

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

VIA GoToWebinar

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10:17 a.m.

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P R O C E E D I N G S

[10:17 a.m.]

1
2
3 DR. CHERNEW: Hello. Thank you for everybody who
4 is joining us online. This is the March MedPAC meeting.
5 As I'm sure you know, we are coming towards the end of our
6 annual MedPAC cycle, which means we have a lot of work to
7 do this meeting, and so without further ado, we're going to
8 jump into an issue that is important, I think, for all the
9 Commissioners, which is access to care in rural areas. And
10 to present the material, I am going to turn it over to
11 Carolyn. Carolyn, you're up.

12 MS. SAN SOUCIE: Thank you, Mike. Good morning.

13 In this presentation, we'll discuss our work
14 towards fulfilling a congressional request to study rural
15 beneficiaries' access to care. Before I begin, I'd like to
16 thank Alison Binkowski and Evan Christman for their
17 assistance with this work.

18 Also, the audience can download a PDF version of
19 these slides in the handout section of the control panel on
20 the right-hand side of the screen.

21 The House Committee on Ways and Means submitted a
22 bipartisan request for the Commission to update its June

1 2012 report on rural beneficiaries' access to care.

2 The committee also requested information on
3 beneficiaries who are dually eligible for Medicare and
4 Medicaid, reside in a medically underserved area, or have
5 multiple chronic conditions as well as emerging issues that
6 could affect beneficiaries' access to care. We'll come
7 back to you in our next analytic cycle with more
8 information on the specific groups of beneficiaries
9 outlined and any additional, related issues.

10 An interim report is due in June 2021, and a
11 final report is due in June 2022.

12 We have four parts to our presentation today. In
13 the first part, I'll go over direct measures of rural
14 beneficiaries' access to care.

15 We analyzed two sources of survey data for direct
16 measures of access to care to supplement the information
17 from claims data we will go over later in the presentation.

18 First, we used survey data from the MCBS, which
19 suggests that rural and urban beneficiaries have similar
20 satisfaction with access to care. The Commission's
21 analysis of 2018 MCBS data found no substantive differences
22 for several measures of rural and urban beneficiaries'

1 access to care, including identical rates of satisfaction
2 with care, trouble accessing care, and forgoing care.

3 Additionally, the Commission's annual survey of
4 Medicare beneficiaries suggests that rural and urban
5 beneficiaries have similar satisfaction with access to care
6 as well. A similar number of rural and urban beneficiaries
7 reported never having to wait longer than they wanted for
8 an appointment for illness and injury care.

9 While data suggest similar overall satisfaction,
10 some differences do exist, and those differences tend to
11 increase as rurality increases. Based on 2018 MCBS data,
12 most rural beneficiaries are satisfied with their ease of
13 getting to care, but a slightly larger share than urban
14 beneficiaries were dissatisfied with the ease of getting to
15 the doctor from their home, access to medical care on
16 nights and weekends, and availability of specialist care.
17 The higher levels of dissatisfaction may partially be due
18 to the need to travel farther to access care, especially to
19 receive specialty care.

20 Now we'll move on to analyses comparing
21 utilization trends of rural and urban beneficiaries across
22 several types of services.

1 Before we begin discussing information from our
2 analyses of Medicare claims, I wanted to reiterate a
3 subject from our November meeting. As discussed then, the
4 utilization data we present are not risk adjusted nor were
5 they risk adjusted for our 2012 report.

6 Using claims data to risk adjust our utilization
7 analyses may create misleading results.

8 For example, MCBS data suggest that rural
9 beneficiaries are slightly less healthy than their urban
10 counterparts as a higher share of rural beneficiaries
11 reported that their health was "fair" or "poor" in 2018.
12 This finding is consistent with other research that found
13 that, compared with their urban peers, rural beneficiaries
14 have slightly lower life expectancy and have higher rates
15 of smoking, lung cancer, and obesity.

16 However, rural beneficiaries have lower average
17 risk scores than urban beneficiaries, which in theory would
18 imply that they are healthier. This discrepancy leads us
19 to believe that risk adjusting our beneficiary utilization
20 using comorbidities from claims or risk scores could
21 produce misleading results that suggest rural beneficiaries
22 are in less need of care.

1 Now I'll walk through some of the results of our
2 unadjusted numbers.

3 First, I will go over some of the results we
4 presented to you in the fall.

5 Across our utilization analyses, we found that
6 differences in utilization across geographic regions of the
7 country were generally far larger than differences between
8 rural and urban beneficiaries within the same region.
9 However, we did notice a few larger trends as well.

10 Rural beneficiaries had similar inpatient use and
11 higher outpatient use per capita compared with urban
12 beneficiaries in 2018.

13 Rural beneficiaries had fewer E&M encounters than
14 urban beneficiaries in 2018 driven mostly by fewer
15 encounters with specialist physicians. By contrast, most
16 rural beneficiaries had a similar number of primary care
17 E&M encounters compared with urban beneficiaries.

18 Now Brian will go over the E&M data in closer
19 detail with a focus on a new analysis we conducted, one
20 which looked at utilization rates among frontier
21 beneficiaries.

22 MR. O'DONNELL: In response to Commissioner

1 feedback in the fall, we refined our rural categories to
2 include a frontier category. A handful of frontier
3 analyses are included in your mailing materials, and I'll
4 walk through this slide to demonstrate the issues
5 associated with those analyses.

6 As you can see in the table, in 2018, urban
7 beneficiaries averaged 13.4 E&M encounters with clinicians
8 compared with 9.0 for frontier beneficiaries.

9 However, frontier beneficiaries are a small and
10 distinct group of beneficiaries, and at least three factors
11 complicate the interpretation of their service use. First,
12 frontier beneficiaries disproportionately live in low-use
13 states such as Montana and Wyoming. For clinician
14 services, we found that state-level geographic variation
15 explains nearly half the difference between urban and
16 frontier beneficiaries. Second, frontier beneficiaries
17 appear to be slightly healthier than other beneficiaries.
18 And, third, frontier beneficiaries travel much farther to
19 access specialty care, so they may choose to visit
20 specialists less frequently or condense more issues into a
21 single visit.

22 Looking further into the issue of travel

1 distance, in 2018 we found that the median distance an
2 urban beneficiary traveled for an E&M visit with a
3 specialist was 9 miles compared with 26 miles to 58 miles
4 among rural beneficiaries. The difference between rural
5 and urban beneficiaries for visits with primary care
6 physicians was much smaller and, after accounting for
7 travel time, could be negligible.

8 In addition to hospital and clinician services,
9 we also examined two types of post-acute care: SNF and
10 home health care.

11 We found that rural beneficiaries' use of SNF and
12 home health care services per beneficiary was similar to or
13 slightly higher than urban beneficiaries' rates.

14 From 2008 to 2018, SNF use declined among both
15 rural and urban beneficiaries, although it declined about
16 twice as fast among urban beneficiaries. Home health use
17 over the same time period was relatively flat.

18 For both SNF and home health, geographic
19 variation was larger than differences between rural and
20 urban beneficiaries. For example, after trimming outliers,
21 we found that SNF use among rural beneficiaries varied
22 three-fold across states, and home health use varied eight-

1 fold.

2 Our next section focuses on the topic of rural
3 hospital closures. The closure of a rural hospital can
4 have a significant impact on access, given the central role
5 they often play in delivering care in rural communities.
6 Because of that, we carefully track the trends in rural
7 hospital closures each year and have found that closures
8 have increased in recent years.

9 So to better understand the causes and effects of
10 rural closures, we analyzed a cohort of hospitals that
11 closed between 2015 and 2019.

12 Among our cohort of recently closed hospitals, we
13 found dramatic declines in inpatient admissions in the
14 decade prior to closure. For example, from 2005 to 2014,
15 all-payer admissions fell by 53 percent and Medicare
16 admissions fell by 61 percent.

17 These large declines left our cohort of hospitals
18 with an average of only 1.3 all-payer admissions per day
19 prior to closure.

20 Most of the decline in admissions was due to
21 beneficiaries bypassing their local hospital for inpatient
22 care. This finding was consistently echoed in our

1 conversations with stakeholders from rural communities that
2 recently experienced a hospital closure.

3 In contrast to our inpatient findings, we found
4 that rural hospitals continued to be an important source of
5 emergency and outpatient care prior to closure. Emergency
6 department volume increased, and overall hospital
7 outpatient volume declined slightly in the years prior to
8 closure. This suggests that the loss of the hospital
9 emergency department may have caused larger disruptions in
10 access to care than the loss of inpatient services.

11 Now I'll switch gears a bit to discuss what
12 happens after a rural hospital closes.

13 To study the effects among a group of hospitals
14 that closed from 2015 to 2017, we conducted two analyses.

15 First, as seen in the two right-hand columns in
16 the table, we analyzed changes in service use shortly
17 before and after closures among beneficiaries who lived in
18 rural markets with and without a closure.

19 We found that hospital service use declined
20 faster in rural markets with a closure than rural markets
21 without a closure. For example, inpatient admissions
22 declined by an average of 1.4 percent per year in markets

1 with a closure compared with an average decline of 0.8
2 percent per year in rural markets without a closure.

3 However, in our second analysis, in the left-hand
4 side columns on the table, we found that hospital volume
5 was declining faster in the "closure" markets well before
6 the closures occurred. This suggests that factors other
7 than hospital closures may have affected service use.

8 In addition, some of the volume declines among
9 hospital outpatient services may represent shifts to other
10 settings.

11 To examine whether hospital outpatient volume
12 shifted to other settings after a closure, we analyzed
13 changes in E&M encounters with clinicians--across all
14 settings--before and after closures among beneficiaries who
15 lived in rural markets with and without a closure.

16 From 2014 to 2018, E&M encounters per beneficiary
17 increased faster in rural markets with a closure than rural
18 markets without a closure. For example, over that period,
19 we found that E&M encounters at FQHCs increased 11.6
20 percent per year in markets with a closure compared with
21 6.7 percent per year in rural markets without a closure.

22 Similarly, we found that physician fee schedule

1 E&M office visits increased faster in markets with a
2 closure compared with rural markets without a closure.

3 These findings suggest that some of the hospital
4 outpatient declines we observed in markets with a closure
5 was due to shifts in the site of care rather than
6 beneficiaries forgoing care.

7 The last section of our presentation covers a
8 couple changes enacted in legislation that was passed in
9 December 2020 and discusses next steps.

10 First, the Consolidated Appropriations Act of
11 2021 created a new class of hospitals referred to as "rural
12 emergency hospitals," or REHs. REHs will not furnish
13 inpatient care and instead will provide 24/7 ED care and
14 may furnish other services. Medicare will pay REHs a
15 monthly payment to help cover fixed costs. In addition,
16 Medicare will pay these hospitals OPPS rates plus a 5
17 percent add-on for each hospital outpatient service and
18 standard rates for other provider-based services. To
19 become an REH, a critical access hospital or other small
20 rural hospital must have been furnishing care when the
21 Consolidated Appropriations Act was passed.

22 The creation of REHs is consistent with the

1 Commission's 2018 recommendation on rural freestanding EDs.
2 In addition, as discussed in the previous slides, rural
3 beneficiaries have increasingly bypassed their local
4 hospitals for inpatient care but continued to rely on them
5 for ED and outpatient care. In that sense, the new REH
6 designation adapts the Medicare program to changes that
7 have already been occurring in the private market for many
8 years and may allow rural hospitals to eliminate low-volume
9 inpatient units while still meeting the needs of their
10 communities.

11 In an effort to improve access to clinician care
12 in rural areas, the Appropriations Act also substantially
13 increased payment rates for certain rural health clinics.
14 We discuss the details and implications of this change in
15 your mailing materials.

16 So to summarize our findings, survey and claims
17 data suggest that rural and urban beneficiaries have
18 similar access to care.

19 Variations in service use across states were
20 often large, but differences between rural and urban
21 beneficiaries tended to be much smaller.

22 Rural hospital closures could disrupt access to

1 care, but Congress recently enacted provisions to maintain
2 or improve access to ED and outpatient care in rural areas.
3 These changes are substantial, and combined with other
4 emerging trends, such as the expanded use of telehealth,
5 could substantially bolster rural access to care in the
6 future.

7 We are seeking Commissioner feedback on our
8 current work and suggestions for the next cycle.

9 The findings we discussed today will be included
10 in an interim report that is due to the Congress in June
11 2021. The final report is due in June 2022 and will
12 include the congressionally requested stratifications
13 listed on the slide.

14 With that, I look forward to your comments, and I
15 turn it back to Mike.

16 DR. CHERNEW: Great. So thank you. That was
17 really an outstanding presentation on a really important
18 topic, and as the last slide indicates, we are going to
19 continue to look at this area. There's so much going on in
20 the delivery of care that making sure that people across
21 the country, and in this case rural areas, have access to
22 high-quality care is certainly a high MedPAC priority.

1 I'm going to turn it over to Dana Kelley to
2 manage the queue. I know there is one person who has a
3 Round 1 question. Dana?

4 MS. KELLEY: Okay. Bruce, I think you're first.

5 MR. PYENSON: Yes, thank you very much. I really
6 like the report. I've got two questions perhaps for the
7 next cycle of work, but I'll frame them as questions.

8 One is on the issue of risk scores for rural
9 populations, and you've explained well the instability
10 issue perhaps associated with small numbers or lower coding
11 for a variety of reasons.

12 In the past, MedPAC has suggested basing risk
13 scores on two years of data or perhaps more, and I'm
14 wondering if in future -- if that's something you've looked
15 at for this purpose or if that's something you could look
16 at in the future if you think that would be worthwhile.

17 And my second question is on whether it makes
18 sense to evaluate rural hospital closings from the
19 standpoint of Medicare Advantage, whether the network
20 adequacy rules for Medicare Advantage are affected by rural
21 hospital closing or if there's -- if that's not an
22 important consideration.

1 So, again, the two questions, on two years of
2 codes for risk scoring and the effect of rural hospital
3 closings on Medicare Advantage network adequacy.

4 DR. STENSLAND: I think we'll consider both those
5 for the next round. I think they're probably both too big
6 to discuss right now.

7 MR. PYENSON: Thank you.

8 DR. CHERNEW: There is certainly a lot here, and
9 so I really appreciate the comments, Bruce.

10 Dana?

11 MS. KELLEY: Yes. I have Larry with a Round 1
12 question.

13 DR. CASALINO: Is there any thought for 2022 of
14 looking at quality of care for patients, beneficiaries in
15 rural areas? I couldn't quite figure out if that was
16 requested by Congress or not, or whether we are planning to
17 do that.

18 DR. STENSLAND: We --

19 DR. MATHEWS: Go ahead, Jeff.

20 DR. STENSLAND: Yeah. We looked at quality of
21 care in the last report, and we are not planning to do it
22 in this report. It does take a lot of time, and it is

1 controversial, and we thought to keep this manageable we
2 weren't planning on doing that. For example, the last time
3 around we did see higher risk-adjusted mortality at smaller
4 rural hospitals, which is consistent with the volume
5 outcome relationship, but exactly quantifying that again
6 gets difficult to the extent that you think there are two
7 different levels of coding in rural and urban. And so our
8 current plan was not to expand the scope of this to include
9 quality.

10 DR. CASALINO: Jeff, if I might suggest then, at
11 a minimum, in the report at least to address that, you
12 know, because I think some people will look through the
13 report looking for some mention of quality and whether
14 there has been anything on it or if there are plans to do
15 anything on it. So just kind of stating what you just
16 stated and referring people to the prior report might be
17 useful.

18 MS. KELLEY: Okay. That's all I had for Round 1,
19 Mike. Did you want to say anything before we move to Round
20 2?

21 DR. CHERNEW: No. Well, I don't. I think we
22 should just move to Round 2. I will save my comments until

1 we get to the wrap-up.

2 MS. KELLEY: I have Brian first.

3 DR. DeBUSK: Well, first of all, thank you. I'm
4 really glad that we're taking up this issue. I think rural
5 health care and addressing parity in rural health care is
6 obviously very important. I really enjoyed reading the
7 report, so thank you to the authors.

8 First of all, I want to echo some of what Bruce
9 was addressing over coding. You know, the coding disparity
10 in rural health care really underscores the need to code
11 all Medicare beneficiaries more completely and more
12 thoroughly. It just struck me, from a larger perspective,
13 what this means is that there are beneficiaries,
14 disproportionately in rural areas, who have clinical
15 conditions, who have medical complexity, that the program
16 isn't even aware of, from a macro level. And so when we
17 talk about population health, and when we talk about some
18 of the things that we want to do, at a macro level, in
19 Medicare, I don't see how we get that done if we don't even
20 know the conditions that are there. So Bruce's comment
21 about using two years of data I think would be an excellent
22 step forward.

1 I also think that getting rural beneficiaries and
2 all beneficiaries in general in fee-for-service coded more
3 thoroughly also solves a lot of the other issues that we
4 face in Medicare, because when you look at that ratio there
5 is a numerator and a denominator, and when we talk about
6 coding intensity adjustments and things, we tend to focus
7 on the numerator but we forget, if we just bring the
8 denominator up, you will actually get some of that same
9 effect. I mean, you actually created these in coding
10 intensity by simply making sure that the fee-for-service
11 beneficiaries are more properly coded. So it would solve a
12 number of problems.

13 But I would like to focus, really, on the issue
14 of rural hospitals and rural hospital closures. One
15 request for future work, as you study some of these rural
16 hospitals that close, I would like to learn, did
17 affiliation with the larger system help the hospital or did
18 it actually accelerate the bypassing of the hospital? I
19 think these affiliations are very well-intended, and I
20 think in some cases they are absolutely necessary because
21 the rural hospital has no choice.

22 But just empirically, my observations are it

1 seems to actually accelerate the hollowing-out of the
2 hospital and the bypassing, just because those services are
3 seen as attractive or lucrative or that they have the
4 staffing in the urban area to perhaps do those procedures
5 better.

6 And that really gets me to my final point, which
7 is the bypass issue itself. I am really fascinated with
8 this issue of bypass, because I would argue that a big part
9 of that is staffing. I don't think we have the right
10 geographic mix of physicians, and I think that is one of
11 the huge problems that we are facing. I would love, for
12 future work, for us to look at the rural versus urban
13 beneficiaries and look at their distribution, and then
14 compare that to rural and urban distribution of medical
15 school students or residents, because I think that is
16 terribly out of balance. I don't think it's reasonable to
17 assume that a third-generation doctor doing a residency in
18 dermatology in Nashville is going to be particularly
19 excited about moving to rural Tennessee to perform health
20 care.

21 So one of my points I would really like to stress
22 is I think we need, in this analysis, to look at are we

1 producing physicians in the correct proportion to meet
2 rural and urban needs? And if no, I think we should ask
3 the question why, because Medicare is paying the vast
4 majority of these medical education bills, and I can't
5 think of any other aspect of the Medicare program where we
6 simply give, say, a provider money and then tell them to do
7 what they want to do. I mean, we don't go to a hospital
8 and give them funding and say, "Now do the surgeries you
9 want to do." It just doesn't work like that.

10 So I do hope, as we study the rural challenges,
11 that we make sure that we are looking at workforce issues,
12 particularly around physicians, and that we are educating
13 and training the correct geographic mix of those
14 physicians.

15 Thank you.

16 MS. KELLEY: Jon, did you have something on this
17 point, Jon Perlin?

18 MR. PYENSON: Thanks, Dana. Thanks for the
19 chapter, and Brian, for your terrific comments.

20 I'd like to push Brian's second comment just a
21 notch further, which is I think we need to understand what
22 it is about the relationship between the non-affiliated,

1 perhaps, rural hospital and larger systems, because I think
2 he is right -- it can work from both directions.

3 I had the experience, obviously coming from a
4 large health system, speaking the Texas Hospital
5 Association some years ago, and following my comments
6 someone stood up and said, "Let me tell you what your
7 system did to our hospital." Well, I was prepared to say
8 that, oh gosh, just the opposite. She said, "We would not
9 be here without that because the telehealth type of
10 services allowed the patients who needed procedural
11 intervention to be transferred, yet allowed us to retain
12 those patients who could be appropriately supported and
13 cared for in community."

14 So my point being is that I think Brian is
15 absolutely right. It can be detrimental or it can be
16 helpful. But at the moment that we are given authority for
17 the next level of inquiry, let's determine what it is that
18 stabilizes or destabilizes. Thanks.

19 MS. KELLEY: Okay. I have Betty next.

20 DR. RAMBUR: Thank you so much. I appreciated
21 the report.

22 A couple of comments. I really appreciated the

1 inclusion of Frontier counties. They are very different
2 than other kinds of rural counties, and even though it is
3 not a lot people, they do very important contributions to
4 this nation in terms of farming, ranching, and oil
5 production. So thank you for that.

6 I was excited to see the rural emergency hospital
7 piece, so that people could have that Golden Hour to
8 services.

9 And the issue of the challenge with keeping
10 volumes high enough for competency is a real and serious
11 one. So, you know, I don't know how we think about that,
12 but that is definitely a challenge.

13 Brian, I appreciated your comments on the
14 physician workforce. I would just like to also remind us
15 that care is often disproportionately provided by nurse
16 practitioners and PAs in these areas, often people who are
17 from those areas and return to work in those areas.

18 And in terms of going forward, I would be very
19 curious to understand better some of the outcomes of rural
20 service areas that have looked at alternative payment
21 models. So, for example, the rural hospital global budgets
22 in Pennsylvania, Vermont, all-inclusive total cost of care,

1 obviously not for this report but I think that would have
2 some important lessons for us.

3 And the other comment I would have is the report
4 eloquently pointed out that there is less access to
5 specialty care. What I am curious about and wasn't clear
6 to me is how does that impact patients' health and
7 outcomes. You know, across the nation we have a
8 disproportionately specialist-focused system that could
9 fragment care, et cetera, so we see that there is a
10 difference there. But to what extent is there care being
11 coordinated? Are they missing out on essential specialty
12 services that would really make a difference? And
13 obviously that is not for this round.

14 Thank you very much. I really appreciated it.

15 MS. KELLEY: Mike, did you want to jump in here?

16 DR. CHERNEW: Yeah. Sorry. So that is the
17 second time in this session that issues in some ways
18 related to quality of care in rural areas came up. So
19 first let me make a broad statement. Maintaining a high
20 quality of care and access to care in rural areas is sort
21 of a core goal of this entire discussion, and I'm really
22 happy to -- the staff reported that the REH program follows

1 a lot of MedPAC recommendation, which, just for the record,
2 were made prior to my being in the position I am in now.
3 But it clear that there is a tremendous interest in the
4 country and in the Congress on this point.

5 The thing that I think is a challenge, that
6 Betty's comment raises, and Larry's earlier about quality,
7 is that care in rural areas is always going to have some
8 unique features. The volume issue is just going to be
9 fundamentally different in rural areas than urban areas.
10 That's sort of the definition which is why it is a
11 challenge. That means the staffing issues that Brian
12 raised are clearly going to be an issue.

13 Mitra Behroozi, if she is listening, a colleague
14 when I was on MedPAC before, has pointed out there are also
15 some unique challenges in urban areas, but I think we, in
16 terms of travel and a bunch of other things, but in rural
17 areas I think what is exciting is there are new care
18 modalities that may really support quality and access in
19 rural areas, and what we really have to begin to think
20 through, and certainly we are thinking through, is how do
21 we make sure that those new care modalities and other
22 things that might be happening enhance quality and access

1 as opposed to siphon off care in a way that means certain
2 things go away? And that is really the balance that I
3 think we are going to have to try and face.

4 So your point, Betty, about staffing, your points
5 about volume, the points about volume that you made, are
6 really going to be a challenge, and I think we will be
7 going there. But I did want to emphasize, to those
8 listening, that we are aware of these issues and will
9 continue to work hard about how to make sure that we can
10 transform care efficiently without giving up anything on
11 the quality and access side.

12 So I'm going to turn it back to you, Dana, to
13 move on to the next comments.

14 MS. KELLEY: All right. I have Sue next.

15 MS. THOMPSON: Thank you, Dana, and thank you,
16 Michael, and I appreciate this opportunity. I suspect this
17 will be my last opportunity to comment on matters related
18 to rural Medicare beneficiaries. It is a topic, as you all
19 know, I am very close to and very passionate about.

20 And my intent here is to perhaps just connect
21 dots of many topics that we have covered through the course
22 of the past many years and how they might relate to this

1 chapter, and whether that be in the next cycle or however,
2 and much work it takes. But I do think there are a couple
3 of points that are worthy of mentioning.

4 I do like Table 2 very much in the reading. I
5 would like it even better if it included information on the
6 move to value, among our rural providers. There has been,
7 and there continues to remain, many opportunities in the
8 rural areas, and there is a lot of activity in the rural
9 areas in work of moving to value, despite, I think, the
10 focus on many of the urban models.

11 But this may be a comment for a later discussion,
12 but I would love to further tease out what we are learning,
13 in our rural communities in particular, just contrasting
14 pure fee-for-service to the ACOs and then comparing them
15 both to MA. I think it would be interesting to see these
16 results and then compare them to analysis similarly in
17 urban areas. Recognition of the work in the rural areas
18 around ACOs I think might be an important comment here.

19 While the survey data suggests that rural and
20 urban beneficiaries have similar access to care, we
21 continue to note, in the reading and frequently in our
22 discussion, that the MedPAC survey is a small sample.

1 However, in terms of the MCBS, the claims data does show
2 that there are differences. The reading included a
3 statement that stated, "We found that 4 percent of urban
4 beneficiaries were dissatisfied with the ease of getting to
5 the doctor from their home, compared with 7 to 8 percent
6 among rural beneficiaries, and 10 percent among frontier
7 beneficiaries."

8 This statement indicates that rural
9 dissatisfaction rate is double or more of their urban
10 counterparts, and yet the headline of that section in the
11 chapter reads, "Survey data suggests rural and urban
12 beneficiaries have similar access to care." There is a
13 nuance there that I'm not sure we are capturing a central
14 issue to rural access. And we've touched on it. Brian
15 touched on it. Betty touched on it. Michael just
16 commented again, and that's access to providers.

17 You know, I think that this issue of access to
18 primary care, which we have covered over and over, is
19 central to any discussion on rural access, and while the
20 comments related to providers are scattered throughout the
21 paper, there's a footnote around advanced nurse
22 practitioners and PAs, it strikes me that perhaps in a more

1 prominent way or in the next cycle that we call out the
2 topic of access to physicians in rural America. It just
3 seems essential, and it seems to me to be central to so
4 much of what we're talking about. We've commented on
5 quality and our concerns about quality. This is an update
6 to a 2012 chapter. If we would look at workforce issues
7 between 2012 and 2021, in rural America, I would suggest
8 there is a lot of change that has gone on.

9 And finally, there is a comment on expanding
10 cost-based reimbursement for rural health care, that it is
11 not an efficient approach to maintaining access to care.
12 You know, the MedPAC principles about rural health care
13 include access to care -- it doesn't necessarily mean equal
14 travel time -- quality of care should be equal, and then
15 special payments to rural providers should be justified by
16 being targeted, empirically supported, and encourage
17 efficiency.

18 My question is, should the price of access be
19 judged by efficiency? Of the 40 hospitals that closed
20 between 2015 and 2019, only 15 of them -- only 15 of those
21 40 -- were critical access or cost-based reimbursed. The
22 other 25 were PPS, suggesting PPS may not be the answer

1 either, which brings us to this new model, which I know we
2 are quite bullish on, the Rural Emergency Hospital
3 designation. I would suggest it bears very close watching,
4 and I think analysis in states that are rural to frontier
5 need to be watched and conferred. It is consistent. The
6 recommendation is consistent with our previous MedPAC
7 recommendations, which I know we enjoy seeing, but the
8 proof will be in the pudding. And I just strongly
9 encourage us to keep a watchful eye on the implementation
10 and the effect of that Rural Emergency Hospital
11 designation.

12 Thank you.

13 MS. KELLEY: I have Jaewon next.

14 DR. RYU: Thank you. I think a lot of similar
15 these. Just a few additional points. First of all, I
16 really appreciated the chapter. I think it is a critically
17 important topic, with a significant or more than expected
18 share of the Medicare beneficiaries living in these
19 environments, so it is very important work.

20 A few things that did pop out. I share Susan's
21 concern and sentiment, and I also share her affinity for
22 Table 2. And I thought that was a really illustrative

1 table. I think it would also be impactful to see what that
2 has trended over time, because I think especially in the
3 employer-sponsored, you know, if you look at the payer mix
4 section, so to speak, the employer-sponsored is an area
5 that it looks like there is a pretty significant difference
6 between rural environments and urban environments, and it
7 would be interesting to see what that has done over time.
8 I suspect the gap has grown and not shrunk.

9 I also think that kind of analysis around the
10 payer mix would be useful for the hospitals that have
11 closed. If you go back, you know, three, five, whatever
12 years prior to their closure, I suspect the payer mix may
13 be another wrinkle that may have added to the equation.

14 I think it leads me to my second point, which is
15 around the types of services and expectations of distance
16 and travel to access those services. I think there are
17 many services, and they may be on the more subspecialized
18 area of the spectrum, where it is probably appropriate and
19 reasonable that folks are traveling longer distances. You
20 know, transplant might be a great example on the extreme
21 end of that spectrum.

22 There are other services that I think we would

1 all consider to be more core, where you would hope that
2 people aren't having to travel significantly far distances
3 from home. Primary care is a great example of that. And
4 then there are a lot of services that sit in between, but
5 there are some specialty services that probably resemble
6 more of core functions, that you actually need those
7 programs to sustain a hospital, versus, you know, other
8 programs that are not as core that we feel comfortable
9 about people moving and having to travel farther for. It
10 would be good to get to that level of granularity, just one
11 step deeper, in terms of what are the types of services.

12 Cardiology is a good example. I suspect, with
13 the closure of hospitals, I think the bypass dynamic, if we
14 are really drilling into what created the consumer need to
15 bypass and go farther for those services, I suspect it may
16 be in terms of certain services that were no longer
17 available at this platforms, at those hospitals. And as a
18 result, folks had to go further. But being able to glean
19 insights into what those services may have been, I think
20 that may shed some light on that bypass dynamic and also
21 shed some light on are we comfortable with those services
22 not being available closer to home.

1 And I think the last point is the staffing issue
2 that Brian and others raised, and Betty. I think that's
3 exactly right. In many of these environments, I believe
4 the hospitals are the ones that are best positioned to
5 recruit and build programs around a series of providers.
6 But in order to be able to do that, I think there is an
7 interface or an interplay with the ambient payer mix and
8 the ability to support those services.

9 MS. KELLEY: Mike, did you want to jump in here?

10 DR. CHERNEW: I did just for a sec. I think
11 that's exactly right, Jaewon. I think the challenge is to
12 think about the connection between these services because
13 they're obviously not always attendant. If you lose access
14 to one, then maybe it's okay if you lose. There's
15 ramifications for the availability of others that you would
16 rather not lose, and that's sort of one of the issues
17 around emergency -- the recommendation that led to the REH
18 in some ways. You want to make sure that some services
19 stay even if other services go. But your point about
20 thinking about in a service perspective matters enormously.
21 It's just the recognition of the connection between these
22 service lines is analytically quite a challenge.

1 MS. KELLEY: All right. I have David next.

2 DR. GRABOWSKI: Great. Thank you. And thanks to
3 the staff for this great work. I wanted to make just two
4 brief comments.

5 First, both Betty and Sue mentioned alternative
6 payment models, and Betty even touched on global budgets
7 and the Pennsylvania program. It strikes me that the
8 flexibility that global budgets and APMS would provide here
9 might be interesting to think through further. I know
10 MedPAC, we obviously have done a lot of work with APMS.
11 We've obviously done a lot of work with rural areas. But
12 trying to connect those threads in a greater way, and maybe
13 we've done that and I've missed it, but I'm really curious
14 going forward if there's opportunities to think about
15 bringing those two threads together.

16 As a second comment, I was the one that had asked
17 the staff to look at the post-acute care differences across
18 urban and rural areas in terms of utilization. I was
19 really struck by what they found, that on average there
20 weren't big differences there. I hear a lot from folks
21 about big gaps in rural areas in terms of post-acute care
22 services, and maybe it was that final bullet that you had

1 up on Slide 10 that kind of connects the dots here between
2 what I hear a lot from folks and what you're finding. On
3 average, we don't see utilization differences, but we do
4 have some areas out there where there may be big gaps. I
5 think what you stated in that bullet was that the
6 geographic variation was larger than differences between
7 rural and urban beneficiaries in the same state. I'd be
8 curious to know where are those kind of low areas of use in
9 terms of SNF and home health agency. It was an interesting
10 finding. I think that made me feel better that on average
11 we're not seeing big differences. But I still worry about
12 some of those kind of PAC deserts that may be out there.

13 A final comment. I guess I lied. I did have a
14 third comment. I'm really looking forward to seeing what
15 we're going to do on the duals for the last part of this.
16 I think that is an important part of this with rural areas,
17 so I'm excited to see what's to come there. But thanks for
18 this great work, and I like the way it's shaping up.

19 Thanks.

20 MS. KELLEY: Okay. I have Pat next.

21 MS. WANG: Thank you, and I echo my praise for
22 the quality of the chapter as well as the presentations and

1 the comments of my fellow Commissioners. I just had a
2 couple of things.

3 I very much endorse the comments that others have
4 made and that Sue led off with about incorporating more
5 about the presence of value models, whether it's ACO, CMMI,
6 Medicare Advantage, and just sort of whether that has had
7 any impact or influence in these areas.

8 I wondered for the next round whether there
9 should be a little bit more focus on sort of what I'll call
10 like post-pandemic emerging trends in health care, which
11 would include access to and use of telehealth, mental
12 health in particular. Again, this is just anecdotal on my
13 part, but I think that behavioral health issues in non-
14 urban areas, rural frontier, might be something to have a
15 particular focus on in terms of access and so forth.

16 And the final comment is just sort of I want to
17 tuck it into the comments that Bruce and Brian have made
18 around risk scores. I personally don't think that using
19 two years' worth of information is going to help the
20 situation, and I've noted this before. The fundamental
21 problem in my view is that fee-for-service providers get
22 paid by billing procedure codes. Risk scores are

1 determined by diagnosis codes. It is not the way that fee-
2 for-service providers code, and, therefore, I mean, it has
3 come up in a variety of different settings, whether you're
4 an ACO or an MA plan, or what have you. Where HCC risk
5 scores are important for payment, there will be more
6 attention on trying to get providers to code differently.
7 And I can tell you it's really painful, which is why you
8 see a lot of emphasis on trying to correct coding or, you
9 know, sort of augment procedure codes with diagnosis codes,
10 because it's not the way that people in the fee-for-service
11 system have learned how to code.

12 I think it's an underlying issue both with the
13 expansion of ACO models that rely on HCCs, MA which rely on
14 HCCs, and analyses like this to really get at underlying
15 health condition. I think it is an issue going forward
16 that we just need to be aware of. The fee-for-service
17 system does not -- providers do not need to bill diagnosis
18 codes in order to get paid. They get coached and they get
19 trained in appropriate procedure code billing, and that
20 does not drive accurate HCC scores.

21 MS. KELLEY: And the last person I have in the
22 queue is Paul.

1 DR. PAUL GINSBURG: Thanks, Dana. I was very
2 stimulated by the comment that Brian made about the
3 affiliation relationships and what effect that has on care
4 in rural areas. This might be worth looking into more in
5 the next cycle.

6 My sense and my experience has been that probably
7 affiliation does lead to more bypassing. I think it also
8 leads to a beefing up of outpatient services and emergency
9 services in the rural hospital or what was the rural
10 hospital if it closes. And, you know, this actually might
11 be a very -- you know, this is probably consistent with the
12 direction that the Commission recommended in 2018 and which
13 the Congress recently enacted in the appropriations bill to
14 actually facilitate that process of having the rural
15 hospital that did not have much volume becoming a stronger
16 center for outpatient care and emergency services. So
17 perhaps a couple of interviews as part of the next cycle
18 might get us to think a little more carefully about, you
19 know, what would be the ideal affiliation relationships
20 when they happen.

21 MS. KELLEY: Actually, I have Jon Perlin with a
22 comment.

1 DR. PERLIN: This is a comment that sort of
2 intersects between Sue Thompson's terrific comments and
3 Paul's. It gets at this issue of this tension between
4 efficiency and access. You know, while we all hope that
5 COVID is indeed ephemeral, I think we've seen a playout of
6 the tension between efficiency and surge capacity.

7 One of the areas where -- you know, clearly we
8 don't have the same level of expensability as in the area
9 of rural health. So just as a general thought, as we do
10 further work in this area, we need to think about how we --
11 or whether we, in fact, are prepared to fund some degree of
12 inefficiency to support the surge capacity that builds the
13 resilience essential for our population health.

14 Thanks.

15 DR. CHERNEW: Dana, is that the end of the queue?

16 MS. KELLEY: That is the end of the queue.

17 DR. CHERNEW: So I'll summarize briefly and then
18 make one other point. We may end up moving to the value
19 purchasing model on the SNFs sooner than on the schedule.
20 But in any case, a few things I've heard.

21 One is a very strong acknowledgment of the
22 importance of quality and access in rural areas and a

1 recognition that that's not going to mean that rural areas
2 look exactly like urban areas, because it turned out they
3 don't. But we really have to think about how to do that.
4 We need to think about how that is influenced by new care
5 delivery models.

6 I heard loud and clear the importance of systems
7 and the roles that systems play both in supporting the
8 viability of hospitals in selected areas, the change in the
9 care package, and that I think is quite a valuable point.

10 The staffing issues go without saying. I think
11 we talked about staffing in a whole variety of ways.
12 Certainly the COVID issue is emphasized in many places, the
13 staffing concerns.

14 Jaewon pointed out thinking about this in the
15 service level matters a lot for all of these issues, access
16 to what, quality for what, how they put it together, I
17 think that matters.

18 We haven't talked a lot about in this section
19 unique issues related to, you know, social determinants of
20 health or other types of issues that affect rural areas
21 that matter, so I think that might fit into some other
22 types of thinking we have. And I will add another comment,

1 simply because we have some time, from discussions I've had
2 with my friend from Arkansas, Joe Thompson, thinking about
3 Medicaid and the Medicaid expansion and the role that that
4 plays as a payer in support of these other things, also
5 probably an important thing for us to keep on our radar.

6 But we have -- as was said, we are going to be
7 continuing this work. We have a report that will -- this
8 material will be presented in our June report, and then, of
9 course, we will have the report in June 2022 that will do
10 some more stratification. And so these comments have been
11 really very useful as we get to prioritize how to deal with
12 some of the added analysis. We won't be able to do
13 everything, so -- but we'll deal with the added analysis in
14 the June 2022 version.

15 So, again, I'm going to pause for a second and
16 see if there's any other comments that folks want to make.

17 [No response.]

18 DR. CHERNEW: I'm seeing none, so I will thank
19 the staff for their really outstanding work in this area.
20 It combines both an enormous amount of quantitative
21 analysis, a lot of more qualitative analysis, talking to
22 different organizations. Really there's an incredible

1 wealth of knowledge about what's going on, and a real
2 dedication. I need to give the appropriate shout-out to
3 the staff that has been involved in that.

4 So, again, thank you all, those that presented,
5 those that helped prepare the materials, and barring
6 anything else, I think we're going to switch over to the
7 SNF thing. Am I correct that Carol is going to kick us
8 off?

9 MS. KELLEY: Yes, that's correct.

10 DR. CHERNEW: I get the order from the slides.
11 Sometimes the names aren't in order. But we are doing the
12 best we can.

13 DR. CARTER: So I'm ready. Can you hear me?

14 DR. CHERNEW: Yeah, okay. Carol.

15 DR. CARTER: Good. Good morning, everyone.

16 Before I get started I wanted to note that the audience can
17 download a PDF version of these slides in the Handout
18 section of the control panel, that is on the right hand of
19 the screen.

20 Today we'll continue our discussion of MedPAC's
21 mandated report on the SNF value-based purchasing program.
22 Its requirements are listed on the slide. We plan to

1 include the chapter in the June report.

2 This is the fourth presentation on this report.

3 Last September, we reviewed the current program design and
4 summarized the results for its first two years. You
5 discussed the shortcomings of the design and concluded that
6 the program should be eliminated. In October, we outlined
7 an alternative design, estimated its potential impacts, and
8 compared the impacts of the current and alternative
9 designs. In January, we outlined policy options for your
10 consideration.

11 MS. KELLEY: Carol. We lost your audio. Okay.
12 Hang on one second.

13 MS. TABOR: I can take over if needed.

14 MS. KELLEY: Yes, why don't we do that, Ledia.
15 Carol, are you there now?

16 [No response.]

17 MS. KELLEY: No. All right. Ledia, why don't
18 you go ahead. Thank you.

19 MS. TABOR: Okay. I will start where I think she
20 was.

21 In October, we outlined an alternative design,
22 estimated its potential impacts, and compared the impacts

1 of the current and alternative designs. In January, we
2 outlined policy options for your consideration. Today we
3 present the Chair's draft recommendations for your
4 discussion, with a planned vote in April.

5 We'll start with an overview of the results of
6 the current program. Since the January meeting, we have
7 analyzed the third year of results, which are generally
8 consistent with the first two years. In each year, about
9 three-quarters of providers had their payments lowered by
10 the program. Between 21 and 39 percent of SNFs earned back
11 essentially none of the amount withheld, which was 2
12 percent.

13 Few SNFs, between 2 and 3 percent, received the
14 maximum increases. Those increases were relatively small,
15 ranging from 1.6 percent to 3.1 percent net of the
16 withhold. The general consensus is that these incentive
17 payments have not been sufficiently large to motivate
18 improvement.

19 We also found that incentive payments tended to
20 be higher for larger providers, for providers whose
21 patients had lower risk scores, and for providers that
22 treated fewer patients at high social risk, as measured by

1 share of fully dual-eligible beneficiaries. We also found
2 that while the majority of providers were penalized under
3 the program each year, the size of the payment adjustments
4 varied across the three years. These findings helped
5 identify the shortcomings of the current program and spell
6 out the design features of a new one.

7 The next few slides outline each of the five
8 flaws of the current program, how the new value incentive
9 program corrects it, and how we incorporated the design
10 feature into an illustrative model.

11 First, instead of the single measure that is
12 required in statute, the alternative design should score a
13 small set of performance measures focused on outcomes and
14 resource use. The measure set should evolve over time. At
15 earlier meetings, the Commission discussed the need to
16 finalize measures of patient experience that could be added
17 later.

18 In our illustrative model, we used three
19 measures: rates of hospitalization within the SNF stay,
20 successful discharge to the community, and Medicare
21 spending per beneficiary.

22 A second flaw of the current program is that in

1 determining whether to include a provider in the program,
2 it uses a minimum count that is too low to ensure reliable
3 results for low-volume providers. Especially for low-
4 volume providers, the measure is more likely to reflect
5 random variation rather than actual performance.

6 A VIP would incorporate strategies to ensure
7 reliable measure results, by using a higher reliability
8 standard to determine the minimum stay count for inclusion
9 in the program. To include as many providers as possible,
10 the performance period could span multiple years, although
11 there are pros and cons to this approach.

12 In our illustrative modeling, we used a
13 reliability standard of 0.7 compared to the 0.4 used in the
14 current program. This translated to 60 stays for each
15 measure. We also expanded the performance period to 3
16 years.

17 Third, as required by statute, the current
18 program includes cliffs for rewarding performance. As a
19 result, some providers may not have an incentive to
20 improve. The value incentive program establishes a system
21 for distributing rewards with minimal "cliff" effects. All
22 providers are encouraged to improve.

1 In the illustrative modeling, we assessed a
2 provider's performance on each measure against a national
3 distribution. The scales that convert performance to
4 points are continuous, so every achievement is recognized.

5 The fourth flaw is that current VBP does not
6 account for the social risk factors of the beneficiaries a
7 SNF treats. Yet, it is harder for providers that treat
8 high shares of patients at high social risk to have good
9 outcomes. The VIP design considers social risk factors
10 when tying performance points to incentive payments, by
11 using peer grouping. Peer grouping is a way to compare the
12 performances of providers with similar mixes of patients at
13 high social risk. As the share of fully dual-eligible
14 beneficiaries increases, providers have the potential to
15 earn larger rewards for better performance.

16 In our illustrative model, we used 20 peer groups
17 based on the share of fully dual-eligible beneficiaries.
18 Within each peer group, incentive payments are distributed
19 to each provider based on its performance relative to its
20 peers. With this approach, performance scores are not
21 adjusted, while payments are adjusted based on that
22 performance.

