

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Via GoToWebinar

Thursday, October 1, 2020  
10:48 a.m.

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P R O C E E D I N G S

[10:48 a.m.]

1  
2  
3 DR. CHERNEW: Hello, everybody, and welcome to  
4 the October MedPAC meeting. We're very excited for all of  
5 the material, and I'm not going to make a big speech about  
6 it. So I think I want to go first to Dana Kelley for a few  
7 opening remarks, and then we are going to jump into our  
8 first session on skilled nursing facility value-based  
9 purchasing. Dana.

10 Dana, you're muted.

11 MS. KELLEY: Sorry about that. I just wanted to  
12 let our viewers know that we won't have an opportunity for  
13 public comment during the meeting, but we accept public  
14 comments on our website at any time. There is a link on  
15 the Public Meeting page on MedPAC.gov.

16 Go ahead, Mike.

17 DR. CHERNEW: Great. So with that and no further  
18 ado, I want to turn it over to the great staff, and I think  
19 we are going to start with Ledia. Ledia, you're up.

20 MS. TABOR: Great. Good morning. The audience  
21 can download a PDF version of these slides in the handout  
22 section of the control panel on the right-hand side of the

1 screen.

2 Today we'll continue our discussion of MedPAC's  
3 mandated report on the SNF value-based purchasing program.

4 PAMA required MedPAC to evaluate the VBP program.  
5 The statute requires us to review the program's progress,  
6 assess the impacts of beneficiaries' socioeconomic status  
7 on provider performance, consider any unintended  
8 consequences, and make any recommendations as appropriate.

9 Our report is due June 30, 2021. We plan to  
10 include it as a chapter in the June report.

11 During the September meeting, the Commission  
12 reviewed several flaws of the current VBP program. The  
13 Commission concluded that the SNF VBP needs to be  
14 eliminated and replaced with an improved program.

15 Today we'll present a proposed SNF value  
16 incentive program design that aligns with the Commission's  
17 principles for quality measurement and corrects the flaws  
18 of the SNF VBP. The proposed design is consistent with  
19 other designs recommended by the Commission to redesign the  
20 Medicare quality payment program for hospitals and MA  
21 plans. Sam will present results of our illustrative  
22 modeling of the SVF VIP design.

1           Now I'll walk through the five shortcomings of  
2 the SNF VBP we identified and outline how the proposed  
3 design corrects them.

4           Consistent with the Commission's principles for  
5 quality measurement, the SNF VIP would score a small set of  
6 performance measures tied to clinical outcomes and resource  
7 use. The current program scores a single readmission  
8 measure as required by statute. The measures in the SNF  
9 VIP would not be burdensome for providers to report, such  
10 as claims-based measures.

11           The SNF VIP incorporates strategies to ensure  
12 reliable results. The current SNF VBP has a minimum stay  
13 count of 25 which may be too low to ensure reliable results  
14 for low-volume providers, so it may not adequately  
15 differentiate performance across providers.

16           The SNF VIP would use a higher reliability  
17 standard to determine the minimum stay count to ensure  
18 reliable results. Policymakers could consider other  
19 techniques to increase counts for low-volume providers,  
20 like scoring multiple years of data.

21           The SNF VIP would establish a system for  
22 distributing rewards with no cliff effects. The current

1 SNF VBP performance scoring does not encourage all  
2 providers to improve. As required by statute, it awards  
3 points for either improvement or achievement, lowers  
4 payments for the bottom 40 percent of rankings, and its  
5 rewards top out for the best performers. The SNF VIP uses  
6 a simpler scoring based on achievement, where providers are  
7 always better off improving quality to achieve a higher  
8 level than not. By applying a continuous performance-to-  
9 points scale, every achievement in quality is recognized so  
10 there are no cut points or cliffs that need to be crossed  
11 in order for changes in quality to register.

12 Consistent with the Commission's principles, the  
13 SNF VIP would account for differences in patient social  
14 risk factors using a peer grouping mechanism. The SNF VBP  
15 currently does not consider the social risk of a SNF's  
16 patient population.

17 The SNF VIP would stratify providers into peer  
18 groups based on the social risk of their patient  
19 population. Within each peer group, payment adjustments  
20 are based on performance relative to peer facilities.

21 Finally, the SNF VIP would distribute the entire  
22 provider-funded pool of dollars back to providers.

1 Currently, the SNF VBP retains a portion of the incentive  
2 pool as program savings as required by statute. The SNF  
3 VIP would distribute all withheld funds back to providers  
4 as rewards and penalties and would not attempt to achieve  
5 overall Medicare budget savings as part of a quality  
6 payment program.

7           At the September meeting, the Commission  
8 discussed whether the size of the withhold of the VBP was  
9 sufficiently large to change provider behavior.  
10 Policymakers could consider different approaches to setting  
11 the withhold amount, for example, phasing up to a higher  
12 withhold.

13           It also was discussed that the current design  
14 mixes two policy goals: achieving program savings and  
15 implementing value-based payments. The Commission's  
16 previous value incentive programs were designed to be  
17 budget neutral. Separately, in the update discussions  
18 later this fall, you can discuss whether the SNF level of  
19 payment is too high.

20           Now that we have reviewed the overall design of  
21 the SNF VIP, I'll walk through our approach to model an  
22 illustrative SNF VIP using currently available data.

1           We modeled the SNF VIP using three claims-based  
2 measures.

3           The hospitalization measure counts all unplanned  
4 admissions, readmissions, and observation stays during the  
5 SNF stay.

6           The successful discharge to the community  
7 measures captures a patient's outcome after discharge from  
8 the provider. A successful discharge is one in which a  
9 beneficiary was discharged to the community and had no  
10 unplanned hospitalizations and was still alive during the  
11 next 30 days.

12           The third measure, Medicare spending per  
13 beneficiary, is a measure of resource use. This measure  
14 incentivizes providers to furnish efficient care and to  
15 limit its referrals to providers with low hospitalization  
16 rates.

17           We assume that a SNF VIP measure set would be  
18 revised as other measures become available, like patient  
19 experience, or as the accuracy improves for measures such  
20 as changes in patient function.

21           To establish reliable measures results, we  
22 calculated results using a minimum stay count of 60 cases



1 which represents a 0.7 reliability. We also pooled three  
2 years of data to include as many providers as possible.

3 To account for differences in the social risk of  
4 a SNF's mix of patients, we used peer groups so that  
5 comparisons are made across providers with similar mixes of  
6 patients at social risk.

7 To apply the peer grouping mechanism, we defined  
8 the social risk of a provider's mix of patients as its  
9 share of fully dual-eligible beneficiaries treated.

10 We assigned each SNF to 1 of 20 about equal-sized  
11 peer groups based on its share of fully dual-eligible  
12 beneficiaries. The peer groups' average shares of fully  
13 dual-eligible beneficiaries ranged from 3 percent for Peer  
14 Group 1 to 91 percent for Peer Group 20. This is an  
15 illustrative approach to creating peer groups. However,  
16 when implementing the VIP, policymakers could consider  
17 other approaches such as collapsing groups with more  
18 similar shares of fully dual-eligible beneficiaries.

19 For each peer group, we calculated a multiplier  
20 that would distribute rewards and penalties based on  
21 performance within the group.

22 The first step in translating performance to a

1 payment adjustment is to convert each SNF's performance for  
2 each measure to points using a continuous scale (from 0 to  
3 10 points). The scale is based on the distribution of  
4 performances of all SNFs. This way, most providers have  
5 the ability to earn points. Each SNF's total score is the  
6 average of the points across the three measures.

7           Next, we pool all the points and payment  
8 incentives for the SNFs in each peer group. We used a 5  
9 percent withhold to finance these pools. Using a peer  
10 group specific multiplier that converts points to payments,  
11 we distribute the incentive payments back to each provider  
12 based on its performance relative to the SNFs in its peer  
13 group.

14           As a peer group's average share of fully dual-  
15 eligible beneficiaries increased, providers in the group  
16 had the potential to earn larger rewards for higher  
17 quality.

18           This approach does not mask disparities by  
19 adjusting performance rates, but adjusts payments based on  
20 a provider's share of patients at social risk.

21           I'll now turn it over to Sam to review the  
22 results from our modeling.

1           MR. BICKEL-BARLOW: This chart shows the payment  
2 per performance point multiplier for each of the 20 SNF  
3 peer groups that we modeled with a higher peer group number  
4 indicating a higher average share of fully dual-eligible  
5 beneficiaries. The multiplier is applied to each provider  
6 based on its peer group to adjust its payment per SNF VIP  
7 point. The multiplier is calculated for each peer group  
8 based on the total pool of dollars and the total number of  
9 points in that peer group. As the chart shows, the  
10 multiplier increases in peer groups with higher shares of  
11 fully dual-eligible beneficiaries. This means that SNFs  
12 with a higher share of fully dual-eligible beneficiaries  
13 will receive more reward dollars per SNF VIP point they  
14 receive. This effectively counteracts the advantage  
15 providers treating a lower share of fully dual-eligible  
16 beneficiaries would otherwise have on quality metrics  
17 simply because they treat patients with fewer social risk  
18 factors.

19           Now we are going to look at the results of the  
20 payment adjustments of the VIP compared to the VBP.

21           This chart shows the average net payment  
22 adjustment -- under the VBP in grey and the redesigned VIP

1 in blue -- for facilities in five peer groups. For  
2 example, on the left, Peer Group 1 has an average payment  
3 adjustment of negative 0.43 percent under the VBP and -  
4 negative 0.04 percent under the VIP. You can see that  
5 under the VBP, the payment reductions were larger as the  
6 share of fully dual-eligible beneficiaries increased. In  
7 contrast, the average net payment adjustments under the SNF  
8 VIP are close to zero. As a result, the illustrative SNF  
9 VIP would make net payment adjustments more equitable for  
10 SNFs with higher shares of fully dual-eligible  
11 beneficiaries. This eliminates any program incentive for  
12 providers to avoid patients with more social risk factors.

13 Now we'll look at how payment adjustments are  
14 related to the medical complexity of a provider's patient  
15 mix. This chart shows the average net payment adjustments  
16 under the VBP (in grey) and the redesigned VIP (in blue) by  
17 average medical complexity. We used the average risk  
18 scores of the beneficiaries treated by a SNF as a measure  
19 of their medical complexity. On the left are SNFs with low  
20 average risk scores and on the right are those with high  
21 average risk scores.

22 Under the VBP, the payment adjustments became

1 negative as risk scores increased. In contrast, the  
2 average payment adjustments were not strongly related to  
3 the medical complexity of the patients. The SNF VIP is  
4 relatively neutral with respect to average clinical  
5 complexity and would, therefore, dampen incentives to avoid  
6 medically complex patients.

7           There was some variation in the SNF VIP  
8 performance based on provider characteristics. Nonprofit  
9 SNFs slightly outperformed their for-profit and government-  
10 run counterparts, and urban SNFs received slightly larger  
11 average payment adjustments than rural SNFs.

12           Hospital-based SNFs had much larger payment  
13 adjustments on average compared with freestanding  
14 facilities. Hospital-based facilities received more SNF  
15 VIP points for all three quality measures. This reflects  
16 better performance on all three quality measures. For  
17 example, hospital-based SNFs typically have lower  
18 readmission rates (which affects the results for  
19 hospitalization during the stay and MSPB measures) due to  
20 their higher staffing levels and physician presence and  
21 more timely lab results for patients. Though hospital-  
22 based SNFs on average have higher payment adjustments,

1 there are far fewer of them, so the aggregate amount of  
2 dollars going to them is smaller.

3           The proposed SNF VIP provides a workable design  
4 that will conform to the Commission's principles for value-  
5 based payment. The SNF VIP design also addresses the flaws  
6 of the SNF VBP. The benefits of peer grouping were as  
7 intended. As the average share of fully dual-eligible  
8 beneficiaries increased across peer groups, providers in  
9 those groups had the potential to earn larger rewards for  
10 higher quality. Compared to the SNF VBP, the VIP dampens  
11 the incentive to avoid beneficiaries with more social risk  
12 factors through peer grouping and to avoid more medically  
13 complex patients. The more equitable design ensures that  
14 SNFs with varying patient mixes have the opportunity to  
15 perform well.

16           We would like to hear your reactions to the  
17 design of the SNF VIP and the results of the illustrative  
18 modeling. In early 2021, we plan to present policy options  
19 for the Commission to consider as it contemplates  
20 recommendations for replacing the SNF VBP with an improved  
21 design.

22           Thanks.

1 DR. CHERNEW: Great. So in a moment we're going  
2 to go to the reactors and then have this discussion, but  
3 let me just say relative to the SNF VBP, I think this is a  
4 world of improvement and I appreciate all the comments we  
5 had in our last discussion about the concerns and the staff  
6 work that was done. But now we should open it up and,  
7 Dana, I think Betty is first in this discussion.

8 MS. KELLEY: That's correct.

9 DR. RAMBUR: Well, thank you so much, and I  
10 concur with you, Michael, and I just want to thank the  
11 staff for a set of beautifully developed materials.

12 So, first of all, moving to a small set of  
13 claims-based measures that are easily gathered through  
14 claims I thought was a very good solution. I like the ones  
15 that you picked. It provides a lot more nuance without a  
16 lot more measurement effort or fatigue.

17 You noted in there that CMS should develop a way  
18 to implement patient experience and other measures as they  
19 evolve, and I certainly concur with that, and I am not  
20 suggesting we put something in place or codify it here, but  
21 it seems like in the future it would be wonderful to have  
22 some ways of elegantly incorporating a systematic approach

1 to that that would really help providers have a sense of  
2 where things are going. But I think this is perfectly fine  
3 for now.

4 I was initially concerned about just achievement  
5 score, not improvement and achievement, and I realize I  
6 haven't been a part of those previous conversations. They  
7 both matter. Achievement matters, but so does improvement.  
8 And for some very high-functioning groups, it can be hard  
9 to improve, so I understand that. So I'll be interested in  
10 hearing what other Commissioners say about that.

11 I'm very supportive of the case count 0.7  
12 reliability. That was what I was taught was the measure  
13 when I was a graduate student, and I think that that's --  
14 0.7 percent reliability is -- or 0.7 is good.

15 In terms of public reporting of measures and  
16 outcomes, in general I am supportive of this. In my  
17 experience, it is really the financial rewards and  
18 incentives that changes behavior more than simply  
19 reporting. And there is always the potential for gaming  
20 and measurement fixation. I think it would be very  
21 important, if this happens, that it is very clear to the  
22 public that different kinds of organizations are serving



1 different kinds of populations, and that matters.

2           In terms of the pooling with different weights so  
3 that the more recent is weighed more heavily, I thought  
4 about that a lot, and I could not think of potential  
5 negative unintended consequences, and I'd be curious what  
6 my colleagues think. It seems to recognize that  
7 improvement is a long-haul issue.

8           And then in terms of fully distributing the  
9 financial rewards, absolutely yes, and 2 percent is clearly  
10 too low. Can it start at 5 percent? Should it start at 3  
11 and ramp up? I would leave it to some of you to have  
12 thoughts about if it is too disruptive to start at a higher  
13 amount, but there definitely has to be enough financial  
14 incentive for people to really, you know, take these steps.

15           So I thought it was a dramatic improvement over  
16 the last version, and I just thank all of you for your  
17 thoughtful work.

18           DR. CHERNEW: Great. So I need to apologize. I  
19 didn't see clarifying questions, and so I jumped into the  
20 Round 2 questions. But now I realize that I don't get to  
21 see everything. So I think we should jump back to Round 1  
22 questions. I think we have Larry, Marge, David, and Dana,

1 and then we'll pick it up again with David -- in fact,  
2 maybe David, we will make you last depending on other  
3 clarifying questions, and you can just jump right into your  
4 other comment.

5 But why don't we go to Larry for starters.

6 DR. CASALINO: Michael, just a process question.  
7 Either for Round A or Round B, should we just send a  
8 message to Dana when we have a question or a comment or on  
9 this point or circulate to everybody? I think we should be  
10 consistent about that. We're all doing it differently at  
11 different times.

12 DR. CHERNEW: I wish I was wise enough to know  
13 the answer, Larry. I honestly like seeing it. So my  
14 preference, I guess, is if you'd just send it to everybody,  
15 but if that's too burdensome on folks, I don't feel  
16 strongly about that view.

17 DR. CASALINO: I mean, it's actually easier. You  
18 don't have to switch where you're sending the message. So  
19 we could just do that. We'll just -- if we have a question  
20 or comment, we'll just put it where all the Commissioners  
21 and staff can see it.

22 MS. KELLEY: That's fine.

1 DR. CHERNEW: Thank you for the clarifying  
2 question.

3 DR. CASALINO: Well, that's for both, right?  
4 Also when we have comments later on --

5 DR. CHERNEW: Yeah.

6 DR. CASALINO: -- we'll just send it to  
7 everybody.

8 DR. CHERNEW: Absolutely. And, Larry, I'm sure  
9 that wasn't your clarifying question. So why don't you go  
10 ahead with that.

11 DR. CASALINO: Yeah. One very quick one and one  
12 almost as quick.

13 I think someone who looks at the slides or reads  
14 the report quickly might see where the recommendation  
15 proposed is to eliminate the 2 percent withhold, and the  
16 person might ask, "Well, how is Medicare going to save  
17 money on this?" And I think it's in there, the episode-  
18 based spending performance measure and also incentives to  
19 reduce hospital readmissions and so on.

20 But I don't think that that point is made  
21 explicitly anywhere, and it is an important point. So I  
22 would just suggest that you guys explain, explicitly how

1 this can save Medicare money, even without the 2 percent  
2 withhold.

3 My more substantive point or question is this. I  
4 don't want to be too technical, but on page 17 and 22 --  
5 let me just go to page 17 of the report. This is similar  
6 in the slide. So there's a statement right at the end of  
7 the first paragraph on page 17, peer grouping should enable  
8 providers treating a higher share of beneficiaries with  
9 social risks to earn more of a reward for higher quality --  
10 earn more of a reward for higher quality.

11 So I think, it seems to me, it's really important  
12 that -- this is an important point that this be absolutely  
13 crystal clear, so -- and this comes up again on page 22 and  
14 in the slides. So when we say earn more of a reward, do we  
15 mean they would earn more than they would otherwise have  
16 earned in the current incentive system? Or do we mean --  
17 and/or do we mean that a SNF would earn more of a reward if  
18 they're in a high dual eligible peer group? A SNF in the  
19 high dual eligible peer group would get a higher reward,  
20 for a certain level of performance, than a SNF in a lower  
21 level dual eligible peer group which had the same  
22 performance score.

1           I think I know the answer to that, and there's  
2 some explanation on pages 30 and 31, which I won't go into  
3 now. But I think this is such an important point. I think  
4 everywhere it comes up, so page 17, page 22, and maybe  
5 elsewhere, that we be absolutely explicit which do we mean.  
6 Do we mean you'd get more than you would get under the  
7 current system, or do we mean you'd get more than someone  
8 else with the same score but that's in a different  
9 proportion of dual eligible peer group?

10           And maybe you could just answer that question,  
11 Ledia. I think I know the answer, but then I think the  
12 answer every time this gets mentioned, I think it needs to  
13 be explicit because if it's ambiguous, it could cause all  
14 kinds of trouble.

15           And by the way, as usual, terrific set of slides  
16 and terrific report. It's almost superfluous to say that.  
17 I don't know that there's even been a time when the  
18 Commissioners haven't felt like saying it.

19           MS. TABOR: Thank you.

20           The answer is the latter. So we look at the  
21 methodology in isolation without comparing it to the  
22 current VBP. So the way that the methodology works is that

1 we score providers on the same set of -- the same  
2 performance to point scale based on their performance, and  
3 then within each peer group, we convert their points to a  
4 payment adjustment based on a multiplier. And that  
5 multiplier is different by each peer group, and I think in  
6 Slide 12, that's where it demonstrates that, the peer  
7 groups with the higher share of duals have a higher  
8 multiplier, so therefore, they can earn more of a reward  
9 per performance than --

10 DR. CASALINO: For the same score.

11 And just one related clarifying question. Would  
12 the 5 percent withhold -- so the pool from which the  
13 rewards come in each peer group based on a 5 percent  
14 withhold, that pool could also vary in size across peer  
15 groups, more spending in a higher dual eligible peer group,  
16 for example?

17 MS. TABOR: We did assume that each peer group  
18 would have a 5 percent withhold to create the pool of  
19 dollars. The pool of dollars did vary by peer group  
20 because there was an effect basically of size of Medicare  
21 payments. So those -- we did find that those in peer  
22 groups towards the end with the higher shares of duals did

1 have slightly lower pools of dollars just because they have  
2 less Medicare patients.

3 DR. CASALINO: Okay. So if you had a higher dual  
4 eligible peer group, the pool of reward dollars was  
5 actually smaller than in a low SES than a high SES peer  
6 group?

7 MS. TABOR: Yes. And that, we believe, is just a  
8 function of, again, Medicare payment. So it's likely that  
9 the SNFs in the higher peer groups were serving more  
10 Medicaid patients in those.

11 DR. CASALINO: Okay. I'm glad that you clarified  
12 that point too, I think, that the size of the reward pool  
13 isn't the same in every peer group.

14 MS. TABOR: Yeah.

15 DR. CASALINO: Thanks. That's all I have.

16 DR. MATHEWS: Larry, just to answer the first  
17 question you had about how if we are redistributing the  
18 entirety of the withhold, you used the phrase "eliminating  
19 the current 2 percent," how to save money. This was  
20 actually an explicit critique of the current SNF VBP.  
21 That's the statutory provision that 40 percent of SNFs are  
22 required to have a negative payment adjustment under the

1 VBP with something we had identified as a flaw in the  
2 system, and one should not use a quality improvement  
3 program in order to achieve savings. And if you felt that  
4 there were a need for program savings, one should do it  
5 through the form of an update recommendation or a rebasing  
6 or something that is more directly designed to produce  
7 those savings rather than doing it implicitly through a  
8 quality improvement program.

9 DR. CASALINO: Jim, that's really helpful  
10 context, but do we think that this would produce savings?  
11 And if so, should we say it?

12 DR. MATHEWS: I think the way we have set it up,  
13 just for purposes of this discussion, is that the program,  
14 the new program would be budget neutral to the current  
15 level of spending, which does include the net payment  
16 reductions to SNFs as a result of the current VBP.

17 But having set the aggregate amount at that  
18 level, at that point, the VIP would be budget neutral, that  
19 the entirety of the withhold, however it is scaled, would  
20 be given back on the basis of good or poor performance.

21 DR. CHERNEW: Yeah. And I just want to emphasize  
22 the general point that quality payment models aren't



1 necessarily going to be intended to save money or not. We  
2 have a lot of tools to deal with that issue.

3 I want to move to the Round 1 questions so we can  
4 get back to the Round 2 ones. So, Dana, who's next?

5 MS. KELLEY: Marge is next.

6 MS. MARJORIE GINSBURG: Great. Thank you.

7 Fabulous report.

8 I have a couple broad questions, and then I have  
9 some really specific questions. So I think the easiest and  
10 fastest is for me to go ahead and lay them out and the get  
11 the response.

12 The first one, in general, did MedPAC have a role  
13 in designing the specifics of this SNF Act from 2014? And  
14 I'm encouraged that the act requires a report from MedPAC  
15 about the program. From your years of experience, is it  
16 more likely that our recommendations will be followed  
17 because they were requested as part of the act than how we  
18 typically make recommendations to Congress?

19 Those are my -- well, one more broad question.  
20 We have asked for a pause in this process, which is  
21 interesting, because I don't remember in my all of two  
22 years that we've ever asked for the process to basically

1 stop now. If we're asking that now but the report isn't  
2 coming out until June, is there a disconnect there, or is  
3 this request for a pause intended to go forward now?

4 Now just a couple of very specific nitty-gritty  
5 questions. On page 23, it says that the status is going to  
6 be based on Medicaid discharges rather than their status at  
7 admission, and I was just curious why they did that. Is  
8 that to account for the fact -- so you don't count people  
9 who have died, or is it to account for the fact that some  
10 people may come in not on Medicaid but exit on Medicaid;  
11 therefore, their Medicaid numbers would be higher? So just  
12 curious about that.

13 And part of that, then, is how to account for  
14 those who died in a SNF, or is it something simply where  
15 we're not going to deal with it all?

16 So thank you very much.

17 DR. MATHEWS: Ledia, if it's okay with you, I'll  
18 take a run at the first two questions, and then you can try  
19 to make a response to the second ones.

20 With respect to the first question, did we have a  
21 hand in designing the specifics of the current SNF VBP, the  
22 Commission has a long history of stating that fee-for-

1 service payments should not be indifferent to the quality  
2 of care that is provided, and so as a general principle, we  
3 have supported the movement towards VBP approaches. But we  
4 did not have specific input on the current SNF VBP design.  
5 So we take no responsibility for the specifics there.

6           With respect to your second question, yes, we  
7 did, indeed, hear loud and clear the consensus of the  
8 Commission at the September meeting that the current VBP is  
9 flawed enough that it should be stopped in its tracks, and  
10 that as soon as possible, a replacement, hopefully  
11 something that looks like this, could be implemented in its  
12 place.

13           The issue, as you point out, is that these things  
14 don't come together until we craft a formal recommendation  
15 that shows up in the spring of next year. At that point,  
16 the Commission will have an opportunity to refine the  
17 language, make any refinements, and then vote on the  
18 recommendation. So that is when things come together.

19           But in the interim, policymakers, congressional  
20 staff, the interest groups are all very much paying  
21 attention to what the Commission is saying on a month-by-  
22 month basis, and so to the extent the Commission is

1 signaling a preference here to stop the current VBP, that  
2 message is punching through, even in the absence of a  
3 formal recommendation that would appear a couple of months  
4 from now.

5 MS. MARJORIE GINSBURG: Thanks.

6 MS. TABOR: And just to clarify a question on  
7 your clarifying question, Marge, when you have the question  
8 on page 23 about looking at Medicaid status by discharge  
9 versus admitting, do you mean how we calculated the share  
10 of fully dual eligible beneficiaries?

11 So I believe that it was on discharge, but I do  
12 want to go back and check on this. So perhaps I can follow  
13 up by email whether it was based on admission versus  
14 discharge and any effects that would have.

15 MS. MARJORIE GINSBURG: So it was on discharge.

16 MS. TABOR: I do want to double check.

17 MS. MARJORIE GINSBURG: Okay.

18 MS. TABOR: I'll see if I can follow up by email.  
19 That's would be great.

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

21 DR. CHERNEW: No, I'm good. I already jumped too  
22 quickly to support Jim's point about saving money and

1 quality programs.

2 I think the next person is probably Dana for a  
3 Round 1 question, then Wayne. Then we're going to let  
4 David do his Rounds 1 and 2 kind of combined, and we're  
5 going to just seamlessly move into Round 2. So that's the  
6 plan. I hope I haven't missed anybody.

7 So, Dana, Round 1.

8 DR. SAFRAN: Thank you.

9 Two questions on Round 1. One is in the risk  
10 adjustment that you did when you were doing your modeling  
11 on the proposed new program, can you just clarify? Did you  
12 use the same set of risk adjustors for all three measures?  
13 If that's in the chapter, just point me to where that is  
14 but was curious about that.

15 Then I was pleased, of course, to see attention  
16 to the 0.7 reliability, but a little perplexed that 60  
17 residents was the required sample size to get to 0.7  
18 reliability for all three measures. In my experience with  
19 measures like these, especially resource use measures,  
20 they're typically so noisy that you need a larger sample to  
21 get to 0.7. So I just wonder if you could clarify that the  
22 work was done measure by measure and that it does show you

1 that 60 is what's needed for 0.7 there.

2 Thanks.

3 MS. TABOR: Sure. So for the risk adjustment, we  
4 did generally apply the same variables into the risk  
5 adjustment model. They're mainly clinical conditions --  
6 age, sex -- but maybe some nuances, and that's, I would  
7 say, in general, the same. I'm happy to follow up with any  
8 kind of, again, nuances and the differences in the variable  
9 being used.

10 Partly, you know, one reason maybe is that for  
11 the successful discharge, the community measure, we did use  
12 the CMS specification for that piece. So there may be,  
13 again, some slight differences, and I'm happy to follow up  
14 on that.

15 Regarding the 0.7 reliability, we did find that  
16 60 was what was needed to achieve 0.7 reliability. I don't  
17 know if Carol wants to speak more since she led that MSPB  
18 work.

19 DR. CARTER: Yeah. Your question was whether we  
20 calculated it for each measure, and we did. And it was 60  
21 for all three measures.

22 DR. SAFRAN: Thank you.

1 DR. CHERNEW: Wayne, I think you're up.

2 DR. RILEY: Yeah. Thank you.

3 Ledia, a couple questions regarding the model  
4 specifically. There's mention that the model provides more  
5 equitable payments to SNFs with higher shares of low-income  
6 Medicare beneficiaries. Can you talk a little bit about  
7 how that more vulnerable payment result has been teased  
8 out?

9 And then a second closely one -- closely allied  
10 to that is there's mention that there will be less  
11 incentive to admit less clinically complex beneficiaries,  
12 and could you give a little detail on that as well?

13 MS. TABOR: Sure. If I could go, Molly, turn to  
14 Slide 13, I believe, 13 or 14.

15 So, basically, we believe mainly because of peer  
16 grouping that the VIP treats SNFs that treat more dually  
17 eligible patients or those with more social risks more  
18 fairly. I will say our VIP program design is so different  
19 from the VBP. It's hard to say whether it's just the peer  
20 grouping effects. It could be because we're using more  
21 measures. It could be because we have a high reliability  
22 standard and also the peer grouping and even just the fact

1 that we're scoring, having a continuing achievement scale.  
2 So we believe that all of the design elements lead to more  
3 equitable treatment in the VIP because, as you can see in  
4 the blue bar, there's not as much of a difference between  
5 the different providers treating different shares of fully  
6 dual eligible beneficiaries.

7           And then on Slide 14, it's the same concept of  
8 looking at the clinical risk of patients because we did  
9 find in the VBP that SNFs who treat patients with lower  
10 clinical risk do better in the program, and because we kind  
11 of narrowed the blue bars, they're not as starkly different  
12 between these average groups. That's how we think about  
13 the VIP. Because of all the various design elements, it's  
14 more affordable.

15           DR. RILEY: Thank you.

16           MS. KELLEY: So I think next, we're going to do  
17 David with a combined Round 1 and 2, Mike; is that right?

18           DR. CHERNEW: That is right, and then we're going  
19 to go to Dana to continue Round 2. And we'll get everybody  
20 in the queue for the Round 2 questions following what Dana  
21 has to say next, but for now, we're with David.

22           DR. GRABOWSKI: Great. Thanks. And first thanks



1 to Ledia, Sam, and Carol for this great work. I wanted to  
2 ask Ledia first, for my round one question, about Slide 9.  
3 I'm curious about the Medicare spending per beneficiary  
4 measure. How much of the variation, or tell us more about  
5 -- is that largely SNF spending with a little bit of  
6 hospitalization spending? Like what's the breakout there  
7 of that measure? I'm just trying to think about how that  
8 measure differs from the other two measures we have here.  
9 Can you give us a little bit more background on just what  
10 share of the spending is in SNF and what is readmissions  
11 and post-SNF spending? Do you have a sense of that?

12 DR. CARTER: So we did look at this but it was a  
13 while ago so I'd have to get back to you. But you're  
14 right, this measure does capture all of the spending during  
15 the stay in 30 days. And I would say, off the top of my  
16 head, that about half of the spending is for the SNF stay,  
17 but I would have to get back to you to confirm that. But  
18 then it also includes, you know, Part B spending and any  
19 subsequent PAC use. So any home health use where patients  
20 are discharged from the SNF and then go on to use home  
21 health it's going to scoop up the home health spending for  
22 the episode that was triggered with home health. So it's

1 including all of that.

2           So in that sense it's a broader measure of  
3 resource use than just kind of the resources used during  
4 the SNF stay.

5           DR. GRABOWSKI: Great. Thanks. I think going  
6 forward maybe in the chapter to work some of that  
7 information in would be helpful, just so we can get a sense  
8 of how this maybe works alongside the other two.

9           Maybe I'll transition then into my round two  
10 comments. Let me say kind of broadly that I'm on board  
11 with this direction. I believe this new SNF VIP model  
12 improves a very broad SNF VBP program. This is definitely  
13 a step in the right direction.

14           In particular, I really like these three quality  
15 measures together. I think moving from just a single  
16 readmission measure to this set of hospitalizations during  
17 the SNF stay, successful community discharge and Medicare  
18 spending per beneficiary, is a positive step. And although  
19 I believe this is a really good starting point, I hope this  
20 isn't ultimately where the program ends up. I'm very  
21 supportive of moving forward with these measures but I do  
22 believe we have to build the measure set.

1           As someone who has studied SNF quality for 20-  
2 plus years, I wish there were other good measures that I  
3 could point you to right now. I don't think they're out  
4 there, unfortunately. I do believe we need to continue to  
5 push CMS on improving the MDS-based measures. When I think  
6 of SNF care what matters most to our beneficiaries in terms  
7 of quality is really functional improvement. Yet we can't  
8 trust this measure in terms of including it in a SNF VIP  
9 program because it's self-reported by the SNFs themselves.  
10 And so going forward how do we improve the auditing or  
11 otherwise improve the quality of that measure such that it  
12 could be part of this measure set?

13           The other key measure is patient satisfaction,  
14 and the fact that we don't have a national measure, as the  
15 chapter discusses, is really unacceptable. And so that's  
16 another place where I really think we need to push on  
17 improving the data such that going forward we can include a  
18 patient satisfaction measure in the program. So auditing  
19 the MDS and improving patient satisfaction are certainly  
20 two areas.

21           In terms of other tweaks, similar to Betty I like  
22 the idea of using multiple years of data, even with some

1 weighting, maybe 50 percent in the prior year and then 25  
2 percent going back two and three years. Something like  
3 that could be really nice in terms of improving sample  
4 sizes but also weighting the most recent experience  
5 heaviest.

6 I also liked Betty's comment, and I had a similar  
7 thought, about growing kind of the size of the program. I  
8 think initially 2 percent is a really good number, but  
9 going forward if we find that the program is working as  
10 intended, I do like the idea of growing it. SNF VBP, as  
11 we've talked about, needed to be shrunk or even put on hold  
12 or eliminated, but a strong SNF VIP program could actually  
13 increase over time in terms of the weighting there.

14 I think I'll stop on that comment, but just to  
15 reiterate I'm very supportive of this new direction and I  
16 really like where this is headed. Thanks.

17 DR. CHERNEW: Great. Thanks David, and I think  
18 that sends up Dana for round two now, Dana.

19 DR. SAFRAN: Yeah. Thanks very much. And just  
20 echoing both Betty and David's compliments about the  
21 chapter overall and about this new composed parsimonious  
22 but really strong measure set. I really like that you've

1 kind of covered the issues around hospitalization, not just  
2 readmissions but admissions and observation stays. Of  
3 course, successful discharge to the community, that's part  
4 of the heart of the matter, and then spending per  
5 beneficiary.

6           Like David, I'm sort of regretting that the  
7 remaining piece of the heart of the matter, which would be  
8 functional improvement, can't be captured, so I'd like us  
9 to keep that on our agenda to pursue. But there are no  
10 easy answers here. You know, we know that SNF self-  
11 reporting is not a good answer but we also know that with  
12 this population patients self-report measures about health  
13 and functioning or about care experience are difficult, and  
14 it gets really complicated if we try to use proxies.

15           So I don't know what good answers we have for  
16 getting measures of functional status and improvement or  
17 patient experience, but I'd really like us to keep that on  
18 the agenda. Not hold up moving forward, I think this is a  
19 very strong measure set.

20           I also really like some of the other changes that  
21 you've made, some of which have been highlighted. I think  
22 that because of the strong measure set moving to a higher

1 percentage withhold and aiming to get that fully  
2 distributed is the right goal. I am fully supportive of  
3 that.

4 I also am supportive of the idea of three years,  
5 potentially, of rolling, particularly with strong weighting  
6 toward most recent experience. You know, again, a rock and  
7 a hard place on that issue always. You don't want a  
8 provider to have as an anchor on their ability to earn  
9 reward their performance three years ago. But I think  
10 handling that through weighting, as you suggested, is the  
11 best way to go.

12 The 60 beneficiaries per provider maybe starts to  
13 be fairly doable.

14 I also really like the fact that there's no  
15 cliffs, that you've adopted the same kind of approach to  
16 the payment that we have in our other value-based payment  
17 programs, and that methodology really allows us to reward  
18 both performance and improvement in the same framework. So  
19 we don't need separate measures, et cetera, which gets  
20 complex and difficult. So I really like that.

21 My one concern, and it is a sizeable concern, I  
22 will say, is about the social risk factor stratification,

1 and this is a concern that I know I raised over a year ago  
2 when we first started to introduce this methodology. And  
3 so what I'm going to say really applies to our use of this  
4 approach across the board for our value-based incentive  
5 programs. For those who were around at the time I  
6 expressed a concern that would stratification mean that we  
7 were creating a different standard of care for providers  
8 who serve different populations? Because, you know, I  
9 think there are a couple of principles that we should have.  
10 One is we don't want to disadvantage providers who are  
11 serving lower SES populations, and you really show  
12 beautifully in this chapter how by introducing  
13 stratification you serve that principle, and that's really  
14 important.

15 I think our other principle has to be a kind of  
16 universalism, that we have the same standard of care  
17 regardless of who you are or what provider you're attending  
18 and whether that providers serves a low or SES mix. And  
19 there I think we are violating that standard, and, in fact,  
20 I think all of us would be uncomfortable to face out to  
21 Medicare beneficiaries and say, "We've set a lower bar for  
22 you because of your social risk factors or the mix of the

1 provider whose care you're under." And I think we can  
2 serve both the principles that I named.

3           And I'll just say one more thing. Besides the  
4 optics, not want to face out and say that, the other big  
5 concern I have about having the stratification, and within  
6 stratification you're really just competing for performance  
7 against others in your own strata, is that I think it will  
8 serve as a constraint on the improvement we will see in  
9 providers who are serving a lower SES mix.

10           I saw that in the work that I did leading  
11 performance incentives at Blue Cross Massachusetts, where  
12 we did set a universal standard of where we saw providers  
13 who were serving the lowest SES mix move from the bottom of  
14 our network in terms of performance to the top, exceeding  
15 those who were serving a more advantaged mix, and stay  
16 there. And I'm quite sure that never would have happened  
17 had we not had the same bar for everyone.

18           So what I'd love to see us do is find a way to  
19 meet both principles, and I think we can do that by having  
20 higher rewards for those who serve a lower SES mix, or  
21 those with more social risk factors and/or having  
22 additional sort of support payments that go to those who



1 might have more challenges in achieving our universal  
2 standard. But I'd like us to have a universal standard for  
3 performance, not adjust that but adjust the payments that  
4 we make based on the mix of patients that you're serving,  
5 so that we reward those who have a more difficult task.

6 Thanks. Those are my comments.

7 MS. KELLEY: I have Amol next.

8 DR. CHERNEW: Great.

9 DR. NAVATHE: Hi, everyone. So first off, great  
10 work. I commend the rigor and yet the simplicity of the  
11 way that this has been explained and the exhibition, both  
12 the chapter and the slides. So thank you very much to  
13 Ledia, Carol, and the team.

14 So I have several comments that I'm going to run  
15 through, some more philosophical, a few that are very  
16 specific to a couple of more minor points, if you will,  
17 that were raised in the chapter, the paper, and then I'm  
18 going to touch on the social risk set being addressed as  
19 well.

20 So a couple of bigger points. So one thing that  
21 struck me is I generally support -- so I generally support  
22 the approach. Let me just say that first. I think it's

1 definitely a step in the right direction, a big step in the  
2 right direction. One thing that struck me is we talked  
3 about the budget neutrality of this. I think that's been  
4 part of the question and part of our conversation thus far.  
5 And I personally support the idea of a budget-neutral  
6 program here, meaning that this program is not the way for  
7 Medicare to take a haircut on the spending for post-acute  
8 care and SNFs.

9           That being said, I think one thing that's  
10 interesting is that we are calling this value, and to the  
11 extent that it was originally called a VBP program, I think  
12 in that sense there is a collection that if you end up  
13 using a budget-neutral approach that's more of a pure  
14 quality type of program and less about value per se. So I  
15 would be very comfortable with that but I think it might be  
16 worth us explicitly seeing that the intention of this  
17 program then is to reward higher quality, and that there  
18 are other mechanisms, as Michael Chernew has said, that we  
19 could actually deploy savings in the context of set  
20 payments.

21           So I just wanted to make sure that we are very  
22 clear about that because I do think oftentimes we get

1 confused between what is value and what is quality, and  
2 conflating those things make everything more confusing.

3 My second point, somewhat related, is when we  
4 look at Slide 12 it does look -- and this is the one where  
5 four of the providers that are taking care of more dual  
6 beneficiaries, the payment rate per unit of quality, if you  
7 will, seems higher. So this, I think, highlights by  
8 itself, if taken alone, the way that, in some sense, this  
9 slide looks. It makes it seem like there's an inequity  
10 that we're instituting. But I think the context is very  
11 important, that on average the quality performance in this  
12 group is lower, likely related to the other social  
13 characteristics of the population.

14 So I think we should be crystal clear in our  
15 exposition, and I know others like Larry also feel the same  
16 way, that we should make sure that we are very clear about  
17 what the intent of this is. And as you guys do, I think,  
18 as we've done later in the slides and later in the chapter,  
19 talk about the ultimate impact, I think that should be up  
20 front.

21 The other thing that I think is important to  
22 recognize is that this is presumably not a static

1 adjustment, so these multipliers will adjust. If we see,  
2 hopefully, as Dana was saying, if we see that performance  
3 in the higher number of peer groups here improves, then we  
4 would actually get closer to the lower number of peer  
5 groups here, we would actually see this difference go away.

6           So this is not something that we are  
7 systematically mandating into the program. Rather, it's  
8 something that we are inferring from the performance to try  
9 to create a more equitable deployment of the incentive  
10 program resources. I think that's particular important,  
11 because I think we don't want to say that we're  
12 systematically introducing such as "bias."

13           And then I think that begs the question, so how  
14 often will we do that updating? How often do we recommend  
15 doing that update? Is that updating supposed to happen on  
16 a yearly basis? Is it supposed to happen every two years?  
17 I think we need to put a stake in the ground on that to  
18 give a specific anchor on how often these multipliers will  
19 actually be updated. In some sense, obviously, the more  
20 frequent that is practicably possible would be better.

21           A couple of points. I just wanted to echo other  
22 Commissioners. I just wanted to sort of vote behind them.

1 So David and Dana I think talked about the importance of  
2 the assessment data and the patient experience data. I  
3 know David talked about that. I wanted to say that we  
4 should double down on that. You know, there are problems  
5 with that data. There are some challenges. But it's  
6 intrinsically important because it gives us a much finer  
7 ability to understand what's happening at the beneficiary  
8 level, in terms of their functional status and in terms of  
9 their patient experience. So I think that's fundamentally  
10 important and I think we should continue to push that very  
11 strongly.

12 Another point is to back up David's point about  
13 the measures here. So I like these three measures. I  
14 think they are, as you guys have articulated, meant to be  
15 illustrative. You should think about a broader measure set  
16 related to the assessment data of patient experience, and  
17 potentially provide a more explicit roadmap of where we  
18 would like to measures to go. So that way we don't  
19 accidentally get people anchoring, policymakers anchoring  
20 on the three measures that we use as illustration and then  
21 we don't get that advancement in the quality measure sets.

22 A couple of minor points that I want to make and

1 then I'll move to the social risk piece and the peer  
2 grouping. So there was a line in the chapter that talked  
3 about having SNFs that are small in size select their own  
4 providers to be grouped with. I thought that was probably  
5 not a good idea, because that will institute the  
6 opportunity for some sort of gaming, perhaps. I think  
7 rather we would to, again, as we're doing the peer  
8 grouping, so think about what are the cohorts that are  
9 similar to them and think about doing grouping in that way,  
10 if at all, if at all we do grouping. I do support David's  
11 recommendation that we look at multiyear rather than group  
12 SNFs, to preserve that individual organization piece.

