being really realistic about the
2 implications for plans that predominantly serve this
3 population is on the left-hand side of this box. I think
4 it is very, very impactful and has gigantic implications at
5 least for regional plans that are in a community to
6 continue being able to serve the population.

7 I think that all of the suggestions, Eric, that
8 were in your paper do need to be adopted. Plans need to
9 have whatever tools they have with whatever restructuring
10 of the Part D benefit there is, but I think that the
11 concerns that have been raised today, there's going to be
12 tugs and pulls on what to impose on beneficiaries, what to
13 expect of the delivery system, what to expect of the
14 beneficiaries themselves, whose health literacy and English
15 literacy may be very, very low and probably is. So I would
16 just be very cautious about that.

17 Eric, you very correctly pointed out that risk
18 adjustment for the amount of risk that is going to have to
19 shift over to LIS has to be exquisite, but you also pointed
20 out -- and I'm very appreciative -- that your observations
21 are on a national basis, and on an individual plan basis,
22 you could have all kinds of outliers, new drug launches

1 that could just really spell catastrophe for plans that
2 have a mission to serve this population.

3 Risk corridor protection, you mentioned maybe in
4 the catastrophic layer, that could help. I would urge that
5 that be modeled.

6 If you just even look at the 19 percent in the
7 reinsurance layer versus the 3 percent for non-LIS, that's'
8 six times the number of people are going to be -- that an
9 LIS plan is going to be managing and taking risk for in the
10 reinsurance player. The magnitude of these impacts is
11 really big.

12 There was a mention in the paper about plans
13 purchasing private reinsurance, stop-loss insurance. It's
14 very expensive. Maybe CMS could do an at-cost stop-loss
15 program for these programs.

16 But I think that my fundamental concern here is,
17 number one, I really think that -- I urge that the
18 Commissioners be sober about the fact that this policy
19 could have very unintended and very unknown consequences
20 for what plans in the future serve the population. It
21 could have unintended consequences or unintended
22 consequences for plan consolidation, and so it's sort of

1 that's what people want because that's the only type of
2 plan that can withstand this sort of risk. It has to be
3 national. It has to be multi, whatever. People should
4 just have that in their minds.

5 But I think that the other thing that I would
6 like us to keep an open mind about as we go forward with
7 the work is that I don't really know why we think that the
8 benefit structure between non-LIS and LIS must be standard
9 or must be the same. I think there's a reason today that
10 CMS is absorbing more of the cost for this population and
11 that the benefit structure is different, and I think that
12 we should be open to that going forward for LIS.

13 DR. CROSSON: Thank you, Pat.

14 Kathy, are you on this point?

15 MS. BUTO: Yeah, really.

16 I really appreciate what Pat just said because I
17 came into the conversation thinking I totally support the
18 direction that Eric and Shinobu have laid out, but now
19 after the conversation, I really feel as if, number one, we
20 should make no change in beneficiary cost sharing for the
21 LIS population. And the reason for that is I think the
22 structural change that we're advocating, which I very much

1 support, will have an impact on the spending that we're
2 seeing that sort of statically reflects the current state.

3 So I think before we move to looking at changing
4 cost sharing for LIS beneficiaries, it makes sense to see
5 what that structural change will do because it's going to
6 have a big impact.

7 The second thing is after Pat's --

8 DR. CASALINO: What do you mean by "structural
9 change"?

10 MS. BUTO: Just doing away with the coverage gap,
11 this whole restructuring that I think we're coming back to
12 in the next session.

13 But what Pat's comments really struck me is that
14 I think we do want to protect the plans that serve a larger
15 share of LIS beneficiaries, and we might want to think
16 about in that next go-around on the big structural change,
17 a different structure for those plans that maybe has less
18 plan risk absorbing and more federal manufacturer risk
19 taking for that population.

20 In my mind, if plans and manufacturers are taking
21 on more risk in the catastrophic phase, there will be a
22 different dynamic in both the technology provided to

1 physicians and also the behavior of manufacturers. So
2 that's number one.

3 But, two, if they absorb even more risk, if the
4 federal government and manufacturers absorb more risk vis-
5 a-vis the plans that have less ability to controls pending
6 for that category of patients, then I think you'll see an
7 even different behavior on the part of -- there will be
8 more fair risk sharing in my mind if we do that.

9 So I hate to think about two different tiers
10 because then you have cliffs, but it just strikes me that
11 this is a different kind of plan. And we don't want to see
12 these disappear.

13 So I would just say for the next go-round, we
14 ought to think about that.

15 DR. CROSSON: Thank you for that comment, Kathy.

16 I just want to make one point, and that is that
17 Pat, quite rightly and intensely, draws a comparison
18 between large plans and plans like hers. It seems to me
19 that were we to make the kind of differentiation that I
20 think both of you are talking about, it takes us into the
21 situation of having to define, how we define the two types
22 of plans.

1 One case is easy to understand, but then you get
2 into the question of which plan qualifies as having a
3 different structure, or do we have multiple structures,
4 depending on the percentage of LIS beneficiaries and the
5 like? It's important, but it's also complicated.

6 Amol, did you want to comment on this?

7 DR. NAVATHE: Yes. Two points on this point.
8 One is I appreciate, Pat, your point that the level of cost
9 sharing that we're seeing on the other table are
10 appropriate levels of cost sharing, and I think the
11 important thing that we have to recognize is that we can
12 still create differentiation in the levels between
13 preferred and non-preferred and still stay within balance
14 there.

15 There's no differentiation right now, and that
16 may mean we could actually drop the copay for the preferred
17 to create differentiation. So this doesn't necessarily
18 have to be something that's harmful from a financial
19 perspective. I think we just need to create the incentive
20 for cost-conscious behavior.

21 And then to your point, when you do a real-time
22 benefit check, if there's no variation, the doc is not

1 going to do it. Why should I do it if it's not going to
2 benefit my patient? I think if there's a benefit, then you
3 might actually do it.

4 Then the second piece, both to your and Kathy's
5 points -- I'm curious -- is it seems to me that the system
6 change, Kathy, that you're supporting, not the copay side
7 of this, is really what is potentially more challenging for
8 more regional plans like yours, and I think kind of what
9 Jay was getting at. So it's a challenging situation
10 because they're supporting the system change, but it's that
11 system change itself that is actually the most challenging
12 for the regional plans.

13 MS. BUTO: Yeah. But the systems, I'm modifying
14 my support for the system change to say let's consider
15 whether we need another category for the system change. It
16 has a slightly different structure.

17 DR. CROSSON: Okay. So Warner has been waiting
18 patiently, and then I think we're going to have to move on.

19 MR. THOMAS: Thanks, Jay.

20 [Laughter.]

21 MR. THOMAS: I think Pat's comments are really
22 important. I really have not thought about it like that,

1 but I do think this idea of if you do have a plan that has
2 a disproportionate number of -- or higher percentage number
3 of LIS beneficiaries, it sounds like that is a different
4 model that should be thought about.

5 My comments kind of lean back towards, Pat, I
6 think, your comments about there are a large percentage of
7 folks that are in these programs that are LIS beneficiaries
8 who really do have zero patient responsibility, and I think
9 that's great. I think that's an important point because we
10 want to make sure folks that have -- when you look in the
11 paper, risk scores that are almost 50 percent higher than
12 folks that are in the non-LIS plans, we want to make sure
13 they're taking their medicine and they're getting the right
14 care. So I think that's an important component.