1 In discussing the scoring and peer grouping, some
2 Commissioners were concerned that the VIP design could
3 reward the poorest performers of all SNFs, depending on
4 their peer group assignment. A minimum performance
5 standard would prevent this from happening and would be a
6 way to set expectations about the quality of care that
7 providers need to furnish to receive a reward. However, a
8 minimum threshold is likely to disproportionality penalize
9 SNFs that treat a high share of patients at high social
10 risk because they are more likely to have lower performance
11 on quality measures. Thus, a minimum standard would
12 undercut the purpose of peer grouping, which is to counter
13 the disadvantages of these SNFs face in achieving good
14 performance.

15 Others of you said that it was important to have
16 a design that counters the disadvantages SNFs that treat
17 high shares of patients at high social risk face in
18 achieving good outcomes. Both of these positions have
19 merit and there are tradeoffs involved in meeting these two
20 objectives.

21 Based on what we heard as the preponderance of
22 Commissioner input, we focused the VIP design on improving

1 the equity across SNFs and did not include minimum
2 performance standards in our illustrative model. There may
3 be some consolation in knowing that in our model, all of
4 the worst performing SNFs, those in the bottom 14th
5 percentile of performance, were penalized.

6 The fifth shortcoming of the current program is
7 that, as required by law, the amounts withheld from
8 payments are not fully paid out as incentive payments.
9 Rather, the program retains a portion as program savings.
10 The Commission supports value incentive programs that
11 distribute all withheld funds back to providers based on
12 their performances. Each year, the payment adjustments
13 would be calculated to fully spend out the incentive pools.

14 In our illustrative model, 5 percent of SNF
15 payments were withheld and then redistributed back to
16 providers based on their performance. The VIP is not used
17 to achieve Medicare program savings. That said, because
18 the performance measures would encourage providers to lower
19 hospitalizations, for example, Medicare may, achieve
20 program savings.

21 In December 2020, the Congress made changes to
22 the SNF VBP. The Consolidated Appropriations Act of 2021

1 made changes that are consistent with what we've talked
2 about: it gave the Secretary of Health and Human Services
3 the authority to expand the measure set and requires that
4 the data are validated-, which would apply to the provider-
5 reported measures. It also bars the program from applying
6 to providers who do not meet a minimum volume for each
7 measure. Depending on how this provision is implemented,
8 that is, if the current minimum volume remain the same, the
9 results may still be unreliable.

10 The legislated changes do not address three other
11 design flaws: the scoring "cliffs," the lack of
12 consideration of social risk factors, and the program
13 retains a portion of the incentive pool as savings. So
14 while the changes are a positive development, there is more
15 that can be done to improve.

16 The results of our modeling show that the design
17 of the VIP has the intended effect of making payment
18 adjustments more equitable for SNFs treating patients at
19 higher social risk compared to the VBP.

20 On the left are the payment adjustments under the
21 current program, and we show 5 peer groups, with low shares
22 of fully dual-eligible beneficiaries in yellow and high

1 shares in red. On the left, under the current program, the
2 incentive payment adjustments get more negative, that is,
3 the penalties get larger, as the share of dual-eligible
4 beneficiaries increases. In contrast, on the right are the
5 adjustments under the VIP. Under this design, the average
6 adjustments are much smaller and they are more equitable
7 across peer groups. This would counteract the disadvantage
8 these providers have in obtaining good outcomes.

9 We also looked at how the VIP design would affect
10 providers treating medically complex patients compared to
11 the current program. We divided SNFs into three groups of
12 medical complexity based on their beneficiaries' average
13 risk scores, with low in yellow, medium in green, and high
14 in blue. On the left are the results of the current
15 program and on the right are the results of the
16 illustrative model.

17 Under the current program, providers treating the
18 least medically complex patients have positive payment
19 adjustments on average, while providers treating the most
20 medically complex patients have negative payment
21 adjustments. In contrast, under the alternative design,
22 the average payment adjustments were not related to the

1 medical complexity of the patients. Therefore, compared
2 with the current program, the VIP model would make payment
3 adjustments more equitable across SNFs treating different
4 mixes of medically complex patients.

5 Per the Commission's previous discussions, an
6 improved SNF quality payment program with stronger
7 incentives would be paired with other tools to encourage
8 providers to improve. First, public reporting of provider
9 performance, including the measures used in the SNF VIP,
10 motivates providers to improve. CMS should also target
11 technical assistance to low-performing providers so they
12 can develop the skills and infrastructure needed for
13 successful quality improvement. CMS could also enhance its
14 Requirements of Participation and Special Focus Facility
15 Program to more aggressively encourage providers to improve
16 the quality of care they furnish.

17 In summary, the current program is flawed. The
18 VIP design addresses these flaws. Compared to the current
19 program, a replacement VIP design is more likely to
20 motivate providers to improve their quality and would
21 dampen the incentive to avoid beneficiaries with more
22 social risk factors and more medically complex

1 beneficiaries. The recent legislation corrects some flaws
2 of the current program but there is more opportunity for
3 improving the program.

4 I will now present the chair's draft
5 recommendations for your discussion today. We anticipate
6 the Commission will vote on the recommendations at the
7 April meeting.

8 First, the Congress should eliminate Medicare's
9 current skilled nursing facility value-based purchasing
10 program and establish a new value incentive program that
11 scores a small set of performance measures; incorporates
12 strategies to ensure reliable measure results; establishes
13 a system for distributing rewards that minimizes cliff
14 effects; accounts for differences in patient social risk
15 factors using a peer grouping mechanism; and completely
16 distributes a provider-funded pool of dollars as rewards
17 and penalties.

18 This recommendation will not affect program
19 spending. It would be budget neutral to current law.

20 We expect this recommendation to have positive
21 impacts on providers and beneficiaries. Access may improve
22 for beneficiaries at high social risk or who are medically

1 complex. Beneficiaries may experience an increase in the
2 quality of care they receive from SNFs because the
3 providers would have stronger incentives to improve.

4 For providers, the SNF VIP will improve equity
5 across SNFs because it will not disadvantage SNFs that
6 treat patients at high social risk or medically complex
7 patients. We do not expect the program to affect provider
8 participation in Medicare.

9 The second recommendation is that the Secretary
10 should finalize development of and begin to report patient
11 experience measures for skilled nursing facilities. This
12 recommendation will not affect Medicare spending, but CMS
13 may incur additional administrative costs.

14 We do not expect this recommendation to have
15 adverse effects on beneficiaries' access to SNFs or on SNF
16 participation in Medicare.

17 Beneficiaries may experience an improvement in
18 the quality of care they receive from providers because
19 SNFs will have an incentive to improve patient experience
20 when these measures are publicly reported and scored in the
21 SNF VIP. Consumers will have more information about
22 providers when making decisions about where to get care.

1 SNFs will have higher administrative costs when
2 the Secretary requires providers to collect and report
3 patient experience surveys.

4 I will now turn it back to Michael, and look
5 forward to the discussion.

6 DR. CHERNEW: Sorry. Thank you so much. That
7 really reflects an enormous volume of work and an
8 incredibly detailed chapter. I am going to turn it to Dana
9 Kelley to start the Round 1 questions:

10 MS. KELLEY: Okay. And it looks like we have
11 Carol back with us.

12 DR. CARTER: Yep. I lost my internet but I am
13 back. Sorry about that.

14 MS. KELLEY: Great. All right. I have Dana
15 Safran.

16 DR. SAFRAN: Thank you. Really adding to Mike's
17 congratulations on this chapter. This has really developed
18 so well and has really important recommendations in it, and
19 really tremendous work, so compliments to the team on that.

20 I have a couple of questions. One is, did you
21 explore, or are we allowed, or would current legislation
22 allow the use of a VIP program that is rewards only versus

1 having reward and penalty?

2 MS. TABOR: The current legislation would only
3 allow for reward and penalty.

4 DR. SAFRAN: Okay.

5 MS. TABOR: It is not currently written as a
6 rewards-only program.

7 DR. SAFRAN: Okay. Thank you for clarifying
8 that. And then I wonder if you could explain a little bit
9 to us about, in Table 7, how points are set, because I
10 think it has some important bearing on some comments that I
11 have on your treatment of the issue of cliffs, but I want
12 to make sure I understand correctly. So, for example,
13 maybe it's helpful if we kind of have Table 7 in front of
14 us, so I'm looking for my copy. I have way too many tabs
15 open here, so it will take me a moment to surface it.

16 MS. TABOR: I just found it also, and it is the
17 table that shows the points for each measure.

18 DR. SAFRAN: Yeah. So if you could just help us
19 understand, you know, the 0 to 10. You say that
20 performance to points is based on the data distribution,
21 but I didn't see any more information. So does 0 points,
22 for example, correspond to data binomial distribution of,

1 you know, 10th percentile? Give us some insight about how
2 0 to 10 points are defined.

3 MS. TABOR: So the 0 to 10 points is defined
4 using the entire national distribution of performance, so
5 we did not apply any amount of thresholds, and we did apply
6 the data distribution to kind of smooth out some of the
7 unevenness in that national distribution. But I think to
8 your question, that performance to point scale is again
9 based on national distribution with no kind of minimum
10 threshold applied.

11 DR. SAFRAN: So then would I be correct in
12 understanding, looking at that table, in the 0 row, I know
13 that we don't have the ability to put it up in front of
14 everyone, but that, for example, where you've got the
15 hospitalization rate, 23 percent is the score that we see
16 associated with 0 points, does that mean that's the score
17 at the 0 percentile of the data distribution?

18 MS. TABOR: That is correct, yes.

19 DR. SAFRAN: And that, at the other end, 8
20 percent hospitalization rate would be what we'd see at the
21 100th percentile of the data, and that's associated with 10
22 points?

1 MS. TABOR: Correct.

2 DR. SAFRAN: Got it. Okay. Thank you.

3 DR. CHERNEW: I want to jump in on this, in part
4 because I am very conscious that some people in the
5 audience haven't had the benefit of seeing the draft
6 chapter. And it's important that folks at least follow
7 along for this somewhat technical part of the discussion.

8 The way the SNF VIP program works, as is noted,
9 it scores a small set of performance measures. Three were
10 picked. The ultimate score reflects an aggregation of
11 points across each of those three measures. The analysis
12 of how you go from a measure to points for that measure is
13 discussed only briefly, and the question that Dana was
14 asking for those following along was how we go from a score
15 on one of those measures to the specific number of points.

16 The chapter -- the Commissioners will know this,
17 but the audience may not. The chapter doesn't dwell a lot
18 on the answers that Ledia just gave, and we will continue -
19 - I think that's a useful point, Dana -- to think through
20 that part of how this plays out. So I appreciate the
21 answer, but I wanted the people to understand that what
22 we're talking about now was the process of going from

1 measure score to the measure point, which then gets
2 aggregated to get you a total score, and then the total
3 score moves into the actual payment.

4 Now, did I say that clearly? And, Dana, did that
5 capture where your question was?

6 DR. SAFRAN: It did capture where my question
7 was. I think you said it clearly, but I'll ask Ledia to
8 answer.

9 MS. TABOR: Yes, that was clear and correct.

10 DR. CHERNEW: Good. I hope everyone's following
11 the many steps that are going on in this box. We think
12 this issue of going from the performance to the point
13 before you go to the actual payment is something that --
14 I'm glad that you clarified that not just for us, but also
15 for the public. So thank you, Dana.

16 Dana Kelley?

17 MS. KELLEY: There are no more Round 1 questions.
18 Are you ready for me to go to Round 2?

19 DR. CHERNEW: I am ready for you to go to Round
20 2, and I think it's indicative of both the good job the
21 staff did and the hard work and the fact that we've seen a
22 lot of this before that we're able to move as expeditiously

1 as we are. So that's great. I know there are some Round 2
2 questions, so, yes, Dana, you are in charge of the queue.

3 MS. KELLEY: All right. I have Jonathan Jaffery
4 first.

5 DR. JAFFERY: Great. Thanks, Dana.

6 First of all, I want to echo what Mike and Dana
7 and others have said, that this was a great chapter and a
8 great presentation, and just a great body of work. Like
9 Mike said, this has evolved over the years, and I think
10 it's great.

11 I want to put out there that I'm very supportive
12 of moving in this direction. I feel like we certainly do
13 need to move away from the current model as quickly as
14 possible. And I 100 percent support most of the draft
15 recommendations, the small set of performance measures,
16 higher reliability, minimizing cliff effects, and the full
17 rewarding of the provider-funded pools.

18 Since the last meeting, Dana Safran and I
19 actually had a little bit of dialogue, and I'll certainly
20 let her -- she'll be able to comment herself on this. But
21 I still have some concerns about the social risk factor
22 adjustment, and my concerns are based on it still feels

1 like what we're moving towards is a system that ultimately
2 can reward providers as much or more for outcomes that
3 aren't just good for their population of patients.

4 And this, of course, I think it has tremendous
5 implications how we start to think about social
6 determinants of health and how we account for them, which I
7 think we all agree at this point -- it's safe to say we all
8 agree that's crucial. And it has implications that go way
9 beyond the SNF program and into other ones as well.

10 And so, again, I'm very supportive of this as our
11 current step, but I'm hopeful that we could have more
12 discussion perhaps in next year's session, and specifically
13 thinking about is there an opportunity to, rather than pay
14 on the back end this way -- or, rather, adjust for social
15 risk on the back end, is there some method for adjusting
16 payments up front, perhaps somewhat analogous to how we
17 address medical risk in MA and in other areas. It feels
18 like there may be some opportunity to create better
19 incentives there, as long as we're combining them with the
20 same accountability for outcomes in whatever value payments
21 that we have.

22 And so I'm happy to talk about that more or

1 respond to that, but, again, I'm very supportive of this
2 going forward now. But I do feel like we've got an
3 opportunity to maybe think about this in a different way
4 that would address it, again, from that payment model up
5 front and not end up with a system where providers can be
6 rewarded differently for different outcomes based on
7 patient population characteristics of social risk.

8 MS. KELLEY: All right. I have Dana next.

9 DR. SAFRAN: Thank you. So I do express full
10 support for the Chair's draft recommendation. I'm feeling
11 much more comfortable with our treatment in the chapter of
12 social risk factors. Importantly, the fact that a provider
13 serving lower SES earns more for a given level of
14 performance I think is a really important goal. And I
15 don't think the chapter really makes that as explicit as it
16 could, so I'll offer a couple of suggestions as I go, but
17 let me just summarize my thoughts.

18 I also think the fact that in so doing we get a
19 more equal distribution of the dollars. The reward is, of
20 course, something we were looking to accomplish and very
21 positive that we can.

22 I do have a few remaining concerns about it and,

1 number one -- and this one, you know, it's something I hope
2 we can address in the chapter before we finalize it. The
3 fact that we view there to be no lower bound on performance
4 that's worthy of a reward continues to concern me, so I'll
5 say a little bit more about that.

6 The other two are kind of longer-term things that
7 we've talked about before, but just to underscore them
8 here. One is I think we've all recognized that duals is
9 really not an adequate indicator of social risk, and I
10 really would encourage that we over the next year explore
11 and maybe even test some methods that could improve upon
12 this. And I know I shared some ideas for that in our last
13 meeting.

14 The additional one for future consideration, not
15 for this chapter, is, you know, what I think Jonathan just
16 pointed to, and that is, potentially in addition to having
17 this kind of multiplier on rewards that providers serving
18 lower SES gets for a given level of performance, we could
19 consider having an up-front adjustment to budgets based on
20 social risk, you know, much as we do -- I think Jonathan
21 said this -- for clinical status. Understanding that more
22 resources are required for a sicker population, we would be

1 acknowledging more resources are required for populations
2 who are at greater social risk. So I think that's an
3 additional mechanism for us to consider in the future.

4 But now just turning back to the issue of cliffs,
5 I would say that I think -- well, first, to say that on
6 page 43 in the first paragraph, I think that the method
7 that you have defined really does reward both achievement
8 and improvement, but I would just ask you to take another
9 look at the phrasing there, because as you describe moving
10 away from the current model, I wouldn't not want a reader
11 to be confused and think that this model doesn't still
12 reward both achievement and improvement. Even though the
13 previous model did those separately, this one very
14 elegantly does it with, you know, a continuous curve. And
15 I think that's really valuable to emphasize.

16 I continue to feel that we should have a lower
17 score that we think is not worthy of reward. I have a
18 different point of view from that expressed in the chapter,
19 that that, you know, would be unfair to providers who serve
20 a lower SES population or demotivating to them. My own
21 experience in creating incentive programs along these lines
22 for a commercial population was that, you know, before we

1 implemented a model very much scoring the way that you're
2 describing, but setting a lower bound on what is
3 performance for the other reward. If you looked at our
4 population, we would have seen that there would have been
5 no rewards being given to providers with lower SES. But we
6 went ahead and set those lower bounds, and lo and behold,
7 what happened was that those who were serving the lower SES
8 population really rose to the challenge and actually grew
9 to be among the top performers, exceeding performance of
10 those serving more advantaged populations.

11 So I would urge us not to assume that by setting
12 a reasonably high bar that folks would be unable to meet
13 that based on who they're serving.

14 One suggestion is that in order to help, you
15 know, just all of us be more informed about that, I think
16 that expanding on your Table 10 -- or, sorry, Table 8 or
17 possibly having a different table that shows us not just
18 the average performance points by peer group, but also the
19 range, maybe the inter-quartile range, maybe the min and
20 max, would really give us a better understanding of the
21 distribution of performance that we see at these different
22 peer grouping levels.

1 But even if it's the case that we see, you know,
2 uniformly low performance in Peer Group 20, I would still
3 urge us to believe that that group is capable of delivering
4 high performance when the incentive model urges them to do
5 so.

6 And then I'll wrap up. I'm just scanning my
7 notes to see if there was anything else I wanted to say
8 here. Oh, I should have included this in Round 1, so I
9 apologize. I did have a question about the discharge to
10 community measure and how that treats patients at the end
11 of life. Most notably, I'm questioning whether the measure
12 disincentivizes discharge to home because if a patient who
13 is at the end of life then passes away, that counts against
14 that SNF, so I wanted to understand how that measure is
15 treating the issue of patients who are known to be at end
16 of life.

17 Thank you.

18 MS. TABOR: Unless Carol knows off the top of her
19 head, Dana, we'll follow up with you afterwards about how
20 hospice patients are treated with the measures. I don't
21 have it at my fingertips.

22 DR. SAFRAN: Sure. Oh, I'm sorry, one final

1 thing that I did want to say for your consideration. One
2 important way to handle this issue of setting a lower bound
3 of performance that can be rewarded and your concern that
4 that could lead to a kind of cliff or unfairness for those
5 who have a score, you know, just a decimal place away from
6 where that lower bound is set, a treatment of that that we
7 used very successfully in my work was to just create a
8 buffer score around that lower bound that is set in a way
9 that states essentially a 95 percent confidence interval
10 but just one-sided, so that we have -- you know, there is
11 less than a 5 percent risk of misclassifying a provider as
12 low performing and getting no reward if indeed they're so
13 close to the cut point that, you know, we could just round
14 up and assume that they make it. So I would just offer
15 that as something for your consideration as well.

16 MS. KELLEY: Okay. So I had a couple of people
17 who wanted to react to things that Jonathan and Dana said,
18 so I'm going to let them get in here for a second, and then
19 we'll move on with the queue. Larry, did you want to
20 comment on something?

21 DR. CASALINO: Yeah, Dana, I had just a specific
22 question for Jonathan, and then I had earlier asked to be

1 in the queue for comments. It turns out those comments are
2 relevant to what Jonathan and Dana have been talking about.
3 But I think there are other people in the comments queue
4 before me, so I'm happy to just ask Jonathan the question
5 now and come back later whenever my turn originally was in
6 the queue to give my comments, although they are on the
7 Jonathan and Dana topic. So however you want to do it.

8 DR. CHERNEW: Larry, I think you should just,
9 again, as always, say what you need to say, try to be more
10 concise than I usually am. You should probably try and
11 wrap it in now as long as it's on point.

12 DR. CASALINO: Okay. Yeah, I think I can be
13 quite concise. So my question for Jonathan -- Jonathan,
14 it's an interesting point you made in terms of trying to
15 deal with the SDOH issue. The recommendation is to deal
16 with it through the rewards and the peer grouping, and you
17 suggested that we consider, instead of giving the money to
18 rewards potentially, giving it basically to higher up-front
19 payments for patients with higher social risk. Is that
20 correct?

21 DR. JAFFERY: That's correct, although I suppose
22 they're not necessarily mutually exclusive, but, yeah,

1 that's correct.

2 DR. CASALINO: Can you just say a bit more about
3 why you might prefer the latter to the former?

4 DR. JAFFERY: Yeah, I think probably two factors
5 in general. I would say one I mentioned already in the
6 concern, the ongoing concern that you could still as a
7 provider have a greater reward, significantly potentially
8 greater reward for worse outcomes and that masks some of
9 that. But I think the other piece has to do with kind of
10 investments and having been on the provider side both in
11 ACOs and health systems in general and, you know, people's
12 difficulty getting their heads around or overall reluctance
13 or challenges to investing in things that will impact the
14 social determinants, again, with proper metrics and
15 accountability coupled with it, having those payments up
16 front explicitly be tied to those kinds of investments I
17 think made incent organizations and providers to actually
18 move in that direction more. And part of it has to do with
19 the ongoing cash flow issue, if you know as you're getting
20 payments, you're getting greater payments specifically
21 designed for these investments as opposed to tied to some
22 outcome that comes, as you know, often two years later. So

1 it's often that the operators of these provider groups --
2 it's a little bit harder for them to connect to that cash
3 flow issue that is coming so much further down the road.
4 So those are some of the things behind that.

5 DR. CASALINO: Thanks, Jonathan. I'm not going
6 to comment on your suggestion. I'd be interested to hear
7 what others say, except as you were talking, it just
8 occurred to me in the chapter we'll get to later on about
9 alternative payment models, it is highlighted that the
10 second investment model, where organizations were being
11 given cash up front, basically organizations that were
12 small or rural or whatever, actually was one of the most
13 successful models in terms of improving quality and dealing
14 with -- and generating savings for Medicare. So that could
15 tend to support what you're saying. I haven't thought it
16 through enough to have a pro or con myself.

17 What I originally wanted to say about SDOH -- and
18 it's relevant to what you and Dana were saying -- is I
19 think the issue of how to account for some provider
20 organizations having more disadvantaged patients to care
21 for, obviously that's not unique to this situation. It
22 comes up again and again and again. And I would just like

1 to tie that to the public reporting component of the
2 chapter, because I do think that public reporting is a way
3 to -- the issue is we don't want to make the rich get
4 richer and the poor get poorer by really penalizing
5 organizations that take care of a high share of
6 disadvantaged patients.

7 On the other hand, we don't want to permanently
8 reward organizations that take care of disadvantaged
9 patients for giving a lower level of performance to them.
10 So the question is what to do about that.

11 I think public reporting -- I don't think there
12 is a perfect solution, but I think that public reporting
13 can help a bit with that. And the point there would be
14 that if the reporting includes both the reporting within
15 peer groups and reporting of performance compared to the
16 national standard, I think that people then can see --
17 people in the community, for example, community leaders,
18 organization leaders, they can see, okay, we did pretty
19 well relative to our peer group; we're getting a nice
20 reward here. But, actually, we're not that good if you
21 look at us compared to the whole national sample, national
22 population, and, therefore, we ought to do better.

1 So I do think public reporting can help with this
2 conundrum, and to the point it was mentioned public
3 reporting in the text box and then again in the last -- in
4 the discussion, I think on the last page in the discussion.
5 But I would suggest making the public reporting more
6 prominent, not just relegating it to a text box, and
7 possibly even elevate it to the level of a third
8 recommendation, that these three measures should be
9 publicly reported by CMS, and they should be reported both
10 in relation to peer groupings of dual eligibles and in
11 relation to -- nationally, in relation to all SNFs.

12 MS. KELLEY: Mike, did you want to get in here?

13 DR. CHERNEW: I just want to respond to one
14 comment of Jonathan's and then we'll move through that. So
15 first, thank you, Jonathan. I think your point about up-
16 front payment and then form of payment is important, and
17 we'll consider that.

18 I will just point out that one of the
19 characteristics of the VIP as it's being reported is it's
20 not only balancing out the money across organizations by
21 the different peer groups, but it also gives peer groups in
22 lower SES categories a greater marginal incentive to

1 improve. In other words, not only do they get more money
2 for the baseline level in a particular way to battle down
3 for payment so we're not pulling money away from those
4 folks, but we're also increasing the marginal incentive to
5 those groups to improve. And so I just wanted to point
6 that out. The math is something hard to present in a
7 public session, but that is the way it works.

8 Dana, back to you.

9 MS. KELLEY: I think Amol had something to say on
10 this issue.

11 DR. NAVATHE: Yes. Thanks, Dana, and thanks,
12 team, for the great work on this chapter, and I think in an
13 ongoing fashion, I very much appreciate it. I do want to
14 first just start out and say that I do support the
15 Chairman's draft recommendation here.

16 I think, as the conversation has highlighted,
17 this is relatively complicated issue. What I would say is
18 I think I appreciate, and one of the reasons I am so
19 supportive of the recommendation, is I think we have taken
20 a relatively practical approach here, and I think the goal
21 should be -- and I don't think we need to articulate this
22 in the recommendation per se -- is that we have a practical

1 recommendation that is actionable, given the universe of
2 data and methodology that we have currently, but that
3 doesn't mean that it is a full stop, we're done here on
4 this topic. As Larry and others have highlighted, this is
5 an issue that pervades much of the work that we do. It is
6 not restricted in any way to the SNF work itself.

7 And so I think sort of trying to solve it as part
8 of this program would potentially be too challenging and
9 kind of not the bar that we should be focusing on.

10 I think the approach around peer grouping and
11 using dual eligibility and social risk is critically
12 important. I think we should also acknowledge that it is
13 not the perfect measure, as Dana points out. So yes, we
14 should be seeking, over time, ways to get to better social
15 risk measures. That being said, again, it is probably
16 practical, and we should highlight also that it is not
17 something that MedPAC has sort of generated itself but it's
18 something that the ASPE report has highlighted is the best
19 and most reliable indicators of social risk, based on the
20 work that they have done.

21 So I think noting that we are kind of building on
22 other work that's been done in this space is important, I

1 think, to contextualize why we use that measure, because
2 certainly it is not a perfect measure and it certainly
3 doesn't capture all measures of social risk.

4 The other point, I think, just to make on this is
5 relatedly, I think -- you know, Jonathan and Dana both have
6 highlighted that there are other ways that we could
7 approach addressing this challenge around variation in
8 social risk in patient populations. It seems, in this
9 particular report, and I think particularly based on the
10 request that Congress has made, we are, to some extent,
11 living within the world of a value incentive program and
12 the type of structure of a pay-for-performance kind of
13 structure. And given that, again, not that this is a
14 universal way we could approach it, but we are taking a
15 practical approach to try to address it within that
16 construct.

17 I do think that Larry's point about the public
18 reporting is important and perhaps doesn't have to be a
19 third recommendation per se but could actually be tucked in
20 as a bullet point under the Chairman's draft recommendation
21 number 1. It, I think, does touch upon this point that
22 there are a number of different ways that we could try to

1 address social risk, challenges with social risk, that have
2 been written about, again, by ASPE and National Academy of
3 Medicine and others.

4 Publicly reporting and specifically even taking
5 one step further, which we don't need to put right now but
6 we could consider in the future is looking at populations
7 that traditionally do face social disadvantages, and taking
8 one step further in terms of public reporting those
9 measures and, in fact, stratifying based on different
10 groups, I guess in this context, duals versus non-duals,
11 could be a way to actually try to push that forward, and
12 something that we might consider, if not for this
13 particular report, maybe in the next one as we continue to
14 do work in the broad space around addressing incentives for
15 social risk.

16 I do have one point of sort of personal
17 reflection from work that I've done. As Dana has done a
18 lot of work in the commercial space, I have also worked
19 with a number of insurers on designing programs. And I
20 think I agree with her point, generally, around the minimum
21 threshold. It can actually also create a strong incentive
22 to improve for groups that are facing greater social risk,

1 to actually be that impetus, if you will, that shot.

2 That being said, I think we should be careful or
3 cautious about that, because we should be sure that it is
4 something that is actually actionable. In other programs
5 that we've designed, my team has designed, with other
6 commercial insurers, including the managed Medicaid
7 populations, in interviews we've done with providers they
8 have noted that the minimum threshold that was previously
9 used in one of the incentive programs was actually quite
10 discouraging, and, in fact, disincentivizing because it
11 felt unreachable, effectively, which is something that
12 you've noted, I think, in the chapter.

13 So I think it an important concept that Dana
14 brings up. I think, however, the bar for us to be
15 confident around that being achievable should be actually
16 relatively high, and given where we are now I think the
17 approach that we've taken currently is one that I support.

18 So let me stop there, but thank you again for
19 this very great work, and I support the work that we've
20 done.

21 MS. KELLEY: Okay. I have David next.

22 DR. GRABOWSKI: Great. Thanks. And first, thank

1 you to Carol and Ledia. This reflects a large amount of
2 really strong work, and I'll start by saying I'm very
3 supportive of the Chair's draft recommendation.

4 I have sort of a long history with this program.
5 I actually was part of the team that evaluated the CMS
6 demonstration that this program, the SNF VBP, is based on.
7 We were highly critical of what was then the nursing home
8 value-based payment program. That program was flawed. CMS
9 then took that and turned it into the SNF VBP, which is a
10 current flawed program. So it's great to see this SNF VIP
11 shaping up and actually correcting a lot of these
12 longstanding issues.

13 Obviously, there are still some challenges here,
14 and some of my fellow commissioners have already raised
15 these. I wanted to touch on just a few points. One is
16 obvious and that's the measure set. We have three measures
17 included in the SNF VIP. I like all three of those
18 measures. I'm really happy that we included the second
19 recommendation about building a patient experience measure.
20 That can be done. We have a lot of the work already out
21 there in the field, and I don't think that is a big ask of
22 the field, to actually develop that and move forward with a

1 patient experience measure.

2 In terms of other possible measures, I think we
3 pushed the claims data here as far as we can. The only
4 other candidate that I might see here would be mortality,
5 and I think that's the wrong measure for this population.
6 So I would discourage us from including mortality as a
7 measure in this program.

8 Kind of the elephant in the room is that we are
9 really not capturing, I think, what's most important to a
10 lot of beneficiaries, and Carol and I have talked a lot
11 about this over the years. But it is functional
12 improvement, and that is really what everybody cares about.
13 We have this instrument, the minimum data set, that
14 measures that. The unfortunate part about this, and we
15 always go in circles with this point, is that it's
16 provider-reported, and obviously there are a lot of
17 incentives around that reporting. I was really struck by
18 Carol's work just showing how coding can really change even
19 from being discharged from a SNF and going to an HHA, and
20 within days, lo and behold, people's assessment changes
21 dramatically, just based on who is doing the assessment and
22 the incentives these different providers have.

1 So I wonder, is there an opportunity here, in
2 addition, to kind of, Recommendation 2, is there a way to
3 push on accuracy of the MDS? There is such rich
4 information there. CMS bases a lot of their quality
5 reporting -- if you go on Nursing Home Compare -- around
6 the MDS. I wonder if there is an opportunity there, or is
7 that just a lost cause? We've always been dismissive as a
8 Commission of those data, I think because of their self-
9 reported nature, and I just wonder if there's more than can
10 be done there, whether it's auditing, whether it's other
11 oversight activities, that we can improve that. I really
12 think, at the end of the day, that is what we care about.

13 Two other more minor points. One, I really like
14 that we're using multiple years of data in terms of
15 rewarding facilities here. I don't like the thresholds of
16 dropping facilities with low numbers out of the program. I
17 do wonder, however, if we could think about some sort of
18 weighting scheme, and you mentioned this in the chapter,
19 but weighting the most recent year a little bit more than
20 prior years. And I don't know how that then impacts just
21 the sample that's needed, per facility, to make this work,
22 but I like that a lot.

1 Finally, Dana and others have already spoken on
2 the social risk factors. I think that is a priority not
3 just for this work but more generally for MedPAC. I think,
4 as Amol said, the share of duals is an improvement on
5 nothing in the program right now in terms of adjustment,
6 but going forward is there something more that we could do
7 towards improving that? I think that should be an area of
8 priority.

9 Final point. Jonathan, I was really struck by
10 your comment about up-front dollars. I have evaluated
11 several of these programs, in terms of SNF value-based
12 payment programs. The only one we ever found a positive
13 return around was this program in Minnesota. The acronym
14 is PIPP. I am not going to be able the exact to spell it
15 out for you right now. But what was exciting, it's the
16 only program we've found that actually had a positive
17 impact, and the dollars are largely paid upfront with a
18 small withhold on the back end. I won't get into all the
19 details of the program, but I was really struck by your
20 comment. There's something about upfront payment that was
21 really, I think, a big part of the success of that program.

22 Stepping back once again, I'm very supportive of

1 these draft recommendations and really excited about the
2 way this work is shaping up. So thanks to Carol and Ledia,
3 and I'll stop there.

4 MS. KELLEY: I have Jon Perlin next.

5 DR. PERLIN: Well, David is always so incredibly
6 eloquent that I can almost say ditto. But the points are
7 really very symmetric. Let me just be clear that I agree
8 with the rationale, agreeing with the recommendations, and
9 I agree with accelerating patient experience.

10 I do want to add my voice to the concerns on some
11 of the methodology. You know, when you adjust the results
12 it is really a transform function to payment, so
13 effectively it's kind of the same thing. And I really like
14 Larry Casalino's concept of publishing the performance
15 data, both against peer group as well as in the context of
16 national performance. I think that, in my experience, in
17 the VA system, the public accountability and context was,
18 frankly, the greatest driver in performance change.

19 I also think we've got to wrestle with this issue
20 of small numbers, because what happens when you add the
21 numbers together for multiple years is that you may come up
22 with something that, on the analytic side, is technical

1 powered to answer the question, but on the predictive side
2 mismatches the period of time that the data are garnered
3 with the period of time that the beneficiary or family
4 might be seeking to make judgment about the predicted
5 utility of those data. In other words, you know, if a
6 beneficiary's average stay is a quarter, having three years
7 of data doesn't necessarily predict what will or will not
8 occur in that specific quarter. So I think it's a bit of a
9 finesse but a good one to heavily weight the more recent.

10 You know, I'm going to sound like a broken record
11 on this, but I think David's point the limitations of
12 claims data is a good one, and I want to make two
13 additional points on this. First, you know, we're looking
14 for outcomes data, and I subscribe to the utility of
15 outcomes data and whether a patient in a nursing facility
16 goes back to a hospital or is discharged to community, are
17 wonderful outcomes. But, you know, we are pushing the
18 limits of the administrative data. So we need to begin
19 thinking about how we can get more clinical data, and
20 whether those are emerging electronic data, that is one
21 bucket. I want to reference my VA experience as well. We
22 tracked functional status for all patients, and the VSF

1 inventory we actually got down to the SF-12 as a measure of
2 function, and frankly it was the most compelling data, both
3 in terms of trying to identify improvement opportunities
4 and to mark progress.

5 The next aspect is that, you know, I know we have
6 a sort of visceral aversion to process measures, but when
7 they are tightly linked with outcomes, like seat belts,
8 then there's a role and the good part is that they don't
9 need to be risk adjusted.

10 I think we need to step back, in our next body of
11 work, outside of this specifically, because the absence of
12 data that more accurately reflect on social determinants,
13 social vulnerabilities is increasingly problematic, and our
14 proxies are so imprecise that at the risk of compelling
15 providers to acquire more data or burdening the patient
16 and/or family, we need a mechanism to really identify what
17 those risks are so that we can stratify. And that gets
18 back to Jonathan Jaffery's point, which I think is really
19 well taken, which is the decoupling of reimbursement for a
20 higher vulnerability population from normalizing
21 performance on the back end.

22 And along those lines, one final point. I'm

1 worried about a circularity with medical spending per
2 beneficiary. Think about this for a moment. If you take
3 care of a more vulnerable population, the reason we are
4 going through these permutations around trying to risk
5 adjust is because it's our thought that it will be harder
6 to achieve certain better outcomes and more resources may
7 be necessary to achieve those outcomes.

8 So I ask the question, is MSPB really the key
9 there, or are we introducing a problem that actually needs
10 to be solved on the basis of data that help us better
11 understand the social vulnerabilities and pay for that, as
12 opposed to not confusing the issue circularly when that
13 becomes an outcome measure rather than a part of the
14 premise of what's necessary and what should be incentivized
15 to take care of those patients.

16 Thanks.

17 MS. KELLEY: I have Marge next.

18 MS. MARJORIE GINSBURG: Yes, thank you. This is
19 a fabulous report, great work, and very stimulating
20 discussion.

21 Like so many of you, I was particularly focused
22 on the peer grouping, and I'm really concerned about it,

1 concerned about it in that I support it. What I'm not sure
2 of is what is the best way to make this a fair distribution
3 of dollars tied to quality of work. And certainly Jonathan
4 sounded like he wanted to dump it, if I may shorten your
5 consensus. I think I heard Dana say if we compensate those
6 with higher duals then is that not a way to even the
7 playing field and then everybody can be evaluated in the
8 same grouping, which also has appeal.

9 But my main reason for having jumped into the
10 queue is that I think this is so important, and we've got
11 five different recommendations that we are posing. Have we
12 ever prioritized our recommendations in such a way as to
13 really emphasize this one is really important? And at
14 least to me, this one is really important. Without the
15 peer grouping, however we do it, the rest of it just
16 doesn't feel as impactful as it needs to be.

17 Thank you.

18 DR. CHERNEW: So I want to jump in quickly. I
19 want to ask a few questions, just to make sure. First to
20 Dana Safran. Dana, my interpretation of your comment was
21 not to doubt where we are going but to consider changing
22 the way we move from the performance on a particular

1 measure to the points associated with it. Am I reading
2 what you said correctly?

3 DR. SAFRAN: Sorry, Michael. Can you say that
4 again? You said it quickly and I didn't catch it.

5 DR. CHERNEW: Yeah. I'm sorry. Marge said
6 something, sort of interpreting what you said, and I want
7 to make sure that I am interpreting what you said
8 correctly.

9 So my interpretation of what you said was that
10 you are supportive of where we're going but you would like
11 to give more thought to how we translate measures to points
12 --

13 DR. SAFRAN: Correct.

14 DR. CHERNEW: -- around minimum standards, to
15 which Amol responded. I just want to make sure that I
16 understood you correctly.

17 DR. SAFRAN: Correct. I mean, just to be really
18 explicit, if we think back to that Table 7 that I was
19 talking about, I don't know that I would put the beginning
20 of the continuum at the 0 percentile, as we do in that --

21 DR. CHERNEW: Actually --

22 DR. SAFRAN: -- yeah.

1 DR. CHERNEW: -- the key part for this
2 discussion, frankly, was whether or not I should interpret
3 what you said and dump it, which is not how I interpreted
4 it.

5 DR. SAFRAN: Oh no, not at all. Not at all. I'm
6 very supportive of this direction. I just was asking that
7 we consider the idea of what the score too low to merit a
8 reward.

9 DR. CHERNEW: I got it. And similarly, to
10 Jonathan, my interpretation of what you said, and I'm just
11 really trying to make sure that we're on the same page, is
12 that you were supportive of the recommendation the way we
13 were going and that we should consider, in addition, some
14 amount of upfront payment in a way that helps achieve some
15 of our other goals, but that wasn't a negation, if you
16 will, of how we've set things up, or not. But the point is
17 I want to make sure that I interpreted your earlier
18 comments correctly, because obviously one of the key things
19 that matters here is people's assessment of where the
20 recommendation is, because next month we are going to get
21 to vote.

22 DR. JAFFERY: Yes, that is correct, sort of

1 building on what Amol had said, this is, I think, a very
2 practical approach to get us to significant improvements
3 immediately, and what I'm getting at is hopefully some
4 further discussion that impacts things beyond just the SNF
5 value incentive program, but how we think about SDOH
6 broadly.

7 DR. CHERNEW: I understand, and the idea of it in
8 general, in this case and beyond, is, of course, some of it
9 is both the timing of the payment and then some of it is
10 what is the payment a function of, if that makes sense.
11 But, again, given where we are, the point of the
12 discussion, which has been very rich, is to not only help
13 us get to where we need to be in April but to think about
14 where we're going to go beyond. Certainly there's going to
15 be more years of MedPAC, and I hope to be here, and
16 certainly we will be continuing to discuss quality and
17 quality measurement programs. They're obviously
18 unbelievably important. CMS has done a lot of really
19 thoughtful thinking about it. There's really great people
20 there. And I think the more that we continue to do this,
21 the more valuable our discussions can be. But at least
22 where we are now, it's really important to understand what

1 you're all thinking about specifically at this stage,
2 recognizing it's not the end, it's just a step in the
3 process. So thank you, and, Marge, thank you.

4 Now, Dana, back to you and the queue.

5 MS. KELLEY: I have Brian next.

6 DR. DeBUSK: Well, first of all, thank you.
7 Great chapter. And I do support the Chairman's
8 recommendation completely. Carol, Ledia, Sam, I always
9 enjoy your work in this area, so thank you.

10 I want to focus a little bit on the peer grouping
11 mechanism and just take a moment to endorse our larger
12 approach to SEC -- or SES adjustment in general. I'm a
13 huge fan of peer grouping, huge fan of the compartments,
14 and I want to mention -- and these are things that we've
15 discussed in the past, but I want to take a moment and
16 point out that there's a philosophical argument around
17 using these peer groups and compartments, which is, you
18 know, you wouldn't want to build a pass for poor-quality
19 care into the regression models so that we actually have
20 coefficients that give providers who treat -- who hold
21 beneficiaries who are a more socioeconomic risk to lower
22 standards. So I think there's sort of an obvious

1 philosophical issue here.

2 But I also want to point out I think there's a
3 mathematical issue here, too, because the socioeconomic
4 variables are so often confounded with clinical conditions.
5 I mean, is someone an unstable diabetic because they are in
6 a high socioeconomic risk group? Or are they in that high
7 socioeconomic risk group because they are an unstable
8 diabetic? And I think -- I'd like to just take a moment
9 and appeal to the practicality of the approach that we've
10 taken, because it does avoid the difficult philosophical
11 issue, but it also avoids some of the difficult
12 mathematical issues associated with confounded variables.

13 And beyond that, you know, when we talk about,
14 well, do we do a minimum, do we do floors, do we do
15 ceilings, do we base all this on improvement? You know,
16 I'm going to take a moment and just think about the MedPAC
17 staff and other policymakers who have to analyze all this
18 data. Every time you introduce a floor or a ceiling or a
19 minimum, you're introducing a nonlinearity analysis, which
20 is going to make this data more difficult to tabulate,
21 analyze, report. So I think there are a lot of issues
22 there.

1 I do want to also support Larry's comments, and I
2 think, Jon, you echoed them, on this idea of publicly
3 reporting in absolute terms as well as providing the
4 relative terms for the peer grouping and the mechanisms. I
5 think publicly reporting both would be very important. So
6 it's exciting to see that idea develop, as well as with the
7 peer groups we did preserve the notion that we can tailor
8 the specific remedies to each peer group.

9 For example, if you're in Risk Group 20, the
10 highest socioeconomic risk, maybe you need technical
11 support or additional funding; whereas, if you're in the
12 least socioeconomic risk, you know, maybe you do need an
13 even stiffer penalty. But the ability to tailor our
14 treatment of each peer group I think is another really,
15 really important feature of this broader mechanism that
16 we're using to account for SES.

17 The final thing, I've noticed this discussion
18 about making up-front adjustments or payment that
19 incorporate SES, and what I'm assuming here is that we're
20 talking about incorporating these measures into the minimum
21 data set and you're using them, say, for the beneficiary's
22 placement into a resource utilization group. The one thing

1 I wanted to point out here was to exercise some caution.
2 If you look at functional measures and consider all the
3 issues that we've had regarding functional measures, unless
4 these SES measures are absolute -- you know, what Zip code
5 do you live in, you know, family income, things like that -
6 - it's going to be really, really difficult. You know,
7 this may be the functional measures reporting problem all
8 over again, because as we know, when you tie reporting to
9 payment, unless you're absolutely objective, you're really
10 inviting upcoding, for lack of a better term.