13           And then another thing, you know, with 20 peer  
14 groups it feels like there's probably quite a bit of  
15 stratification and we don't end up with cliffs at the peer  
16 group thresholds. I think it's important that we make sure  
17 that that's true. Otherwise you could imagine somewhere in  
18 the distribution you get a group that's in peer group 10  
19 and another one in peer group 11 that are essentially  
20 identical but who have different payment rates, as we're  
21 seeing, in the context of the value programs. I think we  
22 should just be mindful of that, to the extent that there

1 are natural cutoffs for distribution that would be more  
2 ideal, which you guys did highlight in the chapter.

3           Okay. Last point is on the peer grouping and  
4 social risk point. So I agree with Dana that it's  
5 fundamentally a very important topic. I think we have to  
6 recognize that there is no perfect solution here. In some  
7 sense there is a tradeoff between allocating more resources  
8 and recognizing the complexities that there are facing SNFs  
9 or any provider that's taking care of a lot of low SES or  
10 dual-eligible beneficiaries. At the same time, virtually  
11 anything that we do to try to acknowledge that will, in  
12 practice, whether we call it that or not, set a different  
13 standard, if you will.

14           And so I think what we have to state very clearly  
15 in our principles, as MedPAC, in terms of wanting everybody  
16 to attain high standard of quality regardless of what type  
17 of population they provide their service, and that we also  
18 want to make sure that we're not perpetuating any  
19 disadvantages that exist already in our payment systems and  
20 our nonpayment systems around these providers that are in  
21 communities serving a lot of low SES populations.

22           I think stating those two things is extremely

1 important. I'm supportive, in general, of the peer grouping  
2 methodology because I think it does do a lot more benefit  
3 than it does harm, as long as we're clear about stating our  
4 values around this.

5           And the one last point I will say is that like  
6 Dana I have had experience of designing programs around  
7 this, around performance, and in Hawaii where we designed a  
8 new program, we also found that the lower performing, if  
9 you will, providers actually disproportionately improved.  
10 In that case, we actually had recognition of improvement as  
11 a very important feature, and that was the way we addressed  
12 it.

13           So I think there are multiple ways -- my point  
14 here is there are multiple ways to address this. I think  
15 it's important that we state our values very clearly.  
16 Thank you.

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

18           DR. CHERNEW: Yeah. I just want to say one quick  
19 thing in response to Amol's early point on budget  
20 neutrality. I think in many things that MedPAC does,  
21 there's sometimes an effort to get the level of payment  
22 right, save money or not, and other times there's an effort



1 to get the form of payment right, get the incentives right  
2 in those type of ways.

3 In many, many cases, I think it's useful not to  
4 conflate those, and budget neutrality is an easy way of  
5 doing that to get us to focus on sort of the form of  
6 payment, which I think really is the main thing in this  
7 particular area right now. Later, there are those other  
8 tools where we can do that. So I think it varies. I would  
9 view budget neutrality often as motivated by a desire to  
10 get us to focus on the form as opposed to the level of  
11 payment and things. But since we have got to keep moving -  
12 - we've got 25 minutes left -- I think we should move on to  
13 the next Round 2 speaker.

14 MS. KELLEY: All right. That's Brian.

15 DR. DeBUSK: Thank you, and I'd like to echo the  
16 other comments. I think this is a great step in the right  
17 direction. I think it's very consistent, methodologically  
18 consistent with some of the other incentive programs that  
19 we have done, so I just want to compliment the staff for  
20 some excellent work.

21 I want to take a moment and focus on peer groups.  
22 I agree with some of the other comments. Amol, I really

1 liked your term "tradeoff." I mean, it's the peer grouping  
2 versus incorporating the social risk variables into the  
3 model is clearly a tradeoff. I lean toward peer grouping  
4 just because it acts like a firewall between different  
5 levels of social risk and contains the conflation, I would  
6 say, to a compartment.

7           The other thing I like about peer groups, though,  
8 is it allows us to treat different peer groups differently.  
9 So, for example, in the lowest-risk peer group, we may want  
10 to just deal with financial penalties. As you get into the  
11 higher and higher degrees of social risk, the answer there  
12 may not be penalties for that peer group. The answer there  
13 may be technical assistance and other forms of  
14 socioeconomic support.

15           So I want to applaud the work, and, again, I  
16 loved the treatment of this chapter. But I hope we do not  
17 -- I hope we recognize in the chapter that we can tailor  
18 our response to good and bad performance based on peer  
19 group.

20           The other thing I wanted to mention -- and,  
21 Larry, I think you had made this point earlier, and Dana --  
22 I think it's important that we report performance

1 nationally, even if we do financial rewards and penalties  
2 within the peer group level, because we wouldn't want  
3 anyone thinking that they're in a high-quality or low-  
4 quality SNF when in reality it's just a function of their  
5 relative rankings within a relatively narrowly defined  
6 group.

7           The final thing I want to mention is the time  
8 sensitivity of this. On page 35 of the reading material  
9 and it was also on Chart 14 of the presentation, you talked  
10 a little bit about how the SNF VBP that's in place now  
11 seems to have a bias to offer penalties associated with  
12 higher risk score beneficiaries. As we've seen in the SNF  
13 segment, these providers are very fluid. They're very  
14 responsive to changes in incentives, and they've just  
15 undergone one major change. Today might actually be the  
16 anniversary of the most recent change that shifts payments  
17 away from rehabilitation and toward non-rehabilitative --  
18 the ancillary services.

19           My concern is I'd hate to see the industry  
20 recrystallize around this new norm under the existing SNF  
21 VBP where they do shy away or avoid the higher-risk  
22 patients. Again, the industry is in a lot of flux right

1 now, and I think pausing this program -- I do think there's  
2 a sense of urgency and a sense of immediacy here to pause  
3 this program because we could inadvertently create an  
4 incentive to stay away from those beneficiaries, and I  
5 don't think we want to do that.

6 Thank you.

7 MS. KELLEY: Larry.

8 DR. CASALINO: Yeah, two points. On the budget  
9 neutrality/savings issue, clearly this is budget neutral --  
10 would be budget neutral in the sense of the entire withhold  
11 is returned as rewards to SNFs. But I actually think that  
12 the program, if it works, would save money for Medicare,  
13 maybe quite a lot, because all three performance measures,  
14 you know, to the extent that SNFs score highly on the  
15 performance measures, they're going to be saving Medicare  
16 money by reducing hospital admissions and so on.

17 So unless there's some reason that I'm not aware  
18 of for not making this point clearly, I think it would be  
19 worth making. Withholds match incentives, that is budget  
20 neutral. But, in fact, this could save a ton of money for  
21 Medicare if the SNFs do well on the performance measures.  
22 If they do well on the performance measures, it has to save

1 money. So, in my opinion, that's pointing out.

2           But what I had first raised my hand to address  
3 was the issue that Dana has so well raised, and Amol and  
4 Brian spoke to well, I think. There is a tradeoff --  
5 right? -- between rewarding everybody equally for an equal  
6 performance score, in which case SNFs that take care of  
7 poorer patients are going to be disadvantaged because  
8 they'll have a harder time getting a good performance  
9 score, and so perhaps this can lead to the rich getting  
10 richer and the poor getting poorer, so to speak, and  
11 increase the status. But Dana's right that if we reward  
12 unequally for the same performance score, then one could  
13 argue that, in effect, we're saying, okay, you can take  
14 worse care of dual eligibles forever, and we'll continue to  
15 reward you.

16           So these are conflicting principles. This comes  
17 up in every value-based program, and as several people have  
18 said, there's no perfect solution. But I want to say that  
19 I think we can maybe elaborate a little bit more on this in  
20 what we wind up proposing.

21           There's basically three tools that we have for  
22 trying to increase performance: we can give financial

1 incentives, we can give technical assistance, and/or we can  
2 do some more public reporting, right? And I think by kind  
3 of jiggering our use of those three tools, we can do the  
4 best we can to resolve something that has no perfect  
5 solution, the problem I just mentioned.

6           So I would support the financial incentives as  
7 proposed in the staff's report, and I totally agree it is  
8 better to do it by peer groups than by putting a risk  
9 adjustment parameter into a formula because that is totally  
10 nontransparent then. Then you have no chance to see what  
11 the actual performance is.

12           But, you know, in response to Dana's very valid  
13 concern, I think technical assistance for the poorer or  
14 SNFs -- or the SNFs that take care of poorer populations  
15 would be a good thing. I don't think that's enough,  
16 though. I don't think just technical assistance without  
17 some adjustment in the financial incentives would be  
18 enough.

19           So I support the higher pay for the same  
20 performance score in high dually eligible peer groups, but  
21 I think that we can counteract the argument that this would  
22 reward people for taking worse care for dual-eligible

1 patients forever with public reporting, which I think does  
2 have some impact. So I would argue that this program  
3 should include public reporting of the performance of SNFs  
4 both in relation to all other SNFs in the country, in  
5 relation to all other SNFs in their geographic area,  
6 however we define that, and in relation to others in their  
7 peer group. And that way anybody who wanted to, whether it  
8 is a patient, a family member, or policymaker, a SNF  
9 executive, a referring physician, a referring hospital,  
10 would be able to look and see how is this SNF doing. So  
11 you could have a SNF that's not performing all that well,  
12 but because of our peer group stratification it's getting  
13 decent financial incentives, but it would still be visible,  
14 but that SNF is not providing that great care, and  
15 hopefully that would provide some incentive to improve, and  
16 also patients, family members, referring physicians, and  
17 hospitals could take action based on that public reporting.

18 So that's as close as I can get to solve what is  
19 a problem that has no perfect solution.

20 MS. KELLEY: Jon Perlin.

21 DR. PERLIN: Well, Larry Casalino, as always,  
22 teed up my comments very well. I appreciate it and I

1 appreciate the great work.

2           Let me just thank the team. I'm strongly in  
3 favor of moving forward, but I think we have to recognize  
4 that this is a journey, not a destination.

5           My hesitancy is around the need to go back for  
6 three years of data of the creation of what are lagging  
7 indicators for a couple of reasons. First, as has been  
8 brought out, improved performance or deteriorated  
9 performance, even if weighted more heavily toward more  
10 recent data, still makes it long to convert into the actual  
11 metric. But that's actually the lesser of my concerns.

12           The greater of my concerns ties to Larry's point,  
13 which is about the signal. That is, when you go for three  
14 years, for example, to accrue the data necessary to get  
15 reliability, one of the things you inadvertently created is  
16 a situation in which the extended measurement period, three  
17 years, is not consistent with the period of utilization of  
18 the beneficiary. And so it's not necessarily predictive of  
19 the experience, good, bad, or otherwise, that a beneficiary  
20 might expect.

21           This point about public reporting I think is  
22 absolutely imperative, and I think some of the health



1 services research would strongly indicate that in the  
2 instance of relatively mild financial incentives, in fact,  
3 it is the public accountability that actually is the  
4 greater of the levers in terms of affecting performance.  
5 And it's in that regard that I would hope that one of the  
6 goals of this type of set of metrics is not just the  
7 financial reward but to allow providers, patients,  
8 consumers, advocates, et cetera, to help determine where  
9 the care is better or where it's not as good to make the  
10 most informed decisions.

11           So I just offer that not as a recommendation that  
12 we do anything other than move forward because the  
13 preceding program is so substantially flawed, but really to  
14 set our sights on how we move to the next level.

15           Now, David and others subsequently brought up the  
16 notion of patient function and patient experience. Dana  
17 rightly pointed out the complexity of experience in a  
18 situation where in many instances you need a proxy report,  
19 and we're all aware of the concerns about, you know,  
20 interpretability of functional assessment. And this is  
21 where I get to the notion of, okay, if this is a journey,  
22 what next?

1           Well, wouldn't you really want to have a balanced  
2 scorecard? Wouldn't you really want to have the numerator  
3 and denominator aspects of value, the quality, and I put  
4 safety up there, too, in relation not to the cost?  
5 Wouldn't you want measures of function and experience as  
6 part of that?

7           Which leads me to the question: Why are we  
8 having such difficulty getting to credible data? And it  
9 leads me to this observation: that I would hope part of  
10 the ongoing direction here is to telegraph the need for  
11 electronic data, electronic quality measures, where there  
12 is not interpretability but, in fact, a measure of  
13 production is actually a byproduct of the care process  
14 itself so they can gain insights into function, perhaps not  
15 experience but into potentially things that matter.

16           That leads me to my final point. I note that  
17 skilled nursing facilities have a panoply of patient types.  
18 Many of their patients are older. Full disclosure, I'm on  
19 the board of advisers of the Age-Friendly Health Systems,  
20 which parses into four M's: the issues of mobility, issues  
21 of mentation, medication, and what matters to the patient.  
22 I would hope that as we then create the construct, we can

1 extract greater data, that we also begin to think not only  
2 from the public accountability and the sort of referral  
3 perspectives, but from the perspective of the patient  
4 themselves in terms of what matters to them.

5 Final comment. You know, I happen to just think  
6 it's also important that these programs always support  
7 access for those beneficiaries who need it. Thanks.

8 MS. KELLEY: Okay. Jaewon, you're next.

9 DR. RYU: Thanks, Dana. You know, I'll pile on  
10 here. I like our direction here as well. I think it  
11 addresses many of the unintended consequences and  
12 incentives in the current, you know, VBP model. And I  
13 think it's a marked improvement for that reason.

14 I like the peer grouping approach. I like the  
15 illustrative metrics. I think the only thing that I would  
16 offer -- you know, I agree with many of the comments  
17 already stated, but I think the patient experience measure  
18 is something that I would love to see as part of what we're  
19 either going out with as a recommendation or soon  
20 thereafter to be incorporated.

21 The other is this notion of improvement. I would  
22 offer that, you know, maybe it makes sense to have an

1 actual separate improvement measure, a portion of the  
2 withhold that could actually reward improvement measured  
3 over a period of time. Maybe it's not just a single year  
4 but consistent demonstration of improvement.

5 I think alongside Larry's comment around public  
6 reporting, offering that extra incentive for folks to  
7 continue to improve across any of the peer groups, I think  
8 having a dedicated amount that's rewarding improvement will  
9 help to bolster that.

10 Thanks.

11 MS. KELLEY: Paul?

12 DR. CHERNEW: Paul, you are muted.

13 DR. PAUL GINSBURG: Yes, sorry about that.

14 First, I'm very supportive of this approach. I like the  
15 direction it's going. A couple of comments.

16 I'm really intrigued that Amol brought up the  
17 issue that this is really a quality program, and maybe we  
18 should just call it that. And Brian's comment about, you  
19 know, being concerned about SNFs wanting to serve high-risk  
20 -- high social risk populations I think is very important.  
21 It really -- whereas, this started out as a quality or  
22 value program, the details are critical to whether it's an

1 access program. And I'm concerned both about institutions,  
2 you know, not being interested in duals and also concerned  
3 about the institutions that historically treat the duals  
4 not being unfavorably impacted.

5 I can't discuss this fully, but I have always  
6 been uneasy about having distinct rewards for improvement  
7 over good performance because the incentives in a sense --  
8 and I'm really concerned about the equity of penalizing the  
9 organizations that are not terrible, so that's something I  
10 really need to think about, hear more discussion about  
11 going forward.

12 DR. CHERNEW: All right. I'm going to make a  
13 comment, and then a few folks haven't spoken, and so I'm  
14 going to do what I'll call a lightning Round 2, which is  
15 I'm going to call folks out just to get a general sense if  
16 you're on board with this basic approach. While you think  
17 about your answer to that question, I'll make a comment on  
18 improvement and more a broad comment.

19 A lot of this is about the nuances of the math,  
20 which we will work through and come back with you. In the  
21 particular improvement case, for example, you always get  
22 value for improvement because even in an absolute model,

1 you get more money if you go from a lower to a higher  
2 performance. The question is essentially by how much, and  
3 should we double-weight your improvement in the axis scale  
4 and then have a separate value for actual improvement? So  
5 we will think through the math of all of this, and, of  
6 course, in implementation there will be some options how to  
7 get the exact details right.

8 I think the most important thing that I've heard  
9 so far is the basic principles that Dana outlined very  
10 nicely, which is, first of all -- I'm going to expand on  
11 them. First of all, we want quality improved for  
12 everybody. Second of all, we want to make sure that we  
13 don't disadvantage the providers that are serving the most  
14 disadvantaged populations. We're very worried about  
15 disparities. And third was the point of universality. We  
16 don't want to appear or otherwise hold -- give  
17 organizations a pass because of the populations that they  
18 serve. And I think the challenge we will work on going  
19 forward is taking those basic ideas for which there seems  
20 to be broad agreement and converting it into math, which is  
21 never fun, and certainly never fun to do in a GoToMeeting.

22 So that said, I'm going to go down how you're

1 based on the screen, and please don't make a long comment  
2 because we don't have a lot of time, although certainly  
3 there's time for a short comment. So let me start with  
4 you, Karen, just to get a sense of where you are with our  
5 direction.

6 DR. DeSALVO: All right. Thank you. I like the  
7 general direction. You know, clearly this area needs  
8 improvement, and the team has done a great job of thinking  
9 about how to move forward in a principled fashion that  
10 aligns with other value work that we're doing as MedPAC. I  
11 very much think that we still in all areas, not just in the  
12 area of SNF, have to work through this challenge of not  
13 only people who are dually eligible, with dual eligible  
14 being a marker of lower socioeconomic status or other  
15 social challenge, but this is going to continue to be an  
16 increasingly complex area.

17 So I like the fact that we're asking these tough  
18 questions about whether peer grouping is enough or if we  
19 should be doing more or something different. I agree with  
20 Dana's principles around how to think to approach it.

21 I just want to make one comment, though, as we're  
22 thinking about social -- whether or not social drivers can

1 influence care or outcomes and/or there should be some  
2 additional rewards to the SNFs to support lower-income  
3 Medicare beneficiaries. One of the challenges, of course,  
4 for appropriate community discharge is that those  
5 beneficiaries need safe quality housing with running water  
6 and electricity and social support when they leave the SNF.  
7 So there's a problem on the other side even if we make  
8 investments in the SNF to help them with their quality  
9 improvement and other work. We should just remember that  
10 there are some other complexities as beneficiaries leave  
11 that safer environment of an institution, at least with  
12 respect to them having additional resources that would come  
13 through added payments and have a place for safe discharge.  
14 I'm not saying that we should solve all of that from here.  
15 I just want us to recognize that as we're thinking about  
16 performance, because there's a reality that that may cause  
17 some people to need to be readmitted or to be more  
18 difficult for them to be discharged.

19 Thank you.

20 DR. CHERNEW: Great. Thank you, Karen.

21 Next on my screen is Marge. You may have said  
22 what you needed to say in Round 1, but I just want to give



1 you a chance, Marge, to briefly signal or nod if you're on  
2 board.

3 MS. MARJORIE GINSBURG: This was a fabulous  
4 discussion, and as much as I completely appreciate Dana's  
5 views and perspective on this, the peer grouping to me was,  
6 in fact, number one when I looked at all of the  
7 recommendations. I was most excited, if that's the right  
8 word, for the concept of the peer grouping, and perhaps  
9 somewhere, we're going to find a way to compromise on  
10 whether we can do without it versus doing with it. But the  
11 fact is these SNFs are serving a different population, a  
12 much more difficult population, and there has to be a way  
13 to legitimately reward high-quality care. So that's my  
14 main comment.

15 The only other thing I wanted to mention about  
16 the peer grouping is the discussion at the hospital SNFs  
17 sort of shouted out to me maybe we ought to take them out.  
18 They really, to me, don't fit well into the rest of the  
19 community-based SNFs. So that was just an add-on but not  
20 critical.

21 Great discussion. Thank you.

22 DR. CHERNEW: Thanks, Marge.

1           Again, I apologize for moving quickly. Jonathan,  
2 if you have a general reaction?

3           DR. JAFFERY: Yeah. Thanks, Mike.

4           So like others, I'm generally very supportive of  
5 this. I think it's a great step in the right direction, a  
6 pretty big leap forward.

7           I'll just make two very brief comments to respond  
8 to what some others have said.

9           Amol, you brought up the issue of the word  
10 "value," and I think it's significant to acknowledge that  
11 the word "value" is being thrown out a lot now in health  
12 care and some combination of quality and cost or resource  
13 utilization. I just think it's something that we might  
14 want to think through because it does get used a lot now.

15           But maybe a more substantive comment is to think  
16 about what Dana has brought up. I really appreciate Dana  
17 bringing up these points. For many years, I've been  
18 concerned about quality measures creating different  
19 standards for different groups, and you've made me think a  
20 lot, start to think at least a lot deeper about this now.

21           The one comment I'll add about, though, is we've  
22 talked about how to help with resources for organizations

1 that are serving different, maybe more marginalized or  
2 higher-risk populations. And we've talked about technical  
3 assistance, and I always wonder exactly what we mean by  
4 that. And I wonder if there's some way that we should  
5 think about how we can support organizations up front with  
6 additional resources, perhaps through some sort of payment  
7 mechanisms since that's a lot of what our charge is as  
8 opposed to just on the back end as an adjustment after the  
9 fact for achieving certain goals.

10 So I'll leave it at that. Thank you.

11 DR. CHERNEW: Great. Thank you.

12 I think next, just on my screen, it looks like  
13 it's Sue Thompson. She just jumped around on my screen.

14 [No response.]

15 DR. CHERNEW: Sue, I can't see you. Let's go to  
16 Bruce, and then we'll go to Sue.

17 MS. THOMPSON: I'm sorry. I was messing with my  
18 camera. I'm sorry.

19 DR. CHERNEW: All right. We'll go to Sue, then  
20 Bruce.

21 MS. THOMPSON: Okay. Generally, I agree. I will  
22 be brief.

1           Again, I want to join the chorus of the  
2 Commissioners in terms of the good work done by the staff  
3 directionally. This is absolutely great work. I also want  
4 to call out the commentary by Dana. I think that was  
5 exceptional in terms of adding richness to the discussion  
6 along with other Commissioners as well.

7           I would put a note of caution about removing the  
8 hospital-based SNFs, as I'm hearing in some of the most  
9 recent commentary. I think in rural America, these  
10 critical access hospitals use the swing-bed concept.  
11 They're putting patients into swing beds, and they become  
12 SNF providers.

13           Also, in the narrative of the chapter, there was  
14 a comment about why hospital-based SNFs perform better, and  
15 likely, it's because of staffing levels and the  
16 availability of physicians. I think there's good  
17 information out there to support it's a nursing staff  
18 availability that drives the difference in terms of why the  
19 outcomes are better, and I think there's some lessons to be  
20 learned there.

21           I just want to caution us from thinking we should  
22 pull these hospital-based SNF information out of this work.

1 I think there's something to learn there.

2 So those would be my comments. Thanks, Mike.

3 DR. CHERNEW: Okay, great. Then I'm going to go  
4 to Bruce next and then Wayne and Pat.

5 MR. PYENSON: Well, thank you very much, Mike.

6 I am very supportive of the direction. I think  
7 the work is first rate and very insightful.

8 In the coming months, I'd like to see some  
9 consideration of the movement towards mandatory bundled  
10 payments after the BPCIA program and how we can craft this  
11 very good work into that future. That's not very many  
12 years ahead of us, but I'm supportive of the direction.

13 DR. CHERNEW: Great. Wayne?

14 DR. RILEY: Yes. Thank you, Chairman.

15 I want to thank Sue for raising the issues of  
16 nursing. As an internist having referred patients to SNFs  
17 throughout my practice and career and then having family  
18 members in SNF, the secret sauce is nursing, and when  
19 there's good nursing staff and good nursing training, it  
20 really does make a difference in terms of the quality, not  
21 only the objective measures of quality, but also the family  
22 satisfaction and I would argue probably the patient

1 satisfaction as well.

2 I think Marge's point was right to raise the  
3 issue, but I would still because of also the rural issue,  
4 as Sue mentioned, retain the hospital-based SNFs in the  
5 program.

6 But terrific work by the staff. I think we  
7 talked about making sure that we do not do anything that  
8 exacerbates the difficult terrain that dual eligible  
9 patients have to traverse to get care and also to get SNF  
10 care when they need it, if and when they need it. So I  
11 think this is superb work, and I endorse.

12 DR. CHERNEW: Wayne, thank you, and that leaves  
13 Pat. I'm going to go to you, and since Dana led off a lot  
14 of this conversation, I'm going to give Dana 20 seconds or  
15 so to give a final point because we're coming up to the  
16 end.

17 Pat?

18 MS. WANG: I am supportive of the direction in  
19 the chapter. I think it's really, really good work.

20 A couple of emphases that I would put, I really  
21 endorse what others have said about the importance of  
22 continuing work on developing measures of functional status

1 and patient satisfaction. So I think that's good for  
2 emphasis.

3 I actually really like Larry Casalino's comments  
4 about public reporting. I think whatever we're doing  
5 inside to try to level the playing field for facilities  
6 that are taking care of more vulnerable patients, it's very  
7 important still to unblind all this information and make it  
8 transparent to people so that they have sort of unweighted  
9 and unadjusted information to make their decisions.

10 And the final thing, though, which is sort of  
11 related is that -- and we've talked about this before. I  
12 know that we use dual eligible status to adjust for SES. I  
13 really, really want to encourage us to at least in or a  
14 chapter to encourage measure developers and others to make  
15 this more sophisticated. Dual eligible status is such a  
16 blunt instrument.

17 We know so much more about folks who are near  
18 dual, non-dual. I mean, it's much, much more than whether  
19 you are a dual eligible as to whether or not you should be  
20 recognized or a facility should be recognized as treating a  
21 lot of folks with complicating conditions.

22 And I really appreciate Karen DeSalvo's comments

1 about at a certain point, there's only so much that a  
2 facility can do. The environment of the community and the  
3 housing, et cetera, the neighborhoods into which people are  
4 returning is beyond the control of the facility, and I just  
5 think that we need to recognize that there are certain  
6 things that these components of the delivery system just  
7 really can't handle on their own.

8 Thank you.

9 DR. CHERNEW: Pat, thank you.

10 That point on using duals is, I think, spot on  
11 actually, and if we had another bunch of time, I'm sure we  
12 could go around and make a comment on that. But we don't.

13 So, Dana, you're going to get the last word. I  
14 can't see where you are now, but you're somewhere.

15 DR. SAFRAN: Just really quickly, I think this  
16 was a fantastic discussion. I only wanted to make one  
17 clarification based on something that Marge said.

18 I wanted to be very clear, I'm not at all arguing  
19 against having the peer grouping. I think peer grouping is  
20 a really important advance that the team has made. What I  
21 was trying to express was that we not use peer grouping as  
22 a basis for setting this performance standard, but rather



1 that we use it as a basis for setting how much of a reward  
2 or how much support providers get.

3 And I love Larry's additional point about using  
4 it for public reporting so that we can see how providers  
5 within peer groups compare with others in that peer group  
6 at the same time that we're showing how a provider performs  
7 relative to the country and relative to their region.

8 So I just wanted to be really clear. I was not  
9 at all saying we should dispense with this innovation of  
10 peer grouping, just that it not be used to set different  
11 performance standards. There should be universal standard  
12 of performance, and let's adjust rewards and support based  
13 on peer groups.

14 Thanks.

15 DR. CHERNEW: Dana, that was incredibly helpful,  
16 and I know I said I want to move on. But I want to make  
17 one other point.

18 I think the way this actually works -- and,  
19 again, I'm not going to have discussion on this now, but  
20 luckily, we get to meet other times. I think the way this  
21 actually works is you get points based on national  
22 standards, and the peer grouping is largely used to

1 determine how much money those points translate into.

2           But I think it's crucial that your original point  
3 about universality, not different standards, and getting  
4 the incentives right across the board is spot on.

5           So, again, we will in a later time or offline  
6 talk about the nuances of the math that this was designed.  
7 I think Carol is going to give me a thumbs-up on the screen  
8 or not, but I think this design to try and have national  
9 standards for the points you get and not have a standard  
10 influenced by the peer group you're in and the peer  
11 grouping, I think, is largely used to translate it into  
12 money, although literally there might be other ways to do  
13 that.

14           But now I've taken us too long, and I feel badly  
15 because the hospice stuff is most important and is another  
16 great job. So I'm going to skip any great intro except to  
17 thank you all and switch over now to the next item on our  
18 agenda, which is the hospice payment chapter. And I think  
19 that's going to be Kim.

20           So now I'm just -- there we go. We have the  
21 slides up. I just don't see Kim, but, Kim, just jump in  
22 whenever you're ready.

1 MS. NEUMAN: I'm here. Good morning.

2 So today we are going to talk about issues with  
3 the hospice payment system and potential new policy  
4 directions that could be explored in future research. I'd  
5 like to thank Evan Christman, Kathryn Linehan, and Jamila  
6 Torain for their contributions to this work.

7 As a reminder, the audience can download a PDF  
8 version of the slides in the handout section of the control  
9 panel on the right-hand side of the screen.

10 We are going to talk about two primary issues  
11 with the hospice payment system. First, aggregate payments  
12 substantially exceed providers' costs, and margins vary  
13 widely by length of stay. We'll discuss a site-neutral  
14 payment policy for long hospice stays as a possible  
15 approach to address this.

16 Second, we will discuss concerns about outlier  
17 utilization patterns among some hospice providers and the  
18 potential to develop a compliance threshold policy to  
19 address this.

20 Both of these items are in response to issues  
21 raised by Commissioners at the October 2019 meeting.  
22 Before we discuss each, let's review some background on

1 hospice and the hospice payment system.

2           Hospice provides palliative and supportive  
3 services for beneficiaries with terminal illnesses who  
4 choose to enroll.

5 To be eligible, a beneficiary must have a life expectancy  
6 of six months or less if the disease runs its normal  
7 course. There is no limit on how long a beneficiary can be  
8 in hospice as long as a physician certifies that he or she  
9 continues to meet this criterion.

10           Beneficiaries who choose to enroll in hospice  
11 agree to forgo curative care for the terminal condition and  
12 related conditions.

13           The hospice benefit covers a range of services;  
14 for example, visits from nurses, social workers, aides,  
15 therapists; drug, durable medical equipment, and supplies;  
16 short-term inpatient or respite care and other palliative  
17 services in the patient's plan of care; and in addition,  
18 bereavement for the family.

19           Medicare spent \$19.2 billion on hospice services  
20 in 2018. Medicare pays a daily rate for hospice, and this  
21 rate is paid regardless of whether the patient received  
22 services on a particular day.

1           There are four levels of care. Routine home care  
2 is the most common, accounting for 98 percent of days. The  
3 three other levels of care offer more intensive services to  
4 manage a crisis or offer respite care.

5           The hospice payment system also includes an  
6 aggregate cap that limits the total payments a provider can  
7 receive in a year. If a provider's payments during the  
8 year exceeds the number of beneficiaries treated multiplied  
9 by the cap amount, the hospice must repay the excess to the  
10 Medicare program. As we saw last year, the cap has the  
11 effect of reducing payments to providers with unusually  
12 long stays and high margins.

13           As we consider Medicare spending on hospice, it  
14 is important to note the role that long hospice stays play.  
15 Although a relatively small share of beneficiaries have  
16 long stays, long stays account for the majority of Medicare  
17 spending. Only about 14 percent of hospice enrollees who  
18 died in 2018 had stays exceeding 180 days, but nearly 60  
19 percent of total Medicare hospice spending in 2018, or \$11  
20 billion, was on behalf of beneficiaries with stays  
21 exceeding 180 days. And of that \$11 billion, about \$7.3  
22 billion was for additional hospice care for patients who

1 had already received at least 180 days of hospice.

2 As we have discussed before, long stays in  
3 hospice have been profitable due to the per diem nature of  
4 the payment system and hospices cost structure.

5 Prior to 2016, routine home care C was paid a  
6 uniform daily rate. Because hospices provide more services  
7 at the beginning and end of an episode and fewer in the  
8 middle, this has meant that longer stays have been more  
9 profitable.

10 In 2009, the Commission recommended the hospice  
11 payment system move from a flat payment per day to a U-  
12 shaped payment structure, and directionally consistent with  
13 that recommendation in 2016, CMS modified the payment  
14 structure for routine home care with a higher payment rate  
15 for Days 1 through 60 and a lower rate for Day 61 and  
16 beyond, and providers also receive additional payment for  
17 nurse and social worker visits in the last week of life.

18 More recently, in 2020, CMS rebalanced the  
19 payment rates for the three less frequent levels of care,  
20 increasing them substantially.

21 Although CMS estimated that the routine home care  
22 payment rates exceeded costs by 18 percent, CMS only

1 reduced the routine home care rates slightly because the  
2 statute requires changes be budget neutral. Although the  
3 changes made by CMS in 2016 and 2020 are improvements, the  
4 issues remain.

5           And findings from our March 2020 report  
6 illustrate this. In that report we found that the  
7 aggregate level of hospice payment substantially exceeded  
8 providers' costs.  
9 We estimated an aggregate Medicare margin in 2017 of 12.6  
10 percent, and as has historically been the case,  
11 profitability varied widely by length of stay.

12           Grouping providers into quintiles based on the  
13 share of the providers' patients with stays greater than  
14 180 days, the aggregate margin ranged from about -5 percent  
15 for providers in the lowest length-of-stay quintile to  
16 about 22 percent in the second highest length-of-stay  
17 quintile. The slight dip in margins in the highest length-  
18 of-stay quintile reflects the effect of the hospice  
19 aggregate cap.

20           Based on our analysis of hospice financial  
21 performance and other payment adequacy indicators, in March  
22 2020, the Commission concluded that the aggregate level of

1 payment could be reduced and would be sufficient to cover  
2 high-quality hospice care.

3           In March 2020, the Commission made a two-part  
4 recommendation, which has not been acted on by Congress.  
5 The first part was freezing the Fiscal Year 2021 payment  
6 rates at 2020 levels. The second part was wage adjusting  
7 and reducing the hospice aggregate cap by 20 percent as a  
8 way to focus payment reductions on hospice providers with  
9 unusually long stays and high margins.

10           The table here illustrates the effect of the  
11 hospice cap recommendation based on our simulation using  
12 2017 data.

13           Next.

14           If you look at the last row in the table, it  
15 shows the effect of the cap policy on the 20 percent of  
16 providers with the most long stays. Payment to these  
17 providers would be reduced substantially, with their  
18 payment to cost ratio declining from 122 percent to 103  
19 percent.

20           But payments would continue to substantially  
21 exceed costs for some providers, as also shown here in the  
22 chart if you look at the payment to cost ratio for the next



1 two highest length-of-stay quintiles.

2           So what this means is that if Congress were to  
3 adopt the cap policy in the future it would reduce payments  
4 to providers with the most lost days but it would not fully  
5 eliminate the distortions in the payment system where long  
6 stays can be quite profitable, particularly for providers  
7 who keep their utilization patterns near but below the cap.  
8 Given this, there could be merit in considering additional  
9 adjustments to the routine home care payment rates for long  
10 stays.

11           At the October 2019 meeting, Commissioners raised  
12 the idea that long hospice stays for some patients may be  
13 substituting for other types of care such as home health  
14 care, and raised the possibility of adjusting payments for  
15 hospice stays accordingly. Building on that discussion, we  
16 could explore developing a site-neutral payment adjustment  
17 for long hospice stays using home health as a starting  
18 point.

19           Although there are important differences between  
20 hospice and home health, home health could provide an  
21 appropriate payment benchmark for long hospice stays for  
22 several reasons. Both hospice and home health offer visits

1 from similar types of practitioners: nurses, aides, social  
2 workers, and therapists. With long stays in hospice, a  
3 larger portion of care is occurring earlier in the disease  
4 trajectory where patients are likely to be more stable, and  
5 as such may be more akin to home health care than shorter  
6 hospice stays where the patient is nearing the end of life  
7 and typically experiences increased needs for hospice  
8 nursing and psychosocial supports.

9           As hospice length of stay increases, aide minutes  
10 make up an increasingly larger portion of total visit  
11 minutes while nurse minutes decline. The greater share of  
12 hospice time devoted to aide visits among patients with the  
13 longest stays may suggest that hospice may be performing  
14 some of the same functions as custodial care. At the same  
15 time, any effort to develop a payment adjustment for long  
16 hospice stays based on home health would need to take into  
17 account the differences between the two benefits, with one  
18 of the biggest being that hospice covers a broader set of  
19 services than home health.

20           As an example, this next slide sketches out one  
21 approach to constructing a payment adjustment for long  
22 hospice stays based partly on home health rates, while

1 being mindful of the differences between hospice and home  
2 health. First, we could rely on the home health per-visit  
3 payment rates for each type of discipline -- nurses, aides,  
4 social workers, and therapists -- to estimate how much the  
5 visits received by hospice beneficiaries would have been  
6 paid if home health payment rates were used.

7           Using the home health per visit payment rates  
8 instead of the home health episode payment rates helps to  
9 address the differences in the mix and frequency of visits  
10 between home health and hospice patients. Since some items  
11 like drugs, DME, and certain other services are covered by  
12 hospice but not home health, we could develop estimates of  
13 the costs of these additional items and services using data  
14 from hospice cost reports.

15           Summing together the estimated visit costs, based  
16 on home health rates, and the other costs, based on hospice  
17 cost report data, we could develop a benchmark site-neutral  
18 payment amount for long hospice stays. This benchmark  
19 payment amount could be compared to the average amount  
20 hospices are paid for long stays under the current hospice  
21 payment system to develop an adjustment factor.

22           To develop a site-neutral payment adjustment for

1 long hospice stays, a number of design questions would have  
2 to be considered. For example, what length of stay would  
3 trigger site-neutral payment? Would the payment adjustment  
4 apply to the entire stay or to only those hospice days  
5 beyond the threshold? Would there be a period near the  
6 end of life that is exempt from site-neutral payment? How  
7 would the policy be structured to best minimize the  
8 potential for providers to avoid site-neutral payment by  
9 discharging and readmitting patients to hospice, and how  
10 should the policy be structured to treat providers  
11 equitably in situations where patients switch hospices and  
12 receive care from multiple providers?

13           Next, we will turn to the issue of providers with  
14 outlier utilization patterns. This is an issue that also  
15 came up at the October meeting last year, where several  
16 Commissioners expressed interest in steps to address  
17 providers without unusual utilization patterns that raise  
18 program integrity concerns.

19           As shown in the chart, some providers have much  
20 longer stays than other providers. And as we've discussed  
21 before, length of stay varies by diagnosis and patient  
22 location so providers that wish to do so can focus on

1 patients likely to have long stays. OIG has also reported  
2 on cases of some providers enrolling patients not eligible  
3 for the benefit.

4           Some providers have unusually high live discharge  
5 rates, as can be seen from the distribution in the chart.  
6 Although hospices are expected to have some live  
7 discharges, an unusually high rate raises concerns. Very  
8 high live discharge rates may indicate that a hospice  
9 provider is not meeting the needs of patients and families  
10 or is admitting patients who do not meet the eligibility  
11 criteria. In addition, a study by Abt Associates for CMS  
12 found evidence suggesting that some hospice providers  
13 inappropriately encourage beneficiaries to revoke hospice  
14 or inappropriately discharge patients to avoid hospice  
15 aggregate cap liabilities.

16           The care provide by hospices with unusually long  
17 stays and high live discharge rates differs from the care  
18 provided by other hospice providers in some ways. Hospices  
19 treating a mix of patients with very long stays are  
20 providing more days of care earlier in the disease  
21 trajectory when patients tend to be more stable and have  
22 less-intense care needs. In addition, unusually high live

1 discharge rates seem inconsistent with the mission of  
2 hospice which is to support patients through the last days  
3 of life.

4           In other sectors, such as IRFs and LTCHs,  
5 Medicare has used compliance thresholds to counter  
6 incentives for patient selection and encourage providers to  
7 focus on patients most appropriate for that level of care.  
8 Compliance thresholds are blunt tools, but they are  
9 sometimes turned to when other approaches are not  
10 successful. With a compliance threshold, Medicare defines  
11 certain criteria that a provider must meet to qualify to be  
12 paid as that type of provider. Examples are the IRF 60  
13 percent rule and LTCH 50 percent rule, as discussed in more  
14 detail in your paper.

15           We could explore this type of approach for  
16 hospice providers. For example, a policy could be  
17 developed where hospice providers whose length of stay or  
18 live discharge rates for its patient population exceeds a  
19 specified threshold would receive a reduced payment rate  
20 for all patients. Having this type of policy in place may  
21 help reduce the potential for patient selection under the  
22 hospice payment system and reduce the potential for hospice

1 business models focused on revenue generation strategies.

2 To develop a compliance threshold for hospice  
3 providers, a number of policy design question would have to  
4 be considered. For example, what would be the basis of the  
5 threshold -- length of stay, live discharge rates, or an  
6 alternative metric? If hospice length of stay, what is an  
7 appropriate metric -- share of stays exceeding 180 days,  
8 average length of stay, or an alternative? At what level  
9 should the threshold be set? What would be the  
10 consequences of not meeting the compliance threshold, for  
11 example, a lower payment rate or no longer qualifying to be  
12 a Medicare hospice provider? And finally, to what time  
13 period would that consequence apply, retrospectively or  
14 going forward for a specified period?

15 So in summary, to address issues with the hospice  
16 payment system, we could conduct future work to explore a  
17 site neutral payment adjustment for long hospice stays and  
18 a compliance threshold for hospice providers. It would be  
19 helpful to get Commissioner guidance on these research  
20 directions and issues to consider for future work.

21 DR. CHERNEW: Terrific. From what I've seen, the  
22 first person in the round one queue is Larry. So Larry,

1 you're up.

2 DR. CASALINO: Yeah. Very interesting and really  
3 kind of disturbing report.

4 Just a quick question. If we were to say that  
5 for certain long stay days that occur, you know, somewhere  
6 in the middle, let's say, of a person's care cycle in the  
7 weeks before they are dying, if we wanted to pay those at a  
8 lower rate I think you guys were suggesting let's base  
9 their lower rate off the home health rate plus some  
10 addition payment for special things that a hospice  
11 provides.

12 But if I understood correctly, at least, from  
13 what we discussed last meeting, is that maybe these long  
14 stay days, quote/unquote, in the middle of the cycle, are  
15 really home health days and that's what they should be. For  
16 example, for a patient with Alzheimer's who is living at  
17 home and don't need these specialized SNF resources. If  
18 that's the case, why would we pay an additional amount  
19 beyond a home health payment rate for hospice resources, I  
20 should say, that aren't really necessary during those days?

21 Because my understanding is, we wouldn't be  
22 paying, you know, fee-for-service depending on whether the



1 nurse shows up or not in those days. It would just be a  
2 different hospice per diem rate than an HHA rate for those  
3 days. And if the patients are just getting home health  
4 services, why not just pay at that rate and not make the  
5 hospice per diem higher for those days. That, to me, would  
6 be truly site neutral.

7 MS. NEUMAN: So there are some differences in the  
8 services covered by hospice and home health, and the two  
9 things that come to mind immediately are drugs and durable  
10 medical equipment. So if a beneficiary is in hospice and  
11 there are drugs that they have been previously using to  
12 address the symptoms of their chronic condition, those  
13 medicines would have been previously paid through Part D.  
14 But once a beneficiary goes into hospice those medicines  
15 are supposed to be paid by the hospice.

16 And so a difference between hospice and home  
17 health is the hospice will have been absorbing those  
18 medication costs whereas the home health agency would not  
19 have been. Those would have been paid through Part D. So  
20 that's an example of where you might want to think about,  
21 if you were going to pursue this approach, possibly adding  
22 on to the home health rate.

1 DR. CASALINO: Thanks.

2 MS. KELLEY: I have Brian next with a round one  
3 question.

4 DR. DeBUSK: Okay. Thank you. I have two  
5 questions. First of all, how many NPIs are in this space?  
6 I'm under the impression this is a really fragmented  
7 industry and that there are a lot of providers who even  
8 have multiple NPIs. Can you speak to that please?

9 MS. NEUMAN: Are you asking how many provider  
10 numbers there are?

11 DR. DeBUSK: Yeah. How many providers are in  
12 this space, and to what extent do they use multiple  
13 numbers? For example, the DME industry used to be marked  
14 by, you know, one operating have five or six or seven  
15 different numbers. Is that similar to hospice, in hospice?

16 MS. NEUMAN: So in hospice there are about 4,600  
17 provider numbers, roughly, and there are companies that  
18 have multiple locations and can use different provider  
19 numbers for those different locations. So yes, there is  
20 some of that. We have never looked at that in detail, sort  
21 of trying to get at the corporate entity and then how many  
22 numbers per entity there are.