15 The other thing -- I don't know if this should
16 have been probably in Round 1, but I don't know if we're
17 able to look at the LIS beneficiaries and track them back
18 to either Medicaid or Medicare plans and see what is their
19 cost, trend, and impact on this system there. My guess is
20 folks that are more compliant and have drugs and are taking
21 them in the Part D plan over time have a lower cost
22 structure in the MA plans, I would think, but I'm not sure

1 if any of the people you interviewed talked about that or
2 not.

3 I do think the big issue here is -- and it is
4 kind of brought up here -- huge risk transferred to the
5 plans, but right now, I mean, the manufacturers, there's
6 not a lot of manufacturer discount. When you look at the
7 LIS beneficiaries, I kind of equate this back to -- not to
8 throw a wrench in the work, but the 340B program. That is
9 pharma's contribution to Medicare and Medicaid.

10 And I think in the Part D program, I think we
11 should be looking towards the manufacturers to have a more
12 significant discount for the program overall and a
13 disproportionate significant discount for the program where
14 we have LIS beneficiaries. They win tremendously in these
15 programs, and I think Larry's point about getting the
16 faxes, about use this one, don't use this one, use this
17 one, well, that's because they can set their own prices.
18 And they're changing all the time. If there was a price,
19 you would not get those faxes all the time. You would
20 basically know what you're going to pay for the drug, and
21 you could decide whether it's on the formulary or not.
22 Because we don't do that, therefore, we get faxes every

1 week, or now emails, about kind of what's going on about
2 this situation.

3 I think, pushing once again, if you want to play
4 in this program, you ought to set your rates as a
5 manufacturer, and if we can't go that route because we
6 think it's too dramatic, there should be significant
7 discounts from the manufacturers to play in this program
8 because of the tremendous cost and the vulnerable
9 population we have here.

10 So I would encourage us in our illustrative
11 proposal to have a much higher percentage of that, what's
12 going out of risk share going to the capitated payments to
13 go to manufacturer discounts and to have them have a much
14 higher proportion of the risk in the program, especially
15 with 19 percent of LIS being in over the catastrophic
16 benefit. That to me just seems like it would really lend
17 itself to have a lot more leaning in from the plan.

18 So maybe I'll just stop there.

19 DR. CROSSON: Larry?

20 DR. CASALINO: A quick question for Pat, just a
21 question, not a speech.

22 DR. CROSSON: Yes.

1 DR. CASALINO: Since you spoke, several people
2 have referred to identifying the plans. You talk about by
3 percentage of LIS beneficiaries that they provide care for.
4 Is that a definition that's adequate for you, or would you
5 require something more?

6 MS. WANG: I think if you just describe a dual
7 SNP or the SNP plans, they are by definition all dual or
8 LIS, Eric, right?

9 I mean, Eric had pointed out in his paper that
10 the concentration of LIS in certain plan types is a result
11 of deliberate federal policy. So a dual SNP is all dual.
12 I don't know if there are other criteria.

13 I appreciate everybody's sensitivity to the
14 point. I have to say I share Jay's concern about trying to
15 define types of plans. I mean, a D-SNP can be relied on to
16 be all LIS, and there are other types of plans of that
17 nature too.

18 I think it's difficult to sort of go lower down
19 and say, "Well, you're a standalone regional not-for-profit
20 plan as opposed to you're a D-SNP that is part of a parent
21 organization that is in 45 states. It's hard to make that
22 level of distinction.

1 I think the most important thing that is
2 important here is the differentiation, I think, about the
3 type of structure of the Part D redesign for plans serving
4 LIS, and I think it's hard to dive below that more.

5 I like Warner's suggestions and Kathy's
6 suggestion, especially in the reinsurance layer of just
7 getting a little more help in there from the other parties.

8 And I to think that, frankly, there's a reason
9 that CMS has had a lot of participation in the reinsurance
10 layer for the LIS population, and I don't really want to
11 see it get out completely to the same extent as the non-low
12 income.

13 Also, I have to say I think that Amol - I know
14 there's a lot of sensitivity to changing cost sharing where
15 it exists, but differentiating between preferred and non-
16 preferred, I think, is an appropriate way to go. Even
17 simple things like allowing plans, even if there's no
18 differentiation in cost sharing, to put the drugs on
19 different tiers, just to show like it's a zero cost share,
20 it's LIS Category 3, just to sort of signal to a
21 prescriber, this is the preferred generic, this is the
22 preferred drug, the preferred brand.

1 Right now, the requirement, it's one tier.
2 Everything is just jumbled together. These are not huge
3 changes, but they are stubborn to be changed.

4 MR. THOMAS: Just a quick comment on that.

5 I think we could be overly complex about trying
6 to say, well, this is a plan that's regional and this sort
7 of thing, or we could just say, you can look at the
8 percentage of the total population that's LIS or not. I
9 mean, that would cover, you know, a regional plan that has
10 a disproportionate amount of LIS would basically
11 potentially qualify. One that's national, that has, you
12 know, a smaller percentage, or maybe has a lot in one
13 pocket but overall does not have a higher percentage of
14 LIS, I think you could, you know, work through that.

15 But I think this idea of creating some protection
16 of plans that have a disproportionate percentage of LIS
17 beneficiaries I think would be relatively easy to quantify
18 and define in any sort of, you know, structure, or
19 restructure of the plans.

20 DR. CROSSON: Last point.

21 DR. RYU: I actually think Pat's point, it was
22 the LIS side but also even on the non-LIS side there's a

1 significant risk transfer. So if you look at the red bar
2 there, it's going up 60 percent, you know, between the
3 current and the proposed. I wonder if this is just
4 something that could be mitigated through, you know, the
5 reinsurance, and stop loss coverage, and having CMS or
6 others help with that, versus trying to parse out, you
7 know, maybe you do something even above and beyond that for
8 those with significant LIS.

9 But I think the unintended consequences point is
10 at play, not just for LIS or not -- oh, sorry -- for LIS.
11 I think it's also still in play for the non, where it's
12 going to favor the larger health plans that, you know, are
13 multi-state, perhaps for-profit, to be able to absorb, you
14 know, significantly more risk.

15 DR. PAUL GINSBURG: Can I just -- it sounds like
16 you are questioning the whole basic approach of changing
17 the, you know, reducing the reinsurance, because of, you
18 know, these reasons.

19 DR. RYU: I think the idea of the risk transfer
20 resonates. I get that and I think that's correct. I think
21 it's the right way to go. I just wish there was some way
22 to protect the exposure so that we don't have an unintended

1 consequence by making that move that we're encouraging even
2 more consolidation in the insurance market. And maybe, you
3 know, consolidation to some extent, you know, it's not
4 necessarily a bad thing. It's just I think the playing
5 field may not be even with such a significant transfer.

6 MS. BUTO: And maybe with playing with the
7 percentages -- as Eric said, this is illustrative -- if you
8 change the percentages it changes that exposure.

9 DR. CROSSON: Okay. Interesting discussion.
10 Eric, we wish you luck here.

11 [Laughter.]

12 DR. CROSSON: We will be looking forward to
13 hearing from you again. And Shinobu, thank you for riding
14 shotgun.

15 So we will move on to the last November
16 presentation.

17 [Pause.]

18 DR. CROSSON: Okay. For the final presentation
19 we are going to focus in on the body of work that we've
20 been doing on ACOs, and specifically the MSSP model, and
21 receive some new information about the impact of those
22 programs, specifically on post-acute care. And it looks

1 like Evan here, and Evan is going to start. And we've got
2 Luis and Jeff, in this case, is riding shotgun on this
3 presentation.