11 And those were my comments, and thank you.

12 MS. KELLEY: I have Betty next.

13 DR. RAMBUR: Thank you so much for an excellent
14 report and excellent comments from the other Commissioners.
15 I'll be very brief, just to say I believe that this is a
16 very important step forward. When I look at Slide 13, it
17 seems to me there is not only an imperative for change;
18 it's an ethical imperative for change. So I strongly
19 support this.

20 I support the public reporting of peers and then
21 also in aggregate, and I think this is important
22 information for families as well as information that can

1 spur behavior change.

2 I just would underscore David's comment about
3 mortality not being a good measure. Death is not always
4 the enemy, as we know.

5 I support having both achievement and improvement
6 scores and more heavily weighing the later years.

7 And in terms of the up-front payment, I think
8 that is a very intriguing idea, and I just would need more
9 information to study it more, understand if there's
10 differences by ownership of the facility, or whatever. So
11 that's an intriguing idea that would be interesting to hear
12 more about. But I strongly support these recommendations.

13 MS. KELLEY: Okay. That's the end of the queue,
14 Mike.

15 DR. CHERNEW: Great. So not all of you spoke,
16 which is fine. I do think there is merit, as we're going
17 to move towards the vote in April, to get people's general,
18 even if very brief, reactions. So I'm going to ramble on
19 for another second or two while people compose themselves
20 and to give you some hint of what's going to happen. Then
21 I'm going to ask -- we're going to start with Bruce to just
22 give a very quick sense of, you know, you're okay with

1 where we're going, you don't have to make a long -- I'm
2 really looking for --

3 MR. PYENSON: Yeah, I'm --

4 DR. CHERNEW: -- a comfort level, because, again,
5 it [inaudible]. I wish we were truly in public. I guess
6 we're virtually in public. But part of this is not just --
7 it's for us to express and me to express and give the
8 public a sense of where we are.

9 So now I'm done rambling. Dana, I think I'll run
10 through -- you can correct me if I misspoke, but, Bruce,
11 did you have any just broad reaction?

12 MR. PYENSON: Yes, I'm very supportive of the
13 recommendations as they stand and would echo Brian's
14 comment about making sure that this is relatively simple
15 for the reasons he said.

16 I also would remind Commissioners of our
17 recommendations for the update for SNF in this context,
18 that, you know, the SNF program has been a source of
19 attention on an aggregate basis for the levels of payment.
20 So for all of those reasons, I support these
21 recommendations.

22 DR. CHERNEW: Bruce, thank you. Karen, can I ask

1 you for just a quick reaction?

2 DR. DeSALVO: Sorry, I was looking for my button.
3 Yeah, I'm happy to, and actually it's a bunch of S's. I'm
4 supportive of the Chairman's draft recommendations. I am
5 in favor of the way this team has continued to try to take
6 an overly simple process but keep it simple, meaning make a
7 significant improvement and it's got some crispness and
8 clarity that people could understand and articulate that I
9 think resonates with some of the other quality program
10 improvements that the MedPAC team has been doing. So thank
11 you for that.

12 The social risk component is complicated. I very
13 much appreciate how deeply you're thinking about it. I
14 honestly think you're taking reasonable steps, and as
15 others have said, I hope we continue to be leaders and
16 understanding not only how to do stratification based on
17 social risk of patient populations, but then begin to think
18 about ownership, accountability, payment systems to address
19 that social risk, not only in the context of the acute-care
20 setting or the post-acute care setting, as the case may be,
21 but also for those beneficiaries when they're not in
22 institutions.

1 And then I just in particular want to call out
2 the ongoing great work you've been doing to think about
3 patient experience or self-report, and I appreciated that
4 there's some discussion in the chapter balancing more
5 complex measures, you know, up to 50 questions, shorter
6 versions, four questions. What can we do that really makes
7 it as easy as possible, reduce any friction to make sure
8 we're hearing the voice of those being served and other
9 family members?

10 So thank you, and that's all I have.

11 DR. CHERNEW: Karen, thank you.

12 Wayne, can I ask you for just a quick reaction?

13 DR. RILEY: Yes, Chairman. Fully supportive. I
14 think these are two great recommendations. Nothing more to
15 add.

16 DR. CHERNEW: Thanks, Wayne. Jaewon. Jaewon, I
17 don't see you. I don't see everybody. Maybe Jaewon had to
18 drop for a bit, so we will move

19 MS. KELLEY: Actually, yes, Jaewon did have to
20 drop off for a moment.

21 DR. CHERNEW: Okay. So we'll catch up there.
22 Sue Thompson.

1 MS. THOMPSON: Yes, and I too will be very brief.
2 I'm very supportive of the Chairman's draft
3 recommendations, and I'll take just a moment because I want
4 to say a special thank you to Ledia and to Sam, but in
5 particular to Carol Carter for her ongoing investment in
6 time and energy around all of our work in post-acute, but
7 particularly skilled nursing. So thank you, Carol. Your
8 work is noticed and appreciated.

9 DR. CHERNEW: Great. So Pat.

10 MS. WANG: I'm supportive of the recommendation
11 as drafted, and I am very keenly interested in our
12 continuing the discussion around how to address social risk
13 factors, social determinants of health. I don't think this
14 is going to be an easy one if we really want to get it
15 right. So I think we should invest the time in it. But I
16 think that the recommendations are very good. Thanks.

17 DR. CHERNEW: And Paul.

18 DR. PAUL GINSBURG: Yes, I support the
19 recommendations enthusiastically, and it was a great draft
20 chapter. And I also support the fact that it's important
21 to act soon on this, and I think we're doing very feasible,
22 practical things now, and I support many of the other

1 thoughts about things we should be talking about in the
2 future to go even further.

3 DR. CHERNEW: Great. So I'm going to wrap up in
4 a second. I'm going to pause to see if anyone else is
5 going to add something.

6 Okay. So in addition to my gratitude to the
7 entire staff and recognition of the importance of this --
8 and I'll emphasize that I happen to know it's not just
9 important to us; it's very important to CMS and, obviously,
10 people in the field that we do this well. I think it's
11 important that we do it well in a way that in many ways
12 minimizes the administrative burden associated with doing
13 that. But let me try and tell you some of the themes that
14 I heard here.

15 First, I heard general support from the
16 recommendations and where they're going, which is am
17 grateful for. And, of course, a lot of the direction we
18 went is because of the work that you all have done in
19 addition to the staff, so I'm very grateful for that.

20 I've heard there's a number of things that we
21 need to consider as we move forward. They include -- I
22 should probably say include but not limited to. That

1 sounds too legalistic. One is thinking about the
2 possibility of up-front payments, thinking about how we can
3 include some clinical insight as opposed to statistical
4 insight in the scoring, particularly around minimum
5 standards of things, because I think it is very clear and I
6 will emphasize we very much want to make sure that the
7 payment mechanism adjusts for social determinant-type
8 issues, SES issues, but we very much do not want to in any
9 way give a pass to organizations to not provide high-
10 quality care. And that is a challenging thing to do
11 mathematically, and we will continue to do that, and I
12 think the expertise of those on the Commission that know a
13 lot more about that than I is really valuable. So that's a
14 combination of understanding that this is not just the
15 statistical, it is a clinical exercise, but it also is one
16 that we have to think about, you know, what we're willing
17 to reward.

18 I heard very clearly, I think starting with
19 Larry, the point about public reporting that matters, and I
20 think we'll think about how to incorporate that idea into
21 the work flow. There's some challenges there. And the
22 last thing that I would say -- hopefully I haven't missed

1 much -- is the role of data and measurement challenges,
2 understanding that this is really a difficult analytic
3 issue. And several of you have made really important
4 points about essentially the right call on the outcomes and
5 measurement.

6 I would just add one personal view related to
7 some work we've done that I very much recognize and
8 appreciate the shortcomings of claims data when you're
9 trying to understand quality, and I think it's really
10 frustrating for people that look at the world through a
11 clinical lens to think that you're limited in claims data.

12 I do think it is not necessarily an either/or in
13 some ways, and so certainly as a recommendation around
14 things like experience measures matters, but there are
15 other ways that some of the claims data might be used. For
16 example, I think you could use it to target places that
17 might need more attention. There's a bunch of other
18 analytic things you could do with the data besides simply
19 putting it into a measure and then creating a payment
20 around that measure. And I think we will continue to
21 ponder creative ways to use data.

22 For those of you in many environments, there's

1 been a real revolution in data science, writ large. A lot
2 of that is around how to use existing data smarter in a
3 bunch of ways. And I think with some advance analytics we
4 may be able to do that in ways that are a little bit more
5 advanced than the standard approach of here's our measure,
6 here's your score, here's your payment. And that is much
7 beyond where we are going to get to this cycle, so I want
8 to be clear. You're not going to see a lot of that in the
9 chapter or in any changes you'll see next month. But I
10 think it is very clearly heard, and as we move forward to
11 future cycles, understanding the role of some of our
12 imperfect but easily accessible claims data and the role of
13 more challenging to get clinical data, it's important to
14 understand how we can incorporate and combine those two
15 things together. But that is a future thing, so for now I
16 think I'm going to stick with thanks.

17 First, Jim or Carol, Ledia or others want to add
18 anything to this discussion?

19 [No response.]

20 DR. CHERNEW: I see some heads shaking no. Any
21 other comments that Commissioners may want to make?

22 DR. CASALINO: Michael, I'd just like to

1 underscore David's comment about functional status. We
2 didn't really discuss that much, but I'm very supportive of
3 the recommendations, very enthusiastic about them. But I
4 think, you know, going forward, it's an issue we might want
5 to revisit, and I'd be particularly interested in knowing
6 from staff and Commissioners who know much more than I do
7 about how operationally feasible could it be and how
8 effective could it be to have something like audits, for
9 example, with pretty draconian penalties on self-reported
10 functional status, because it is such an important measure
11 -- everywhere, really, but particularly in the SNF context.
12 And, you know, going forward, I'd hate to see us just give
13 up on that, and so I think more discussion about whether
14 there's any way it could be done that would get past the
15 flaws of self-reporting, at least to some extent, would be
16 valuable.

17 DR. CHERNEW: Thank you, Larry.

18 MS. TABOR: I can add one thing to that point.
19 The Consolidated Appropriations Act of 2021 has called for
20 the validation of the data, and they cited an example like
21 how the current inpatient quality data is audited. So
22 obviously there's a lot of questions of what the audit

1 process is going to look like and how it's implemented, but
2 I think that there is potential for hope for improvement in
3 those provider report measures based on the current
4 legislation.

5 DR. CHERNEW: Larry, I think there's a lot of
6 challenges in measuring functional status. It's a little
7 bit different than measuring certain other things. We're
8 not going to go through that point now, but I think your
9 point and I think the first thing David said is what people
10 really care about in many ways is functional status. And,
11 by the way, I would argue it's not just improvement; it's
12 halting a decline in functional status. People care about
13 their functional status. As I age, I will tell you I care
14 much more about my functional status. But it is a
15 particularly challenging thing and it's a potentially very
16 costly thing to measure well, so we need to think about how
17 to build -- this might be a place where more advanced data
18 science could help target our data collection in various
19 ways.

20 We have a lot more thinking to do, and honestly,
21 many of you are more expert than I in this area, and so
22 this is going to be something that will persist. And I

1 would add this issue of quality measurement that is so
2 incredibly important is going to persist across all of the
3 different sectors we deal with. So I'm very glad to have
4 you all so engaged in this discussion.

5 Okay. So this leads to the last part of the
6 morning session, which is this is a public meeting. It is
7 sometimes easy to forget that since we don't get to see the
8 public in front of us as we do when we're actually meeting
9 in person. But I am very aware that the public is here and
10 am grateful for it. So I would like to say to those
11 listening that we really do look forward to your comments.
12 You will see a number of ways in which we listen to the
13 things that you do and how the things that you say to us
14 work its way into the work that we're doing and then into
15 our chapters. So you can reach out to me; you can reach
16 out to the staff; you can go to the website. There are
17 many ways to reach us, and I really do want to encourage
18 public feedback on the discussion we had here, both this
19 one about the SNF VIP but also the rural health access
20 chapter, access to care in rural areas chapter.

21 So, Jim, do you want to say anything else to the
22 public, writ large?

1 DR. MATHEWS: No. I think you've covered
2 everything.

3 DR. CHERNEW: So great. So, again, we are a
4 little early, which is fine. I am hungry anyway. We're
5 going to reconvene at 1:00 p.m. Eastern. So I look forward
6 to that. Until then --

7 DR. PAUL GINSBURG: Mike, do you mean 2:00 p.m.?
8 2:00 p.m., Mike?

9 DR. CHERNEW: Oh, I'm sorry. Yes. Thank you,
10 Paul. That is an important role for people to correct me
11 when I'm wrong.

12 We're going to reconvene at 2:00 p.m. Eastern to
13 continue today's meeting. So, again, I want to thank all
14 of you. I want to thank the public for joining. I'm very
15 much looking forward to the afternoon and very much
16 appreciate all the comments we had this morning. But for
17 now, we're going to get a little bit more time for lunch,
18 and I'll see you all again at 2:00 -- count 'em, 1, 2 --
19 p.m. Are we good? Thanks, everybody.

20 [Whereupon, at 12:38 p.m., the Commission was
21 recessed, to reconvene at 2:00 p.m. this same day.]

22

1 We'll then briefly summarize studies of the
2 impacts of the three main types of APMs and touch on some
3 barriers that may be preventing APMs from having larger
4 impacts on spending and quality.

5 We'll then mention some unintended consequences
6 of CMS implementing multiple concurrent APMs and consider
7 the Chair's draft recommendation, which attempts to capture
8 the Commission's thinking at the January meeting and
9 recommends that CMS implement fewer, more coordinated APMs.

10 In your discussion, we'll be looking for feedback
11 on what we've presented and any requested revisions to our
12 draft paper.

13 We'll then be back in front of you at the April
14 meeting for a formal vote, and our paper will appear as a
15 chapter in our June report.

16 CMMI was established in the Affordable Care Act
17 in 2010 to test innovative payment and care delivery models
18 that reduce Medicare or Medicaid spending while preserving
19 or enhancing care quality.

20 Congress included 27 potential models for CMMI to
21 consider in its authorizing statute and appropriated \$10
22 billion to CMMI every ten years, in perpetuity.

1 CMMI models are typically implemented for three
2 to five years, but may be expanded into a permanent,
3 nationwide program -- without requiring an act of Congress
4 -- if they are found to decrease spending without
5 decreasing quality or to increase quality without
6 increasing spending.

7 CMMI has come up with seven categories to
8 describe its models. Only three of these are what we might
9 call "alternative payment models."

10 APMs focus on altering the way clinicians are
11 paid and include CMMI's accountable care models, episode-
12 based payment models, and primary care transformation
13 models.

14 In contrast, CMMI's four other categories of
15 models include efforts like testing new care delivery
16 models funded through temporary fee-for-service billing
17 codes or grants, technical assistance to providers, and new
18 health plans or care coordination programs for
19 beneficiaries dually enrolled in Medicare and Medicaid.

20 Five years after CMMI was authorized, Congress
21 passed the Medicare Access and CHIP Reauthorization Act of
22 2015, known as MACRA, which created a new 5 percent bonus

1 for clinicians in advanced alternative payment models,
2 which we call "A-APMs."

3 These models require providers to assume "more
4 than nominal" financial risk. The models must also use
5 quality measures comparable to those used in MIPS and must
6 require providers to use electronic health records that
7 meet federal standards.

8 The 5 percent A-APM bonus is available annually
9 from 2019 through 2024 to clinicians with a sufficient
10 percent of payments or patients in A-APMs. Starting in
11 2026, clinicians in A-APMs will qualify for higher annual
12 updates to their fee schedule rates than clinicians not in
13 these models.

14 CMMI has implemented 54 models over its first ten
15 years, many of which have attracted large numbers of
16 participating providers.

17 Only four of these models have been certified by
18 CMS actuaries as having met the criteria to be expanded
19 into a permanent, nationwide program.

20 Only one of these was an A-APM. It was the
21 Pioneer ACO model. CMS incorporated lessons learned from
22 Pioneer into the Medicare Shared Savings Program's Track 3,

1 which in turn evolved into the current "enhanced" track.

2 MSSP is the largest APM in Medicare and is not
3 operated by CMMI; instead, it is a permanent program
4 created by Congress.

5 In 2021, CMMI is expected to operate 13 APMs,
6 involving over 30 tracks for providers to choose from.
7 Most of these APMs have tracks that qualify as A-APMs,
8 since their payment model involves financial risk for
9 providers. Clinicians in these models can qualify for the
10 5 percent bonus I mentioned earlier.

11 According to federally funded evaluations of
12 Medicare's APMs, as well as studies by other researchers of
13 these and other models, APMs have not yet had the impacts
14 on spending and quality that many would like to see.

15 ACOs have the best track record so far -- often
16 producing gross savings, and sometimes producing net
17 savings, although these savings are usually less than 1
18 percent.

19 Quality impacts tend to be small, when they are
20 achieved, and most often consist of reductions in ED visits
21 or increases in the delivery of some preventive services.

22 Episode-based payment models have had somewhat

1 less success. They often produce gross savings, but rarely
2 produce net savings -- with the notable exception of hip
3 and knee replacements, which have saved Medicare 2 percent
4 among hospitals mandated to take bundled payments for these
5 episodes. Studies generally find little to no impact on
6 quality, although the mandatory model I just mentioned
7 reduced rates of readmissions and complications.

8 Primary care transformation models have been
9 studied to a much greater extent than ACOs and episode-
10 based payment models, but have shown more mixed findings in
11 terms of their ability to generate savings. This may in
12 part be due to the wide heterogeneity in the models that
13 have been studied so far. These models generally have
14 little to no effect on quality, but when they do improve
15 quality, they tend to influence the same types of metrics
16 as ACOs.

17 I'll now pass things over to Geoff.

18 MR. GERHARDT: In addition to the impacts on
19 spending and quality described in the previous slide, some
20 observers theorize that APMs potentially have other
21 positive impacts on the health care system, although some
22 of these effects can be hard to quantify.

1 For example, improvements in care delivery
2 patterns prompted by a Medicare APM may lead to changes in
3 the way that providers treat patients insured by other
4 payers.

5 In another example, reductions in gross spending
6 associated with ACOs and other models may have resulted in
7 lower spending on Medicare Advantage, since MA payments are
8 tied to fee-for-service spending.

9 The APMs implemented by CMS also signals to
10 providers that Medicare's ultimate goal is to transition
11 away from purely fee-for-service payment incentives. This
12 may, in turn, be helping to raise provider awareness of the
13 costs they generate and the need to change care patterns to
14 focus more on prevention and efficient utilization.

15 Medicare's pursuit of APMs might also have
16 encouraged other payers to pursue alternative payment
17 arrangements, which could have contributed to the slowdown
18 in growth of national health care spending.

19 It's worth taking a moment to consider why more
20 models have not generated net savings for Medicare or led
21 to substantial improvements in quality.

22 Since many APMs are layered on top of fee-for-

1 service payment systems, the incentives in fee-for-service
2 to increase provider revenue by maximizing volume may
3 outweigh the APM's incentives to reduce volume.

4 And while incentives under fee-for-service are
5 relatively easy for providers to understand and respond to,
6 the incentives in APMs can be extremely complex and
7 difficult for providers to fully understand. The
8 complexity of models may be suppressing provider
9 participation and limiting the effectiveness of incentives
10 for providers to change behavior.

11 In addition, certain providers -- especially
12 those who are employed by a large health care organization
13 -- may be partially or completely shielded from the
14 financial incentives in APMs.

15 Models where participation is voluntary or
16 providers have choices about what services they are
17 financially accountable for are likely to predominantly
18 attract providers that expect to receive performance
19 bonuses without substantially changing their behavior.

20 Infrastructure investments, such as care
21 management staff and data analysis, may be needed to
22 achieve APM performance goals. Some providers may not be

1 able to afford these investments or believe they won't pay
2 off during the model's implementation period.

3 And, finally, beneficiaries attributed to an APM
4 may not have any incentive to change their own behavior,
5 placing the onus for improvement entirely on providers.

6 In addition to the potential barriers to success
7 listed on the previous slide --

8 [Feedback.]

9 DR. CHERNEW: I think someone needs to mute.

10 MR. GERHARDT: I'll try again.

11 In addition to the potential barriers to success
12 listed on the previous slide, there can also be challenges
13 associated with CMS' practice of operating a large number
14 of essentially independent, concurrent models, which we'll
15 discuss on the next two slides.

16 CMS generally does not allow providers to
17 participate in more than one ACO model, but providers and
18 beneficiaries are often permitted to simultaneously
19 participate in multiple types of APMs. For example,
20 providers participating in the MSSP or the NextGen program
21 may also participate in bundled payment models like BCPI
22 Advanced, and beneficiaries attributed to an MSSP ACO may

1 be aligned to a practice in the Comprehensive Primary Care
2 Plus model.

3 While overlapping model participation can
4 increase the participation in APMs, it can also create
5 problematic interactive effects.

6 One potential problem is that having providers
7 participate in multiple APMs can dilute the effectiveness
8 of incentives to bring down costs and improve care if the
9 models present providers with differing financial
10 incentives and operational requirements.

11 Another complicating factor is that performance
12 payments made under a model are often included in the total
13 spending performance of another model, thus making it more
14 difficult to achieve savings relative to the second model's
15 spending target.

16 Having beneficiaries attributed to multiple
17 models can also weaken incentives to bring down costs.

18 To prevent savings -- or costs -- from being
19 double counted, CMS has developed rules about how costs
20 attributable to beneficiaries in multiple APMs are
21 allocated between models. These rules can result in
22 performance payments being divided between models in

1 unanticipated ways, potentially reducing the effectiveness
2 of those payments to change provider behavior.

3 Finally, the prevalence of multiple overlapping
4 models can complicate efforts to isolate and measure the
5 effects of a given APM on spending and quality. With so
6 many models being implemented simultaneously, it is often
7 difficult for evaluators to construct a comparison group
8 that have not been influenced by similar models.

9 CMS deserves credit for implementing a variety of
10 innovative alternative payment and service delivery models
11 over the last decade.

12 However, Commissioners have expressed concern
13 that CMS' approach to testing a large number of independent
14 APMs simultaneously may be inhibiting models' ability to
15 reach their full potential. At the January meeting, many
16 Commissioners were supportive of a policy option that would
17 address this concern by urging CMS to take a more
18 streamlined, integrated approach to implementation of APMs.

19 As such, the Chair's draft recommendation reads:

20 The Secretary should implement a more coordinated
21 portfolio of fewer alternative payment models that support
22 the strategic objectives of reducing spending and improving

1 quality.

2 By urging CMS to implement a smaller suite of
3 models where financial incentives to reduce spending are
4 better aligned, the recommendation could increase the
5 degree to which providers change their behavior in response
6 to model incentives. This could lead to greater reductions
7 in Medicare spending, depending on how the recommendation
8 is carried out by CMS and how providers respond to the
9 smaller group of models.

10 Similarly, beneficiaries should benefit from the
11 recommendation, assuming the smaller suite of models are
12 more effective in encouraging providers to improve care
13 coordination, health outcomes, and other factors important
14 to beneficiaries. To the extent that the recommendation
15 leads to reductions in spending, beneficiaries would also
16 benefit from potentially lower cost sharing and premiums.

17 The recommendation is also likely to have
18 benefits for providers through more predictable financial
19 incentives, reduced administrative burden, and a more
20 consistent set of goals and parameters across models.

21 We now return to the draft recommendation.

22 After we get your feedback today, we will return

1 in April for a formal vote and an accompanying chapter in
2 the June report.

3 We look forward to your input and any questions
4 your might have. I'll now hand things back to Mike.

5 DR. CHERNEW: I'm just a placeholder. I am going
6 to hand things over to Dana Kelley to run the Round 1 queue
7 and then the Round 2 queue. Dana.

8 MS. KELLEY: I think we have one person for Round
9 1, and that is Marge.

10 DR. CHERNEW: And Dana Safran actually, I think,
11 Round 1 request. But go on, Marge.

12 MS. MARJORIE GINSBURG: Okay. This is a quickie.
13 What we've identified, the problems, can't be blinded to
14 CMMI. Have there been any discussions with the leadership
15 there about these problems? Surely they know what we're
16 suggesting, but it just seems so apparent that there are
17 problems with this. I'm just curious whether staff have
18 had conversations with CMMI about these particular issues.

19 MS. BURTON: We have not.

20 MS. KELLEY: Okay. Dana?

21 DR. SAFRAN: Yes, thank you. Just two questions
22 for the team, and, first, thank you for this really

1 excellent work. This chapter has taken shape so nicely.

2 You have a new figure, Figure 3, and it looks
3 like the source of the data for that are from the Health
4 Care Payment Learning and Action network. But I did have a
5 question about it, and that is, the categories of shared
6 savings, upside only or bonus only shared savings, you
7 know, two-sided, which, you know, the parenthetical says
8 "with financial risk." And then there is a separate
9 category of partial capitation, full capitation, global
10 budgets. And I'm failing to grasp how we can be parsing
11 those things since they almost always come in pairs, right?
12 So you could have a global budget contract that has shared
13 savings only. You could have a global budget contract that
14 has two-sided risk.

15 And so can you just help me understand how we are
16 differentiating the amount, whether it is one-sided or two-
17 sided risk, from whether it is a capitated versus budgeted
18 model?

19 MS. BURTON: When a payment model has multiple
20 features, the instructions that the LAN gives to
21 respondents is that they should assign the feature that I
22 guess is the most prominent in the payment model. But we

1 can get back to you offline to discuss this further.

2 DR. SAFRAN: Okay, sounds good. I think we don't
3 want to confuse our readers, because, you know, it could
4 look like there's so much shared savings out there and not
5 understand, you know, those are shared savings that are
6 embedded in global budget models, et cetera. So it seems
7 worth looking at that.

8 My other question was about the direct
9 contracting text box, and in light of the announcement
10 earlier this week about the geographic model, maybe this
11 isn't so relevant anymore, but I'll ask it anyway. For the
12 provider in global models, you noted, "Spending targets
13 were discounted 2 to 5 percent." And then when you were
14 talking about the geographic model, you talked about the
15 rates being discounted 2 to 5 percent. And I just wanted
16 to understand, is the discounting actually applying to
17 different things in these models? Or if not, why are we
18 using different language?

19 MR. GERHARDT: I think that it's based off the
20 same basis, but there are some details about the geographic
21 option that haven't been fully explained or the geographic
22 model that haven't been fully explained. So we can go back

1 and try to clarify that, what the basis is or whether
2 there's any difference between the two.

3 DR. SAFRAN: Okay, great. And I'll come back
4 with Round 2 comments, but just while I'm mentioning this
5 text box, I think it would be good to add something to it
6 that just gives a little information about the level of
7 participation that has been seen so far. So I'll just
8 throw that in and come back later with Round 2.

9 Thank you.

10 MS. KELLEY: Larry, did you have a Round 1
11 question?

12 Larry, we can't hear you.

13 DR. CASALINO: I'll never be able to say this as
14 articulately as I just did. I wasn't going to say this,
15 but Dana's comment made me think it's probably worth
16 bringing up. I have found it always ambiguous when CMS
17 talks about percentage of payments in alternative payment
18 models that involve some financial risk, and I think that
19 ambiguity also comes through into this chapter, which it
20 goes without saying I think is great. Someday there's
21 going to be a chapter that isn't great, but I haven't seen
22 one yet. I mean that seriously, not facetiously.

1 But, for example, looking at Figure 2 -- one
2 could do this looking at either figure -- where by 2025
3 supposedly 100 percent -- the goal is for HHS to have 100
4 percent of health care payments in traditional Medicare be
5 in alternative payment models that involve some financial
6 risk. At least for myself, if I tried to parse that and
7 ask what does that mean exactly, does that mean that all
8 fee-for-service providers are going to be in alternative
9 payment models? Does it mean that every dollar that
10 traditional Medicare pays has some financial risk attached
11 to it? And I could think of alternative hypotheses about
12 what it might mean as well.

13 So I wouldn't mind a comment on that now, but
14 also for the chapter, I think it would be helpful to be as
15 unambiguous as possible about that, because this is kind of
16 an important point. And I think over the years, with HHS
17 at least, it has led to -- the ambiguity has in my mind led
18 to probably an exaggerated impression for some people of
19 how much health care payment really is in alternative
20 payment models now or has incentives tied to it.

21 MS. BURTON: I think that's something we need to
22 do a little digging on, but we can address it in the next

1 version.

2 DR. CASALINO: Great.

3 MS. KELLEY: Sue, do you have a Round 1 question?

4 MS. THOMPSON: Thank you, Dana. I do. Just to
5 level set -- and maybe I'm the only one, but I want to be
6 reminded of the relationship and the authority between CMS
7 and CMMI, and as the recommendation is drafted, our
8 recommendation is towards the Secretary. So, yeah, just
9 clarify again the authority and freedom, if you will, of
10 CMMI to act independently.

11 MS. BURTON: CMMI sits within CMS which sits
12 within HHS. I'm not really sure how to answer your
13 question. I'm wondering if maybe Jeff or Jim has something
14 here.

15 DR. CHERNEW: Could I say my understanding?
16 Although I would defer to Jim first.

17 DR. MATHEWS: Go ahead, Mike.

18 DR. CHERNEW: CMMI has a very specific charge
19 about testing models and diffusing models in a very
20 specific way. And so while at the end of the day I think
21 they have a lot of authority in terms of what they do, they
22 do have to be responsive to basically their charter, and

1 their charter is set out broader than what they do. And I
2 think that is where -- in part, that is where some of the
3 constrain may lie.

4 And I would say more broadly that's why this is a
5 recommendation to the Secretary, although it doesn't mean
6 that it couldn't be -- in fact, I think it would be
7 coordinated with CMMI, but it's not completely clear how
8 far CMMI could go with their existing legislative charter.

9 That's my sense, and, again, I am not an expert
10 in this exact area, so maybe Rachel, Jeff, Jim, or anyone
11 else on the phone may have some sense of that.

12 MR. GERHARDT: So I'll just say CMMI is, of
13 course, a center within CMS. It was authorized within
14 Title 18. CMS is within HHS, which is where we
15 traditionally direct these kind of recommendations to. But
16 I think part of the point that we're trying to make with
17 this is that this is more than just something for CMMI to
18 be thinking about because the largest APM program, MSSP, is
19 not actually administered by CMMI. It's administered by
20 CM, that CMS as an entity needs to be thinking holistically
21 about how to do its APMs. So cross-cutting across both
22 CMMI and other centers within CMS that implement APMs.

1 MS. THOMPSON: Thank you. I just remember at the
2 outset CMMI, they had broad authority, and I just call it
3 out. But thank you very much. That's my question.

4 DR. CHERNEW: I think they do have broad
5 authority, but I do think they have some limits in their
6 charge as to what they're supposed to do. In some ways,
7 we're making a recommendation to have them scale back in a
8 particular way. And so I do think that we'll continue to
9 work through those administrative and logistical lines, but
10 by making a recommendation to the Secretary in some sense
11 we're at a level that subsumes what's below that, at least
12 in my view. But with below, it doesn't necessarily subsume
13 what's above it. I don't know if that makes sense, and I'm
14 sure not an expert. So later when I ask for public
15 comment, the public can send something to MedPAC on this.

16 So, Dana, am I right that that was the last Round
17 1 question?

18 MS. KELLEY: Yes.

19 DR. CHERNEW: So then, Dana, can we start with
20 Round 2?

21 MS. KELLEY: Sure can. Paul, you're first.

22 DR. PAUL GINSBURG: Good. I really enjoyed

1 reading the chapter. I thought it was, you know, very
2 succinct and covered a lot of ground.

3 After I read it, I start thinking about, you
4 know, too many models, lack of coordination, or maybe just
5 poor coordination, and I started thinking that perhaps
6 coordination is a bigger problem than numbers. And, you
7 know, the key to coordination is that we have our
8 population models, plus the ACOs; we have our episode
9 models; we have our primary care models. And it's the
10 coordination among those categories that I think has been a
11 real drag to the system.

12 I don't know that having too many ACOs is that
13 big a problem. It is a problem with their voluntary and
14 where a provider organization can select themselves into
15 the flavor of ACOs that works better for them. But to the
16 degree that coordination is the bigger problem, I think we
17 need to make sure that comes through in the chapter.

18 The second of three comments I had is that when
19 we make the recommendation, the Chairman's recommendation,
20 which, you know, is fine with me, we just stop there. And,
21 you know, this is -- as opposed to sketching out a bit
22 about how CMS might actually go about doing this. And we

1 don't have to give them a blueprint, but just, I think,
2 give them a little more than just, you know, this
3 pronouncement that we need better coordination and fewer
4 models.

5 The third comment I had was that I think it's
6 really important to convey to the readers that this
7 recommendation about numbers of models and coordination
8 between them is really part of a broader strategy about
9 bringing more care into these alternative payment models
10 and in a sense, you know, remind people of the big picture
11 at the beginning and then outline how this particular
12 recommendation fits into this, and maybe even mentions,
13 even though we're going to need another cycle, at least, to
14 go through the other aspects of, you know, what else is
15 coming and where this fits in with that.

16 MS. KELLEY: Mike, I can't tell if you're trying
17 to speak here.

18 DR. CHERNEW: No. I thought -- I think we should
19 keep going. I will have some wrap-up comments, but I think
20 it's important that we get through the queue before I give
21 my reactions.

22 MS. KELLEY: Okay. Dana, you're next.

1 DR. SAFRAN: Thank you. I had to step away for a
2 brief moment, so I apologize if anything I say here is
3 redundant to Paul without giving credit to Paul. I just
4 didn't hear a lot of what you shared, Paul.

5 So the first comment I had was -- by the way, I
6 should say I fully support the Chairman's draft
7 recommendation. So the first comment I had was that I
8 think that the chapter has come a long way. I really like
9 the addition of Table 1. And in part what I like about it
10 is it begins to share some granularity, not just broad
11 sweeping statements about APMs and whether they seem to be
12 working or not, but really like which kinds of APMs seem to
13 be working and how much.

14 To that end, I think that the overall text needs
15 to do a better job of mirroring that, especially in light
16 of recommendations that are to develop a more coordinated
17 and parsimonious set of programs, it really fits with that
18 recommendation that we're saying, you know, not just
19 something broad and sweeping about APMs in general and
20 whether they're working, but which kinds appear to be
21 working.

22 You know, when I looked at the data in Table 1,

1 what I saw which really was encouraging is four out of 15
2 programs had net savings, five programs had net losses, and
3 six were indeterminant. That to me paints a very different
4 picture from what people typically, you know, who are
5 talking negatively about APMs would say. That's more than
6 a quarter of these programs listed having net savings.

7 And it gets better than that, I think, when you
8 look at the groupings because you see that two of three
9 full-fledged ACO programs had net savings, and that's
10 really differentiated from the episode programs that you
11 list where one in five did, and then with the primary care
12 where neither did.

13 So I think there's an intelligence that we get
14 with that table about the groupings and which programs
15 appear to be working and not that we just need to draw out
16 a little bit better in this text. So that's my first
17 comment, and also, you know, that would lead to some
18 adjustments, especially in the executive summary and the
19 final summary segment of the chapter.

20 Then just a couple other probably much smaller
21 points from me. One is in the executive summary I think it
22 will be very valuable to highlight and maybe even cross-

1 reference the work that we'll be publishing on Medicare
2 Advantage. You know, in that work, which I know we'll be
3 talking about later today, we're talking about a program
4 that's 35 years old and has never showed savings. And to
5 not reference that in a relatively new program where, you
6 know, there, I think, can be tremendous skepticism and
7 questioning about what values it's delivering, I think we
8 have to just point to the issue that we shouldn't be
9 holding these to different standards, or if we think we
10 should, to be explicit about why.

11 And then a couple final things. I think on page
12 30 where you're talking about, you know, the various
13 reasons that may have impeded success, in one paragraph
14 we're talking about mixed incentives. I think it would be
15 helpful to just clarify that part of what we're talking
16 about is organizations versus physicians within those
17 organizations, and in the case of organizations, that they
18 likely have mixed incentives, not because the programs are
19 laid on top of fee-for-service infrastructure, but because
20 they have a combination of patients that they're seeing for
21 which they have accountability for total cost of care, and
22 other patients who they do not where, you know, they're

1 seeing them on a referral basis or they are somebody else's
2 budgeted population, and that that creates some mixed
3 incentives; and that, you know, as you point out in a
4 separate comment, physician compensation may be completely
5 divorced from the incentives. So I thought it would be
6 helpful to tease that out.

7 And then, finally, I would just say when you're
8 talking about the voluntary nature, I thought it is helpful
9 to also point out that the ability of providers to opt out
10 and, therefore, the attrition could also be leading to
11 lower participation rates obviously than if the models were
12 more mandatory.

13 So thanks for that, and, again, thank you for a
14 really terrific piece of work.

15 MS. KELLEY: Brian.

16 DR. DeBUSK: First of all, I want to echo the
17 comments. This was a really great chapter, and I think
18 that the summaries of the various models that were done
19 were particularly powerful. It was really grounded all in
20 one place.

21 I do support the Chairman's recommendation. I
22 think there's merit in streamlining the models. If

1 anything, CMMI might actually welcome the release because
2 I'm sure they get pressed from a lot of different sides to
3 pursue a lot of different programs.

4 You know, once we get past this recommendation,
5 it's going to come down to which models make the cut, and I
6 think that's an entirely different conversation. I think
7 when we agree that there are fewer, that we should narrow
8 the models down, it's sort of implicit that we all assume
9 that our favorite model isn't going to get cut.

10 But I also want to agree with Paul's comments
11 regarding coordination of those models. I do think there's
12 a coordinating challenge, again, assuming that we have,
13 say, a population health, an episodic, and a primary care
14 model. The coordination is going to be really key, and I
15 know we're going to have a conversation about do you
16 allocate savings between models or do you follow more of a
17 precedence where one model supersedes the other? I
18 personally would favor savings an allocation model, but,
19 again, that's something we'll do in the next cycle.

20 I also hope that we harmonize as many elements as
21 we can, whether it's how we do attribution, how we do risk
22 adjustments, how we allow risk adjustments to affect

1 benchmarks, how we measure quality. I think there's a
2 great opportunity as we streamline and simplify the classes
3 of models to also address harmonizing the various elements
4 and standardize everywhere we can.

5 The chapter does touch on this, but I would also
6 just for the record like to comment on the fact that all of
7 these models or essentially all these models are still
8 largely built on fee-for-service, and I think you have a
9 very inductive chassis there. I think a lot of energy and
10 effort is put into just simply containing the highly
11 inductive effects of fee-for-service. So I do remain
12 concerned that virtually all APMs are layered on top of
13 that fee-for-service chassis.

14 The other thing I hope we get a chance to discuss
15 is the issue that fee-for-service itself -- people do well
16 in fee-for-service. I mean, you know, we're going to
17 publish a report talking about the 6 to 7 percent operating
18 margins that hospitals have. I just read an article the
19 other day that was talking about physicians that, you know,
20 one-third of all physicians are in the top 1 percent of
21 income earners. And I don't think there's anything wrong
22 with that. I actually think that's a good thing. But I

1 think it underscores the fact that fee-for-service is a
2 comfortable place. There are a lot of people who really
3 thrive and do well. And I think when you start talking
4 about APMs, making the case for change and trying to drive
5 change there is going to be very difficult considering how
6 comfortable fee-for-service is.

7 And that actually brings me to my final comment,
8 which I really appreciated what Dana had to say about the
9 spillover issues. I think that's the other challenge. You
10 know, normally when we talk about does the shared savings
11 model even make financial sense, it triggers this esoteric
12 conversation about, well, you know, what's the variable
13 cost of the hospital or what's the percent of shared
14 savings?

15 But here's an exercise that I think would be
16 really interesting to look at. Let's say you have one ACO
17 patient that -- or one patient or beneficiary that you
18 could actually stop an admission or an ED visit on. And
19 let's say you had 100 percent shared savings share and you
20 had zero fixed costs, so it was completely variable cost.
21 Even in that model, I think you would find that if that
22 behavior spilled over say to another Medicare beneficiary

1 or to a commercial patient, I think what you would find is
2 that the benefit of those shared savings, when it's layered
3 on top of fee-for-service, quickly get wiped out. And just
4 imagine sort of the context for ACOs in general then. You
5 know, if they're successful in the Medicare compartment, in
6 theory they would induce behaviors that would spill over
7 into commercial patients, which instead of reimbursing at
8 91 percent of cost, like Medicare patients do, reimburse at
9 typically double the Medicare -- 180 to 200 percent of
10 Medicare. It wouldn't take a lot of that spillover to
11 completely wipe out the financial benefit of ACOs.

12 So I hope as we go forward, we'll look at the
13 financial backdrop as well and the fee-for-service chassis
14 and realize that we're building all of these models,
15 essentially all of them on a highly inductive chassis.

16 And those are my comments. Thank you.

17 MS. KELLEY: Mike, did you want to jump in here?

18 DR. CHERNEW: I just wanted to say a few things
19 to go forward. The first thing is, just for the folks
20 listening, this is the first step in a series of steps in
21 an arc of activity that will span many cycles and that much
22 of what was discussed, to Paul's comment, for example, are

1 very well taken, about how we move forward is going to be a
2 major endeavor next cycle. But again, as was mentioned,
3 because we may not always agree, because we have haven't
4 attacked all of the analysis, we haven't yet been ready to
5 give very specific notions about how to go forward in
6 substance or process, although certainly we plan to
7 continue that work and to engage with stakeholders as that
8 work is going on. So that's the first part.

9 The second part is, earlier drafts of this
10 recommendation have language like "synergistic and
11 coordinated models." That made the recommendation long and
12 people thought, in discussions, that synergistic and
13 coordinated were a little vague. We will give some thought
14 to the exacting wording. It sounds like people are calling
15 for synergic, coordinated models. So we will continue to
16 think through the actual language here, but the key point
17 is, it is not simply fewer models. It's the recognition
18 that the models interact and the desire to have a portfolio
19 that works together as opposed to a bunch of standalone
20 models, because standalone models, in a world of many
21 models, every model affects everything else.

22 So I'm going to leave it there for now, and I may

1 come back to this theme later. Yes, Dana, you can go on in
2 the queue.

3 MS. KELLEY: David is next.

4 DR. GRABOWSKI: Great. Thanks, Dana, and thanks
5 to Rachel and Geoff for this great work. And I'll start by
6 saying I support the Chair's draft recommendation.

7 I'm going to keep it brief because Dana actually
8 made my main point, and that point is that I think we've
9 done a lot of the hard work in reviewing the prior
10 programs, and that information is there. But I really
11 agree with Dana. I don't know that we really rolled this
12 up and summarized the success of the prior APMs and what's
13 working. And if we're going to try to move to fewer models
14 I think we want to do that in a thoughtful way and build on
15 the literature. And right now it feels like, you go into
16 the details of that table, and Dana already did this, of
17 kind of going through and telling us which kinds of models
18 work. I think things have been a little bit more
19 successful than we characterize it.

20 I would point to Slide 7 in your presentation,
21 with net savings sometimes a bit small, rarely, usually not
22 measured, quality gains inconsistent, little to no impact,

1 inconsistent and small improvements. If you showed me that
2 and said we're going to do fewer models or consolidate, I
3 would say why even bother? We should probably pack this
4 in. So I don't think that we are really kind of packaging
5 this. I understand the sort of coordination of the models
6 will ultimately, and fewer models will lead to better
7 outcomes. I understand the spillovers argument that Dana
8 and Brian made. But I really think we need to kind of
9 message this a little bit better, especially around the
10 ACOs and which of those ACOs have worked and why.

11 So I just think, in sort of summarizing the
12 literature, we could do a better job of that, because
13 ultimately -- I wrote it down and I hope I wrote down what
14 you said right, Dana -- which APMs are working and in what
15 ways, and I think that's what we want to ultimately know.
16 And I think we've done the hard work in terms of the
17 details here, but we need to synthesize this.

18 And I guess maybe this connects to a point Jon
19 Perlin makes often, and I really like, that we need to be
20 systematic in how we summarize the evidence and sort of
21 come up with recommendations. And here's an example of
22 that, where I think some of the better-done studies should

1 be weighted more than just this kind of vast denominator of
2 work that's been done in this area.

3 So once again, thank you for this. I'm very
4 supportive of the recommendation and like the way this is
5 going. Thank you.

6 MS. KELLEY: Amol?

7 DR. NAVATHE: Thanks, Dana. So thanks, Geoff and
8 Rachel, for all the work that you've put in here. I think
9 it is clearly reflected in the direction of the chapter and
10 very, very much appreciated.