1 DR. DeBUSK: Okay. I was -- and this will be  
2 round two. I was just trying to unwind how effective a  
3 solution would be if they can just simply switch from one  
4 provider number to another. That's round two.

5 My second question was, how does the hospice  
6 revenue cycle work, in general? For example, if a provider  
7 gets the aggregate cap, how is that actually -- I mean,  
8 does Medicare quit paying for the year? I mean, these are  
9 daily bills, I would assume. How does that whole revenue  
10 cycle work?

11 MS. NEUMAN: So with the aggregate cap what  
12 happens is the cap year ends in the fall of a year, and  
13 then in the spring the hospice is required to do their own  
14 self cap calculation, and based on that in initial data if  
15 they're over the cap they're required to submit money to  
16 the MACs, or to come up with a payment arrangement with the  
17 MACs. And if they don't then Medicare can stop payment to  
18 the hospice.

19 DR. DeBUSK: So there's a mechanism in place now  
20 for if we do develop policy that has a claw-back or a bill-  
21 back, all that machinery is in place already.

22 MS. NEUMAN: Yes, there is a machinery sort of,

1 an infrastructure surrounding the cap.

2 DR. DeBUSK: Okay. Thank you. Those were my  
3 questions.

4 MS. KELLEY: Bruce, did you have one?

5 MR. PYENSON: I did. Thank you very much, Kim.  
6 This is terrific work. I've got two questions. One is in  
7 the reading material, on page 9, you identify that hospice  
8 has a focus on nursing homes, and I think ALFs tend to have  
9 patients with longer hospice lengths of stay, and they also  
10 have an efficiency because of very small travel time in a  
11 facility between patients. And my first question is  
12 whether the home health program recognizes a difference in  
13 reimbursement in such situations, and whether that could be  
14 applied to hospice. So that's one set of questions,  
15 perhaps a related question in the case of NORCs naturally  
16 occurring retirement communities.

17 The second question is, as I believe the data, we  
18 are examining includes patients receiving hospice services  
19 who are enrolled in Medicare Advantage. I believe all of  
20 that flows into the Part A data that we're looking at. And  
21 with the move towards MA taking risk for hospice, what all  
22 that would do to our thinking here. And part of that is do

1 we see actually different patterns of hospice use in  
2 patients who come from an MA plan versus others?

3 So two questions. Sorry. Very different  
4 questions.

5 MS. NEUMAN: So on the first one, you are asking  
6 about home health and assisted living facilities and if the  
7 payments are different. Evan, you should correct me if I'm  
8 wrong but I believe they are not.

9 The second thing is about the MA population in  
10 hospice, and the beneficiaries who are in MA plans that  
11 then get referred to hospice and are under effectively the  
12 same hospice system as fee-for-service beneficiaries  
13 currently, we've looked at their utilization patterns and,  
14 in general, they are pretty similar. Maybe the median  
15 length of stay is a tad longer and maybe the long stay tail  
16 is a tad shorter, but it's not that much. It's pretty  
17 similar. So that's what we know with the data that we have  
18 at this point.

19 MR. PYENSON: But for me, a policy recommendation  
20 standpoint, if MA absorbs the risk for hospice patients in  
21 the future, I think that means that the volumes we're  
22 looking at go down by about half.

1 MS. NEUMAN: The volumes would go down, yes.  
2 Yes.

3 MS. KELLEY: Karen, did you have a round one  
4 question?

5 DR. DeSALVO: Thanks, Dana. My question has a  
6 little bit to do with the other side of the equation, and  
7 just to ask, there's some clinical characteristics of the  
8 patients that are in longer stay and, as always, I really  
9 appreciate the staff trying to shed some more light here.  
10 And given that a lot of them have neurologic diagnoses I  
11 just wondered if there's more detail you could share about  
12 whether those individuals also, if we note they had other  
13 comorbidities as well. So were they potentially people who  
14 also had other significant conditions but were admitted to  
15 hospice purely for neurologic conditions but were more  
16 medically complex going in? There's a cost question behind  
17 that, I think. I'm just trying to understand what are the  
18 other factors driving the higher costs in addition to  
19 potentially length of stay.

20 MS. NEUMAN: So it's a good question. We have  
21 not looked at the sort of clinical profile of the  
22 neurologic patients and the sort of array of comorbidities.

1 It's something that is on the claims data so it would be  
2 possible to look at something like that.

3 DR. DeSALVO: Thanks.

4 MS. KELLEY: That's all I have for round one,  
5 Mike. Should we start with round two?

6 MS. MARJORIE GINSBURG: Actually I had a round  
7 one question, if you don't mind if I jump in.

8 MS. KELLEY: Go ahead.

9 MS. MARJORIE GINSBURG: Actually, I'm glad Bruce  
10 brought up the question about MA, because that was one of  
11 my questions. But the main one is this issue about the  
12 eligibility criteria to be in hospice. It was fuzzy. And  
13 yet there was a reference on one of the pages, page 5,  
14 where it talks about eligibility criteria but there was no  
15 additional information on what that meant besides  
16 diagnosis. Clearly this must be key to the differences  
17 we're seeing in the super-utilizers and those who are not.

18 So I wonder if staff could talk at all about what  
19 other eligibility criteria are part of the system here.  
20 Thank you.

21 MS. NEUMAN: The main criterion is that the  
22 patient have a life expectancy of six months or less if the

1 disease runs its normal course, as determined by a  
2 physician.

3           There are policy documents the MACs have that  
4 give some guidance on sort of where that line might fall  
5 for patients with a certain condition, but a lot of it is  
6 up to the judgment of the physician.

7           MS. KELLEY: All right. If we're done with Round  
8 1, we can go to Round 2, Mike.

9           DR. CASALINO: If I could just follow up.

10          DR. CHERNEW: Yeah.

11          DR. CASALINO: Karen is it the patient's  
12 physician and the hospice physician has to certify the six  
13 months or just the patient's physician?

14          MS. NEUMAN: So when a beneficiary first enters  
15 hospice, it's both their attending physician and the  
16 hospice physician subsequent to the first benefit period,  
17 so each recertification, it's only the hospice physician  
18 that has to make that judgment.

19          DR. CASALINO: I see. So there's all kinds of  
20 things that the hospice physician could do to select  
21 patients that would be favorable to the hospice one way or  
22 the other, other than just increasing the volume of



1 patients.

2 MS. NEUMAN: It's possible that you could, you  
3 know, enroll or seek out referral sources that have sort of  
4 a different mix of patients at different points in the  
5 disease trajectory. That's possible if an entity wanted to  
6 do it.

7 DR. CASALINO: And there's a tremendous amount of  
8 judgment and uncertainty involved in deciding how long you  
9 expect the patient to live, and your decisions along those  
10 lines could be favorable to the hospice you work for.

11 Okay. Thanks.

12 DR. CHERNEW: Great. So now we're going to  
13 switch to Round 2. I think we have Sue was first for Round  
14 2, and then we're going to go to Marge. I think that's  
15 going to be the order.

16 MS. THOMPSON: Very good. Thank you.

17 Just to set context for my comments on this  
18 chapter, a reminder that in 2018, we're talking about \$19  
19 billion in total spent on hospice, and that's on the total  
20 Medicare spend in 2018 of \$750 billion. So we're talking  
21 about the total hospice spend being 2 percent of our total  
22 Medicare spend. So just keep that in mind. We have a \$750

1 billion issue, and I want to talk a little bit about  
2 thinking about hospice a little differently, because much  
3 like my sentiments after reviewing the context chapter last  
4 month, I felt less than satisfied with the progress we've  
5 made over the course of the past five MedPAC cycles, while  
6 I've had an opportunity, I think, every year to comment on  
7 hospice.

8           We're concerned with long hospice stays and the  
9 distortions in the payment system that quite likely are  
10 incentives to creating more long hospice stays. So do we  
11 believe that long-term hospice beneficiaries do not receive  
12 value? Do we believe that restructuring payments will lead  
13 to long-term modification of bad actor behavior? Is this a  
14 program integrity issue to deal with those that play games  
15 with a payment system, and are we thinking broadly enough  
16 about what hospice means to the overall Medicare program?  
17 And I wonder if we're asking a complete set of questions.

18           So to illustrate my very conflicted thinking  
19 here, I'm going to go out on a limb a bit to share my own  
20 personal experience with Medicare hospice services.

21           In 2013, my father left this good earth at the  
22 age of 83 following a fall on ice while getting out of his

1 car on an icy January day in Iowa, resulting in a traumatic  
2 head injury with cerebral head bleed, following a long  
3 history of cardiomyopathy with atrial fib that required an  
4 escalation. He spent his last week of life at our hometown  
5 nursing facility with the support of hospice, and we said  
6 goodbye to my mom just after midnight on Christmas Day in  
7 2017. She was 85 years old. She enjoyed the support of  
8 hospice while residing in an independent living facility  
9 for 13 months after being diagnosed with pancreatic cancer.

10 At the time of each of their diagnoses, my  
11 parents were offered additional medical and procedural  
12 therapies. Dad was offered a trip by Life Flight from the  
13 local critical access hospital to the University of  
14 Nebraska Medical Center, where they proposed doing a  
15 craniotomy followed by vascular procedures to stop the head  
16 bleed followed by whatever rehab service would be needed  
17 following whatever his neural status might be following his  
18 stroke, with certainty of compromised quality of his life.  
19 For my mother, her choice is including stenting various  
20 ducts and vessels followed by aggressive chemotherapy.

21 Both of my parents chose to reject these  
22 aggressive therapies and opted to enjoy the best quality of

1 life possible with the support of hospice. My sister, also  
2 a nurse, and I did not have a crystal ball in either case.  
3 Dad lived less than a week. Mother lived an incredible 13  
4 months.

5 Hospice services contributed immeasurably to the  
6 quality of both of my parents passing to their next life,  
7 and quite likely, as this story is completely told, their  
8 choice saved the Medicare program substantial dollars.

9 So I'm left to wonder. On behalf of the total  
10 Medicare beneficiary population and on behalf of the future  
11 of the Medicare program, are we asking a complete set of  
12 questions, and are we missing the forest for the trees?

13 According to a study by Kelley, Deb, and  
14 Morrison, included in the National Hospice and Palliative  
15 Care organization's 2019 annual report, the total Medicare  
16 savings between hospice and non-hospice patients with a 15-  
17 to-30-day length of stay was \$6,430. These savings to  
18 Medicare declined as the length of stay increases.  
19 However, even with the length of stay up to 105 days, the  
20 savings are in excess of \$2,500.

21 So instead of attempting to limit Medicare  
22 hospice participation and payments, should we not be

1 putting at least some of our focus on recommendations,  
2 encourage the timely enrollment of qualified patients into  
3 the hospice program?

4           As a reminder, Medicare beneficiaries make the  
5 selection. It is one with substantial consequence. What  
6 is the comparison of hospice cost and curative cost? What  
7 is the total cost avoidance by the Medicare population  
8 based upon the election of hospice compared to a craniotomy  
9 followed by an ICU stay, followed by long rehab services,  
10 or going down a long-term chemotherapy protocol?

11           This chapter focuses on unusual utilization  
12 patterns among some hospice providers, and if program  
13 integrity issues exist -- and they do -- then let's focus  
14 our recommendations on proving compliance and enforcement  
15 of rules that already exist.

16           I struggle with creating a new set of payment  
17 formulas that will only create a new game for the bad  
18 actors to manipulate and leave the good hospice providers  
19 with additional complexity and regulatory burden to sort  
20 through while they're doing the right thing, improving the  
21 experience of the Medicare beneficiary while reducing  
22 Medicare spend.

1           So I recommend we spend more time understanding  
2 and putting into context of this discussion, the cost  
3 avoidance opportunity the Medicare program experiences  
4 through its hospice programming.

5           However, the chapter calls for comment on the  
6 concept of using site neutral, and I struggle with this. I  
7 have a hard time comparing hospice and home care. It seems  
8 faulty, as the inputs of labor, the skill mix, the drugs,  
9 the equipment, and the outputs are substantially different.

10           The chapter does a nice job of listing these  
11 differences, and the narrative ultimately seems to imply  
12 that hospice is home care plus a few more benefits, to  
13 which I just don't agree. But nevertheless, my preference  
14 would be perhaps for a more episode-based approach to  
15 payment for hospice with payments rising for longer stays  
16 but at a decreasing rate.

17           But nevertheless, should we proceed down a path  
18 of site-neutral discussion, which I anticipate we will, I  
19 would offer these reactions. I would favor a length of  
20 stay greater than 365 days before triggering a site-neutral  
21 payment. For those stays that do meet the criteria, I  
22 would support the payment adjustment applied only to those

1 days beyond that threshold. I would support for very long  
2 stays where the patient is ultimately discharged deceased  
3 that the last seven days be exempt from the site-neutral  
4 payment. I would suggest that policy could be structured  
5 to lessen the potential for providers to avoid site-neutral  
6 payment by discharging patients and readmitting them to  
7 hospice by setting thresholds. Threshold for payment  
8 should be based on high percent of long length of stay and  
9 high percent of live discharges, using a national  
10 benchmark.

11           It would be important to note the reason for live  
12 discharges within these metrics, including patient and  
13 family choice, relocation, they found a new treatment, or  
14 perhaps the hospice determined the patient is no longer  
15 terminal.

16           The consequences of not meeting compliance  
17 thresholds should be similar in concept to the lower  
18 payment rate setting for not participating in required  
19 quality reporting, and yes, some recognition for small  
20 providers to address concerns about random variation in  
21 very small patient populations is relevant and important.

22           And for those patients that switch hospices,

1 which can only happen once during a certification period,  
2 they would stay in the same benefit period so their days  
3 would continue to accrue.

4 In summary, making recommendations regarding  
5 payment adjustments to the hospice program seems somewhat  
6 narrow in our thinking. Attempting to modify behavior  
7 through payment system restructuring without including the  
8 context of the cost avoidance opportunity, hospice provides  
9 to Medicare, seems to me to be a missed opportunity.

10 As a family member who was blessed to have  
11 experienced the hospice benefits afforded to my parents and  
12 as a MedPAC Commissioner concerns for the sustainability of  
13 this Medicare program, I encourage us to take a broader  
14 view concerning hospice to be an important puzzle piece  
15 towards solving our \$750 billion problem.

16 Thank you.

17 DR. CHERNEW: Okay. Thanks, Sue. As always,  
18 eloquent.

19 Marge?

20 MS. MARJORIE GINSBURG: Well, I'm glad Sue went  
21 first. Sometimes I felt like we were reading entirely  
22 different chapters.



1 I actually started part of my career as a home  
2 care nurse. This was before hospice even came into being,  
3 but I also have very strong feelings about the benefit of  
4 hospice, having used it for a variety of family members.

5 But I look at the billions that we lose through  
6 it not as a tiny segment of this big pie that we spent but  
7 as money that taxpayers are paying that they shouldn't be  
8 paying, and no way do I think we should jeopardize the  
9 existence of hospice or discourage the new hospice programs  
10 coming into being.

11 But I am not happy with the billions we are  
12 wasting because there are hospice programs that are gaming  
13 the system, and those are words that are in this report.  
14 They use the word "gaming," and even though it's a small  
15 slice of the Medicare pie, it has consequence. And the  
16 fact that we might just leave it alone, to me, is  
17 definitely not what MedPAC should be doing.

18 Like Sue -- I think this was like Sue -- I don't  
19 support encouraging it to become part of the neutral  
20 setting, whatever that terminology is, because I think  
21 there is a tremendous difference between hospice services  
22 and home care services. There are too many differences in

1 those kinds of programs that make the idea of setting the  
2 neutral setting payment the same. So I don't support going  
3 there.

4 I do support compliance thresholds, and how we  
5 set this up, I'm not sure, but I have this vision that we  
6 give hospice program -- if they're outside the compliance  
7 threshold for one year, we give them a warning. If they're  
8 outside the compliance threshold two of three years  
9 altogether, then they go on probation. They're basically  
10 taken off the hospice rolls for those three years, and then  
11 they can get back in.

12 I was kind of surprised by the low thresholds of  
13 compliance thresholds that were given, the 60 percent and  
14 50 percent. I can't understand how that can be so low, and  
15 I'm envisioning compliance thresholds more in the nature of  
16 80 percent, that you have to make that cut at that level.

17 So those are basically where my thoughts are. I  
18 don't think we should give hospices as pass because they're  
19 wonderful and they do great things and we love them. I  
20 think we should hold them to the same kind of standard we  
21 hold every other Medicare provider in terms of integrity  
22 and the legitimate use of taxpayer dollars.

1 Thank you.

2 MS. KELLEY: Okay. I have Brian next.

3 DR. DeBUSK: Thank you, and thanks to the staff  
4 for an excellent chapter.

5 There was a lot of contrast between Sue's  
6 comments and Marge's comments. Actually, I do understand  
7 the important role that hospice plays to the program and to  
8 families.

9 In reading this chapter, the thing that jumped  
10 out at me, though, was that there is a group of pretty  
11 obvious offenders. I mean, I can fight some of the  
12 statistics, but that 95th or 90th percentile is really  
13 somewhat outrageous in some cases.

14 The one thing I'd like to recommend, I'm not sure  
15 the site-neutral payment to home health is necessarily  
16 relevant, but I do definitely think that these worst  
17 offenders need to be paid at a lower rate. So I strongly  
18 support paying them at a lower rate, and here's my thought.  
19 And this is a little bit against the tide.

20 I know we don't like payment discontinuities. We  
21 label them as "cliffs." This might be one of those rare  
22 situations where a cliff helps the program, and for

1 example, I think the 5 percent APM bonus in MACRA is a  
2 beneficial cliff. It's a payment discontinuity that  
3 rewards a particular type of behavior.

4 In this situation, we may want to look at where  
5 the cut points are, and for example, the worst offending  
6 hospices, we may only want to pay them at 60 percent or 80  
7 percent of the fee schedule.

8 So I think if we could look at the cut points and  
9 find the worst group of offenders, find that next tranche  
10 of offenders, and use two or three payment discontinuities  
11 there. I think what you do is every year you keep bringing  
12 that average up, because the worst offenders obviously  
13 wouldn't want to fall off that edge. So we should see  
14 length-of-stay shortening.

15 That was why I had the question earlier about NPI  
16 numbers, Kim. I was just concerned that if every hospice  
17 or if a lot of these offenders had a number of NPI numbers  
18 they could use, they could just simply move between them.  
19 But here, I do think this is an example where a cliff could  
20 be beneficial.

21 Thank you.

22 MS. KELLEY: Mike, do you want to jump in?

1 DR. CHERNEW: Yeah. sure. We're going to go on  
2 in a second, but, Brian, I want to just push on this for a  
3 minute.

4 So, first of all, just to lay the groundwork for  
5 the people here who I think know but certainly for the  
6 folks listening at home, we're not moving now towards a  
7 recommendation this cycle. We're really getting direction  
8 for where to go forward. So hearing these comments are  
9 very useful, including, Brian, your comment about cliffs  
10 and how they might be useful, including the hesitancy to  
11 deal with the home health site neutral stuff and those  
12 types of questions.

13 The thing that I want to throw on the table  
14 earlier rather than later is there's another approach for  
15 our work going forward that might think about different  
16 types of episode models where there can be predictions and  
17 variation around predictions and try in getting the  
18 averages right. So as we go forward, I think we're doing  
19 the exact right thing, which is thinking through, broadly  
20 speaking, as much out of the box as we can, basic  
21 directions for accomplishing our goal.

22 There is the program integrity approach. There's

1 a sort of cliff-type approach, and then I want to throw on  
2 the table maybe an episode approach.

3 I'm not a hospice expert. I did have two  
4 grandparents in hospice, and the hospices were absolutely  
5 angels. But I'm interested in people's broad thinking  
6 about where our broad body of work could go to hopefully  
7 shape a recommendation in future cycles.

8 So with that, Dana, let's move on down the queue.

9 MS. KELLEY: All right. I have David.

10 DR. GRABOWSKI: Great. First, thanks to Kim for  
11 this incredible work.

12 So hospice length of stay has been increasing.  
13 The types of beneficiaries accessing this benefit have  
14 really been shifting. This largely started as a benefit  
15 for cancer patients. Today it's a much more heterogeneous  
16 group of beneficiaries using hospice, especially those with  
17 dementia. Based on MedPAC analyses it's pretty clear  
18 Medicare is overpaying for a lot of these long stays, and  
19 these long stays are grouped in particular agencies. That  
20 needs to be fixed.

21 However, it's also pretty clear that hospice is  
22 really filling an important coverage gap for our

1 beneficiaries with dementia and other conditions. These  
2 beneficiaries lack broader palliative care. They also, in  
3 many instances, lack long-term care. And hospice provides  
4 coverage for both, although I would argue imperfectly.

5           And so I think we sort of have these dual  
6 purposes. One is how do we eliminate wasteful hospice use  
7 while also filling a coverage gap for beneficiaries with  
8 dementia and other conditions? In my opinion we can and we  
9 should be doing both.

10           First, in terms of MedPAC's prior  
11 recommendations, tightening the agency-level cap and  
12 implementing a wage adjustment on that cap, I believe both  
13 of these are really smart and useful reforms. They really  
14 target that inappropriate, wasteful use of hospice in  
15 certain agencies. They, of course, don't fix the bigger  
16 issues around the clinical needs of beneficiaries with  
17 dementia.

18           I feel very similarly about the compliance  
19 thresholds, in that they are great at targeting the  
20 inappropriate use, that wasteful use, but they don't really  
21 get at kind of this coverage gap for our beneficiaries.

22           I generally like site-neutral payment models, but

1 similar to Sue and Marge I'm really worried about this  
2 site-neutral payment model in that I don't think hospice  
3 and Medicare home health are all that similar. I actually  
4 think the better sort of comparison with hospice here would  
5 actually be home care, which is financed, of course, by  
6 either Medicaid or privately out-of-pocket. I think  
7 hospice is maybe substituting for home care, not the  
8 skilled home health care that Medicare pays for. So I'm  
9 not very supportive of moving forward with site-neutral  
10 payment.

11           The chapter also raised kind of other ideas, and  
12 I just wanted to touch on two. One was episode-based  
13 payment. I like this approach. I think it could encourage  
14 some greater flexibility in service delivery if designed  
15 correctly. It could both eliminate some of the wasteful  
16 use but also fill some of the gaps for our beneficiaries.  
17 It would, of course, need to be, like any episode-based  
18 payment model, we'd need to think about low utilization.  
19 We'd need to think about quality measures. There's a lot  
20 to be built in. But I do like that approach.

21           My final comment. We're scheduled to have a  
22 discussion during this meeting on APMs, alternative payment



1 models, tomorrow. We never think about hospice in APMs.  
2 Indeed, they are often left out. I actually think there is  
3 a role for hospice in that discussion and I hope that, over  
4 time, we could think about building hospice into  
5 alternative payment models, because I actually think there  
6 is a real opportunity there, in terms of thinking about  
7 some of the tradeoffs that beneficiaries experience towards  
8 the end of life.

9 I'll stop there. Thanks.

10 MS. KELLEY: Amol, did you have something on one  
11 of David's points?

12 DR. NAVATHE: No. Just a general comment.

13 MS. KELLEY: Okay. I will add you to the queue  
14 then, if that's all right. Jon Perlin, you're next.

15 DR. PERLIN: Thanks for a terrific chapter. I  
16 really have a provocative couple of comments. I align very  
17 much with David on this. You know, philosophically we've  
18 got two issues on the table. One is bona fide need amongst  
19 beneficiaries. The second is misuse or inappropriate use  
20 of the hospice program itself. I think we need to address  
21 the first. My comments are really on the latter.

22 It leads me also to thinking about episode

1 payment, potentially a clip or a clawback, as well. I'm  
2 not a fan of the application of site-neutral payment for  
3 this reason. In this instance, we are conflating the issue  
4 of duration of services with intensity of services. And,  
5 you know, the arbitrage that's going on is a low-intensity  
6 need at a higher-intensity reimbursement.

7           And it really leads me to think that a better  
8 approach, is one that's alluded to, I believe our chair may  
9 have suggested many moons ago, which is really a U-shaped  
10 approach. Because if you think about clinically the  
11 intensity of service in a hospice episode, really orienting  
12 to the new patient, understanding that patient's needs is a  
13 high-intensity activity. There may be a more stable  
14 period, particularly in a more protracted length of stay.  
15 And then as the end comes and the patient succumbs there  
16 may be additional services that are required, that's  
17 certainly what the literature would suggest.

18           So with that in mind it really maps the intensity  
19 of services with an episode-based approach. To be sure, I  
20 think we're probably never going to come up with a system  
21 that's perfect, and Brian's point about a cliff or outlier  
22 or even a retrospective clawback or disproportionate rate

1 of patients over six months or disproportionate rate of  
2 discharge and readmission to try to get around this, would  
3 seem to be a set of mechanisms that gets at the issue of  
4 intensity. Thanks.

5 MS. KELLEY: I have Bruce next.

6 MR. PYENSON: Thank you. I would like to agree  
7 with David and Jonathan on not seeing the value of a site-  
8 neutral approach, but also to point out my opinion that the  
9 work that MedPAC has done in the past, the recommendation  
10 for a U-shaped reimbursement and some of the other changes,  
11 I think should be reiterated. That work, I think, would go  
12 a long way to solving, on a payment basis, the dynamics.

13 I would like to point out that it seems as though  
14 the monitoring of hospices based on their length of stay  
15 and the outlier cases could be redirected to identify the  
16 performance of the certifying physicians, and I think that  
17 might be a better tool to understanding where the issues  
18 are coming from and to create the right kind of attention  
19 to get the issue fixed.

20 And finally I think the issue of integration with  
21 Medicare Advantage is another approach that will take care  
22 -- could potentially deal with a lot of the high portion of

1 the issue as Medicare Advantage is expected to cover 50  
2 percent of beneficiaries in a few years.

3 Thank you. This has been a terrific work,  
4 terrific conversation.

5 DR. CHERNEW: Bruce, just to respond quickly, I  
6 was indeed on MedPAC when we made the U-shaped  
7 recommendation. In fact, I have a published peer review  
8 paper advocating for the U-shaped. What I understand,  
9 because I asked Jim about this a few days ago, is it's not  
10 clear we can have a huge effect by pushing just that, and  
11 what we're looking for going forward is sort of where to go  
12 beyond that. We're moving a bit toward the program  
13 integrity or episode approach, and I think we'll continue  
14 going there.

15 I say that now because at the end I'm going to  
16 want to summarize to give people a sense of where I think  
17 we're going, and then we won't have time to go around again  
18 but people could send messages about how they think my  
19 summary was.

20 But I think Amol is probably next.

21 MR. PYENSON: Thank you. I would ask Jim to  
22 share that analysis that says that won't fix the problem,

1 because I think that would be very helpful.

2 DR. CHERNEW: Yeah, and I see him writing that  
3 down.

4 MS. KELLEY: Mike, I have Karen next.

5 DR. CHERNEW: Oh, I'm sorry. Actually, Karen,  
6 then Amol. I'm sorry. Karen.

7 DR. DeSALVO: No problem, and I'll try to be  
8 quick, given the time. I just very much want to say thank  
9 you to the staff for the thoughtful iteration of this. You  
10 listened to a lot of our comments last time.

11 Like Sue I'm passionate about this area, not only  
12 as a clinician but from personal family experience, and I  
13 think that, you know, the flip side of the program  
14 integrity piece is the number of beneficiaries who should  
15 have access or should take advantage of this kind of  
16 service and don't. So I always want to balance trying to  
17 encourage uptake of this really important service with our  
18 interest in capping unnecessary spending or really looking  
19 for challenges and program integrity.

20 And what I would ask going forward, though, is,  
21 one, can we just make sure we are lifting up more than just  
22 the cost issue and thinking about the beneficiaries, the

1 impact on them with respect to experience, service quality.  
2 The OIG report from a little more than a year ago really, I  
3 think, highlighted some important issues that, you know,  
4 maybe as much as 80 percent of the programs have some kind  
5 of a complaint or problems.

6           So there's some underlying quality and experience  
7 opportunities here for improvement but also, I just want to  
8 make sure that we're thinking about the beneficiary's  
9 experience in the systems. And that's just one as we go  
10 forward, and thinking about it a little more commentary and  
11 understanding of who's in a hospice, who is not, what are  
12 our opportunities to make sure that their service and  
13 experience is of the highest quality and value to them, not  
14 just to the program.

15           But I want to raise something also which is a  
16 third way issue. I understand very much the drive for this  
17 site-neutral payment and to think about can home health,  
18 for example, be a way that we could couch or shape the  
19 payment. I still think that there's some other opportunity  
20 here for us to consider, which is that there is a new type  
21 of benefit, that we're not meeting a need of long-term  
22 debilitated Medicare beneficiaries who them or their

1 families need extra support, especially if they want to try  
2 to stay home.

3           So I hope we'll have a little bandwidth over time  
4 to think about whether there's a new kind of service  
5 benefit, something that meets the needs of these  
6 potentially high-risk and long-term hospice clients. I'm  
7 not sure if it's all just about the revenue or recoupment  
8 from the providers, but that there's some need for  
9 beneficiaries that may only grow as more age and live  
10 longer and acquire dementia and other neurologic  
11 conditions.

12           So if we can put that on the agenda somewhere in  
13 the future, I think that might do a lot of good. It might  
14 be just worth understanding, again, whether the program is  
15 meeting the epidemiologic and clinical changes that are  
16 happening to the beneficiaries. Thanks.

17           MS. KELLEY: I have Betty next.

18           DR. RAMBUR: Thank you so much. So I found this  
19 to be very disturbing as well. I've spent a lot of my life  
20 worrying about overtreatment at the end of life, and I can  
21 tell you that there's nothing that causes more moral  
22 distress to nurses and nursing students than what they see

1 in this cascade of treatment that happens, oftentimes which  
2 then ends with families having to decide to discontinue  
3 treatments that maybe weren't in the best interest to begin  
4 with. And I could go into a story about how my father was  
5 offered dialysis as he was dying. So, you know, we've seen  
6 this first-hand, so I very much support the earlier  
7 comments and what Sue said so eloquently about cost  
8 avoidance.

9           That said, I was stunned to see a 12.6 margin. I  
10 mean, that's astonishing. So we have, you know, the most  
11 vulnerable of people, of which we will all be someday. So  
12 I'm very interested in the ideas around Medicaid Advantage.  
13 I think David mentioned about alternative payment models  
14 and I think that's very interesting, episode-based  
15 payments, or something new, as just was said. Because I  
16 think this need to really create the opportunity for this  
17 sort of healing death that people can have, and cost  
18 avoidance, without having some of this gaming is really an  
19 opportunity if we can figure this out.

20           So I'm really excited to be thinking about all of  
21 this with you.

22           MS. KELLEY: I have Jonathan Jaffery next.



1 DR. JAFFERY: Thanks, Dana. Yeah, I'll try to be  
2 brief. I'm in agreement with many of the comments that  
3 have been made, including some of the ways that David and  
4 Jon framed this around these kind of dual purposes. We  
5 clearly are not meeting the need of a group of  
6 beneficiaries in some ways but there is a need to manage  
7 some of the compliance issues. So, like others, I don't  
8 think that a site-neutral payment adjustment really meets  
9 those dual needs, or even moves us necessarily in the  
10 optimal direction for that.

11 You know, to Brian's points about cliffs, and I  
12 think a compliance threshold may help us think about that a  
13 little bit. I sit on the board of a local hospice, one  
14 that has a pretty high number of beneficiaries in nursing  
15 homes and assisted living, and also with dementia, and yet  
16 still has an average length of stay and live discharge rate  
17 that's in the 25th percentile. So I think there is some  
18 need for us to address some of these, maybe they're  
19 outliers. Maybe it's even more common than that.

20 But my two last comments will be I think  
21 exploring more about episode-based payments I think is a  
22 really interesting idea. I don't have in my mind yet

1 exactly how that might work but I think that's something  
2 for us to think about. And then to get to one of the  
3 specific questions that had come up in the slides, talking  
4 about what are the consequences if we get to a threshold  
5 policy, I would not favor no longer qualifying as a hospice  
6 provider as an early step. I think that could be very  
7 disruptive. I think that's a pretty harsh penalty in some  
8 ways. So I think rather than that, a lower payment rate  
9 that might be prospective for the next year. Hospice is so  
10 reliant on Medicare as a payer that I think that would have  
11 a pretty strong message. Thank you.

12 MS. KELLEY: Pat?

13 MS. WANG: Thanks. So thanks to Sue for context,  
14 really impactful about the value of hospice and a bigger  
15 global picture. I am concerned, though, that the profit  
16 margins really do seem extraordinary, and so I think we do  
17 have to look further into the payment systems.

18 I am supportive about continuing the work around  
19 compliance, because there do seem to be some outliers and  
20 there seems to be ample reason to believe that compliance  
21 thresholds of some kind are necessary.

22 The one thing I wonder about, though, and David

1 Grabowski stimulates this thinking very, very much, the  
2 nature of patients in hospice has shifted tremendously.  
3 And as David says, you know, and Karen alluded to this,  
4 maybe there's a different benefit happening here. In  
5 addition to thinking about varying payment by day and  
6 episode, is it worthwhile to look at different conditions  
7 to essentially kind of case-mix adjust hospice patients?  
8 Because it does seem that the lower lengths of stay, for  
9 cancer patients in particular, do fit with the original  
10 payment model. Their lengths of stay are lower. They seem  
11 to be well within, you know, the boundaries of what's  
12 expected.

13           It does seem that the resource utilization for  
14 folks with dementia and Alzheimer's would be quite  
15 different from those with cancer. And I wonder, given the  
16 mix of patients, whether we could understand first more  
17 about who is in that neurological condition and whether it  
18 would be worthwhile to pursue a line of inquiry around  
19 different resource utilization, because that might be a way  
20 to address sort of right-sizing payment levels, regardless  
21 of length of stay. Thanks.

22           DR. CHERNEW: Thanks, Pat. In fact, I think a

1 case-mix adjustment and an episode model have some  
2 similarities to them, but I think, Amol, let's go to you  
3 and then I'll begin to think about a wrap-up comment.

4 DR. NAVATHE: Great. So I just want to say I  
5 thought a lot of the thoughts I -- I express support for  
6 the direction that we're going in exploring these. I, too,  
7 support exploring an episode-based model, perhaps here less  
8 excited about site neutral.

9 The one thing that struck me is given, you know,  
10 in Slide 5 we had 60 percent of hospice spending for the  
11 greater than 180-day length of stay is it seems to me that  
12 we want to be careful to have a program designed also to  
13 address program integrity issues. We don't want to hold  
14 the program design hostage to these small hospice outliers  
15 that are perhaps doing bad behaviors. And so as part of  
16 our work, I think it might be nice for us to actually carve  
17 out a piece and say this is where program integrity has a  
18 role to play. And so setting that aside, how do we design  
19 a program that works for the vast majority of hospices who  
20 are unlikely to be truly bad actors, if you will.

21 So that's just a point I wanted to add to what  
22 we've said thus far. Thanks.

1 DR. CHERNEW: Let's go to Paul. Paul, I think  
2 you're going to be the last comment before me.

3 DR. PAUL GINSBURG: Okay. Just keep this, you  
4 know, I think it's unfortunate that we use the term "site  
5 neutral" because I don't think that's really what we were  
6 talking about. I think we were talking about paying less  
7 for certain stays, and we don't have to link it to home  
8 health. We could just decide X percent less. But I think  
9 the issue is in dealing with program integrity, are we  
10 going to focus on the stays that seem to be outliers or the  
11 organizations which have a lot of those stays that seem to  
12 be outliers? It's probably a better direction to focus on  
13 the organizations.

14 DR. CHERNEW: Okay. Then let me try and wrap up  
15 quickly as we get to the bottom of the hour and towards  
16 lunch.

17 First, let me reiterate a point that I've made  
18 repeatedly. There's a difference between the level and  
19 form of payment. If we're worried that there's too much  
20 profitability in this sector, I'm not going to comment on  
21 it now. You've all done a lot of work in this part because  
22 there's going to be a payment update recommendation. We

1 can deal with that with the payment update recommendation.

2           This is really a discussion about the form of  
3 payment and the way to deal with things that aren't simply  
4 an up or down on the payment update rule. And I think what  
5 I'm hearing is linking it to site neutral seems to -- I  
6 agree with Paul, it has been a little distracting. But at  
7 the core we're going to have to come up with an approach  
8 that tries to balance this concern about program integrity  
9 and the concern about overall spending, recognizing -- and  
10 I think I want to emphasize particularly for people who are  
11 listening at home, there seems to be -- and I certainly  
12 share this -- universal appreciation for the job that is  
13 done in hospice and a recognition that we have to maintain  
14 and in some ways potentially even expand use of hospices in  
15 certain situations. We have to do that in a way that  
16 maintains reasonable fiscal stewardship. And what I'm  
17 hearing is that we should explore -- and we'll think about  
18 how to do this and come back to you -- two broad  
19 strategies. One I would put in the program integrity kind  
20 of bucket, and the other I would put in the payment reform  
21 kind of bucket, which could include certain types of case  
22 mix adjustments, certain types of episode models,

1 incorporating into A-APMs, thinking about how this is  
2 working in MA, a whole slew of things that fit into that  
3 broader getting the incentives right and deciding how to go  
4 about doing that.

5           So I think we will continue to work through those  
6 things, and I appreciate all of the ideas that have come up  
7 here today. It's actually very useful.

8           I may let Kim react, if she wants, to where we  
9 are. Kim, do you have any reactions, anything you want to  
10 say as we begin to wrap this up?

11           MS. NEUMAN: No, not [inaudible].

12           MS. KELLEY: Kim, we lost your audio there for a  
13 moment.

14           MS. NEUMAN: Oh, sorry. I was just saying that I  
15 think that's a good summary of, you know, directions that  
16 we can pursue going forward. So this has been very  
17 helpful.

18           DR. CHERNEW: Okay. So, Dana, is there anyone  
19 I'm missing? Anything I haven't seen? I'm sorry. Since  
20 we're not moving to a recommendation, I'm not forcing all  
21 of you to weigh in. But you obviously are free to weigh in  
22 whenever you want to. Besides, we're at the bottom of the

1 hour, which is our break time.

2 So, Dana, is there anything I'm missing?

3 MS. KELLEY: No, I don't think so. I just want  
4 to remind our viewers that public comments can be submitted  
5 using the link on the Public Meetings page at MedPAC.gov.  
6 And that's all I have, Mike.

7 DR. CHERNEW: Great. Yeah, so we're going to --  
8 I'll go to lunch. I wish we could go to lunch together  
9 because Lord knows there's no food like Reagan Building  
10 food. And then we're going to come back, we're scheduled  
11 to come back at 2:15. It would be great if you could try,  
12 at least for the Commissioners, to get on somewhere between  
13 -- you know, around 2:10, maybe shortly after that so we're  
14 already to go at 2:15. I think we're going to have two  
15 really good topics after the break. Remember it's a  
16 different link, and, again, thank you all for the session  
17 this morning, and I look forward to our afternoon sessions,  
18 and thanks to everybody who is listening at home. Please  
19 reach out if you have comments.

20 Jim, do you have anything you want to add before  
21 I say "happy lunch"?

22 DR. MATHEWS: No. All good.



1 DR. CHERNEW: Okay. Happy lunch, everybody. See  
2 you around 2:10

3 [Whereupon, at 1:32 p.m., the meeting was  
4 recessed, to reconvene at 2:15 p.m. this same day.]

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1 for-service spending.

2           Despite long-held expectations that private plans  
3 would achieve savings relative to fee-for-service Medicare,  
4 over 35 years no aggregate savings have been realized. We  
5 are presenting a new benchmark approach that builds on the  
6 Commission's public discussion in November 2019. This  
7 approach can be calibrated to improve equity and achieve an  
8 appropriate level of financial pressure on MA payments.

9           In today's presentation, I will provide some  
10 context about the level of financial pressure in MA and  
11 fee-for-service programs and highlight differences in the  
12 two programs' benefit structures.

13           Next, I will review the current MA payment system  
14 and describe issues with its method of setting benchmarks.

15           Then Luis will present an alternative approach to  
16 setting benchmarks. Discussion about that approach will  
17 help shape our work for this cycle.

18           We start by looking at Medicare payments over  
19 time. Research on this topic learns that although private  
20 plans have generated savings in some high-spending regions  
21 of the country, no private plan program has ever yielded  
22 aggregate savings for Medicare. During the early period

1 with payment rates set at 95 percent of fee-for-service  
2 spending and continuing up to 2004, payments to private  
3 plans were biased due to favorably risk selection such that  
4 payments averaged 5 to 7 percent above fee-for-service  
5 costs for similar beneficiaries.

6           Although an improved risk adjustment system was  
7 introduced in 2004, a new benchmark policy introduced by  
8 the Medicare Modernization Act significantly increased  
9 payments to MA plans, reaching a peak in 2009 at 14 percent  
10 above fee-for-service spending. Subsequently, the  
11 Affordable Care Act revised MA benchmark policy and  
12 payments declined. With the ACA revisions fully phased in,  
13 average MA plan payments have been steady for the past few  
14 years, with plans receiving about 2 to 3 percent more than  
15 fee-for-service costs for similar beneficiaries.

16           Although some predicted that MA plan offerings  
17 and enrollment would have declined under the ACA payment  
18 reductions, instead MA plans were able to reduce costs and  
19 increase benefits. The MA program hosts a robust set of  
20 plan offerings and has been growing steadily. Between 2016  
21 and 2020, the share of Medicare beneficiaries enrolled in  
22 MA rose from 32 to 39 percent. The average number of plan

1 choices increased from 18 to 27 plans, and the availability  
2 of a zero-dollar premium plan rose from 81 to 93 percent of  
3 Medicare beneficiaries.

4           Extra benefits include reduced cost sharing,  
5 reduced Part B and Part D premiums, and health-related  
6 benefits such as vision and dental coverage or gym  
7 memberships. The annual value of all extra benefits  
8 increased by about 50 percent, reaching nearly \$1,500 for  
9 2020 and accounting for 13 percent of all MA plan payments.  
10 All of these metrics are near or at record levels in the MA  
11 program.

12           Comparing the MA benefit such to fee-for-service,  
13 one difference is that for most plan enrollees, the choice  
14 of providers is limited to their plan's provider network.  
15 Enrollees accept this limitation in exchange for reduced  
16 cost sharing and health-related benefits the plans offer,  
17 often at no additional cost to the enrollee.

18           In fee-for-service, reduced cost sharing and  
19 additional benefits are available to some through an  
20 employer-sponsored plan while others may purchase a Medigap  
21 supplemental coverage plan. These plans, however, can have  
22 significant costs and excess limitations.

1           In today's discussion, the Commission should  
2 consider whether to expect Medicare savings from the MA  
3 program. If overall benchmarks are not reduced, the  
4 existing system is unlikely to translate plan efficiencies  
5 into savings for the Medicare program. The Commission  
6 should also consider whether the benefit structures are  
7 equitably balanced. Thirteen percent of MA plan payments  
8 fund extra benefits that are not available to fee-for-  
9 service enrollees and that are inequitably available among  
10 MA enrollees due to differing benchmark levels.

11           These inequities exist in the current system  
12 where MA plan quality is not meaningfully measured, and  
13 encounter data limitations hinder our ability to understand  
14 plan efficiency.

15           Next, let's review how Medicare currently pays MA  
16 plans. 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. This share, called the "rebate," ranges  
4 from 50 to 70 percent of the difference and averages about  
5 65 percent. Plans must use their rebate to provide the  
6 extra benefits I mentioned earlier. The remainder of the  
7 bid and the benchmark difference is retained by Medicare.  
8 In the rare cases that a plan bids above the benchmark,  
9 Medicare pays the plan its benchmark, and enrollees must  
10 pay a premium to make up the difference.

11           Now let's look at the current system for setting  
12 benchmarks. A benchmark is established for each county  
13 based on per capita fee-for-service spending. Counties are  
14 ranked lowest to highest and divided into quartiles. For  
15 counties in the lowest spending quartile, benchmarks are  
16 set at 115 percent of local fee-for-service spending.

17           Moving up the quartiles, county benchmarks are  
18 set at 107.5 percent, 100 percent, and then 95 percent of  
19 local fee-for-service spending in the highest-spending  
20 quartile. In counties with low fee-for-service spending,  
21 benchmarks are set above fee-for-service to help attract MA  
22 plans, and in counties with high fee-for-service spending,

1 benchmarks are set lower than fee-for-service to generate  
2 Medicare savings.