4 So, Evan, it is up to you. Go ahead.

5 MR. CHRISTMAN: Thank you, Jay. As you said, in
6 this session we will be assessing the impact of MSSP ACOs
7 on spending and utilization for post-acute care. And
8 again, as you point out, I would like to acknowledge the
9 many contributions of Luis Serna, Jeff Stensland, and David
10 Glass to this work.

11 As an overview, today's presentation will have
12 three parts. First, I will review why post-acute care is
13 seen as an opportunity for ACOs to produce savings.
14 Second, I will briefly review prior analyses of MSSP ACOs
15 by MedPAC and others to provide a frame of reference. And
16 finally, I will walk through our new analysis, looking at
17 the impact of MSSP ACOs on PAC and acute care hospital
18 spending.

19 Starting with the first point, ACOs have sought
20 to address PAC services because they are used frequently
21 and account for a significant share of Medicare
22 expenditures. About 40 percent of hospital discharges are

1 followed by a stay at a SNF, home health agency, IRF, or
2 LTCH. Payment for these services accounted for \$59 billion
3 in Medicare fee-for-service expenditures in 2017.

4 MedPAC and others have long noted that spending
5 for PAC services varies widely across geographic regions,
6 often demonstrating more variation than other Medicare
7 services. These variations suggest inefficiency and
8 potential overuse. In addition, PAC services may be a good
9 opportunity for ACOs to improve care because these
10 providers overlap in the services they provide and the
11 patients they serve. Medicare operates separate payment
12 systems for each setting, despite these overlaps. These
13 factors raise concerns about whether patients are being
14 served in the most appropriate and lowest cost site of
15 care.

16 There have been multiple studies of ACOs.
17 Generally they have found that ACOs appear to lower
18 spending growth for acute hospital care and PAC services
19 relative to non-ACO populations. Acute care hospital
20 services and PAC generally account for the majority of ACO
21 spending impacts, and relatively little impact is found in
22 other payment systems.

1 For example, one study by McWilliams and others
2 found that MSSP ACOs reduced the per beneficiary spending
3 growth by about \$197, equal to about 2 percent of 2014 Part
4 A and B spending.

5 As you may recall, MedPAC also published an
6 examination of MSSP ACOs in our June 2019 report. Our
7 analysis found that expenditures for beneficiaries assigned
8 to an MSSP ACO increased slower than a comparison
9 population. Over a four-year period, the rate of growth in
10 Medicare expenditures was 1 to 2 percentage points lower
11 for the MSSP ACO group.

12 It is worth noting that the spending impacts
13 measured in these analyses do not include MSSP shared
14 savings payments to ACOs. Including these payments would
15 raise Medicare spending for ACOs and bring their
16 expenditure growth closer to the trend of the comparison
17 populations.

18 The analysis of PAC spending and utilization I am
19 about to present builds on the analysis of MSSP ACO
20 spending we presented this spring. As we discussed in the
21 last cycle, measuring ACO savings requires caution because
22 assignment to an ACO can change over time. Our analysis

1 found that assignment could be affected by service use,
2 which, in turn, can be a function of patient health status.
3 As a result, it is appropriate to use an "intent to treat"
4 approach that holds beneficiary assignment constant across
5 the period studied.

6 In this approach, beneficiaries are assigned to
7 two groups. The first is our treatment group. This
8 consists of beneficiaries who were in an MSSP ACO in 2013.
9 The second is our comparison group. This consists of fee-
10 for-service beneficiaries in the same market as ACOs, and
11 they are weighted to match the ACO population for
12 demographic and clinical factors.

13 In the intent to treat approach, we follow the
14 same beneficiaries across time. As a result, no new
15 beneficiaries enter our cohort after 2012 and the average
16 age of the beneficiaries in our study increases, and we
17 expect average spending to increase for both groups every
18 year as a result.

19 This analysis measures the impact of ACOs by
20 comparing the growth in expenditures for these two groups.
21 If the ACO group has a lower growth in expenditures than
22 the control group, than this relative reduction may be

1 thought of as a savings, while if the reverse is true, ACOs
2 would be more expensive than traditional fee-for-service.

3 There is more about why we used intent to treat
4 in the paper. We discussed this issue in more detail last
5 spring, and we will gladly take any questions you have
6 about this approach.

7 I would also note that this analysis, again, does not
8 include the shared savings payments made to ACOs that
9 qualified for them. If they were, the ACO spending growth
10 would be higher.

11 This slide compares the growth in expenditures
12 for our two groups of beneficiaries for three Medicare
13 services: acute inpatient hospital, skilled nursing
14 facilities, and home health care. The first and second
15 columns in the red box indicate the spending growth for
16 these two groups, and comparing these two columns indicates
17 which group of beneficiaries had a lower growth in
18 expenditures. The third column in the yellow box shows
19 this difference in absolute dollars.

20 As you can see, for all of these services the
21 MSSP ACO group had lower expenditure growth than the
22 comparison group, suggesting some savings for the MSSP

1 ACOs.

2 From the bottom line on the chart, you can see
3 that, across these three services the MSSP ACO population
4 had spending growth that was \$98 lower than the comparison
5 group over this period. Of this \$98 relative difference,
6 about \$69 of it was attributable to lower growth in acute
7 inpatient hospital spending. SNF spending increased by \$23
8 less for the MSSP ACO group, and home health spending
9 increased by \$6 less.

10 The last column on the right gives you a sense of
11 the decrease compared to the average Medicare spending for
12 a beneficiary during the period. They indicate that on
13 average, spending for MSSP ACO beneficiaries was 1 to 2.8
14 percentage points lower relative to the average spending in
15 each of these categories over this period.

16 This next slide compares the growth in PAC
17 utilization for our two groups of beneficiaries, and the
18 columns follow a format similar to the previous slide. The
19 unit of measurement here is the number of PAC encounters
20 per 100 beneficiaries, and PAC encounters include a SNF,
21 IRF, or LTCH stay and home health episodes.

22 As you can see by looking at the third column,

1 for all of these services the MSSP ACO group again had
2 lower utilization growth than the comparison group.
3 However, the relative difference is fairly small. The
4 overall growth was lower by 0.2 encounters per 100
5 beneficiaries or less.

6 The fourth column displays the difference in
7 Column 3 relative to the average number of PAC encounters
8 for these categories. And as you can see, the difference
9 in utilization growth is modest, equaling 1 percent or less
10 of the average utilization in each of these categories.

11 It is notable that the relative difference in
12 utilization for SNF, the percentage in the last column, is
13 less than the relative decline for SNF spending on the
14 prior slide. This suggests that the frequency of admission
15 to a SNF has not declined much, and that much of the
16 decline in spending on the prior slide is due to fewer days
17 of SNF care under Medicare's per diem PPS for SNFs.

18 We observe a similar pattern in looking at the
19 change in discharges to PAC from the hospital over time.
20 It appears that MSSP ACOs have not significantly slowed the
21 frequency of PAC use, suggesting the bulk of the savings we
22 showed in the prior slides are due to lower spending per

1 PAC stay. This slide examines how the rate of
2 hospitalization has changed, and how the incidence of PAC
3 use after hospitalization has changed.

4 This table shows that all hospitalizations with
5 PAC increased at a slightly lower rate for the MSSP ACO
6 group, by less than 0.1 discharges per 100 beneficiaries,
7 as you can see on the third column of this chart.

8 In contrast, hospitalization without PAC,
9 experienced a more significant slowdown, as discharges in
10 this category increased by 0.3 hospitalizations per 100
11 beneficiaries less for the MSSP ACO group.