11 I, too, would just like to register my support
12 for the Chairman's draft recommendation here. I do think
13 we are definitely headed in the right direction, and it is
14 great to see that.

15 I wanted to, I guess, offer a couple of
16 consideration in terms of somewhat like what David was
17 saying around framing early interpretation, and link it to
18 where I think we are at the kind of arc of APMs in a broad
19 sense, or Medicare programming, where we are headed.

20 So, for example, if we think about -- I really
21 like the fact that on Slide 7 now, in that table, we
22 actually articulate gross savings and net savings, and

1 actually differentiate the two things, because think
2 sometimes they get kind of mashed together. And I think
3 both are critically important, but they tell us two
4 different things. In some sense, if you think about gross
5 savings, the question is, did health care providers change
6 their practice patterns relative to what would have
7 otherwise just been the status quo under fee-for-service?
8 So while gross savings doesn't mean net dollars to the
9 Medicare program, it does indicate something pretty
10 important in terms of the ability for a model to start to
11 shift practice patterns over time.

12 The net savings part, of course, is, in some
13 sense, the Holy Grail of the state Medicare program
14 dollars, and that is clearly a higher bar in some respect.
15 But, at the same time, that could also be interpreted, in
16 part, about the program design, so the way the financial
17 structure of the program itself is. So if we're successful
18 in shifting practice patterns, then we could alter the
19 financial formula, to some extent, to try to generate
20 better savings or further savings, or move from not quite
21 generating savings but to generating savings to the
22 Medicare program.

1 So I just wanted to make sure that we are
2 articulating that interpretation appropriately in our
3 chapter, because I think it is a nuanced point, to some
4 extent, but I don't think it's a subtle point that should
5 be overlooked. And I think, in some sense, if we link this
6 to the arc of innovation, if you will, for the Medicare
7 program, I think had discussed in prior public meetings
8 about this work, that the first decade saw a lot of
9 innovation, just a ton of models coming out there, which I
10 think was most likely very appropriate for where the
11 innovation center was, kind of getting out of the gates.
12 And perhaps now we're shifting more towards this approach
13 that we are recommending, towards kind of synthesizing and
14 coordination.

15 So in some sense, if we applied a yardstick of,
16 are we generating savings to the Medicare program for every
17 model, for each model category, that may, in fact, not be
18 the right yardstick to measure. In fact, we might change
19 the question a little bit and say, can we achieve gross
20 savings, can we achieve practice pattern changes, can we
21 achieve, even at times, net savings within a category? And
22 if the answer to that, which I think at least for ACOs and

1 episode-based payments, the answer is yes for both of those
2 things -- we can change practice patterns and, at times, we
3 can generate net savings to the program as well -- then I
4 think that gives us a lot of energy and direction to move
5 toward, and say, okay, let's consolidate around those
6 program designs and the flavors and design principles that
7 are generating the kinds of practice patterns that we want
8 to see, and then we can try to coordinate. We can try to
9 simplify down, and we can try to coordinate amongst those
10 models.

11 And similarly, on the quality gain side, I think
12 we have to also remember that the goal here is either to
13 keep spending static, and improve quality -- ideally, of
14 course, improving both -- or, on the flip side, keep
15 quality more or less the same and improve in terms of
16 costs. So when we frame things around quality gains alone,
17 I think it does mixed-message a little bit what we're
18 trying to get at there, where if we can actually keep
19 quality fairly consistent, if you will, and generate
20 savings, that's also a really good thing. So we shouldn't
21 lose sight of that.

22 So I think some reframing around that Slide 7

1 table and some of the interpretation there, kind of linking
2 to where we are in this arc of innovation, I think will do
3 us a service and actually creating a cogent argument, if
4 you will, leading to the Chairman's draft recommendation.

5 But broadly speaking, let me echo the prior
6 Commissioners' comments, which is I love the direction
7 we're going in. I think it is clear that we are making a
8 lot of progress in that direction. There is a lot of work
9 for us to do yet, I think, in this space, and I'm excited
10 to be headed in that direction, and Brian and Dana and
11 others have mentioned some of these ideas of harmonizing
12 and standardizing that could actually have impact that even
13 extends beyond the Medicare program itself.

14 So thank you very much for all the work that you
15 guys have done here.

16 MS. KELLEY: Paul, did you have a comment on
17 something Amol said?

18 DR. PAUL GINSBURG: Yes. I'm really glad Amol
19 brought up the issue about the importance of the growth
20 savings estimates in these studies. And just a thought I
21 have is that, you know, now often the net savings are a lot
22 less than the gross savings because of all that's being

1 done to attract providers into these programs, to get them
2 to try it.

3 I would imagine, down the road, when the models
4 get better and there's more experience, and that there's
5 more participation in APMs, you know, kind of the bonuses
6 offered to coax participation likely won't be as important,
7 so the net savings may come up closer to the gross savings
8 as we move forward. So, you know, if it approaches solid
9 gross savings, and even it doesn't have net savings today,
10 that doesn't mean we should dismiss it.

11 MS. KELLEY: Okay. Betty.

12 DR. RAMBUR: Thank you. Thank you for an
13 excellent report, and I appreciate the comments of the
14 Commissioners. Probably my comments will come as no
15 surprise but I'll say them anyway.

16 First of all, I am happy to see us making a
17 recommendation to get at the dizzying array of different
18 models. It's very confusing for people at the working
19 surface to try to sort it all out.

20 When I look at Table 1, the one thing that, of
21 course, immediately struck me is one of the areas that had
22 the checkmarks all the way through is the mandatory, the

1 mandatory joint category, that had gross savings, net
2 savings, and quality improvement. And I would like to see
3 us have these recommendations -- I support these
4 recommendations but more specificity, including more
5 mandated and more risk bearing.

6 I will complement what Brian had said about the
7 fee-for-service chassis, because if you are socialized and
8 marinated in fee-for-service, every cell in your body has
9 that as an instinct. And in the report it says the
10 incentives are easy to understand and respond to, and they
11 are. They are easy to generate a lot of services and a lot
12 of revenue for the person billing fee-for-service, whether
13 it makes an impact or not.

14 So I'm really supportive of this direction. I
15 appreciated the comments on greater coordination. I am
16 pleased to have been sort of illuminated about the
17 importance of gross savings, what it means in terms of
18 practice patterns, but I would like to see us having a
19 little more teeth in it in terms of recommending more
20 mandatory and more full risk bearing. Thank you.

21 MS. KELLEY: Jonathan Jaffery.

22 DR. JAFFERY: Thanks, Dana. Let me start off

1 echoing everyone's comments about what a great chapter and
2 what a great evolution of this work is. It really feels
3 like we are moving things down the road here, and I fully
4 support the Chairman's draft recommendation. I think this
5 is a great place for us to be now.

6 I will just maybe make a few comments about
7 things that sort of signal some thoughts about what we can
8 do, because as Mike has said a few times now, this is a
9 multi-cycle process, and I don't think it's too early for
10 us to be thinking about this with some more concreteness,
11 how we're going forward.

12 So a few things that I would like to see. Betty
13 just talked about one of them, these mandatory models. I
14 think providers will -- we do see that they change
15 behavior. Often they will when forced to and won't when
16 it's optional, and as Brian pointed out, fee-for-service is
17 actually really easy, and for those of us who sit in some
18 of these health systems and talk to folks who have been
19 doing this for a long time, it is just really, really
20 straightforward to think about fee-for-service, when some
21 of these other things are not as straightforward. So,
22 given those options, you can sort of default to keep doing

1 what you've always been doing.

2 We've done a lot of work, over the last couple of
3 cycles, about attribution, at least within ACO models. I
4 think that's great. We've talked about the need to do some
5 more here. And some of the things that I'd like to call
6 out for the next year is really thinking about predictable
7 benchmarks, particularly in ACOs, but I think that's going
8 to be really key, and it probably leads us more down the
9 road towards capitation of global budgets.

10 And then just one final comment about the
11 coordination piece. I won't go on and on about things that
12 others have said. I really appreciated how Paul brought
13 this up, and it's clear, I think, that at least
14 theoretically we could have lots of models and be
15 coordinated and make that work, but if we're not
16 coordinated even with a few models, that's going to be a
17 problem. So the coordination is key.

18 And I think there was one other thing that we may
19 want to explore as we tease things out in the next few
20 cycles, not just thinking about coordination between
21 models, as an example, ACOs and episode payments -- I think
22 there is actually some concrete work we probably should

1 think about fleshing out there -- but it's not just about
2 beneficiary attribution in those models or provider
3 participation, but I think there's also a coordination
4 piece in thinking about what are options for providers when
5 they're going to have multiple groups of patients, or
6 populations of patients, coming in that will be in
7 different categories, and not just because of different
8 payers but even within the Medicare population.

9 So what I really mean by that is thinking
10 probably more about specialists, especially those who have
11 a wide geographic catchment area, how do we get the
12 incentives lined up properly for folks like that -- and
13 actually this goes for hospitals too, and maybe some other
14 providers -- but how do we get those incentives lined up if
15 they've got one maybe sizeable portion of their patient
16 population coming in, in some of these models now, but
17 they're still getting fee-for-service coming from all sorts
18 of other places? And how do we really get to kind of
19 global risk or a situation where we've got 100 percent of
20 payments in some sort of risk model when there are those
21 kinds of arrangements still happening from somebody coming
22 far away for services. So I'd like to see us explore that

1 a little bit too, and think about how that fits in with
2 these.

3 But again, great work and fully supportive of
4 where we're headed with this right now.

5 MS. KELLEY: Jaewon?

6 DR. RYU: Yeah, thank you, Rachel and Geoff, for
7 a really neat chapter on a key subject. I would also echo
8 the support for the draft recommendation. I think it makes
9 a lot of sense for a whole lot of reasons, as folks have
10 mentioned.

11 I do want to get back to something that Paul
12 raised, because I think there is an opportunity, I would
13 agree with Paul, in terms of how do you take the next steps
14 on this. And, in particular, how do you streamline? How
15 do you get to fewer of these programs? And it seems like
16 there are a couple of different dimensions. We've talked a
17 lot, and folks have mentioned the gross and the net
18 savings, and I think keeping an eye on both of those and
19 taking those into consideration makes a lot of sense to
20 guide us to the programs that have been more successful.

21 At the same time, I just want to make sure, and
22 hopefully if I could put in a request, on Table 1 it would

1 be neat to see how many beneficiaries are wrapped up in
2 each of these programs, because I think the notion of
3 uptake should also be a consideration. Which of these
4 programs have had greater uptake? I think the ones with
5 greater uptake, with gross and ideally even net savings,
6 that seems like the sweet spot that we would want to focus
7 on, as opposed to trying to introduce folks to a model
8 that's totally new from where they currently reside.

9 And then the other dimension that might be useful
10 in terms of how we get to a smaller number is we've talked
11 before about categories of programs, and I think there are
12 some categories that many of these fit into. Some are sort
13 of population-based programs, like the MSSP, and then
14 others are more episode-based. And I think there's some
15 framework that we could perhaps offer in terms of are we
16 shooting for a program from this category and a program on
17 that category. I think there's just a little more that we
18 can do to sort of frame out the skeleton, if you will, and
19 then go from there.

20 MS. KELLEY: Larry?

21 DR. CASALINO: Thanks, Dana. Three quite quick
22 comments on the report, and then a more substantive comment

1 about moving forward.

2 Compliments to the staff for the report. It is
3 such a large and complex area and it is really hard to get
4 one's hands around it. I think you guys did a good job.

5 I would make three suggestions on the report.
6 One is, consider maybe putting in a bit of context about
7 how it came about that CMMI initiated so many models. I
8 think, as the report is written, this could be taken as an
9 implicit, pretty strong criticism of CMMI putting in so
10 many models, although I don't think that is what we intend.
11 So maybe just little bit about that. It is quite easy to
12 think of the reasons why so many models were put in place,
13 and they are very understandable reasons. Probably, in
14 retrospect, there were some mistakes made as well, but it
15 is easy to be a Monday morning quarterback. So maybe just
16 a little bit about, historically, why we got so many
17 models. That's the first point about the report.

18 The second is, I agree with Dana and David. They
19 didn't put this maybe quite as bluntly, but the report
20 might be a little too negative, or maybe not quite positive
21 enough about what APMS have been performing so far. Dana's
22 count was pretty persuasive, and also the suggestion of

1 comparing to Medicare Advantage, which has never generated
2 net savings, is probably worth a sentence or two. So I
3 think it would be a shame if the report is framed as maybe
4 a little too hopeless. It's a stronger word, but --

5 And then the third comment, and Dana mentioned
6 this and I'll say it in slightly different terms, I think
7 it is important to distinguish -- "providers" covers a lot
8 of ground in this report, as it often does. You know,
9 different kinds of organizations but also different kinds
10 of organizations and individual clinicians. And leaving
11 the different kinds of organizations out, I think it is
12 really often very important to distinguish between the
13 organization in which a physician, say, works, and the
14 individual physician. I think the incentives for
15 organizations can be different. They can be stronger. And
16 their purpose is different. It's to get organizations to
17 invest in processes to improve the care they provide,
18 invest in infrastructure, and give them some return on
19 investments for the millions of dollars they can spend on
20 that. It's different for physicians. For physicians, we
21 want to change their behavior, and that's best done within
22 their organization.

1 And so I think, just in editing the report, it
2 might be useful throughout, really, to think about
3 organizations versus physicians when you talk about
4 providers, and it might even lead to some new insights.

5 So those are three comments on the report. The
6 last thing I want to say is just, going forward, I think
7 this is going to be the hardest thing, at least since I've
8 been on the Commission, that we've tried to do. I
9 certainly support the recommendation. Having fewer APMs,
10 models, is probably good, and certainly we want them to be
11 coordinated. But I think we're going to have to discuss,
12 very explicitly, what we mean by coordination. It would be
13 great to coordinate on attribution rules and quality
14 measure rules and so on, but I think we mean more than that
15 by coordination. I'm not going to try to define it now,
16 but just to ask a few questions, again, specifically and
17 operationally, what does it mean to have fewer coordinated
18 APMs?

19 Let's say that we had an ACO, and the big problem
20 here, I think, is coordination between ACOs and programs
21 that are aimed at specific specialties, like primary care,
22 or oncology, or nephrology/end-stage renal disease, for

1 example, or orthopedists with joint replacement. I think
2 that if we had an ACO -- let's imagine one that had very
3 strong financial incentives but slowly capitulated, let's
4 stay. So very strong financial incentives to reduce
5 spending, and given some good quality incentives in there
6 as well. You would think that ACO would pick problem areas
7 and work with them to generate lower costs and higher
8 quality, whether that be joint replacement, whether it be
9 oncology care, whether it be end-stage renal disease,
10 whether it be primary care.

11 So what is the purpose of having, let's just call
12 them specialty-specific models, like the ones I've just
13 mentioned. Do we think that we'll need them permanently,
14 for physicians who aren't in highly incentivized ACOs, or
15 do we want to test how well episode payment works, in case
16 ACOs turn out not to work, and we would rely on bundled
17 payments for some things? Or within an ACO, the ACO might
18 try to pay the providers or physicians involved in the
19 particular specialty or a particular kind of disease, like
20 ESRD, in a bundled way.

21 So thinking about it that way, you know, as long
22 as there are ACOs and bundled payments, let's just say,

1 shorthand for these specialty-specific things, we're always
2 going to run into the problem of -- it's going to be very
3 hard to not have overlap between the physicians and
4 hospitals who are in ACOs and the ones who are in bundled
5 payments, unless we have very, very select sets of
6 providers in bundled payments and then a separate set of
7 providers, completely separate, in ACOs.

8 So I think probably what I'm saying could be
9 thought about more deeply, but I think my point is we
10 really need to think about coordination, and it isn't so
11 obvious, to me at least, how easy it is to coordinate
12 between ACOs and specialty-specific things, and even to
13 address the question, what is our ultimate vision? Is it
14 to have lots of multi-specialty organizations that take
15 basically a global cap, and there's no need to bundle
16 anything, or, do we envision some kind of permanent system
17 in which there are ACOs but there are also bundled payments
18 for various things, and primary care practices that have
19 special programs for them that aren't in ACOs. So I think
20 this is going to be very difficult.

21 MS. KELLEY: Pat. Pat, we can't hear you.

22 Can you try now, Pat?

1 MS. WANG: Yes. Can you hear me now?

2 MS. KELLEY: Yes.

3 MS. WANG: Okay. Great chapter. I support the
4 recommendation. Comments that Paul started out with and
5 others have echoed about kind of wanting to say more in the
6 recommendation I think also resonate, but I think that this
7 recommendation maybe less is more because it's almost like
8 a downpayment on the next body of work, and this is the
9 first step. That's the way that I see this, because I
10 don't think we can get all of the comments, because I think
11 we're racing ahead to try to solve the problem, and this
12 is, I think, intended to be the first step conceptually.

13 The goals that I would hope that we could hear or
14 in the next phase keep in mind, you know, Medicare is the
15 gold standard payment system for the country, and to the
16 extent that Medicare does something, it influences
17 everybody else. It influences commercial payers. It
18 influences Medicaid. And I hope that we can keep in our
19 mind that the goal is what's on the screen here, but to me
20 the goal is to promote payment models that start to pervade
21 the entire health care system and that have influence,
22 because all of the comments that people have made about

1 fee-for-service chassis, the two feet in different boats
2 and all of that, the problem is that none of these payment
3 models occupies enough of a provider's revenue world to
4 really change the way they practice. That's the issue --
5 right? -- is getting over a threshold amount so that all of
6 the incentives for a provider are more this way than that
7 way. So I think that that's a concept.

8 People have talked about mandatory models, and I
9 understand why you're talking about it in that language. I
10 would think about it slightly differently, that one of the
11 purposes of testing these things is to find out how to
12 permanently change the payment structure of Medicare. So
13 if it's joint replacements that have been experimented with
14 and it's a good idea, that's the new way that we -- there
15 is no other way to pay for joints. And whether it's, you
16 know, bundling specialty payments or what have you, I kind
17 of feel like that should be an ultimate goal of testing
18 these models, is to permanently make them part of the
19 Medicare lexicon.

20 I hope that as we go forward we can include in
21 our conversations the importance of beneficiary engagement.
22 The other thing that is very special about Medicare,

1 remember, is that the insurance coverage status is stable.
2 Unlike Medicaid where it's in and out based on eligibility
3 recertification, commercial, you change employers, you have
4 a completely different structure around you, Medicare, once
5 you're in, you're in for good. And, you know, that's very,
6 very precious, and I think it gives much more opportunity
7 to engage beneficiaries in a consistent way with consistent
8 signaling.

9 The final comment is I agree with some of the
10 comments about trying to emphasize a little bit more of the
11 positive in the chapter with the language of the chapter
12 pointing out some of the things folks have said about Table
13 1, just noting the success of some of the models. I think
14 it's really quite important because this is very hard work.

15 That said, I find the comparison in service of
16 let's support APMs by saying, oh, but, you know, like we
17 don't hold Medicare Advantage to the same standard because
18 they've never saved the program money is an apples-and-
19 oranges or maybe an apple-and-pomegranate comparison that I
20 would just -- I don't think it's a good one. MA is an
21 insurance program. They're insurance companies. This is a
22 provider sort of redesign payment policy thing. To the

1 extent that an MA program uses APMs, that's an apples-to-
2 apples. But if you want to just toe to toe on who is
3 saving money on delivering the A-B benefit, MA is going to
4 win. So I would be very careful about that. The reason
5 that MA is more expensive, which we're going to talk about
6 next, is because of all the supplemental benefits. They're
7 actually delivering the A-B benefit for less, as the past
8 work has shown. So I'd be careful about using that. I
9 think it's an apple and an orange. I think the APM chapter
10 can stand on its own as having a lot of value, and our
11 support for APMs does not need to be compared to an
12 insurance company program to say that it has value.

13 Thanks.

14 DR. CHERNEW: Let me just say really quickly
15 we're almost at time. We have two more people. I would
16 like to wrap up afterwards, so for Bruce and then I think
17 Marge, can you please be conscious of being concise? I'm
18 sorry. We are where we are in terms of the time. I think
19 Bruce is next. Is that right, Dana?

20 MS. KELLEY: That is correct.

21 DR. CHERNEW: Oh, and Sue. Sue, I think you're
22 on the list, too. Okay, concise. Bruce.

1 MR. PYENSON: Well, thank you very much. I'm
2 supporting the Chair's draft recommendations, and we've
3 heard a lot of really great, great comments.

4 Overall, I think the chapter is not nearly
5 aggressive enough. I would like to see much more direct
6 statements and I think whether we can get that in this
7 round or not is not clear to me.

8 In my view, APMs are the latest version of a
9 great experiment on whether the health care system can be
10 improved and its cost reduced by encouraging providers and
11 organizations to be smarter. It's an experiment. I keep
12 remembering Uwe Reinhardt's statement, "It's the price,
13 Stupid." And APMs are the alternative to that, and it's an
14 experiment. And we're seeing if it's going to work or not.

15 Looking at the list of obstacles on Slide 9, I
16 think the first obstacle there is overwhelmingly the most
17 important. And if that's not addressed -- which is
18 providers in APMs may continue to have incentives to
19 maximize utilization. They may have fee-for-service
20 incentives that are bigger than the incentives of the APM.
21 If that's not addressed in anything CMMI produces, it will
22 be a failure.

1 So I think the other arguments there are either
2 derivative or, frankly, wrong. In particular, saying that
3 models' incentives can be hard for providers to understand
4 strikes me as not very realistic. You could think of
5 physicians at the top of their class. You could give them
6 a multiple-choice question. Here's the design for
7 reimbursement. A patient comes in with back pain. In the
8 context of this design, do you send them for imaging? Do
9 you send them for physical therapy? Do you send them to
10 the orthopedic surgeon? You know, I'm sorry -- I'm not a
11 clinician -- if that's awkward choices. But I don't think
12 the evidence is there that the incentives are too hard to
13 understand. And let's keep in mind, as others have said,
14 Jonathan in particular, that we're dealing with
15 organizations, not individuals.

16 So, overall, I find myself -- this is key work.
17 It's terrific work. I support the recommendation. But I
18 think we have to be more aggressive and think more
19 poignantly about making this work. Thank you.

20 MS. KELLEY: Sue.

21 MS. THOMPSON: Thanks, Dana. And building on
22 those comments Bruce just made in terms of complexity, you

1 know, while the incentives may seem simple, simply even
2 managing the quality metrics and being clear with providers
3 and up-to-date with providers on the variation in quality
4 metrics of the various plans that exist within a network,
5 that an ACO holds, in the reading, I mean, we know that
6 most consistently ACOs are reducing emergency Department
7 visits, increasing delivery of preventative services and
8 chronic disease management. That's good, but those are not
9 measurements in Medicare's 2021 quality measures.

10 So, you know, I just think it's really important
11 to recognize what incentives seem simple is not so simple
12 for the practicing physician and provider.

13 Also, I want to call out in the reading the
14 comment made about success by a few private insurers with
15 primary care transformation models. Assuming success means
16 reducing cost and improving quality, it would be
17 interesting to understand what's the common thread. What's
18 happening in integrated health care systems that enabled
19 them to success for those commercial plans? But I think
20 that goes into the category of what are we learning and
21 whether we need to continue to roll out and perhaps move
22 into the mandatory discussion, which I have to tell you, as

1 I listened to the discussion today around mandatory, I had
2 a little bit of palpitation thinking about those providers
3 out there who many ACO networks would not necessarily be
4 very interested in taking into their ACO network. So if
5 this becomes mandatory and assuming ACOs survive as an
6 alternative payment model in some way, shape, or form, do
7 not underestimate the challenge of some providers finding a
8 home and participation in APM.

9 So, you know, with that, I wish everyone all the
10 best. I will watch this conversation carefully into the
11 next season of discussion. Thank you.

12 MS. KELLEY: Marge, I think you're the last one.

13 MS. MARJORIE GINSBURG: Yes, and I raised my
14 hand, and then Pat spoke before I did, so I just wanted to
15 say I completely agree with Pat regarding leaving the MAs
16 out of this. Not only is it apples and oranges, MAs do
17 save money; it's just that we haven't captured it yet.
18 It's all going to them. So it really should not be part of
19 this chapter at all.

20 So, anyway, thank you, Pat, for mentioning that.

21 DR. CHERNEW: Okay. I think we're at time. I am
22 going to wrap up briefly. Then we're going to move on to

1 the Medicare Advantage chapter, which does indeed save
2 money growth but not net. But, in any case, we'll save
3 that.

4 Here's what I heard. There's some discussion
5 about the language of the recommendation, and I think
6 Larry's comment about what is coordination and a whole slew
7 of other things really highlights why we ended up with the
8 recommendation draft that we do, is that as soon as you
9 begin to say more in that, it becomes very complicated.
10 You have to define a bunch of general terms, which gets to
11 a broader point, which is while I hear -- and, believe me,
12 I've heard from a lot of you. While I hear there's a
13 desire to say more and do more, I guarantee there are
14 differences amongst us that we haven't yet done the
15 analysis, the hallmark of our work, to know exactly what we
16 want to say about things like population-based versus
17 episode, how benchmarks evolve, what should be mandatory
18 versus what should not be mandatory, a whole slew of things
19 like that.

20 We will, I promise you, get to those topics, but
21 I fear that in this particular sense I don't want to go
22 give a sort of shoot-from-the-hip guidance about what

1 should happen. I think it's much more complicated when you
2 get into the details, although we will work in the wording
3 of the chapter to try and do that.

4 The last thing that I heard that we will work on
5 is -- and, actually, I think there was actually quite a lot
6 of consensus on this point. And I actually believe that
7 the staff and folks understand there are a lot of pockets
8 of success in APMs. It is sometimes diluted by things that
9 haven't worked, and, Jon Perlin, I think he would probably
10 say something like we have to call out those things as
11 well, to give Jon credit for what I suspect he would say.

12 In any case, that is all true, but I do think we
13 can work on the tone of how we present the evidence,
14 because I really do think there is not only success; you
15 will see in some cases, for example, the success grows over
16 time. I think you will see the success is concentrated in
17 some models in sort of types of organizations. And so one
18 might think about a portfolio of models where different
19 payment models are designed for different types of
20 organizations.

21 There's just a lot, a lot -- maybe I should
22 emphasize -- I don't have enough time since we're out

1 enough -- a lot to be done. But we will work very much on
2 that. I think this is the first step towards changing the
3 thinking about how we're going to transform payments so
4 things work together as opposed to just test and diffuse,
5 test and diffuse. But there is a lot of uncertainty and a
6 lot of work to be done on exactly how to make those things
7 work.

8 So, again, you know it's a passion of mine, and
9 we will get to it. I could not be happier to have you all
10 along on this journey. But with that said, I think it's
11 important that we turn to the next session, which is on
12 Medicare Advantage. So, Andy, are you going first?

13 DR. JOHNSON: Yes.

14 DR. CHERNEW: Okay. So I'm turning it to Andy,
15 and we're going to talk about MA.

16 DR. JOHNSON: Good afternoon. This presentation
17 addresses the system for setting benchmarks, used in
18 calculating payment rates for Medicare Advantage plans.

19 The audience can download a PDF version of these
20 slides in the handout section of the control panel on the
21 right side of the screen.

22 Today we will discuss how the current benchmark

1 system results in inequities in payment rates and in the
2 availability of extra benefits. Unlike our payment
3 adequacy analysis for Original or fee-for-service Medicare,
4 where we consider the direct financial pressure necessary
5 to constrain providers' costs, the MA payment system
6 passively tracks changes in fee-for-service spending.

7 Despite long-held expectations that private plans
8 would achieve savings relative to fee-for-service Medicare,
9 over 35 years no aggregate savings have been realized.

10 In light of prior Commission discussion in
11 November 2019 and October and December of 2020, we have
12 worked with the Chair to develop a recommendation for a new
13 approach to establishing MA benchmarks that reflects the
14 Commission's discussion.

15 In today's presentation, I will provide some
16 background comparing MA and fee-for-service programs,
17 including differences in the two programs' benefit
18 structures and levels of Medicare spending.

19 I also will review the current MA payment system
20 and describe issues with its method of setting benchmarks.

21 Luis will discuss an alternative approach to
22 setting benchmarks and will present the Chair's draft

1 recommendation for replacing the current benchmark system
2 with the alternative approach.

3 We start by looking at Medicare payments over
4 time. Studies find that although private plans have
5 generated savings in some high-spending regions of the
6 country, no private plan program has ever yielded aggregate
7 savings to Medicare.

8 Prior to 2004, including the early period when
9 payment rates were set at 95 percent of fee-for-service
10 spending, payments to private plans were biased due to
11 favorable selection such that payments averaged 5 to 7
12 percent above fee-for-service costs for similar
13 beneficiaries.

14 Although an improved risk adjustment system was
15 introduced in 2004, the Medicare Modernization Act
16 introduced a new benchmark policy that significantly
17 increased payments to MA plans, reaching a peak in 2009 at
18 17 percent above fee-for-service spending.

19 Subsequently, the Affordable Care Act revised MA
20 benchmark policy and payments declined. With the ACA
21 revisions fully phased in, average MA plan payments have
22 been steady for the past few years, with plans receiving

1 about 3 to 4 percent more than fee-for-service costs for
2 similar beneficiaries.

3 Before we move on, I want to address an industry
4 blog post that misrepresents MedPAC's assessment of MA and
5 fee-for-service spending levels and offer some clarity.
6 The blog focuses on a slide presented in our Context for
7 Medicare Payment Policy September presentation. The
8 context chapter focuses on relative spending growth rates
9 among the different parts of the Medicare program -- MA,
10 fee-for-service, and Part D, and is not intended for
11 comparing MA and fee-for-service spending levels.

12 MedPAC does compare MA and fee-for-service
13 spending levels and since 2004 has reported the results in
14 the Medicare Advantage status report chapter that appears
15 in our March report to the Congress. The result of these
16 annual comparisons are aggregated on the previous slide.
17 Our analysis accounts for differences in health status, the
18 geographic distribution of enrollment, Medicare spending
19 for hospice and graduate medical education, and diagnostic
20 coding that inflates MA risk scores.

21 Separately, MedPAC has recognize that the CMS
22 method of calculating fee-for-service spending when setting

1 MA benchmarks could be improved.

2 In 2017, the Commission recommended that, for
3 setting benchmarks, fee-for-service spending could be
4 calculated exclusively using beneficiaries who have both
5 Part A and Part B Medicare, which aligns with the
6 enrollment requirements from MA. We estimated that making
7 this change would increase estimated fee-for-service
8 spending by one percentage point and would move the line in
9 the previous slide down by about one percentage point.
10 Anything for all of these factors is necessary for an
11 apples-to-apples comparison of MA and fee-for-service
12 spending, and our conclusion continues to be that, when
13 compared fairly and accurately, Medicare spends more for MA
14 than for fee-for-service Medicare.

15 Now we move on to a more broad view of the MA
16 program. Some predicted that the MA plan offerings and
17 enrollment would decline under the ACA payment reductions.
18 Instead, MA plans were able to reduce costs and increase
19 benefits. The MA program hosts a robust set of plan
20 offerings and has been growing steadily.

21 Between 2016 and 2021, the share of Medicare
22 beneficiaries enrolled in MA rose from 33 percent to 46

1 percent, and the average number of plan choices increased
2 from 18 to 32 plans, and the availability of a zero premium
3 plans rose from 81 to 96 percent of Medicare beneficiaries.

4 Extra benefits include reduced cost sharing,
5 reduced Part B and Part D premiums, and a wide range of
6 health-related benefits, including vision and dental
7 coverage, gym memberships, food assistance, and pest
8 control. The annual value of all extra benefits increased
9 by more than 70 percent over the past 5 years, reaching
10 nearly \$1,700 for 2021 and accounting for 14 percent of all
11 MA payments.

12 All of these metrics are near or at record levels
13 in the MA program.

14 When choosing between a Medicare Advantage plan
15 and fee-for-service Medicare, beneficiaries consider
16 whether they prefer the unrestricted provider networks and
17 less utilization management in fee-for-service Medicare or
18 the reduced cost sharing and health-related benefits that
19 plans offer, often at no additional cost to the enrollee.

20 In fee-for-service, reduced cost sharing and
21 additional benefits are available to some through an
22 employer-sponsored plan, while others may purchase a

1 Medigap supplemental coverage plan. These plans, however,
2 can have significant cost and access limitations.

3 Noting the record high level of extra benefits
4 available in MA, which are not available in fee-for-
5 service, we consider whether the tradeoff is equitably
6 balanced for beneficiaries.

7 Furthermore, among MA enrollees, the availability
8 of these extra benefits varies across the country due to
9 differing benchmark levels. These inequities could be
10 reduced under the alternative benchmark system we will
11 discuss today.

12

13 Next we consider the substantial efficiency MA
14 plans demonstrate relative to fee-for-service Medicare.
15 2021 MA plans bids for Part A and Part B services are 87
16 percent of fee-for-service spending, and 91 percent of
17 projected MA enrollees are in plans bidding below fee-for-
18 service spending.

19 However, for the same year, Medicare will pay MA
20 plans 4 percent more than fee-for-service Medicare would
21 spend for similar beneficiaries. Quality bonuses partially
22 account for the high MA payment levels, but even after

1 excluding the effect of quality bonuses, base benchmarks
2 are 3 percent above fee-for-service spending.

3 Without reforms to the benchmark system, Medicare
4 will continue to pay more for MA than for fee-for-service
5 Medicare. In considering the alternative approach to
6 benchmarks, the Commission should consider the level of
7 Medicare savings we should expect from the MA program.

8 We note that inequities on the previous slide and
9 the high payment levels noted here exist in the current
10 system where MA plan quality is not meaningfully measured
11 and encounter data limitations hinder our ability to
12 understand plan efficiency.

13

14 Next let's review how Medicare currently pays MA
15 plans.

16 Each plan calculates a bid, which represents the
17 plan's needed revenue to cover the Part A and Part B
18 benefits for a beneficiary. The bid is compared to a
19 benchmark, which is a bidding target based on average fee-
20 for-service spending. I will explain how benchmarks are
21 set on the next slide.

22 If a plan's bid is below the benchmark, which is

1 the case for almost all plans, Medicare will pay the plan
2 its bid plus a share of the difference between the bid and
3 the benchmark.

4 This share, called a "rebate," ranges from 50 and
5 70 percent of the difference and averages about 65 percent.
6 Plans must use their rebate to provide the extra benefits I
7 mentioned earlier. The remainder of the bid and benchmark
8 difference is retained by Medicare.

9 In the rare cases that a plan bids above the
10 benchmark, Medicare pays the plan its benchmark and
11 enrollees must pay a premium to make up the difference.

12 Now let's look at the current system for setting
13 benchmarks. A benchmark is established for each county
14 based on per capita fee-for-service spending.

15 Counties are ranked lowest to highest and divided
16 into quartiles. For counties in the lowest-spending
17 quartile, benchmarks are set at 115 percent of local fee-
18 for-service spending.

19 Moving up the quartiles, county benchmarks are
20 set at 107.5 percent, 100 percent, and in the highest-
21 spending quartile set at 95 percent of local fee-for-
22 service spending.

1 In counties with low fee-for-service spending,
2 benchmarks are set above fee-for-service to help attract MA
3 plans, and in counties with high fee-for-service spending
4 benchmarks are set lower than fee-for-service to generate
5 Medicare savings.

6 As noted earlier, the 2021 benchmarks average 103
7 percent of fee-for-service spending, if you ignore the
8 impact of quality bonuses, which the Commission has
9 recommended eliminating.

10 I will briefly mention a few issues with the
11 current benchmark system that are described more thoroughly
12 in your paper.

13 First, areas with benchmarks set 15 percent above
14 fee-for-service have attracted a disproportionate share of
15 MA enrollment.

16 Second, the quartile system creates benchmark
17 cliffs where small differences in county fee-for-service
18 spending result in large differences in benchmarks.

19 And, finally, despite plans' demonstrated
20 efficiency relative to fee-for-service, with bids averaging
21 87 percent of fee-for-service spending, the current system
22 of benchmarks results in payments to plans that are higher

1 than fee-for-service spending would be for similar
2 beneficiaries.

3 Now I'll turn it over to Luis to discuss a new
4 approach for establishing benchmarks.

5 MR. SERNA: Some issues with MA benchmarks could
6 be more fully addressed with major changes to the MA
7 program, such as uniformity in benefits. Changes like this
8 would likely entail more extensive changes to the MA
9 benefit structure. Over the long term, the Commission
10 could discuss these kinds of issues.

11 In the short term, alternatives exist that could
12 be implemented immediately. A short-term alternative would
13 not preclude any longer-term structural changes to MA.

14 A revised benchmark system should have attributes
15 that leverage the efficiency of MA plans and support their
16 wide availability.

17 Over the course of multiple public meeting
18 discussions, attributes of a benchmark alternative that
19 Commissioners have generally favored are: one, eliminating
20 benchmark cliffs; two, bringing benchmarks closer to fee-
21 for-service spending in the 115 percent and the 107.5
22 percent quartiles; three, putting at least some additional

1 pressure on some benchmarks in the 95 percent quartile;
2 and, four, an immediate change in benchmarks that is not
3 overly disruptive to basic supplemental coverage.

4 In October and December, we presented an
5 alternative system for establishing benchmarks that
6 conforms to these improvements and immediately replaces the
7 current quartile structure. This system removes the
8 quartile-based payments by blending local area and national
9 spending. It achieves savings by applying a discount
10 factor to benchmarks. We simulated benchmarks and payments
11 for this alternative relative to current policy.

12 Building on Scott Harrison's work last cycle, we
13 compare our simulations with 2020 base benchmarks, which do
14 not include quality bonus and are an estimated 103 percent
15 of fee-for-service. Including quality bonus would have
16 increased benchmarks by four to five percentage points.

17 A blended benchmark alternative would also
18 include prior MedPAC recommendations, which we have
19 incorporated into our simulations where applicable.

20 We simulate a blended benchmark with a 75 percent
21 rebate. More detail on the underlying assumptions used for
22 our simulations can be found in your mailing material.

1 First, we turn to the weighting of local and
2 national fee-for-service spending. We rank-ordered
3 counties by local fee-for-service spending as seen by the
4 light blue line.

5 When we plot current base benchmarks, we see
6 several discontinuities relative to local fee-for-service
7 spending -- as seen by the gray line with pervasive peaks
8 and valleys.

9 After modeling various local and national
10 weights, we found that blended benchmarks under a 50/50
11 weighting structure conformed to the Commission's guidance
12 of better leveraging plan efficiency without constraining
13 beneficiary access to plans.

14 Overall, an equal blend of local and national
15 spending was the only option that moved benchmarks in the
16 lowest spending areas much closer to fee-for-service, while
17 also applying modest additional pressure on the highest
18 spending areas.

19 We simulated blended benchmarks using MedPAC
20 areas and found that nearly all MA markets had an average
21 bid below the blended benchmark; 90 percent of MA market
22 areas had an average bid more than 5 percent below the

1 blended benchmark. Thus, plan efficiencies could be
2 further leveraged through a discount rate.

3 Without applying a discount rate, the program is
4 unlikely to share in plan efficiencies and achieve savings.
5 We simulated a 75 percent rebate and compared payments
6 using a discount rate of 0 percent with a discount rate of
7 2 percent. Lowering all blended benchmarks by 2 percent
8 yields savings of 2 percent.

9 While a blended benchmark structure would remove
10 the payment quartiles, we examined payments by quartile of
11 fee-for-service spending to compare with current policy.
12 As seen in the cells on the right-hand side circled in
13 yellow, a 2 percent discount rate helps ensure modest
14 savings of 1 percent in the two highest quartile areas.

15 We also simulated plan availability under a 2
16 percent discount rate. Assuming no change in 2020 bids,
17 which is likely conservative given that bid levels
18 decreased in 2021, nearly all beneficiaries would continue
19 to have an MA plan available with enough rebate dollars to
20 cover 2020 levels of cost sharing. On average, even
21 beneficiaries in the lowest-spending quartile areas
22 (indicated in yellow text) would have access to six

1 different plan sponsors offering 15 plans that could
2 provide 2020 levels of cost sharing.

3 Results were similar when we examined the ability
4 of plans to provide 2020 levels of both cost sharing and
5 premium reductions. Taking these measures together, a 2
6 percent discount rate would have a relatively modest
7 disruption to beneficiary access to MA basic supplemental
8 coverage.

9 In summary, the MA sector is extremely robust,
10 but the MA benchmark system is flawed and has not yielded
11 aggregate savings to Medicare.

12 An alternative benchmark approach would better
13 balance efficiency with equity.

14 Payment would be set on a continuous scale of
15 local fee-for-service spending.

16 Benchmarks currently above local fee-for-service
17 spending would be brought closer to local spending levels.

18 Additional modest efficiencies would be leveraged
19 in areas where plans bid far below local fee-for-service
20 spending.

21 And there would be minimal disruption to basic
22 supplemental coverage, such as cost-sharing reductions.

1 That brings us to the Chair's draft
2 recommendation, which reads:

3 The Congress should replace the current Medicare
4 Advantage benchmark policy with a new MA benchmark policy
5 that applies: a relatively equal blend of per capita local
6 area fee-for-service spending with price-standardized per
7 capita national fee-for-service spending; a rebate of at
8 least 75 percent; a discount rate of at least 2 percent;
9 and prior MedPAC MA benchmark recommendations -- using
10 geographic markets as MA payment areas, using the fee-for-
11 service population with both Parts A and B in benchmarks,
12 and eliminating the current pre-ACA cap on benchmarks.

13 Relative to current law, this recommendation
14 would lower program spending.

15 Based on our simulations, we do not expect this
16 recommendation to have adverse effects on beneficiaries'
17 access to plans. MA would continue to be a viable
18 alternative for beneficiaries seeking supplemental coverage
19 of cost sharing and lower premiums.

20 Beneficiaries would likely see reduced coverage
21 of extra benefits because plans will have lower payments;
22 the magnitude of change in extra benefits depends on plan

1 response; plans may choose to reduce profits or otherwise
2 lower their cost of providing the Medicare benefit -- that
3 is, they would become more efficient through lower bids.

4 Our simulations indicate a small effect on plan
5 participation in MA, with little constraint on the plan
6 options currently available. Without any change in bidding
7 behavior, nearly all plan sponsors would be able to offer
8 plans with enough rebate revenue to maintain the same level
9 of cost sharing and premium reductions as currently exists.

10 Now I turn it back to Mike.

11 MS. KELLEY: Mike, we can't hear you.

12 DR. CHERNEW: Sorry. I had to switch to my phone
13 because I was having some technical issues.

14 So wonderful. That was a terrific chapter. I
15 know we started late, so please, everybody, be concise so
16 everybody who wants to talk can talk. And I'm going to
17 turn it over to Dana to start the Round 1 questions.

18 MS. KELLEY: I have Larry first.

19 DR. CASALINO: Two quick questions for Andy and
20 Luis. By the way, great job of making a complicated
21 subject very clear. Could you show Slide 9 again?

22 I must be missing something extremely obvious

1 here, but if each quartile has the same number of counties
2 in it and you want to get the average benchmark, would you
3 just add the four percentages in the current benchmark
4 column and divide them by four? Which wouldn't come out to
5 103 percent, so I must be missing something here.

6 DR. JOHNSON: There is an equal number of
7 counties in each of these four quartiles with the exception
8 of the territories are included in one alone, but the
9 number of beneficiaries in each is not the same. And as
10 the counties have changed their ranking and the lowest to
11 highest fee-for-service spending ranking, some of the
12 larger counties in terms of enrollment have moved up
13 towards the 115 percentile and changed the average bid --
14 excuse me, the average benchmark.

15 DR. CASALINO: So you got the 103 percent by
16 basically an average weighted by the number of
17 beneficiaries in each county?

18 DR. JOHNSON: That's right.

19 DR. CASALINO: Okay. Great. Maybe that's
20 explained in the report, but if it's not, maybe it ought to
21 be in case you have people like me reading it.

22 Then could we just look at the last slide again?

1 Is there a slide after this? Maybe it slide -- yeah, this
2 one. So the next to the last bullet point, beneficiaries
3 would likely see reduced coverage. It depends on plan
4 responses. Is that possibly too strong a statement, the
5 reduced coverage? I mean, there's a lot of competition in
6 Medicare Advantage right now among plans, and the plans are
7 very profitable. So if they have -- if plans are receiving
8 somewhat lower payments, can we really predict that they're
9 going to reduce benefits? Or might they just not reduce
10 profits because they are profitable and because there is
11 pretty intense competition? So I don't know exactly how or
12 why we would make a firm statement like they'd likely see
13 reduced coverage of beneficiaries.