3           The 2020 benchmarks average 103 percent of fee-  
4 for-service spending if you ignore the impact of quality  
5 bonuses, which the Commission has recommended eliminating.

6           I will briefly mention a few issues with the  
7 current benchmark system that are described more thoroughly  
8 in the paper.

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

12           Second, the quartile system generates benchmark  
13 cliffs where small differences in county fee-for-service  
14 spending result in large differences in benchmarks.

15           Finally, despite plans' demonstrated efficiency  
16 relative to fee-for-service, with bids averaging 88 percent  
17 of fee-for-service spending, the current system of  
18 benchmarks results in payments to MA plans that are higher  
19 than fee-for-service would be for similar beneficiaries.

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

22           MR. SERNA: Some issues with MA benchmarks could



1 be more fully addressed with major changes to the MA  
2 program, such as uniformity and benefits. Changes like  
3 this would likely entail a larger overhaul to the MA  
4 benefit structure. Over the long term, the Commission  
5 could discuss these kinds of issues. In the short term,  
6 alternatives exist that could be implemented immediately.  
7 A short-term alternative would not preclude any longer-term  
8 structural changes to MA. A revised benchmark system  
9 should have attributes that apply fiscal pressure on MA  
10 plans and support wide availability of plans without paying  
11 excessive rates.

12           These attributes are consistent with general  
13 preferences that many Commissioners favored during our  
14 discussion of MA benchmark alternatives last November:  
15 eliminating benchmark cliffs, bringing benchmarks closer to  
16 fee-for-service spending in the 115 percent and the 107.5  
17 percent quartiles, putting additional pressure on some  
18 benchmarks in the 95 percent quartile, and an immediate  
19 change in benchmarks that is not overly disruptive to basic  
20 supplemental coverage.

21           We have spent the intervening time thinking of an  
22 alternative that more uniformly achieves these preferences.

1 Thus, we present an alternative system for establishing  
2 benchmarks that conforms to Commissioners' preferences and  
3 immediately replaces the current quartile structure. The  
4 system removes the quartile base payments by blending local  
5 area and national spending. It achieves savings by  
6 applying a discount factor to benchmarks. We simulated  
7 benchmarks and payments for this alternative relative to  
8 current policy.

9           We compare our simulations with current base  
10 benchmarks which do not include quality bonuses and are an  
11 estimated 103 percent of fee-for-service. A blended  
12 benchmark alternative would also include prior MedPAC  
13 recommendations which we have incorporated into our  
14 simulations where applicable. We simulate a blended  
15 benchmark with a 75 percent rebate. As we alluded to  
16 earlier, an alternative structure for MA supplemental  
17 benefits will require a longer-term discussion in the  
18 future. More detail on the underlying assumptions used for  
19 our simulations can be found in your mailing material.

20           There are three parts of a blended benchmark  
21 alternative and which we will ask the Commission to focus  
22 on: one, how to weight local and national spending in the

1 blend; two, whether benchmarks should have a floor and  
2 ceiling relative to local fee-for-service spending; three,  
3 what level of savings should be incorporated into  
4 benchmarks through a discount rate? We will go through  
5 these aspects in the next few slides.

6           First, we turn to the weighting of local and  
7 national fee-for-service spending. We focus on comparing  
8 current base benchmarks, as seen in the row in italics,  
9 with blended benchmarks under 50/50 weighting. While we  
10 modeled three different local and national weights, the  
11 50/50 blend is the most promising. We are happy to discuss  
12 the other options that are also detailed in your mailing  
13 material.

14           Overall, a 50/50 blend was the only option that  
15 moved benchmarks in the lowest-spending areas much closer  
16 to fee-for-service while also applying some additional  
17 pressure on the highest-spending areas. For example,  
18 looking at the 10th percentile with fee-for-service  
19 spending in the second column, benchmarks would be lowered  
20 to 106 percent of fee-for-service, which is down from 113  
21 percent currently.

22           One related consideration is whether Medicare

1 should set benchmarks in the lowest-spending areas above  
2 fee-for-service spending in perpetuity or gradually  
3 decrease benchmarks closer to 100 percent local fee-for-  
4 service in these areas.

5           Next, we turned to whether it is appropriate to  
6 apply a benchmark ceiling and floor relative to fee-for-  
7 service spending. Under 50/50 blended benchmarks, 529  
8 counties had benchmarks below the current 95 percent  
9 quartile factor.

10           We looked at the average bid within each of these  
11 areas and found that MA plans showed a propensity to bid  
12 far below fee-for-service spending in most of these areas.  
13 We also found that once blended benchmarks dropped below 90  
14 percent of fee-for-service, they tended to affect rural  
15 areas with low shares of MA enrollment.

16           To balance plan availability and the impact on  
17 overall spending, we simulated a blended benchmark under  
18 two contrasting scenarios: one, a 95 percent floor with  
19 115 percent ceiling; and, two, a 90 percent floor with 115  
20 percent ceiling.

21           Now we turn to a level of savings that the  
22 program should target through a discount rate. Without

1 applying the discount rate, the program is unlikely to  
2 share in plan efficiencies and achieve savings. We  
3 simulated a discount rate of 2 percent. Under a 95 percent  
4 floor, lowering all blended benchmarks by 2 percent yields  
5 savings of 1 percent. Savings of 2 percent are yielded  
6 with a 90 percent floor.

7           While a blended benchmark structure would remove  
8 the payment quartiles, we examined payments by quartile  
9 with fee-for-service spending to compare with current  
10 policy. As seen in this cell on the right-hand side  
11 circled in yellow, a 90 percent floor helps ensure modest  
12 savings of 1 percent in the highest quartile areas.

13           With that, we pull together three policies: a  
14 50/50 blend, a 90 percent floor, and a 2 percent discount  
15 rate. We use these assumptions to assess availability of  
16 basic supplemental coverage in the next slide.

17           Under a blended benchmark structure, nearly all  
18 beneficiaries would continue to have an MA plan available  
19 with enough rebate dollars to cover 2020 levels of cost  
20 sharing. Also, beneficiaries would have access to nearly  
21 the same number of plan sponsors that could cover cost  
22 sharing under current policy. Even beneficiaries in the

1 lowest-spending quartile areas, indicated by the second  
2 column, would have access to five different plan sponsors  
3 offering 12 plans that could provide 2020 levels of cost  
4 sharing.

5           Results were similar when we examined the ability  
6 of plans to provide 2020 levels of both cost sharing and  
7 premium reductions. Taking these measures together, the  
8 relative disruption to beneficiary access to MA basic  
9 supplemental coverage would likely be modest. These  
10 simulations do not assume any change in plan bids. If  
11 plans reduce their bids by half of the decrease in  
12 benchmarks, nearly all plans would be able to maintain  
13 current levels of both cost sharing and premium reductions.

14           Overall, blended benchmarks are one immediate way  
15 to help Medicare realize MA's potential. The Commission's  
16 June 2020 report contends that the growth in Medicare  
17 spending poses a significant challenge, and MA, along with  
18 ACOs, have the potential to serve as vehicles that address  
19 that challenge.

20           MA has not realized this potential in no small  
21 part because of its benchmark structure. Applying  
22 appropriate financial pressure to MA benchmarks through a

1 blended structure could help the program realize savings  
2 and broaden value-based payment in Medicare as plans become  
3 more efficient overall.

4 Over the long term, we may examine the potential  
5 for a more substantial overhaul of the MA payment system.  
6 As noted in MedPAC's earlier work, several other aspects of  
7 the Medicare program are worth considering in conjunction  
8 with such an overhaul, such as redesigning of the Medicare  
9 benefit and standardizing MA plan options.

10 The approach we discuss today would not preclude  
11 such longer-term changes to the MA program but would more  
12 immediately address current problems created by MA  
13 benchmarks and produce savings to Medicare. In the near  
14 term, we are seeking input on a blended benchmark  
15 alternative that could be implemented relatively quickly.

16 For Commissioner discussion, we have the  
17 following questions:

18 Does a blended benchmark of local area and  
19 national fee-for-service spending appropriately balance  
20 financial pressure with geographic equity?

21 Should additional financial pressure be phased in  
22 for areas where benchmarks would still be above fee-for-

1 service spending?

2 Is it appropriate to have a benchmark floor and  
3 ceiling relative to fee-for-service spending in each local  
4 area?

5 And, finally, is 2 percent the appropriate level  
6 of savings for the Medicare program to share in MA  
7 efficiencies?

8 We look forward to your discussion, and now I  
9 turn it over to Mike.

10 DR. CHERNEW: Thanks so much, Andy and Luis.  
11 That was terrific.

12 There is so much here. I have not seen any Round  
13 1 questions, which, by the way, is good. Don't feel  
14 obliged to have one, although, Pat, I am going to lead off  
15 with you for Round 2 anyway. So maybe I could just go to  
16 you, Pat, and you could ask your Round 1 question and jump  
17 into your Round 2 comments. If anyone else has -- oh,  
18 Jaewon does. Here we go. We're getting some.

19 All right. Pat, you go first with Round 1, and  
20 then we'll go to Round 2.

21 MS. WANG: Round 1, yeah, I think that makes  
22 sense. Okay. Yeah, there's a lot here, so my questions



1 may be relevant or not relevant.

2           So the blend takes the market area, in this case  
3 county area, fee-for-service per capita spending and blends  
4 it with the sort of median of all counties or market areas  
5 so treated, right?

6           MR. SERNA: That's correct, yes.

7           MS. WANG: Okay. Is the national average cost  
8 component of that adjusted for cost of living before  
9 blending, or is it just a straight dollar amount per  
10 capita?

11           MR. SERNA: It's a straight dollar amount per  
12 capita that's risk-adjusted to a beneficiary with average  
13 risk.

14           MS. WANG: Okay. In the paper on page 18,  
15 Footnote 12, it kind of goes through some of these  
16 components of blending. But I am not sure that I'm  
17 following it because the terms -- you know, I can interpret  
18 the terms to mean different things. So could you just  
19 clarify? It says that national spending, you know,  
20 assuming -- so you have local area spending and national  
21 spending being the median of the local area per capita  
22 amounts. It then says that beneficiary average fee-for-

1 service spending was 4 percent higher than county median  
2 fee-for-service spending in 2020. What does that mean?

3 MR. SERNA: The United States per capita cost was  
4 4 percent higher than the median --

5 MS. WANG: Okay.

6 MR. SERNA: -- across all local areas.

7 MS. WANG: I got you. So if you just took a  
8 straight average of the fee-for-service per capita, per  
9 beneficiary spending would be 4 percent above the way that  
10 we've done it here --

11 MR. SERNA: Yeah.

12 MS. WANG: -- which is the median of the  
13 counties.

14 MR. SERNA: Yes.

15 MS. WANG: Do you know further what taking the  
16 median of the median of all of the counties further does?

17 MR. SERNA: We don't. So we use CMS' estimates  
18 at county level, and they report the average.

19 MS. WANG: Okay.

20 MR. SERNA: In each county.

21 MS. WANG: Are there other instances in Medicare  
22 payment policy where we have taken unadjusted national

1 average cost calculated this way, medians of county fee-  
2 for-service spending unadjusted to blend into things like  
3 hospital wage index or RBRVS or what have you, actual  
4 dollar amounts to drive payment levels?

5 MR. SERNA: I can't speak to that.

6 MS. WANG: Okay. It's just curiosity. And can I  
7 just ask you, on Slide 17 can you just say what -- there  
8 was the last bullet that applying this financial pressure  
9 through blended benchmark structure could help broaden the  
10 use of value-based payment. Can you explain what that  
11 means? How do you see that happening?

12 MR. SERNA: Sure. So the thought is that as a  
13 little bit more financial pressure is applied to plans,  
14 they'll have to use payment structures that use more value-  
15 based payment. Of course, half or more plans are still  
16 using fee-for-service payment.

17 MS. WANG: Okay. Thank you.

18 MS. KELLEY: Okay. I have Jaewon.

19 DR. RYU: Yeah. I have a quick follow-up  
20 question on one of Pat's question and then a separate  
21 question. The separate question is on Slide 13.

22 You had mentioned -- I think, Luis, you had

1 mentioned that you modeled 50-50, and then I think 70-30  
2 and 90-10. And you made a quick mention of if you had  
3 weighted it the other way, where there would be more  
4 national versus local, it would not yield net savings? Or  
5 can you just walk through that again?

6           So, for example, if the mix was 30-70 instead of  
7 70-30, what would this chart look like?

8           MR. SERNA: All right. So it would put less  
9 financial pressure on the local areas and put more on the -  
10 - I'm sorry -- on the low spending areas and put more on  
11 the high spending areas.

12           So the thought from what we gathered from the  
13 November discussion was that several Commissioners wanted  
14 to bring spending closer to fee-for-service, closer to 100  
15 percent local fee-for-service. So that's basically what we  
16 found is if you go below a 50 percent local weight, you  
17 start deviating from that much more.

18           DR. RYU: Okay. Then the other question gets  
19 back to the wage index question that Pat asked. If you had  
20 adjusted for wage index differences, what would the spread  
21 look like across the different quartiles? Do we have a  
22 sense of that? In other words, how much of the spread is a

1 result of the wage index differences, I guess?

2 MR. SERNA: So I can't speak to that directly. I  
3 would assume that some of it is, but I can't speak to that  
4 directly.

5 The reason why CMS does it this way is because  
6 it's what the actual payments are. So if you get more into  
7 kind of cost-of-living adjustments, you get further away  
8 from what plans are actually paid, and you make this that  
9 much more complex.

10 DR. RYU: Thanks.

11 MS. KELLEY: Larry, did you have something on  
12 this point?

13 DR. CHERNEW: Paul had something on this point.

14 DR. PAUL GINSBURG: Yeah. Let me begin. I was  
15 perplexed about these questions about wage adjustments  
16 because this is all pegged to the fee-for-service  
17 experience, which already has all the wage input and other  
18 adjustments build into it. So as long as Medicare  
19 Advantage is being pegged to the fee-for-service spending,  
20 it's got all those adjustments built in.

21 DR. CASALINO: Yeah. Dana, I was going to say  
22 exactly that, except Paul said it more concisely.

1 DR. CHERNEW: Yeah. I think when we visit that,  
2 I don't want to get distracted here, but it's really the  
3 national part which has an overall thing. So if you were  
4 looking in Miami, you'd have the Miami local, which is all  
5 that built in, I understand, but the national portion of  
6 the blend wouldn't have the Miami-specific adjustment. So  
7 some of the amount has to stay consistent.

8 I don't think that's a big deal for the issues we  
9 have to resolve here. So we can sort through that when we  
10 get to where a recommendation might be. We're obviously  
11 not quite there yet, but I think, Pat, you raise a very  
12 good point. I think it is, in some sense, what I would  
13 call a technical fix to the -- or a technical adjustment to  
14 what's been proposed, but I don't think it's a fundamental  
15 change in the nature of what we're doing.

16 Luis and Andy, do you have any reaction to that?

17 MR. SERNA: That's exactly right. Yep.

18 MS. KELLEY: Okay. Bruce, I have you next with a  
19 Round 1 question.

20 MR. PYENSON: Yeah. Thank you very much. This  
21 is really terrific work and very provocative, which is a  
22 compliment.

1 I've got two questions. One is in the various  
2 simulations, you have described the assumption that plan  
3 bid behavior does not change, and in a couple places,  
4 you've said that plans might actually bid lower.

5 But I'm wondering if you've considered that some  
6 of these changes would cause plans to bid higher, and in  
7 particular, there's enormous pressure, as you mentioned,  
8 for plans to bid low to generate rebate because that's how  
9 you get members through the supplement benefits.

10 What I would ask, how do you think about that,  
11 the opposite happening, with some of the changes, that some  
12 of these changes could actually cause plans to bid higher  
13 than they're bidding now, and what effect would that have?  
14 That's one question.

15 The second question, which folks are used to  
16 hearing me ask about, is on page 22, you talk about a  
17 gradual phase-in of some of these changes, but I don't see  
18 any rationale for gradual change or a comparison to changes  
19 that had been done in previous years, some of which were  
20 pretty dramatic. And MA grew through those. So do you  
21 have any evidence that suggests a gradual change for these  
22 kinds of changes has any justification?

1 Thank you.

2 MR. SERNA: Yeah. Sure. So I'll take the first  
3 question. So on the first question, when we thought about  
4 this, what we reported in the past is that when plans lose  
5 their Star bonus status, they tend to lower bids to keep  
6 the same level of rebates to stay competitive at a rebate  
7 level because there is so much competition in a typical MA  
8 market. It seems likely that plans would want to maintain  
9 their rebate levels, and that's how they responded in the  
10 past.

11 And that's another reason why we also did the  
12 analysis that looked at the availability of plan sponsors,  
13 which was close to unchanged as far as the number of plan  
14 sponsors that could offer a plan with the same levels of  
15 both cost sharing and premium reductions.

16 MR. PYENSON: Just to follow, maybe I wasn't  
17 clear on my question. If the rebate and supplemental  
18 benefits are -- so a plan might decide to take a loss so  
19 that it would gain members to be able to spread its  
20 administrative costs and to gain scale, and without -- so  
21 that's part of what's driving lower bids.

22 Some of the changers we're talking about would



1 take away that incentive to reduce bids, and so I think  
2 plan behavior is just really important. And I'm wondering,  
3 trying to think of how to think of the different sides of  
4 that.

5 MR. SERNA: Sure.

6 DR. CHERNEW: If I can jump in, Andy and Luis?

7 MR. SERNA: Yeah. You can go ahead.

8 DR. CHERNEW: I've done some research on this.  
9 There is a literature on this. I think the general sense  
10 is I'm going to give you a number for my paper because I'm  
11 not egocentric, but others, Mike Geruso, for example, has  
12 done papers and finds a somewhat similar number.

13 A \$1 change in the bid, a drop in the bid, has  
14 been shown to have a -- a drop in the benchmark has been  
15 shown to have roughly a 50 cents drop in the bid, which is  
16 consistent largely with what Luis and Andy were saying  
17 earlier.

18 I suppose the converse is true. If you raise the  
19 benchmark, you might expect bids to go up but not dollar  
20 for dollar. So that's a scoring issue that one could  
21 adjust, and I think there's this core question about  
22 whether we should in the formula have anyone end up with a

1 higher benchmark or whether we should pressure all around.  
2 That's a question I'll leave for Round 2.

3 But the sort of Round 1 version of your question  
4 is I think the academic literature is pretty clear that if  
5 the benchmarks go down, the bids go down, but not dollar  
6 for dollar.

7 MR. PYENSON: Yeah. I'm glad the academics are  
8 looking at this, the behavior of what actuaries are asked  
9 to do, like offer some insight from the real world. So I  
10 think the issue that we're asking is not the empirical  
11 behavior but the motives and what would happen in a change.

12 DR. CHERNEW: We'll continue that probably in a  
13 different round.

14 Luis, do you want to jump in?

15 MR. SERNA: Right. So from a behavioral  
16 perspective, we would see the same, roughly the same number  
17 of plan sponsors in each market, so that competitive  
18 incentive would still be there to offer high levels of  
19 rebate dollars, even as you put more financial pressure on  
20 plans.

21 MS. KELLEY: Marge, do you have a Round 1  
22 question?

1 MS. MARJORIE GINSBURG: Yes, I do. Thank you.

2 I'm interested in the research on the impact of  
3 patient cost sharing on the decisions about choosing  
4 original versus an MA plan.

5 Everybody knows that if you get a supplemental  
6 plan, you have almost no cost sharing whatsoever. With an  
7 MA plan, you have lower monthly premium costs to get in,  
8 but once you're in, you have higher cost sharing when  
9 you're seeing providers and such.

10 So the question then becomes are MA plans doing  
11 better because of their cost sharing is reducing demand,  
12 and once you're on original Medicare with a supplemental,  
13 with very little cost sharing, is that what is inducing a  
14 higher demand because there's so little stop there? So  
15 it's this balancing of the impact of cost sharing on  
16 beneficiaries' decisions.

17 So I hope this isn't too far afield, but I wonder  
18 if our staff can talk about that at all.

19 MR. SERNA: So we commissioned a study, I think,  
20 in 2009, and that's exactly what we found, and we also  
21 reported in 2012. And Bruce has done similar work seeing  
22 that there is an inducement of higher utilization when you

1 have first dollar coverage. So that's is at least  
2 partially where MA plans are getting some of their  
3 efficiencies from.

4 MS. MARJORIE GINSBURG: Maybe this is an add-on  
5 to that, and maybe this is a question for the future, and  
6 that is MA plans using their extra dollars to provide extra  
7 benefits but not necessarily lower cost sharing, and  
8 whether that at all is -- we just leave that alone or  
9 whether we as MedPAC have any comments that luring people  
10 in with gym memberships is not necessarily the best use of  
11 the taxpayers' dollars.

12 MS. KELLEY: Dana, did you have a Round 1  
13 question? Oh, I'm sorry. Andy?

14 MS. MARJORIE GINSBURG: That was a question, I  
15 think.

16 DR. JOHNSON: I was going to say I think that's  
17 some of the commentary in the paper about the potential for  
18 that concern, and that there is some limit on the amount of  
19 cost sharing reductions that plans would be willing to  
20 offer, that they wouldn't want to go all the way to a  
21 first-dollar coverage situation like Medigap plans sell.

22 So there is some money going to other extra

1 benefits that the plans offer, and that share is growing.  
2 So we are highlighting that for discussion at the  
3 Commission.

4 MS. KELLEY: Dana?

5 DR. SAFRAN: Yeah. Just a couple of questions  
6 from me, and this slide that you have up is a good one for  
7 my questions.

8 So one is that I'm trying to understand your  
9 appreciation, let's call it, for 50-50 versus the 70-30,  
10 because I thought that based on some discussion that we had  
11 last time that one of our objectives was really trying to  
12 get everyone as close to 100 percent of Medicare as  
13 possible, which, of course, 70-30 does -- actually, 90-10  
14 does even better, but so I was just curious about that.

15 And then I also wondered why do we not test some  
16 models, or did you, that weighed nationally more heavily  
17 than local?

18 MR. SERNA: So what you said is true that that  
19 was one of the preferences that Commissioners expressed,  
20 but also given the options that were presented in November,  
21 there was also a lot of discomfort expressed with raising  
22 benchmarks for some plans, plans that had a 95 percent

1 quartile factor now going to 100 percent.

2           There was also a little bit of concern for plans  
3 serving the lower spending areas and whether they would be  
4 able to have basic supplemental coverage available for  
5 beneficiaries if this change were to happen immediately.

6           So we were trying to balance those two things in  
7 tandem, and the 50-50 blend was the one that balanced those  
8 two things.

9           Of course, we did look at several different kinds  
10 of weighting factors, aside from these three, but once we  
11 got to a lower local weight, we started to get away from  
12 the other preference that you express, which is getting  
13 everyone closer to 100 percent of fee-for-service.

14           Now, whether you would rather go with a different  
15 weighting structure, that's up to the Commission.

16           DR. SAFRAN: I think it would be helpful to just  
17 see what that would look like because I think if we stand  
18 back and we understand that Medicare pays the same rates  
19 pretty much across the board and so the differences we're  
20 seeing by market are not about different prices for the  
21 most part, they're about different utilization patterns, it  
22 does make you want to lean toward a national benchmark

1 versus a local one that might perpetuate those differences.

2           So maybe that was a Round 2 comment, but since I  
3 have to sign off for a little bit in four minutes, I'll  
4 just squeeze that in there.

5           Another question I have is, do we have any  
6 information or evidence about how quality outcomes or  
7 experiences compare across the quartiles? In other words,  
8 we know we're giving people more benefits, but do we know  
9 if there's a difference in performance across the  
10 quartiles?

11           MR. SERNA: We don't really have a comparison  
12 across the quartiles, mostly because the quality  
13 measurement is done at the contract level, which can span  
14 wide geographic areas, sometimes non-contiguous states, and  
15 that those are going to cover, in a given contract,  
16 multiple counties in different quartiles. Aside from the  
17 other issues we have with the measurement of quality in MA,  
18 there's that reason we haven't done a quartile-by-quartile  
19 comparison.

20           DR. SAFRAN: Okay. And then my last question,  
21 kind of thinking about our ACO work, is there a reason that  
22 benchmarks can't be set relative to a plan's own historical

1 experience and then a blend of local and national?

2 MR. SERNA: That's certainly a possibility,  
3 though that would be for you all to discuss.

4 DR. SAFRAN: Okay. Thank you.

5 MS. KELLEY: Amol?

6 MR. SERNA: In some way --

7 MS. KELLEY: Oh, sorry.

8 MR. SERNA: The historical experience is included  
9 in the bid, and the basis of that has some -- the basis of  
10 the bid has some historical information, but that would be  
11 a different policy of basing benchmarks on some prior bid  
12 information.

13 DR. SAFRAN: Thank you.

14 MS. KELLEY: Amol?

15 DR. NAVATHE: I'm going to forego. I'll just  
16 comment in Round 2.

17 MS. KELLEY: Jim, did you have something you  
18 wanted to get in here?

19 DR. MATHEWS: Yes, I did. So to go back to the  
20 question that Pat asked early on in Round 1, Pat, you asked  
21 if there was precedent for Medicare using national and  
22 local blends in other payment areas. I don't have any



1 direct analog for you, but it would not surprise me if one  
2 exists.

3           But there was an indirect one in that currently  
4 MSSP benchmarks are set using a blend of the ACO-specific  
5 experience and the regional experience, and so there is a  
6 little bit of precedence that we could point to for  
7 proposing something like this.

8           DR. CHERNEW: Okay. I think we have 45 minutes.  
9 I imagine we're going to have a rich discussion. I'm going  
10 to go to Pat in a second. I just want to make an important  
11 framing point.

12           There are two distinct questions on the table and  
13 I want to be clear when you talk as to what you're relating  
14 to. One is what I will call, broadly speaking, the  
15 direction of the form of payment, essential a local blend,  
16 and the second is what I would call technical adjustments  
17 or preferences about how aggressive or not aggressive to  
18 be. So an example would be adjusting for geographic area,  
19 the national part, or moving from 50/50 or 90/10, or in the  
20 other direction, as Dana was talking about, or changing any  
21 other aspects of the discount factor or other things that  
22 are going on.

1 I'm really looking for a sense of how aggressive  
2 you think one might be in terms of setting the formula.  
3 But that is a different question than the type of formula  
4 that uses blend as opposed to the quartile cliff. And  
5 understand that we could take the formula and make it more  
6 flexible. So we could have a different blend even if  
7 you're above or below the national average or some version  
8 of that, if you wanted to do something differently.

9 For now, let's go on to you, Pat. Then we're  
10 going to go to Bruce and to Jaewon.

11 MS. WANG: Great. Thank you, and thank you for  
12 the work. I think attacking the failings of the quartile  
13 system is a really good idea, and I just appreciate,  
14 Michael, what you just said about, you know, tinkering with  
15 elements of it.

16 So there are a couple of comments. First, you  
17 know, I do want to reiterate the importance of the  
18 Commission's past work on encounter data submission, the  
19 risk score recommendations, particularly moving to two  
20 years, contract consolidation and Stars, because these are  
21 all things, especially the last two, that have driven up  
22 the bidding behavior and the cost of the MA program. So I

1 want to start with the importance of those.

2 I also, when it comes to, not the lower -- the  
3 higher fee-for-service quartiles, reiterate, as the paper  
4 notes, that those quartiles do save money for fee-for-  
5 service today, so the aggregate overall observation that  
6 their no savings is aggregated and it's not broken down by  
7 the quartiles.

8 On the tone of the paper I just want to kind of,  
9 for the future, I just want to make a comment that I think  
10 that there's a tone in the paper around supplemental  
11 benefits that needs to come down a little bit, you know,  
12 because on pages 9 and 10, for example, there is some  
13 suspicion that supplemental benefits are kind of being  
14 gamed because plans can load admin and profit into them,  
15 and I just don't think that's a correct assumption. I  
16 think supplemental benefits are real benefits to a lot of  
17 people. You know, actual experience is used for the  
18 supplemental benefits. You allocate what dollars you have,  
19 based on utilization.

20 So there is some kind of suggestion in the paper  
21 that I suggest we tone down a little, that somehow plans  
22 are loading up kind of phony supplemental benefits to

1 leverage this admin and profit thing.

2           I will also say that our experience is that the  
3 supplemental benefits, besides cost-sharing reductions and  
4 premium buy-downs, are very valuable to a lot of  
5 beneficiaries, particularly lower-income, not even down to  
6 dual status, but lower income. Oral care, falls  
7 prevention, medically tailored meals post-discharge, these  
8 are all very valuable, they are highly utilized, and I do  
9 think they have a relationship to reducing avoidable  
10 readmission and so forth.

11           In terms of work, you know, the blend which I  
12 appreciate this may be technical, but on Slide 13 this work  
13 I think succeeds in eliminating the cliffs, but my  
14 understanding from the subsequent recommendation to take an  
15 additional 2 percent discount factors, it doesn't actually  
16 save money.

17           And so I guess that my question is whether, you  
18 know, sort of why are we doing this, and it goes to Dana's  
19 question around if it's to get the benchmarks closer to 100  
20 percent of fee-for-service, I think that the middle  
21 scenario is a little bit more attractive. It's harder on  
22 the low fee-for-service areas but it maintains some of the

1 status quo in the high fee-for-service areas. I don't  
2 think that you can go below 95 percent. Just my personal  
3 view.

4 I realize that in the high-level analyses that  
5 you did within the quartiles it might appear, from a  
6 percentage basis, that that's viable from a modeling  
7 perspective, but my great concern is that there's a huge  
8 amount of heterogeneity inside of each of those quartiles,  
9 and that those high-level sort of conclusions around you  
10 can bid at 90 percent, you can bid at 80 percent are a  
11 little bit too broad a generalization. That's what I fear,  
12 and I worry about that.

13 The question that I raised about the cost-of-  
14 living adjustment for the national spending, if I could  
15 just belabor that for a second. I understand, Paul,  
16 absolutely I agree with you that the local area spending  
17 obviously certainly reflects things like modification that  
18 we do have in the fee-for-service system, wage index, and  
19 RBRVS being two that I can think of. You know, Jim, I  
20 appreciate your comment about the ACOs and the blend  
21 regional and national, but I think that that has more to do  
22 with the trend factor that's applied to establish the

1 benchmark as opposed to the actual dollars.

2           And so I guess where I'm still struggling a  
3 little bit, and when you look at this chart on page 13 it  
4 kind of bears it out, the high fee-for-service areas sort  
5 of -- their benchmarks go up when the blend relies more on  
6 local spending, and the converse is true of the low fee-  
7 for-service areas. I guess that I sort of feel like  
8 there's a relationship between the high fee-for-service  
9 spending areas and cost of living that's reflected in wage  
10 index and some of those other modifications that we do make  
11 to the payment system. It's not all uniform. It just  
12 concerns me that the fee-for-service amount that we are  
13 blending is actually pulling down averages in different  
14 areas, or raising them maybe not appropriately. I may be  
15 wrong about that but it's kind of a question.

16           Again, the quartile analysis in Figure 2 is kind  
17 of the basis for testing the different scenarios. This is  
18 okay, it puts more pressure, people can still afford  
19 supplemental benefits. You know, there's an implicit sort  
20 of theme, like if I could overstate it -- it's not stated  
21 this way in the paper, of course -- but the only  
22 supplemental benefits worth really preserving are cost-

1 sharing reductions and premium buydowns, which I totally  
2 support, cautionary note about the value of other  
3 supplemental benefits, although I certainly understand the  
4 desire to rationalize them a little bit, and I think that's  
5 fine. But I would just be a little bit careful about that.

6           Again, I'm nervous that Figure 2 sort of starting  
7 point that is our benchmark to sort of say we can go  
8 deeper, we can go deeper. The 95th percentile, or the  
9 highest quartile in there, there's mention in the paper  
10 about very outlier characteristics of the Miami-Dade  
11 experience, and I just worry that outlier situations like  
12 that, high and low, may be distorting what is shown in that  
13 quartile analysis.

14           The other thing, and I asked to this when we saw  
15 a version of this earlier, in that Figure 2 quartile  
16 analysis it includes the Stars bonus, but the subsequent  
17 modeling assumes that there is no Stars bonus. I'm still a  
18 little bit worried that the distribution of the Stars bonus  
19 may also be skewing the way the quartiles look and what the  
20 bidding behavior looks like. So I wonder whether there is  
21 a possibility of taking that out and sort of doing an  
22 apples-to-apples comparison -- here's the quartiles today

1 and the bidding behavior with Stars included in the revenue  
2 available and here's what it looks like without the  
3 revenue. I also wonder whether it might be worthwhile, in  
4 looking at the quartile analysis, to take out the outliers,  
5 high and low, so that you -- whether that increases the  
6 reliability of it.

7           The reason that I asked about the value-based  
8 payment comment, Luis, which I really appreciate and I  
9 think it should be a goal of the MA program, absolutely,  
10 and it has to do with my worry about, you know, like Slide  
11 13, lowering benchmarks in the high fee-for-service areas,  
12 even below where they are now, and then taking an  
13 additional 2 percent discount factor. At a certain point,  
14 providers will do better under fee-for-service, because  
15 fee-for-service will actually represent their sort of  
16 special adjustments for cost of living.

17           And I think that I actually have the opposite  
18 concern to your optimism that it would actually pull back  
19 on value-based arrangements, because providers, at a  
20 certain point, would feel like I'm better off just taking  
21 my fee-for-service payment fully loaded than having to deal  
22 with a plan whose benchmark is now 90, which is going to



1 squeeze the heck out of me, because the 90 percent is  
2 actually based on a blend that represents lower-cost  
3 providers. So I'm nervous about that.

4           The final comment, I guess, is, again,  
5 reiterating, I think we should not go below 95 percent,  
6 however we get there. I think that's really too  
7 aggressive. I would prefer to see us fiddle more with  
8 rebate percentages than benchmarks, the reason being if the  
9 desire is to get savings and to sort of smooth a little bit  
10 the availability of supplemental benefits, I'd rather that  
11 a community plan, which is not able to bid 90 percent, not  
12 able to bid the AB benefit for something that makes sense  
13 in a 90 percent benchmark, could have the opportunity still  
14 to bid their actual experience for providing the AB benefit  
15 and maybe provide less in supplemental benefits so that  
16 they don't get put out of business. I'm concerned about  
17 the heterogeneity and the substories that exist inside of  
18 the rolled-up analysis and observations about the  
19 quartiles.

20           The final thing that I would say is -- this is  
21 just a personal -- the term "geographic equity" is used in  
22 the paper, and I think that what is meant there is equity

1 of the availability of supplemental benefits, you know,  
2 people in one part of the country should have access to the  
3 same supplemental benefits as in other parts of the  
4 country, and so part of this blending proposal is to try to  
5 get there.

6           If it's possible to use a different word or a  
7 different term than that, I mean, especially these days,  
8 honestly, I think of geographic equity as being we're  
9 sending more money to the Bronx, not less money to the  
10 Bronx, and I have a personal reaction to the use of the  
11 word "equity" in that term. Just a personal thing.

12           The last thing, you know, let me just throw this  
13 in. A curiosity that I have always had in setting the  
14 benchmarks, whether it's today or under a future proposal  
15 like this, is the treatment of DSH and UCP that is paid to  
16 hospitals serving high proportions of low-income and  
17 uninsured patients. Unlike IME, which is pulled out on the  
18 benchmarks side as well on the payment side, mostly, DSH is  
19 not.

20           And so to the extent that -- and I'll use my  
21 example of Bronx County, overwhelmingly minority,  
22 overwhelmingly poor, highest COVID death rate in New York

1 State, multiple, multiple issues of social determinants of  
2 health and health inequities -- the rate of DSH payments  
3 and the concentration of high-DSH hospitals there drives  
4 the fee-for-service benchmark. And we could have an  
5 interesting conversation about how that translates to plans  
6 that are serving folks who live there.

7           But I just wonder whether that is also something  
8 in this blending approach that might be worth taking a look  
9 at, because the more you blend to national averages the  
10 more all of these distinctions, which were put in there for  
11 a reason, to target specific situations, gets sort of  
12 washed out in the blend. And so I guess that I would want  
13 to make sure that -- it might be an area of opportunity  
14 also to think about, not as an SES adjustment per se but to  
15 do something in benchmarks that represents the condition of  
16 a locality as opposed to trying to come up with SES  
17 adjustments for members, if that makes sense. I'm happy to  
18 pursue that further with you.

19           Those are my comments. I'm sorry. It's --

20           DR. CHERNEW: No, I was just thanking you,  
21 because we have a half an hour and we have about 16 people  
22 to talk.

1 MS. WANG: Thank you.

2 DR. CHERNEW: So I want to thank you, Pat. Luis,  
3 I think you want to say something, so remember, we have  
4 about a half an hour and about 16 people to talk.

5 MR. SERNA: Yeah. I just want to clarify that we  
6 did look at the distribution with any quartile by plan,  
7 which is what Figure 2, it's bids relative to fee-for-  
8 service spending, so that's apart from the actual  
9 benchmarks. And we also looked at it by county, where most  
10 counties within that highest spending quartiles bid far  
11 below fee-for-service spending. That's it. Thanks.

12 DR. CHERNEW: Okay. Bruce, if you can go with  
13 your comments, and then we'll go to Jaewon, and then I'm  
14 going to try and make sure we can move quickly through  
15 people, to make sure everyone gets to comment on our  
16 direction. Bruce.

17 MR. PYENSON: Thank you. Both Pat and I are from  
18 New York so we talk fast.

19 I share Pat's concerns, almost all of them, but I  
20 am supportive of the proposal and I think we can address  
21 the concerns that she has. And it's really important to  
22 address those concerns.

1           One thing, I've been very struck in my four years  
2 as a MedPAC Commissioner at the deep support for Medicare  
3 Advantage that the current crew of Commissioners and others  
4 I've interacted with, and I think that's because we  
5 recognize that there is something about Medicare Advantage  
6 that addresses population health, that addresses medical  
7 management, that addresses quality, socioeconomic  
8 determinants, other aspects of health care that's missing,  
9 that's largely missing from the fee-for-service world, and  
10 in the past we've characterized ACOs as sort of halfway to  
11 Medicare Advantage. So I think Medicare Advantage is  
12 something, there's broad consensus to support.

13           I think the framework that has been presented to  
14 us is a stepping stone in the right direction to have the  
15 Medicare program gain from the successes of Medicare  
16 Advantage. I'm going to suggest some other things,  
17 additional things that have to be done and things that I  
18 think should be done to address the disadvantage that plans  
19 that focus on local populations have, and some of the other  
20 gaming. Some of this are things that MedPAC has  
21 recommended in the past that are absolutely essential for  
22 the survival of the local plans and the various provider-

1 sponsored plans, and I'll get to that in a minute.

2           What I would say about the framework, I am not  
3 particularly concerned with the cliffs in and of themselves  
4 that the current benchmarks have. I think they're not  
5 elegant and there's better ways of doing things. What I  
6 would say is that a simple weighted average of national and  
7 local is better than the cliffs, but it's also too simple.

8           In actuarial science we often use a credibility  
9 formula -- it's a curve -- and that could provide a greater  
10 weight for national, for the highest-cost areas and a lower  
11 weight for national in the lowest-cost areas. It's way  
12 less complicated than anything we're doing now with  
13 benchmarks, so I think there's some real validity there  
14 from a policy and a flexibility standpoint. So I would  
15 urge us to --

16           DR. CHERNEW: I'm sorry to interrupt, and mostly  
17 because I want to emphasize a point. Pat said she wasn't  
18 comfortable going lower than 95 percent in the highest set  
19 of counties and you just made a comment that implies you  
20 are comfortable going below 95 percent in the highest fee-  
21 for-service counties. So sometimes it's really impactful  
22 if I just can call out a very specific modeling choice. I

1 know there's not a lot of time.

2 MR. PYENSON: Well, you know, that's a very  
3 specific modeling choice but I think the answer is  
4 different if you're in a high-cost area or if you're in a  
5 low-cost area. I think a reasonable goal for policy is  
6 that the low-cost areas are doing something right and  
7 they're doing it okay, and we don't want to encourage them  
8 to go higher cost. They should not be higher cost. I  
9 think my overall perspective is that we need to move the  
10 system to overall lower cost, so otherwise we are never  
11 going to meet the goals, the bold goals that, as we said,  
12 the Susan Thompson challenge. So I call that a credibility  
13 formula, and once we've created it, we can calibrate it in  
14 various ways.

15 I do want to emphasize that the current system is  
16 incredibly complex and it's really hard to take one thing  
17 at a time, or even a few things at a time. And in  
18 particular, the world we live in, in MA, is this endless  
19 cycle of bids where the bids are created at pretty much the  
20 beginning of the year when you don't even know what the  
21 results from the previous bid were. And the Medicare  
22 Advantage plans are chasing members through supplemental

1 benefits that often are much more marketing than anything  
2 of substance. And, frankly, you know, we all talk about  
3 evidence-based medicine, and there's probably zero or  
4 negative evidence for a bunch of the benefits I've seen.

5 I think we should move to standards for  
6 supplemental benefits to take away this chaos of  
7 redesigning supplement benefits every 12 months. And in  
8 particular, we've talked about value-based insurance design  
9 and value and how hard it is. The very basic value here is  
10 that we could consider that supplemental benefits have to  
11 go to reduce the Part B premium, have to go to reduce cost-  
12 sharing, and maybe a limited amount for supplemental  
13 benefits. If we do that, that could force the plans to  
14 compete on real value, meaning dollars saved by Medicare  
15 beneficiaries.

16 I think supplemental benefits are critical for  
17 dual eligibles, so we need to address the duals in a  
18 different way. And so I would separate the dual eligibles,  
19 including low-income subsidy folks, from the broader  
20 population of Medicare Advantage, because there are  
21 particular needs there that supplemental benefits, as we  
22 have them now, are addressing, and they're really



1 important.

2           But I want to end by saying that the previous  
3 MedPAC recommendations are really critical to fixing the  
4 benchmarks. So we have -- one of the recommendations was  
5 to use two years of history for risk score calculation.  
6 Why is that critical? Well, that takes away most of the  
7 value of risk score optimization. We have organizations  
8 that are investing hugely in optimizing risk scores,  
9 optimizing quality, the various metrics that are out there,  
10 which they can do because they're well-capitalized  
11 organizations, and the innovators have a rough time doing  
12 that, smaller regional plans. So some of those  
13 recommendations are absolutely critical to fixing  
14 benchmarks, fixing supplemental benefits, and getting a  
15 level playing field. Otherwise, what we risk doing is  
16 actually promoting the further consolidation of the  
17 industry, which is not a good thing in my mind.

18           So I'll hand over the virtual microphone to you,  
19 Mike.

20           DR. CHERNEW: Great. So, again, now we have 20  
21 minutes and we have 15 people -- or 14 people. So, again,  
22 I'm going to -- I apologize in advance if I start making

1 noises while you're talking, but I really do need to get  
2 everybody in, and that's going to send us to Jaewon, and  
3 then we're going to go to Brian, Larry, Jonathan, David.  
4 But then I will do a slashed version where I'm going to  
5 look for very quick reactions to where we're going.  
6 Jaewon.

7 DR. RYU: Yeah, so thank you. Just a couple  
8 thoughts.

9 On the form of payment from a broad concept  
10 standpoint, I'm in favor of some sort of blended approach  
11 that gets us away from the cliffs and the quartiles. I  
12 think that makes sense.

13 That being said, I think -- and Bruce touched on  
14 this, as did Pat. I think the story differs depending on  
15 which of those quartiles or which end of the spectrum  
16 you're in. And at a very high level, I think about the  
17 Medicare Advantage program, the goal, if you're a plan, is  
18 to beat fee-for-service. And if you're in an environment  
19 or a county geography where the spending levels are already  
20 low, it becomes that much tougher to beat fee-for-service  
21 versus if you're in one of the higher-spending counties.

22 Now, that's all other things being equal, but I

1 think the concern is all other things aren't necessarily  
2 equal. So you might be in a higher spending county or  
3 area, and you may have more lower-income members. And, of  
4 course, that makes it tough or tougher to beat fee-for-  
5 service spend as well.

6           So I just feel like if there's some way to  
7 recognize those differences, and it may need to be a  
8 slightly different formula or split between local and  
9 national, depending on where you are not only  
10 geographically with what the fee-for-service level of  
11 spending is, but also where you are relative to, you know,  
12 the mix of your population, I think a model that takes  
13 those things into account would be more desirable.