12 Overall, this chart suggests that ACOs have
13 modestly reduced the rate of hospitalization for
14 beneficiaries, but most of this reduction is due to a
15 slowdown in hospitalizations that were not followed by PAC.
16 It appears that MSSP ACOs have not reduced the growth in
17 PAC use after hospitalization by a meaningful degree.

18 To review, our analysis found that MSSP ACOs
19 appear to have slightly slowed spending growth in acute
20 hospital and PAC services over a four-year period relative
21 to a comparison population. Most of any slowdown was in
22 acute hospital services, and PAC spending accounted for a

1 relatively smaller share of the impact.

2 To the extent that MSSP ACOs had an impact, they
3 did slightly slow the growth in SNF and home health care.
4 However, the greatest impact for PAC appears to be for SNF,
5 and it appears that most of the savings have come from
6 shorter SNF stays, and not less frequent SNF admission.

7 Finally, it does not appear that MSSP ACOs had
8 any significant effect on PAC referral patterns after
9 hospitalization. There was a slight decline in PAC use
10 after hospitalizations, but the magnitude of the decline
11 was small and does not suggest that ACOs are aggressively
12 curbing PAC use or moving patients to less costly PAC sites
13 when feasible.

14 This analysis suggests several questions that
15 Commissioners may want to discuss. First, why have ACOs
16 had such a limited impact on PAC utilization? What change
17 to the MSSP would encourage ACOs to reduce unnecessary PAC
18 utilization? And finally, will the shift to two-sided risk
19 improve incentives for PAC program savings?

20 This completes my presentation, and we look
21 forward to your discussion.

22 DR. CROSSON: Thanks, Evan. This is new

1 information, or relatively new information. I think in the
2 past we've thought that there was a larger impact on PAC
3 spending than this analysis shows, marginally. And so the
4 thinking was like, well, this is low-hanging fruit, if you
5 will, because for an ACO, in effect, particularly one that
6 involves physicians and hospitals and their spending, post-
7 acute care spending is somebody else's money, and therefore
8 might be the first area of focus for an organization with
9 risk, or with just upside.

10 This data suggests that that may not be as true
11 as we thought in the past. And so the questions you have
12 asked here are good ones, and that has to do with why not?

13 Jon, do you want to --

14 DR. PERLIN: Yeah, it is exactly to this point.
15 I think you've framed it up terrifically, and so my
16 question is this: Is it possible that there are some
17 unmeasured factors that might be extraordinarily important?
18 I think there's -- unless I'm reading the research, which I
19 think is absolutely terrific, incorrectly, there's a sort
20 of baseline assumption that the PAC encounters that occur -
21 - or the PAC encounters that occur are distributed to the
22 beneficiaries in an equal and available manner. You know,

1 is there a way to correct for the availability or
2 unavailability of the best, the right level of care for a
3 particular beneficiary? Just to give it a little more
4 tangible aspect, if I have a patient in a hospital and I'm
5 part of an ACO and I've got a choice between a higher level
6 of care or no post-acute care, I will revert to the higher
7 level of care. And, unfortunately, those resources aren't
8 uniformly distributed.

9 Similarly, one could imagine a situation in which
10 family supports may vary and a patient doesn't go to the
11 lowest level of care that's appropriate but, in fact, to a
12 higher level of care. So I'm just wondering if there might
13 be unmeasured factors related to the availability or
14 unavailability of certain PAC resources or family resources
15 that, in fact, exert a greater impact on the proactive
16 management within the ACO, so directly to your question.

17 DR. DeBUSK: On that, actually, I think intent to
18 treat would see through that because you would have --
19 let's say there is, you know, four LTCHs in a market, so
20 there are all these -- and three IRFs, so there are all
21 these expensive options. In their intent-to-treat model,
22 they take the 2013 ACO member, but then they pull a

1 clinically equivalent member into the other cohort from
2 that same geography. Is that correct? It's from the same
3 MSA.

4 DR. PERLIN: That's correct.

5 DR. DeBUSK: So in theory, those four LTCHs and
6 three IRFs are within that beneficiary's grasp as well.

7 DR. PERLIN: I wonder if it wouldn't correct for
8 PAC versus no PAC, but not necessarily level of care.

9 MR. CHRISTMAN: I guess I'm not sure I am
10 entirely following your question, but what I would say is
11 that certainly moving patients out of the higher-cost
12 settings has been something that people have speculated
13 would be something ACOs did. And, you know, I guess we
14 haven't observed much of that, and I think that's been
15 broadly consistent with other studies.

16 But I guess the other point I would make is in
17 terms of ACOs and post-acute care and whether they're going
18 to make a difference, of the \$59 billion that's in PAC, 51
19 of it is in home health and SNF. So if they're going to
20 get serious dollars out of this, it's going to come out of
21 two categories of providers that are pretty broadly
22 available, or at least as broadly available as any Medicare

1 service. And I think that, you know, the result we find
2 here is that even for these relatively common, broadly
3 available services, they have not significantly shifted
4 utilization.

5 DR. CROSSON: Okay. Further questions? David.

6 DR. GRABOWSKI: On this point, I think, Brian,
7 your response to Jon was correct on sort of the area
8 resources, like the presence of LTCHs and IRFs.

9 The second part of his question, however, I think
10 is -- he's spot on that there may be real differences there
11 about, you know, family supports, income, resources that
12 are unobserved, and it's unclear to me -- I'll talk more in
13 the second round, but I don't know if the intent to treat,
14 if you're following this individual out over time, if that
15 actually gets at some of those issues. And we can come --

16 DR. DeBUSK: I think you and I are [off
17 microphone]. I think you and I are going to have a similar
18 -- because I have a similar question about intent to treat
19 along the same line and, Jon, arguably along your line,
20 too. Let's say I have a 75-year-old frequent flyer
21 diabetic and they get attributed to the ACO, obviously,
22 because they're showing up to the doctor's office, showing

1 up to the hospital.

2 Now, in their intent-to-treat model -- which I do
3 like overall; I'm on board -- you're going to have to go
4 from that same MSA and get another 75-year-old diabetic who
5 didn't frequent fly enough to be attributed to the ACO, or
6 maybe they did but their pattern was erratic. For some
7 reason or another, they weren't attributed to the ACO. I
8 would argue you've got a little bit of a bias there because
9 the attributed person in that cohort is going to -- even
10 though they're both 75-year-old diabetics, to get
11 attributed you have to have certain characteristics, again,
12 a frequent fly is my example.

13 I'm wondering if there's a bias where, when you
14 do this calculation, it's going to make the ACO-attributed
15 people look a little bit more expensive just because the
16 non-attributed people gained the benefit of -- in some
17 cases they're ghosts. I mean, we never see them.

18 DR. STENSLAND: I think our comparison group is
19 all attributed people. They're just attributed to somebody
20 else. So we're comparing attributed to attributed, and if
21 you never saw anybody, you're not in either group.

22 DR. DeBUSK: Then what if you've got a 2013 ACO

1 group and then you've got a group that wasn't attributed to
2 an ACO in 2013?

3 DR. STENSLAND: So they were attributed to non-
4 ACO doctors. They saw a non-ACO --

5 DR. DeBUSK: Okay. So you still have to have
6 equal levels of attribution or comparable levels of
7 attribution. Okay. So that would save them on that.

8 DR. PERLIN: And that's where the unobserved
9 variable, such as family characteristics or potentially
10 momentary availability of a particular type of resource,
11 you know, might --

12 DR. DeBUSK: Large numbers should fix that,
13 though. I would think that would average out, wouldn't it?

14 MR. CHRISTMAN: I mean, I think it's certainly
15 true that the results might be disturbed by unmeasured
16 factors. But I guess another way to -- the best answer I
17 can come up with your question, you know, is there's
18 900,000 people in the ACO group and about 4 million in the
19 comparison group. And to the extent that the factors
20 you're talking about are correlated with patient
21 demographics and clinical conditions, we are picking up,
22 you know, differences in family income and living

1 situation.