14 MR. SERNA: That's definitely an issue. It
15 depends on client response to lower benchmarks. So I think
16 when we simulate this we assume no change in bidding
17 levels, which, of course, we know that at least some plans
18 can lower their bids relative to 2020 levels. But that is
19 correct, and we said that in the narrative, but on the
20 slide, we could definitely tone down the language or make
21 it seem less clear how plans would actually respond.

22 DR. CASALINO: Yeah, I think that might be wise.

1 If I was a health plan executive, I really want you to sign
2 up with my plan, and I was making a lot of money from MA, I
3 might be willing to make a little less money than have you
4 switch to another plan.

5 MS. KELLEY: I have Pat next, with a Round 1
6 question.

7 MS. WANG: This is just real quick. Luis, I
8 think I heard you say, when you were explaining the 103
9 percent, you said it excludes quality, which if you
10 included quality would add another 4 to 5 percent?

11 MR. SERNA: That's correct.

12 MS. WANG: Did I hear that correctly? Okay. You
13 see, that 4 to 5 percent, is that apples to apples to
14 what's in Table 11 in the Appendix, because it estimates
15 the impact of the MedPAC recommendation to eliminate the
16 quality bonus as 2 percent.

17 MR. SERNA: So that's level of payment. So when
18 we calculate the level of payment, not the level of change
19 in benchmark.

20 MS. WANG: Oh, oh --

21 MR. SERNA: So level of payment will be based on
22 the rebate, which is the difference between the bid and the

1 benchmark.

2 MS. WANG: So the benchmark goes up 4 to 5
3 percent, but after you go through all the bid mechanics,
4 the actual payment is 2 percent.

5 MR. SERNA: Two or 3 percent, yeah.

6 MS. WANG: Two to 3 percent to the plan. Okay.
7 Got it. Thank you.

8 MS. KELLEY: Bruce?

9 MR. PYENSON: I have a question on Slide 18.
10 Thank you. Is part of the recommendation the elimination
11 of the bonus, is one question. And another question, I
12 thought earlier in our discussions we had consideration of
13 standardization of supplemental benefits. Is that
14 something for a later consideration, and we sort of put
15 that off? So two questions, the elimination of the bonus
16 and the standardization of supplemental benefits.

17 MR. SERNA: So the elimination of the bonus is
18 not explicitly part of the recommendation as currently
19 stands. If you all want that included in the last bullet,
20 that can be included. Of course, part of this is a
21 continuation of the recommendation on eliminating the
22 quality bonus and replacing it with the MA value incentive

1 program, which left rebates open. So in this case we said,
2 in our draft recommendation, we have the rebates would be
3 at least 75 percent. But if you want it explicitly -- for
4 that recommendation to be an explicit part of the late
5 bullet here, I think that would be for you all to discuss.

6 On the second point -- oh, go ahead.

7 DR. CHERNEW: No, you finish, Luis, and then I
8 will jump in.

9 MR. SERNA: On the second point, for
10 standardization of supplemental benefits, that is something
11 that could potentially explore in another cycle but it is
12 not something that we're addressing this go-around.

13 DR. CHERNEW: Jim, did you want to say something?

14 DR. MATHEWS: I do, but I don't want to conflict
15 with whatever you might have on deck.

16 DR. CHERNEW: That's funny because I don't want
17 to conflict with what you might have on deck. You guys get
18 to see the deliberation real time.

19 So the recommendation that you guys made prior to
20 my being in the current position stands already as an
21 independent recommendation, and we have not discussed
22 incorporating them per se, because what you are alluding

1 to, Bruce, I think it is a reasonable point to have some
2 recognition in the chapter of the relationship between them
3 or not. But this recommendation does not subsume the
4 previous recommendation, just to be clear. I wasn't part
5 of the Commission when that previous recommendation was
6 made, and there's issues with the interaction, I
7 understand.

8 And regarding your second point about
9 standardization, that would have to be something for
10 another cycle. There is, of course, a process by which we
11 get to recommendation, going through a policy options
12 meeting and then the meeting we're having now, which is the
13 draft recommendation, you know, the meeting on the
14 recommendations. So it takes a while to do, for example,
15 the analysis behind something like that, and that would
16 have to be some different cycle, and certainly I am open to
17 some discussion about that. Of course, just pros and cons,
18 that would have to be discussed. And because they're pros
19 and cons we're not really ready to cycle to think about any
20 standardization issue.

21 Jim, how did I do. I've got move this cat so I
22 can see your face.

1 DR. MATHEWS: Yeah, no worries. So I agree
2 completely with your comments on standardization of extra
3 benefits. It is something we can contemplate next cycle.
4 With respect to explicitly including the QBP recommendation
5 as part of this package, for myself, for whatever it's
6 worth, I would urge the Commissioners to regard that as a
7 separate standalone recommendation, and to the extent we
8 have scooped up prior recommendations as the last clause of
9 this bullet, they are recommendations that pertain directly
10 to how Medicare calculates benchmarks and thus are directly
11 relevant to this question at hand. And that is the
12 distinction I would make as to why some of our prior
13 recommendations are here and others are not.

14 MR. PYENSON: Okay. That was a nuance I hadn't
15 appreciated. Thank you.

16 MS. KELLEY: I have Marge next with a Round 1
17 question, if we're ready to move.

18 MS. MARJORIE GINSBURG: Yes, and this is such a
19 basic question I'm embarrassed to ask it, but I'm finally
20 getting up my nerve to ask it.

21 So the quartile chart that shows low spending
22 fee-for-service folks equates then to a much higher

1 benchmark, would you explain to me why? If they're in a
2 low-spending area for fee-for-service, why would we not
3 assume that it's a low-spending area for MA plans? Why
4 would we give them so much more? I don't get it. Anyway,
5 thank you.

6 DR. JOHNSON: At the time that ACA was passed, I
7 think the thinking was that there was a balancing of two
8 goals. One is availability of MA plans as an option for
9 beneficiaries broadly across the country, and another was
10 to bring the benchmarks down from where they were at much
11 higher earlier levels. And so I think the higher
12 benchmarks for low-spending fee-for-service areas is part
13 of the goal to allow for a broad plan availability to
14 beneficiaries where the benchmarks are below fee-for-
15 service spending in high-spending areas and an attempt to
16 balance it, but as we've noted, the balance is not perfect
17 and there isn't a stabilizing mechanism that maintains that
18 balance over time, so the benchmarks have actually risen up
19 to 103 percent now.

20 MS. MARJORIE GINSBURG: Thank you.

21 DR. CHERNEW: Marge? I think part of the issue
22 is there was some concern generally about beneficiaries in

1 areas that were officially practicing medicine being
2 disadvantaged because they wouldn't have access to the
3 added benefits that beneficiaries in higher-spending fee-
4 for-service areas would have access to. So it wouldn't be
5 particularly valuable for a bunch of people in some places
6 to get free vision or dental care, for example, and other
7 places not because they happened to be in places that are
8 practicing more efficient medicine. I don't know if that's
9 redundant, but Andy and Luis, that's my understanding.
10 Again, it wasn't our thinking, just to be super clear. I
11 think that was the thinking of Congress, and I hesitate to
12 put myself in the shoes of what they actually doing or
13 thinking. So that's just one guy's interpretation.

14 MS. MARJORIE GINSBURG: I realize that what we're
15 offering now is a way to start bringing that difference
16 down, and probably at this point it would be futile to try
17 to put a little more juice into that, even though that
18 would be my inclination. But I will leave it at that.
19 Thank you.

20 DR. CHERNEW: Okay. So, yeah. I believe now we
21 are ready to start Round 2.

22 MS. KELLEY: All right. Pat is up first.

1 MS. WANG: Thanks. So, Andy and Luis, thank you
2 again. The content in the chapter is always top-notch. I
3 think it's really clear, and you did manage to explain
4 something with a lot of moving pieces. It's incredibly
5 complicated.

6 I am generally supportive of the direction in the
7 recommendations because I think that it is time for
8 benchmarks to be rationalized from the quartile system, as
9 Andy noted, the quartiles were set that they were at a
10 different time when people were trying to incentivize
11 different things happening in MA. Those things have more
12 than happened, there are cliffs, and it's important to
13 replace it.

14 I think that there is an elegance to what you
15 have developed, and the way that I view it as kind of a
16 framework that has a lot of levers that policymakers
17 ultimately can toggle when they decide the ultimate level
18 of how they want this to play out in different geographies.

19 Having said that, I do want to make a couple of
20 comments. You know, we've spent a lot of time, and we just
21 had a conversation about this in the last session, about
22 this thing about MA has never saved money, MA is more

1 expensive than fee-for-service. And a couple of things,
2 okay. It's kind of like a starting rallying cry for this
3 kind of work. In my opinion, the wording of the chapter
4 overuses that rallying cry, because if really all we wanted
5 to care about was MA costing less than fee-for-service then
6 we would bring down the counties that are over 100 percent
7 in benchmark, and then that problem would be solved, right?
8 As you pointed out, Andy, half of the counties have always
9 saved money compared to fee-for-service, even with the
10 supplemental benefits.

11 That's not really the problem that we're trying
12 solve here. So I just offer that, as I think you're kind
13 of overselling the need for benchmark reform by relying a
14 little bit too heavily on that kind of rallying cry.

15 And really, I think that the issue around it's
16 more than fee-for-service, we're not getting money back
17 from it, I think that the question that ultimately gets
18 posed by looking at MA is what is the value of the program.
19 As you point out, when it comes to bidding on the A/B
20 benefit, MA plans are efficient. What is happening to the
21 rest of the money, though, is that it is being spent on
22 supplemental benefits. Yes, there's profit for the plans -

1 - I know that people focus on that -- but 14 percent of the
2 payments now are going to supplemental benefits, which are
3 going to beneficiaries, not to line a CEO's pockets. Okay?

4 And so when we talk about the value of the
5 program, there's like, okay, if we just want it to cost
6 less to deliver the A/B benefit, that's one statement. Can
7 you get that without having a market incentive in there? I
8 would say no. And so supplemental benefits are important,
9 and you have built that into your modeling.

10 But I would just be a little bit careful about
11 the broad-brush statements about the program is costing too
12 much, because the value of the program to a lot of people
13 is in the supplemental benefits, and that's why it's
14 costing more.

15 I wish that we could compare things like quality
16 and consumer satisfaction more directly between MA and fee-
17 for-service, and, you know, the MedPAC recommendations in
18 the past around encounter data and things like that are
19 really important, and I hope that we can keep pushing in
20 the direction of comparing quality and satisfaction,
21 because I think that there will be additional value that
22 emerges in the MA program.

1 On the issue of supplemental benefits, I also
2 just want to offer this sort of suggestion for the wording
3 in the chapter. There's a lot of focus on cost-sharing
4 reductions and premium buy-downs, as kind of the worthy
5 benefits, and more skepticism that is applied to other
6 kinds of supplemental benefits -- dental, vision. Gym
7 membership always highlights it. You know, get them off
8 the screens. It's just like a hot-button issue for people
9 so you take a couple of bucks off of the bid.

10 The point is that supplemental benefits are very,
11 very valuable to people who join MA. People who join MA
12 are lower income and non-white, compared to who is left in
13 the fee-for-service system. Dental benefits, vision, non-
14 emergency transportation, which I can tell you a lot of
15 plans are using right now to transport their members to and
16 from vaccination sites, because they are not taking Ubers,
17 you know, they have real value.

18 And so I think there's a tone that comes out in
19 the writing that's very dismissive of supplemental
20 benefits. Look, if people say nothing can be offered in MA
21 that's not offered in fee-for-service, that's a big policy
22 statement. But I don't think people have said that yet, so

1 I would just be a little bit more careful the way that we
2 talk about that.

3 Also, I mean, I just have to say this. I said
4 this the last time, and I may be just off. But I find the
5 use of the word "equity" as a driving force for the chapter
6 to be -- it just lands wrong with me. I know what you're
7 trying to say, that benefits are uneven, depending on where
8 people live and what quartile their plan might be in. But
9 the ultimate result of this is that, you know, plan rates
10 are going to get cut, so benefits, whether you believe
11 they'll come down or not, they will be pressured. I happen
12 to think that there will be some depression in extra
13 benefits. So it kind of doesn't sit right, the way you
14 achieve equity is to cut benefits for everybody. And some
15 of those benefits might be falling -- those benefit
16 reductions might be falling on very underserved
17 populations.

18 So, you know, I'm uncomfortable with the word
19 "equity." If we wanted to talk about equity and benchmark
20 policy, maybe we would be talking about calculating the
21 social vulnerability index for different counties and
22 making the benchmarks higher because it's where underserved

1 people live. That, to me, is the better way to talk about
2 equity and benchmark setting. It's just, no, I just want
3 to share the reaction.

4 The last thing that I want to say is that I
5 completely endorse what Jim said in response to Bruce's
6 question about quality. If you look at the other
7 recommendations and the impacts that are listed in the
8 appendix of the paper, you know, just between the risk
9 score recommendations, which I support, by the way, and the
10 quality, which I have some concerns about, it's 4 to 5
11 percent of payment. If I think it's very important for me
12 to view this chapter as a standalone chapter, to try to
13 rationalize and improve the benchmark system, I do not at
14 all support this thinking that it somehow pulls in all of
15 these other recommendations.

16 And I would even suggest, and request, actually,
17 that there be consideration of putting a text box in that
18 explains that all of these recommendations do interact with
19 each other. They're not just like, you know, blocks that
20 you snap together and then you have a whole new payment
21 system. Folks who look at these and are thinking about
22 reforming the MA payment system need to be aware that there

1 are many, many moving pieces, and what they decide to do
2 here is going to affect another recommendation that we have
3 made in the past that is freestanding. So that would be my
4 request.

5 Thank you.

6 MS. KELLEY: Jon Perlin, did you have a reaction
7 to this?

8 DR. PERLIN: Let me first express my general
9 support of the direction. On Pat's point about the use of
10 supplemental benefits, it sure would be helpful to have
11 some additional analysis around how beneficiaries are using
12 a portion of particular benefits that are used, et cetera.
13 Thanks.

14 DR. JOHNSON: To my knowledge there isn't really
15 any data on what the utilization is of specific benefits.
16 We do have information about the benefits that are offered
17 in the health-related benefits category, but we don't have
18 information about how much they're used, and I haven't been
19 able to study what effects they might have on either
20 quality metrics or changing spending levels, and things
21 like that. But just something we would like to do.

22 DR. PERLIN: No, I appreciate that, Andy, and it

1 maybe something that you have to go to the MA plan to
2 actually find out, and that may be highly proprietary, but
3 it sure would be illuminating to see how those supplemental
4 benefits are used. Thanks.

5 DR. CHERNEW: Can I say one thing that's related
6 to that? This is a little bit of a clarifying question and
7 I realize is out of bounds. But one of the key issues of
8 how the supplemental benefits are valued when you're sort
9 of buying down the rebate dollars -- so the plans get a
10 certain amount of rebate dollars and then they offset a
11 benefits, and the benefits have a sort of dollar value
12 assigned to them which is based on some assessment of how
13 expensive they would be to offer and how much they are
14 used. Is that basically a correct assessment, Andy, and do
15 you have a sense of how well CMS values those benefits in
16 particular ways when they get offered? I'm not sure that
17 question made sense, but I think that speaks to Jon's
18 comment, because the use would influence the dollar value
19 tied to them, at least on average.

20 MS. WANG: Michael --

21 DR. JOHNSON: I think that is generally right.
22 We haven't gone through on an extra benefit by extra

1 benefit basis to figure out how closely linked they are,
2 and depending on things like membership that are not
3 utilization-based but might be available for anybody to
4 use, whether or not they are used, the plan might incur an
5 expense either way.

6 But, Pat, why don't you go ahead.

7 MS. WANG: I'm sorry. I was going to say I
8 believe I'm correct. When a plan files a bid, like when I
9 file my bid for 2022, I'm going to have to list the actual
10 utilization of the dental benefit, like the actual value.
11 I'm going to project an actuarial value for that but I'm
12 going to report, you know, based on past experience so that
13 CMS can test the validity of my bid, and Bruce probably
14 knows that. You have to report what actually happened.

15 I also want to say, you know, I realize -- and I
16 think Luis and Andy, you kind of underscored this in the
17 paper -- that when it comes to a premium buydown for B or
18 D, it's a fixed-dollar amount. You know exactly how that
19 is. When you put a dental or vision or non-emergency
20 transportation, hearing aids, you don't exactly know what
21 the actual take is going to be, based on who is in your
22 plan, what have you. But as I said, there is a sort of

1 like a reconciliation year by year to actual, and I think
2 it's really not any different than when any insurance
3 company is putting together their package of benefits with
4 these kinds of things, like for a commercial carrier. They
5 don't know how many people are going to use them, so you do
6 your best, based on past experience, to forecast the
7 actuarial value, and that's what goes into your bid. I
8 think I said that right. I'm looking at Bruce, because he
9 might know.

10 MR. PYENSON: Yeah, I agree with you on the bid
11 side. The question is, is there an ultimate settlement
12 that shows up publicly for the line items, so that the bid
13 is a projection and that gets scrutinized by the auditors
14 of the bids, before the bid gets approved. But I think the
15 question is, there's also a question on is there scrutiny
16 in some sort of public way on whether what was put in for
17 the bid turned out, you know, a year and a half, two years
18 later, to be right, and I think that's where there's less
19 information.

20 MR. SERNA: Yes, and I just want to make one
21 point of clarification. In the bid data we don't know
22 specifically for an individual supplemental benefit what

1 the base use is or what the projected use is, on any of the
2 supplemental benefits. So that information is aggregated
3 and base-year data does not have it at the supplemental
4 benefit level, so we wouldn't know the uptake of vision or
5 dental.

6 I will say that the one study that we did find
7 looked at sample of 1.9 million MA beneficiaries that had
8 dental coverage in 2018, and found that 12 percent of the
9 beneficiaries with dental coverage actually used that
10 coverage in that year.

11 MR. PYENSON: I think, could MedPAC request the
12 bid workup, the details?

13 MR. SERNA: To my knowledge that data isn't
14 available. What we have available is what's reconciled by
15 OACT.

16 MS. KELLEY: Okay. I think Paul is next.

17 DR. PAUL GINSBURG: Thanks, Dana. You know, when
18 I think about this issue of where to set the benchmarks, I
19 want to go back to the beginning of private health plans in
20 Medicare, which goes back to the 1980s. And there was a
21 vision that these plans would be more efficient and there
22 would be some type of sharing of the benefits, of the

1 efficiencies between the beneficiaries and the Medicare
2 program, the taxpayers. And, of course, it took a long
3 time before it was clear that there were efficiencies. But
4 now it's very clear, just from the measurements that we've
5 made, into our efficiency, and it's clear from how low the
6 bids are in relation to the benchmark.

7 So we are really talking now about, okay, how
8 should we share these efficiencies between the program and
9 the beneficiaries, and clearly if we're paying more, if the
10 Medicare program is paying more than it pays the fee-for-
11 service, you know, then it's not getting any of the
12 efficiencies, and in a sense it's losing money, despite the
13 presence of substantial efficiencies.

14 So we're really talking about how to bring it
15 down, and in the administered pricing system, probably the
16 way these things happen is, so you push it down somewhat
17 and you look around, and you look around to see, well, you
18 know, how many choices are available to beneficiaries? Is
19 the enrollment growing or is it shrinking? And at this
20 point, all of that type of evidence that you see in the
21 market is consistent with the fact that the Medicare
22 program is paying too much.

1 So it's not a matter of whether it should be at
2 parity. It likely should be substantially below parity,
3 and, of course, the Chairman's draft recommendation, which
4 I support fully, basically suggests let's start with a 2
5 percent discount rate. Maybe we should reach even further,
6 but the important thing is that we should go below parity
7 and not think that we're taking something from anyone.
8 It's just a matter of the Medicare program is becoming
9 extremely fiscally stressed. The whole Federal Government
10 is becoming extremely fiscally stressed. So the notion of
11 this sharing of the gains from efficiency between the
12 beneficiaries and the taxpayers I think is more important
13 than ever.

14 MS. KELLEY: Bruce.

15 MR. PYENSON: Thank you. In looking at the
16 recommendation, I agree with Pat that there's a disconnect
17 between this recommendation and the historical analysis
18 that says MA has not saved money, and Paul's point. When I
19 look at the combined package, this is, I think, pretty
20 close to budget neutral. The discount rate of 2 percent is
21 probably countered by the increase in the rebate. It's
22 also probably countered, to some extent, by the prior

1 MedPAC MA benchmark recommendations, using both Part A and
2 B would actually increase the benchmarks, as I think was
3 noted.

4 So I think this is a needed fix to an overly
5 complex benchmark approach, but I don't view this as
6 addressing the issue of the Medicare program getting much
7 more value out of the MA program. So I'm not opposed to
8 the draft recommendation. I would prefer to see something
9 more aggressive as far as the discount rate goes.

10 MS. KELLEY: Jon.

11 MR. SERNA: I'm sorry. Just one point of
12 clarification. The 2 percent rate, in our simulation,
13 would equate to 2 percent reduction in [inaudible]. So
14 without the discount rate, that everything interact as
15 close to budget neutral but with the 2 percent discount
16 rate you would achieve savings of 2 percent.

17 MR. PYENSON: And maybe I missed this, and I
18 apologize, but increasing the rebate from whatever the
19 average is now, which is below 75 percent, to above 75
20 percent, how did that interact?

21 MR. SERNA: Right. So what you have is you have
22 benchmarks being a blend of location and national fee-for-

1 service spending. So you are reducing benchmark levels in
2 that sense, and that is then offset by the 75 percent
3 [inaudible] an average of 5 percent rebate to a 75 percent
4 rebate. And so that gets you to basically 0 percent. So
5 you need the discount rate to achieve savings.

6 MR. PYENSON: Okay. So the 2 percent -- but the
7 other, the prior MedPAC recommendations, I don't recall --
8 I think we're assuming the geographic markets is a wash,
9 makes sense. It's not a money-saver but it makes sense.
10 The Parts A and B is 1 percent higher. And I don't
11 remember if there was any estimate for the pre-ACA cap,
12 eliminating that.

13 DR. JOHNSON: Eliminating the cap would increase
14 spending a little bit. I don't remember the number off
15 hand, and I'm sorry, Luis, I was getting some cutting out
16 when you were explaining. But I think the net effect, as
17 you just said, Bruce, is that using both A and B for
18 benchmarks would increase spending. Eliminating the cap
19 would increase spending. Increasing the rebate from 65
20 percent to 75 percent would increase spending. But all of
21 that roughly nets up 0 when you consider the 50/50 blend of
22 local and national, the new setup for the benchmarks,

1 before the discount rate.

2 MR. PYENSON: So we built in the prior MedPAC,
3 the benchmark recommendations into our simulation?

4 MR. SERNA: That's correct.

5 MR. PYENSON: Okay. Thank you. Somehow I missed
6 that. That was a Round 1 question. Thank you.

7 MS. KELLEY: Okay. I think it's Jon Perlin next.

8 DR. PERLIN: No. I'm all right.

9 MS. KELLEY: All right. Then we'll go to Marge.

10 MS. MARJORIE GINSBURG: Yes. I'm troubled by the
11 supplemental benefits for MA, and even though I fully
12 appreciate their value, particularly the non-emergency
13 medical transportation -- great -- remember, I'm a shift
14 counselor so I deal with this stuff a lot.

15 But what I'm troubled by, go to the bottom line,
16 is that these extra benefits are being paid for by
17 taxpayers. That's all the taxpayers. And that continues
18 to trouble me that this is a system that makes sense. Now
19 if the MA plans can figure out a way maintain the extra
20 benefits and still bring money back into the coffers,
21 great. But if the extra benefits is what's causing the
22 total cost of MA plans to continue to be above the cost of

1 fee-for-service, I think there's a philosophical problem I
2 have with that.

3 So I just wanted to share that.

4 MS. KELLEY: Larry.

5 DR. CASALINO: Yeah, Paul's comment a little
6 while ago was so simple and clear, as usual, Paul, it made
7 me think. And it made me start to think along the same
8 lines as what Marge just said. I mean, maybe someone could
9 tell me if this experiment is wrong. Let's say that I'm a
10 particularly sophisticated beneficiary in an area where the
11 benchmark is well above fee-for-service, and I say, "Gosh,
12 my friend, Jon, gets all these benefits from Medicare and I
13 don't get them." We're paying the same taxes for it, and I
14 understand that Medicare is actually paying more for Jon
15 than Medicare is paying for me. So that's how I can get
16 the equal benefits. How is that fair? Is this an
17 inaccurate way of thinking about it, or how would one
18 respond to that sophisticated beneficiary? I think I'm
19 saying the same thing Marge just said.

20 DR. CHERNEW: Can I jump in, or Andy and Luis, do
21 you want to go first? I have a response.

22 Okay. I'm going to jump in. I wish could see

1 you all better. You're very small on my screen.

2 So I think there's sort of two issues that tie in
3 your comment, Marge, and Paul's much earlier comments. I
4 think there's a general sense that on the Commission and
5 the recommendation that we don't think Medicare Advantage
6 should pay more than comparable fee-for-service, pay more
7 for a comparable beneficiary. Then there's the question
8 that Paul raised, and I heard from several others of you,
9 which is, actually, Medicare Advantage is much more
10 efficient, and the program should share the savings exactly
11 as we think about this, for example, in alternative payment
12 models, that the saving should be shared. How much and how
13 quickly is a separate issue.

14 So I don't think the issue now is justifying or
15 not why MA should be paid more than fee-for-service. I
16 think there's a general sense, and I think this
17 recommendation reflects it, that they shouldn't. It is
18 really, additionally, there's a lot of savings and maybe we
19 can balance some of those out, which is very much in the
20 spirit of what Pat said in her comment.

21 And I don't know if that answers your question,
22 Larry, but our response to the person you're talking about

1 would be, yes, we understand. That's one of the reasons
2 why, one of the considerations for why we're recommending
3 the changes that we're recommending.

4 DR. CASALINO: But, Mike, going back again to my
5 beneficiary, if Medicare Advantage is giving my friend the
6 extra benefits, if Medicare is paying the exact same amount
7 for Jon and for me, but Jon is in Medicare Advantage and
8 his Medicare Advantage plan is so efficient that it's
9 giving him these benefits, without getting extra money from
10 Medicare, then I said, "Gosh, I want to join too," right?
11 But if, in fact, Medicare is actually paying more for Jon
12 than Medicare is paying for me, and the benefits are being
13 finance out of that, at least in part, than I would say how
14 is that fair?

15 DR. CHERNEW: Yeah, and I understand, and in some
16 sense I think we are agreeing. Yes, that's right. We're
17 not advocating that Medicare Advantage be paid more.

18 DR. CASALINO: Well, but in certain counties
19 Medicare Advantage would be paid more, right?

20 DR. PAUL GINSBURG: If I can jump in here.

21 DR. CHERNEW: Go ahead, Paul.

22 DR. PAUL GINSBURG: I think Larry is bringing up

1 the "it's a geographic variation" issue.

2 DR. CHERNEW: Yes. Right. I understand.

3 DR. PAUL GINSBURG: The concept of sharing the
4 savings between the beneficiaries, and, of course, they
5 come in the form of extra benefits in the program, but that
6 the way Congress did this, with 115 and the 95 percent, now
7 is it basically deliberately giving too much to the
8 beneficiaries that live in the low-cost fee-for-service
9 area for political reasons. It's not what I would call a
10 rational policy. But, you know, we understand it for what
11 it is.

12 So I think Larry's point, you know, is a way to
13 demonstrate the problem with that policy of not trying to
14 do this as a rational sharing thing but just saying, oh, we
15 have some goodies. Let's throw them around in a way that
16 makes most sense politically.

17 MS. KELLEY: Mike, we have come to the end of the
18 Round 2 queue.

19 DR. CHERNEW: Can you hear me?

20 MS. KELLEY: Yes.

21 DR. CHERNEW: Okay. So in a moment I'm going to
22 -- we have a bit more time -- I'm going to go, at some

1 point, around and get people's views, because we haven't
2 heard from many of you, to get a sense -- and it can be
3 very brief -- about your general reactions. It's important
4 for us to highlight what those reactions are.

5 I agree, Paul, your answer was much better than
6 mine, to Larry's question. I think the only thing I would
7 note is in any of the markets, if someone wanted to get the
8 benefits they could join MA, and typically they have to
9 give something up in those areas, in terms of maybe
10 subjecting themselves to a different network or some other
11 thing. But I think your view about the way it came to
12 pass, which is, I think, broadly a recognition of people
13 wanting some similarity in benefits, availability of extra
14 benefits across areas, is probably accurate.

15 I'm going to pause for a second to see if anyone
16 wants to jump in.

17 DR. DeSALVO: It's Karen. I was going to jump in
18 on two points, if I could.

19 DR. CHERNEW: Go ahead, Karen.

20 DR. DeSALVO: Okay. I think, first is that I'm
21 not trying to mince words, but I definitely agree with what
22 Pat said about equity. The use of that word, especially in

1 2021, doesn't seem fitting. And so I understand where you
2 were trying to go, but I would be careful about using it
3 because it implies that there's an interest at really
4 looking at disparities in care and access and outcomes,
5 based on color of skin, other characteristics, and that's
6 not really exactly what the chapter is about.

7 I think the second thing I just wanted to raise
8 is a suggestion going forward, that perhaps the team has
9 done but I'm not sure I remember, is hearing from
10 beneficiaries who have been in and out of MA and fee-for-
11 service, to understand this notion of supplemental benefits
12 or how it's been different for them, in the good or bad,
13 because I think there are a lot of presumptions that we may
14 be making, and it would probably be helpful to hear
15 directly, especially if we could find beneficiaries who had
16 been in both system and could have some reflections. Thank
17 you.

18 DR. CHERNEW: Jaewon -- I'm just going to start
19 going around, by the way. You can be very brief if you
20 want. Jaewon, I'm turning to you.

21 DR. RYU: Sure. Thanks. I'm generally in
22 support of the draft recommendations. I think conceptually

1 they make sense. I get the need for the discount rate. I
2 also understand and appreciate that the current system with
3 the quartiles as clunky at best and probably not
4 sustainable long term.

5 I would hesitate before going any more aggressive
6 than the 2 percent, however, without understanding how much
7 of the extra payments are fueled by the supplemental
8 benefits. I think that normalization comment that Pat made
9 earlier is an important one in understanding exactly how
10 much of the payments are going towards the supplemental
11 would be helpful before we went any more aggressive on the
12 discount.

13 DR. CHERNEW: Thanks, Jaewon. Betty? Betty, can
14 you hear me? We can't hear you, Betty.

15 DR. RAMBUR: There. Thank you. For some reason
16 it wasn't unmuting. Maybe that's a message. But thank you
17 for the report, and I really appreciate the conversation to
18 help flesh this out, because this is not an area I've had a
19 lot of responsibility before, so I found it really helpful.

20 I am generally in support. I do think it is a
21 needed fix, and I really resonate with what Paul said about
22 the fiscally stressed situation that we're in. I thought

1 the questions of fairness are really an interesting one.

2 I don't know whether it should go further than
3 Bruce suggested, or maybe as Jaewon just suggested, this is
4 far enough, but I'm supportive and would look forward to
5 see if there is more that could be done in the future, or
6 recommended in the future.

7 DR. CHERNEW: Betty, thank you. Dana Safran?

8 DR. SAFRAN: Yes, thanks. Really good, rich
9 discussion, and really excellent content, well written, in
10 the chapter.

11 I am in support of the draft recommendation, but
12 I will be brief. I think Paul's comments, for me, really
13 were very valuable, you know, the idea that there is no
14 argument that there are efficiencies. It's a question of
15 how those are getting allocated and who gets to share in
16 them.

17 And in the subsequent conversation about
18 supplemental benefits and the fairness or appropriateness
19 of those, I guess in my own mind I think particularly in
20 2021, where we've evolved so far in this program and so far
21 in our thinking about health and health care and social
22 determinants of health, I kind of recoil at the idea of

1 questioning the kinds of supplemental benefits that are
2 being provided, because I think they start to go at some,
3 not all, social determinants of health.

4 And so I sit here kind of rather liking the fact
5 that beneficiaries have a choice between system, and that
6 when they choose the MA plan they are getting the benefits,
7 and that could inform that choice. It does inform that
8 choice.

9 I do understand, though, the concern about
10 whether that is potentially creating -- I don't think it
11 was said this way, but potentially creating a two-tiered
12 system, where those who really are sicker and need every
13 bid of the medical benefits don't get the opportunity to
14 have those supplemental beneficiaries that are available
15 through MA, and that does give me some pause.

16 So those are just my observations. Overall, I do
17 think that we need to continue to have an effort in this
18 program to be sure that some of those efficiencies turn
19 into savings for the program, and I think that the draft
20 recommendation gives us a good start on that road. Thanks.

21 DR. CHERNEW: Dana, thank you. Wayne, do you
22 have any thoughts?

1 DR. RILEY: Yeah, no. I think we've had a
2 wholesome discussion on this. This is a program, just
3 personally, I have struggled with, with some of my own
4 relatives. The thing that is alluring to them is something
5 we've already highlighted, is the benefits -- hearing aids,
6 transportation, dental, et cetera -- but I share the
7 concern, the asymmetry in terms of how Medicare
8 beneficiaries experience their care vis-à-vis the Advantage
9 program versus regular Medicare. And Karen is right.
10 We've got to be careful how we use the word "equity" in the
11 context of this discussion.

12 DR. CHERNEW: Wayne, thank you. Sue Thompson.

13 MS. THOMPSON: Thank you, Michael. I am
14 supportive of the Chair's draft recommendation. I'm
15 supportive of the new benchmarking calculation proposal. I
16 am struck by the contrasting opinions of Pat and Marge, who
17 I consider both of whom to have had a lot of experience
18 working with the beneficiary community, in MA. And, yeah,
19 I was really taken by both of you in these comments, and I
20 think there's a lot of further discussion to have here, and
21 would love to hear from each of you more. Because it does
22 seem like our primary goal should be to right-size MA costs

1 with fee-for-service, and when and how we play these
2 supplemental benefits, you know, should they be funded
3 after the cost, equivalent to fee-for-service? There is
4 some synchronization there around those benefits in the
5 broader context of, you know, what I've heard Marge say
6 before, that MA is the poor man's Medicare, and yet these
7 social determinants of health that we are just beginning to
8 get our arms around, seem to be, intentioned to be
9 addressed by these additional benefits.

10 So again, no answers in my comments here other
11 than to say I love the tension in that question, and I just
12 think it's worthy of a lot more discussion and good
13 thinking. So those would be my comments. Thanks,
14 Michael.

15 DR. CHERNEW: Sue, thank you so much. Brian.
16 Brian, we can't hear you, and I know you, and usually we
17 can.

18 DR. DeBUSK: Sorry, I was muted. Yeah, this is a
19 really complex issue, and I do support the recommendations
20 as written. I think there's some really good technical
21 fixes in this chapter, removing the quartiles,
22 standardizing the rebate, and addressing the frailty

1 associated with county-level calculations. I also think
2 the philosophical discussion on spending levels, expecting
3 this program to general program savings seems reasonable.
4 The 2 percent amount seems appropriate.

5 What I hope we continue to do, though, is
6 understand plan-bidding behaviors and the behavioral
7 response when we make these changes, because I'm a little
8 fascinated. For example, you noticed as the rebates
9 continue to grow, the cost-sharing reductions seem to level
10 out. And I think these MA plans have really figured out
11 how to balance plan attractiveness, you know, where you
12 certainly don't expose the members to full Medicare cost-
13 sharing, versus induced volume. And I think they know and
14 understand some things around how much cost-sharing is too
15 much or too little, and I hope we study that, because if
16 these changes would get implemented, I think there's an
17 opportunity here to try to figure that one out, and also to
18 tease apart extra benefits. Because again, not all extra
19 benefits are the same. Someone who desperately needs
20 transportation assistance to get to their doctor is very
21 different than someone who has been given a gym membership
22 25 miles away from their home. So I hope we tease apart,

1 too, the notion of maybe standardizing the extra benefits
2 is good step.

3 The other thing that I've seen the staff work in
4 the past on something that's always fascinated me --
5 studying the behavioral response of plans that lost bonus
6 status. So what happens when there's a shock to a plan and
7 their benchmark changes dramatically, for example, if they
8 lose bonus status? Based on what I saw before, it looked
9 like the majority of that reduction, they did reduce their
10 bid, but then it looked like that reduction in the bid
11 simply got passed on to providers, or the bulk of that did.
12 And as we prepare to publish this chapter, if there's any
13 more information on studying how plans respond when they
14 lose their quality bonus, and who gets the cuts, we may be
15 able to glean some insight into how plans would respond to
16 the changes that we're discussing in this chapter.

17 Those are my comments. Thank you.

18 MS. KELLEY: Mike, we can't hear you.

19 DR. CHERNEW: I'm sorry. We're having mute
20 problems today. I noted a few more people on the list that
21 I wanted to hear from, David Grabowski and Jonathan, but I
22 know that Paul and Bruce wanted to say something on

1 supplemental benefits very quickly. So if you guys could
2 go really quick to make sure we have time for David and
3 Jon, then that would be terrific. Paul, you, then Bruce,
4 very quickly, and then we'll go from there.

5 DR. PAUL GINSBURG: I wanted to help reconcile
6 the perspective between Pat and Marge on supplemental
7 benefits. To me, when there is a lot to be shared with the
8 beneficiaries, which is where we are now, most of it comes
9 in the form of supplemental benefits, and some of them
10 everyone thinks is great, like not charging the
11 beneficiaries a premium for the catastrophic benefit that
12 plans are required to provide, or having drug benefits and
13 not having a premium for them.

14 It's just that there is so much surplus to
15 distribute to the beneficiaries that I remember Andy, some
16 meetings ago, making the comment about plans running out of
17 ideas as to how to give supplemental benefits, and
18 obviously this is, I think, what Marge is picking up on.
19 Some of them just don't seem worth the resources that go
20 into them.

21 So I suspect some of these issue about, you know,
22 are some supplemental benefits not worthwhile, will go away

1 once we stop overpaying by so much, because there won't be
2 as much to find ways to transfer.

3 DR. CHERNEW: Paul, thank you. And now we had,
4 I'm sorry, I think it's Bruce.

5 MR. PYENSON: I agree with Paul. I want to point
6 out the work that MedPAC did, I think about 10 years ago,
7 that identified the induced utilization of Medigap plans.
8 I think the number at that point was close to 20 percent,
9 because Medigap plans take away substantially the cost-
10 sharing of the 20 percent co-insurance in Part B and cost-
11 sharing in Part A.

12 Now, what has the net effect of, of course, is
13 increasing the underlying cost of Part A and Part B, and
14 that raises the benchmark. So we have an artificially --
15 perhaps I'm using the term "artificially inflated
16 benchmark" because of Medigap, which then is passed on to
17 the MA plans, who are obligated to just cover the core
18 benefits of Medicare plus, you know, catastrophic, things
19 like that.

20 So I think if we're going to open this up, I hope
21 very soon we could revisit the work that MedPAC did on
22 Medigap, and start to reframe both sides. Now, it's not

1 obvious. There's real benefits of both. There are people
2 who don't buy Medigap as well. But I think opening that up
3 would be very helpful.

4 DR. CHERNEW: Great. Bruce, thank you very much.
5 And now we get to David, and then we're going to close out
6 with Jonathan. David?

7 DR. GRABOWSKI: Great. Thanks, Mike. I just
8 wanted to first start by saying I'm supportive of the draft
9 recommendation. I really like how this work is shaping up.
10 I like the language Brian used, that we have a set of great
11 sort of technical fixes here, and I'm supportive of all of
12 them. If ever kind of a Medicare policy was ripe for a
13 MedPAC recommendation it's these sort of quartiles and the
14 cliffs there. That seems right in our wheelhouse to fix.

15 I think Brian is correct, however, that there's
16 kind of philosophical set of issues going forward around
17 kind of putting dollars into the system, and I like Sue's
18 term of how to right-size this system. So I hope -- and,
19 Mike, you've already said it, but I think this is the start
20 of a workplan for us. These are a great set of
21 recommendations and kind of getting some of the technical
22 aspects of the program right, but we have more work to do.

1 So thanks to the staff for this great work, and I
2 look forward to seeing where this goes next. Thanks.

3 DR. CHERNEW: Great. David, thank you.
4 Jonathan, you're going to get the penultimate word, because
5 I'm going to say something when you're done. Jonathan.

6 DR. JAFFERY: Great. Thanks, Mike. And so I'll
7 just start off with I, too, am very supportive of the draft
8 recommendation. I think it's a great package of things put
9 together and culminates a bunch of work.

10 Since I'm going almost last I'll just take a
11 moment to reflect on the conversation so far. It's pretty
12 clear that the issue about supplemental benefits has
13 generated a lot of discussion and a lot of thinking, I
14 think for all of us, but certainly for me. I guess my
15 takeaway right now on it is it pulls together a number of
16 things that folks said. Dana pointed out, rightly, that
17 there's a real opportunity for these benefits to fill some
18 of the needs around social determinants that we all
19 recognize are important. And, of course, as Brian pointed
20 out, there's a balance there because some of these may
21 address those more than others.

22 But, Jon, you brought this up early, and Andy,

1 you spoke to it as well, that despite having supplemental
2 benefits for years, we don't really have a good sense of
3 which ones are even used, and by which populations, and how
4 they have an impact on spending or outcomes. To me that's
5 not only important to know, it's a really key opportunity.
6 If we can use that information to understand where those
7 taxpayer dollars are being spent and how they actually
8 improve outcomes or not, then we should be thinking about
9 how we would build that into the program more broadly,
10 particularly as it gives us an opportunity to address the
11 social determinants of health.

12 So thanks, Mike, and back to you for the final,
13 final words.

14 DR. CHERNEW: Yes, so I'll try and follow
15 quickly. So first of all, again, my thanks to the staff
16 and all of you for your comments.

17 First let me note that this in many ways is a
18 good problem to have. The fact that we have a program
19 which, at least in a growth sense, can produce savings of
20 the magnitudes that we think exist in MA is, I think, by
21 and large, due to the good thing, and should be viewed as a
22 success, particularly our goal, in many ways, is to design

1 an APM program that could come close.

2 The challenge, which is one that I won't take a
3 strong position on, at least right now, in many ways, is
4 exactly how the potential savings should be distributed
5 between the beneficiaries and the programs, in a range of
6 ways, and the formulas that we're discussing do that.

7 What I hear -- I'll start with Pat's comment,
8 that parity isn't the goal, that we're trying to design an
9 efficient system, and I think that resonates well with me,
10 Pat. I'm watching you. The light looks great coming in
11 from your window. But I think that was a really good way
12 to start out this discussion. And that was followed up by
13 sort of the comments that Paul and others made, Bruce,
14 about how we share those efficiencies, both within the
15 particular counties and then across the particular
16 counties. This formula, I think, is a starting point to
17 get there. We are going to try and do a better job in the
18 chapter of acknowledging how different recommendations
19 interact.

20 I would be remiss if I didn't acknowledge that I
21 was coming in on top of a bunch of outstanding work that
22 happened by the Commissioners, some of which includes you

1 all before me, and of course the staff before me. But we
2 are on a journey, and I do think we will work in a way to
3 both maintain the efficiencies of MA -- it's a really
4 important program -- and give some thought as to how those
5 efficiencies get distributed across geographies and across
6 the program and beneficiaries, et cetera.

7 So I'm glad to hear the general support for the
8 direction we're going in, and I am really looking forward
9 to continuing to work on this chapter.

10 So with that we are now essentially exactly on
11 time, and we're going to -- I think Dan, or Shinobu - I'm
12 not sure who is going to be speaking first. I usually say
13 Dan because the name is first on the screen that I see.
14 Dan, is it going to you?

15 DR. ZABINSKI: Yes, it is.

16 DR. CHERNEW: Okay. So to discuss the
17 relationship between clinician services and other Medicare
18 services. So, Dan, take it away.

19 DR. ZABINSKI: Thank you, Mike. Good afternoon.

20 Shinobu and I are going to present our results
21 from an analysis that was mandated by the Medicare Access
22 and CHIP Reauthorization Act, or MACRA.

1 For the broader audience, PDF versions of the
2 slides are available on the webinar control panel on the
3 right side of your screen.