14           MS. KELLEY: Brian.

15           DR. CHERNEW: Thanks, Jaewon.

16           DR. DeBUSK: Thank you. First of all, I really  
17 enjoyed reading the chapter. I think the methodology is  
18 sound. I really like the 50/50 split. I think it creates  
19 the right balance between a drag on the high-spend areas as  
20 well as giving a little bit back or giving a little bit of  
21 room for the low-spend area. So I like the 50/50. I do  
22 like you taking the rebates straight up to 75 -- to a fixed

1 75 percent. Again, I think the methodology is good, and I  
2 support it.

3 Thank you.

4 DR. CHERNEW: Brian, that was brilliant in its  
5 brevity.

6 MS. KELLEY: Larry is next.

7 DR. CASALINO: I'll also be brief and won't get  
8 into detail, but I wondered reading this why it wasn't more  
9 aggressive. You know, we have several decades of Medicare  
10 Advantage now. It hasn't saved money ever. What has  
11 happened is some large health plans have become very large  
12 risk themselves with taxpayer money and begin buying up  
13 other components of the industry.

14 There is perhaps for some people a presumption  
15 that Medicare Advantage is important for advancing  
16 population health. However, as other Commission reports  
17 have shown, there really is no evidence that Medicare  
18 Advantage improves quality, never mind -- in narrow  
19 measures, never mind population health.

20 I think without going into the details, just in  
21 the interest of time, to me decision after decision in the  
22 report was very conservative and very unaggressive toward

1 plans. But I think the reason for that -- and I'll finish  
2 with this -- is not some kind of bias on anybody's part,  
3 but more kind of an attempt, which isn't too explicit in  
4 what's been written and presented so far, to deal t  
5 heterogeneity and particularly maybe heterogeneity in plan  
6 size and type. So there is a big difference between a  
7 small nonprofit local plan or even a regional plan and a  
8 big publicly traded national plan or international insurer,  
9 let's say. And there are other kinds of heterogeneity as  
10 well, including the geographic heterogeneity we've talked  
11 about and probably some others.

12 I think it might be better to try to think is  
13 there a way to address the heterogeneity directly without  
14 it making us, in my mind at least, too unaggressive in  
15 trying to get the Medicare Advantage plan program to  
16 actually save money for Medicare and demonstrably improve  
17 outcomes for patients.

18 DR. CHERNEW: So, Larry, I'm going to ask you but  
19 then future speakers as well about how you feel about  
20 aggressiveness in the higher fee-for-service spending  
21 areas. When you say that we're not being aggressive  
22 enough, what you just said, do you mean across the

1 quartiles or specific to any given type of quartile? I'm  
2 just thinking about the formula going forward.

3 DR. CASALINO: Yeah, yeah. So, I mean, that's  
4 one form of heterogeneity. I think there are people on the  
5 Commission better situated to speak to that than I am,  
6 Michael. So I'm not trying to dodge the question, but just  
7 not to use up any more time. It's an important question.

8 DR. CHERNEW: Perfect. Thank you.

9 DR. CASALINO: But I guess I would just say we  
10 shouldn't let an unspoken mental model that, oh, there's  
11 heterogeneity out there and we don't want to hurt plans of  
12 a certain type. We shouldn't let that tail wag the whole  
13 dog and let another decade go by where Medicare Advantage  
14 is still not saving money for Medicare and still not  
15 proving that it's improving care for patients.

16 MS. KELLEY: Jonathan Jaffery is next.

17 DR. JAFFERY: Thanks, Dana. So I'll also try to  
18 be brief. I also sort of endorse a number of the things  
19 that Larry just brought up and would favor being a bit more  
20 aggressive. I don't know, Mike, if this will get to your  
21 last comment, but I think Dana started to talk about this  
22 before she fell off the call, but I think there's an

1 overarching issue here about propagating some of the  
2 unjustified geographic variability in spending. We may hit  
3 on this tomorrow morning as well talking about advanced  
4 APMs and ACOs. But I think that to me that's a place that  
5 we need to start thinking about how do we get toward some  
6 sort of national benchmark overall. And, actually, Jaewon,  
7 you mentioned that there's, you know, higher-spending areas  
8 that may be easier to beat fee-for-service. That's the  
9 very similar issue with ACOs.

10           And so I would like to see us think about ways to  
11 be more aggressive and move towards that model, which then  
12 may suggest that we can be more aggressive in some of those  
13 higher fee-for-service spend areas to start with. So I'll  
14 leave it at that and probably talk about this more  
15 tomorrow.

16           MS. KELLEY: David?

17           DR. GRABOWSKI: Great, thanks. First, terrific  
18 work. I have about 25, 20 minutes of comments -- I'm  
19 kidding, Mike. I promise to be brief here.

20           I'm very supportive of this blended approach. I  
21 really think this is a nice kind of pathway. I in an  
22 earlier meeting was supportive of a competitive bidding

1 approach, and I appreciate why, and I think the chapter  
2 outlined that well, why we can't get there in the short  
3 term. But I believe this begins to correct issues with  
4 cliffs and geographic variation while also putting greater  
5 fiscal pressure on some of the plans.

6 I'm with Larry, Jonathan, and others in terms of  
7 being more aggressive in regards to weighting, use of the  
8 ceiling and floor, discount. I would favor a more  
9 aggressive approach. I believe the MA market is strong,  
10 and access to plans will be there under this blended  
11 approach, even with more aggressive rules.

12 A final point I'll make, and this is really to  
13 echo Bruce and Pat's remarks earlier. I, too, am worried  
14 about dually eligible beneficiaries in lower-income areas.  
15 I believe we can do what's proposed here and ensure  
16 sufficient payments to plans that serve these individuals.  
17 I think those goals aren't mutually exclusive, but they can  
18 be complementary, and so I would love to see that built in  
19 here. Let's not make those competing goals but, rather,  
20 ensure that we're also looking out for those lower-income  
21 dually eligible beneficiaries.

22 Thanks, Mike.



1 DR. CHERNEW: Terrific. Dana, was David the last  
2 in the official queue?

3 MS. KELLEY: Yes, he was.

4 DR. CHERNEW: Great. So now I'm going to go  
5 around starting with the people that haven't spoken,  
6 although if you want to jump in and you've spoken, you can.  
7 I think I saw Paul raising his hand. What I'm most  
8 interested to get us forward is to understand again sort of  
9 concisely, if you're supportive of the blend, several  
10 people have said they were, but remember I'm concerned if  
11 there's going to be a lot of opposition if a recommendation  
12 comes with that kind of approach, and then how aggressive  
13 you want us to be overall and particularly in various  
14 versions of the quartiles. You don't have to have an  
15 opinion on everything, but if there's something that's  
16 important to you, I'd like to hear that now, because you  
17 can imagine what's going through my mind in trying to think  
18 about where we can get the consensus, and that's best  
19 served by pointed comments about specific things.

20 So maybe we'll start with you, Paul.

21 DR. PAUL GINSBURG: Sure. I support the blended  
22 approach. I think it's a very effective way of getting at

1 a long festering problem. Striking that when Medicare paid  
2 too much in the 115 percent counties, what it got is a rush  
3 of MA, and it probably wasn't a very productive investment.

4 I would be more aggressive overall. I really  
5 like the point that has been made by a number that the  
6 previous MedPAC recommendations about coding and about  
7 quality bonuses are actually the most -- the first things  
8 that should come, but I'm not going to hold this, any  
9 approach to reduce the overspending we've had, hostage to  
10 if we can't get them through. So I'll just stop there.

11 DR. CHERNEW: Paul, thank you. Next on my list  
12 would be Karen, and then I'm going to go probably to Sue  
13 Thompson.

14 DR. DeSALVO: Well, I guess just on principle I  
15 think the more -- so the shaping principles for me as we  
16 move to first lower cost for the Medicare program, but not  
17 do that in a way that breaks a pathway of an accountable  
18 entity system, Medicare Advantage, that seems to be well  
19 liked or received by an increasing number of beneficiaries.  
20 So I respect and recognize we need to be aggressive in  
21 terms of savings, but also want to reflect that we need to  
22 be balancing that with quality, as we understand more about

1 the quality of the program and how to compare that to fee-  
2 for-service and other programs. I think that's going to  
3 help us get some better insights into what the Medicare  
4 program is actually buying here.

5 I do want to make the comment about the  
6 supplemental benefits which I know sometimes we think of as  
7 gym memberships, but there's a lot more that is done in the  
8 supplemental benefits that Bruce mentioned and maybe Pat  
9 about social determinants of health and ways that we're  
10 thinking more holistically about people's health and  
11 offering benefits, frankly, that even matter for physical  
12 health like dental. And so I just want to be cautious that  
13 we're being -- they have transparency about the quality and  
14 the value of what the beneficiaries are getting. Clearly,  
15 there's something in these programs they really like, but  
16 there's also a goal that's being met around having an  
17 accountable entity that's responsible for the total cost of  
18 health over time.

19 And then finally I just want to say, as always,  
20 we want to make sure we're not leaving anyone behind, so  
21 lower-income and dually eligible beneficiaries, I agree  
22 with David, I don't think we -- I don't think it's an

1 either/or. I don't think we have to make a choice, but I  
2 do think we need to pay a lot of attention to how  
3 aggressive we're being in terms of the benchmark and what  
4 that does to lower-income not only beneficiaries but some  
5 of the smaller regional plans that support them.

6 DR. CHERNEW: Thanks, Karen. Next on my screen  
7 is Susan Thompson and after that will be Amol.

8 MS. THOMPSON: Thank you, Michael. I'll attempt  
9 to be very succinct.

10 Broadly speaking, I do like the idea of blending  
11 national and regional cost. I think it's a fair way of  
12 encouraging MA plans in low-cost areas while providing some  
13 relief to the high-cost areas. But it's certainly a better  
14 methodology than the quartile scheme today.

15 On the technical side, I don't necessarily agree  
16 with adding the discount. That seems heavy-handed in a way  
17 to meet a goal that we might better meet in other ways,  
18 such as switching the Stars program to budget neutral or  
19 maybe getting after some of these rebates that we're  
20 paying. But, nevertheless, I just want to close my  
21 comments by saying we have 40 percent of our Medicare  
22 beneficiaries in an MA plan, so I really appreciate this

1 conversation and the fact we're getting after this.

2 I also just also want to jump on Jonathan  
3 Jaffery's comments about the connection of this  
4 conversation to that that we will have tomorrow around APMS  
5 and that I believe we're at a point we need to have a lot  
6 of conversation about harmonizing the benchmarks of MA to  
7 the work we've done in ACOs.

8 So I'll close with that. Thank you.

9 DR. CHERNEW: Thank you, Susan. Amol, and then  
10 after Amol is going to be Wayne.

11 DR. NAVATHE: Great. Thanks, Mike. So I think  
12 very elegant work, Luis and Andy, so thanks for putting it  
13 together.

14 I would like to voice my support, I think like  
15 many Commissioners, for the blended approach. While I  
16 think there's a lot of different things that we have work  
17 to do on, I think there's a practical approach here that  
18 accomplishes a lot of the goals. So I would say thumbs up  
19 on that.

20 I also, like David and others, would support a  
21 generally more aggressive tack here. For example, in the  
22 higher-spending areas, I think we could be comfortable

1 based on the bidding behavior that we're looking at right  
2 now, going below 95 percent.

3 I think broadly speaking I agree with Sue,  
4 though, it would be nice to see some symmetry across how we  
5 deal with MA and how we deal with A-APMs. Notably, on the  
6 APM side, we oftentimes in episode-based models and others  
7 feel comfortable doing discount rates to guarantee savings  
8 to Medicare. So it doesn't seem to me anathema to be able  
9 to do that on the MA side to drive a little bit more on the  
10 savings front.

11 I think in general I very much appreciate the  
12 idea that supplemental benefits have a lot of value in  
13 duals and low SES populations. I do think that we should  
14 also think about the value of how premium reductions are  
15 also extremely important. While we may not get there  
16 today, I think thinking about how we might reform that to  
17 guarantee more premium reductions as part of the bid below  
18 benchmark percentage or something like that should be an  
19 important piece of future work going forward, as well as  
20 some of the things that David outlined around competitive  
21 bidding and the like.

22 Thanks.

1 DR. CHERNEW: Amol, terrific. Wayne, we're going  
2 to go to you, then Jon Perlin is on my list, or at least on  
3 my screen.

4 DR. RILEY: Yes, I fully concur with the blended  
5 approach, as has been articulated by many of the  
6 Commissioners, and I really appreciate Pat bringing up the  
7 county-specific sort of dimensions, particularly in lower-  
8 income and the dual-eligible community, because as David  
9 said, you know, the goal is not mutually exclusive. So I  
10 am supportive, and I agree that an aggressive approach is  
11 probably prudent and warranted given the penetration of  
12 Medicare Advantage plans around the country, that we won't  
13 hopefully do too much harm by being aggressive, so fully  
14 supportive.

15 DR. CHERNEW: Thank you, Wayne. And then I think  
16 we have Jon Perlin.

17 DR. PERLIN: Thanks. Let me make three points on  
18 this. I appreciate the sense of the Commission that we  
19 want to see MedPAC succeed, and Bruce outlined some of the  
20 reasons. There's active management, there's quality,  
21 there's a population focus, and that active management is  
22 what the payers do.

1           I support a blend. I will diverge a little here  
2 from Bruce, I do think it's important to phase in both for  
3 the protection of the payers as well as the providers. I  
4 think Pat said it well. One immediate effect would be to  
5 sort of squeeze the providers, and not in the sense of  
6 active management of care, but in terms of other actions  
7 like denials, et cetera.

8           That said, I really like Bruce's notion of a two-  
9 year risk score to take some of the emphasis off of annual  
10 optimization.

11           Second, I would not be draconian in the high-  
12 spend areas, even with some of the area wage adjustments or  
13 readjustments, et cetera. The reasons for the high cost  
14 may not be under provider or payers' control, so I have  
15 some angst about that

16           And then, finally, with respect to the  
17 supplemental benefits, I think we need to specify the  
18 standard or essential benefits, but, you know, so there's  
19 more capacity to compare population outcomes, et cetera, in  
20 a reasonable way. But I wouldn't eliminate the  
21 supplemental benefits because I think if these are tools  
22 that the payer can use to actively manage and improve the



1 utilization, why would you strip them? I think those  
2 things become more self-limiting with the blended approach.  
3 And, by the way, one point that I forgot to make that in  
4 the phasing in, I would phase in over an increasing percent  
5 of national.

6 Thanks

7 DR. CHERNEW: Jon, thank you. I'm going to go to  
8 Betty, then Marge, and I think Dana is going to get the  
9 last word. I hope I've got everybody. If not, message me.  
10 Betty.

11 DR. RAMBUR: Thank you.

12 So in our materials, we had a question posed to  
13 us: Should Medicare Advantage have a greater role in  
14 Medicare solvency? And obviously, the answer is yes, and  
15 we're certainly hearing that. I support the blended  
16 benchmarks.

17 When I was first looking at this material and  
18 thinking about this comparison to fee-for-service, I was  
19 somewhat concerned, and of course, fee-for-service has a  
20 lot of inefficiency baked into the cake and a lot of small  
21 area variation that we know a lot about. So I would  
22 support a pretty aggressive approach in the high-spending

1 areas.

2 In terms of supplemental benefits, I need to  
3 ponder that a little bit. I had been more convinced by the  
4 data that hadn't found a lot of outcomes from it, but I'm  
5 also hearing and pondering the arguments for individuals  
6 from disadvantaged backgrounds benefitting from those. So  
7 I'm still pondering that piece, but I really appreciate the  
8 conversation and the effort.

9 Thank you.

10 DR. CHERNEW: Great. Marge?

11 MS. MARJORIE GINSBURG: Yes. Well, like, I  
12 think, the rest of you, I also support the blended  
13 approach.

14 I also support a really aggressive approach. It  
15 has been gnawing at me from day one that we pay MA plans so  
16 much and Medicare has not seen the financial advantage for  
17 the way this has been set up.

18 On the other hand, we also need to be realistic  
19 and pragmatic, and it worries me how often we make really  
20 fabulous recommendations that never get picked up by  
21 Congress or CMS. So it's let's do everything possible to  
22 make this work financially as well as good quality care,

1 but let's also get recommendations that we have some  
2 confidence are going to get passed.

3 Thank you.

4 DR. CHERNEW: And that brings us to Dana, and I  
5 think, Dana, you're going to have the last work. If I've  
6 forgot anybody again, Dana Kelley, let me know.

7 DR. SAFRAN: Thank you, Michael.

8 I will preface my remarks by saying I'm very  
9 sorry that I missed 30 minutes of the conversation, so  
10 really apologize if I'm repeating anything and really am  
11 sorry that I don't get to pick up and underscore things my  
12 colleagues have said.

13 I'll start by saying something that sounds like  
14 it has been mentioned, but the fact that this program has  
15 never had net savings was just so stunning to me and  
16 particularly in light of the conversation we'll have  
17 tomorrow and that, you know, the national conversation  
18 that's ongoing about the APM program and holding it to  
19 account, as we should, for achieving that savings. So  
20 that's just stunning and says to me we do need to get after  
21 this, as everyone has already emphasized.

22 I think I do like the blending approach. I

1 really support that, but as I indicated with my Round 1  
2 questions, I'd like us to understand what the numbers would  
3 look like if we weighted more heavily toward national  
4 versus local and also explore the possibility of including  
5 a plan's own historic benchmark.

6           It sounds like I missed a great suggestion by  
7 Bruce around the possibility of two-year risk scores, which  
8 I think is a great idea, but I also wonder about using a  
9 provider's own historic benchmark or own historic spending  
10 as part of what gets into the benchmark as another way to  
11 help us reduce their kind of ever escalating impact of the  
12 risk scoring that we're seeing.

13           It strikes me that I don't think we fully  
14 understand what's driving the differences in spending  
15 across the quartiles, and I think that's critically  
16 important for us to do in order to really know how  
17 aggressively to go after this. So I would just say that if  
18 possible, doing some analysis to really understand the  
19 drivers of the differences in spending across the quartiles  
20 would be very valuable, but it could be that where that  
21 lands us is, yes, we should be really quite aggressive with  
22 our benchmark in the highest-spending quartile and strive

1 to get the lowest spending to something like 100 percent of  
2 fee-for-service, not so far above it.

3           Then finally, I would say that I would really  
4 encourage us. I heard Andy's explanation of all the  
5 complexity of trying to understand quality, patient  
6 experience, and outcomes across the quartiles, but that  
7 notwithstanding, I think we should do some work to really  
8 understand are we getting better performance from these  
9 different quartiles because I think that can further  
10 underscore the rationale for what we'll propose here  
11 because I suspect, as I imagine the rest of you do, that  
12 we're not going to find the areas where we're spending  
13 more, we're getting so much better patient experience, so  
14 much better quality or outcomes.

15           That's all. Thank you.

16           DR. CHERNEW: Dana, thank you.

17           I will say one thing in response to your comment,  
18 and then we need to move on to indirect medical education.  
19 There's obviously been decades since the work that Wennberg  
20 and the Dartmouth people did looking at geographic  
21 variation. I've even participated in some of that work  
22 with the National Academy of Sciences and other things.

1           My take is twofold, particularly in Medicare,  
2 where in Medicare, it's not prices. It's practice  
3 patterns. There's differences in how much of that is, for  
4 example, post-acute care versus not post-acute care, and  
5 there's literally, as I know you know, decades of research  
6 on geographic variation.

7           My take of the bottom line is we don't have a  
8 really good smoking gun for why the practice patterns vary  
9 so significantly across the country, and my general take is  
10 while I wish I knew the answer, mostly just like to publish  
11 more papers, I think we're going to have to act before we  
12 have full knowledge about what's going on. And we're going  
13 to have to decide how to do that.

14           So to wrap this up, I'm going to go back and  
15 brainstorm with Jim. What I took from this is, there's a  
16 lot of support for the blend. There's some heterogeneity  
17 for the level of aggressiveness. I probably heard slightly  
18 more speakers on the side of more aggressive than less. I  
19 think Pat's concerns are real, and, Pat, you and I can talk  
20 about some details of that. But that's sort of what I've  
21 taken away from where we are, and instead of belaboring  
22 that much more, I think we should jump right into the

1 indirect medical education session.

2           So I'm passing it over now to Alison and Jeff.  
3 I'm not sure which is speaking first. I guess I'll tell by  
4 the voice.

5           MS. BINKOWSKI: Thanks, Mike. This is Alison.

6           DR. CHERNEW: Hi, Alison. Thank you. Take it  
7 away.

8           MS. BINKOWSKI: I am excited to continue a  
9 discussion of Medicare's indirect medical education  
10 payments to acute care teaching hospitals. As a reminder,  
11 the audience can download a PDF version of these slides in  
12 the handout section of the control panel on the right-hand  
13 side of the screen.

14           Today's presentation builds off work presented in  
15 September 2019, with modifications and additional analyses  
16 in response to Commissioner comments and further research.  
17 This presentation will cover three topics: first, an  
18 overview of current Medicare IME policy; second, concerns  
19 with IME policy and potential principles for reform; and  
20 third, results from an illustrative revised IME policy  
21 consistent with these principles.

22           We anticipate that the information in this

1 presentation and your mailing materials will form the basis  
2 of the Commission's June 2021 report.

3           As a reminder, Medicare makes two types of  
4 additional payments to acute care teaching hospitals for  
5 the provision of graduate medical education. The first  
6 type is direct graduate medical education payments, which  
7 totaled \$4 billion in Fiscal Year 2018. These payments  
8 support teaching hospitals' direct costs of sponsoring  
9 residency programs, such as resident stipends and physician  
10 salaries, and are made outside of the inpatient PPSs. The  
11 larger type is indirect medical education payments, which  
12 totaled \$10 billion in Fiscal Year 2018.

13           These payments support teaching hospitals' higher  
14 costs of inpatient care that are not otherwise accounted  
15 for in the Medicare payment policy, such as unmeasured  
16 patient severity and additional costs associated with the  
17 teaching of residents. IME payments are calculated as a  
18 percentage add-on to inpatient PPS payments.

19           The treatment of teaching hospitals' IME costs  
20 varies across the three hospital PPSs and does not align  
21 with teaching hospitals' additional patient care costs.

22           When Congress created the inpatient operating



1 PPS, it specified an IME adjustment in statute, which it  
2 described as a proxy for factors which may increase  
3 teaching hospitals' costs that were not fully accounted for  
4 in the new PPS. The level of the IME adjustment was  
5 originally set at twice the estimated effect of teaching on  
6 hospitals' inpatient operating costs and remains well above  
7 the empirically justified level.

8           In contrast, Congress did not specify whether an  
9 IME adjustment should be included in the inpatient capital  
10 or outpatient PPSs.

11           HCFA decided to include an IME adjustment in the  
12 inpatient capital PPS but based it on its estimate of the  
13 effect of teaching on hospitals' total inpatient costs, not  
14 just capital costs.

15           CMS considered adding an IME adjustment to the  
16 outpatient PPS but stated it was not necessary to ensure  
17 equitable payments to teaching hospitals.

18           We note that because the inpatient operating IME  
19 adjustment is set in statute, if CMS had implemented an IME  
20 adjustment to outpatient PPS, aggregate IME payments would  
21 have only further increased above empirically justified  
22 levels.

1           The IME adjustment and resulting IME payments  
2 vary across the inpatient operating and capital PPSs but at  
3 a high level. For each teaching hospital, CMS calculates  
4 the hospital's teaching intensity, which is a measure of  
5 the hospital's residents relative to its inpatient size and  
6 subject to caps. The hospital's teaching intensity is  
7 converted to an IME percentage add-on, and this IME  
8 percentage add-on is multiplied by the base DRG payment for  
9 a Medicare beneficiary's inpatient stay. The result is  
10 Medicare's IME payment.

11           In Fiscal Year 2018, teaching hospitals received  
12 \$9.5 billion in IME payments from the IME adjustment in the  
13 inpatient operating PPS, including \$6.3 billion for  
14 facility beneficiaries' inpatient stays and \$3.2 billion  
15 for MA beneficiaries' stays. Teaching hospitals also  
16 received a \$0.4 billion in IME payments from the adjustment  
17 in the inpatient capital PPS.

18           The magnitude of the IME adjustments varied  
19 substantially across teaching hospitals. Specifically, in  
20 Fiscal Year 2018, the median IME percentage add-on to  
21 inpatient operating payments, as indicated by the middle  
22 line in the box, was approximately 6 percent. The middle

1 half of teaching hospitals, as indicated by the box,  
2 received an IME adjustment between 2 and 15 percent.  
3 However, some teaching hospitals received just lower or  
4 substantially higher IME adjustment, as indicated by the  
5 dashed whiskers, ranging from less than 0.1 percent to over  
6 33 percent among the top 5 percent of teaching hospitals.  
7 The distribution of IME percentage add-ons to inpatient  
8 capital PPS payments was similar.

9           The Commission and others have raised two main  
10 concerns with Medicare's current IME policy, that it only  
11 applies to care provided in inpatient clinical settings and  
12 that it is not aligned with teaching hospitals' additional  
13 patient care costs in each setting.

14           These two concerns could be addressed in a  
15 revised IME policy. First, moving to an IME policy that  
16 applied to care provided in both inpatient and outpatient  
17 settings would help align IME payments with the  
18 contemporary spectrum of settings in which hospital care  
19 and resident training occurs and make IME payments more  
20 equitable for teaching hospitals that have shifted or will  
21 shift in the future to providing more care and resident  
22 training in outpatient settings. Second, keeping aggregate

1    IME payments initially budget neutral to current policy but  
2    distributing them across settings proportionally to the  
3    effect of teaching on costs would maintain Medicare's  
4    current level of support to teaching hospitals but better  
5    align IME payments with teaching hospitals' additional  
6    patient care costs in each setting.

7            Once empirically justified IME payments exceeded  
8    those under current law, IME payments would be set at their  
9    empirically justified levels. This revised policy would  
10   therefore maintain the higher than justified IME payments  
11   in the short term and increase IME payments relative to  
12   current law in the long term.

13           The updated IME policy could also be designed to  
14   address other concerns. Specifically, the IME policy could  
15   be made more consistent by having the Medicare program make  
16   IME payments for care provided to both fee-for-service and  
17   MA beneficiaries. This revision to a more consistent  
18   policy would ensure teaching hospitals receive equal IME  
19   support for their care of fee-for-service and MA  
20   beneficiaries.

21           To accurately calculate IME payments for hospital  
22   outpatient care provided to MA beneficiaries, Medicare

1 could start requiring hospitals to submit informational  
2 claims on MA beneficiaries' use of hospital outpatient  
3 services, as they currently do for inpatient services, a  
4 requirement that would not only support equitable IME  
5 payments, but also provide a valuable data source to  
6 validate MA plan-submitted encounter data.

7           Second, to increase the accuracy of IME  
8 adjustments and minimize adverse incentives, IME  
9 adjustments should only apply to payments for items,  
10 services, and locations when teaching hospitals have  
11 additional patient care costs that are not accounted for in  
12 current payment policy. Therefore, a new IME adjustment  
13 should not apply to separately payable drugs and devices  
14 nor to outpatient locations where residents do not train.

15           Lastly, to harmonize IME policy across settings  
16 and allow for adjustments over time, CMS could be given the  
17 flexibility to implement a revised IME policy consistent  
18 with these broad principles and to update it over time  
19 through rulemaking.

20           While the effect of a revised IME policy would  
21 depend on the specific design features chosen and related  
22 implementation decisions, to give the Commission a sense of

1 how IME payments might change and the effect on teaching  
2 hospitals' Medicare fee-for-service inpatient and  
3 outpatient revenue, we modeled one revised IME policy  
4 consistent with the principles described in the prior two  
5 slides.

6           These include making IME payments for both  
7 inpatient and outpatient care and maintaining aggregate IME  
8 payments budget neutral to current policy but distributing  
9 them proportionally to teaching hospitals' additional costs  
10 in each setting. More details on the illustrative policy  
11 are in Table 4 and the methodological text box in your  
12 mailing materials.

13           Our regressions showed that the effect of  
14 teaching on patient care costs varied across the hospital  
15 PPSs and differed substantially from current policy.

16           Specifically, under our illustrative policy, the  
17 median IME adjustment in 2018 would have been 2.5 percent  
18 for the inpatient operating PPS, which is less than half of  
19 the median adjustment under current policy and is  
20 consistent with prior MedPAC results; zero percent for the  
21 inpatient capital PPS, as there was no significant effect  
22 of teaching on capital costs, consistent with CMS's

1 conclusion in its 1991 proposed rule; and 4.7 percent for  
2 the outpatient PPS.

3           This larger estimate of the effect of teaching on  
4 patient care costs in outpatient settings could be driven  
5 by several factors, including the more limited policy  
6 adjustments in the outpatient PPS and that resident labor  
7 can substitute for nursing and other clinical care in  
8 inpatient settings.

9           Consistent with the empirical estimates of  
10 teaching hospitals' additional costs described in the prior  
11 slide, under our illustrative budget-neutral inpatient and  
12 outpatient policy, aggregate IME payments would be  
13 maintained but shift towards outpatient care.

14           In particular, as shown in the left-most bar,  
15 current policy IME payments totaled \$10 billion in 2018,  
16 with 95 percent from adjustments to inpatient operating  
17 payments, split across the care of fee-for-service and MA  
18 beneficiaries, and the remaining 5 percent from adjustments  
19 to inpatient capital payments.

20           As shown in the middle bar, under an illustrative  
21 empirically justified but not budget-neutral policy,  
22 aggregate IME payments in 2018 would have decreased and

1 shifted towards outpatient settings, with the share of IME  
2 payments from adjustments to outpatient payments increasing  
3 from zero to 50 percent.

4 Finally, as shown in the right-most bar, payments  
5 could be proportionally scaled such that they are budget  
6 neutral to current policy.

7 While a budget-neutral inpatient and outpatient  
8 IME policy would not change aggregate IME payments, the  
9 redistribution of IME payments towards outpatient settings  
10 would redistribute IME payments towards more outpatient-  
11 centric hospitals.

12 For example, under our illustrative policy, IME  
13 payments to very inpatient-centric teaching hospitals would  
14 have decreased to 22 percent, while IME payments to very  
15 outpatient-centric hospitals would have increased 28  
16 percent. While these are material shifts in IME payments,  
17 the change in IME FFS payments represent only a 1.5 percent  
18 decrease or increase in these hospitals' Medicare fee-for-  
19 service inpatient and outpatient payments.

20 Commensurate with the distribution of more  
21 inpatient- and outpatient-centric hospitals, there would  
22 also be shifts among other groups of hospitals, including



1 decreases in IME payments at for-profit hospitals with a  
2 high share of low-income patients and increases in IME  
3 payments at small and rural teaching hospitals.

4           The results on this slide are from a single year  
5 and assume no behavioral changes. To the extent that the  
6 revised policy facilitated more inpatient-centric hospitals  
7 to become more outpatient-centric, the redistributions  
8 would be attenuated.

9           In summary, current IME policy does not reflect  
10 or support the increasing shift towards outpatient care nor  
11 do IME payments align with teaching hospitals' additional  
12 costs in each setting.

13           During the upcoming discussion session, we look  
14 forward to answering any clarifying questions Commissioners  
15 may have.

16           In addition, we would like the Commission's  
17 feedback on the potential principles for IME reform  
18 summarized in this slide and any other comments on the  
19 information to include in a potential June 2021 chapter.

20           With that, I turn it back to Mike and look  
21 forward to the discussion.

22           DR. CHERNEW: Alison, that was terrific.

1           We are going to start Round 1. The gold star  
2 goes to Bruce for getting his name in the queue early. So,  
3 Bruce?

4           MR. PYENSON: Thank you. On, I think it's page  
5 18, there's a discussion of the case -- inpatient cases  
6 versus outpatient cases. And I'm wondering if you could  
7 describe what's in the outpatient case. My guess is that's  
8 mostly emergency room and outpatient surgery. So I wonder  
9 if you could, like do you have handy the average dollars  
10 per case or what's in there?

11          MS. BINKOWSKI: Unfortunately I do not on my  
12 fingertips have that information, but I can follow up with  
13 you after the call. I suspect that it's mostly ER and  
14 outpatient surgery.

15          MR. PYENSON: So it's not like clinic visits and  
16 things like that. It's really the hospital facility-based  
17 services, and the facility component of that?

18          MS. BINKOWSKI: From a payment perspective, not a  
19 volume perspective. Jeff, did you have something to add?

20          DR. STENSLAND: I'm just going to say that there  
21 will be some additions to the clinic visits, the way we  
22 have it structured, but how large that will be as a share

1 of the total, we'll have to get back to you on.

2 MR. PYENSON: Okay. Thank you.

3 MS. KELLEY: I have Pat next.

4 MS. WANG: Thank you. On page 25 of the mailing  
5 materials I wanted to ask whether you could portray this or  
6 display this according to teaching intensity, unless I  
7 missed it. I mean, it's inpatient size and inpatient beds,  
8 but what about by teaching intensity and what the impact of  
9 the proposal or the thinking would be. I also wanted to  
10 ask why there is such a big negative impact on high-DSH  
11 hospitals of the new calculation. It looks a little  
12 alarming.

13 MS. BINKOWSKI: So taking those in turn, on page  
14 24 we did look at it based on teaching intensity and we  
15 found it was relatively stable across those groups. And we  
16 didn't include it in the table but that's certainly  
17 something that we could. With regards to the highest share  
18 of DSH, the highest quartile, we found that those hospitals  
19 were more inpatient centric, that they received a higher  
20 share of their payments from inpatient, and therefore,  
21 that's the driver of why their payments would shift.

22 DR. STENSLAND: And we want to emphasize these

1 are averages for the group. So within any one of these  
2 groups there will be some distribution of some winners and  
3 some losers.

4 MS. KELLEY: I have Amol next.

5 DR. NAVATHE: So a similar question. I think it  
6 would be helpful to look at that table by teaching  
7 intensity. My question, which is highly related, was how  
8 does the inpatient centrality metric that we're using here  
9 correspond or relate? How is that associated with the  
10 resident-to-bed ratio that we conventionally use for  
11 teaching intensity?

12 MS. BINKOWSKI: Yeah, I will need to follow up  
13 with you on the exact numbers there. There is a  
14 correlation but there are also hospitals with a lot of  
15 residents that are more outpatient centric and there are  
16 ones that are more inpatient. So I can get back to you  
17 with some specifics.

18 DR. NAVATHE: Great. Thanks.

19 MS. KELLEY: Larry?

20 DR. CASALINO: Yeah. If I were a leader at a  
21 teaching hospital, I think I would say, "Oh, my God, MedPAC  
22 is going to do something with IME." And then I would have

1 said, "Oh, look, they're changing their method, it's  
2 supposed to be budget neutral, I'm relieved. At least I'm  
3 relieved if I have a decent amount of outpatient care. But  
4 then I would see -- on the slide that's on now, for  
5 example, slide 12 -- over time transitions that empirically  
6 are just like IME payments."

7           So then I would, if I were that leader but also,  
8 actually if I'm me, I'd try to figure out -- I guess I  
9 don't really understand, technically, how empirically,  
10 justify IME payments increase over time, you know, relative  
11 to the budget now. So the proposal is budget neutral now,  
12 but in 10 years, or 5 years or whatever, would you still  
13 say it's budget neutral if the comparison is to what IME  
14 payments hospitals would be receiving if none of these  
15 recommendations were implemented?

16           MS. BINKOWSKI: Yeah. So the Commission can  
17 continue to, you know, discuss variations to this, but what  
18 was proposed in the paper is that it would only turn to  
19 empirically justified payments once those exceeded those  
20 that were in effect under current law. And the reason  
21 empirically justified payments we suspect will increase  
22 over time is because there's a higher IME adjustment

1 percentage to outpatient payments and they are faster  
2 growing.

3 DR. CASALINO: Okay. It might be helpful to just  
4 explain that a bit more in future reading materials. It  
5 might just be me having a hard time grasping it, but I what  
6 you said is actually very helpful.

7 MS. KELLEY: I have one last round one question  
8 from Jaewon.

9 DR. RYU: Yeah. I just had a question around  
10 what are the inputs for estimating the cost? I'm guessing  
11 it's the cost report, and I think this touches on Bruce's  
12 earlier question around if clinics are included as well, as  
13 those costs also derived out of that same cost report? I'm  
14 just trying to understand what are those data inputs that  
15 help us approximately what cost is?

16 MS. BINKOWSKI: So yes, we did use the cost  
17 reports specifically which will include everything that's  
18 designed a hospital outpatient. It won't include, for  
19 example, rural health clinics, but it would include off-  
20 campus departments and others. So it is a little bit of a  
21 gray area.

22 Do you have more to add, Jeff? We can't hear

1 you, Jeff.

2 DR. STENSLAND: Yeah, maybe this is obvious but  
3 it's just going to be the hospital costs. Like none of the  
4 actual physician salaries will be in there as a cost. It's  
5 going to be the facility costs.

6 DR. RYU: Got it. So to the extent there's  
7 clinic activity, it would only be hospital-based clinics  
8 then. Is that right?

9 DR. STENSLAND: And we had discussed hospital-  
10 based clinics that are on the main campus, or a clinic  
11 where they're actually doing teaching. So if you just  
12 acquired a practice and you didn't do any teaching at that  
13 practice you wouldn't get any IME in that practice.

14 DR. RYU: Okay. Thank you.

15 MS. KELLEY: It looks like there's a few more  
16 questions. Pat?

17 MS. WANG: Thanks. I'm sorry. This occurred to  
18 me afterwards. Is IME case-mix adjusted?

19 MS. BINKOWSKI: So yes, IME is applied to the  
20 wage and case-mix adjusted base rate.

21 MS. WANG: Okay. I don't know if it -- I mean,  
22 that's -- so that's a distributional issue too. There's

1 inpatient beds, there's the IRB. Is case-mix index,  
2 average case-mix, like if it's a big academic medical  
3 center, IME payments might be higher because case mix is  
4 currently higher, which would influence the impact, I  
5 guess, in this redistribution?

6 MS. BINKOWSKI: I will continue to think more  
7 about it, but the new IME policy that would apply to these  
8 base payments would have the same case mix before and  
9 after. So I think what you're talking is maybe certain  
10 hospitals teaching more severe patients on the inpatient  
11 side but less on the outpatient side, and there's a lot of  
12 heterogeneity in that.

13 MS. WANG: So on the outpatient side, how would  
14 you similarly adjust for patient acuity or intensity of the  
15 outpatient service? Is there a way to do that, or would it  
16 be a flat add-on, are you thinking?

17 MS. BINKOWSKI: So the way that we modeled it was  
18 just based on a percentage add-on to the APC. Certain APCs  
19 take into account levels of patient severity, but, you  
20 know, to a lesser extent than in the inpatient setting,  
21 because there's not an equivalent of like MS APCs. So  
22 there's some level of case mix adjustment.



1 MS. WANG: Okay. And the final question is --  
2 I'm sorry?

3 DR. CHERNEW: No. It's just we've got to move on  
4 to round two at some point. Remember, this is round one  
5 questions. You know, I realize there's an intention to  
6 engage, so go on, Pat, but please very brief questions, and  
7 hopefully brief answers.

8 MS. WANG: I'll save it for round two and make an  
9 assumption on the answer. Thanks.

10 DR. CHERNEW: Okay. I think there was someone  
11 left, Dana, in round one?

12 MS. KELLEY: Yes. I think Jon Perlin had a  
13 question.

14 DR. PERLIN: Thanks. Quick question. How are  
15 the number of outpatient clinics measured? Behind my  
16 question is that fungible? What's one clinic today is that  
17 now five tomorrow?

18 MS. BINKOWSKI: So I'm not -- I'd need to look at  
19 more about the way outpatients, the count of them is  
20 measured, but the count of clinics wouldn't affect this.  
21 It's about what counts as a hospital outpatient department.  
22 And as Jeff said before, because we're saying the new

1 outpatient adjustment would only apply where resident  
2 training occurred, if they acquired more or split, you  
3 know, provider practices that would not affect payment. Do  
4 you have more to add, Jeff?

5 DR. DeSALVO: Could you say that one more time,  
6 Alison?

7 MS. BINKOWSKI: The short version was nothing is  
8 based on the count of outpatient clinics, and it also would  
9 only apply to the locations where residents actually  
10 trained.

11 MS. KELLEY: Bruce, did you have one more  
12 question?

13 MR. PYENSON: Yeah, just very quick on semantics.  
14 This slide talks about principles, and I think of MedPAC  
15 principles as being something else, like, you know,  
16 Medicare should know the quality of the outcomes for what  
17 it's spending money on. Are these really principles in  
18 that sense or are they maybe modeling principles as opposed  
19 to policy principles? Because this kind of really locks us  
20 into some pretty specific approaches.

21 MS. BINKOWSKI: Yeah, I'll defer to -- yeah,  
22 there are a lot of different implementation decisions that

1 could be done within these, what we were calling  
2 principles. We're open to other language.

3 DR. MATHEWS: We could call them --

4 DR. CHERNEW: I'm sorry. Bruce, these are just  
5 the traits of the proposal that's sort of on the table and  
6 what's trying to happen, the characteristics of the of what  
7 we're proposing, which is going to lead me to my next  
8 point. I'm sorry for pushing us along. I know you all  
9 want to get to the happy hour.

10 I'm going to go to Wayne in a moment, but the key  
11 thing here is I think Alison and Jeff laid out a direction  
12 to go in, and I know you all may have many broad thoughts  
13 on IME and various issues, but understand what really  
14 matters in this context is how you feel about that  
15 correction concretely, and if you have concerns, what  
16 concrete things you might think we should think about.

17 So with that I'm going to you, Wayne. Wayne, I  
18 think you're muted.

19 DR. RILEY: Thank you, Mike. Quick observations  
20 because I don't think you need too many reactions from me  
21 on this topic. But this is obviously something that MedPAC  
22 has taken a long look at over the years. And given Alison

1 and Jeff did a great job on the paper, you know, from where  
2 I sit, having been in academic medical centers all of my  
3 professional life as a physician and teaching, I'm a little  
4 bit battle-scarred, bruised, and battered like Karen and  
5 maybe others who have been in teaching situations, trying  
6 to get more teaching into the, quote/unquote, "outpatient  
7 setting." And that's been a battle even within the  
8 specialties, and I wonder how robust is the data to suggest  
9 that there's been that much migration into teaching in the  
10 outpatient setting. Because at least anecdotally it  
11 doesn't feel like it's been a big sea change. It may be  
12 there. I may just be oblivious to the data. So I wonder  
13 about that.

14           Second comment is I worry that we have to be  
15 careful that whatever modification to IME policy doesn't  
16 panelize inpatient teaching, or teaching in the inpatient  
17 center. And obviously this is sort of somewhat related to  
18 what we're going through now. We could not manage this  
19 pandemic as an outpatient national enterprise, and so you  
20 don't want to overly penalize inpatient teaching.

21           The other thought I had is where Pat mentioned  
22 the DSH. I happen to lead an organization that is a DSH

1 hospital. And I checked to see what our IME apportion is  
2 today and just as the paper reflects in respect we get more  
3 direct Medicare GME than we get indirect, which again  
4 underscores what I would refer to as the heterogeneity  
5 among teaching hospitals, that from where I sit, serving in  
6 a safety net hospital community, you know, any major shift  
7 in IME may not inure to our benefit and the benefit of the  
8 patients that my particular teaching hospital, and several  
9 others, particularly in inner cities, will experience. So  
10 I'm worried about that as well.

11           You know, when this was all set up, the  
12 regression models, back, I guess, in the '90s or so, you  
13 know, how good were the regression models to factor in  
14 something we had talked about earlier in terms of social  
15 determinants of health and social, quote/unquote,  
16 "factors." I suspect maybe a little bit but probably not  
17 as much as a model should do in 2020 and 2021 and beyond.  
18 So I wonder about sort of the modeling assumptions that  
19 undergird some of the way that this is played out over the  
20 years.

21           Those of us, again, who have been in academic  
22 medicine, we know that even in the outpatient setting we

1 see very, very challenging patients that would not  
2 necessarily be the same in other parts of the community and  
3 other practitioners. So there is a level of complexity in  
4 outpatient teaching hospital care that is not to be sort of  
5 sublimated.