2 And I think one thing that happens with post-
3 acute care is, you know, the pathways aren't -- the
4 clinical pathways aren't as well understood as people
5 think. I appreciate concerns about things like caregiver,
6 but probably the poster child for things not always
7 balancing the way you would think is, you know, in 2006 CMS
8 began enforcing the standards for being an IRF more
9 strictly, and some patients were pushed out. And, you
10 know, people were thinking, well, this is going to push a
11 lot of individuals into SNF because, you know, that's the
12 progression people thought would happen. And there were a
13 surprising number, I think it was, hip and knee patients
14 who ended up in home health, and that was an instance where
15 people might have said, well, can they go home because they
16 don't have -- you know, do they have a caregiver? And I
17 think in that instance at least people were surprised that
18 the jump was not IRF to SNF; it was IRF to home health.

19 And so I do appreciate your point that some
20 factors like caregiver might affect placement. On the
21 other hand, I think we've seen some things that surprise us
22 about the substitutability of these locations.

1 DR. CROSSON: Okay. Additional questions? I see
2 Marge, Brian, Bruce, Sue.

3 MS. MARJORIE GINSBURG: There is such little
4 impact between the ACO and non-ACO that it occurred to me
5 that, you know, maybe the sweet spot has been reached.
6 Maybe, in fact, the levels of use of PAC are appropriate
7 for this population and their medical needs.

8 So do we have any other -- we always compare ACO
9 versus non-ACO beneficiaries. Do we have this information
10 at all for patients who are part of MA plans? We have
11 these two groups, and we seem to keep them so separate,
12 it's very hard for me to understand what is a desirable
13 level of PAC use.

14 MR. CHRISTMAN: So, narrowly, about -- what do we
15 know about MA? My colleague, Andy Johnson, covers that
16 work for us, and he's done a lot of work looking at the MA
17 encounter data for SNF and home health. And I think we
18 still struggle with its completeness. We still see a lot
19 of problems. You know, I think there is some work that has
20 been done with the data. I think it suggests, you know, in
21 some instances that it's lower. But I think from, you
22 know, the Commission's perspective, we heavily caveat that

1 and say that, you know, we're kind of spoiled on PAC
2 because we can compare the assessment data people submit
3 for all their Medicare patients, MA and non-MA, and fee-
4 for-service to this encounter data and sort of use it as a
5 ground truth test of how complete is the data. And when we
6 look at it, we find a lot of stuff is missing from the
7 encounter data.

8 So there's stuff out there, but, you know, I
9 think our feeling is that it needs to be handled with care,
10 and we're still kind of waiting for the data to get better.

11 MR. SERNA: And I'll add that we do know that MA
12 plans have more utilization management tools at their
13 disposal so they can push down on rates, they can do things
14 like prior authorization after a certain number of days,
15 things you won't see in fee-for-service.

16 DR. CROSSON: Brian.

17 DR. DeBUSK: So I had two questions. First of
18 all, great report. I had two questions.

19 First of all, you know, when you look at -- and I
20 asked this I guess two years ago. When you look at the
21 pool of ACO participants, you know, we'll come up with a
22 gross number. Well, the savings, we think, using the

1 intent-to-treat model, is 2 percent. Do we have a feel for
2 the dilution that occurs? I do think there are at least
3 some people in the ACO program who don't really understand
4 what they're getting into. There's more of a novelty
5 approach as opposed to a transformational approach. Have
6 we looked at -- for example, when we look at hospitals,
7 sometimes we'll look at the best performers, and we'll
8 define a criteria. Are the results 2 percent savings plus
9 or minus 1 percent? Or are the results 2 percent savings
10 plus or minus 15 percent where there is maybe a group of 10
11 or 20 percent that are just outperforming -- you know. Do
12 you have a feel for that?

13 MR. SERNA: So I think in general we have
14 observed that in high utilization areas there are more ACO
15 savings, so you are going to get more savings in those
16 high-use areas than you are in the low-use areas.

17 DR. DeBUSK: But, no, I'm asking have you tried -
18 - Jeff knows. You got it.

19 DR. STENSLAND: My guess is it's probably true
20 because certainly anecdotally we hear some ACOs where the
21 physicians are much more engaged than other ACOs where the
22 physicians might not even know they're in an ACO or not.

1 And so you would expect there to be some different
2 performance, and we're looking at the average performance.
3 But that is something that we just haven't been able to
4 quantify. Like we don't have any variable we can stick in
5 our model right now that says, oh, you're really a top
6 performer or you're engaged or something like that.

7 DR. DeBUSK: Well, let's say you came back and 2
8 percent is the number using intent to treat. How would it
9 color your opinion if I said, okay, the top 20 percent of
10 the performers weren't 2 percent, they were 3.5 percent?
11 Or if I said the top 20 percent of the performers weren't 2
12 percent, they were 15 percent? How does that color your -
13 -

14 DR. STENSLAND: I don't know. They're not 15
15 percent, but --

16 DR. DeBUSK: That might not be what I'm saying.
17 I'm trying to be hyperbolic.

18 DR. STENSLAND: Part of the difficulty here is a
19 lot of these are small places, like 10,000 or 15,000. So 5
20 percent of the time you're going to have a 4 percent shift.

21 DR. DeBUSK: Okay.

22 DR. STENSLAND: And a 4 percent shift is like

1 fantastic if you're an ACO, if you can get a 4 percent
2 shift. But you have a 5 percent random chance of getting
3 it anyways.

4 DR. DeBUSK: Right.

5 DR. STENSLAND: So that whole --

6 DR. DeBUSK: Oh, trust me, I feel your pain.

7 [Laughter.]

8 DR. STENSLAND: Okay. That makes it difficult.

9 DR. DeBUSK: I'm just trying to get to if there
10 was some way to systematically push out maybe the people
11 who are in it for the novelty or, you know, for the
12 cocktail party conversation of, yeah, we started an ACO,
13 and maybe find the ones that are really performing. And I
14 realize it's a little bit of a self-defining variable. I
15 just wonder if there's a treatment we could use, you know,
16 analogous to what we do for hospitals. You know, we
17 calculate the top performers, Medicare performers, and try
18 to treat them differently or at least use them in our
19 analysis. Anyway, just a thought, because I've often
20 wondered how much variation is there.

21 My second question was this: You're not seeing a
22 lot of ACO-PAC rationalization. But if you look at BPCI

1 and lower joint replacement, the results were dramatic, I
2 mean double-digit PAC utilization.

3 Is there any way from claims-based data to go
4 back and see did we -- did that actually happen, say, in
5 ACOs with joint replacement, too, and it just got diluted?
6 You know, if you've got double-digit savings and a 10
7 percent service, all of a sudden you've got single-digit
8 savings.

9 DR. STENSLAND: I'm deferring this one to Amol,
10 who knows more about lower joint and ACOs than I think
11 anybody else around the table.

12 DR. NAVATHE: So we've done a few different
13 analyses. I've looked at the overlap and interactions
14 here. And, overall, ACOs don't seem to have tremendous
15 impact on PAC, regardless of condition. In fact, we've
16 also done a study where we looked at hospital ACOs, because
17 you would think that, because of locus of control,
18 hospitals that are in ACOs would have more of an incentive
19 to change their discharge processes. And for non-
20 attributed beneficiaries, they have nil effect, even nil
21 effect on lower extremity joint replacement. We looked
22 specifically at that.