4 Now, MACRA requires MedPAC to submit reports to
5 the Congress that evaluate the relationship between
6 physician and other health professional services and
7 services provided under Parts A, B, and D of Medicare.

8 We are directed to evaluate the relationship of
9 both program spending and service use. Note that for the
10 rest of this presentation, we will refer to services that
11 are provided by physicians and other health professionals
12 as "clinician services."

13 MACRA indicates that an initial report for this
14 study was due July 1, 2017, which we submitted as part of
15 the Commission's June 2017 Report to the Congress.

16 MACRA also requires a final report due July 1,
17 2021, and that is the analysis we present today.

18 In this final report, we're largely repeating our
19 initial analysis using the most recent data. The Congress
20 requested information but did not ask for policy guidance;
21 therefore, the initial and final reports are strictly
22 informative and don't include any policy recommendations.

1 The analysis we present today has two broad
2 parts. I will discuss the relationship between clinician
3 services and non-clinician Part A and Part B services. And
4 Shinobu will discuss the relationship between clinician
5 services and Part D drugs.

6 A key concept throughout our discussion is the
7 correlation between clinician services and all Part A, B,
8 and D services.

9 A positive correlation suggests that clinician
10 services and all other services are complements, which
11 means that as clinician services increase, all other
12 services also increase.

13 A negative correlation suggests that clinician
14 services and all other services are substitutes, which
15 means that as clinician services increase, all other
16 services decrease.

17 MACRA requires that we look at both program
18 spending and beneficiaries' service use, and we emphasize
19 that these are different measures.

20 Program spending is monetary outlays by Medicare,
21 and we made no adjustments to our spending data.

22 It's important to know that spending will differ

1 between regions or years because of differences in Medicare
2 prices, demographics, and beneficiaries' health status.

3 In contrast, service use reflects volume and
4 service intensity, meaning that basic things like simple X-
5 rays have lower service use than more complicated things
6 like CT scans.

7 To measure service use, we start with spending
8 data, and then we arrive at service use by removing from
9 the spending data geographic differences in Medicare
10 prices, beneficiaries' demographics, and their health
11 status.

12 In our analysis, we focused on beneficiaries in
13 fee-for-service Medicare and excluded Medicare Advantage
14 enrollees because MACRA directs us to evaluate Parts A, B,
15 and D of Medicare but not Part C.

16 We evaluated how the relationship between
17 clinician and non-clinician services changed over time at
18 the national level.

19 We also evaluated the relationship between
20 clinician and non-clinician services at a point in time at
21 the level of what we call MedPAC units.

22 The MedPAC units are our attempt at defining

1 health care markets and are largely based on metropolitan
2 statistical areas, and there are 484 MedPAC units in our
3 study.

4 We started our analysis by evaluating how
5 Medicare program spending on clinician services as a share
6 of program spending on all Part A and Part B services
7 changed over time. This is a national-level analysis, and
8 we used data from the Medicare Trustees' reports.

9 On this diagram, the lower blue line shows that
10 spending on clinician services as a share of program
11 spending on all Part A and Part B services fluctuated over
12 a 10-year period from 2009 through 2019.

13 The maximum share for clinician services during
14 this period was 19.6 percent in 2011, and the minimum was
15 17.6 percent in 2018.

16 In addition to the services they provide,
17 clinicians also have substantial control over their
18 patients' drugs and lab tests. So for the upper red line,
19 we added the Part B drugs and labs furnished in physician
20 offices to the clinician services. This measure shows less
21 fluctuation than the lower blue line that represents only
22 clinician services, with a maximum of 23.8 percent in 2014

1 and a minimum of 22.8 percent in 2009.

2 A caveat is that we believe service use is a
3 better measure than the spending data presented on the
4 slide because spending is affected by prices, demographics,
5 and health status, which can distort perceptions of
6 providers' practice patterns and how service use differs
7 between years and between regions.

8 For example, during the 2009 to 2019 period,
9 updates to clinician payment rates were smaller than the
10 updates in the other fee-for-service payment systems.

11 Because we view service use as the better
12 measure, the rest of our analysis of Parts A and B focused
13 on service use rather than program spending.

14 We started our analysis of service use with a
15 national-level time-series analysis that evaluated how use
16 of clinician services as a percent of all Part A and Part B
17 services changed from 2013 to 2018.

18 We found that use of clinician services as a
19 share of all Part A and Part B services decreased only
20 slightly from 24.3 percent in 2013 to 23.8 percent in 2018.

21 In addition to evaluating service use at the
22 national level, we evaluated use of Part A and Part B

1 services at the level of our 484 geographic units.

2 For the geographic units, we measured the
3 correlation between the percent change from 2013 to 2018 in
4 use of clinician services and the percent change in use of
5 all non-clinician Part A and Part B services.

6 We performed a regression that had percent change
7 in clinician services as the explanatory variable and
8 percent change in the non-clinician Part A and Part B
9 services as the dependent variable. The regression results
10 include a very small coefficient on percent change in
11 clinician services and a low R-squared of just 0.01.

12 This diagram shows the relationship between the
13 percent change in use of clinician services and the percent
14 change in use of non-clinician Part A and Part B services
15 for our 484 geographic units.

16 If there was a close, strong relationship between
17 these two measures, you'd see these data points clustered
18 tightly around a straight line.

19 But we see a loose relationship, without
20 clustering around any line, indicating little or no
21 correlation.

22 Our final evaluation of Part A and Part B

1 services was a cross-sectional analysis of the correlation
2 between the per capita use of clinician services in 2018
3 and the per capita use of non-clinician Part A and Part B
4 services across our 484 geographic units.

5 A regression that has per capita use of non-
6 clinician Part A and Part B services as the dependent
7 variable and per capita use of clinician services as the
8 explanatory variable reveals a slight negative correlation
9 as the coefficient on use of clinician services was
10 negative 0.15.

11 However, the R-squared from this regression was
12 just 0.01, meaning that little of the variation in use of
13 non-clinician services is explained by differences in the
14 use of clinician services among our geographic areas.

15 Finding low explanatory power reinforces what we
16 just discussed, with little relationship between use of
17 clinician services and use of non-clinician services.

18 On this diagram we show the relationship between
19 the per capita use of clinician services and per capita use
20 of non-clinician Part A and Part B services. As you can
21 see, there really isn't a clear, discernible relationship
22 between these two measures.

1 Now I'll turn the presentation to Shinobu, and
2 she'll discuss the relationship between clinician services
3 and Part D drugs.

4 MS. SUZUKI: The analytical framework generally
5 follows the method Dan just described for the analysis of
6 Parts A and B service use.

7 One main difference is that, for this part, we
8 focus on a subset of fee-for-service beneficiaries who are
9 enrolled in Part D. Beneficiaries who receive drug
10 coverage from sources other than Part D are not included in
11 the analysis.

12 We adjust gross drug spending for demographic
13 characteristics and health status to arrive at a measure of
14 prescription drug use, and we used the same regression-
15 based correlation analysis.

16 The patterns of Part D enrollment among fee-for-
17 service beneficiaries have changed over time.

18 First, more fee-for-service beneficiaries were
19 covered under Part D in 2018 than in 2013.

20 Second, a smaller share of Part D enrollees were
21 in stand-alone PDPs in 2018 than in 2013.

22 You can see this in the table: Fee-for-service

1 beneficiaries covered under Part D grew from 24 million in
2 2013 to 27 million in 2018. As a share of all fee-for-
3 service enrollees, the share with Part D coverage increased
4 from 61 percent to 67 percent.

5 But as a share of all Part D enrollees, these
6 beneficiaries accounted for 58 percent in 2018, down from
7 64 percent in 2013. This reflects the underlying trend
8 that has increasingly shifted enrollment towards Medicare
9 Advantage. So more beneficiaries are getting their drug
10 coverage through Part D drug plans operated by MA plans.

11 In part, due to this change, demographic
12 characteristics for the study cohort were somewhat
13 different between the 2013 and 2018 cohorts.

14 For example, compared with 2013, a smaller share
15 of beneficiaries were disabled beneficiaries under age 65
16 and receive Part D's low-income subsidy.

17 When we looked at per capita spending, we found
18 that growth rates in these two sectors diverged after 2013.

19 In the second column of the table, you can see
20 that spending on clinician services and Part D drugs grew
21 at similar rates between 2008 and 2013 -- by 12 percent and
22 10 percent, respectively. But for the 2013 to 2018 period,

1 it's 1 percent for clinician services compared with 26
2 percent for Part D drugs. This 26 percent growth is
3 notable because of the magnitude relative to the period
4 before 2013, but also because of what drove that growth.

5 For the 2008 to 2013 period, the growth in Part D
6 spending was mostly due to increase in the number of
7 prescriptions filled.

8 In contrast, for the 2013 to 2018 period,
9 spending growth was mostly due to higher prices, driven
10 primarily by new drugs and biologics launched after 2013.

11 In our analysis of service use -- that is,
12 spending adjusted for demographic and health status -- we
13 found a positive relationship between clinician service use
14 and prescription drug use.

15 Looking at the change in service use between 2013
16 and 2018, we found a positive correlation between clinician
17 service use and drug use, with a coefficient of 0.36. But
18 the R-squared was about 0.08, meaning that clinician
19 service use explained only 8 percent of the variation in
20 Part D drug use. This suggests that there is very little
21 relationship between the growth rates in service use in
22 these two sectors.

1 When we looked at the level of service use across
2 geographic areas, we found modest positive correlation
3 between clinician service use and drug use in both 2013 and
4 2018 -- a coefficient of about 0.3 and R-squared of over
5 0.2 -- suggesting they may be complements. This finding is
6 not surprising given that most prescriptions are written by
7 clinicians during office visits.

8 To summarize, our findings suggest clinician
9 services are neither clear complements to nor substitutes
10 for other Parts A and B services, and they may be modest
11 complements to Part D drugs,

12 However, our analysis cannot be used to draw
13 conclusions about causality as our analysis only examined
14 the existence of correlation between service use.

15 Our findings are aggregate results, based on
16 comparisons of service use across geographic areas. As a
17 result, they may not represent any individual circumstances
18 or specific geographic areas.

19 As Dan mentioned at the beginning, this is a
20 congressionally mandated report due no later than July 1st
21 of this year.

22 We plan to incorporate your comments from today's

1 discussion and include this material in our June 2021
2 report.

3 With that, we'll turn it back over to Mike.

4 DR. CHERNEW: Shinobu, thank you very much.
5 There was a lot of work that went behind this, and I
6 understand there's intense interest in this. I'm going to
7 see if there's any clarifying questions for a moment.

8 [Pause.]

9 DR. CHERNEW: So we're going to go to Betty.
10 Betty, you're up.

11 DR. RAMBUR: So I have a really naive question,
12 and maybe I just couldn't understand it from the materials.
13 So I understand the answer here to the question, but it
14 would help me to better understand the context of what was
15 Congress trying to understand about this, because it was
16 related to MACRA, it seemed, from the material. So I felt
17 like antecedent to this answer that there is something that
18 I'm not understanding.

19 DR. ZABINSKI: Jim, do you want to take that or -
20 -

21 DR. MATHEWS: Yeah, I was going to say either
22 Mike or I might want to take this one. Mike?

1 DR. CHERNEW: I was not around when we were asked
2 to do this, so I do not have any line of sight on the
3 answer. So I'm going to turn it over to you, Jim.

4 DR. MATHEWS: Yeah, basically this was driven by
5 one of the major medical society organizations who were
6 making the assertion that an increase in utilization of
7 physician services would result in decreases in other
8 services and, therefore, that extra spending on physician
9 services might actually produce savings for the Medicare
10 program. I believe that was one of the, you know, subtexts
11 underlying this legislation.

12 DR. RAMBUR: Thank you. I knew there had to be
13 an antecedent. Thank you.

14 DR. CHERNEW: I'm going to turn it over to Dana
15 to manage at least the Round 1 queue. Dana.

16 MS. KELLEY: Okay. I see we have Marge next.

17 MS. MARJORIE GINSBURG: Yeah, and this may
18 actually be related to Betty's question. The first thing
19 that occurred to me is that this is a report about number
20 crunching, and it seems to me usually when we get a request
21 to do a report outside of our usual work, it's a little
22 more nuanced, more policy-ish. Why didn't this assignment

1 just go directly to CMS? Is there really something more
2 meaningful about asking MedPAC to do this rather than
3 asking CMS to do it?

4 DR. MATHEWS: I don't have an answer to that
5 question. Sometimes, you know, the congressional
6 committees make a determination about who is best poised to
7 do a particular analysis. Sometimes it's CMS, sometimes
8 it's GAO, and sometimes it happens to be us, and we drew
9 the straw here.

10 MS. KELLEY: Pat.

11 MS. WANG: Thanks. Can you hear me?

12 MS. KELLEY: Yes.

13 MS. WANG: Okay. Betty, thank you for asking the
14 question because I was also puzzled, and, you know, the
15 fact of the matter is that there was a huge amount of very
16 careful analysis, and it's just that the result doesn't
17 seem earth-shattering that makes us puzzled, but the fact
18 of the matter is that until you do the work, you don't
19 really know.

20 I guess that I had a question whether a similar
21 analytical endeavor has ever been undertaken to evaluate
22 the same question, but restricting it to primary care

1 clinician services and whether there is a relationship,
2 because that's the more common wisdom, right? Better
3 primary care, more primary care results in lower overall
4 spending because you eliminate unnecessary stuff. I just
5 am curious, because this study, you know, presumably
6 involves every specialist, super-specialist, provider type
7 that there was, and so maybe there's still some gems inside
8 of the work that just need to be isolated and pulled out.

9 DR. ZABINSKI: Well, I'm not aware of any
10 specific study that has done that. It's a good question,
11 and it would be nice to find out. But I'm not aware of any
12 that exist.

13 MS. KELLEY: That's all I have, Mike.

14 DR. CHERNEW: Yes, so I again will speak for a
15 bit, and please, folks, if you have comments -- I said
16 raise your hand -- send a note to the Organizers and
17 Panelists. But in any case, so this question about
18 tradeoffs is one that actually has been looked at a lot in
19 the academic literature. I won't speak to all of it. The
20 analytics are obviously complicated because of the
21 potential for confounders. I think Dan and Shinobu were
22 very clear that we aren't making causal statements in this.

1 There's sort of complexities. If you have a
2 surgery, you need both a physician and a hospital most of
3 the time. There's another complexity that maybe, Dan or
4 Shinobu, you want to talk to about how this is affected by
5 consolidation. I know there's some stuff in the material
6 about that. In other words, you could get a change in
7 clinician utilization and facility utilization or other
8 services based on the industry structures, so consolidation
9 can have an effect, which is another thing that you might
10 want to discuss.

11 But before I let you do that, there has been,
12 going back at least to the RAND Health Insurance
13 Experiment, some work that speaks to this. For example, in
14 the RAND Health Insurance Experiment, they had randomized
15 people into one plan that made inpatient care free but
16 charged a lot for outpatient care. And if you compare that
17 to when both are free, they found indeed that there was
18 less outpatient care in the plan that charged for
19 outpatient care. So chalk up a piece of evidence for
20 downward sloping demand curve.

21 The more surprising thing was, in fact, they
22 found in that plan that charged more for outpatient care

1 that use of inpatient care also went down. And there seems
2 to be a real connection in many ways because when people
3 get brought into the system, say through outpatient care,
4 clinical care, a lot of things are found, critical things
5 are found, and they ended up finding their way into other
6 types of care. And I think that that basic finding that
7 many people in the world view clinical care how your -- not
8 clinical care -- how your care by clinicians and care by
9 other types of more expensive care as substitutes, more
10 often than not the literature I think has found that there
11 are complements, for better or worse. It's not an area
12 that I've done a lot of work in, but I think we can
13 continue to think through that given our ability to really
14 get at some of these very complicated analytic issues.

15 But that's my take on where much of the
16 literature is. By the way, the RAND Health Insurance
17 Experiment also looked at better mental health coverage, so
18 there's a subset of this analysis about the relationship
19 between mental health and other service use. And, frankly,
20 there's analysis going the other direction. If you adhere
21 to your drug regimes more closely, you save through some
22 often, and, in fact, the CBO does assume an offset

1 assumption related to use of services to manage chronic
2 conditions.

3 In any case, that's a long-winded comment that
4 can be summarized that there's a lot of complicated
5 connections here, causality is really hard to get at, but
6 if you want to react to some of the points, like
7 consolidation or the past literature, Dan or Shinobu, I'm
8 all ears.

9 [No response.]

10 DR. CHERNEW: Or maybe you don't want to comment.

11 DR. ZABINSKI: Well, one thing I'll say is that
12 past work that we've done on geographic variation, we have
13 found -- how do I say it? The only real, you know,
14 substitution effect we found was between physician offices
15 and hospital outpatient departments, and I think that's
16 what's showing up on that one slide where we have this
17 slight negative coefficient of minus 0.015. I think that's
18 what's going on with that. And so, you know, like I said,
19 that's the only area in our own work that we've ever found
20 that there's really any substitution effect going on.

21 MS. KELLEY: Betty, did you want to jump in here?

22 DR. RAMBUR: I was just going to say, given that

1 it seems that some of us had a question about how -- you
2 know, the antecedent to this, maybe just a little bit of
3 context in the report would be helpful so that anybody
4 picking it up could, you know, understand a bit of the
5 background and the rationale for why the work was done.

6 Thank you.

7 MS. KELLEY: Brian.

8 DR. DeBUSK: The one comment I wanted to make,
9 and, you know, others have alluded to this, but you can see
10 in underlying questions that Congress was trying to tease
11 apart in asking these questions about the relationship
12 between clinician services, and they're good questions, but
13 I think this is an opportunity or maybe this is an
14 opportunity in the report to point out that there are
15 serious limitations in our claims infrastructure. And, you
16 know, maybe this could also be the start of a road map to
17 how we could improve claims and produce more meaning for
18 data in the Medicare program over the next several years.

19 Thank you.

20 MS. KELLEY: I think that's it, Mike.

21 [Pause.]

22 MS. KELLEY: Mike, we can't hear you.

1 DR. CHERNEW: When I'm on my phone, I forget when
2 I'm muted or not. So I thought that as well. So it's been
3 a long and very productive day, I think, and I'm not going
4 to push everybody on this because we don't have a
5 recommendation. Now, I'm sure we'll have other chances to
6 think about this type of issue, and certainly the
7 connection between services is an important topic, so, Dan
8 and Shinobu, I very much appreciate the work.

9 So that brings our day to a close. I will make
10 the comment I always do at the end of each morning or
11 afternoon session, which is to reach out to the public and
12 say these are very important issues. I really thank
13 everybody in the public who has listened to this
14 discussion. I hope they found it useful. We very much
15 would like to hear from you in the public, so please reach
16 out to the staff on the website. There's a lot of ways
17 that you can get a hold of us to give your feedback and
18 your insight into the topics we've discussed. So I hope
19 that that part is clear, our desire to hear from folks.

20 To the Commissioners, I'd like to thank you all
21 for your time today and your insights on all of these
22 topics. We are a little early, and so I think we're going

1 to -- I'm going to turn to Jim in a minute. I think we're
2 going to move our virtual happy hour to 5:30 from 6:00 if
3 that's okay. So I hope that works with everybody's
4 schedule.

5 Jim, do you need to do anything logistically in
6 order to do that?

7 MS. KELLEY: We'll take care of it, Mike.

8 DR. MATHEWS: Yeah, yeah.

9 DR. MATHEWS: Yeah, we'll just send around an
10 updated appointment with the link, so it should be fairly
11 easy.

12 DR. CHERNEW: Okay. So, everybody, look for
13 that. And, again, does anyone want to add anything before
14 a hearty thank you and good-bye?

15 [No response.]

16 DR. CHERNEW: So here's the hearty thank you and
17 good-bye. Thank you and good-bye, and thanks to the
18 public. We will see you again tomorrow morning for our
19 Friday session. Have a good night, everybody.

20 [Whereupon, at 5:15 p.m., the Commission was
21 recessed, to reconvene at 9:30 a.m. on Friday, March 5,
22 2021.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

VIA GoToWebinar

Friday, March 5, 2021
9:32 a.m.

COMMISSIONERS PRESENT:

MICHAEL CHERNEW, PhD, Chair
PAUL GINSBURG, PhD, Vice Chair
LAWRENCE P. CASALINO, MD, PhD
BRIAN DeBUSK, PhD
KAREN B. DeSALVO, MD, MPH, Msc
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P R O C E E D I N G S

[9:32 a.m.]

1
2
3 DR. CHERNEW: Welcome, everybody, to our Friday
4 morning session of the March MedPAC meeting. I think we
5 had a very constructive and interesting day yesterday, and
6 I hope to continue that dialogue today.

7 We're going to start this morning with the
8 discussion of indirect medical education payments, so I am,
9 without further ado, going to turn it over to Alison.
10 Alison, you're up.

11 MS. BINKOWSKI: Thanks, Mike.

12 Good morning, everyone. I am excited to continue
13 the Commission's discussion of revising Medicare's indirect
14 medical education payments to better reflect teaching
15 hospitals' costs. As a reminder, the audience can download
16 a PDF version of these slides in the handout section of the
17 control panel on the right-hand side of the screen.

18 Today's presentation builds off work presented in
19 September 2019 and October 2020, with modifications in
20 response to Commissioners' comments and newer data. In
21 particular, we updated our illustrative model to use an
22 inpatient and outpatient measure of teaching intensity: a

1 hospital's ratio of residents to patients.

2 At the end of this presentation, we will present
3 the Chair's draft recommendation for the Commission's
4 consideration.

5 We anticipate that the information in this
6 presentation and your mailing materials will form the basis
7 of a chapter in the Commission's June 2021 report.

8 As a reminder, Medicare makes two types of
9 additional payments to the roughly 1,100 IPPS teaching
10 hospitals for the provision of graduate medical education.

11 The first type is direct graduate medical
12 education payments, which totaled nearly \$4 billion in
13 fiscal year 2019. These payments support teaching
14 hospitals' direct costs of sponsoring residency programs,
15 such as resident stipends and physician salaries, and are
16 made outside of Medicare's prospective payment systems.

17 The larger type is indirect medical education
18 payments, which totaled over \$10 billion. These IME
19 payments support teaching hospitals' higher costs of
20 inpatient care that are not otherwise accounted for in
21 Medicare's inpatient prospective payment systems, such as
22 unmeasured patient severity and additional patient care

1 costs associated with the teaching of residents, and are
2 implemented as a percentage adjustment to IPPS payments.
3 Together these medical education payments supported the
4 training of about 90,000 residents.

5 Medicare's treatment of teaching hospitals' IME
6 costs varies across the three hospital prospective payment
7 systems, as does the flexibility granted to CMS.

8 While there are numerous differences, a key
9 difference is that the Congress specified the IME
10 adjustment in the inpatient operating PPS in statute, but
11 left flexibility for the other two hospital PPSs. HCFA --
12 the predecessor to CMS -- added an IME adjustment to the
13 inpatient capital PPS but to date has not added an IME
14 adjustment to the outpatient PPS.

15 The Commission has raised two main concerns with
16 Medicare's current IME policy.

17 First, Medicare's IME policy is inpatient-centric
18 and does not reflect the current range of settings in which
19 residents train. This inpatient-centric approach is
20 reflected both in the lack of IME payments for outpatient
21 services and in primarily measuring a hospital's teaching
22 intensity as its ratio of residents-per-inpatient beds.

1 Second, the current levels of the IME adjustments
2 do not reflect teaching hospitals' additional costs of
3 treating fee-for-service beneficiaries, including higher
4 than empirically justified levels for inpatient services
5 and zero for outpatient services.

6 As a result, Medicare overpays teaching hospitals
7 for their indirect costs of medical education in inpatient
8 settings and underpays for those costs in outpatient
9 settings, creating financial incentives that may slow the
10 movement of resident training and patient care from
11 inpatient to outpatient settings.

12 In addition, Medicare's IME policy is
13 inconsistent in its treatment of MA beneficiaries. The
14 Medicare program directly makes inpatient operating IME
15 payments for the care MA beneficiaries (and these are
16 carved out of MA benchmarks), but does not do so for
17 inpatient capital IME payments.

18 Based on these concerns and the Commission's
19 October 2020 discussion, we identified a set of principles
20 for IME payment reform.

21 First, IME policy should reflect the range of
22 settings in which residents train. To do so, Medicare

1 should: make IME payments for both inpatient and
2 outpatient services; and base IME payment adjustments on
3 hospitals' ratio of residents to patients across inpatient
4 and outpatient settings

5 Second, IME payments should better reflect
6 teaching hospitals' additional costs in each setting,
7 without reducing aggregate IME payments relative to current
8 law. To do so, Medicare should transition to empirically
9 justified levels of inpatient and outpatient IME payments
10 by initially applying a budget-neutrality adjustment, such
11 that aggregate IME payments are budget-neutral to current
12 law. Once empirically justified IME payments matched and
13 then exceeded those under current law, IME payments should
14 be set at those levels. The revised policy would,
15 therefore, maintain aggregate IME payments in the short
16 term and increase IME payments relative to current law in
17 the long term.

18 Lastly, IME policy should support the care of
19 both fee-for-service and MA beneficiaries, with the
20 Medicare program consistently making IME payments for MA
21 beneficiaries (and carving these out of MA benchmarks).

22 For the purposes of illustration, we modeled a

1 budget-neutral inpatient and outpatient IME policy
2 consistent with the principles outlined in the prior slide.

3 The key aspects of the revised IME policy included:

4 Expanding the set of services that receive IME
5 payments to include all inpatient and outpatient services
6 provided to FFS or MA beneficiaries, exclusive of
7 separately payable drugs and devices;

8 Updating the measure of teaching intensity to a
9 hospital's resident-to-patient ratio, which would better
10 reflect hospitals' level of teaching intensity across
11 inpatient and outpatient settings. In addition, this
12 measure would avoid creating an adverse incentive for
13 hospitals to acquire physician practices, as doing so would
14 simultaneously increase the volume of outpatient services
15 the IME adjustment is applied to and decrease the magnitude
16 of the IME adjustment for all services due to the increase
17 in a hospital's patients;

18 Setting each IME adjustment at the empirically
19 justified estimate of teaching hospitals' additional costs
20 not otherwise accounted for in each PPS;

21 And, lastly, adjusting the empirically justified
22 IME payments such that aggregate IME payments are not

1 reduced relative to current policy.

2 Revising IME policy to better reflect teaching
3 hospitals' additional inpatient and outpatient costs while
4 not reducing aggregate IME payments would, by construction,
5 maintain aggregate IME payments but shift them towards
6 outpatient care.

7 As shown in the left-most bar, under current
8 policy IME payments totaled \$10.1 billion in fiscal 2019,
9 all of which were for inpatient care.

10 As shown in the middle bar, under the
11 illustrative empirically justified IME policy, aggregate
12 IME payments would have decreased and shifted towards
13 outpatient settings, with the share of IME payments from
14 adjustments to outpatient payments increasing from 0 to
15 nearly 50 percent, and inpatient capital IME payments being
16 eliminated.

17 Finally, as shown in the right-most bar, under
18 the budget-neutral policy, these empirical payments were
19 proportionally scaled such that aggregate IME payments
20 equaled those under current law but better reflected
21 teaching hospitals' additional costs in each setting.

22 For the majority of teaching hospitals, a budget-

1 neutral inpatient and outpatient IME policy would result in
2 a small change in their total inpatient and outpatient fee-
3 for-service payments.

4 As shown in the figure, under our illustrative
5 model, a majority of teaching hospitals would see a less
6 than 0.5 percent change in their total fee-for-service
7 payments and nearly three-quarters would see a less than 1
8 percent change.

9 While the budget-neutral inpatient and outpatient
10 IME policy would maintain aggregate IME payments, it would
11 redistribute them towards hospitals that are underpaid
12 under the current inpatient-centric policy. This includes
13 teaching hospitals that both provide a relatively high
14 share of their care to Medicare beneficiaries in outpatient
15 settings, as these hospitals would see relatively large
16 gains in the set of IME-eligible services that IME
17 adjustments would be applied to; and have an inpatient and
18 outpatient measure of teaching intensity (i.e. resident-to-
19 patient ratio) that is relatively high compared to the
20 primary inpatient-capacity measure used in current policy
21 (the resident-to-bed ratio), as these hospitals would see a
22 smaller decrease in their inpatient IME adjustment

1 percentage and have a larger outpatient IME adjustment.

2 In other words, the revised IME policy would
3 shift IME payments towards teaching hospitals that are, or
4 will become, more outpatient-centric in their care of
5 Medicare beneficiaries; and have a high ratio of residents
6 to patients, relative to residents per inpatient beds.

7 For most groups of teaching hospitals, the
8 budget-neutral inpatient and outpatient IME policy would
9 result in a small change in total inpatient and outpatient
10 fee-for-service payments. This is because while certain
11 groups of hospitals tend to be more outpatient-centric in
12 their care of Medicare beneficiaries, these same groups of
13 hospitals tended to also have a larger percentage decrease
14 in their calculated measure of teaching intensity from the
15 switch to residents per patient.

16 One exception is that the revised IME policy
17 would shift IME payments towards small teaching hospitals
18 with less than 150 beds. We estimate that these hospitals'
19 total fee-for-service payments would increase 0.6 percent,
20 as they were generally more Medicare outpatient-centric,
21 but had a similar decrease in teaching intensity as the
22 typical teaching hospital.

1 In summary, current IME policy is outdated and
2 does not reflect the contemporary range of settings in
3 which hospitals train residents and treat patients; nor
4 teaching hospitals' additional costs in each setting.
5 Transitioning to an empirically justified inpatient and
6 outpatient IME policy would update IME payments to better
7 reflect teaching hospitals' additional costs while not
8 reducing Medicare's aggregate support to teaching
9 hospitals.

10 Within the broad principles outlined in this
11 presentation, Congress could grant CMS flexibility on
12 implementation of the revised IME policy, including whether
13 to phase in the revised IME policy for the subset of
14 teaching hospitals more substantially affected or exempt
15 new outpatient IME payments from beneficiary cost-sharing
16 requirements and calculations of Part B premiums.

17 The Chair's draft recommendation reads:

18 The Congress should require CMS to transition to
19 empirically justified indirect medical education
20 adjustments to both inpatient and outpatient Medicare
21 payments.

22 As aggregate IME payments would initially be

1 budget neutral, the revised IME policy would initially not
2 affect Medicare spending, but would reduce Part A spending
3 and increase Part B spending; however, over time it is
4 likely the revised policy would facilitate the continued
5 shift to outpatient care, which would eventually increase
6 Medicare spending on IME relative to current law, but
7 decrease Medicare spending on inpatient services.

8 We do not anticipate the revised IME policy to
9 affect Medicare beneficiaries' access to care or hospitals'
10 willingness to treat Medicare beneficiaries.

11 Depending on implementation, the addition of
12 outpatient IME payments may cause slight increases in
13 Medicare beneficiaries' Part B cost sharing and premiums.

14 Lastly, the revised IME payments would be more
15 equitable to teaching hospitals that have already, or will
16 in the future, shift to providing more resident training
17 and care of Medicare beneficiaries in outpatient settings.

18 And with that, I turn it back to Mike.

19 DR. CHERNEW: Terrific. Thank you. This has
20 been a topic that MedPAC has been working on for a long,
21 long time.

22 I'm going to turn it over, again, like yesterday,

1 to Dana Kelley to go through the Round 1 and the Round 2
2 questions, so, Dana, who is first up? Dana?

3 MS. KELLEY: I am sorry. I have Brian first.

4 DR. DeBUSK: Thank you. Thank you for the really
5 good presentation.

6 I wanted to mention, on page 5 of the reading
7 material, Table 1, the add-on payment itself uses an
8 exponential function using that ratio of residents to beds.
9 It's actually allowed residents, I presume. So that's a
10 constant in a capped program.

11 But here's my specific question. Have the staff
12 modeled the relationship -- because presumably if you did
13 more inpatient volume, you would need more inpatient beds,
14 which would dilute the numerator -- or the denominator of
15 that exponential. But then the payment, the add-on payment
16 that you get would be applied to all of your inpatient
17 cases. Can you speak to that formula just a little bit?
18 Because it seems like there should be a way to optimize
19 that. I wouldn't necessarily say "game," but there should
20 be a mathematical way to optimize that yield, maybe through
21 reducing length of stay or sending them on to SNFs sooner
22 or PAC. Could you just speak to how the math of that

1 specific function meets the operation in a hospital?

2 MS. BINKOWSKI: I can speak a little bit about
3 that function. I think you're referring to the inpatient
4 operating PPS function.

5 DR. DeBUSK: Yes.

6 MS. BINKOWSKI: Which is 1.35 times one resident-
7 to-bed ratio to the exponent 0.405 minus 1, for those that
8 don't have the benefit of Table 1 from the mailing
9 materials in front of them. So, yes, there are different
10 ways that hospitals can be incentivized to try to maximize
11 those payments. One of those involves reducing the number
12 of beds that you have. However, there are also other IME
13 policies that we don't discuss in this paper that in most
14 cases cap a hospital's resident-to-bed ratio at their level
15 in the prior year. So there are other policies that try to
16 prevent certain forms of gaming.

17 I can go into more details, but I don't want to
18 sidetrack us.

19 DR. DeBUSK: No, that's okay. So there are other
20 safeguards. That formula just struck me as particularly
21 vulnerable.

22 On page 7 of the reading material, Figure 2, you

1 have a whisker plot, and it looks like the nominal
2 adjustment's around 6 percent. But I notice on that plot
3 you've got hospitals that are running that all the way out
4 to the 25 to 33 percent range. Can you speak to those? Is
5 that linked to the vulnerability in that formula? Or is
6 there something else that we need to know?

7 MS. BINKOWSKI: So for those that don't have the
8 mailing materials, Figure 2 shows the wide distribution in
9 the range of IME adjustments across teaching hospitals,
10 and, yes, the median adjustment is about 6 percent, but it
11 can be over 40 percent for the top 5 percent of teaching
12 hospitals, and that is true and is a reflection of two
13 factors, one of which is that some hospitals really do have
14 a high level of residents relative to inpatient beds. For
15 example, think of certain eye hospitals, and there's also
16 incentives for hospitals to maximize their policy. So on
17 the inpatient capital side, there is an absolute cap on how
18 high the IME adjustment can be and on the inpatient
19 operating side there is no. In our illustrative policy, we
20 did apply a cap.

21 DR. DeBUSK: Okay. So we wouldn't necessarily
22 say hospitals that are, say, 33 percent add-on payments

1 doing, you know, half a billion in inpatient volume, you
2 would say these are probably outliers where there's
3 circumstances, like you said, an eye hospital where you're
4 doing -- where you have a very skewed ratio.

5 MS. BINKOWSKI: Yes, I'd say --

6 DR. DeBUSK: Or are there --

7 MS. BINKOWSKI: -- those hospitals that are more
8 unique circumstances about them.

9 DR. DeBUSK: Okay. And then, finally, you know,
10 on the presentation, on Chart 8, I had a question. These
11 hospitals that had this greater than 3 percent change, are
12 those the same hospitals we've been talking about?

13 MS. BINKOWSKI: Many of them are, but these are a
14 heterogeneous group of hospitals. I don't have specific
15 characteristics off the top of my head to list them. I can
16 follow up with you after the meeting.

17 DR. DeBUSK: Well, thank you. I'll save the rest
18 for Round 2, but thank you.

19 DR. CHERNEW: Dana?

20 MS. KELLEY: Yes, I have Pat next.

21 MS. WANG: Thank you, Dana. Actually, just
22 picking up on Brian's last question, does it make sense to

1 add a column or a new table that is similar to Table 4 that
2 shows sort of the change from the current IME fee-for-
3 service -- you know, the impact on current IME fee-for-
4 service payments by bed size, location, et cetera, to do
5 one that cross-walks under the current system, hospitals'
6 intern- and resident-to-bed ratio under the current formula
7 to their new teaching factor, whatever we're calling it?
8 Does that even make it -- you wouldn't call it an IRB
9 anymore, but you'd call it something, just to get at
10 Brian's question about is it -- which are the hospitals
11 that are being most affected by the policy? And is that
12 related to the current teaching intensity? Is it related
13 to something else? I mean, you have it cut by sort of
14 number of beds, but I just wonder whether that could also
15 be informative.

16 I wanted to ask you a couple of questions about
17 the definition of sort of outpatient services and residents
18 who count. Could you just address would outpatient
19 equivalence be calculated for observation unit stays,
20 telehealth? I don't even know how that's treated today,
21 but we know that that's going to be a little bit more
22 prevalent going forward for ambulatory care. And if you

1 could remind us if a teaching hospital has a relationship
2 with a community health center, for example, or an FQHC and
3 residents rotate through there, how would that kind of
4 situation be handled? Does the hospital have to sort of
5 own the outpatient site, or if it's rotating residents
6 through, how does that factor in?

7 MS. BINKOWSKI: So as we mentioned in the paper,
8 one of our recommendations, or aspects of the potential
9 principles, is that the IME adjustment for outpatient
10 sources should only apply to locations where residents
11 rotate. Currently, CMS does not collect information at
12 that level, so we were not able to model the extent to
13 which residents currently rotate to some of these
14 locations, such as community health centers. But they
15 could start collecting it.

16 MS. WANG: Okay. So this is the modeling. So
17 we're not making specific recommendations about the types
18 of non-inpatient settings? Would the definition just be
19 any place where a resident is?

20 MS. BINKOWSKI: So in terms of our outpatient
21 adjustment it would be anywhere where OPSS payment applies
22 and the resident rotates.

1 MS. WANG: OPPS. Okay. Interesting. Okay.

2 The other question I had was, would it be
3 necessary for this kind of policy to be paid for from Part
4 B? Is there sort of a statutory requirement that the cost
5 would have to be borne by Part B, and therefore individual
6 beneficiaries as opposed to remain in Part A and be funded
7 more generally through taxes?

8 MS. BINKOWSKI: That's something we'll need to
9 continue to consult with CBO and others on.

10 MS. WANG: Okay. Thank you.

11 MS. KELLEY: I have Larry next.

12 DR. CASALINO: Yes. Three pretty quick
13 questions. One is, so you've arranged the recommendation
14 so that the policy would be budget neutral relative to
15 existing law, and I think you said, at one point, and the
16 chapter says that over time, relative to existing law, it
17 would actually give more IME money to teaching hospitals.
18 Is that statement going to be questioned in the sense that,
19 are people going to say, potentially, yes, compared to
20 existing law but the law does usually change over time to,
21 to give them more money over time, so that the effect over
22 time, in that case, would be unknown whether it would

1 reduce or increase or keep budget neutral the IME payments
2 to teaching hospitals. So that's my first question.

3 MS. BINKOWSKI: If I understand your question,
4 our statement is specific relative to current law. Our
5 crystal ball is as good as yours and everyone else's as to
6 how a law might change in the future.

7 DR. CASALINO: Fair enough. And then I actually
8 also was going to ask the same question as Pat and Brian
9 asked. It would be nice to know a bit more about the types
10 of hospitals -- I think you said they're heterogeneous --
11 who get the plus or minus 3 percent or more. You know,
12 that's a fairly significant hit to margin, probably, for a
13 lot of hospitals. But I guess that's a statement and not a
14 question, since it's already been asked. But it would be
15 nice to know a little bit more about who they are.

16 And then the last question is, the draft
17 recommendation doesn't say anything about the budget
18 neutrality, although the report is pretty explicit about
19 that, the chapter, and that, of course, is going to be
20 something that is going to be of concern to affected
21 hospitals. Can you say a little bit more about that?

22 MS. BINKOWSKI: I will refer to Mike on that.

1 DR. CHERNEW: This is a complicated question,
2 Larry, and your thoughts are useful. What you say is
3 actually completely true, that the recommendation is short
4 and is a little bit vague in that it says transition. It
5 doesn't explain, in the actual recommendation, what
6 transition means. I think the chapter is pretty clear
7 about what we mean by that.

8 And so, you know, I'm a little six of one, half
9 dozen of another on the nuance in the wording, but I think
10 the point you raise is a valid one, and I'll discuss with
11 Jim and the staff if we want to tweak the wording. But
12 your point is correct, and there is a bit of a semantic
13 issue about how broad we want the recommendation to be, and
14 frankly, how constraining we want it to be for CMS. By
15 keeping it this way, we give it a little more flexibility
16 than we would if we made the recommendation really very
17 precise.

18 I personally like that level of flexibility. I
19 have a sense that there's people that think we should
20 transition quicker than might happen if we said that.
21 There might be some people who think we just transition
22 slower. So, Jim, do you want to react?

1 DR. CASALINO: Michael, these are not rhetorical
2 question, by the way. They are real questions. I'm not
3 trying to sneak an argument into Round 1 here. But
4 actually what you just said makes me realize that there's
5 something that I thought I understood but maybe I don't,
6 and it could be important.

7 So I think my read of the chapter was
8 transitioning to empirically-justified, if that was taken
9 absolutely literally, would not be budget neutral but would
10 lower payments now relative to current law. And so I
11 thought that the recommendation to transition to
12 empirically-justified and the recommendation in the
13 chapter, where the modeling in the chapter of keeping
14 things budget neutral, are not the same thing, and, in
15 fact, conceptually are a little bit in conflict with each
16 other. Both can be done, but the empirically-justified
17 wouldn't lead to budget neutrality, I don't think, if I
18 understood correctly.

19 DR. CHERNEW: Jim is going to say something in a
20 minute, but I think the issue is what you mean by the word
21 "transition," or what we mean by the word "transition,"
22 right? It is the budget neutrality, keep it budget-

1 neutral, relative to current law during this sort of
2 transition, and then you get to an empirically-justified
3 rate after that point. So I'm not completely sure if
4 that's clear. Just for timing, because I don't want to
5 dwell on it too much now, but the intent was to have a
6 little more flexible recommendation, but the chapter, I
7 think, is pretty clear in what we're pushing for.

8 But, Jim, I see your head nodding. Do you want
9 to jump in?

10 DR. MATHEWS: Sure.

11 DR. CHERNEW: Jim, you go, then Larry.

12 DR. MATHEWS: Okay. The intent of the policy as
13 described in the paper and as illustrated on Slide 7 is
14 that at the outset of the redistribution of IME dollars the
15 current levels of IME adjustments would be maintained at
16 the roughly \$10 billion level. Over time, on a year-over-
17 year basis, IME spending would be maintained at that level,
18 but given historical trends we see very slight year-over-
19 year declines in hospital inpatient care and relatively
20 robust year-over-year increases in hospital outpatient
21 care.

22 So eventually the empirically-justified indirect

1 costs of medical education will rise to the level
2 equivalent to the current aggregate spending amount, and at
3 that point it will increase at the empirically-justified
4 level, and because outpatient services are growing faster
5 than inpatient, that is what causes this to cost more over
6 the long term.

7 Does that help?

8 DR. CASALINO: Very much, and now that you're
9 saying it, that is actually fairly clear in the chapter.
10 It's written as clearly, I think, as it can be, now that
11 you mention it. It isn't easy to understand in one quick
12 read, but yeah.

13 DR. MATHEWS: Understood, and I agree with Mike.
14 We would like to keep the recommendation language as
15 parsimonious as possible for the reasons he mentioned, but
16 in our conversations with CBO, who is going to arbitrate
17 the score here, we've been very clear about the intent,
18 and, you know, are walking through the rationale with them
19 in close detail.

20 DR. CASALINO: Thanks, Jim.

21 MS. KELLEY: Paul, did you want to get in on this
22 point?

1 DR. PAUL GINSBURG: Yes. I was going to hold
2 this for Round 2, but I had this reaction to the draft
3 recommendation that's, I knew that this issue, about
4 wanting to give some flexibility on the budget neutrality
5 issues, but I find just the entire recommendation sounds
6 more like a goal than a recommendation, for a policy
7 change, you know, just saying that we should pay both on
8 inpatients and outpatients. I think we need to say more,
9 perhaps in a subpoint, about what we're actually talking
10 about [audio break - inaudible] just adjustments to both
11 inpatient and outpatient Medicare payment. See, to me that
12 just doesn't give me enough about what the Commission
13 really has in mind.

14 DR. CHERNEW: So in some sense that's the
15 comment, and the spirit of Larry's comment, about the
16 wording of the recommendation as opposed to the substance
17 of where we're trying to go and how specific we want to be.
18 So I think in the interest of time we'll have a discussion
19 about the wording again. The intent is to allow
20 flexibility. We don't have a specific -- I don't know what
21 the right word is -- we didn't want to be as detailed as is
22 in the chapter about specifically what got modeled, to

1 allow some flexibility, but we probably can think through
2 the actual wording so people get some sense of what we're
3 talking about. The goal, that I agree, to your point that
4 this part of it is aspiration, is to make the IME payment
5 system less inpatient-centric, and do so in a way that
6 doesn't take a lot of money out of the system to start
7 with.