6           Again, you know, this is a tough topic for the  
7 teaching hospital community, but I hope that in arriving at  
8 whatever reforms that we try to take a balanced approach,  
9 that we keep in mind that the heterogeneity among teaching  
10 hospitals is real, the balance sheets of these hospitals  
11 are very different. You know, and again, I guess I have  
12 PTSD from my own experience here in Brooklyn and having  
13 worked pretty much in predominantly safety net teaching  
14 hospital environments throughout my career. So I'm very  
15 sensitive to that, particularly at this time.

16           So I'll turn it back to you, Mike.

17           DR. CHERNEW: Thanks. I think Jonathan -- do I  
18 have that right, Dana? -- and then Brian.

19           MS. KELLEY: Yes, Jonathan is next.

20           DR. JAFFERY: Great. Thanks, Mike. This is a  
21 great discussion, a great discussion, a great chapter and  
22 presentation. It is very complex of an issue.

1           So just to address the notion of how we react to  
2 where we want to go directionally, I'll say that in  
3 general, I'm very much in support of trying to modernize  
4 the funding to align with kind of current and future --  
5 current practice and future goals of where training does  
6 occur and where we want teaching of patient care, where we  
7 see patient care occurring.

8           But I think others have brought up -- and, Wayne,  
9 you spoke of it eloquently just a minute ago around the  
10 significant heterogeneity that exists, and so I think the  
11 question is how do we do this. If we're going to make a  
12 transition, how does it happen fairly and smoothly?

13           I think it's Slide 11, the one before this, where  
14 you show some of the impact on different, currently very  
15 inpatient-centric for outpatient. I get the point that on  
16 overall, fee-for-service payments, it's not a huge amount,  
17 but those are pretty significant swings in the IME  
18 payments, 22 and 28 percent and other things, and the DSH  
19 payment comments that Pat brought up and Wayne commented.

20           So I think trying to find how we do we phase this  
21 in, you speak of this in the chapter, and I think to me, a  
22 phased-in approach is the right way to go, starting with

1 like you proposed, a budget-neutral approach, so that we're  
2 not just taking money away from teaching hospitals right  
3 now.

4 In the chapter on, I think, page 26, you  
5 described a couple of approaches and one to have annual  
6 decreases to other updates. That seemed like a clever way  
7 to try and sort of smoothly adjust payments and remove some  
8 of the unpredictability.

9 Just two more quick things. I like the idea of  
10 giving Congress -- sort of having Congress outline  
11 principles and allowing CMS to adjust the policy over time  
12 and give some flexibility, not just for this policy. I  
13 think that we could see some advantage to that in some  
14 other areas as well.

15 And I guess the one thing that has already come  
16 up a little bit here and I still think needs some fleshing  
17 out there, when we're talking about where residents --  
18 where outpatient resident teaching occurs. You spoke a  
19 little bit about hospital outpatient departments. I don't  
20 fully understand yet how we're going to measure that and  
21 what the optimal way to do that is over time.

22 There may be a lot more fluid movement of where



1 residents spend their time in the outpatient center, an  
2 outpatient setting. We've got this pretty straightforward  
3 in some ways, resident-to-bed ratio, which I think some of  
4 us may argue that it's flawed, but we can understand some  
5 of those flaws. So I guess that would be another place  
6 that I'd like to see a little bit more discussion on this  
7 in future parts of this overall discussion.

8 Thank you.

9 MS. KELLEY: I have Brian next.

10 DR. DeBUSK: Thank you.

11 I was really, really excited to see this chapter  
12 come up again. GME in general has needed an overall for  
13 decades. I've been dealing with residency development  
14 since 2007 when we first started setting up medical  
15 schools, and I knew we were in trouble the moment I saw a  
16 payment formula that had it to the exponentiation of 0.45,  
17 I think, is the number they used. I mean, the formula is  
18 just -- it's ridiculous.

19 So I'm really, really excited to see us take this  
20 on. I think this chapter outlines really the very first  
21 steps, though, the bare minimum. Just getting the payment  
22 distributed more equally between inpatient and outpatient

1 is a great first step, walking those levels down to their  
2 empirical levels.

3 I actually spoke with Ray Stowers, a former  
4 MedPAC Commissioner, former president of the American  
5 Osteopathic Association. He was part of the discussions  
6 with Congress back in the mid-'80s when they cut the  
7 original deal on IME payments, and they literally took the  
8 cost estimate for IME and just doubled it. And that's how  
9 they built it in the package.

10 And I think the assumption at least was that  
11 those levels would be brought down over time, and I think  
12 largely they have, simply because the IME payments are just  
13 bolted straight onto the fee-for-service schedule. So as  
14 fee-for-service inflates, so did the payments.

15 The other thing that I want to talk about,  
16 though, MedPAC got it right. They got it right back in  
17 June of 2010. There is a wonderful report, for those of  
18 you who haven't read it, entitled "Graduate Medical  
19 Education Financing: Focusing on Educational Priorities,"  
20 great report, and it makes observations -- again, this is  
21 10 years ago -- looking at do we have the graduate medical  
22 education program that produces the right mix of physicians

1 by specialty. Are they producing the right geographic mix?  
2 Are we getting value for the money? I mean, these were  
3 questions that MedPAC was asking 10 years ago, and they're  
4 all very valid questions today.

5 So, again, I want to applaud this chapter. I  
6 think it's wonderful. I think a half a loaf is better than  
7 nothing. So, again, I'm a huge advocate for the things  
8 that are being proposed here.

9 What I would ask us to do is, as we revisit this  
10 topic, just consider this, thinking big picture. Do we  
11 really want to take payments tied directly to volume? I  
12 mean, we're supposed to be moving from volume to value, but  
13 we're basically financing graduate medical education with  
14 no regard to geographic mix, to the quality of the  
15 programs, to the mix of specialties. But we're financing  
16 the program with basically add-on payments to the inpatient  
17 fee schedule, and I can't think of -- you know, it's one of  
18 the more regressive things that we do.

19 So I know I'm on a little bit of a soapbox here,  
20 but wonderful chapter, wonderful topic, and I hope that  
21 this is the first step toward broader GME and particularly  
22 IME, but GME, in general, reform. Thank you.

1 MS. KELLEY: I have Pat next.

2 MS. WANG: Thank you.

3 It's great work. I think it's incredibly  
4 important to encourage more investment in ambulatory care,  
5 and so I really applaud the findings and the general  
6 direction and where this would lead.

7 What I was going to ask in the Round 1 was  
8 related to the fact that IME is inpatient only now and the  
9 only places that provide inpatient care are hospitals, when  
10 IME moves to ambulatory, you have a diversity of ambulatory  
11 care settings that I think you would want to encourage, we  
12 would want to encourage residency training in, like FQHCs.

13 I'd just ask you to think about the unintended  
14 consequence of restricting outpatient IME to the hospital-  
15 based outpatient recognized clinic because it could cause  
16 folks to pull people back so that they can get IME, where  
17 what we should be doing, especially in the primary care  
18 area, is sending people out to the community. I don't know  
19 if there's a way to get at that. That's one.

20 The second thing is I am concerned about the  
21 finding on high DSH hospitals and the inpatient-ness,  
22 Alison, that you mentioned. I don't know. I'm just

1 saying, is it time to have a companion recommendation that  
2 DHS similarly be unbundled between inpatient and outpatient  
3 to kind of make those work in sync? To Wayne's point,  
4 outpatient care for underserved populations can be very,  
5 very complicated. So maybe DSH should also be distributed  
6 to match this, so there's not as big an impact.

7           To Brian's point, IME is still based on the per-  
8 click claim for each unit of service, and I don't know  
9 whether you guys have thought about ways of stimulating IME  
10 payments for population health training because that's what  
11 Jonathan works on in his day job and what many, many people  
12 are trying to push towards. And I think that still,  
13 there's a counterincentive in there about training people  
14 to practice better population health that may result in  
15 fewer clicks or units of service or being filled with other  
16 kinds of units of service, like care managers reaching out  
17 or social workers reaching out, that there's this  
18 counterincentive because you're not getting your full IME  
19 payment in.

20           I just wanted to ask you. You probably have  
21 thought about this, but to encourage you to think more  
22 about whether there is a way to do some sort of bundled IME

1 payment or something that would recognize population health  
2 training and not penalize people for reducing the clicks  
3 and units of service.

4           And the final thing that I will say is I think  
5 that this is very, very important work. I will voice a  
6 little bit of a worry for the most inpatient-centric  
7 teaching settings, like academic medical centers who -- I  
8 get that the empirical level doesn't support the level of  
9 payment anymore. We all know that it's baked into their  
10 infrastructure. Their all-payer margins are low. Their  
11 Medicare margins are high because of programs like this,  
12 but their total margins are low compared to non-major  
13 teaching hospitals, AMCs. So I just want to voice a  
14 concern about sort of going -- just figuring out how to  
15 address that in a transition or otherwise.

16           Thank you.

17           MS. KELLEY: Betty, I have you next.

18           DR. RAMBUR: Thank you.

19           I think my comments, hopefully, build well on  
20 that. As I think some of you know, I've spent a lot of my  
21 career as an academic administrator, including in an  
22 academic medical center but on the nursing and health

1 sciences sides. And it's actually from that perspective, a  
2 very curious and interesting thing to ponder, the magnitude  
3 of the subsidy that we'd have a graduate medical education  
4 that really comes from Medicare.

5 Residents certainly -- you know, there's a  
6 discussion of cost, but they also provide a great deal of  
7 labor, particularly over time. So who benefits from that  
8 labor, and how is that factored in?

9 I do think starting to think about outpatient is  
10 a good thing; however, we're still talking about very  
11 facility-centric. And as Pat mentioned in terms of FQHCs  
12 and other kinds of places, how do we start to really align  
13 payment policy so that it addresses evolving societal need?  
14 How do we think about workforce development? Because what  
15 we catalyze with these funds will be created.

16 And then, finally, I know that this is not on the  
17 docket for this conversation, but I can't resist by  
18 commenting. What's the accountability of residents whose  
19 education was, thus, subsidized to accept Medicare patients  
20 down the line?

21 Thank you.

22 MS. KELLEY: Karen, I have you next.

1 DR. DeSALVO: Great. Thank you, guys.

2 So I'll just start by saying, generally, I  
3 support the direction of the chapter, and I think it's a  
4 really great first step. It seems like I share some of the  
5 thinking of some other folks, so just a few comments here.

6 First, I'd like to see the principles either  
7 renamed or to go up a layer, just so that it's clear what  
8 we're trying to get to is more upstream, preventive care  
9 and services and being able to meet beneficiaries where  
10 they are. It's embedded in the chapter, and, Alison, you  
11 described it well in your remarks. But it doesn't come out  
12 crisply. If we're going to present these to Congress, it  
13 feels more financially oriented and like we're being  
14 reactive to what's happening in the field. Whereas, I  
15 think to Wayne's point, we want to be more proactive  
16 because the field is not able to move in this direction  
17 because of the financial constraints and maybe some other  
18 issues. So I would just request that we think about  
19 shaping the principles in that way.

20 I guess from a power standpoint, it feels like we  
21 are moving to more outpatient, but I agree that this is  
22 still -- sorry for my hospital friends -- feels like the



1 power and the money still rests with the hospital, and that  
2 there are some ways that we might really want to push that  
3 envelope as you go forward, so just to the point, for  
4 example, of hospital outpatient departments are being  
5 physically on-site. Even if you started to stretch it, you  
6 can see a context where this would encourage the  
7 acquisition of provider practices instead of partnering  
8 with community-based health centers or private practices.  
9 So, again, thinking about how the money flow really  
10 encourages a partnership with the outpatient environment  
11 and not that what is now a power structure where the  
12 hospital manages the money and residents and decides on  
13 essentially the curriculum.

14           But I agree with trying to pull it off the fee-  
15 for-service chassis and get on to some kind of a population  
16 payment chassis. That would be really great if we could  
17 think about how to do it.

18           I just want to make a final general comment,  
19 having done a lot of teaching and management in the  
20 academic environment. I think the further you could push  
21 this to really -- again, I'm going to use the word "power"  
22 -- to put the power in an outpatient environment, defined

1 very generously, not just a clinic, not just an ER, but  
2 really an environment that's ambulatory or home-based or  
3 virtual, you start to create bandwidth for the faculty in  
4 that environment to become better role models, to do more  
5 quality improvement work, to do more outpatient research.  
6 And that creates a pathway next for our pipeline, the next  
7 generation of physicians and others who are exposed to  
8 those kinds of role models in the outpatient environment  
9 that we just don't really have access to right now.

10           Most of the academic role models for trainees are  
11 in the inpatient environment. That's where they see the  
12 cool quality improvement and research and the leadership  
13 happening. So they see that as a pathway to how they want  
14 to focus their attention, and I just think it would be  
15 fantastic, the more we can create that kind of bandwidth  
16 and leadership opportunity for outpatient leaders and in  
17 the academic environment to really spend the time with  
18 trainees, to spend the time with the patients, but also  
19 doing that, the sort of population health work or the  
20 systems improvement work that is so much better role model  
21 than the inpatient environment because there are more  
22 resources there, not only GME but all the other kinds of

1 resources that we described.

2           So I love the direction. I think we need to keep  
3 going because we need to help pull the system along, not  
4 just react to where it's saying it wants to go, and I think  
5 it will do a lot of good, not just for today but for the  
6 next generation of trainees and beneficiaries.

7           Thanks.

8           MS. KELLEY: Jaewon?

9           DR. RYU: Yeah. A lot of similar comments, but  
10 I'll summarize a couple things that I'd like to throw in.

11           So, one, totally supportive of budget neutrality  
12 and the redistribution towards the outpatient setting for  
13 all the reasons that folks stated.

14           I think, two, I think to Karen's point, this  
15 really should go ideally beyond hospital-based clinics, per  
16 se. I think I can't help but go back to our primary care  
17 chapter from last year that illustrated that -- I think one  
18 of the things correlated with driving more people into  
19 primary care to have an interest in that area was exposing  
20 them to other models and other environments, whether it's  
21 FQHC, traditional clinics, models in the home, and so  
22 forth. And I think we probably want the program to have

1 some recognition that those are valuable settings to have  
2 resident education happen in. So I think ideally it would  
3 be great if there was a way to push into those settings and  
4 not limit it to simply hospital-based clinics.

5 But that leads to number three, and I think it's  
6 a hesitation and concern around how do you estimate cost in  
7 that environment, in those other environments. I don't  
8 think it's as straightforward as the inpatient setting, and  
9 so if you have a model like what's being proposed where  
10 you're trying to keep track of what is an empirically  
11 justifiable cost structure, I think it's a lot more nuanced  
12 and complicated when you take into account the outpatient  
13 settings.

14 Just as a quick example and maybe a simplest  
15 example, having an additional resident in inpatient rounds  
16 doesn't slow down rounds. Having an additional resident in  
17 an outpatient clinic, it does slow down that clinic, but  
18 exactly to what extent and how do you quantify that, I  
19 think those are tougher to get at. And so if there was  
20 some thought into how that could be done, I think that  
21 would really help as you fast-forward this model into the  
22 future.

1 MS. KELLEY: Bruce.

2 MR. PYENSON: I agree with a lot of the comments  
3 that others have made. I would just point out that we've  
4 spent hours and hours talking about the need for more  
5 primary care and hours and hours about the problems with  
6 fee-for-service, but as presented, this program doesn't  
7 address primary care even though it's about training, and  
8 it's all coupled onto fee-for-service.

9 I do support the proposal as a first step, which  
10 is why I think we should not call what we're doing as  
11 principles. It's a first step. And I'd like to suggest a  
12 next step which is to move residency -- on a pilot basis,  
13 move some residency into Medicare Advantage to actually  
14 give Medicare Advantage plans on a pilot basis the  
15 responsibility for residency training. I think Kaiser does  
16 that now, along with their medical school. But I think the  
17 large payers have huge training operations that they  
18 currently do for their own employees. They fund huge  
19 amounts of academic training as well for their employees,  
20 probably on a vaster scale than for the big plans than any  
21 academic medical center.

22 So I think there's some real value there on a

1 primary care basis, and let them come up with a way to move  
2 residents into primary care organizations. A lot of  
3 details to work out, a lot of challenges coming up with the  
4 right dollars. But there's an opportunity there that I  
5 think after we get through the fixes that we're proposing  
6 has some promise.

7 Thank you.

8 DR. CHERNEW: Thanks, Bruce. We're going to move  
9 on in a second. I just want to give people a time check.  
10 We have about 20 minutes, a little bit less, and about 10  
11 people. We can all do the math. So, okay, who's next,  
12 Dana?

13 MS. KELLEY: Paul.

14 DR. PAUL GINSBURG: Thanks. A lot of what I was  
15 going to say has been covered by others probably better  
16 than I could have done. I just want to reinforce the fact  
17 that, over time, there's so many specialties that have very  
18 little involvement in the inpatient setting and actually  
19 very little involvement with the hospital outpatient  
20 setting. So I think we not only need to support this  
21 approach of moving some of the money to outpatient, but  
22 it's really worth looking into how we can get some of it

1 moved beyond the hospital setting to where the training can  
2 most effectively be done.

3           So others have said, probably more articulately  
4 than I have, I think that is a real priority.

5           MS. KELLEY: Jon Perlin.

6           DR. PERLIN: Thanks. You know, like many of you,  
7 I started my career helping to lead a large residency  
8 program, I grew up around academic health systems, et  
9 cetera. And, you know, I've strongly supported the notion  
10 of moving the dollars into the outpatient environment,  
11 those environments where the new health staff are training  
12 and should be trained. But I do have some concerns about  
13 the context.

14           In a perfect world, you know, the funds would be  
15 appropriate to the additional cost, but it's not a perfect  
16 world. It's a world in which we know that risk is  
17 concentrated in certain sorts of medical centers. It's a  
18 world in which we know that there's, you know, on average  
19 losses on Medicare patients. And so I think one has to  
20 figure this imperfect issue into the imperfect context.

21           And so I worry, when Jeff said there will be  
22 winners and losers, that the averages don't tell the story

1 of detail, and some of those losers, particularly when the  
2 average shows that high DSH hospitals lose 6 percent,  
3 becomes particularly concerning. So I think we need to do  
4 another level of homework which is really to determine what  
5 the impact would be on individual institutions. I worry  
6 about this as well for two additional reasons. One, the  
7 unintended consequences, could it suppress the training of  
8 specialties that are desperately needed? I don't know if  
9 any of my other colleagues have tried to hire general  
10 surgeons. They're extremely rare, and, you know, that's  
11 not typically an outpatient-based specialty.

12           And, finally, I just did a little vetting of this  
13 with a colleague who came from a large for-profit system  
14 who had run residency programs there, and I asked what  
15 would happen if in my old life we made plans to eliminate X  
16 number of residency spots. And so as we're looking to a  
17 period of time where we would certainly see more engagement  
18 of all members of the care team, we're also looking to a  
19 period of time where we know there will be physician  
20 shortages. And, you know, something where the reaction  
21 could actually be cutting slots would seem to be  
22 counterproductive.



1           So I favor strongly support for the new training  
2 environments, but really concerned about unintended  
3 consequences around redistribution. The system is on its  
4 face absolutely imperfect.

5           Thanks.

6           MS. KELLEY: Larry.

7           DR. CASALINO: Yeah, just two quick points. One,  
8 we haven't talked about this too much, but I think we could  
9 probably agree without too much trouble that if we were  
10 going to go -- if we could start with a clean slate and  
11 just go back to the drawing board and think about, well,  
12 what's -- just worry about what's the most rational way to  
13 support academic medical centers or teaching hospitals, we  
14 probably would come up with a way that's completely  
15 different. And so a lot of reasons why we're not going to  
16 do that today, but this just goes along with the people  
17 that have already suggested that we might not want to use  
18 the word "principles" for what we're doing because this is  
19 really more on a superficial level.

20           The other point I'd like to make, you know, I  
21 read this and I thought this is very good. I agree with  
22 attaching some support to outpatient as well as inpatient

1 activities. But the comments that Pat and Betty made, and  
2 then especially Karen, have really made me reconsider,  
3 especially Karen's comment. There has been one Medicare  
4 policy after another that has had the unintended  
5 consequence of giving hospitals financial incentives to  
6 acquire physician practices, and, you know, it has  
7 distorted -- in a very short time, it has greatly distorted  
8 the demography of the delivery system, and we don't know if  
9 that's a good thing or a bad thing insofar as there's  
10 evidence so far -- and I think Laurence Baker just came out  
11 with a review of this. I just got it sent to me. I  
12 haven't read it yet. But insofar as there's evidence, it  
13 looks like it's bad for costs and doesn't do anything for  
14 quality.

15           So, you know, any policy -- I hate to see one  
16 more policy that would have the unintended consequence of  
17 essentially subsidizing hospitals to acquire more  
18 practices. And I guess for me that would actually -- that  
19 consideration would actually outweigh the attractiveness of  
20 tying IME to some extent to outpatient care as opposed to  
21 just inpatient care.

22           So I guess to support this recommendation as is,

1 I'd have to be persuaded that it wouldn't subsidize  
2 hospitals to go out and buy more practices, and so far, it  
3 looks to me like it does or would.

4 MS. KELLEY: Mike, that's the end of the queue.

5 DR. CHERNEW: Great. So because we're trying to  
6 move forward hopefully to get to a recommendation, I do  
7 want to be sure to hear from everybody. So I'm going to do  
8 another lightning round. To give you a little sense of the  
9 order, again, some of the faces bounce around on my screen.  
10 I'm going to do David and if you could quit moving around,  
11 then I'll do Amol, and then we'll go from there. But I  
12 think the key thing here is two-fold. One is Brian said  
13 the original model started with a basically doubling of  
14 what people thought would be empirically justified for  
15 cost. We can decide how aggressive to be. That's a  
16 somewhat separate question than this sort of move to  
17 outpatient. And I take both the support for that for the  
18 delivery system and, Larry, obviously, your concern about  
19 consolidation and those types of things is one that I  
20 share.

21 So let's go to David and then Amol, and then  
22 we'll move through it. Please, what I'm mostly looking for

1 is a view about how you feel about the direction that we're  
2 going as we try and get to some form of recommendation on  
3 IME. David.

4 DR. GRABOWSKI: Great. Thanks, Mike. I'm very  
5 supportive of this direction. I do share the same concern  
6 that you, Larry, and others have about consolidation, but I  
7 really like the way this is going. And similar to what  
8 Brian suggested earlier, this has been long overdue for  
9 some reform, so I'm glad we're focusing on it.

10 Thanks.

11 DR. CHERNEW: Thanks, David. We'll do Amol, and  
12 then just to give you heads up, we're going to go to Dana.

13 DR. NAVATHE: Thanks, Mike. So pretty similar  
14 comments. I think -- I'm broadly supportive of the general  
15 direction. I think the questions around DSH hospitals,  
16 consolidation, amongst other things, do give me a little  
17 bit of pause. So I think in some sense the general  
18 direction feels okay. I don't know that we want to make  
19 huge rapid changes or propose huge rapid changes. I think  
20 as people have pointed out what we call "principles" here  
21 probably shouldn't be called "principles." I think they're  
22 directional in nature, and it would be good and helpful, as

1 others have suggested to take a deeper look, just as Jon  
2 Perlin suggested, for example, just to make sure that we're  
3 not doing more harm than good.

4 But, again, just to recap, I do support the  
5 general direction that we're going in.

6 [Pause.]

7 MS. KELLEY: Have we lost Mike?

8 [No response.]

9 MS. KELLEY: Mike, do you want to --

10 DR. SAFRAN: I think Mike wanted me to chime in.

11 DR. CHERNEW: Yes, I did. I'm having an earpiece  
12 problem, so why don't you go ahead, Dana, and then just in  
13 case I lose you all again, we're going to go to Betty,  
14 Marge, and Sue will round out the session.

15 DR. SAFRAN: Great. Yeah, I really have very  
16 little to add to the excellent comments and discussion.  
17 I'm supportive of this work. Larry's concern about  
18 possible further acquisitions by hospitals of primary care  
19 is an important one that I hope we'll pay to, as well as  
20 just, you know, really thoughtful attention to unintended  
21 consequences. But I really appreciate the start to this  
22 work and support moving forward.

1           Thanks.

2           DR. CHERNEW: Great. Thank you, Dana. Betty.

3           DR. RAMBUR: I've previously spoken. I have  
4 nothing to add except to share I concur that we have to  
5 make sure that we do not incent additional acquisitions,  
6 mergers, et cetera.

7           DR. CHERNEW: Sorry. My recordkeeping's not so  
8 good. Marge.

9           MS. MARJORIE GINSBURG: Yeah, I'm on board with  
10 everyone else with the similar caveat about making sure we  
11 don't have unintended consequences. Whenever given an  
12 opportunity for large health care systems to make their  
13 systems larger, they will all take advantage of it. So we  
14 need to be particularly attentive to that.

15          DR. CHERNEW: Thank you, Marge. Sue.

16          MS. THOMPSON: Yes, and I'll close quickly.  
17 Generally, I'm quite supportive. I was happy to see the  
18 chapter appear in the bundle of material this time. I  
19 would just close out that I really do like the opportunity  
20 of connecting this work to other challenges we have,  
21 including addressing primary care shortages and overall  
22 transforming the health care system from fee-for-service to

1 value by thinking about incenting opportunities for  
2 training and environments where population health is the  
3 centerpiece of the work.

4 So thank you. That would conclude my comments.

5 DR. CHERNEW: Sue, thank you.

6 So I will wrap up in a minute, but, Alison and  
7 Jeff, do you have any reactions to this? I think the most  
8 important one would be the concern about consolidation,  
9 thinking through that. We can talk about that now or  
10 offline. Why don't I give you a chance to talk before I  
11 wrap up?

12 Alison, I think you're muted.

13 MS. BINKOWSKI: I think we can continue this  
14 offline. It was a really helpful discussion. I think we  
15 did try to address minimizing adverse incentives, including  
16 acquisitions in the future, and we did include some  
17 information on not just the aggregate support on different  
18 groups of hospitals, but how it would apply in the 70th  
19 percentile, but those are both things we can get into.

20 DR. RILEY: Yeah, Mike, this is Wayne. Don't  
21 forget the DSH hospital impact as well.

22 DR. CHERNEW: Yes. Thanks, Wayne. I should have

1 let you have the first and the last word. Jeff.

2 DR. STENSLAND: I think it's -- we're going to  
3 work through the details later. The natural tension is  
4 going to be there's some concern about DSH hospitals and  
5 some of the more inpatient-centric hospitals losing  
6 something and a desire to make it budget neutral and a  
7 desire to give some more money to some things outside of  
8 the hospital, so that process of -- that will be a  
9 difficult math to work out. I think the acquisition to  
10 physician practices, there might be some more creative  
11 solutions we can do on that.

12 DR. CHERNEW: Yes, I think that's right. And,  
13 Wayne, thank you for the point about DSH hospitals. I  
14 think the challenge we're going to face in all of our work  
15 as we try and implement the Thompson principle of being  
16 bold and concerned about what we spend is it turns out when  
17 you spend less, someone gets less. And most of the actors  
18 are doing good things in a whole variety of ways. That's  
19 true in hospice. It's true in graduate medical education.

20 I think we're going to continue to struggle with  
21 those types of tensions. I am struck by the discrepancy  
22 between what I would call the empirically justified amount



1 and the way that we're paying right now. And I think that  
2 if we face a problem in particular types of organizations  
3 or particular things, sometimes my instinct is to try and  
4 correct the formula, and then find ways if we think more  
5 money belongs in DSH hospitals to give more money to DSH  
6 hospitals, not to have an IME payment system that is not  
7 particularly efficient, for example. There's a whole range  
8 of other things in which that would be true for me.

9           So just to give you an idea of where we're going  
10 to go, we will regroup. We're going to move this forward.  
11 I did hear a lot of support for moving it forward. I heard  
12 a lot of general support for the principle of expanding  
13 this to be a little bit less inpatient-centric, and as this  
14 becomes closer to a recommendation and more concrete, I  
15 continue to look forward to your feedback about how we can  
16 make sure that it's an improvement over the existing  
17 system. And I do believe that medical education is sort of  
18 the foundation for the entire American health care system.  
19 So we do have to give a lot of thought to the incentives  
20 and the consequences of how we train our physicians of the  
21 future and do that in a way that supports the delivery  
22 system as we make that transition.

1           So I'll give a lot of thought to it. It's  
2 honestly not my area compared to something like MA or APMS,  
3 but I have learned a ton, and I really appreciate the  
4 comments. So many of you have had so much time in  
5 organizations and, frankly, being trained, that makes this  
6 helpful for me.

7           So I think I've got -- did anyone not get a  
8 chance to talk?

9           [No response.]

10          DR. CHERNEW: All right. Then we are going to,  
11 with three minutes under budget, adjourn. There will be --  
12 I think there's a happy hour invitation so we can get  
13 together and just catch up and relax. But, again, I really  
14 want to thank the staff across the board, not just Jeff and  
15 Alison for this presentation, but all the staff that  
16 presented today. They always do a terrific job, and,  
17 again, I want to thank you for your comments. I think we  
18 had four important sessions, and I think we really had some  
19 really good discussions and got to where I hope we're  
20 moving in the right direction in all those places.

21          So, again, we start tomorrow morning at 9:30.  
22 Please try and come at 9:25 so we can actually really start

1 at 9:30. And thank you very much to the audience. I'll  
2 reiterate there's ways on the website and others ways to  
3 reach us.

4 Dana or Jim, do you want to add any thank you's,  
5 comments, or just a sigh of relief that the day's over?  
6 Whatever it is that works for you.

7 DR. MATHEWS: All good.

8 MS. KELLEY: All set, Mike.

9 DR. CHERNEW: Okay. Then with that, a hearty  
10 good-bye for today, and we'll catch up tonight or tomorrow.

11 [Whereupon, at 4:59 p.m., the meeting was  
12 recessed, to reconvene at 9:30 a.m. on Friday, October 2,  
13 2020.]

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MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Via GoToWebinar

Friday, October 2, 2020  
9:30 a.m.

COMMISSIONERS PRESENT:

MICHAEL CHERNEW, PhD, Chair  
PAUL GINSBURG, PhD, Vice Chair  
LAWRENCE P. CASALINO, MD, PhD  
BRIAN DeBUSK, PhD  
KAREN B. DeSALVO, MD, MPH, Msc  
MARJORIE E. GINSBURG, BSN, MPH  
DAVID GRABOWSKI, PhD  
JONATHAN B. JAFFERY, MD, MS, MMM  
AMOL S. NAVATHE, MD, PhD  
JONATHAN PERLIN, MD, PhD, MSHA  
BRUCE PYENSON, FSA, MAAA  
BETTY RAMBUR, PhD, RN, FAAN  
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Vertical integration and Medicare payment policy	
- Rachel Schmidt.....	75

P R O C E E D I N G S

[9:30 a.m.]

1  
2  
3 DR. CHERNEW: Hello, everybody, and welcome to  
4 our Friday morning session of the October MedPAC meeting.  
5 I thought we had a great day yesterday. I'm looking  
6 forward to a good day today.

7 We have two important topics. The one we're  
8 doing now is one of my favorites, alternative payment  
9 models, and then we're going to have a session on vertical  
10 integration. Because I happen to have some inside  
11 information that a lot of people want to talk today, I'm  
12 going to say nothing else except hand it right over to  
13 Geoff. So, Geoff, you're up.

14 \* MR. GERHARDT: Thank you. Good morning. Today  
15 Rachel Burton and I are going to talk about the evolution  
16 of Medicare's advanced alternative payment models.

17 Several other analysts contributed to this  
18 presentation, so you might hear from David Glass, Luis  
19 Serna, Jeff Stensland, Nancy Ray, or others answering your  
20 questions in the Q&A section.

21 As a reminder to the audience, a PDF version of  
22 these slides can be downloaded from the handout section of

1 the control panel on the right hand of the screen.

2 We begin today's presentation by highlighting the  
3 major legislative actions on alternative payment models  
4 that have occurred over the last ten years.

5 Then we will provide an overview of each of the  
6 three types of Medicare's advanced alternative payment  
7 models and highlight some of the changes made to these  
8 models over the last decade.

9 Based on our review of past and current models,  
10 we identify some additional changes that might further  
11 improve the models going forward. We would like to get  
12 your input on these ideas, as well as any others you might  
13 have.

14 We'll start today by providing some history about  
15 the development of advanced alternative payment models,  
16 also known as A-APMs.

17 Medicare has designed and tested alternative  
18 payment models for decades. In 2010, the Affordable Care  
19 Act made several important changes. The law mandated that  
20 CMS create a permanent accountable care organization  
21 program, called the Medicare Shared Savings Program.

22 The ACA also created the Center for Medicare and

1 Medicaid Innovation, which is charged with creating A-APMs  
2 that show promise in improving quality of care while  
3 slowing growth in program costs. CMMI is allocated \$10  
4 billion every ten years, and models may be expanded in  
5 scope and duration if doing so would reduce spending  
6 without decreasing quality or improve quality without  
7 increasing spending.

8           MACRA, which was enacted in 2015, introduced the  
9 concept of advanced alternative payment models.

10           Advanced APMs are models which meet criteria for  
11 use of electronic health records, quality measurement, and  
12 level of financial risk on providers beyond what non-  
13 Advanced APMs require. MACRA encourages qualifying  
14 providers to participate in Advanced APMs by offering an  
15 annual 5 percent bonus for professional services above what  
16 they would be paid if they weren't in an A-APM.

17           The creation of CMMI, combined with the MACRA  
18 incentive, have led to growth in the number of providers  
19 participating in A-APMs and beneficiaries who receive care  
20 from them. CMS reports that during 2018, 183,000  
21 clinicians participated in an Advanced APM and collected an  
22 A-APM bonus, compared to 99,000 the year before.



1           Next, I'll turn to an overview of current and  
2 forthcoming A-APMs.

3           Advanced alternative payment models generally  
4 fall into three categories.

5           The first category is population-based models.  
6 These types of models are also sometimes referred to as  
7 shared savings models or accountable care organizations.

8           The second category is episode-based payment  
9 models, also known as bundled payment models.

10          The third category is advanced primary care  
11 models.

12          One of the reasons we're exploring this topic is  
13 that based on evaluations of A-APMs tested to date, these  
14 models have not produced the results stakeholders and  
15 policymakers are hoping for.

16          Generally speaking, evaluation reports and other  
17 studies of these models find that the quality of care is  
18 maintained, and oftentimes some measures improved.

19          Some models also have shown changes in  
20 utilization patterns, such as decreases in emergency  
21 department visits, hospitalizations, and use of  
22 institutional post-acute care.

1           These utilization changes have sometimes resulted  
2 in gross reductions in Medicare spending per beneficiary  
3 compared to beneficiaries cared for by comparison  
4 providers.

5           However, the reduction in gross spending is often  
6 outweighed by shared savings or performance payments made  
7 to participating providers, resulting in statistically  
8 insignificant changes or increases in net Medicare  
9 spending.

10           The type of APMs that the most clinicians  
11 participate in are population-based payment models, also  
12 known as ACO models. About a quarter of original Medicare  
13 beneficiaries are in this type of model.

14           This slide gives some high-level information  
15 about four current population-based models. More detailed  
16 fact sheets for these models -- as well as the other  
17 Advanced APMs we will review today -- are available in  
18 Commissioners' mailing materials.

19           ACOs are groups of providers who agree to be held  
20 accountable for the cost and quality of care delivered to a  
21 defined population of patients over a one-year period.

22           For each organization, CMS sets a spending target

1 for assigned beneficiaries, called a "benchmark."

2           If actual spending for an ACO's beneficiaries is  
3 below the benchmark, the organization can receive a share  
4 of the savings it generates.

5           On the other hand, if an organization's spending  
6 exceeds its benchmark, it may owe a share of the cost  
7 overruns if it has opted for a "two-sided" risk  
8 arrangement.

9           Performance on quality measures is used to adjust  
10 the size of organization's shared savings and losses.

11           I'll note that in addition to broad-based models  
12 like MSSP and NextGen ACOs, CMS has also tested an ACO-  
13 style model for beneficiaries with end-stage renal disease.

14           The population-based payment model with the most  
15 participants is the Medicare Shared Savings Program.

16           During the eight years of MSSP's existence, CMS  
17 has made several updates, many of which were finalized in a  
18 2018 redesign that CMS termed "Pathways to Success."

19           These updates were partly intended to encourage  
20 more ACO participation and included requiring participating  
21 ACOs to assume greater financial risk more quickly.

22           Pathways to Success also employs longer five-year

1 contracts and offers ACOs annual flexibility in determining  
2 whether beneficiaries are assigned retrospectively or  
3 prospectively.

4 Pathways to Success also made several changes to  
5 the way benchmarks are calculated, including basing  
6 benchmarks on an ACO's historical spending blended with  
7 their region and allowing ACOs' beneficiaries' risk scores  
8 to increase their benchmarks by up to 3 percent.

9 Next year CMS plans to launch a new ACO-style  
10 model, called "Direct Contracting," which can be thought of  
11 as a successor to the NextGen model.

12 Both are two-sided models, but Direct Contracting  
13 will allow providers to take on less risk sharing, if they  
14 want.

15 Direct Contracting also requires that providers  
16 receive some form of prospective payments; whereas, this  
17 was optional in NextGen.

18 Direct Contracting will also allow beneficiary  
19 assignment to happen as often as quarterly, instead of the  
20 usual annual determination. And it will allow smaller ACOs  
21 to participate and not require prior experience with risk  
22 sharing.

1           The agency also plans to launch a version of this  
2 model for beneficiaries with chronic kidney disease.

3           CMS has tested many versions of bundled payment  
4 models over the years, going back to the Heart Bypass  
5 Center Demonstration in the 1990s.

6           On this slide we provide some basic information  
7 about the three episode-based payment models that are  
8 currently underway and another that is scheduled to begin  
9 in January. More detail about each of these models is in  
10 your mailing material.

11           All episode-based payment models share a basic  
12 premise: hold providers accountable for the cost of  
13 services furnished over a specified period of time  
14 (commonly 90 days) during and following a triggering  
15 clinical event (such as knee replacement surgery).

16           On the next slide, I will talk about some of the  
17 trends we have seen as different approaches to these models  
18 have been tested.

19           The vast majority of Medicare's episode-based  
20 models have paid providers on a fee-for-service basis, then  
21 reconciled actual spending to the episode's target price.

22           There have been calls for more prospective

1 payment models that would make a single payment for each  
2 episode of care. But CMS has found providers face  
3 challenges in implementing prospective payments, especially  
4 when multiple providers are involved in a patient's care.  
5 The upcoming Radiation Oncology model will use prospective  
6 payments, although the range of costs covered by that model  
7 are narrower than other episode-based models, so it should  
8 be easier to implement.

9           The agency has also faced challenges when trying  
10 to implement mandatory models, and most have been  
11 voluntary. The CJR model was originally mandatory in 67  
12 metro areas, but was later reduced to mandatory in just 34.  
13 And three proposed mandatory models were canceled in 2017  
14 before being implemented.

15           Another notable trend has been movement away from  
16 episodes triggered only by hospital stays. Episodes in  
17 most current models can be triggered either by inpatient or  
18 outpatient events.

19           Finally, target prices in newer models tend to be  
20 adjusted for more factors, such as case mix and peer group  
21 characteristics. This has the effect of making target  
22 prices more specific to each provider, which is seen as

1 more likely to attract participation in voluntary models.

2 I'll now turn things over to Rachel to talk about  
3 advanced primary care models.

4 MS. BURTON: Over the past ten years, Medicare  
5 has experimented with several advanced primary care payment  
6 models, which are summarized as fact sheets in your  
7 mailing.

8 The current iteration is called "Comprehensive  
9 Primary Care Plus," or CPC+, and has 2,700 practices in it.

10 Advanced primary care models ask practices to  
11 engage in care processes associated with the patient-  
12 centered medical home model of care and offer technical  
13 assistance with this.

14 They in turn offer risk-adjusted payments per  
15 beneficiary per month layered on top of existing fee-for-  
16 service payments, and they tie a portion of model payments  
17 to performance on quality measures. These models are also  
18 usually multi-payer efforts.

19 In the forthcoming Primary Care First, the agency  
20 has made some changes that depart from CPC+.

21 CMS will offer much larger performance bonuses  
22 than before and base them primarily on performance on one

1 measure -- acute hospital utilization.

2 CMS has offered increasingly large monthly  
3 payments per beneficiary in its models, and Primary Care  
4 First continues this trend.

5 It will also shift some of participants' fee-for-  
6 service payments into capitated payments, which is an  
7 approach CMS experimented with in CPC+ but on a smaller  
8 scale, with only half that model's practices.

9 And, finally, the geographic reach of these  
10 models has been gradually expanding: primary care  
11 practices in 14 states and five cities can currently  
12 participate in CPC+, and Primary Care First will include  
13 those areas plus eight additional states.

14 I'll also note that CMS is planning to launch a  
15 model called Kidney Care First, which is based on Primary  
16 Care First but tailored to beneficiaries with chronic  
17 kidney disease.

18 In reviewing the various models we've talked  
19 about in this presentation, some issues emerged to us.  
20 These could be addressed through some model changes that we  
21 hope you will discuss and give us feedback on.

22 Before I get into these, I want to make an



1 overarching point, which is that in designing models, CMS  
2 has to navigate a tension between making models effective  
3 and attracting broad provider participation.

4           Models that have stringent spending or quality  
5 targets might generate net savings for Medicare, but they  
6 may not attract very many participants.

7           On the other hand, if you make models easier to  
8 succeed in, a lot of providers may be attracted to the  
9 models, but they might not generate savings for Medicare.

10           More specifically, ways that models could be  
11 improved include strengthening providers' incentives to  
12 deliver care more efficiently, such as by increasing the  
13 percent of shared savings and losses used in models,  
14 setting benchmarks lower, limiting the degree to which  
15 beneficiaries' risk score growth can inflate benchmarks,  
16 and lowering episode-based payment models' target prices  
17 through deeper discounts or quality withholds.

18           Of course, the things I just mentioned are hard  
19 to do in a voluntary model, since providers can exit such  
20 models if they think they are not financially advantageous  
21 enough for them.

22           But if CMS were to make greater use of mandatory

1 participation in models, it could do all of the things I  
2 just mentioned and, thus, increase the likelihood of  
3 generating net savings for Medicare.

4           Models could also experiment with more actively  
5 engaging beneficiaries in choosing where they get their  
6 care, such as by distributing information on who the high-  
7 value providers are in their area.

8           There are also some changes that might increase  
9 the likelihood of evaluators detecting impacts of payment  
10 models.

11           CMS could pare down the number of models it tests  
12 and instead focus on those models that hold the most  
13 promise, which could reduce provider confusion. If CMS  
14 enrolled larger numbers of providers in these models, it  
15 could also detect smaller-sized impacts with statistical  
16 significance.

17           CMS could also randomly assign providers into a  
18 treatment group that participates in a new payment model  
19 and a control group that does not.

20           CMS could test models over longer periods of  
21 time, because some studies have found that models take more  
22 than five years to generate net savings.

1           And, finally, CMS could freeze a model's features  
2 over its testing period rather than making annual  
3 adjustments, so providers can spend more time refining care  
4 processes and less time learning new rules every year.

5           We also note that new types of models could be  
6 tested, such as models focused on managing specific high-  
7 cost chronic conditions, simplified models geared towards  
8 independent practices, and, finally, models that test  
9 utilization management tools successfully used by private  
10 insurers, such as prior authorization or preferred provider  
11 networks.

12           As you consider how A-APMs could be improved,  
13 we're particularly interested in your thoughts on: testing  
14 fewer models; prioritizing or deprioritizing certain types  
15 of models; changing or expanding certain features of  
16 existing models; randomizing providers that are interested  
17 in a model into a treatment and control group; lengthening  
18 models' test periods, with fewer adjustments made during  
19 those testing periods; making greater use of mandatory  
20 participation in models; and developing condition-specific  
21 models.

22           Now that we've given you some food for thought,

1 we'll turn things back over to Mike.

2 DR. CHERNEW: Thank you. Sorry. One second to  
3 realize I'm on my headphones.

4 Usually I don't make comments before we jump in.  
5 We're going to do Round 1 questions. But I do on this  
6 particular topic want to say a few things. So first some  
7 reactions, and then some guidance on where I think we're  
8 going.