1 So I think it seems -- my reading of the
2 literature is somewhat similar to what they have here,
3 which is in general it looks like the predominant part of
4 the ACO effect is on avoiding hospitalization as opposed to
5 on managing the hospital-to-PAC transition, which tends to
6 be much more focused on what the hospital is doing and only
7 a subset of ACOs have hospitals in them. And so hospital-
8 targeted programs like bundled payments tend to have much
9 stronger effects on the PAC transition.

10 DR. DeBUSK: And it's my impression that BPCI for
11 lower joint, that there was a dramatic rationalization in
12 PAC. Is that --

13 DR. NAVATHE: There's a big difference, right.
14 It's about \$1,100 of savings per lower extremity joint
15 replacement.

16 DR. DeBUSK: Out of a \$22,000-ish bill?

17 DR. NAVATHE: Initial estimates were off a base
18 of \$30,000. That was the first Lewin Group study that was
19 done. Since then, the estimates have come down a little
20 bit as the overall spending on joint replacement episodes
21 has come down. So now it's closer to \$22,000, and the
22 estimates are probably closer to \$500 to \$600 per episode.

1 [Inaudible comment.]

2 DR. NAVATHE: Total, but the majority of that is
3 shifting SNF to home health.

4 DR. CROSSON: Okay. I've got Bruce, Sue, and
5 Jonathan. Bruce.

6 MR. PYENSON: Yeah, just a data question related
7 to CJR and BPCI. In the hierarchy of a bundle versus an
8 ACO, are we including or excluding the PAC from such
9 bundles in our analysis?

10 MR. CHRISTMAN: I guess I'm -- I'm not sure I'm
11 following your question. This includes all claims for both
12 populations, so we haven't dropped them if they're in BPCI.

13 MR. PYENSON: Okay.

14 DR. CROSSON: Sue.

15 MS. THOMPSON: Thank you. You know, when we say
16 ACO, it's a term that has many definitions. And the data
17 that we're using is from 2012 to 2016, so I just want to
18 clarify how many different ACOs, what kinds of ACOs,
19 geographically how many lives were covered. Just give me a
20 little more description there.

21 MR. CHRISTMAN: I think the number we have on the
22 paper is there's about 560 ACOs. You know, the sample we

1 worked with reflected all of the ACOs that were in effect
2 in 2013. So I can't really off the top of my head speak to
3 the geographic distribution of those, but, you know, it was
4 the whole program.

5 MS. THOMPSON: So in 2013, MSSP, upside risk,
6 downside risk?

7 MR. CHRISTMAN: I believe most were in upside
8 risk.

9 MS. THOMPSON: Upside only?

10 MR. CHRISTMAN: I think there was -- yeah.

11 MS. THOMPSON: All upside only? Okay. So what
12 do we know about the comparison of ACOs with upside risk
13 only compared to those that have taken upside/downside risk
14 at 80 percent, 100 percent? Do we have any analysis of the
15 differences in performance and utilization of SNF in those
16 two populations?

17 MR. SERNA: Well, I think we have the -- there's
18 the Next Gen evaluation, which basically is upside and
19 downside risk, and that found savings as well. The
20 magnitude is similar. So there have been different
21 evaluations, including this one, where the magnitudes seem
22 to be directionally consistent. The ACO investment model,

1 the valuation for the rural ACOs, the Next Gen evaluation,
2 MSSP. So in the neighborhood of 1 to 2 percent seems to be
3 consistent.

4 MS. THOMPSON: And as we think about utilization
5 of PAC we're talking about admissions to PAC. Have we
6 looked at length of stay, managing the length of stay in
7 PAC, and just talk a little more about that.

8 MR. CHRISTMAN: Sure. I mean, the big one is
9 when folks have looked at SNF length of stay it's come down
10 a little bit, and that's where it appears to be that the
11 biggest bucket of dollars for PAC are coming from. I mean,
12 the difference is, gosh, I think it's somewhere between
13 half a day and a day in the leverage length of stay, so
14 it's something. But I think, you know, something that's
15 leading to a net reduction, I think that's sort of the
16 biggest thing for PAC.

17 MS. THOMPSON: Thank you.

18 DR. CROSSON: Jonathan.

19 DR. JAFFERY: Yeah, thanks. So, first of all,
20 Brian, I started with an ACO seven years ago and I don't
21 think I've yet found an opportunity to bring that up at a
22 cocktail party.

1 [Laughter.]

2 DR. JAFFERY: So in the reading you talk about
3 one of the reasons for thinking about PAC use is that there
4 is a lot of variability across the country. And so I
5 wonder if you looked at this in looking at that cut. Are
6 there ACOs in areas that are high PAC spend at baseline?
7 In fact, going back to this notion that we've seen over and
8 over again, where it's the baseline high cost ACOs that are
9 able to get savings at least early, which is, I would
10 argue, we are still talking about here, even over four
11 years. So were you able to look at that, or could you tier
12 it that way?

13 MR. CHRISTMAN: I believe in prior analysis -- we
14 haven't looked at specifically in terms of the distribution
15 of PAC spending, but we looked in terms of overall
16 spending, and generally the two are correlated. And I
17 believe it is sort of, in general, when you guys looked at
18 it, there's been a little bit more action in the higher
19 baseline spending areas. And so, you know, I think that
20 would support the idea that, you know, probably the areas
21 with higher PAC spending are doing a little bit better than
22 average.

1 DR. JAFFERY: I mean, I guess, that seems like a
2 really crucial question, if we're thinking that there's an
3 opportunity here to because of the variability that trying
4 to understand that in the places that vary and are high
5 cost, maybe we actually did come down a significant amount.
6 I'm thinking about the CJR experience.

7 So I don't think our ACO has had a significant
8 amount of change in PAC spending, but I do know that when
9 we were participating in CHR we went from, you know, 55
10 percent -- I mean, that's where we made all the savings.
11 We went from 55 percent SNF admission to 20 percent, pretty
12 quickly.

13 DR. CROSSON: Okay. Seeing no more questions we
14 will move on to the discussion period, and I think, David,
15 you are going to kick it off.

16 DR. GRABOWSKI: Great. Thanks, Jay. I think the
17 encouraging part about this report is that the results were
18 largely confirmatory. You found there were savings, there
19 were savings in inpatient and post-acute, and the savings
20 were smaller, if I could can use an academic word, modest.
21 We use that when we don't want to confess that our results
22 are small.

1 [Laughter.]

2 DR. GRABOWSKI: Something in the 1 to 2 percent
3 range. And think the difference between this work and
4 maybe some of the research in the literature is just the
5 distribution that was in inpatient versus PAC.

6 So I wanted to do two things with my time. The
7 first was kind of make a policy point and the second was
8 push a little bit on some of the methods.

9 First, on the policy side, Sue began this kind of
10 line in her round of questioning, but an ACO is not an ACO
11 is not an ACO, and you're looking at the MSSP over the 2012
12 to 2016. As you note in the chapter, we had this dramatic
13 change in the program with the Pathways to Success. It
14 changed beneficiary assignment. It changed how we set the
15 benchmarks. It changed, you know, going from one-sided to
16 two-sided risk. It's basically we've taken the snow globe
17 and we shook it, and it's a whole new ballgame here.