8 I think those are the sort of main points of what
9 we were modeling.

10 DR. PAUL GINSBURG: That's right. So that would
11 be a kind of a first statement, and then there could be
12 follow-up statements to bring some of the precision in the
13 chapter and be very specific about where we think
14 flexibility should be given, et cetera.

15 DR. CHERNEW: Yeah, and the movements from things
16 like residents to bed residents to patients, for example,
17 is something that we model but is not in the rec. I
18 understand that. So we will have a broader discussion
19 about what I'm hearing from both you and Larry, and I
20 realize we are in a Round 1 situation so maybe I'm just
21 screwing things up. But some more specificity in the rec
22 we will consider, and then we will obviously come back to

1 when we get to next month. Jim, are we onboard with that?

2 DR. MATHEWS: Sure.

3 DR. CHERNEW: Okay. We're still in Round 1, and
4 so I want to be conscious that this is an hour-long
5 session, so I will try and be briefer. But Dana, why don't
6 we move along, if everyone else can be concise.

7 MS. KELLEY: I think we have one last Round 1
8 question from Bruce.

9 MR. PYENSON: Thank you. I'll be brief. These
10 are questions about Figure 7, and just noting that the
11 inpatient capital seems to disappear, I think. I know
12 there is some discussion in the write-up that MA plans are
13 not tabbed with inpatient capital for IME. It looks like
14 that would continue to be the case because nobody would get
15 that. It would be redistributed. Am I interpreting that
16 correctly?

17 MS. BINKOWSKI: Correct. We found no empirical
18 justification for an IME adjustment to patient capital
19 payments.

20 MR. PYENSON: Thank you. Just another question
21 about this. There are several different figures for the
22 percentage of current IME that is empirically justified

1 that are in the text. This chart looks like it uses
2 roughly 70 percent. Am I correct in assuming that that's
3 illustrative?

4 MS. BINKOWSKI: Yes, it does depend on a specific
5 modeling decision, the exact percentage, but the main
6 points are consistent, that inpatient operating IME
7 payments are roughly 40 percent empirically justified,
8 which is consistent with what we've presented in the past,
9 and that when you add outpatient you're in the ballpark of
10 70 percent.

11 MR. PYENSON: And maybe this is a failure on my
12 part to understand. I can see going from 10.1 in Figure 7
13 to the, looks like, 3.8, that's roughly the 40 percent, but
14 we're adding on top of that -- so the empirically justified
15 portion of the middle bar of Figure 7 is really only the
16 two bottom blocks. Is that right?

17 MS. BINKOWSKI: That's the empirically justified
18 IME payments for inpatient services, are the bottom blocks.

19 MR. PYENSON: So I guess I'm confused about what
20 empirically justified means. I thought it was the expense
21 of residents, but maybe I was wrong about that.

22 MS. BINKOWSKI: It's teaching hospitals'

1 additional patient care costs from having residents that
2 are not otherwise accounted for in the prospective payment
3 systems.

4 DR. CHERNEW: It's the outcome of the regression,
5 essentially, that looks at total cost of the residents to
6 beds. Am I right with that, Alison?

7 MS. BINKOWSKI: Yes, except that there are two
8 different regressions, really three with inpatient, and one
9 for each setting, and so that's why --

10 DR. CHERNEW: So basically it's the regression
11 that's looking at costs of residents to beds. It's not a
12 direct reimbursement for anything. That's in the direct
13 part.

14 MR. PYENSON: Right. So you're saying there's
15 data on residency costs. There's residency costs that are
16 evident in the data, but are not associated with inpatient.

17 MS. BINKOWSKI: They are associated with
18 outpatient care, is what the top two bars are.

19 DR. CHERNEW: There's an impact of residents on
20 overall outpatient spending. I think that's the way you'd
21 say it, Alison. In other words, the key point here is
22 indirect, so it's a question of having a teaching program

1 on broad expenses, not expenses like resident salaries or
2 whatever. It's expense overall for care delivery. And I
3 think, Alison, what you're saying, at least my
4 understanding is, if you have residents there's an
5 empirical increase in your expenses for care delivery,
6 outpatient care delivery.

7 DR. STENSLAND: I think intuitively we can kind
8 of think of that lower \$3.8 billion, is these are the extra
9 inpatient costs. You have residents running around and
10 they're ordering extra tests for your inpatients. This
11 increases the cost of care. That's in the \$3.8 billion.
12 And then the upper part, the \$3.5 billion, is on the
13 outpatient side, and that means you have residents running
14 around, and maybe you're having some outpatient visits, but
15 maybe it slows things down when the patient first sees the
16 resident. Then the attending comes in and talks to him, so
17 there's some extra costs on the outpatient side also. Just
18 the cost per unit of output seems to increase when you have
19 the residents running around in both these settings, and
20 that's what the addition of all of those four bars are.

21 DR. CHERNEW: We should move along because we
22 have a lot of Round 2 questions, and we don't have a lot of

1 Round 2 time. So I'm sorry for pushing us forward but I
2 think we have got to move.

3 MS. KELLEY: Okay. I have Paul with a Round 2
4 question.

5 DR. PAUL GINSBURG: Sure. You know, I think
6 everybody knows that there's a lot of teaching activity
7 that happens in the outpatient setting, and that this has
8 been growing for decades, over time. But I find that this
9 chapter, the only evidence it presents are the results from
10 the model, the model of costs. And it seems as though
11 there is a call for putting some descriptive information,
12 just at the beginning of the chapter, to give people a
13 sense of the magnitude of this change in graduate medical
14 education over time, or just, in a sense, how much
15 education is going on in the outpatient setting today. I
16 know there are some specialties that have almost no
17 inpatients at all, so presumably most of their training of
18 residents is happening in outpatient settings.

19 So I think it would make it easier for the reader
20 to see evidence beyond the regression that we report.

21 Another comment, and I'll be quick about this, is
22 that it would be better if we allocated funding to

1 outpatient training beyond the hospital outpatient
2 departments, you know, in community health centers, in
3 independent family practices, and maybe there are practical
4 reasons why we can't do that. But it would be, I think,
5 desirable to do that, particularly to remove some of the
6 additional incentive for hospitals to acquire practices to
7 the degree that they can get compensation for indirect
8 medical education, even if they don't own the outpatient
9 facility where it's being done.

10 MS. KELLEY: Okay, Jon Perlin.

11 DR. PERLIN: Thanks. Let me just build on from
12 Paul.

13 This does redistribute funds obviously, but I'm
14 not sure -- and this is spoken as someone who started his
15 administrative career running a residency program and
16 through my leadership at VA had relationships with nearly
17 every residency program. It's not clear that it achieves
18 the objective of incentivizing more outpatient training.

19 Building specifically on something Paul said, the
20 ability to go and do outpatient care is obviously very
21 specialty-dependent. Re both Brian's and Paul's comments
22 that may have unintended consequences, I think it lays the

1 course to create a desirability of practice acquisition,
2 which is obviously something our Commission has had
3 concerns about. And I'm not sure how the transition from a
4 ratio of residents to beds to residents to patients thwarts
5 that. In fact, it likely incentivizes that specifically
6 because that's actually how you get patients into the
7 environment.

8 Third, two or more hospitals that have very
9 similar patient ratios, but very different service mixes
10 and patient complexities, contrast to the general role that
11 complexity varies with scale, the hospitals serving the
12 higher-acuity needs, albeit even adjusted by CMI, could be
13 disadvantaged, and that disadvantage may be exacerbated
14 particularly in areas where there are more vulnerable
15 patient populations or another scenario where there's a
16 high density of training programs. Take, for example, New
17 York City where a region that is actually over-bedded and
18 the number of new patients is beyond capacity, but you've
19 now just changed the capacity to create what I think we'd
20 have to acknowledge is not a local good but a national
21 good, and that's the production of trained physician care
22 providers.

1 The fourth point is really the training takes
2 place at the sites where the critical experience is
3 available to meet the board requirements, and the ability
4 to shift clinical experience to the outpatient, for
5 example, for OB or surgical specialties is decidedly
6 limited. And, you know, the complex cases that one needs
7 to train with are available primarily in the inpatient
8 setting. So if you create a pressure against that, it is
9 clear that we will have specialties training decreasing,
10 but you also may exacerbate problems like the well-known
11 crisis in the production of general surgery as an example.

12 Beyond that, in a more colloquial sense, we all
13 need to train for the more complex case and scale down, not
14 the less complex and scale up.

15 I want to come back and agree with Larry on the
16 point about transparency and making the modeling available
17 for examination. It would be helpful to understand how
18 these redistributions work and have the ability to assess
19 whether or how they impact the stated goals.

20 And, finally, a couple points. Yearly numbers
21 may vary. You know, while this past year was obviously an
22 extraordinary and catastrophic outlier, and even smoothing

1 with three-year rolling average, it's incredibly disruptive
2 and entities hosting graduate medical education, the year-
3 over-year uncertainty to host graduate medical education at
4 scale; otherwise, they will cut back in the number of
5 slots, especially at times where the physician need is
6 increasing, not declining.

7 So all of that said, it leads me to think that we
8 have some more work to do, and that we should consider a
9 pilot program at a limited site to see if it actually does
10 incentivize behaviors that appear to be beyond really
11 what's more of a sort of gestalt goal than, I think, a
12 fully featured recommendation at this juncture.

13 Thanks.

14 MS. KELLEY: Brian.

15 DR. DeBUSK: Thank you. Well, I was really glad
16 to see this chapter appear in the reading material. You
17 know, from a big-picture perspective, you look at the
18 things that could impact the Medicare program and our
19 beneficiaries, medical education is probably one of the
20 largest influences on the future of the program and the
21 trajectory of the program and its beneficiaries that we
22 could have. So I'm really glad that we took this up, and I

1 think this is very important.

2 I do agree, I like Paul's comments, and I want to
3 build on that, about illustrating some of the various
4 effects. I would love to see, you know, how does the
5 existing formula break down, say, in an eye hospital that
6 has almost no inpatient procedures. What range of
7 adjustments can be made to the formula? What opportunities
8 are there to manipulate or manage that formula?

9 As far as the recommendation in the chapter, I
10 wholeheartedly support making the fixes that are addressed
11 in the chapter. To me, these are very much technical
12 fixes, and this is a core payment accuracy issue. I mean,
13 this is really exactly -- you know, the charges that we
14 have been given is to make sure that payments are accurate.
15 And here we have a theoretical discrepancy. I mean, we're
16 paying on inpatient volume. We're not paying on outpatient
17 volume, and it's growing quickly. But we're seeing that
18 discrepancy in the empirical data. I mean, we are watching
19 this discrepancy unfold in front of us. And I think
20 there's a little bit of a burning platform here because,
21 over time, as we don't recognize outpatient procedures, and
22 as that portion grows, eventually the overpayments that are

1 here are going to be consumed, and they're going to turn
2 into underpayments unless we develop a way to incorporate
3 outpatient medical education into these formulas. So I
4 think the status quo of not doing anything is
5 unsustainable. At some point we're going to have to make
6 this correction.

7 The other issue -- and, again, this builds on the
8 questions earlier -- to me, looking at that formula, the
9 RVR, the exponentiated formula, it does look like that
10 would also be vulnerable to a hospital's specific post-
11 acute care strategy. And I would suspect that hospitals
12 that minimize lengths of stay by turning to post-acute care
13 or hosting their own post-acute care would have materially
14 higher add-on payments just simply by adopting that
15 strategy.

16 So, again, that's another issue that really
17 concerns me. I think this is a big, big payment accuracy
18 issue, and I'm really glad to see that we've addressed it.

19 My final point, because the recommendation that
20 we made -- and, gosh, it's probably been over ten years
21 ago, well over ten years ago now. I also think the program
22 needs to account for the need -- or medical education needs

1 to account for the geographic and specialty needs of the
2 Medicare program. Right now this notion that we're just
3 going to simply give a group of Medicare providers money
4 and they're just going to make the combination of physician
5 specialties and geographic specialties that they need
6 really strikes me as a little bit absurd. I mean, we do
7 not do that in any other Medicare program. We don't simply
8 pay a hospital for drugs and say now go administer the
9 drugs you like or want to administer. We don't let
10 physicians pick and choose the mix of procedures they want
11 to do.

12 So it seems like part of this ongoing work, I
13 hope that we do recognize the need that with Medicare
14 paying the vast majority of medical education bills, that
15 Medicare should have some say in what specialties and what
16 geographic mix of physicians are produced by the program.

17 And those are my comments. Thank you.

18 DR. CHERNEW: Okay. Given the time where we are,
19 we will continue this discussion, but I do want to keep
20 going along quickly. I think we're going to go over a
21 little bit this session for sure. Hopefully we can
22 minimize our overage. Dana.

1 MS. KELLEY: Jonathan Jaffery.

2 DR. JAFFERY: Yeah, thank you, and given the time
3 crunch, I'll try and be pretty brief. Clearly, this is an
4 important topic that MedPAC and Congress has been grappling
5 with for quite a while, so I'm glad we're taking it up.
6 And I largely appreciate the many points that fellow
7 Commissioners have made.

8 There are two specific concerns I just wanted to
9 call out. One relates to Paul's initial comments about
10 being a little bit more direct, perhaps, in our language in
11 the recommendation. And if you look at Slide 11, we talk
12 about Congress granting CMS flexibility, and I understand
13 the idea of trying to allow that flexibility. But in
14 particular, the penultimate bullet point on the slide where
15 we talk about maybe allowing CMS flexibility to include --
16 whether to include a phased-in policy for substantive
17 teaching hospitals, maybe I'm not remembering this
18 correctly, but I feel like in our previous discussion this
19 cycle, we're a little bit more specific about that. And to
20 me that's quite important that we don't see large swings
21 for individual hospitals in either direction in a given
22 year.

1 And so I think that's an important policy point
2 that we should be more declarative about, and CMS can still
3 get some flexibility on how to implement that, but I don't
4 think the -- to me, whether to implement it, we should be
5 more direct about that.

6 And the second concern I have is more of a
7 practical one, and this notion that outpatient IME
8 ultimately would be determined based on where residents do
9 their -- have their rotations or what-not, I guess I'm just
10 not clear how that will work practically because that can
11 change -- unlike the inpatient setting, where it probably
12 doesn't change quite as much, and you've got these
13 formulas, even flawed, about resident-to-bed ratio, that
14 might be very, very fluid. And so I'm just -- I haven't
15 figured out and I'm not sure I saw anything in the reading
16 that explains to me how we would make that work or how CMS
17 would make that work.

18 So I'll leave it there with those comments, and
19 thanks for the opportunity.

20 MS. KELLEY: Betty.

21 DR. RAMBUR: Thank you. In the interest of time,
22 I'll only share my most burning comments.

1 First of all, I have been very concerned about
2 the mismatch between this enormous workforce creation
3 subsidy and the needs of Medicare beneficiaries and
4 taxpayers. And perhaps I'm just not tracing this
5 particular piece, but in terms of empirical justified, the
6 arguments don't seem to always recognize the revenue
7 generation that these residents create, or at least I'm not
8 understanding how that's included. And I'll just briefly
9 comment on the study by Chandra, Wilensky and others that
10 talked about the substantial amounts of services to
11 patients, thereby generating substantial revenues for
12 hospitals, particularly after the first year of residency.
13 So that's one piece that I'm still trying to struggle with.

14 I want to comment on Brian's comment, which I
15 very much appreciated, in terms of Medicare subsidizing
16 this education and is it really geographically and
17 specialty-wise getting us where we want to go. Just this
18 month in JAMA, Royce traced out the relationship between
19 GME growth and specialty growth with a 209 percent increase
20 in plastic surgery, 190 in neurosurgery, 153 percent in
21 dermatology, and not a corollary growth in primary care.
22 So I would hope, whether we think about it this cycle, next

1 cycle, or multiple cycles, I think we really have to think
2 about how do we get the primary care workforce that we
3 need.

4 Someone earlier talked about specialty -- the
5 difficult specialty care, the intensive education. I would
6 just say procedural intensity is one thing, but primary
7 care is complex, it's difficult, as you know. And I'll
8 conclude by saying we hear over and over again about NPs
9 and PAs playing an increasing role in delivery of primary
10 care in ACOs, in rural areas, and in underserved areas.
11 And, of course, these rules were set before these
12 disciplines had even emerged. And so these arcane rules
13 really limit our ability to use these resources to prepare
14 the workforce that we need in primary care, and I'll just
15 comment that the graduate nurse education demonstration
16 program has important implications for Medicare policy in
17 terms of enhancing access to primary care.

18 Thank you.

19 MS. KELLEY: Okay. Jaewon, you're next.

20 DR. RYU: Yes, thanks, Dana. I generally like
21 the draft recommendation. I do think there's a -- and
22 others touched on this earlier. I do think there's a

1 little bit of a dissonance between how the chapter frames
2 it up and then the draft recommendation itself. I
3 appreciate and see the benefit of the flexibility, but I
4 wonder if it's a matter of framing of how we tee it up in
5 the chapter so that it doesn't feel like, you know, we're
6 focused so much on budget neutrality and then silent on it
7 in the recommendation.

8 I see the validity of not changing the
9 recommendation approach and affording that flexibility.
10 Maybe it's a matter of just shifting the framing in the
11 chapter itself.

12 I like the transition approach to getting to an
13 empirically justified model, and I like in particular sort
14 of the budget neutrality to allow the costs to sort of
15 catch up to what current law provides for. I think that is
16 a clever and less disruptive way of transitioning into the
17 model.

18 I also think the transition to outpatient is
19 important, and I couldn't agree more with a comment that
20 Paul made around some value of having some description in
21 the chapter. I think this is one place where there might
22 be value just to illustrate where and how extra cost gets

1 baked in, especially on the outpatient teaching side. I
2 think people are more intuitively familiar on the inpatient
3 side. There may be ordering of more tests and so forth.

4 On the outpatient side, teaching significantly
5 slows down a clinic, I would even argue more so than the
6 inpatient environment. So I think that would also be
7 helpful.

8 And then, lastly, I share some of the comments
9 made in Round 1 where it would be helpful to have a little
10 more detail on how the impact would cut differentially
11 across different segments of the teaching hospitals that
12 are out there.

13 MS. KELLEY: Karen.

14 DR. DeSALVO: So, first of all, thank you for
15 addressing this important topic. I'll just start by
16 sharing that I do think Jon's right that having
17 opportunities to train in the inpatient environment with
18 really highly acute patients is important and scaling, as
19 we described it, down or upstream or however you want to
20 share it. And I could support the general direction of the
21 draft recommendation. I do want to flag that, in general,
22 I am concerned about continuing to anchor GME resourcing on

1 hospital-based systems and on a system that may
2 inadvertently drive increase in services to increase -- to
3 show that there's more need as opposed to a population
4 level indicator. So within the hospital framework, if we
5 could get to a world in which there is an accountability
6 for a set population, that would certainly not -- that
7 would be preferable than just services, which I think we
8 could imagine you'd start to turn up if we couldn't
9 identify new patients.

10 And then I want to just ask that somewhere in the
11 future that you consider a complete shift, which would be
12 to anchor the training dollars into the medical schools or
13 the nursing schools rather than through the hospitals. And
14 I'm sure I'll get a lot of emails about that, but if we
15 really wanted to think about how to train a workforce for
16 beneficiaries' and not for a health care system's needs,
17 that might be an important consideration to go back in
18 history and think about how we used to do it and that there
19 might be a better way.

20 Thanks.

21 MS. KELLEY: Pat.

22 MS. WANG: Thanks. This echoes some of the

1 comments that have been made. Just in general, it's
2 unfortunate that we have to anchor so much of payment
3 policy, especially for something like IME, to units of
4 service. And so we're shifting from inpatient units of
5 service to OPPS paid units of service, but some of the
6 underlying concerns that Karen just mentioned I think get
7 created.

8 I'll go a step further. I have concerns -- you
9 know, I think it's very important to recognize teaching in
10 non-inpatient services, so I'll just start there. The work
11 is very important. But I actually have a concern that the
12 linking -- so today IME is linked to inpatient care and
13 resident-to-bed ratios. I think that teaching hospitals
14 sort of manage that relationship in a way to ensure, you
15 know, that payment is where it's supposed to be. And then
16 if they want to subsidize residents rotating through an
17 FQHC, they can kind of do that because their ratio's -- you
18 know, they can sort of subsidize that.

19 I'm worried a little bit that shifting now to the
20 unit of service OPPS is going to create a disincentive to
21 send people out because, again, it's make every unit of
22 service count. I worry that it could cause folks to sort

1 of kind of bring people more inside as though we have to
2 stick to OPPTS paid services because that's the only kind of
3 ambulatory care that we're going to get credit for. And so
4 I'm a little bit nervous about that.

5 And so in the chapter, I think it would be -- in
6 an ideal world, at some point, you know, I think, one, I
7 agree with Karen, a more population health-based budget. I
8 don't know about medical schools, but even if you anchor it
9 in the teaching hospital, maybe it's something that CMMI
10 can consider in the future to set sort of prospective IME
11 budgets to allow teaching hospitals to have some
12 flexibility in where they send residents without fear that
13 because it's not OPPTS paid and it's in an FQHC, that
14 they're somehow going to lose money from it.

15 I would really like there to be something in the
16 chapter or consideration of recommending that IME continue
17 to be paid from the Part A trust fund. I am nervous given
18 the stress that Part B premiums are already placing on
19 beneficiaries, that this shift of IME to outpatient
20 settings is going to fall on beneficiaries directly to
21 subsidize through increases in their Part B premiums, even
22 if they never use the services of a teaching hospital. You

1 know, having it more generally supported through the Part
2 A, more broad-based, you know, sort of taxing mechanism I
3 think is preferable, and I think that we should say that.

4 The third thing is this reminds me a little bit
5 about the conversation yesterday about MA benchmarks.
6 Obviously, this recommendation has lots of interactions
7 with other parts of payment policy. It has implications
8 for update factors. If the array of impact remains the
9 same, then the update factors that we just all voted on,
10 and the information we saw, might need to be -- that
11 analysis might need to be changed somewhat.

12 It also might have an impact on how direct GME is
13 calculated because I believe that that is still tied to
14 inpatient days. I may be wrong about that. But, you know,
15 without trying to solve all of those problems, I think it
16 might be helpful to again include a text box or something
17 in the chapter itself that recognizes that this policy and
18 the shifts that it would create do have interactions with
19 other parts of Medicare payment policy that need to be
20 recognized and taken up.

21 Thanks.

22 MS. KELLEY: Wayne? Is Wayne with us?

1 DR. RILEY: Can you hear me now?

2 MS. KELLEY: Yes, we can. Thank you.

3 DR. RILEY: Great. Great discussion. Just a
4 comment, philosophically, about the whole discussion. You
5 know, I was just thinking through the breadth of my career
6 we've always aspired for some sort of all-payer GME
7 program, which is a pipe dream, and it remains a pipe dream
8 in some respects because many of us felt that the Medicare
9 program alone should not bear the total burden for graduate
10 medical education. But given that headwind, you know, we
11 have to be careful not to do anything that sort of harms
12 inpatient training. You know, I'm a primary care
13 internist, but, you know, as someone just said, and I think
14 it was Jonathan, it is very time-consuming to train young
15 doctors in outpatient settings. It's one of the best
16 training sites, but it's labor intensive, it's slow, it
17 lowers productivity and patient throughput, et cetera. So
18 we have to be sort of careful.

19 And then on a daily basis, you know, those of us
20 who have residency training programs, I don't think I've
21 ever been in a meeting where my GME folks have come to me
22 and said, "We have to make a change in the way we're

1 training some of our residents, based on Medicare policy."
2 It's generally based on residency review committee policy,
3 and ACGME, the accrediting body for residency. So that's
4 been the other historical headwind, to even more of what
5 Paul alluded to, you know, movement to training in
6 outpatient settings is the accrediting bodies for the
7 specialties.

8 So again, I think this is great work. I know
9 this is not going to be our first bite at the apple in
10 terms IME and GME, in general.

11 MS. KELLEY: And the last comment from Bruce.

12 MR. PYENSON: Thank you. I think the discussion
13 has been terrific. As I think Jaewon mentioned, I support
14 the Chair's draft recommendation as written, because I
15 think the flexibility is needed there. This is a seminal
16 document. There's a lot of really wonderful work in there,
17 but it's obviously not the last statement, and I worry
18 about paralysis with more and more analysis, that we're not
19 going to be able to perform in this session.

20 So my comments are mostly about the choice of
21 further work, and I agree with Brian and Betty. The
22 influence over the choice of specialty and the geomix is

1 critical. I would point to Slide 8 for people who might be
2 concerned about the impact of these changes on hospitals,
3 and point out that this is just the impact on Medicare fee-
4 for-service, that the actual impact on hospital revenue as
5 a whole would, for most organizations, be much, much
6 smaller, and some of the specialty hospitals are not known
7 for catering to Medicare patients. So my view is this is
8 pretty convincing that I'm not especially worried about
9 disrupting hospitals and their revenue.

10 Betty mentioned evidence of billing by residents.
11 I would ask if we can, in this document, to reference
12 MedPAC's proposal on incident-to-billing, and I think that
13 is a standing proposal. Presumably it would apply to
14 residents as well as NPs and PAs. And I think that would
15 create a lot more transparency on what's going on with
16 residents and the revenue they might be generating.

17 And finally, I appreciate Karen's comment and
18 others on anchoring to hospital. I think that is a great
19 topic for the future, so I appreciate you raising it.

20 But just to summarize, I really do support the
21 recommendation as written. This is just terrific work. I
22 don't agree with all the different nuances. There's a lot

1 more to do, but I think this is just really terrific
2 foundational work.

3 DR. CHERNEW: So I'm going to try and be brief in
4 my summary. Just for the audience at home, I did not plant
5 Bruce as the last word on this, and per what Wayne said,
6 this is not certainly our only bite at the apple. I feel
7 like we've been eating this apple for a long time. We've
8 been here, even when I was on the Commission before, which
9 you can't see me in person but I look old, and it's been a
10 long time.

11 And I do think, again, to what Brian said, given
12 the trend to inpatient care we are going to need to change.
13 I think it's important to point out that over time this
14 actually putting more money into the system of educating
15 folks and putting them into a place we think is important.

16 All of that said, I very much hear two comments.
17 One of them is, there's a lot of operational nuance behind
18 this, which was understood, and then there are some
19 concerns and then some support for the exact wording of the
20 recommendation. Again, the core issue there, in the
21 recommendation, was recognizing some of these concerns to
22 be a little bit more, in Paul's words, aspirational, less

1 precise, as CMS begins to figure out how to put a new model
2 in place. And I think in the original recommendation, the
3 one you see here, we did not want to be too prescriptive,
4 recognizing some of the issues that have been raised.

5 So I guess we're going to move on now. I believe
6 -- sorry, I've been listening to this -- I believe that
7 vaccines are next, and we will come back after some
8 conferring with the staff on where we are exactly on the
9 recommendation. But this was a very rich discussion.

10 So we are now going to go to the vaccine chapter.
11 We are going to be a little pressed for time, so please
12 keep that in mind, but I do want to hear from everybody as
13 we go forward. And I think, Nancy, are you leading us off.

14 MS. RAY: That is correct. Thank you, Michael.

15 Good morning. The audience can download a PDF
16 of the slides on the right-hand side of the screen.

17 Today we are going to continue our discussion
18 from the September and January meetings about policy
19 options that would improve Medicare coverage and payment
20 for preventive vaccines. There was good consensus among
21 Commissions for both policy options. Now we are at the
22 stage to present a draft recommendation. The goal for

1 today's session will be to solicit feedback on the chair's
2 draft recommendation, with the intent of having a final
3 recommendation for you to vote on in April and publication
4 of this work in the June 2021 report.

5 Medicare's coverage of vaccines and
6 administration of the vaccine is split between Part B and
7 Part D. Part B covers preventive vaccines that have been
8 specifically named in the statute, that is flu,
9 pneumococcal, and hepatitis B for beneficiaries at medium
10 or high risk. The CARES Act added Part B coverage of COVID-
11 19 vaccines.

12 In limited circumstances, Part B also covers
13 certain other vaccines when used in response to an injury
14 or direct exposure, for example, to rabies or tetanus.

15 Part D covers all commercially available
16 preventive vaccine not covered by Part B. Shingles
17 accounts for the vast majority of Part D vaccine doses.
18 When Part B or Part D cover the vaccine, they also cover
19 the vaccine's administration.

20 A few differences between Part B and D coverage.
21 Part B-covered preventive vaccines and the vaccine
22 administration are not subject to cost-sharing, whereas

1 Part D plans are permitted to charge cost-sharing for
2 vaccines the associated administration. These amounts vary
3 by plan and benefit phase.

4 Part B vaccines are administered in a variety of
5 settings. Mass immunizers such as pharmacies and physician
6 offices are the most common sites of administration but
7 hospitals, skilled nursing facilities, home health agencies
8 and dialysis facilities also bill Part B for vaccines.

9 Part D vaccines are mostly administered in
10 pharmacies, but a system referred to as clearinghouses have
11 been developed so physicians can generally bill Part D for
12 vaccines.

13 In June 2007, the Commission recommended that all
14 Medicare vaccine coverage be moved to Part B. One of the
15 factors motivating that recommendation were concerns that
16 physicians would have difficulty billing Part D plans and
17 concerns that patients would have to pay for vaccines up
18 front and seek reimbursement from plans afterwards,
19 potentially deterring access. Since then, steps have been
20 taken to lessen these billing issues under Part D.
21 However, there continues to be strong rationales for moving
22 coverage of all preventive vaccines to Part B.

1 Moving all vaccine coverage to Part B would
2 promote wider access to vaccines. More beneficiaries have
3 Part B coverage than Part D coverage. Part B vaccines are
4 administered in a wider variety of settings than Part D
5 vaccines. It may also be less confusing to beneficiaries
6 and providers to have all vaccine coverage under one part,
7 instead of split across Part B and D.

8 No cost-sharing for preventive vaccines and the
9 vaccines' administration would ensure cost is not an access
10 barrier for beneficiaries. When the Congress covered prior
11 preventive vaccines, for flu, pneumococcal, and hepatitis
12 B, under Part B it did so without cost-sharing for the
13 vaccine and the vaccine's administration.

14 MS. NEUMAN: Next we'll discuss how Medicare pays
15 for vaccines. There are number of pricing metrics involved
16 in vaccine payment, so this first slide has a quick review
17 of the pricing terminology. First there is average
18 wholesale price. This is a list price, and the analogy
19 often made is that it is like the sticker price on a car
20 and it doesn't necessarily reflect actual prices.

21 A second concept is wholesale acquisition cost.
22 This is the price at which the manufacturer sells to the

1 wholesaler or directly to customers, and it does not
2 incorporate discounts or rebates.

3 There is also average sales price. Is the
4 average price realized by the manufacturer for sales to
5 most purchasers, net of rebates and discounts, with some
6 exceptions. Medicare uses ASP+6 percent as the basis
7 payment for most Part B-covered drugs and biologicals that
8 are not vaccines.

9 Now turning to how Medicare pays for vaccines.
10 For Part B-covered preventive vaccine, like flu and
11 pneumococcal, Medicare pays most immunizers like physicians
12 and pharmacies at a rate of 95 percent of AWP. A small
13 portion of vaccine doses furnished by certain types of
14 providers are paid reasonable cost.

15 For the vaccines that Part B covers in limited
16 circumstances in response to an injury or direct exposure,
17 like rabies, tetanus, and hepatitis A, Medicare pays 106
18 percent of the average sales price. Part D pays for
19 vaccines based on plan-negotiated rates with pharmacies.
20 Part D plans may also negotiate manufacturer rebates,
21 although we don't know whether that occurs for vaccines.

22 In addition to paying for the vaccine, Part B and

1 D also make separate payment for the administration of the
2 vaccine. Note that in situations where the Federal
3 Government directly purchases vaccines, like is occurring
4 with the COVID-19 vaccines, Medicare only pays for the
5 administration of the vaccine, not the vaccine itself.

6 We have analyzed how Medicare's various payment
7 rates for vaccines compare to wholesale acquisition cost.
8 What this analysis shows is that for Part B preventive
9 vaccines, Medicare's 95 percent of AWP payment is
10 substantially above wholesale acquisition cost, and you can
11 see that in the column on the far left of the slide. For
12 vaccines covered by Part D, the median plan payment rate is
13 typically a couple percentage points above WAC, and you can
14 see that in the column on the right.

15 For the few vaccines covered in limited
16 circumstances by Part B at a rate of 106 percent of ASP, we
17 see that 106 percent of ASP is substantially below WAC for
18 those products for which we have data.

19 The prior analysis suggests that there are
20 opportunities to improve Medicare payment for vaccines.
21 WAC is a better measure of drug prices than AWP. Payment
22 for Part B vaccines based on WAC, for example, at 103

1 percent of WAC, would moderately lower payment rates from
2 95 percent of AWP, but would do so in a way that would be
3 expected to ensure that all immunizers can obtain the
4 vaccine at prices within the Medicare payment amount.

5 Although WAC is a better measure of drug prices
6 than AWP, it does not reflect discounts or rebates.
7 Ultimately a payment rate based on ASP might be most
8 appropriate, as it would reflect the average actual market
9 price. However, it would be helpful to have more data
10 before considering an ASP-based payment for vaccines, for
11 several reasons.

12 With vaccines, there is uncertainty about how the
13 two-quarter lag in ASP would affect Medicare payment rates,
14 especially given the seasonality of the influenza vaccine.
15 Because ASP is an average, we do not know how much vaccine
16 acquisition prices vary across purchasers. Understanding
17 that price variation could help inform whether 106 percent
18 of ASP or an alternate add-on to ASP is appropriate.

19 In light of the issues discussed today about
20 vaccine coverage and payment, the Chair has the following
21 draft recommendation for your consideration. It reads:

22 The Congress should cover all appropriate

1 preventive vaccines and their administration under Part B
2 instead of Part D without cost-sharing, and modify
3 Medicare's payment rate for Part B-covered preventive
4 vaccines to be 103 percent of wholesale acquisition cost,
5 and require vaccine manufacturers to report average sales
6 price data to CMS for analysis.

7 The first part of the draft recommendation is
8 intended to improve access to preventive vaccines by moving
9 all coverage to Part B and eliminating cost-sharing. This
10 is similar to the Commission's 2007 recommendation, except
11 that the 2007 recommendation did not address cost-sharing.
12 The second part of this draft recommendation is intended to
13 improve payment accuracy for Part B preventive vaccines.

14 The implications of the draft recommendation are,
15 in terms of spending there are several dynamics and the
16 overall effect is uncertain. With respect to the first
17 part of the draft recommendation putting all preventive
18 vaccine coverage under Part B, on the one hand, the policy
19 may increase spending by improving access and reducing
20 cost-sharing for the shingles vaccine, the predominant
21 vaccine covered by Part D. On the other hand, if shingles
22 vaccination rates increase as a result of the policy, fewer

1 beneficiaries may acquire shingles and Medicare spending on
2 services to treat shingles may be reduced.

3 With respect to future vaccines not yet
4 developed, there is more uncertainty about effects, but the
5 same general dynamics would be at play.

6 With respect to the second part of the
7 recommendation on payment for Part B vaccines, the policy
8 would reduce Medicare program spending, due to savings from
9 paying 103 percent WAC instead of a higher rate.

10 In terms of beneficiaries and providers, we
11 expect that this policy would improve beneficiary access to
12 vaccines because more beneficiaries have coverage under
13 Part B than Part D and because beneficiaries would face no
14 cost-sharing for vaccines under Part B.

15 In terms of providers, covering all appropriate
16 preventive vaccines under Part B would facilitate the
17 administration of vaccines by a wide variety of providers,
18 and we do not expect the draft recommendation to adversely
19 affect providers' willingness or ability to furnish
20 vaccines.

21 So that brings us to the end of the presentation.
22 We would be happy to answer any questions and we look

1 forward to your discussion today of the Chair's draft
2 recommendation. Going forward, as Nancy said, the plan is
3 come back in April with a vote on a final recommendation
4 and to have a chapter on Medicare vaccine coverage and
5 payment in the June report.

6 DR. CHERNEW: Great. Thank you both. That was
7 wonderful. Dana, I think we should start the Round 1, and
8 remind everybody if you have comments, get in the queue.

9 MS. KELLEY: I have Paul with a Round 1 question.

10 DR. PAUL GINSBURG: Sorry. Two quick things.
11 One is that as far as the low take-up of the Shingrex
12 vaccine, I think the data were from 2018, and my
13 recollection is that there was a huge supply and demand
14 imbalance at that point, where people were looking all over
15 to get it, and that probably take-up would have been a lot
16 higher if the supply had been there. So anything you could
17 do to get a more recent number might be relevant.

18 Speaking of recent numbers there was something
19 about intentions to take the COVID-19 vaccine, and I just
20 want to mention that this is changing rapidly from month to
21 month. The latest Kaiser Family Foundation poll is much
22 more stronger intents to take it. So we should plan to

1 update this with the latest information before we go to
2 press.

3 MS. KELLEY: That's all I have for Round 1,
4 unless anyone wants to jump in.

5 [No response.]

6 MS. KELLEY: All right. Then we'll go to Round
7 2, Mike?

8 DR. CHERNEW: Are there people in the Round 2
9 queue, Dana? I haven't seen them.

10 MS. KELLEY: I have one person, Bruce.

11 DR. CHERNEW: Bruce, you're up.

12 MR. PYENSON: I support the recommendation as
13 written. On a longer-term basis, I think that vaccination
14 topic, along with a handful of other topics such as
15 telehealth, are moving into the public health realm and are
16 perhaps not best treated as part of an acute care medical
17 system, which is what Part B is.

18 So I think for future work of the Commission I
19 would put that concept out there, that medicalizing some
20 aspects of public health is probably not the best way to
21 address them, but I do support this shift, this
22 recommendation.

1 DR. CHERNEW: Thank you. Dana, I don't know if
2 there's anyone else in the queue. I see Karen. Actually,
3 Dana, I'm giving it back to you, since I'm only seeing part
4 of the queue.

5 MS. KELLEY: Okay. I think Karen is next.

6 DR. DeSALVO: Thank you. Bruce, I just want to
7 say thank you for that comment about how important it is to
8 not medicalize what is a public health good, and we
9 certainly have done that in the vaccine realm, for adults
10 and children, and it creates added complexity. And in this
11 case, for example, if a beneficiary maybe doesn't have Part
12 B or Part D, then that creates additional struggles for
13 them to access vaccinations, and what we really want is for
14 those to be as easy as possible to get, due to the
15 preventive nature of vaccines. So thank you for raising
16 it.

17 It would be great to have the time to sort out
18 how this could be less of a reimbursement schedule and more
19 about a public health good.

20 MS. KELLEY: I think that's it, Mike.

21 DR. CHERNEW: Okay. So surprisingly, we now have
22 a little bit of time, and so given that we can at least

1 have a quick go-around, or maybe, Dana, you can go around,
2 just to get people's general sense. Betty do you want to
3 start? Again, I'm not looking for a lot of comments. Just
4 a general gestalt of where people are.

5 DR. RAMBUR: I just wanted to say that I support
6 this strongly, and I also concur with the previous comments
7 about public health. I just wanted to really compliment
8 the staff, because as a new Commissioners, when I first got
9 this I really couldn't muddle my way through what the
10 differences were, and it's very clear to me now. It's very
11 clear to me that this is the right recommendation, so thank
12 you.

13 DR. CHERNEW: Betty, thank you. I'm going to
14 jump in. I'm basically going to go alphabetically, so you
15 will be able to figure out where folks are. So Larry?

16 DR. CASALINO: Yeah. I think this is very nice
17 work and strongly support the recommendation.

18 DR. CHERNEW: Brian?

19 DR. DeBUSK: I agree with Larry. I think this is
20 very good work and I completely support the recommendation.
21 Thank you.

22 DR. CHERNEW: We'll do Marge and Paul. Marge?

1 MS. MARJORIE GINSBURG: Yes, I concur with the
2 others as well. I wonder, on the recommendation, and there
3 are really two issues. One is move them all to Part B and
4 the other is the 103 percent wholesale acquisition cost.
5 And I guess my only suggestion was whether those should be
6 two separate bullet points. They're two very distinct
7 issues and I want to make sure that they don't get lost in
8 the word shuffle. Thank you.

9 DR. CHERNEW: Paul.

10 DR. PAUL GINSBURG: Yeah, sure. Very good work.
11 I want to praise the staff, and I support the
12 recommendation. Perhaps this really should be two
13 recommendations rather than one, but that's a detail that
14 can be worked out between the meetings.

15 DR. CHERNEW: Thanks, Paul. David.

16 DR. GRABOWSKI: Yes. Thanks, Mike. I also
17 support the draft recommendation, and I actually like what
18 Marge and Paul just suggested, of separating this out,
19 because I don't think they're necessarily -- they're both
20 very important but they don't need to be bundled together.
21 So separating them into two recommendations makes a lot of
22 sense. Thanks.

1 DR. CHERNEW: Thanks. Jonathan.

2 DR. JAFFERY: Yeah. I echo my fellow
3 Commissioners' comments that this is great work, and I
4 fully support the draft recommendation.

5 DR. CHERNEW: Okay. Jon Perlin.

6 DR. PERLIN: I also agree with my fellow
7 Commissioners, but I don't disagree with Bruce in theory,
8 but I do just not want to miss the opportunity to note, if
9 you look at the December 19th American Journal of Managed
10 Care study, for all Americans vaccines reduced health care
11 spending by about \$27 billion. There's another study that
12 has perhaps a different type of rigor, and it looks at the
13 adult population, November 16, and it finds for the adult
14 population vaccines are an unmitigated need for \$9 billion
15 of care a year, or \$4.7 to \$15.2 million. Now it didn't
16 break it out specifically for Medicare beneficiary
17 population, but obviously older, more chronic disease-
18 burdened, more vulnerable, so some significant piece of
19 that.

20 So this is one of the areas where I find the math
21 really compelling in terms of the purview, and would hope
22 that, in some larger standards, a greater rationalization

1 of the public health infrastructure. But in terms of our
2 opportunity to influence across quality and access within
3 the Medicare program itself I think this one is an absolute
4 winner, so I strongly endorse. Thanks.

5 DR. CHERNEW: Thanks. Betty, I believe you spoke
6 on this. I want to see your head. Am I right about that?
7 Then I'm going to go on to Wayne.

8 DR. RAMBUR: You already called on me. I mean,
9 I've already commented, yes. Yes, I have spoken. I'm
10 good. I support it.

11 DR. CHERNEW: We are going to Wayne.

12 DR. RILEY: Yes, I support, Chairman, and I agree
13 with adjusting it to two separate -- can you hear me?

14 MS. KELLEY: Yes, Wayne, we can hear you. Go
15 ahead.

16 DR. RILEY: Yes. Just I support fully and I like
17 the adjustment to make two separate, very strong
18 recommendations around this.

19 MS. KELLEY: Mike, we're having some trouble with
20 your mic.

21 DR. CHERNEW: [Inaudible.]

22 MS. KELLEY: Mike, we can't hear you. I'm sorry.

1 I think you were going through alphabetically, so I think
2 perhaps Sue, we haven't heard from Sue yet.

3 MS. THOMPSON: Thank you, Dana. Yes, I too
4 support the recommendations, and also agree --

5 DR. CHERNEW: -- Jaewon, then we'll have Dana --

6 MS. THOMPSON: Can you hear me, Dana?

7 MS. KELLEY: Sorry, Mike. We're still having
8 trouble with you. I will try and roll through the rest of
9 the commissioners. Okay? So we'll let Sue continue.

10 MS. THOMPSON: And I'll conclude. I support the
11 recommendations. Thank you.

12 MS. KELLEY: Dana Safran?

13 DR. SAFRAN: Yes, I fully support the Chairman's
14 draft recommendation and like the idea of splitting into
15 two recommendations. Thank you.

16 MS. KELLEY: And with my kind of wacky
17 alphabetical order here, Pat is next.

18 MS. WANG: No problem. Thanks. I support the
19 recommendation. I guess that if there were any -- and
20 perhaps I should have put this in Round 2 -- I'm not facile
21 with WAC versus AWP versus ASP. I guess the one thing, you
22 know, the chapter concluded that the impact on cost was

1 uncertain. You know, I think that this is the right
2 proposal to, you know, really streamline the distribution
3 of vaccines for beneficiaries.