9 The first reaction is my overwhelming personal  
10 belief is that we have too many models that overlap, and  
11 there's no clear sense of how they all fit together, and  
12 that we're not going to be able to test a bunch of things  
13 or so a bunch of things until we get to some coherent set  
14 of models.

15 I want to point out that if you test five -- if  
16 you're running 40 models, which is roughly what are being  
17 run, and you test all of them supposedly against doing none  
18 of the models, and then you put a bunch of models together,  
19 the result you get is not just the sum of the results of  
20 all the individual tests because the models interact with  
21 each other. So I think basically CMS is a portfolio  
22 problem. They have to come up with a set of models that

1 will work well together.

2           A few other basic points. Obviously, I agree  
3 that many of these models don't save, but I want to  
4 emphasize some of these models do save, not a ton but they  
5 do save, not just in utilization but for Medicare overall.  
6 And I feel that very strongly. So I think what we're going  
7 to need to think through is that these models, even if they  
8 don't save a lot, they provide some flexibility for  
9 providers. We use them all the time when we think about  
10 how to deal, for example, with telehealth and a whole bunch  
11 of other things. So my motivation isn't simply saving  
12 money. I think it's a conceptually important way to pay.  
13 We have to sort through how to set all of this up.

14           The last point and the reason why I jumped in  
15 before Round 1 is I want to emphasize this to my fellow  
16 Commissioners. This is a big, big area, and this is a  
17 multi-cycle commitment that we're going to have to make as  
18 a Commission. And I want to do that in a somewhat  
19 systematic way instead of taking scattershot actions on  
20 very specific recommendations. So I really want you to  
21 think through the number and the coordination of models and  
22 sort of focus on the portfolio as we go through this, and

1 we will through many discussions, hopefully in person, be  
2 able to talk about a whole slew of some of the specific  
3 design features.

4 So that's for the Commissioners and for the folks  
5 on the line. Otherwise, that's where my head is. And now  
6 I'm looking forward to hearing everybody else's comments.

7 So, Dana, I'm going to go to you. We'll do Round  
8 1, and then we'll jump into Round 2.

9 MS. KELLEY: So far, I think we have just one  
10 Round 1 question from Dana Safran.

11 DR. SAFRAN: Thank you. Yeah, one question. I  
12 didn't see in the chapter any information about some of the  
13 programs and whether they have gross savings. You were  
14 pretty consistent about reporting net savings, and then  
15 sometimes you said there were gross, but other times you  
16 were just silent. So, in particular, do you have  
17 information on whether NextGen had gross savings and  
18 whether PCMH had gross savings?

19 MS. BURTON: I can speak to the PCMH question. I  
20 believe CPC+ did not really affect gross spending, but I  
21 can check that and get back to you. And I'm going to defer  
22 to our ACO team on your next-gen question.

1 DR. CHERNEW: I don't think CPC+ made gross  
2 savings, if I recall the evidence correctly.

3 MR. SERNA: So on the next-gen evaluation, after  
4 year two, the comparison group changed from beneficiaries  
5 who are not assigned to an ACO to all beneficiaries. So  
6 the comparison group included beneficiaries who are  
7 assigned to an MSSP ACO, and in that instance, there were  
8 no net savings.

9 DR. SAFRAN: I was asking about gross savings,  
10 not savings.

11 MR. SERNA: There were gross savings. Yes, there  
12 were gross savings.

13 DR. SAFRAN: Thank you.

14 DR. CHERNEW: And again, that's compared to other  
15 ACOs that were running or at least in the control group,  
16 just to emphasize my point.

17 MR. SERNA: Yes.

18 DR. CHERNEW: I'm going to shut up now.

19 Actually, I'm not because I think we're going to  
20 Round 2. I think we've already done Round 1.

21 MS. KELLEY: I think we are done.

22 DR. CHERNEW: Okay. So we're going to kick it

1 off with Amol, and just for people to know, it's going to  
2 be Amol, Karen, and then Dana. Then we have a few people  
3 that have said already they want to go after that, and then  
4 we'll go through. But, Amol, to you

5 DR. NAVATHE: Great. Thanks, Mike.

6 So I apologize to the extent that some of my  
7 remarks are going to overlap with Mike's and perhaps other  
8 Commissioners but hopefully will offer a structured view  
9 here.

10 So I'm going to cover kind of five different  
11 areas that I think we can push forward in terms of sort of  
12 advancing the work that we're doing and advancing the  
13 chapter, perhaps, so one covering context and goals of A-  
14 APMs; second, vision strategy; third, key issues and design  
15 principles; fourth, other things that were just outright,  
16 we being the broader health policy community outright  
17 missing; and then five, some sort of minor points around  
18 how we're describing models.

19 So before I launch in, Geoff, Rachel, team, this  
20 is a huge topic, as Mike just noted. I think you guys did  
21 an amazing job of synthesizing and covering an overview  
22 that is an expansive topic into something that's very



1 digestible, so commend the great work and recognize how  
2 much hard work it has taken to get here.

3 I'm extremely excited that we're taking on this  
4 work, given that I think we've had a fairly focused view in  
5 the past, we being the Commission here. That predates me,  
6 certainly, around ACOs, and it's nice to see the aperture  
7 here widening and thinking about the whole suite of A-APM  
8 types, if you will.

9 Okay. So diving into the context and goals, I  
10 think one thing that would be helpful here is to set out  
11 immediately and say what is the goal from A-APMs. I think  
12 we talk a little bit about costs, controlling cost growth,  
13 which I think makes sense, but there are areas of trying to  
14 improve quality and patient experience that are also  
15 important.

16 And I think probably the biggest thing that I  
17 think we need to say is something around stimulating  
18 practice transformation. So without the A-APMs, we  
19 probably wouldn't catalyze the type of changes that could  
20 actually lead to cost growth reductions or savings, and  
21 while we may not get there in V1.0, the fact that we might  
22 stimulate those kinds of practice transformations that will

1 also potentially spill over more broadly into the  
2 community, changing people's expectations of what's going  
3 to happen in the future, people here being clinicians and  
4 health care delivery organizations, that's really  
5 fundamentally important as part of the A-APM strategy for  
6 CMS. So I think we should try to be forthcoming about  
7 articulating those pieces.

8 I think our synthesis of the evidence is good in  
9 the sense that we're quite comprehensive, and I think the  
10 tables are very nice. I wonder if we can't put those types  
11 of tables in an appendix, in fact, and focus more on some  
12 of the questions that we've already heard from Dana and  
13 others, maybe a summary table of here are the models, here  
14 are the ones that have achieved gross savings, here are the  
15 ones that have achieved net savings. I think that might be  
16 a more rapid way to get a sense of what's working and  
17 what's maybe not working as well.

18 And I think it will also highlight this point  
19 that today it seems like we have a potpourri of different  
20 A-APMs, even within the three big model types that you guys  
21 have outlined, and to me, it feels like one really major  
22 piece of value that the Commission can add here is to

1 articulate a vision and a strategy for how all of these  
2 models, all the testing that we have done historically and  
3 perhaps the testing that will happen next in the next  
4 decade, how can this all fit together? And how can we  
5 actually move toward a common strategy or a common approach  
6 that will, one, select the best models, the winners, if you  
7 will, and double down on them, perhaps expanding them, and  
8 a second piece, which is how do these different models  
9 actually fit together in the first place?

10 I could imagine that we could do some great work  
11 that talks about how each of these different types --  
12 population-based models like ACO, the advanced primary care  
13 models, and episodes -- all actually fit together, where  
14 it's not necessarily picking the best one of the three, if  
15 you will, but picking the best ones within the three in a  
16 way that actually stitch together and actually coordinate.

17 so that, I think, also will support Mike's call,  
18 in some sense, to trim the models because I think that will  
19 give us a more unified approach of how we might actually do  
20 that in the first place, so definitely wanted to articulate  
21 that it would be great if we could take on some sort of  
22 vision and strategy work as part of this broader

1    workstream.

2                    So moving on to the next bucket, key issues and  
3    design principles, I think there's a number of areas that  
4    we can also push forward the broader thinking here. I  
5    think there was actually a place very early in the chapter  
6    on the first page, the third sentence or something that  
7    talked about how A-APMs are a way for providers to capture  
8    savings, decrease spending, without incurring any loss of  
9    revenue. And I think that's true in some models, like the  
10   bundled payment models, the BPCI and CJR-type models, not  
11   necessarily true, for example, a hospital-based ACO.

12                   So I think we should be clear about where we're  
13   aligned on these principles and not, and I think I would  
14   also make the point strongly that I think if we do look at  
15   the evidence, when participants are expected to cut their  
16   own revenue or their own reimbursement, those models on  
17   average tend not to do as well, and that may be a design  
18   principle in general that we want to veer away from as we  
19   think about a strategy and A-APM choice going down the  
20   road.

21                   Other points around design principles. So I  
22   think there was a discussion, which I was appreciative of,

1 around the voluntary and mandatory. You guys teed up  
2 questions around voluntary and mandatory. I think the  
3 discussion of mandatory can probably be refined a little  
4 bit. There are aspects around selection between voluntary  
5 and mandatory that I think also can be refined. In  
6 particular, there are some bad types of selection for sure,  
7 but there are also some good types of selection. If you  
8 have participants that have the most opportunity for  
9 savings as the ones who select into voluntary models, we  
10 might actually get disproportionate impact from them.

11 That being said, there's also potentially  
12 pernicious types of selection that mandatory models  
13 address. So I think there's some more that we can do  
14 probably to refine our exposition on that piece.

15 And I think connecting back to the goals, one  
16 thing that I feel is a prevailing undercurrent of the way  
17 we have written the current chapter is that we have to see  
18 savings in the short term to feel like an A-APM model is  
19 successful.

20 And I was wondering that myself because if we're  
21 able to catalyze practice transformation for these models  
22 that accrue savings to Medicare hypothetically for

1 perpetuity or catalyzes a very broad shift that spills over  
2 from the A-APM group to providers nationally, then maybe we  
3 actually have a longer-term horizon, and getting gross  
4 savings but not net savings in the short run actually might  
5 be considered a win.

6           So I think, again, in the spirit of broadening  
7 our aperture, I think there's also sort of a breadth, but  
8 then there's also a longitudinal horizon that could be good  
9 if we have sort of a vision or a strategy for how CMS and  
10 CMI and legislators might think about that.

11           Number four, what do I think we might be missing?  
12 So I think the number one thing that strikes me is the  
13 focus on disparities in particular and populations who are  
14 living with disparities and disadvantaged vulnerable  
15 populations. There's evidence that A-APMs aren't available  
16 to communities that have a disproportionate share of duals,  
17 for example, and if we're expecting these A-APMs to be one  
18 of the key mechanisms to improve quality and patient  
19 experience as well as change practice and save cost, in  
20 particular, in this case, out-of-pocket expenditures, it  
21 feels like this is a huge miss for us not to be addressing  
22 directly, us directly as well as A-APMs directly. And I

1 would put a huge call on us to see if we can incorporate  
2 some piece of this agenda directly into our work. How can  
3 A-APMs more effectively help close the disparities gap?

4           A couple of minor points here at the end. So I  
5 think as I read through the paper in general, I thought  
6 fairly objective. I did feel that sometimes that we were  
7 almost a little bit too negative on A-APMs. The ACO  
8 chapter, for example, I think, didn't recognize some of the  
9 places where there were modest savings, even if they're  
10 just gross savings, connected to the idea that it's hard to  
11 change practice. I think that could be a way to actually  
12 identify something positive there.

13           Similarly, on bundles, which are, of course, near  
14 and dear to my heart based on the work that I do, I felt  
15 like there's on the mandatory side, the fact that we  
16 actually could mandate a mandatory bundle and that it did  
17 as well as it did is something quite remarkable, actually.  
18 And now, of course, we have the radiation oncology model  
19 that's going to be a mandatory model, and Brad Smith from  
20 CMMI recently sent out a letter saying that successful to  
21 the BPCI advanced model is going to be mandatory.

22           So I think articulating more around the success

1 there and why we think it might be successful and important  
2 would be perhaps a fair representation there in general.

3           So overall, if I were to recap, I think this is  
4 great work. I'm super excited that we're taking this on,  
5 broadening our view, both in terms of breadth and in terms  
6 of longitudinally. I would love to see us take on more in  
7 terms of the vision and strategy. I actually don't even  
8 feel the necessity in some sense to make specific  
9 recommendations as part of this chapter, given that we're  
10 starting out pretty early, but more can be articulated in a  
11 way that all this can work together in a more systematic  
12 and strategic way than I think perhaps has happened over  
13 the last decade.

14           Thank you.

15           DR. CHERNEW: Amol, that's great.

16           I think we're going to you now, Karen.

17           DR. DeSALVO: Great. Thank you.

18           I agree with so much of what Amol just shared and  
19 including commending the staff for putting together this  
20 tome, which is a gift to the policy and the health care  
21 world. It gives us a really great sense of where we are  
22 and how we got here, so thank you for this deep work that's



1 going to guide the Commission's work but I think guide a  
2 lot of people outside of the Commission.

3 I want to see that what we're learning from all  
4 this A-APM work is that we're moving towards a world where  
5 beneficiaries are partnered with accountable entities and  
6 have a known primary care physician or provider, that  
7 system inclusive of the beneficiaries accountable for the  
8 total cost and total health outcomes, and that kind of a  
9 model where it's a global budget that allows the kind of  
10 simplicity and flexibility that I know patients are hungry  
11 for. At least that's what I understand from them, and I  
12 can tell you that doctors want that level of simplicity  
13 that comes with that kind of global budgeting, particularly  
14 in the primary care sphere. So that's a lot of the lens  
15 that I'll bring to the rest of my comments.

16 I think that the counter-rate simplicity of  
17 moving these learnings on these various types of  
18 alternative payment models to a broader accountable entity  
19 model is one that allows us to have some more flexibility.

20 I'll just share a quick story about a patient I  
21 think about a lot. He's somebody that started falling  
22 under my care. He had been in and out of the hospital,

1 basically spending more time in the hospital than out. He  
2 had significant chronic conditions of his liver, his  
3 kidneys, his heart, his lungs, his blood system. He had  
4 diabetes. He had hypertension. He had heart failure. He  
5 had an artificial valve. I mean, this person had a hit in  
6 every organ but also had a great desire for quality of life  
7 and to spend time with his grandkids and wanted to be out of  
8 the hospital more than in.

9           The journey that we went on included an episode  
10 where I had just discharged him from the hospital for heart  
11 failure, and he came back shortly thereafter in heart  
12 failure, again, despite having been well optimized, as we  
13 say in medicine.

14           So I went to his home and did a visit and learned  
15 in that visit that he had been told to take his medication  
16 with pickle juice. So he had this green jar sitting next  
17 to him on the table next to his easy chair, and the thing  
18 was loaded with salt. And it became clear to me that one  
19 of the reasons he was coming back in heart failure was that  
20 he was drinking salt as soon as he got home -- and began to  
21 talk with me and his wife and learn more about their diet  
22 and what was happening in their lives, and through that and

1 a series of other strategies, we were able to get him to  
2 that place of quality of life where he was home more than  
3 in the hospital. And that took a level of human connection  
4 but also flexibility.

5 The way that I was paid as a primary care  
6 provider was to be able to do that kind of work, to spend  
7 extra time with that person who was extra sick but also  
8 understand his context, not just the medical conditions  
9 that he had and not just see him when he came into the  
10 health system.

11 And it sticks with me because that's exactly the  
12 kind of relationship and experience that I think all  
13 doctors and patients want to have when they're really sick.  
14 They want to have that kind of flexibility to know that  
15 they can do the right thing and do it in a way that allows  
16 them to meet people where they are.

17 And I think, honestly, that's where CMMI started  
18 year ago was with this idea that we could achieve the  
19 triple aim, that we would make the experience of care  
20 better, including the quality of care and satisfaction with  
21 care, that we would improve the health of individuals and  
22 populations, and that we would do that at a lower cost

1 overall, and began and did a lot of good work in  
2 partnership with the private sector.

3           But I think over the course of time, it got so  
4 noisy that we can't find the signal in what we're doing in  
5 all these alternative payment models. We could pull out a  
6 thesaurus and print a lot of words, "cacophony," et cetera.  
7 But I think the point that we're all feeling is we're not  
8 sure which of the models is making difference to achieve  
9 the triple aim or to give the kind of simplicity or  
10 flexibility that people on the front lines desperately  
11 want, just to focus on health, and then also how can we  
12 understand how much overlap there is. What does the Venn  
13 diagram look like for one patient or one clinician that's  
14 operating in a number of alternative payment models? So I  
15 strongly encourage this idea of simplicity.

16           I do also think that we need to give the strategy  
17 a refresh. It's not uncommon for kind of an innovation arm  
18 to get a lot of ideas rolling, but I think it's time to hit  
19 the reset button and really get back to the roots of what  
20 CMMI was laid out to do and think about a strategy that I  
21 hope we can inform as the Commission but also want to  
22 remember that there's been work done in some of these areas

1 about how to transition the health system across the  
2 continuum to -- of these four types of alternative payment  
3 models. So, for example, the Health Care Transformation  
4 Task Force or Learning in Action network have thought a lot  
5 with the private sector about how to create an all-payer  
6 approach that would move off of the fee-for-service chassis  
7 and onto a global budgeting chassis.

8 I want to just make a comment about creating  
9 models that are focused on specific high-cost conditions.  
10 It may come as no surprise, having shared that story of my  
11 patient, that that's not what happens in people's bodies.  
12 Unfortunately or fortunately, they don't have just one  
13 high-cost condition. They have multiple medical  
14 conditions, especially individuals that are high cost and  
15 high need.

16 So I would err rather for us to really understand  
17 better how cognitive specialties, how primary care can be  
18 appropriately rewarded and have the resources necessary to  
19 focus on high-cost, chronic individuals that are both  
20 complex medically and socially and do the best for not just  
21 repairing them when they're sick but actually moving  
22 upstream to improve their health.

1           I think we are on a journey to understand how to  
2 better fund primary care in this country, but we've made a  
3 lot of progress. And I would like to see us really double  
4 down in understanding that and not just thinking about  
5 people as a disease but really as a person in the context  
6 in which they live, which is the last comment I want to  
7 make.

8           And that's about opening the aperture. I had the  
9 same word that you had, Amol, but my aperture is inclusive  
10 of equity. I think that's exactly right, but it also  
11 includes the social determinants of health.

12           We talk a lot about social determinants in this  
13 Commission, and I think we've made some good progress in  
14 trying to incorporate that into our thinking, but as we've  
15 articulated, it's not just about the kind of insurance  
16 product that you have or it's not just about your finances.  
17 The social determinants are where we live, learn, work, and  
18 play in the context they're in, and it's a complex  
19 ecosystem.

20           But there's also proportions of addressing social  
21 determinants. There's a social care infrastructure that  
22 can partner with health care. Health care does not and I

1 don't think should not do at all on its own, and so whether  
2 CMMI can think about not just a passthrough set of models  
3 where it gives money to health care and passes that there  
4 the social care sector. But if it has the statutory  
5 authority to do innovation models that invest in the social  
6 care infrastructure in a way that we use CMMI to invest and  
7 modernize in the health care infrastructure, I believe that  
8 would go a long way to helping beneficiaries. And if CMMI  
9 does not have the statutory authority, I would love to see  
10 us think about asking Congress to consider creating an  
11 innovation arm that would be a partner to this health care  
12 innovation, given that social determinants can drive as  
13 much as 80 percent health outcomes and that there's a  
14 social care infrastructure that's woefully unprepared to  
15 partner with the health care system because it's so under-  
16 resourced and hasn't had the kind of attention that health  
17 care has.

18           And I do believe that that accrues benefits to  
19 the Medicare program. I think we're still learning what  
20 that means, but I think we all know from our personal  
21 experience that if you're food insecure or have housing  
22 insecurity or no housing, that that drives medical cost in

1 a whole variety of direct and indirect ways. So I think  
2 the aperture for me would be also expanding the opportunity  
3 for CMMI to directly work with social care systems and/or  
4 to create a separate avenue.

5 Thank you.

6 DR. CHERNEW: Karen, thank you. Dana.

7 DR. SAFRAN: Thank you. Echoing the praise that  
8 Amol and Karen have shared for the staff, really, there is  
9 an enormous amount of information here and it's really very  
10 valuable for all of us. I want to focus my remarks on sort  
11 of four main things and then a couple of small final  
12 comments related to some of the questions you have up on  
13 the screen.

14 The first thing that strikes me is that, you  
15 know, it seems to me that this chapter, in some ways, and  
16 the public policy rhetoric are kind of creating a dividing  
17 and holding APMs to a different standard from the standard  
18 to which we hold the Medicare Advantage program, and I  
19 think we need to address that and highlight that in this  
20 chapter.

21 You know, we spoke yesterday in our session about  
22 Medicare Advantage, about a program that's decades old and



1 has never achieved net savings, and now we have a program  
2 that is, you know, still learning. And some of the models  
3 have, in fact, achieved net savings. I feel like we should  
4 be celebrating that. And I also go back to the point that  
5 you had in one of the early slides that the objective and  
6 the benchmark for expansion of models was either lot save  
7 money without hurting quality or improve quality without  
8 increasing spending.

9           And so I just would flag, you know, that as we  
10 think about the overall framing. And I loved Amol's point  
11 about the value of these programs catalyzing change, and  
12 the kinds of changes that we believe will lead to the more  
13 holistic care of patients, people, that Karen is talking  
14 about. And I'm quite confident we are seeing that in some  
15 of these models, so I'd like to see us shining a light on  
16 that to the importance of type of care transformation  
17 that's being motivated by these models.

18           The second thing I would say is on the issue of  
19 voluntary versus mandatory, I personally fall quite  
20 strongly in the place of thinking that program should be  
21 voluntary, but it should be a very strong signal to  
22 providers that choosing to remain outside of these models

1 is going to be an increasingly unprosperous way to engage  
2 with the Medicare program. And I think some public policy  
3 has done that, but the other problem that we've pointed to  
4 along the way, in this discussion and in the chapter, is  
5 the cacophony of programs.

6           And I do think that in addition to having  
7 programs be voluntary but a strong signal that it will not  
8 be financially lucrative to remain outside of these  
9 programs, I think that we need to have fewer programs and  
10 we need longer tenure to study them, but also longer tenure  
11 for those who are in the programs. So, you know, I know  
12 that some of the more recent programs are testing five-year  
13 periods. I think nothing short of a three-year period for  
14 a program and five-year periods are good because the  
15 ability to give providers certainty about what their  
16 incentives from Medicare will look like over a long stretch  
17 of time will really help catalyze the kind of change that  
18 we're talking about.

19           I for sure saw that in my experience at Blue  
20 Cross Mass, both because we made the program voluntary and  
21 because the contracts were quite long, especially in the  
22 early years they were all five years. We heard provider

1 after provider system tell us that that enabled them to  
2 know that we weren't going to come back at them next year  
3 with a change in the way the model worked, and they could  
4 actually plan for how to be successful in the model.

5 And so I think having longer tenure for the  
6 contracts but then also longer tenure for the programs will  
7 really allow us to establish an evidence base that is more  
8 robust than what we have.

9 I also think that we need to have some  
10 standardization about the evaluation frameworks, because,  
11 you know, that's part of the confusion. Even, you know,  
12 the response to my question about what we know around gross  
13 savings for Next Gen and for PCMH pointed out that there  
14 was a change in the population against which we were  
15 measuring midstream. We really have to highlight the  
16 importance of standardizing the way these programs get  
17 evaluated and having them have a long enough stability that  
18 we can measure what impact they are accomplish, and improve  
19 them along the way.

20 I see no problem with having a provider cohort,  
21 you know, if say cohort number two or three, coming into a  
22 model, having that model have improved the way it does

1 benchmarking, but for those who were in cohort number one  
2 the model stays the same until they renew their contract.  
3 I think that gives us the best of both words.

4           I did toy a little bit -- I'll just share this --  
5 with the idea that if we make any of this mandatory should  
6 we have Medicare make it mandatory that providers who  
7 exceed a certain size or scale need to be in a model that  
8 has accountability for total cost of care? I toyed around  
9 with that in part because of the conversation that will  
10 follow this one, about the consolidation and integration  
11 that we're seeing. So I throw that out as an idea, but  
12 mostly I feel pretty strongly about voluntary models and  
13 them creating a pretty ugly scenario for those who stay  
14 outside of them.

15           The fourth theme I would sound is that we really  
16 still have not addressed hospital payment reform, and that,  
17 by the way, this chapter doesn't draw out any of the  
18 evidence, as far as I recall -- and I apologize if I'm  
19 misremembering -- distinctions in performance that we've  
20 talked about previously between organizations that are  
21 physician-based ACOs versus hospital-based. But I think  
22 that's an important part of the evidence, and I do think --

1 I know I sound this almost every time we talk about ACOs --  
2 that we need to keep working at a model that will change  
3 the fundamental set of incentives for hospitals around  
4 hospital-based care. I know it's very challenging but I  
5 fear that without it, with hospitals now owning so much of  
6 the physician workforce that we're really fighting upstream  
7 with these models.

8           And then a few final comments and thoughts. One  
9 is, you know, we haven't addressed an issue that I think, I  
10 forget if it was Amol or Karen started to point to, and  
11 I'll just flag it as something that may be worth mentioning  
12 in the chapter, that the issue of how physicians are paid  
13 by their organizations really has an important impact on  
14 all of this as well, and I don't know that we can ignore  
15 that.

16           And also, we don't address, in this chapter, that  
17 the quality measures, the performance measures really  
18 continue to need to move toward outcomes-oriented measures.  
19 And we're kind of stalled out on that and still stuck with  
20 a model that's trying to be global in its focus but it's  
21 still process-oriented like fee-for-service in its  
22 measurement, and we really need to address that.

1           Finally, just closing, I think that for sure we  
2 have to address, as you say in the chapter, the gaming  
3 that's happening with moving high-cost beneficiaries to  
4 non-ACO TINs. That seems like a no-brainer. The capping  
5 of risk scoring on benchmarking, I did there too want to  
6 harmonize a little bit of thinking between Medicare  
7 Advantage and ACOs, and also entertain the possibility of  
8 cohorting here, where we might allow -- you know, you talk  
9 about the challenges, and you're right, of getting  
10 providers who are higher spending motivated by the  
11 benchmark to come into a voluntary program while not making  
12 the benchmark such that those who are more efficient are  
13 struggling to meet the benchmark.

14           I don't know why we can't borrow from the  
15 Medicare Advantage book and create different cohorts and  
16 then set benchmarks differently, at least in the early  
17 stage, so that all providers can see in the program a way  
18 that they can succeed, a way that they can help their  
19 program generate savings, and then those benchmark  
20 strategies can converge over time.

21           So I know that was a lot. I will stop there.  
22 Thanks for the opportunity to share these thoughts.

1 DR. CHERNEW: Thanks, Dana. In a second, we're  
2 going to go to Betty. Just a time check. We have 40  
3 minutes about 14 Commissioners, so please be conscious of  
4 the time. This is an expansive, expansive chapter, so I  
5 know everybody has a lot to say, but I do want to make sure  
6 we get the thoughts of everybody.

7 So Betty.

8 DR. RAMBUR: Great. I will try to be succinct.  
9 First of all, I want to again thank the staff and also the  
10 three opening comments. I'll focus on areas that amplify  
11 or perhaps disagree with some of the statements.

12 First of all, I differ a bit and I really support  
13 mandatory bundles in particular. And I don't know if it's  
14 still correct that 17 conditions are responsible for 50  
15 percent of the spend, but I can't see how we cannot  
16 systematically roll those in to episode-based payments,  
17 particularly in specialty care.

18 I will say that I'm probably shaped in part by  
19 this, and I'm dating myself, but I was in my first year as  
20 a nurse practitioner when DRGs were introduced and I was  
21 stunned by the neck-snapping alacrity by which the system  
22 shifted. So I'm still imprinted by that.

1 I just want to mention a bit about my experience  
2 in helping develop Vermont's statewide all-payer ACO. It  
3 is still a work in progress. They are still trying to  
4 onboard enough people. But I just want to underscore that  
5 changing behavior really takes time, and so I strongly  
6 support longer increments.

7 And this year is year three of the model. The  
8 first year was zero. And long-term services and support  
9 Medicaid, which I know is not our authority, but Medicaid  
10 long-term services and support are to be rolled in. And  
11 it's really starting to look at that, that we begin to  
12 really see some behavior change in terms of providers.

13 A previous study found that it takes a high  
14 degree of capitation to catalyze non-visit care, and when  
15 we think about so many of the examples we have, Karen's  
16 example of the person who is drinking the salt water, you  
17 know, the limits of medical care versus something broader  
18 really starts to happen, I think, when you have  
19 accountability for the costs and outcomes for a population.

20 And just briefly, even though I know it's not a  
21 total success, some of the things we saw when the hospitals  
22 couldn't so easily shift the uncompensated care for, for



1 example, people who were homeless, they are really forced  
2 to start to think about how do we reach out to that  
3 population. So we can't rely on altruism. We have to  
4 create the financial incentives.

5 Dana mentioned the issue of how physicians are  
6 paid. I just wanted to briefly mention a study that was  
7 just in Health Affairs that found, I believe it was over  
8 four years, the increase of nurse practitioners and  
9 physician assistants practicing in ACOs went from 18  
10 percent to 38 percent. We talked a bit about workforce  
11 development yesterday. I don't know if there is anything  
12 in here for us to think about. But workforce development,  
13 and also, I know you've previously taken a stance on  
14 incidental-to billing, and I just want to underscore I  
15 think that is an important stance that you took that it  
16 needs to stop.

17 And then finally, in our experience in Vermont,  
18 we were not able to consider Part D in the development of  
19 the all-payer model, and that was for technical reasons,  
20 was my understanding. It wasn't really a policy decision.  
21 But to the extent that models that are looking at all-  
22 inclusive total cost of care with full risk-bearing, it

1 would be really important and wonderful if we could roll  
2 that in.

3           So I do think there needs to be fewer, it needs  
4 to be clearer, and it has to be a strong message that  
5 there's no stopping the train that's pulling away from fee-  
6 for-service. Thank you.

7           DR. CHERNEW: Thank you. Jonathan, you're next.

8           DR. JAFFERY: Thanks, Mike, and thanks, everyone,  
9 for the comments. This has been an amazing discussion. As  
10 others have said, this chapter is really fantastic. I  
11 really appreciate this classification of the population-  
12 based episode and advanced primary care and also this  
13 distinction between population-based and advanced primary  
14 care. So I learned a little bit and I think it's a really  
15 great framework for us to keep this conversation going.  
16 I'll try to stick to comments that push us towards this  
17 idea of setting a vision, and like Mike said, this is a  
18 multi-cycle process.

19           So first of all, in thinking about the discussion  
20 questions on the slide that's up, absolutely, I'm concerned  
21 that there are too many models and that they keep changing.  
22 It's very, very difficult to operate under some of these

1 circumstances. Next Gen is a five-year plan. I think it's  
2 now on six years, because it got extended a year through  
3 COVID. But as a six-year model it's really more than just  
4 one model. It keeps changing, and it's very challenging to  
5 keep up.

6           There were some comments about direct contracting  
7 being an extension of that, and that's a great concept and  
8 I think that there are some aspects of that that make  
9 sense, in terms of an evolution such as more frequent  
10 reconciliation. But I can tell you, as an operator, it  
11 does not feel like it's just an extension. It feels like  
12 we're starting over and trying to figure out what are the  
13 rules of this new model. So I think simplifying them and  
14 having multi-year performance periods would really be  
15 helpful.

16           A couple other thoughts to try and build on what  
17 some others have said, in terms of vision for Advanced  
18 APMs. I think moving beyond this idea of technical  
19 assistance and dissemination of best practices towards  
20 trying to incorporate some of the successful elements that  
21 we've learned about might be helpful, and I think this  
22 speaks to what Amol was talking about in terms of practice

1 transformation.

2           There are some things. We have talked about  
3 shifting to home-based care and where the advantages are  
4 there. There are things that we know work that might be  
5 embedded into some of these models, and I think that's  
6 probably more in terms of maybe that's a next cycle  
7 discussion, but I think it's something we should keep in  
8 mind.

9           I'd really like to flesh out how to integrate  
10 episodic payments with the population-based payments with  
11 the ACOs. That, I think, is an important idea and concept,  
12 and I think there's some work we could do to model that and  
13 figure out how the fortunes for both ACOs and the  
14 specialists could rise and fall together, based on success  
15 or failure of some of those episodes.

16           Related to that, this issue of should we develop  
17 models to manage high-cost conditions, I am going to  
18 strongly echo what Karen put forth. I am not in favor of  
19 that. First of all, I think it's going to create more  
20 silos and goes against the idea of fewer models. But, I  
21 mean, Karen, your example was a great one and it's really  
22 the pickle juice idea that struck home for me.

1           But, you know, that's not a rare situation. My  
2 practice as a specialist, of course, is a little different  
3 than Karen's, but I have very few patients that have just  
4 one condition, and the management for one often -- optimal  
5 management for one sometimes, not infrequently, conflicts  
6 with the optimal management for another. And so I'd much  
7 rather see that we focus on these high-cost populations,  
8 and specialists can fit in with episodes. The episodes  
9 don't have to be 90 days after a procedure. They can be a  
10 year. They can harmonize with the ACO payment period.

11           A couple other quick comments. In terms of  
12 mandatory, I don't feel as strongly, like Dana does,  
13 against mandatory. I'm a little bit more in keeping with  
14 what Betty was thinking about. I recall Paul making a  
15 comment a few meetings ago about DRGs going mandatory and  
16 how if we hadn't done that, we probably wouldn't have them  
17 still, and that really struck me.

18           I think Dana's points about thinking through, are  
19 there some characteristics or criteria for an organization  
20 to be put into a mandatory model that maybe moves more  
21 towards some of the bigger systems, especially as we're  
22 getting more and more consolidation, I think is an

1 important one to think about as opposed to mandatory models  
2 based simply on geography. But those are some things that  
3 I think we should think through.

4           And then, finally, I think the biggest issue  
5 perhaps is really still around the benchmarks, and here,  
6 like people have said before, we really, really need to  
7 harmonize this with how we're thinking about MA, and this  
8 really connects nicely with yesterday's conversation. But  
9 to just have a model that keeps continuously lowering the  
10 benchmark doesn't make sense. It doesn't seem sustainable.  
11 I'm not sure it's a desirable thing in terms of overall  
12 levels of spending.

13           So, ultimately, trying to find benchmarking for  
14 ACO models and MA that sets a target based on some national  
15 goals, takes into account the tremendous geographic  
16 variability that we see, and then set a growth rate and  
17 work towards that. There may be some opportunities for us  
18 to model what that could look like in terms of overall  
19 savings. So what if per-beneficiary per-year spending for  
20 all Medicare beneficiaries occurred at, say, the 50th  
21 percentile or 25th percentile, where we are seeing ACOs,  
22 what would that look like in terms of overall spending?

1 What would that do to the hospital trust fund solvency?

2 In September we heard about what would be needed  
3 to maintain solvency in terms of a \$1,000 decrease per  
4 year, but that sort of implies to me a shift down of  
5 everybody, and I'm not sure that everybody needs to shift  
6 the same amount. We've got very high-spend areas and we've  
7 got some areas that aren't as high spending. So there is  
8 some additional modeling that we might think about there in  
9 terms of how would we think about benchmarks setting for  
10 that, target setting.

11 So I will stop there and thank you for the  
12 opportunity to comment.

13 MS. KELLEY: Okay. Brian, you're next.

14 DR. DeBUSK: Thank you, and I share the other  
15 Commissioners' enthusiasm over this chapter. I think it's  
16 very relevant work.

17 Going straight to the discussion slide, I see us  
18 consolidating to one population health model. We can call  
19 it an "ACO," we can call it "direct contracting," but one  
20 pop health model, I think we consolidate around one  
21 episodic model. I think the episodic model is sort of your  
22 classic BPCI-A version. But I also think that we create

1 some chronic disease management episodes that can go in  
2 there as well. So we may have acute episodes like lower  
3 joint replacements, but then we may also have chronic  
4 episodes, like a 90- or a 120-day COPD management episode  
5 or a diabetes management episode. I think that could all  
6 comfortably fit under this one episodic framework.

7           Then I think we should have one primary care  
8 model, and I think the paper alluded to that. But I think  
9 the primary care model should be compatible, and I'm going  
10 to talk a little bit about what I think compatibility  
11 really means, compatible with the episodic models, because  
12 I think that is -- it is inevitable that you're going to  
13 have people in, say, a Primary Care First model that are  
14 going to need a joint replacement, or you're going to have  
15 someone who maybe is in the Primary Care First model but  
16 who needs more specialized care for their diabetes or for  
17 their heart disease.

18           The other thing I want to mention is I think the  
19 primary care model that we do needs to conveniently walk.  
20 We need to be able to take the primary care model, scale it  
21 into a physician-led ACO or whatever we're going to call  
22 our people health model, and then scale that into a full-



1 blown hospital and physician consolidated population health  
2 model. So I think there needs to be basically crosswalks  
3 between those three basic frameworks: pop health,  
4 episodes, and primary care. But, again, there needs to be  
5 convection between those models and compatibility.

6 I am comfortable making these mandatory for  
7 providers. I think CJR proved that you can do that. And I  
8 also think we're going to have to create some beneficiary  
9 incentives or maybe even disincentives for not  
10 participating in these models. Medigap basically means  
11 that only 11 percent of our beneficiaries are exposed to  
12 any cost sharing at all. The only lever that we have left  
13 -- and it's an uncomfortable lever -- is the Part B  
14 premium. But I do think we need to revisit -- for people  
15 who actively refuse to participate in any of these models,  
16 who truly want the old fee-for-service chassis, it just  
17 doesn't seem right that they don't pay some surcharge or  
18 some incremental amount on the Part B premium; or,  
19 conversely, the people who do participate in these models  
20 should maybe enjoy a reduced Part B premium.

21 I think locking these models in for three to five  
22 years is great. I think we should codify some of the

1   waivers in statute. I don't think people should wait each  
2   year to see what their waivers look like or which waivers  
3   are going to be included with which model. I think those  
4   all need to be set in law.

5           I do think we need to adopt some common features.  
6   Other Commissioners mentioned this, so I won't belabor  
7   them, but I think we need to have a common benchmark  
8   development mechanism. I think we need to adopt a  
9   philosophy on risk scoring and how much or how little of  
10  the HCC model we're going to use. And then I think we need  
11  to stick to that throughout all the models, particularly so  
12  that you can have this flow from one model to the next.

13           I think we need to have shared quality metrics.  
14  Others have mentioned -- I think we need to be compatible  
15  with MA. I really liked the MA benchmarks being 50  
16  national, 50 local, because in theory we could set our  
17  population health benchmarks the same way.

18           The last piece of this first round is  
19  compatibility. You know, when we talk about models being  
20  compatible, to me 85 percent of compatibility is really  
21  just setting precedents for how shared savings or how  
22  shared losses are distributed. Compatibility to me is just

1 being able to say if someone in a population health model  
2 enters into an episode and comes out, this is how we're  
3 going to distribute those savings or losses. And to me, I  
4 think it would be tedious, but to Michael's point earlier,  
5 if we consolidate these platforms down to a limited number  
6 of models, it shouldn't be hard to develop crosswalks for  
7 how to share and split those savings.

8           The last thing I want to touch on -- and it's the  
9 windmill I've tilted for a few years now -- MSSP is ten  
10 years old, and we've had basically mediocre, tepid results  
11 so far. And I just want to take a brief moment -- I know  
12 we're tight on time -- and reflect. For ten years, very  
13 talented, very passionate people have done really high-  
14 quality work trying to make these models work, and we don't  
15 have the profound results -- I think ten years ago when the  
16 ACA was passed, if someone had said this is where we're  
17 going to be ten years later, I don't think anyone would  
18 have believed it. And I've really narrowed it down to two  
19 hypotheses: either care coordination and focusing on high-  
20 value services is just a failed idea and it doesn't work  
21 and we need to focus on prices; or we've built these models  
22 on the wrong foundation.

1           So I do want to -- and I don't believe, by the  
2 way, Hypothesis 1. I do believe in care coordination. I  
3 do believe it's not just about prices. But I think we're  
4 going to have to get away -- and several Commissioners have  
5 mentioned this. We've got to get away from the fee-for-  
6 service chassis. And getting away means really three  
7 things: number one, it's not building your models directly  
8 on top of fee-for-service; number two, it's incorporating  
9 some type of global payment into these models. For  
10 example, CPC+ track 2 uses a global payment. Primary Care  
11 First uses a portion of the revenue from global payments.

12           But then the third element is I think we need to  
13 send a message that fee-for-service isn't going to be  
14 business as usual. We've seen the acceleration of the  
15 Medicare Trust Fund's depletion, Part A Trust Fund's  
16 depletion. Providers need to understand that it isn't  
17 going to be business as usual in fee-for-service no matter  
18 what. And I think that's one of the big things that we've  
19 missed in the last ten years in all of these alternative  
20 payment models, is the null hypothesis, the failed  
21 experiment is everybody gets to do what they've done the  
22 entire time, their entire career. And I think that one of

1 the messages that we need to send as we do this next round  
2 of A-APMs, we need to create a vision for what fee-for-  
3 service is going to look like as the trust fund depletes;  
4 beyond the depletion of the trust fund -- for example,  
5 maybe at 2027 maybe we cap all fee-for-service rates.  
6 Maybe we don't do updates to fee-for-service after a  
7 certain date, and people make their incremental revenue and  
8 their bonuses through A-APMs.

9           So, again, that was just my one plug to please  
10 let's consider not discarding fee-for-service, but at least  
11 decoupling it through the use of some global payments or a  
12 blend of global payments and fee-for-service.

13           Thank you. Those are my comments.

14           DR. CHERNEW: Brian, just an update --

15           DR. RAMBUR: Michael, at least for me, I can't  
16 hear you. Michael, it's all watery for me. I don't know  
17 if the others are able to hear him.

18           DR. CHERNEW: Maybe this will be better.

19           PARTICIPANT: It's better.

20           DR. CHERNEW: We have 20 minutes and ten people,  
21 and do the math, but I look forward to going ahead. Dana,  
22 go to the next person.

1 MS. KELLEY: Bruce, your turn.

2 MR. PYENSON: Thank you very much. I'll be very  
3 brief. It strikes me that one of the advantages of  
4 Medicare fee-for-service historically, although the rates  
5 were low, it was simple. And what we're seeing with ACOs  
6 might be very unattractive and very unappealing because of  
7 its complexity. So I am supporting fewer models.

8 I would decouple lengthening models, testing  
9 periods with fewer changes. We need fewer changes. I've  
10 called for multi-year bids for Medicare Advantage. It's  
11 the annual zoo of responding to changes that's simply not  
12 worth it, so we need stability there.

13 I would point out in this group of MedPAC  
14 Commissioners I'm one of the few people who's neither a  
15 clinician nor an academic, and I would caution folks to  
16 keep in mind that what may be some of the things that are  
17 being suggested and recommended would seem very odd to  
18 people not from your background. I can say as an actuary  
19 nobody paid the actuarial profession to transform our  
20 practice from paper to electronic. I don't think anyone  
21 paid the attorneys to do that. I don't think any  
22 government paid the CPAs to do that or the engineers. So

1 let's focus on what the outcomes are; otherwise, we're  
2 going to sound very self-centered to a bunch of people.

3 I like Betty support mandatory models, and I  
4 think the direction is already going there with the bundled  
5 payment program. So let's keep things simple, stable, and  
6 not micromanage the poor clinicians. Let's not blame the  
7 clinicians and let's not blame the patients.

8 MS. KELLEY: All right. David, you're next.

9 DR. GRABOWSKI: Great, thanks. Like other  
10 Commissioners, I'm very excited that we're embarking on  
11 this work. Lots of good comments already, so I'll be very  
12 focused in my remarks.

13 First, I'm very much in favor of moving to fewer  
14 models. Medicare's approach to date has been to put up a  
15 lot of shots on goal by implementing lots of different  
16 models. The idea is if you take enough shots, something's  
17 bound to go in. Unfortunately, as we've been discussing,  
18 lots of unintended consequences to this approach. Too many  
19 models provides conflicting incentives to participants and  
20 makes it difficult for the Medicare program to understand  
21 what works and what doesn't.

22 Most importantly, all these different conflicting

1 models don't serve our beneficiaries very well. We often  
2 use the phrase "less is more" in our meetings, and we hear  
3 it a lot in health care. But when it comes to A-APMs, once  
4 again less is more.