18 And so how much can we learn from this model, and
19 I think Sue was already pushing you on that, kind of that
20 has, you know, one-sided risk and we know all the features
21 of MSSP over that period, and apply them to kind of what we
22 have going forward. And I think, as a Commission, we will

1 need to think about that very critically, of how do we kind
2 of connect the dots. It's not clear to me that the savings
3 we observed under the MSSP are going to necessarily apply
4 going forward. In fact, there might not be savings going
5 forward.

6 And so I just think we have to acknowledge that.
7 And, yes, we can learn from this but the ability to apply
8 it directly just isn't there.

9 So the second point, and this will be a little
10 wonky so I apologize in advance, there's a real debate in
11 the literature about kind of the right methods to use in
12 evaluating ACOs. You guys use this intent-to-treat
13 approach, where you take beneficiaries who are attributed
14 and then follow them -- continuously attributed and follow
15 them out over time. And as you note in the chapter, there
16 is real potential for bias here, and that individuals who
17 are continually attributed are going to have health care
18 costs at some point, and potentially die, and we see this
19 kind of increase in their spending. You try to address
20 that in the chapter by taking out the decedents, or
21 including the decedents, and try to run some checks there.

22 The way that the literature has dealt with this,

1 and largely the McWilliams work, has been to use a
2 different intent to treat, where they take kind of, at the
3 outset, those physician practices that are in the ACO, kind
4 of assign them at that time, and then, you know, that's the
5 intent to treat, that they're in whether they drop out of
6 the ACO or in the ACO. They are in from the beginning, and
7 that's the intent to treat. And then he uses kind of a
8 repeated or a cross-section each year. Rather than
9 following the same individuals it is a new set of
10 individuals in each year.

11 And I think the encouraging part is that you're
12 getting similar results, but I'm a little worried -- and
13 there was a nice NBER working paper by McWilliams and
14 Chernew and others in that group, that suggest, you know,
15 there's real potential bias here with the approach we're
16 using. So I don't want MedPAC to get out ahead of this
17 with an approach that I think is real susceptible to bias.
18 And they have a great figure. Jay, you wouldn't let me use
19 overheads for my comments, so I'll just describe it to you
20 and then maybe I could forward it around.

21 But in the NBER working paper they show Medicare
22 spending over time, and with this repeated cross-sections

1 or cohort it's very flat, or maybe it increases a little
2 bit with the secular increase in Medicare spending. With
3 this group that's continually attributed, it's flat and
4 then it kicks up right towards the end, and that's kind of
5 what we would expect, you know. As you're sort of
6 continuously attributed at some point you're kind of
7 approaching health care costs.

8 And so I really worry about this kind of group.
9 It's encouraging you're getting similar results, but I just
10 worry about using this as the MedPAC approach. We know we
11 have a MedPAC approach to measuring markets and we have a
12 MedPAC approach to quality measurement. I wouldn't want
13 this to be the MedPAC approach to evaluating ACOs.
14 Precedent is really important here. And so I don't think
15 there's anything wrong with these current results, but I
16 just worry about us, you know, going forward with a method
17 that I think is going to leave us susceptible to some
18 criticism.

19 So I will stop there and I will open it up.
20 Thanks.

21 DR. CROSSON: Thank you, David. I mean, one
22 thing -- we'll get into discussion further, but one thing

1 that's struck me so far in the conversation is the
2 differential results that appear to accrue from the bundled
3 payment experiments. And the question, in keeping with
4 this first question here, is there something we can learn
5 there? Is this condition-specific or is it something about
6 the payment incentives differential? What do people think?

7 Brian.

8 DR. DeBUSK: I think specifically to answer your
9 question, I think there is tremendous power in being able
10 to look at a physician and say, "You're responsible for
11 this orthopedic episode from start to finish." And I do
12 think one of the things we won't measure, that occurred in
13 the lower joint BPCI is the patient selection and the
14 grooming. You know, a patient with a BMI of 50 doesn't
15 typically get to go through a BPCI, but they're going to go
16 through a hospital ACO.

17 But I do think we shouldn't underestimate the
18 behavioral impact of looking an orthopedic surgeon in the
19 eye and saying, "Your target price is \$22,000. If you use
20 PAC responsibly, if you do these other things responsibly,
21 you are going to get \$500. You are going to get \$750." It
22 does change -- it dramatically changes orthopedic surgeon

1 behavior, and I think that's what's missing in ACOs. I
2 almost feel like they're too nebulous for a lot of
3 providers to understand, if I do this I gain this benefit.
4 I just don't think there's a connection there.

5 DR. CROSSON: Jonathan.

6 DR. JAFFERY: Yeah. So maybe building on that a
7 little bit, I think if you think about a hip and knee and
8 you're working with orthopedic surgeons it is very well
9 defined, and you are not really fundamentally changing what
10 they're doing. There may be something about the patient
11 selection and there may be some things, but if you think
12 about where they're going to find savings it really was --
13 it was in moving away from SNFs. The main cost to the
14 bundle is the DRG, which didn't really change if they were
15 going to be part of the program. But beyond that, you are
16 not fundamentally changing how they are delivering care.

17 What we are talking about with the ACO is a
18 completely different thing. We're talking about
19 fundamentally changing an entire care model from one way
20 we're focused on, you see somebody in clinic, you submit a
21 claim, you get paid, you don't repeat. And the entire
22 structure, the entire system is set up, and it's been that

1 for decades.

2 I think what we're seeing here is that real
3 change takes time. I'm actually a little encouraged to see
4 that we're seeing some change in admissions. And it may be
5 that the amount of time that we're seeing is not quite
6 enough. I mean, we saw that experience coming from not a
7 high spending area. You know, after four years we're just
8 starting to see some changes -- not enough to get shared
9 savings -- and then year five and year six and year seven
10 starts to increase.

11 Dana is not here but her experience in Blue Cross
12 Blue Shield of Massachusetts suggests the same thing, that
13 year one had some changes in some low-hanging fruit but it
14 was year four you were starting to see fundamental things,
15 and by year eight you were seeing real changes.

16 So I don't think we can underestimate the fact
17 that what we're talking about with ACOs, unlike the
18 bundles, is an actual care model change that is hugely
19 fundamental to how we deliver care. And, you know, it goes
20 beyond the physician engagement piece.

21

22 I mean, I would guess that there are a bunch of

1 folks at UW who don't know we're in an ACO and couldn't
2 define what that means. And sometimes that really hurts
3 our ability to do things and sometimes it may not matter so
4 much, because what we're doing is putting in place a team-
5 based care model. And they may not know we're an ACO but
6 they know that now they have behavioral health and primary
7 care and that helps their patients get point of care
8 behavioral health, and that helps improve their quality of
9 care and decrease bad outcomes and lower costs.

10 So I will stop there.

11 DR. CROSSON: Thank you. Amol.

12 DR. NAVATHE: So I have several thoughts and I'm
13 going to try to limit what I say here. I think one thing,
14 just to respond to David, so I think my sense is the reason
15 that they are probably getting the same results is that
16 they are following the same pattern in the comparison group
17 of continuous attribution that will dull some of that
18 effect, which makes the bias probably smaller than it would
19 be otherwise. So I think that helps you guys out, which is
20 good.

21 That being said, I think the notion of selection
22 here is important, and I think there are a couple of pieces

1 that are worth probably digging into a little bit in
2 follow-up work. So one thing is I think there's actually
3 mixed literature on whether ACO-attributed populations are
4 sicker or more disadvantaged or less disadvantaged. I
5 think I've seen some stuff that suggests that they are more
6 clinically vulnerable. I have seen other stuff that ACOs
7 seem to locate in places with less low socioeconomic status
8 and beneficiaries are a less disadvantaged population. So
9 how your population shakes out here would be helpful to
10 actually understand the characteristics of your ACO-
11 attributed group and the comparison group, in terms of few
12 of these types of factors. So clinical risk and other SES
13 factors would be helpful.