4 If it were possible to understand more about, you
5 know, switching to Part B and then, in addition with this,
6 like where is the money shifting? Is the manufacturer of
7 the vaccine -- I mean, I don't think any manufacturer of
8 vaccine counts on vaccine production to make their bottom
9 line, but it's an important part of their business. Are
10 the winning or losing under the shift to Part B and then
11 the further shift to 103 percent of WAC? There are rebates
12 in the ASP calculation, I guess. Those go away under this
13 AWP. It's just, there is some money that is moving around.
14 I just don't know if it's possible to understand more about
15 that. If it's too esoteric and too much work, forget it,
16 but it is, for me, something that is kind of missing in
17 shifting these around. Maybe it's cost-neutral to the
18 system, but are there components of the system that are
19 gaining or losing? I don't know.

20 DR. CHERNEW: Okay.

21 MS. WANG: I don't know if Kim or Nancy, you can
22 just say it's negligible, and that would answer my

1 question.

2 MS. NEUMAN: As far as the effects on the
3 manufacturer?

4 MS. WANG: I guess so, yeah, or pharmacies'
5 reimbursement for administering vaccine. They are getting
6 paid, I guess, at a negotiated rate from Part D for the
7 ones that they are administering. It just might be a
8 little bit helpful to have a tiny bit more insight into
9 that.

10 MS. NEUMAN: So I could speak to the pricing of
11 the vaccine and Nancy could speak to the administration
12 piece, I think.

13 So on the vaccine piece, we saw, in one of the
14 slides, how currently under Part D shingles is paid at
15 about 101 percent of WAC at the median. So if you went to
16 103 percent of WAC under Part B it's pretty close to the
17 same rate. So pharmacies should feel about the same under
18 the two scenarios, at least with regard to shingles, which
19 is the predominant Part D vaccine that would be moving.

20 In terms of administration --

21 MS. RAY: In terms of administration we found
22 that the admin fee across all providers under Part B, the

1 average was roughly \$20, and that across Part D, which is
2 primarily at pharmacies, it was also \$20. So in terms of
3 admin fee we don't see a big impact.

4 MS. WANG: Thank you.

5 MS. KELLEY: And I believe the last person is
6 Jaewon.

7 DR. RYU: I support the draft recommendation as
8 well.

9 MS. KELLEY: Okay, Mike. I think we've heard
10 from everyone.

11 DR. CHERNEW: And I think I'm back. I'm sorry I
12 had an internet snafu. Can you hear me?

13 MS. KELLEY: Yes, we can.

14 DR. CHERNEW: Somehow GoToMeeting gets sick of my
15 voice after a while. I start with clarity and then when
16 it's tired of me it stops. But in any case, I am back,
17 which is good.

18 I think that was a very useful discussion. I'm
19 glad there seems to be a lot of consensus, so I think we
20 can now move ahead. We have our last session coming up on
21 separately payable drugs, I think, and that is going to be
22 Dan, who earlier this morning was having some internet

1 issues, but Dan, I hope you're with us.

2 DR. ZABINSKI: Can you hear me?

3 DR. CHERNEW: Yes, I can hear you.

4 DR. ZABINSKI: Should I just start?

5 DR. CHERNEW: Yes, you should just start.

6 DR. ZABINSKI: Okay. Here we go. Today we're
7 going to talk about how drugs are paid in the hospital
8 outpatient prospective payment system, or the OPPI, and how
9 the drug payment in that system could be improved.

10 For the broader audience, PDF versions of the
11 slides are available on your webinar control panel on the
12 right side of your screen.

13 Previously, we had produced analyses of how to
14 improve the system of drug payment in the OPPI in the
15 Commission's June 2020 Report to the Congress and in a
16 presentation at the November 2020 public meeting, and
17 responses to Commissioner's thoughts and comments on those
18 analyses has led us to today's presentation.

19 The analysis that you're about to see and the
20 work that has been done by Nancy Ray and Kim Neuman on drug
21 payment are the start of an effort to develop a consistent
22 approach of paying for drugs throughout fee-for-service

1 Medicare.

2 I'd also like to thank Kim and Nancy for their
3 guidance and assistance on today's presentation.

4 I think it will be helpful to provide an overview
5 of what we'll be talking about today. We'll start by
6 discussing the unit of payment in the OPPS, and that will
7 be followed by an explanation of how drugs are paid.

8 In the OPPS, some drugs are paid separately, and
9 we'll talk about the current policies for separately
10 payable drugs, including concerns we have about those
11 policies, and then we'll talk about how Medicare payment
12 for separately payable drugs in the OPPS could be improved.

13 To get a full understanding of the issues that
14 we'll discuss today, it's important to have a general
15 understanding of the unit of payment in the OPPS.

16 Now, most Medicare payments in the OPPS are for
17 primary services, which are usually the reason for an HOPD
18 visit such as a surgical procedure or an emergency
19 department visit.

20 The OPPS uses bundled payments in which the cost
21 of most ancillary items are packaged with the primary
22 service into a single payment unit.

1 For example, suppose someone injures their arm
2 and goes to an ED. In this case, the physician may order
3 an X-ray, and the ED visit is the reason the patient is
4 there, so it's the primary service and paid separately,
5 while the X-ray is an ancillary and its cost is packaged
6 into the payment rate of the ED visit.

7 It's important to understand that when an item is
8 packaged, that does not mean there is no reimbursement for
9 the item. Instead, the cost of the item is reflected in
10 the payment rate of the related primary service.

11 The benefit of packaging the primary service and
12 its related ancillary items into a single payment unit is
13 that bundles provide powerful incentives for providers to
14 seek the lowest-cost, most efficient method to furnish a
15 primary service. Given the strength of these incentives,
16 payments outside the bundle should be carefully considered.

17 Like services, many drugs covered under the OPPS
18 are supplies to primary services, and others are the reason
19 for a visit.

20 In general, drugs that are the reason for a visit
21 are those in which the only service provided with the drug
22 is the drug administration, and many of them are for cancer

1 treatment. All other drugs are supplies to a service.

2 Under the OPSS, there is a similarity in how
3 drugs and services are paid because many drugs are packaged
4 and some are paid separately.

5 The importance of separately payable drugs in the
6 OPSS has increased as program spending on separately
7 payable drugs has increased rapidly from \$5.1 billion in
8 2011 to \$14.8 billion in 2019. Most of this growth was for
9 high-cost cancer treatment drugs.

10 The OPSS has two policies for separately payable
11 drugs. One is the pass-through policy, which was created
12 by the Congress, and the other is the policy for separately
13 payable non-pass-through drugs, which was largely created
14 through regulation. And even though both policies offer
15 separate payment for drugs, they serve somewhat different
16 purposes.

17 The pass-through policy focuses on drugs that are
18 new to the market. It exists because during the
19 development of the OPSS there was concern that for new
20 drugs the needed cost and use data would not be available
21 to include their cost in the payment rates of the related
22 services.

1 In response, the Congress created the pass-
2 through policy. The central purpose of this policy is to
3 provide separate payments for a limited time for costly new
4 drugs, to mitigate providers' financial risk, and to
5 encourage use of those drugs.

6 The pass-through policy includes both drugs that
7 are supplies and those that are the reason for a visit.
8 Pass-through drugs that are supplies to a service become
9 packaged drugs when their pass-through status expires, but
10 those that are the reason for a visit can become separately
11 payable non-pass-through drugs.

12 The policy for the separately payable non-pass-
13 through drugs focuses on drugs that are established on the
14 market rather than new drugs. The intent is to provide
15 adequate payment for relatively costly drugs to ensure
16 their use, which, again, mitigates providers' financial
17 risk.

18 Through regulation, CMS has established that
19 drugs that are supplies to a service cannot be separately
20 payable non-pass-through drugs. Therefore, it's implicit
21 in this policy that separately payable non-pass-through
22 drugs are drugs that are the reason for a visit.

1 These two policies for separately payable drugs
2 have different criteria for eligibility.

3 For a drug to be eligible for the pass-through
4 payments it must be new to the market and have a cost that
5 exceeds three thresholds that are related to the payment
6 rate of the related primary service.

7 Having pass-through status has a definite time
8 limit; drugs can have this status for two to three years.
9 When pass-through status expires, a drug can become a
10 separately payable non-pass-through drug or it is packaged.

11 For a drug to be eligible for the separately
12 payable non-pass-through policy, it, first of all, must not
13 be a pass-through drug because the program is for
14 established drugs, not new drugs. It also must have a cost
15 per day that exceeds a threshold, which CMS has set at \$130
16 for 2021, but CMS updates that threshold for drug price
17 inflation each year.

18 Once again, CMS has established that drugs that
19 are supplies cannot be separately payable non-pass-through
20 drugs.

21 Finally, there is no specified time limit for
22 these drugs. They can hold this status as long as cost per

1 day exceeds the required cost threshold.

2 A concern that we have about the drug payment
3 policies in the OPSS is that both the pass-through and the
4 separately payable non-pass-through policies include drugs
5 that are the reason for a visit.

6 A small issue is that this makes the
7 administration of the OPSS system of drug payment more
8 complex than it needs to be. But a more substantive issue
9 is that for hospitals that obtain their drugs through the
10 340B program, there is financial advantage for using some
11 pass-through drugs rather than similar separately payable
12 non-pass-through drugs.

13 Specifically, by statute, OPSS payment rates for
14 all pass-through drugs must be ASP plus 6 percent. In
15 contrast, through regulation, CMS has established that
16 payment rates for separately payable non-pass-through drugs
17 must be set at ASP minus 22.5 percent if it is obtained
18 through the 340B program and at ASP plus 6 percent if it is
19 obtained outside the 340B program.

20 Therefore, 340B providers have different payment
21 rates for pass-through and separately payable non-pass-
22 through drugs. So in some instances, 340B providers have a

1 financial incentive to use pass-through drugs over
2 therapeutically similar non-pass-through drugs.

3 We also have a couple concerns specific to the
4 pass-through policy. One is that it is not restricted to
5 drugs that are supplies to a service. And, second, it does
6 not include a clinical superiority requirement.

7 The lack of a clinical superiority requirement is
8 especially important. Without one, Medicare can make
9 additional separate payments for a new and potentially much
10 higher-cost drug that is no more effective than a similar
11 competing drug that's already on the market.

12 Medicare payments for drugs that are supplies to
13 a service could be improved by restricting the pass-through
14 policy to drugs that are supplies to a service, which would
15 mean that the policy would exclude drugs that are the
16 reason for a visit.

17 This change would level the payment rates among
18 drugs that are the reason for a visit, which would mitigate
19 the financial benefit among 340B hospitals from using pass-
20 through drugs over separately payable non-pass-through
21 drugs and would reduce Medicare spending on drugs.

22 In addition, payment for drugs that are supplies

1 could be improved by adding a clinical superiority
2 requirement to the current criteria for pass-through
3 eligibility.

4 Adding a clinical superiority requirement would
5 raise the bar for drugs to qualify for the pass-through
6 payments beyond simply being high cost. Also,
7 manufacturers would have incentive to devote resources to
8 develop drugs that offer better clinical performance.

9 CMS would have to make the final decision about
10 how to determine whether a drug is clinically superior to
11 similar products, but we believe the criteria that CMS uses
12 to determine whether drugs show clinical superiority to
13 qualify for the NTAP Program in the inpatient PPS are a
14 viable option.

15 To improve Medicare payment for drugs that are
16 the reason for a visit, the policy for separately payable
17 non-pass-through drugs could be expanded to include new
18 drugs that are the reason for a visit. Currently, these
19 drugs are paid largely separately under the pass-through
20 policy.

21 As we just discussed in regard to the pass-
22 through policy, this would mitigate the financial benefit

1 for 340B providers to use some pass-through drugs over
2 similar separately payable non-pass-through drugs.

3 For the separately payable non-pass-through
4 policy, we should continue have a policy that requires a
5 drug to have costs per day that exceed a threshold, but
6 we're not certain if the current threshold of \$130 per day
7 is the right one.

8 Also, the policy should continue to exclude drugs
9 that are supplies to a service.

10 On this slide, we have the eligibility criteria
11 that would occur for the pass-through and the separately
12 payable non-pass-through policies if the modifications to
13 these policies that we just discussed were implemented. We
14 have bolded the criteria that would be new or modified.

15 For pass-through drugs, they would still have to
16 be new drugs, but the policy would exclude drugs that are
17 the reason for a visit.

18 In addition, a drug would have to show clinical
19 superiority over similar drugs that are used in the same
20 primary service.

21 Finally, drugs would still have to have costs
22 that exceed three thresholds related to the outpatient PPS

1 payment rate of the applicable service.

2 For a drug to qualify for the separately payable
3 non-pass-through policy, the drug would have to be the
4 reason for a visit.

5 The policy would be expanded to include both new
6 and established drugs. Currently, new drugs that are the
7 reason for the visit typically obtain separately payable
8 status through the pass-through policy.

9 Lastly, drug cost per day would still have to
10 exceed a cost threshold.

11 And a final note: Drugs that don't fall into
12 either the pass-through or the separately payable non-pass-
13 through categories are packaged.

14 Now, on this slide, we have a summary of the key
15 effects of the changes that we've discussed, and I want to
16 emphasize that the first bullet and the last sub-bullet
17 really summarize the effects.

18 In particular, the clinical superiority
19 requirement would raise the bar for drugs to have pass-
20 through status beyond simply being high cost.

21 In addition, the changes that we propose would
22 result in drugs that are the reason for a visit no longer

1 being eligible for the pass-through policy.

2 Therefore, all drugs that are the reason for a
3 visit would obtain separately payable status under the
4 separately payable non-pass-through policy.

5 This change would level the payment rates among
6 drugs that are the reason for a visit because under current
7 policy, for drugs obtained through the 340B program, pass-
8 through drugs have payment rates of ASP plus 6 percent,
9 while the separately payable non-pass-through drugs have
10 payment rates set at ASP minus 22.5 percent.

11 So in light of our discussion today, the Chair
12 has two draft recommendations for the Commission's
13 consideration.

14 The first of these draft recommendations is
15 related to the pass-through policy: The Congress should
16 direct the Secretary to modify the pass-through policy in
17 the hospital outpatient prospective payment system so that
18 it includes only drugs and biologics that function as
19 supplies to a service and applies only to drugs and
20 biologics that are clinically superior to their packaged
21 analogs.

22 This draft recommendation is directed toward the

1 Congress because congressional action is required to make
2 these changes to the pass-through policy.

3 The second draft recommendations is related to
4 the separately payable non-pass-through policy: The
5 Secretary should specify that the separately payable non-
6 pass-through policy in the outpatient prospective payment
7 system applies only to drugs and biologics that are the
8 reason for a visit and meet a defined cost threshold.

9 This draft recommendation is directed toward the
10 Secretary because the separately payable non-pass-through
11 policy was largely developed through regulatory action.

12 And, finally, implications of these two draft
13 recommendations include:

14 For spending, over the short term we anticipate
15 no direct effect on program spending due to budget
16 neutrality requirements in the OPPS. Over the longer term,
17 there may be lower program spending from a similar pass-
18 through policy giving providers incentive to alter their
19 drug choices and limits on the inflationary effects of
20 current policies for separately payable drugs.

21 For providers, they could change drug choices
22 within groups of clinically similar drugs, but we

1 anticipate no effect on beneficiaries' access to needed
2 drugs, and beneficiaries may benefit from improved efficacy
3 of drugs used with outpatient services.

4 That concludes the presentation, and I turn
5 things back to Mike.

6 DR. CHERNEW: Dan, thank you. We're about to
7 jump into the Round 1 and Round 2 questions, so to my
8 fellow Commissioners, please jump in the queue.

9 In the meantime I will say that, like many
10 things, this is really the first bite of a very, very
11 complex apple about how to deal with new innovations given
12 the payment models that we have and encourage both
13 efficient purchasing and the needed innovation. So, Dana,
14 I'm turning it over to you to manage the queues.

15 MS. KELLEY: All right. We have Pat first.

16 MS. WANG: Thanks. And, Dan, thank you for a
17 report that makes this very complex issue, you know, as
18 clear as possible.

19 I'm going to -- because I can't say all of the
20 syllables, I'm going to refer to these as "pass-through
21 drugs" and "spin-tip" (SPNPT) drugs, the separately payable
22 non-pass-through as "spin-tip" because I just can't get all

1 of the syllables out.

2 I just wondered if you could talk a little bit
3 more about the relationship between these two categories.
4 You had mentioned pass-through drugs, once they kind of
5 reach [audio break - inaudible] SPNPT category, but they
6 remain there. Under the proposed recommendation, I suppose
7 that drugs that are the service would just start there and
8 stay there.

9 Is there anything that is gained today from
10 having a drug in pass-through status and then moving to
11 SPNPT? Is there anything that is learned in terms of
12 clinical efficacy or what have you? Are there drugs that
13 start in pass-through status that never make it to SPNPT
14 because something else happens to them? Would we be losing
15 anything by just sort of separating them?

16 The second question I have is: With the new
17 clinical superiority requirement for pass-through drugs,
18 once you effectuate this recommendation and many more drugs
19 just start in SPNPT, is there much left in the category of
20 pass-through to apply a clinical superiority requirement?
21 I guess I'm kind of wondering about the nature of these
22 drugs. Are these specialty drugs that have no

1 alternatives? Is clinical superiority meaningful? Is it
2 something that CMS could easily apply? You had cited the
3 NTAP process, which seems to, you know, sort of weigh the
4 efficacy of alternatives to see what's best with that, what
5 these pass-through drugs are? I guess I'm just curious.
6 It sounds right to apply a clinical superiority
7 requirement. I'm just wondering about the feasibility of
8 it.

9 So those are sort of the two buckets of questions
10 of the relationship today and whether there is any benefit
11 of something starting in pass-through before it gets to
12 SPNPT in terms of clinical efficacy that would be lost;
13 and, second, after this recommendation, in the remaining
14 pass-through drugs, what the practicality of a clinical
15 superiority requirement would be.

16 DR. ZABINSKI: Okay. I don't think anything gets
17 lost, you know, moving a drug, instead of having a drug
18 start out in pass-through and -- I like this idea of "spin-
19 tip." I've been thinking of a way to, you know, make it
20 short and sweet. You know, how to say it? Most of the
21 drugs that would be affected, you know, it's going to be --
22 you know, probably three-quarters are cancer treatment

1 drugs. And, you know, it's pretty unusual for a drug that
2 is in that group, that being the cancer group, that, you
3 know, they can start as pass-through and then they're not
4 able to make it to separately payable non-pass-through.
5 It's just pretty infrequent. So I don't think anything's
6 going to get lost in that sense.

7 And then on the pass-through, you know, what
8 would be left is -- it's things that really -- things, you
9 know, that would be left would be skin substitutes used in
10 skin repair services and anesthesia, you know, some
11 analgesics that are sometimes used in surgeries and
12 contrast agents. And, you know, what we're looking to do
13 is to make sure that, you know, for that type of drug, that
14 they actually offer something better than what's there
15 already in order to get this separate payment for a limited
16 time before the necessary data are collected to include
17 their cost in the related service.

18 Does that answer the question?

19 MS. KELLEY: Pat, we can't hear you.

20 MS. WANG: I'm sorry. Of the costs that would be
21 left in pass-through, are there alternatives that could be
22 considered? I just don't even know. It sounds like what

1 would be left is a relatively small number?

2 DR. ZABINSKI: Yes.

3 MS. WANG: Okay.

4 DR. ZABINSKI: And, you know, I will add that if
5 you read the language, the legislative language, and the
6 regulations that came out during the development of the
7 OPPS, the real intent of the pass-through status initially
8 was for these drugs that are supplies to a service, mostly
9 just for the fact that at that time this idea of the drugs
10 that are the reason for a visit, there weren't many of them
11 at that time so they were really an afterthought. And then
12 when they came into broad being there was no real place to
13 put them, and so that's where they ended up. But I think
14 it's time to move on and develop something better.

15 MS. WANG: Thank you.

16 MS. KELLEY: Okay. I have Jonathan Jaffery next
17 with a Round 1 question. I see that Jonathan said he is
18 covered.

19 DR. JAFFERY: Yeah, I'm covered.

20 MS. KELLEY: Larry, it looks like you are covered
21 now also?

22 DR. CASALINO: Yeah.

1 MS. KELLEY: Okay. Then we'll move to Jon
2 Perlin.

3 DR. PERLIN: Let me also add my thanks for a very
4 clear presentation on an incredibly complex topic. And
5 this may reflect my continuing lack of understanding one
6 nuance, but you had a slide that said that for 340B
7 providers, financial advantage using some pass-through
8 drugs rather than a similar separately payable amount of
9 pass-through drugs, et cetera. Does this recommendation
10 address that issue?

11 DR. ZABINSKI: The attempt is yes. You know, the
12 idea is that right now you've got a lot of these drugs that
13 are the reason for the visit. They make their first stop
14 in the pass-through policy. They stay there for two to
15 three years and get paid at ASP+6, and there's a small
16 advantage that for 340B it's advantageous in a lot of cases
17 to use those drugs rather than a similar drugs that's
18 already established on the market, but it's a separately
19 payable non-pass-through policy. So the payment rate is
20 ASP-22.5 percent.

21 DR. PERLIN: Thanks.

22 MS. KELLEY: Bruce, did you have a Round 1

1 question?

2 MR. PYENSON: I did. My question relates to
3 biosimilars, and in particular, perhaps an interpretation
4 of the second bullet of the Chair's recommendation. There
5 is perhaps often the case where a biosimilar would fall
6 underneath the threshold for the special payment, and since
7 the scientific and medical issues of equivalency have been
8 settled, I'm wondering if the clinically superior would
9 serve to encourage the use of biosimilars. That's one
10 question.

11 The second question related to biosimilars is
12 that the idiosyncrasies of 340B pricing mean that some
13 expensive products that have been around for a while might
14 be what's called "penny priced." And the 22.5 percent
15 discount doesn't come close to reflecting what the
16 acquisition cost. And I'm wondering if this discussion, if
17 our framework can incorporate fixing that in the context of
18 OPSS.

19 DR. ZABINSKI: Okay. First one. I think, yeah,
20 the requirement of a clinical superiority, I think it would
21 encourage the use of the biosimilars. You know, say a
22 biosimilar comes along and it's supposed to be somewhat

1 equivalent to the reference biologic, and if it's not found
2 to be any better in any way then, yeah, it's going to
3 encourage their use, I think.

4 Now on 340B, I think what you're getting at is,
5 you know, you have a drug that's been around awhile, and
6 through the 340B setting of the ceiling prices you're going
7 to end up with really high inflation adjustment and
8 possibly even penny pricing. And so there's still a real
9 advantage to using the drug that's been around awhile.

10 And so, yeah, setting the payment rates on the
11 same basis for new and established drugs doesn't
12 necessarily encourage the use of the new drug because of
13 this, but in general it's going to, I think, be beneficial
14 to leveling the payment rates and encouraging less use on
15 the basis of just financial considerations.

16 And I hope on this last part, I hope I'm
17 answering your question.

18 MR. PYENSON: My question is more on -- I agree
19 the incentive is to use the penny-priced drug, or the lower
20 priced, because the mark-up would be significant. But I'm
21 wondering if the framework we are proposing here would be a
22 way to move to acquisition price as opposed to the -22.5.

1 DR. ZABINSKI: No, it would not aim at that
2 acquisition price, no. The established right now by CMS is
3 ASP-22.5 percent, and that's what the draft recommendations
4 would head to.

5 MR. PYENSON: Okay. Thank you.

6 MS. KELLEY: I have Sue next.

7 MS. THOMPSON: Thank you, Dana, and thank you,
8 Dan, for taking on this complicated work.

9 My question is, if we would adopt the Chairman's
10 draft recommendation, have we quantified savings to
11 Medicare? Do we know what the value is associated with
12 these changes?

13 DR. ZABINSKI: Quantified it? No. Our best
14 guess -- it gets pretty complicated. You know, in all
15 likelihood, providers are going to change their drug
16 choices, and that's going to also, in all likelihood, save
17 the program some money. How much is really difficult to
18 say. So I'm really not certain.

19 DR. MATHEWS: Yeah, let me jump in, and maybe,
20 Sue, I could provide a little more detail. Looking at the
21 qualitative impacts on Slide 5, we wouldn't expect any
22 immediate change to Medicare spending given the way budget

1 neutrality governors pricing under the OPPS, so in year
2 one, nothing.

3 But the most significant part of the
4 recommendation, as it's currently structured, is the
5 inclusion of the clinical superiority requirement for pass-
6 through drugs, and the idea here is that under current
7 policy, in order to get pass-through status and for
8 something to be paid outside of the OPPS bundle, all it has
9 to do is be new and it has to meet a couple of cost
10 thresholds, which create strong insulatory incentives.
11 You know, the higher cost it is, the more likely you'll get
12 separate payment for it.

13 By imposing a clinical superiority requirement,
14 however it's defined, we would ostensibly impose some drag
15 on Medicare paying more for something just because it is
16 high priced over the longer term. That's the expectation
17 here.

18 Does that help at all?

19 MS. THOMPSON: Yes. Short answer, yes. Thanks,
20 Jim.

21 DR. MATHEWS: Nancy, you wanted to get in on a
22 prior comment?

1 MS. RAY: I just want to address Bruce's comment.
2 Bruce, we had a recommendation back in our June 2017 report
3 that called for use of consolidated billing codes for the
4 reference biologic and its biosimilars, so that policy
5 implemented would address, I think, your question.

6 MR. PYENSON: Thank you, Nancy. I recall that.

7 MS. KELLEY: That's all I had for Round 1
8 questions, and I have Bruce with a Round 2, unless I missed
9 someone.

10 DR. CHERNEW: Bruce, you're up. I think Bruce is
11 up.

12 MR. PYENSON: I support the recommendation. I
13 would suggest that we expand the superiority clause to say
14 in the case of equivalency that the billing entity has to
15 use the lower-priced product, or else we could reference
16 the earlier recommendation that Nancy just mentioned. But
17 because I think that would create pressure, some of the
18 most widely used biologics have biosimilars available, and
19 I think we can get more value by encouraging their use.

20 DR. MATHEWS: First, do you mind if I ask a
21 clarify question in response?

22 MR. PYENSON: Sure.

1 DR. MATHEWS: All right. So the basic construct
2 of the policy is currently the OPPS packages certain
3 things. Dan mentioned a couple of them -- anesthesia used
4 in surgery, a couple of other packaged pharmaceutical
5 products. Currently, things can be paid outside of the
6 OPPS and separately payable, if they meet the cost
7 criteria. What we are saying, through the imposition of a
8 clinical superiority requirement, is that if the thing
9 doesn't demonstrate clinical superiority it does not get
10 separately paid, and if a provider wants to use it, they
11 have to do so under the otherwise applicable OPPS payment
12 amount.

13 And so in that scenario, when there is no
14 separate payment because the thing is only equally
15 effective as the thing in the bundle that it replaces, the
16 providers has an automatic incentive to use the older,
17 lower-cost product that is priced as part of the bundle.

18 Does that make sense or did I miss something.

19 MR. PYENSON: It makes sense. So if there is a
20 similarly priced superior product that is historically
21 separately priced, and a biosimilar comes along, how does
22 that interact? And the issue I'm trying to address.

1 DR. CHERNEW: I think, Bruce, if I can just ask a
2 somewhat clarifying question to your Round 2 question. You
3 are talking about what happens if when something comes
4 along, the new thing is less expensive -- this is designed
5 to prevent inflation of things that are more expensive but
6 not better. That's what the intent of this is. There is a
7 separate question, what happens if a biosimilar comes along
8 and we have, as I think Nancy pointed out, a recommendation
9 to deal with aspects of that portion of it. In this
10 discussion, Jim, and maybe if someone else wants to jump
11 in, is how this deals with when a new thing comes along
12 which is less expensive.

13 Is that essentially the issue you're talking
14 about, Bruce?

15 MR. PYENSON: Yes, and if it's nuanced in the way
16 the clinical superiority would no longer apply to the
17 originator. So, Michael, you're right. It's not just the
18 price but the equivalence is there.

19 DR. CHERNEW: Right. So if something was
20 clinically superior and higher priced and got separately
21 passed-through, and something else came along that was
22 lower-priced but the same as the first thing, what happens?

1 I realize that's a nuance that I think is important, that
2 we will have to ponder. Jim, do you want to add to your
3 question?

4 DR. MATHEWS: I'm okay.

5 DR. ZABINSKI: Can I throw something in here? I
6 mean, if it's lower priced and the original product is
7 packaged, and this thing is lower priced than the packaged
8 one, this item is going to be packaged as well, and the
9 provider is going to look at the situation and say, "Well,
10 let's see. We've got a better product and, you know, if
11 it's packaged it actually saves us money to do it." So
12 there's going to be an encouragement. There's going to be
13 an incentive for the provider to use that new item, that's
14 both cheaper and better.

15 MR. PYENSON: And that makes sense if the
16 originator is packaged as well.

17 DR. CHERNEW: Right. That was Bruce's point.
18 Bruce is asking, if I understand correctly, and then we
19 will move on, is if the originator is not packaged, what
20 happens?

21 DR. ZABINSKI: Well, then the question gets -- my
22 question is, are you talking about the drugs that are

1 supplies or drugs that are the reason for a visit?

2 MR. PYENSON: Well, assuming it's the reason for
3 the visit and hence it would qualify under this
4 recommendation for separate payment.

5 DR. ZABINSKI: Well, then they are both going to
6 be paid separately. They're both going to be paid
7 separately, and, you know, then it's up to the provider to
8 choose which one they want to use. But the basis for
9 pricing, you know, the payment rate is going to be ASP-22.5
10 percent if obtained through 340B.

11 DR. CHERNEW: And again, I do want to push us
12 along, but just to reiterate what I think Bruce was saying,
13 if they're both paid separately but one of them is less
14 expensive than the other, I think Bruce would rather have
15 some way to force the use of the less-expensive one. Is
16 that the spirit of what you're saying, Bruce?

17 MR. PYENSON: Correct. And because the
18 originator is not clinically superior, maybe that gives a
19 way to interpret it.

20 DR. CHERNEW: Yeah. So I understand it. We will
21 continue this discussion. I think what I would say is that
22 we tried, back when I was on the Commission before, for

1 example, to deal with a least costly alternative
2 recommendation, which is very much in the spirit of what
3 you're talking about, Bruce. It became actually quite
4 complex for a whole number of reasons.

5 So this recommendation is admittedly more limited
6 to deal with a separate issue, but it certainly does not
7 deal with all of the issues associated with the
8 introduction of biosimilars, for example. And I think it
9 was Nancy -- I'm sorry, your face, Nancy, was cut out -- or
10 it may have been Dan. Someone said there is a separate
11 recommendation about what to do when biosimilars come along
12 and how they get packaged in with other prices. So that's
13 a somewhat separate issues. I think we are a little bit
14 more limited here, but what I hear you say, Bruce, is we
15 maybe could go further but you're okay with where we've
16 gone.

17 MR. PYENSON: Correct.

18 DR. CHERNEW: That's a big sigh on the Zoom, on
19 the GoToMeeting. I apologize for that long back-and-forth.

20 Okay. I think we're ready to move on, if Dana
21 will move us on.

22 MS. KELLEY: Marge.

1 MS. MARJORIE GINSBURG: Great, thank you. Great
2 report, interesting, and, actually, I could understand it.

3 To me, the most significant piece of this is the
4 clinically superior and also the most difficult. The
5 report does a great job, I think, of explaining what
6 "clinically superior" means, how you actually translate
7 that into a real comparison.

8 If this gets adopted, are we expecting the folks
9 who have produced this new drug or biologic to adhere to
10 certain criteria that clearly show that it's clinically
11 superior? In other words, they've got to meet some
12 standard to meet this particular criteria we're putting
13 out, and that also seems to me it might be a big leap.

14 So I don't know whether we need to add in here
15 what that means in real life. What do they actually have
16 to show before it gets accepted?

17 Thank you.

18 DR. MATHEWS: So, Marge, I'm happy to try to make
19 an answer there unless, Dan, you want to. But we have to
20 some extent deliberately avoided being too specific with
21 respect to which clinical criteria might apply here.

22 For myself, I am not a clinician. I know we've

1 got a lot of clinicians on the screen here, but I don't
2 count myself among that esteemed group. But one could
3 arguably define "clinical superiority" in a number of
4 different ways -- you know, greater effectiveness, fewer
5 adverse side effects, broader applicability to a wider
6 population. And we would expect that CMS would be in a
7 better position to establish specific criteria, and they've
8 already got a couple of parts of the program where they
9 have now implemented such requirements. You know, the
10 NTAP's under the IPPS and the TPNIES is under the dialysis
11 facility PPS. The main point that we don't want to lose
12 here is that, you know, the imposition of any clinical
13 superiority requirement would probably be better than no
14 clinical superiority requirement, and you could implement
15 it in a number of different ways where CMS is probably the
16 entity best positioned to figure out what those ways are.

17 MS. KELLEY: Okay. I have Sue next.

18 MS. THOMPSON: Thank you, Dana. My comments may
19 go into the same category as the dreamer comment by Wayne
20 earlier where he was recalling hoping for other payers to
21 support the IME program.

22 So with that as a backdrop, I think somehow from

1 a standpoint of the providers who are working in this
2 environment and trying to manage all this information, we
3 need to somehow influence the PBMs to utilize what CMS has
4 established as these clinically superior medications so
5 they're not practicing with multiple interpretations by
6 payers of what is the superior drug. And the PBM may have
7 a different drug than CMS as what is superior and what
8 their evidence supports. So I just think, again -- and I
9 hate to go down a rabbit hole here, and I won't. But in
10 the world of practice, there's another element out there
11 that I wish we could influence as we move forward with
12 these recommendations.

13 MS. KELLEY: Mike, that's the last comment that I
14 have on my list. But it --

15 DR. CHERNEW: Okay.

16 MS. KELLEY: -- looks like Pat --

17 MS. WANG: I'm sorry. I didn't show up in the
18 queue. Can I make a comment? I don't know why I didn't
19 show up.

20 DR. CHERNEW: Okay. Pat will go ahead, and then
21 it's nice, Pat, because what I was going to do is go in
22 reverse alphabetical order, and it turns out that leads

1 with you. So it's just unbelievably synergistic. Thank
2 you for your name. Go ahead, Pat.

3 MS. WANG: Just a lifelong wish that people would
4 start at the end of the alphabet rather than at the
5 beginning.

6 I support the recommendation, but I wanted to say
7 that I think that it would be -- I understand that the
8 purpose of the recommendation is to address this specific
9 issue. But I think that Bruce's comments and the back and
10 forth was very valuable, and I would support continuing to
11 think about that. And the way that I interpreted what
12 Bruce was saying was that, especially in the pass-through
13 situation, if there is a clinically equivalent that costs
14 less than the drug that was approved for pass-through
15 status, then what is reimbursed is the cost of the lower
16 drug. It's not to say that the clinician has to switch
17 their clinical preference, but just what Medicare will pay
18 for it is based on the sort of more -- the lower-priced
19 clinically efficient drug. And I realize that a lot of
20 these things become packaged, but there's still a period of
21 time that they're pass-through, and you wouldn't want to be
22 held hostage to high launch prices or price increases from

1 a drug where there are good clinical equivalents that are
2 cheaper. So I would encourage us to keep looking at that.

3 DR. CHERNEW: Yeah, so let me just jump in.

4 We're about to go to Dana Safran. This will be, as I think
5 I said at the beginning, an early foray into this issue
6 about how to deal with new products. I think we find
7 ourselves with a big challenge in general -- and, by the
8 way, it's not just drugs. We want to make sure we
9 encourage innovation and a lot of creation of high-value
10 products. We also want to make sure that we have the
11 appropriate incentive not to overpay for those things.
12 This is complicated in general. It's very complicated in
13 the way that it worked with bundling. There are some
14 things we've already done, like recommending biosimilars
15 and the originating product be bundled together. There's
16 other complexities that are coming up in this
17 recommendation between pass-through and separately payable
18 drugs. I think this recommendation virtually moves us in
19 the right direction. It doesn't solve all our problems.

20 And then there's broader issues around how we
21 deal with bundling of new products overall and things that
22 are equivalent. Sometimes they're like a biosimilar.

1 Sometimes they would be in a non-biosimilar context. A
2 drug that's somewhat different but in the same class, how
3 do you deal with that? There's a lot of nuances here, so
4 we will think through as we move forward how to deal with
5 some of these types of issues that become very challenging
6 for our bundled payment models when there's very high-
7 priced things that are hopefully better, but the bundle has
8 a hard time figuring out how to recognize that.

9 I will promise myself never to read the
10 transcript, but what you should hear is this is a
11 complicated issue, we are trying to make a stab at it here.
12 I hope we will come back again next cycle with a more
13 comprehensive way to deal with a challenge which, frankly,
14 in many ways is a good challenge to have, which is new,
15 high-value things, when they're expensive.

16 That is my second sigh today, and that's the
17 lead-in to Dana Safran.

18 DR. SAFRAN: Yes, I'll be very quick, just to say
19 I am in support of the Chair's recommendation. All of us
20 here really appreciate the rich discussion that we've just
21 had. Thank you.

22 DR. CHERNEW: Dana, thank you. Jaewon.

1 DR. RYU: I'm supportive as well.

2 DR. CHERNEW: Jaewon, thank you. Wayne.

3 DR. RILEY: Yes, I support.

4 DR. CHERNEW: Wayne, thank you. Betty.

5 DR. RAMBUR: I support. Thank you.

6 DR. CHERNEW: Betty, thank you. Bruce, you have
7 had a lot to say. This is a good opportunity to allow you
8 to either summarize or clarify some of the things that you
9 think your fellow Commissioners, myself included, might be
10 confused about.

11 MR. PYENSON: I support the recommendation.

12 DR. CHERNEW: So little clarification. Jon
13 Perlin?

14 DR. PERLIN: I was really hoping for Bruce's
15 clarification. I support the recommendation. But I do
16 want to point two things out.

17 One, anytime we try to establish clinical
18 superiority, there are many dimensions of that. It's
19 terribly complex. So I know I'm stating the obvious to the
20 group, but, you know, there will be attributes, and that is
21 something that will be somewhat contentious in certain
22 quarters.

1 Second is I still am not sure that I fully
2 understand how this resolves the 340B issue, and, you know,
3 I think Bruce had commented on that in a way that offered
4 an alternative toward a lower-price approach. But that may
5 just be my lack of understanding. Thanks.

6 DR. CHERNEW: Dana points out that I skipped Sue.
7 Sue, I am so sorry. I don't know why.

8 MS. THOMPSON: I do support the recommendations,
9 and I have no further comments than what I made earlier.
10 Thanks, Michael.

11 DR. CHERNEW: Again, Sue, I am sorry. So now
12 we're at Jonathan Jaffery.

13 DR. JAFFERY: Yeah, thanks, Mike. I support the
14 Chair's draft recommendation.

15 DR. CHERNEW: And, David Grabowski.

16 DR. GRABOWSKI: Thanks, Mike. I also support the
17 draft recommendations.

18 DR. CHERNEW: Marge.

19 MS. MARJORIE GINSBURG: I support it as well.

20 DR. CHERNEW: Okay. Karen.

21 DR. DeSALVO: I support the Chairman's draft
22 recommendations, and I do hope that in future cycles we'll

1 get additional clarity on how to balance clinical efficacy
2 with cost to make sure that we're driving the right out.

3 DR. PAUL GINSBURG: Mike, I think you skipped me.

4 DR. CHERNEW: Oh, yes, because you're in a
5 different place on my list of things. Again, I didn't mean
6 to skip you. I think people can hear the end of a long
7 MedPAC meeting in my voice. But, nevertheless, a good
8 MedPAC meeting, and now Paul.

9 DR. PAUL GINSBURG: Thanks. Yeah, I support the
10 recommendations. I also want to praise Dan for the clarity
11 with which he helped us understand this topic.

12 I do have some thoughts about the issue Bruce
13 raised about a separately payable drug and, you know, a
14 similar comes out. It seems to me we could handle this
15 very simply by just reminding the reader about our 2017
16 recommendation and, thus, you know, that would imply that
17 when a biosimilar comes in for a separately payable drug,
18 the Medicare payment goes down to the biosimilar level and
19 it continues to be a separately payable drug.

20 DR. CHERNEW: Dan, do you want to comment on that
21 and how it fits with our other recommendation? Because I
22 think our previous recommendations get bundled with the

1 originator. I'm not sure, Dan, if you want to say anything
2 about that.

3 DR. ZABINSKI: Yeah, I think that's right. I'm
4 wondering if Kim's available or Nancy, they might actually
5 be able to speak to it a little better. They're the ones
6 who --

7 DR. CHERNEW: The issue I have -- so I'm going to
8 ask a clarifying question on Paul's comment. When the
9 biosimilar is bundled with the original drug, does the
10 price drop to the biosimilar price or does the price end up
11 in the bundled and become sort of average? I had thought
12 it should actually drop, by the way, in a previous
13 conversation I had had, and my understanding was that's not
14 necessarily how it works mechanically if they're bundled
15 together. It may eventually work that way through
16 competition, but that's a little bit beside the point. So
17 if you have a moment, some clarity might illuminate me,
18 maybe the rest of our audience at home. Otherwise, we'll
19 move on.

20 DR. PAUL GINSBURG: Yeah, actually, I'm not sure
21 if it's the two of them are priced together and an average
22 or if it's -- I think it might be. I think the key thing

1 that we want to get across is that there's a separately
2 payable innovator drug, a biosimilar comes along, and a
3 biosimilar's price should go into the calculation as to how
4 much Medicare pays for, you know, either the innovator or
5 the biosimilar drug that is still separately payable.

6 DR. CHERNEW: Yes. And I believe that is true,
7 and I believe there's a recommendation prior to my current
8 role on that point. So reminding people of that I think is
9 a fine view, and that's work that you all did, so I'll just
10 commend you and move on.

11 Are we okay, Paul?

12 DR. PAUL GINSBURG: Yes.

13 DR. CHERNEW: Okay. So this turns us to Brian.

14 DR. DeBUSK: I support the recommendation as
15 written.

16 DR. CHERNEW: And, Larry, you have the last word.

17 DR. CASALINO: Yeah, I strongly support the
18 recommendation. Great work, Daniel and Kim and Nancy.

19 Just one suggestion which I think makes sense.
20 There's a nice schematic in the chapter, Figure 1, with a
21 kind of flow chart of how CMS pays for pass-through drugs.
22 I don't have this fully formulated, but I wonder if one or

1 more schematics in the final chapter could be flow charts
2 that would show how things would work if our recommendation
3 was put into effect. I don't know if that could be done in
4 one schematic or kind of an overview that would include
5 both -- you know, whether it goes through pass-through or
6 separately blah, blah, blah. And then two more schematics,
7 you know, one for each of those categories. But I think
8 that would be very, very helpful and probably pretty easy
9 for you guys to do.

10 DR. ZABINSKI: Yeah, I think so. I don't see a
11 problem right now, so yeah.

12 DR. CHERNEW: All right. So this brings us to
13 the end of this session. I'm going to pause to see if
14 anyone wants to add anything to this discussion.

15 [No response.]

16 DR. CHERNEW: Okay. So I'll thank my fellow
17 Commissioners for the time this morning. I want to reach
18 out to the audience joining us on the GoToWebinar meeting
19 and again remind them that we very much look forward to
20 your input. You can do that in many ways. Contact the
21 staff. I think there's a way to reach us through the
22 website. But please don't be shy. These are important

1 issues, and since we cannot meet physically and we're doing
2 this virtually, it is very important that we make sure to
3 find ways to capture input from the public. So I want to
4 make sure to call that out.

5 As always, I will commend the staff on really
6 very thorough presentations for the meeting, both yesterday
7 and today. It is always really inspiring to see all the
8 work that is done, and, again, thank you to all the
9 Commissioners for your great comments. We're very much
10 looking forward to moving ahead, and I will just speak
11 personally how grateful I am for the tone and the
12 constructiveness of all the feedback that we've been given.

13 So, with that, Jim, do you want to say anything
14 further?

15 DR. MATHEWS: No. We are good.

16 DR. CHERNEW: It's always nice to end knowing
17 we're good, so, again, thank you all, and I look forward to
18 our continued discussions on these topics next month.

19 [Whereupon, at 12:09 p.m., the Commission was
20 adjourned.]

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