14 The other thing I think that we've heard from a
15 lot of folks is some heterogeneity analysis of the ACOs. I
16 think it's kind of interesting, actually. On one hand,
17 this is a voluntary program so we would expect, on average,
18 that ACOs that formed and opted to join would expect to
19 have some impact. And so that, I think, is helpful to size
20 the results or interpret the results.

21 At the same time, you know, some of the
22 heterogeneity analysis that we've heard around higher-

1 spending markets versus lower-spending markets, ACOs that
2 include hospitals versus not include hospitals because PAC
3 is a very hospital-centric thing, I would be helpful.
4 Perhaps also exploring areas where you have greater BPCI
5 participation or CJR participation versus probably a little
6 bit more heavily on the BPCI, since CJR is very focused on
7 one condition.

8 Anecdotally I will tell you, we haven't published
9 this but we are looking at overlap between ACO and bundles
10 in my research group, and we are finding that there seems
11 to be some synergist effect. And so it does probably make
12 sense, actually, to look at that overlap and examine that
13 as a heterogeneity analysis.

14 The last point I wanted to make is to opine, I
15 guess, on the questions a little bit, in the way that Jay
16 has framed, and I think it's interesting because I'm
17 generally very supportive of ACOs. I think it is true what
18 Jonathan has said, that we are seeing increasing results
19 over time, and that's reassuring. I do think that downside
20 risk will help. It does also, at the same time, seem like
21 ACOs are primarily a non-hospital-based mechanism, and the
22 majority of PAC opportunity seems to be a hospital-based

1 mechanism.

2 And so I wonder if ACOs are going to be the right
3 design to attack this problem, relative to complementing
4 them, kind of like, I guess, what CMMI has done to date
5 with both ACOs and bundles, or trying some sort of
6 complementary approach.

7 I think it's, again anecdotally, notable that if
8 you look in the commercial insurance sector, where there is
9 less PAC to be had in the first place, or PAC opportunity
10 to be had, the majority of the larger insurance companies
11 that we have interacted with seem to be pursuing both paths
12 simultaneously rather than one over another. And so that
13 might be also something to learn from, and we're seeing,
14 even in MA we're seeing more episode-based for bundled
15 payment-based approaches.

16 That being said, the one cautionary piece I would
17 note is that there is a lot of condition -- so you asked
18 about the conditions, Jay -- there is a lot of variation in
19 results by condition. To date, we don't see bundled
20 payment type approaches really generating benefits at the
21 level of congestive heart failure and pneumonia and sepsis
22 and the medical condition-based episodes, where it seems

1 like probably there is a lot more opportunity that you see
2 outside.

3 DR. CROSSON: Okay. Warner and Brian, and that
4 will probably be the last comments.

5 MR. THOMAS: Just briefly, I mean, I think one of
6 the things is that, I think going to Jonathan's point, is I
7 think you're going to see this continue to change over
8 time. So it would be interesting to see, the next time we
9 look at this, whether there is a change as these
10 organizations continue to get more traction.

11 I think the other thing is, I would really be
12 interested, you know, going to Brian's point about what are
13 the best reformers and what do they look like, what are
14 they doing? You know, what is the materiality of the
15 impact? I know that, you know, we've seen a pretty big
16 change in our ACO post-acute utilization, but we have set
17 up a structure to deal with it.

18 We looked at -- when we first started this
19 process we used, you know, about 600 different post-acute
20 care providers that we referred to. We went through a
21 process. We sent out RFPs, narrowed it down to 150, and
22 then we narrowed it down to about 80, and we have seen a

1 material change in utilization, because we've got better
2 integration with the ones that we work with, and a better
3 kind of feedback mechanism into the rest of the delivery
4 system. And we've seen the same in the CJR. We have seen
5 improvement there.

6 So I think it really depends on whether that's a
7 focus of the ACO, whether they've set up an infrastructure
8 to deal with it, and it would be interesting to see the
9 ones that -- if any of the ones in your research have seen
10 any materiality beyond 2 percent, because my guess is there
11 are some there. It would be interesting to just identify
12 what are the things they are doing that are driving some of
13 that change.

14 DR. CROSSON: Thank you. Brian.

15 DR. DeBUSK: First of all, really nice work. I
16 love your analytics. I do like your intent-to-treat model.

17 I just wanted to echo what Sue and I think what
18 David and a few other Commissioners mentioned, which is
19 this is 2012 through 2016 data. Let's don't read too much
20 into it.

21 I think the beauty of this chapter is the
22 treatment and the analytic work and the fact that it could

1 be applied against future data and not read too much into
2 2012 through 2016.

3 The one thing I would ask -- and thank you,
4 Warner, for your comment on that too -- let's at least
5 explore ideas to try to identify maybe the true believers.
6 Even if there is bias in the result, if we start with just
7 the top 20 percent performers, lo and behold, we're going
8 to get better performance. Who would have thought?

9 But there may still be merit in trying to look at
10 maybe that top 10 or top 20 percent to say are they
11 performing a little better or are they performing a lot
12 better.

13 The other thing I wanted to mention, again, these
14 results look a little critical of ACOs, and here I am
15 defending the method and defending the data and saying,
16 "Hey, keep going." I do think you're going to hit a wall,
17 though, as we go. I hope you guys will closely follow the
18 economics of an ACO too and try to track down what happens
19 when you shed an inpatient -- let's say I am in an enhanced
20 track now under the new models. What happens when I shed
21 an admission? What are the economics of that? I hope we
22 can follow that really, really closely.

1 The fact that providers still like our 87-cents-
2 on-the-dollar payment makes me think that we're well
3 exceeding their variable cost and eating into some of their
4 fixed cost. Again, they seem to case their 87 cents on the
5 dollar aggressively. That being the case, it does make me
6 question the variable cost, and I really do worry about the
7 economics of the shared savings model at around the 50
8 percent point.

9 So if you guys could help us shed some light on
10 that, I would just hate to set out to create a model where
11 someone has to give up an inpatient admission, shed 50
12 percent of their cost to get 50 percent savings, because to
13 me that feels like a lot of wheel spin.

14 So if we could follow that and follow the top
15 performers in future work, I think that would be great.
16 Thanks.

17 DR. PERLIN: If you believe there is a difference
18 over time and then with the introduction of two-sided risk,
19 it becomes more aggressive in terms of the management, I
20 think it really commends the approach, the McWilliams
21 approach of consecutive cross-sections to be able to detect
22 that difference. So I think the intent-to-treat is fine,

1 but just a model that will really allow you to follow that
2 consecutively.

3 DR. DeBUSK: Would it be onerous for them to run
4 it both ways?

5 You know, I'm willing for them to work as hard as
6 necessary.

7 [Laughter.]

8 DR. PERLIN: Well, there's upside and downside
9 risk.

10 DR. DeBUSK: I never liked you, Jon.

11 DR. CROSSON: Well, with that closing comment,
12 Evan, Luis, Jeff, thank you so much for the work. We
13 appreciate.

14 We have come to the end of the prepared
15 presentations and discussion. We now have time for a
16 public comment period. If there are any of our guests who
17 wish to make a public comment on the matters before the
18 Commission this morning, please come to the microphone.

19 [No response.]

20 DR. CROSSON: Seeing none, we are adjourned until
21 the December meeting.

22 Thank you, Commissioners. Good work.

1 [Whereupon, at 11:12 a.m., the meeting was
2 adjourned.]

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