5 I also want to emphasize beyond shrinking the  
6 number of models that we also need to think a lot not just  
7 how the different models align with one another, but also  
8 how the different elements within a model align with one  
9 another. And one of the examples we've talked about before  
10 during our meetings was the voluntary pathways to success,  
11 the combination, of course, of two-sided risk and this  
12 blending of historical benchmarks with average regional  
13 spending introduced even stronger incentives for ACOs with  
14 high spending for their patients to exit the program and  
15 providers with already low spending to remain or join the  
16 program.

17 These kinds of selection effects happen when we  
18 don't align the different program elements, and I really  
19 think it's important going forward that we think about not  
20 just aligning different models, but aligning those elements  
21 within models.

22 I don't want to get into the weeds today, but I



1 hope discussions about benchmarks will be a big part of our  
2 agenda going forward. I think there's a lot of work to be  
3 done here. So I'm very supportive of kind of making that a  
4 major focus.

5           Similar to others, I am supportive of mandatory  
6 programs. One of my colleagues likes to say, "Mandatory  
7 solves everything, or at least a lot of things when it  
8 comes to selection." Amol mentioned the CJR earlier. We  
9 did research on that, as did others, and found savings with  
10 a mandatory program. Of course, it was very challenging  
11 politically to keep that model in place, and so I really  
12 like Dana's suggestion. If we can't do this in a mandatory  
13 fashion, providing strong financial incentives to get  
14 individual -- get participants even under a voluntary model  
15 to join the program.

16           I'll say quickly, as a researcher, I loved  
17 randomization in the chapter. I'm not going to hold my  
18 breath on that one, but it would be great in terms of  
19 evaluation. But I'm not holding out for that one.

20           The final point I'll make: I very much agree  
21 with the eloquent remarks Karen and Jonathan made around  
22 focusing on those high-cost, high-need patients. And I

1 would go even a little bit further to say are there high-  
2 cost settings that we might focus on? For example, most of  
3 the ACOs to date have been hospital- or physician-led.  
4 There's only one nursing home-led ACO that I'm aware of,  
5 but it's a really intriguing model, and other ways of  
6 taking these kind of base set of models and applying them,  
7 not just to high-cost beneficiaries but also in high-cost  
8 settings.

9 I'll stop there and say thanks and look forward  
10 to our continued work on this issue.

11 MS. KELLEY: Paul, you're next.

12 DR. PAUL GINSBURG: Yeah, thanks. I'm really  
13 glad we're doing this. I thought the staff work was  
14 excellent, and my colleagues have made really valuable  
15 comments.

16 I think the key thing is that we've been doing  
17 demonstrations aggressively for over ten years. We have  
18 learned a fair amount. We could have learned more if, you  
19 know, we had followed some of the advice we talked about.

20 I think that the Commission needs to come up with  
21 a proposed strategy for how we can get from where we are  
22 now to a system that is not a demonstration system, that is

1 a permanent policy, subject to change, of course, like the  
2 DRG system was. And I think we need to say, you know, are  
3 there any more demonstrations that are needed, one that  
4 could go on along with a permanent system? But I think we  
5 really need to come up with a plan to get there and to  
6 recommend that to Congress.

7           You know, some of the issues that are very  
8 important for us to figure out are how the models can fit  
9 together, the mandatory-voluntary, and I think that  
10 mandatory works very well, particularly with episodes. I  
11 think for population-based, it may be more important to  
12 follow Dana's approach of strong incentives to be in, but  
13 not insisting that everyone be in there.

14           I think we should pay some attention to the  
15 potential for commercial insurers to pursue parallel models  
16 and are some models easier if they are enthusiastic for  
17 them to do? I know our primary care models have  
18 deliberately recruited commercial insurer participants in  
19 the areas, but I think we should factor that into our  
20 thinking.

21           So I'll stop there.

22           MS. KELLEY: Jon Perlin.

1 DR. PERLIN: Thanks. Let me agree emphatically  
2 with many of my colleagues' appreciation for this chapter  
3 and this important work.

4 You know, in 2015, I had the privilege of serving  
5 as the Chair of the American Hospital Association, and my  
6 big epiphany that year is that in terms of transformation,  
7 two things are needed, not one: a clear vision of the  
8 destination as well as a clear mechanism for  
9 transformation. The absence of either one is insufficient.  
10 I think that transformation path that Amol alluded to  
11 really begs the question in the context that we have now:  
12 Which path? Which destination? So this potpourri makes  
13 defining the destination journey far less clear.

14 So with respect to the discussion questions, I'm  
15 emphatically in favor of fewer models, clearer, and as  
16 others have said, a lot less complex, and I think with  
17 strong incentives coupled with mechanisms to delineate the  
18 transformation process as well as the ultimate destination.

19 Second, this really leverages my experience in  
20 the VA. I think we need to emphasize the role of the  
21 primary care provider more as an organizing principle,  
22 whether like Jonathan Jaffery it's a nephrologist or,

1 Betty, whether it's a nurse practitioner, whether it a  
2 heart failure doctor, Karen, or an HIV expert. Someone  
3 needs to be the quarterback. What would be the problem?  
4 We're asking a system, a football team, just organize the  
5 play while you're out there. No. Someone needs to call  
6 the play, and I think this lack of focus on the primary  
7 care provider, whoever that might be, I think it's what's  
8 leading to some of the diffusion and lack of capacity to  
9 really sort of simultaneously advocate, understand  
10 professionally what matters, and then sort of make the  
11 system more effective in delivering to those needs.

12           In VA, just on this point, when we moved to  
13 essentially medical home type of concept, not only did  
14 functional longevity and quality metrics go up, the cost  
15 per patient went down.

16           Third, I agree with the points that were made  
17 about bringing MA and A-APMs closer together, and I think a  
18 lot has been said on that, so I won't reiterate.

19           I think we can gain a lot by looking to other  
20 countries like the Netherlands and Israel where there are  
21 uniform benefits packages that could be consistent across  
22 A-APMs and MA and essentially the payers could deliver

1 effectively on those packages, and I included the A-APMs in  
2 that, while the providers could deliver value to those  
3 commissioners of care.

4           And then, finally, putting it all together then,  
5 I would agree with Brian with consolidation to population  
6 health and episode and primary care plan, that those be  
7 integrated, and that the articulation of such be a  
8 mechanism that creates that clear understanding of what  
9 both the transformation process is and what the destination  
10 would be.

11           Thanks.

12           MS. KELLEY: Larry.

13           DR. CASALINO: Yeah. In the interest of time,  
14 I'm going to avoid trying to comment on each issue, but I  
15 just want to make two broad points.

16           One is I think that this -- however this winds up  
17 finally being published, I think we want to avoid being too  
18 critical. Actually, I think what's happened to date is  
19 pretty good. A great deal has been learned, and probably  
20 more importantly, I think what's gone on the last 10 years  
21 with CMMI has kind of begun the organizing of an  
22 atmosphere, I would call it. So it's becoming the case

1 where providers are gradually getting the idea that it  
2 isn't going to be business as usual forever.

3 Now, I think if progress doesn't speed up a bit,  
4 the reverse may start to happen. People may think, okay,  
5 this has been going on for 12, 13 years now, and people  
6 keep saying the train is going to leave the station. Well,  
7 it hasn't left the station yet. We're still doing mostly  
8 fee-for-service. That would be bad.

9 But I think a goal is to make it so that the  
10 taken-for-granted thing to do is to try to improve the  
11 health of your population of patients and not by being paid  
12 for fee-for-service.

13 I agree. I think with the pandemic, we've seen  
14 how quickly the health care system can change, at least for  
15 a short time and about certain things. The DRG example is  
16 a good one in some ways but not in others, I think. Much  
17 easier for hospitals to adapt the DRGs than for the whole  
18 delivery system to adapt to trying to create a population  
19 health.

20 But I agree with those who have said we need to  
21 move as quickly as we can from things that are heavily  
22 based still on a fee-for-service chassis to things that are

1 based on capitation of prepayment.

2           The trouble with this is -- and this gets into  
3 the idea of people have called -- I think Jon just said  
4 this, Jonathan -- you know, what's our strategy for change,  
5 where do we see the process as being. I think the problem  
6 is that -- and Jay wrote about this, Jay Crosson, years  
7 ago. We really have a chicken-and-egg problem. If we had  
8 certain kinds of -- or delivery system organizations, we  
9 could just give full risk capitation and get away from fee-  
10 for-service completely, have some quality patient  
11 experience measures, and we'd be done. But we don't have  
12 that. We're not even close to having that.

13           So I think Jay portrayed it, and it's frustrating  
14 and messy. And it takes time, but I think he's probably  
15 right that we make some payment changes, the provider  
16 organizations change a bit. This enables a bit stronger  
17 payment incentive changes to be given and the provider  
18 organizations change more and so on, so kind of a  
19 ratcheting up. So that's my first comment.

20           Second comment, I'll be briefer, and it's about  
21 episode-based payment. I think the concept that -- for  
22 example, if episode-based payment for joint replacement



1 works well, then let's get episodes for as many things as  
2 we can. And in particular, let's get episodes for chronic  
3 diseases, and so we'll be paying some providers for taking  
4 care of patients with diabetes and other providers are  
5 taking care of their COPD and other providers are taking  
6 care of their heart failure. And I think from what Karen  
7 and others have said, it kind of hints that that may not be  
8 a good idea.

9           Also, the more episode-based payments we have,  
10 the more this kind of gets in the way, evaluation-wise and  
11 in other ways, of having accountable organizations that are  
12 really accountable for the health of -- all the health of  
13 all their patients.

14           So without getting into more detail on this, I  
15 think we -- this isn't discussed often enough, I don't  
16 think. I think we want to think very carefully before we  
17 start to encourage a plethora of episodes as opposed to  
18 trying to get accountable organizations that would take  
19 care of patients, all patients' health care needs.

20           MS. KELLEY: I have Marge next.

21           MS. MARJORIE GINSBURG: Thank you.

22           I just wanted to briefly respond. Brian, I

1 think, so far is the only one that raised a comment of the  
2 involvement of participants, and I think one thing that was  
3 missing from the chapter, but perhaps it was me that missed  
4 it, is what happened to the whole process where the  
5 programs were supposed to notify participants that they are  
6 now in an A-APM. And I've never heard anything more about  
7 it.

8           The fact that people with Medigap insurance have  
9 almost no cost sharing, but it occurred to me -- and this  
10 may be that I read somewhere -- that Medigap plans could  
11 offer a discount for those who are willing to, in fact, be  
12 participants in this program.

13           So it just seems to me the one thing that's  
14 missing here -- and it may not have a gigantic impact on  
15 the success of these programs -- is where are the  
16 beneficiaries in this, and do we need to at least start  
17 testing programs that actively engage participants in the  
18 A-APM that they're a part of?

19           Thank you.

20           MS. KELLEY: Sue?

21           MS. THOMPSON: Thank you, Dana.

22           And I'll be quick as well because I think there's

1 still a few more to go. In terms of a context of this  
2 conversation -- and it was referenced. I think Larry  
3 commented, but between COVID, dealing with this entire  
4 pandemic, managing the complexity of the Next Gen contract  
5 and the constant changes while evaluating direct  
6 contracting looking forward, the bandwidth of interest  
7 around staying enthusiastic in this work is waning across  
8 the folks that I work with and across other organizations  
9 that we're in contact with in this ACO work. So I just  
10 call that out as a bit of the in-the-field context for kind  
11 of continuing at this pace.

12           And so with that, I just would strongly agree  
13 that we have way too many models, and we've got to bring  
14 some conclusion to all this voluntary activity.

15           The ongoing commentary about organizations that  
16 are hospital-based ACOs, first and foremost, patients are  
17 attributed to ACOs by their primary care provider. If  
18 there are hospitals in the ACO, they are increasingly  
19 frustrated that the ACO remains on a fee-for-service  
20 chassis. So the conflicts and the inherent -- the counter-  
21 incentives that go on are very difficult, but rather than  
22 being critical of their less than great performance, I

1 think we need to be thinking about how do we build an  
2 opportunity for hospitals to be incented to reduce  
3 expenses. So I would offer that as a suggestion.

4 I'm strongly in agreement with harmonizing the  
5 benchmarking between ACOs and MA.

6 And finally, we haven't spent a great deal of  
7 time talking about the role of the beneficiary and how we  
8 might do more work either in educating beneficiaries about  
9 their role or building incentives to help reduce  
10 utilization and improve health.

11 Thank you.

12 MS. KELLEY: The last person I have in the queue  
13 is Pat.

14 MS. WANG: Thanks.

15 Just really quickly, I won't repeat the really  
16 thoughtful comments of the other Commissioners.

17 I want to suggest that we not use the word  
18 "mandatory" because it sounds a bit harsh. I prefer to  
19 think of it as once there seems to be promise in some of  
20 these pilots that they become the new methodology for  
21 paying for certain things. I don't think it's a mandatory  
22 issue. I think it's just we decided that this is a better

1 way to pay.

2 I also want to -- I understand the interest in  
3 episodes and bundles, but I actually don't -- I have a lot  
4 of caution about going there. If it's a step along the  
5 way, it's fine, but to me, it's still a unit of surface.  
6 It's an expanded fee-for-service payment, and you can drive  
7 -- you know, I think that you can create different  
8 incentives by creating those kinds of things because then  
9 the more of them that you do, the more revenue you  
10 generate. So it drives towards the point of having some  
11 sort of global budget in the background against which all  
12 of these little bundles are held, because maybe you don't  
13 need to deliver as many bundles, even though they seem  
14 really neat in and of themselves. So that would be my  
15 caution there.

16 And that's all I want to say. Thanks.

17 DR. CHERNEW: So, hopefully -- can you hear me?  
18 I think, Dana, that was the entire queue, showing you once  
19 again the miracle of MedPAC Commissioners staying broadly  
20 on time.

21 I will reach out to some of you that may not have  
22 spoken, but I think in the interest of time, we should

1 probably move on to the next topic which is vertical  
2 integration.

3 I will say for those on the line that there's a  
4 lot of issues here. I've written down some, mandatory  
5 versus voluntary episodes versus population-based, the  
6 principles of benchmarks, downside risk. I have a few  
7 other things. We are not going to be able to address all  
8 of those things this cycle.

9 So I am hoping we will move -- there seems to be  
10 some agreement around harmonizing and trimming the models  
11 and stabilizing them. I think we will move toward a  
12 recommendation in that vein. I hope we can lay out a  
13 little bit of principles around certain things going  
14 forward in the chapter, but some of these issues are very  
15 analytically complex. And so we're going to have to take  
16 them in a targeted and thorough way as opposed to going  
17 around and just getting everybody's views on each  
18 particular one-off design principle.

19 But I really appreciate that discussion, and so  
20 I'm now going to turn it over to Rachel. Thanks so much.

21 \* DR. SCHMIDT: Good morning.

22 Before we begin, I'd like to thank Jeff, Carol,

1 Eric, and Shinobu for their help. And as a reminder to the  
2 audience, you can download a PDF version of the slides in  
3 the handout section of the control panel on the right-hand  
4 side of the screen.

5 In this last session of the October meeting,  
6 we're going to have a big-picture discussion about vertical  
7 integration in health care.

8 Last March, we published a chapter about health  
9 care provider consolidation, with most of the focus on  
10 hospital consolidation and hospital purchases of physician  
11 practices. At the time you discussed that material, some  
12 of you said you'd like to see information about vertical  
13 integration in other sectors. So this morning, we'll talk  
14 briefly about health systems but then look at what health  
15 plans have been up to, because both have implications for  
16 the Medicare program.

17 This material is meant solely as food for thought  
18 as you deliberate policy issues during this cycle.

19 Because Medicare is such a large program,  
20 Medicare policies can influence how providers and health  
21 plans organize themselves as well as the degree of  
22 competition and rivalry among them. Of course, Medicare is

1 not the only factor when health care companies are  
2 considering mergers and acquisitions because we have a  
3 variety of payers in the United States, and market  
4 conditions vary geographically.

5           Nevertheless, here are a few examples of what I  
6 mean. In our March chapter, we noted that higher payments  
7 for physician services at hospitals played a role in  
8 hospital purchases of physician practices. Similarly,  
9 policies aimed at promoting care coordination such as  
10 accountable care organizations and bundled payments may  
11 lead groups of providers to decide that it's easier to  
12 align incentives by purchasing other providers.

13           Medicare has been making changes to how it pays  
14 for post-acute care, and a unified PAC payment system could  
15 have large redistributive effects among types of providers.  
16 Some PAC companies have begun reorganizing themselves in  
17 response.

18           Finally, Medicare's launch of a drug benefit and  
19 the expansion of Medicare Advantage enrollment, we've  
20 observed, have both contributed to changes in the structure  
21 of health plans.

22           Let's look briefly at the state of vertical



1 integration with respect to health systems. This  
2 information comes from the Agency for Healthcare Research  
3 and Quality's Compendium of U.S. health systems. Here, to  
4 be included, a health system had to have at least one non-  
5 federal general acute-care hospital and one physician group  
6 with at least 50 physicians connected through common  
7 ownership or joint management. In 2018, there were 637  
8 health systems that had about 3,400 hospitals affiliated  
9 with just over half a million physicians.

10           Hospitals have been consolidating for decades,  
11 and in 2016, about 70 percent of hospitals and 88 percent  
12 of beds were already in health systems. Those percentages  
13 increased a little bit between 2016 and 2018, but not by  
14 that much. What's surprising is how quickly physicians  
15 have become a part of health systems over those two years.

16           By 2018, about half of physicians were a part of  
17 health systems, including primary care physicians. This  
18 quick increase may reflect steps to align incentives  
19 between hospitals and physicians, measures to help maintain  
20 referral patterns to hospitals, the incentives provided by  
21 higher physician payments at hospital-affiliated offices,  
22 or a combination of all of those factors.

1           Our March chapter has a review of the literature  
2 on the effects of hospital-physician vertical integration.  
3 To summarize, we found that while in theory, integration  
4 could lead to a lower overall volume of services through  
5 greater coordination of care, the empirical literature  
6 suggests that while there may be some substitutions in  
7 types of care, integration does not have a substantial  
8 effect on volume in the aggregate, nor does hospital-  
9 physician integration seem to improve quality. Most  
10 studies show ambiguous or no effects.

11           However, studies have consistently found that  
12 physician-hospital integration leads to higher commercial  
13 payment rates. One reason is that hospitals charge  
14 facility fees for physician services in addition to  
15 professional fees. Another reason is that large hospital-  
16 based practices gain market power and negotiate higher  
17 rates.

18           Medicare and its beneficiaries are insulated from  
19 these effects initially because Medicare sets fee-for-  
20 service prices administratively. However, higher  
21 commercial payment rates could lead providers to pressure  
22 Medicare to increase its rates. Meanwhile, vertical

1 integration is associated with higher payments for both  
2 commercial and Medicare patients because of higher payment  
3 rates for hospital-based care and because physician  
4 referrals patterns may be altered towards hospital  
5 facilities.

6 As hospitals have acquired physician practices,  
7 health plans have responded in kind. But physician  
8 practices are just one way in which health plans have  
9 become vertically integrated.

10 As this slide shows, the major U.S.-managed  
11 health care companies all own their own pharmacy benefit  
12 managers, typically with their own large mail and specialty  
13 pharmacies. In addition to physician practices, major  
14 health plans have purchased other types of settings for  
15 outpatient care and invested in data analytic and  
16 consulting firms. What health plans have not purchased, by  
17 and large, are hospitals, health systems, and other types  
18 of institutional providers.

19 Meanwhile, in the Medicare Advantage and Part D  
20 programs, enrollment is pretty concentrated in plans  
21 offered by vertically integrated managed care companies.  
22 This is an overall look at enrollment, not market by

1 market, but it can still give you a sense of the degree of  
2 concentration. The top three companies in the MA and stand-  
3 alone prescription drug plan sectors account for over half  
4 to nearly two-thirds of all enrollment, and the top 10  
5 plans sponsors account for three-quarters of MA enrollment  
6 to nearly all PDP enrollment.

7           Empirical literature suggests that when insurers  
8 merge with each other and gain market power to negotiate  
9 lower commercial prices with providers, it doesn't  
10 necessarily lead to lower enrollee premiums. Premiums are  
11 lower when there is more competition among insurers in a  
12 market. For the same reason, it is important to promote  
13 competition among MA and Part D plan sponsors.

14           Over the next few slides, we'll consider the  
15 potential implications for Medicare of three categories of  
16 vertical mergers that health plans have engaged in, with  
17 outpatient providers, PBMs, and PAC services.

18           In your mailing materials, there are examples of  
19 vertical mergers that have taken place recently, making  
20 some health plans among the organizations with the largest  
21 number of physician employees or affiliates in the country.  
22 In addition, health plans have acquired chains of retail

1 clinics for lower-acuity services, ambulatory surgical  
2 centers, and multispecialty medical centers that focus on  
3 chronic disease management and senior care.

4 Presumably, a main advantage of this type of  
5 acquisition is that the health plan can include in its  
6 network providers that it believes provide higher quality  
7 or lower cost care and align providers' incentives with  
8 those of the plan through risk-based payments.

9 In turn, by encouraging enrollees to see those  
10 providers or go to lower cost sites of care, the plan could  
11 improve quality and lower costs. Health plans may have more  
12 resources to invest in decision support or quality-  
13 measurement tools for physician groups that they acquire.  
14 Health plans may also vertically integrate with outpatient  
15 providers to assert their own market power, to defensively  
16 counter the market power of health systems, or to remain  
17 competitive with other insurers.

18 Do these forms of vertical integration benefit  
19 the Medicare program and its beneficiaries? There's not a  
20 lot of evidence, but there are reasons to be cautious and  
21 not generalized.

22 For one, acquired practices and providers may not

1 overlap geographically with larger concentrations of a  
2 health plan's MA enrollees. There's overlap in some cases  
3 and not in others. Some of the vertical mergers lead to  
4 direct employment of providers, while others do not. In  
5 situations where a provider is not exclusively employed by  
6 a health plan and they see patients from a variety of  
7 payers, other payment arrangements can undermine incentive  
8 arrangements with the plan.

9           When health plans purchase a number of different  
10 provider groups, the providers may be using a variety of  
11 electronic platforms, and harmonizing those tools can take  
12 time.

13           For health plans that are providing more  
14 convenient access to care through retail clinics and  
15 centers, it is not clear that these care options will  
16 necessarily substitute for care at higher-cost settings and  
17 lead to lower spending. It could lead to more use of  
18 services.

19           Next, let's look at vertical integration with  
20 PBMs, which also own large mail and specialty pharmacies.  
21 Health plans have integrated with and built up large PBMs  
22 that may have market power to negotiate rebates with drug

1 manufacturers and achieve scale in mail dispensing. Those  
2 are important functions as medicines have become a larger  
3 component of health spending.

4           But why doesn't a health plan just write a  
5 contract with an independent PBM? Because of the  
6 complexity of drug pricing, the highly proprietary nature  
7 of rebates, and imperfect competition among PBMs, PBMs have  
8 an information advantage, so it can be difficult to monitor  
9 a PBM contract and costly to enforce it.

10           Health plans may have decided that it's easier to  
11 just buy the PBM. By doing so, the health plan gains  
12 access to information about drug prices net of rebates and  
13 discounts, which can allow it look at tradeoffs between  
14 medical and drug expenses. If instead the health plan had  
15 an arm's-length contract with a separate PBM, the PBM might  
16 have incentive to keep drug spending low even when a  
17 medicine might forestall other kinds of medical expenses.  
18 A vertical merger may align those incentives.

19           Acquiring or building your own PBM and mail and  
20 specialty pharmacies also gives the health plan access to  
21 an important source of data, claims that are typically  
22 adjudicated at the pharmacy. That data can be used in a

1 lot of ways such as monitoring adherence or predicting  
2 future use of services.

3           Does vertical integration between health plans  
4 and PBMs benefit Medicare and beneficiaries? There are  
5 ways it's beneficial, for example, by allowing a health  
6 plan to internalize tradeoffs between drug and medical  
7 treatment options. However, there are also reasons for  
8 caution. There are a number of smaller MA plans that have  
9 contracts with large PBMs owned by competing health plans.  
10 Those smaller plans may still find that because of the  
11 PBM's information advantage about drug prices, it can be  
12 difficult to monitor and costly to enforce their PBM  
13 contract. And because the PBM is owned by a competing  
14 health plan, it might be possible to raise the rival plan's  
15 costs, not obtain the best discounts or rebates on behalf  
16 of the smaller plan.

17           A second reason for caution goes back to the  
18 degree of concentration of MA and Part D enrollment among  
19 relatively few large health plans. If large plan sponsors  
20 are able to achieve efficiencies by acquiring a PBM, that  
21 doesn't mean it will necessarily lead to lower Medicare  
22 payments or enrollee premiums to MA or Part D plans. It's



1 the degree of market competition among health plans that  
2 affects whether they feel pressure to bid lower.

3           And the last point here is just that vertical  
4 integration won't overcome poor incentives in a payment  
5 system. Currently, Part D's benefit structure and subsidy  
6 payments provide incentives for plan sponsors to include  
7 high-cost, high-rebate drugs on their formularies. Those  
8 incentives remain whether a plan sponsor writes a contract  
9 with its PBM or vertically integrates with the PBM.

10           The mailing materials give examples of how health  
11 plans have vertically integrated with companies that  
12 provide PAC services. One strategy has been to directly  
13 acquire PAC providers such as home health agencies. In  
14 that situation, from the health plan's perspective, the  
15 advantages may be similar to those of acquiring physician  
16 practices. The plan can include what it views as higher-  
17 quality, lower-cost providers in its network, align  
18 incentives between the plan and provider through risk-based  
19 contracts, and then encourage enrollees to use those  
20 providers.

21           Under a second strategy, health plans have not  
22 acquired PAC providers, but they have acquired firms that

1 manage PAC services. Such a company would, for example,  
2 track enrollees with inpatient stays, use patient  
3 information to predict whether the individual needs PAC  
4 services, and then help clarify which PAC setting might be  
5 appropriate for functional improvement. In both  
6 approaches, a goal seems to be to encourage enrollees to  
7 use non-institutional PAC or to reduce lengths of stay at  
8 institutional providers if that type of care is needed.

9           Whether vertical integration with PAC companies  
10 benefits Medicare and beneficiaries depends on a number of  
11 things. As was the case with physician practices, PAC  
12 providers that are directly acquired by a health plan may  
13 or may not overlap with the geographic markets where MA  
14 enrollees live. If the PAC provider does not exclusively  
15 serve the health plans' enrollees and there are multiple  
16 payers, the provider may have mixed incentives rather than  
17 being aligned with the health plan.

18           Importantly, there is still some uncertainty as  
19 to whether substituting home-based care for institutional  
20 PAC will improve quality and lower costs. My colleagues  
21 have found that in fee-for-service Medicare, risk-adjusted  
22 rates of with-in stay hospitalization are higher for home

1 health than for other institutional PAC settings, so it is  
2 very important that the decision to use home care be  
3 appropriate to the circumstances of the patient. And  
4 again, even if the vertical integration of PAC companies  
5 does reduce costs, the degree of market competition among  
6 health plans is what is relevant for determining whether  
7 the Medicare program and beneficiaries benefit from any  
8 savings.

9           To summarize, Medicare policies, among other  
10 factors, can influence how providers and health plans  
11 choose to organize themselves, including whether they  
12 integrate vertically. We have seen that hospitals have  
13 been organized into health systems and, increasingly,  
14 health systems have acquired physician practices. Health  
15 plans too have become more vertically integrated with  
16 physician and other outpatient providers, PBMs, and some  
17 PAC companies.

18           However, analysts have pointed to a tension  
19 between more coordinated care and the degree of market  
20 competition that remains once health care firms have  
21 reorganized themselves. Some vertical integration may work  
22 to improve quality and efficiency, but we have also

1 discussed some reasons why we shouldn't expect that all  
2 such deals will benefit Medicare and beneficiaries.

3           When policymakers introduce changes to Medicare,  
4 they are generally focused on the program's goals, making  
5 sure beneficiaries have good access to quality care that is  
6 provided in an efficient manner. But as we consider policy  
7 changes, it is also important to think about how they might  
8 affect market competition among providers and health plans.  
9 Many policies that would directly affect competition, like  
10 antitrust enforcement and state licensing requirements, are  
11 outside of our purview.

12           However, there are some policies within Medicare  
13 that can help promote competition. Carrying out site-  
14 neutral payments and focusing on fewer quality metrics that  
15 measure care outcomes are a couple of examples. As an  
16 increasing share of Medicare beneficiaries obtains their  
17 care through private plans, policies that promote rivalry  
18 and strong competition among MA and Part D plans are  
19 important for ensuring that any efficiencies associated  
20 with vertical integration get passed on to beneficiaries  
21 and the Medicare program.

22           At this point I am happy to answer questions

1 about the material. I would also like to know whether there  
2 are other aspects of vertical integration that you want us  
3 to pursue, or if there are implications for Medicare that  
4 we have missed and that you'd like us to address.

5 MS. KELLEY: Mike, shall we start with the round  
6 one questions?

7 DR. CHERNEW: Absolutely, and I think David is  
8 the first in the queue. I'm not sure.

9 MS. KELLEY: I think that's right.

10 DR. CHERNEW: Hopefully you can hear me.

11 DR. GRABOWSKI: Yeah, great. Thanks, Rachel.

12 This is great work. I had a question on the post-acute  
13 care integration. Do you have any sense of why now? You  
14 know, MA plans have been, you know, using post-acute care  
15 and contracting with post-acute care providers for a long  
16 time. What is stimulating this?

17 And then I think the other part of my question  
18 would be, are these just two deals? I realize these are  
19 two major companies with Humana and United Health, but is  
20 there a sense that this is the way the world is going, or  
21 is this a couple of one-offs? So two questions.

22 DR. SCHMIDT: So I'd say it seems like there's

1 less of this than the other types of examples that we  
2 provided of vertical integration. I'm not sure that it's  
3 just one-off, however. I do see a few other things in the  
4 precedents. Of course, this is not a full inventory of  
5 everything that's going on. This was meant as a thought  
6 piece. So I think there are a few other examples out there  
7 that weren't in your paper.

8           And as for why now, that's a good question. I  
9 think Bruce has communicated ahead of time he has a  
10 hypothesis as to why that is, and I think I'll let him  
11 speak to that. But I think part of it is just that maybe  
12 the fact that you've seen so much growth in Medicare  
13 Advantage enrollment, and there are a few demonstrations on  
14 the horizon, for example, including broadening what  
15 Medicare Advantage plans cover to include hospice, and  
16 maybe it's a realization that they are going to be  
17 responsible for the full variety of care. But maybe I  
18 should also let Bruce have his say too.

19           DR. GRABOWSKI: We can all wait on pins and  
20 needles for Bruce's round two comments here, I guess.  
21 Thanks, Rachel.

22           MS. KELLEY: Amol, did you have a question?

1 DR. NAVATHE: Yeah, I had a quick question. So  
2 on page six of the readings, at the top there is a comment  
3 about horizontal consideration raising private payer  
4 prices, which makes sense, and then there's a comment that  
5 says, "However, higher payment rates could lead providers  
6 to pressure Medicare to increase its rates."

7 And so I just wanted to see if we have any  
8 thoughts around the mechanism would be there, because  
9 otherwise Medicare is collecting cost reports for many of  
10 the different provider types. Medicare is using its  
11 monopsony power, presumably. So it didn't seem clear to me  
12 that there was a mechanism there or what the pathway was,  
13 and I was curious if you guys have more evidence there than  
14 I might be aware of.

15 DR. SCHMIDT: I might invite my hospital  
16 colleague, Jeff, to join in on the answer to this one. But  
17 it may be partly a political sort of argument that, you  
18 know, if there's a wide disparity between commercial and  
19 Medicare rates it just becomes more difficult politically  
20 to hold down, tamp down administrative prices. As to  
21 whether there is evidence of that, this actually taking  
22 place or not, I would ask Jeff if he wants to comment on

1 that.

2 DR. CHERNEW: Can I jump in for a second before  
3 Jeff says something? So first, I watch Twitter to see how  
4 many people looked at the Stensland article in Health  
5 Affairs, which will be fun to discuss. I think the theory,  
6 from some previous work that MedPAC did, is if commercial  
7 rates are high the hospital cost structure inflates, and  
8 once the hospital cost structure inflates to compete for  
9 commercial payments or whatever you believe, that then the  
10 higher hospital -- or it doesn't have to be a hospital --  
11 the higher provider cost structure tends to put pressure on  
12 Medicare rates.

13 Again, we can discuss the evidence of this  
14 broadly, but the question you asked, Amol, was what the  
15 theory was, and that actual work was done, I think, the  
16 last time I was on the Commission, and again, Jeff  
17 Stensland is the co-author on a related paper in Health  
18 Affairs.

19 So now that I got to plug Jeff's paper, we'll let  
20 Jeff say something.

21 DR. STENSLAND: I don't have much to add but I  
22 would say on the hospital side the concern is higher rates,



1 the provider has it, they spend the rates. Once they spend  
2 that money and Medicare rates don't go up initially, it  
3 looks like they're losing money on Medicare, and the lower  
4 the Medicare margins the bigger the losses on Medicare, the  
5 more pressure there will be to increase Medicare rates.

6 The other is simply, on the other sectors, even  
7 the physician sector, to the extent that the private rates  
8 become so much higher than Medicare, eventually there is  
9 this concern that will people stop taking Medicare and then  
10 eventually will there be an access problem. And we haven't  
11 seen that yet but that is a big concern, that the  
12 differential can't get bigger and bigger forever.

13 DR. NAVATHE: Thanks.

14 DR. CHERNEW: So if I followed correctly, we are  
15 now ready for round two. Paul Ginsburg is going to lead us  
16 off. We have a list, I think, of five, and Bruce, I think,  
17 is going to eventually be on that list. But we're going to  
18 now start with Paul.

19 DR. PAUL GINSBURG: Oh, thanks, Mike. I thought  
20 this draft that we read was outstanding, and it fascinated  
21 me with the comprehensiveness of different types of  
22 vertical integration, and the insights in the paper,

1 especially about what different types of vertical  
2 integration mean for Medicare and its beneficiaries.

3           As stated, many of the issues raised were outside  
4 the scope of Medicare policy, but a surprising number of  
5 these issues can be influenced by Medicare policy. So many  
6 of the approaches to vertical integration discussed appear  
7 to have the potential to create value, but the value may  
8 not go to Medicare or its beneficiaries, either because of  
9 poorly designed payment systems, the lack of competition in  
10 areas such as Medicare Advantage, or because of the  
11 combinations likely will reduce competition, either because  
12 of the horizontal integration that's often embedded with  
13 vertical integration, such as when hospitals acquire  
14 physician practices that used to compete with them, or its  
15 impact on discouraging entry into some markets.

16           So if we give the example of insurers and PBMs,  
17 my sense is if the potential data flows between the  
18 insurers and PBMs are creating value, but if only the  
19 largest insurers can create PBMs, the additional advantage  
20 of large insurers over small ones is likely to reduce  
21 competition in insurance.

22           The paper indicated that it was prepared because

1 Commissioners wanted to know more about vertical  
2 integration. We should use it to think about how the  
3 potential for vertical integration should be factored into  
4 our work, and the most obvious policy opportunity for  
5 Medicare is further reducing site differentials in  
6 payments, and MedPAC has done valuable work in this area,  
7 but perhaps it is time to revisit and do more.

8           Another opportunity is to make the Medicare  
9 Advantage market more competitive. Without that, insurer  
10 integration with PBMs or post-acute care may not benefit  
11 the program or its beneficiaries. And even without  
12 competitive bidding steps like standardizing Medicare  
13 Advantage benefits and bringing down benchmarks would  
14 likely help Medicare capture more of the value created by  
15 integration.

16           An area that CMS plays a role in, which we  
17 haven't discussed, is data interoperability. To the degree  
18 that we can proceed quickly to make data interoperability a  
19 reality makes virtual integration a more viable alternative  
20 to mergers and employment, and that would be very much a  
21 positive thing.

22           So hopefully what we are learning about the

1 implications of vertical integration on Medicare and its  
2 beneficiaries can shape our agenda on other policy areas.  
3 Thanks.

4 MS. KELLEY: I have Jon Perlin next.

5 DR. PERLIN: Okay. Thanks, Mike, for asking me  
6 to comment on this area. Rachel, thank you for a terrific,  
7 provocative, and important chapter and discussion. I can't  
8 help but consider this chapter, this conversation, without  
9 referencing the thinking about our last discussion, and,  
10 you know, the late great John Eisenberg always asked "what  
11 would [inaudible] think?" And we are where we are by  
12 virtue of many of the incentives that exist. And I think  
13 Paul just challenged us to think about how our policy  
14 recommendations actually influence that set of incentives  
15 that yields these occurrences.

16 I want to just take as a test case, but I know it  
17 best of all, the area of hospital and physician vertical  
18 integration, and really unpack why hospitals and physicians  
19 do end up in mergers or essentially practices being  
20 acquired. You know, I think that the simplistic view is  
21 that the hospitals do that just to gain referrals, but  
22 Rachel's data actually shows that those alignments don't

1 make all that much of a difference.

2 I think we've not actually looked tightly enough,  
3 closely enough at the physician end, but the chapter,  
4 appropriately, alludes to the impact of regulatory  
5 complexity. There are hundreds of thousands of Medicare  
6 regulations that both hospitals, but in this instance,  
7 physicians need to comport with, and the capacity for a  
8 small practice to do that is very challenging. Capacity to  
9 engage in programs, understand the structure, the reporting  
10 requirement, the information transmission requirements of  
11 value-based purchasing, et cetera, is itself not extremely  
12 complex.

13 I also want to acknowledge, from a physician  
14 perspective, the asymmetry between a small practice and a  
15 highly consolidated market of both commercial as well as,  
16 as was pointed out in the chapter, MA players, and beyond  
17 that, trying to work one's way, as a clinician, though not  
18 just highly consolidated payers but then a myriad of  
19 products underneath, each with their own requirements in  
20 terms of how practice occurs is just an extraordinarily  
21 complex issue.

22 So I posit that actually from the hospital lens

1 that the most compelling reasons for consolidation are  
2 around clinical alignment and efficiency. Obviously,  
3 hospitals are paid under a DRG system, but the care is  
4 driven by the doctor under, who is paid under Part B. The  
5 old saw about the most expensive instrument in a hospital  
6 is a physician's pen. Perhaps today it's a mouse. But  
7 that remains true, and the arbitrage between the DRG and  
8 some say it's really based on efficient practice.

9           So aligning for clinical excellence, whether it's  
10 not meandering through diagnosis, not meandering through  
11 treatment, promoting timely discharge, preventing  
12 readmission, all of that are, I'd say, driving features.

13           I think that we also have to contend with the  
14 fact that there are challenges or circumstances that were  
15 simply not contemplated at the time Medicare was set up in  
16 the '60s. Being on a rotating call schedule is part of  
17 being a doctor. You didn't get paid extra for it. That  
18 was part of being on a voluntary medical staff. Today,  
19 physicians expect payment for that, particularly so at  
20 expensive subspecialties and areas where there's been  
21 attrition or a few new providers, general surgery as an  
22 example. There are thousands of dollars per night, per

1 specialty, that hospitals maintain in terms of providing  
2 and probably required on-call coverage.

3           The clinical alignment itself, third point, is  
4 very complex. I happen to thinking using a preferred  
5 formulary, but here's interesting because the same  
6 incentives apply, like health plans, on higher quality and  
7 lower-cost providers. It was pointed out that the quality  
8 measures may not be better but managing to the quality  
9 measures in an integrated environment is simply easier.  
10 And just to be very blunt about this, a portfolio of  
11 providers in a hospital health system gets winnowed based  
12 on performance efficiency and quality outcomes.

13           So when you step back and you ask why is it as it  
14 is, you need to know the facts and the first principles.  
15 You've got hospitals being paid over here and physicians  
16 being paid over here, and this is where it really takes me  
17 back to the last discussion. Imagine the power when  
18 payments combined performance measurement is symmetric,  
19 integrated, and consistent.

20           So let me stop there and I look forward to  
21 continuing the discussion. Again, thanks for the chapter.

22           DR. CHERNEW: Thanks, Jon. I think we have Larry

1 next. Is that right, Dana?

2 MS. KELLEY: That's right.

3 DR. CASALINO: Okay. I'm not exactly sure how I  
4 got into the queue, but I have two things I can say, very  
5 high level. I'll stay away from the details at least for  
6 right now.

7 One is I really -- first of all, thanks for this  
8 presentation and for the information about vertical  
9 integration between health plans and organizations other  
10 than medical groups. Very interesting to hear and so  
11 little is known about it, so thanks for doing that.

12 So the two points are, one, I really liked your  
13 point, which is not made very much, at least publicly, that  
14 there have been a lot of unintended consequences in terms  
15 of consolidation and vertical integration of Medicare  
16 policies that are aimed at one thing, like 340B or site-  
17 specific payments, that are aimed at one thing but wind up  
18 promoting a consolidation in general and vertical  
19 integration specifically.

20 And it probably would be good to enunciate very  
21 prominently the thought, although I think this is probably  
22 pretty idealistic, that policymakers may want to consider



1 the potential effects on consolidation and vertical  
2 integration in any policy that they're thinking about.

3           Then the second point is that the antitrust  
4 agencies, I guess it wasn't really stressed in the  
5 presentation very much. The antitrust agencies are very,  
6 very, very reluctant to bring vertical integration cases  
7 and especially so in health care.

8           There are Chicago School economists who are quite  
9 sure that vertical integration, for example, between a  
10 hospital and a physician group cannot lead to higher prices  
11 paid by the health plan. This is fairly amusing because  
12 in, I would say, hundreds of interviews of the last 10  
13 years with health plan executives and hospital executives  
14 and medical group leaders, I have yet to find one who  
15 doesn't think that that kind of integration leads to higher  
16 prices from the health plan.

17           So I think the agencies are reluctant to bring  
18 these antitrust cases in any kind of vertical integration  
19 in part because I think a lot of the economists in the  
20 agencies don't believe that vertical integration is a  
21 problem, but also because they're hard cases to win. And  
22 the agencies are very risk averse and hate to lose cases.

1           We talked a little bit that the presentation does  
2 -- it's been mentioned this morning that a lot of things  
3 are beyond the scope of what MedPAC and do, and certainly  
4 antitrust enforcement is beyond the scope of what MedPAC  
5 can do, but it may not be beyond the scope of MedPAC to  
6 point out, if we come to believe this, that consolidation  
7 in general and vertical integration specifically are  
8 problems, and that the antitrust agencies might want to  
9 take a closer look at this in health care.

10           MS. KELLEY: Okay. I have Brian next.

11           DR. DeBUSK: Thank you. With some of the other  
12 Commissioners' comments, I'm really glad that we're looking  
13 into this area. I think this is a very important area.

14           First, I do want to mention I think that A-APMs  
15 sources are an overarching theme. I think A-APMs really  
16 are a solution to a lot of these vertical integration  
17 challenges. So I'm hoping that we see that as the long-  
18 term solution, A-APMs and market-driven programs.

19           As far as hospital to hospital and hospital to  
20 physician integration, I am really glad that we're now, for  
21 example, in the other sessions, looking at policies that  
22 could inadvertently drive that because I do think it leads

1 to higher prices.

2           Jeff, I really do agree with the sentiment that  
3 higher commercial rates drive hospital cost structure,  
4 which then drives cost reports, which then drives Medicare  
5 rates, and I do think there's a connection there.

6           And I just want to take a moment, though, and  
7 speak up for hospitals because imagine the position that  
8 they're in. Consider how difficult it is for us to measure  
9 equality. We're doing peer grouping. We're trying to look  
10 at the standardizing sets of measures. I mean, we as a  
11 Commission wrestle with measuring quality. Imagine how the  
12 public has to deal with that. They don't really have good  
13 transparent quality measures that they can use. So  
14 facility do become a proxy for quality, and it does -- I  
15 mean, there's a lot of brass and glass lobbies out there  
16 that are used to attract those commercial payments.

17           So, again, it makes total sense to me that  
18 commercial rates drive cost structure, drive cost reports,  
19 drive Medicare rates. That connection seems pretty easy.

20           The other thing that I want to talk about,  
21 though, is this insurer-provider-PBM-pharmacy  
22 consolidation. You know, it's much newer. It's not like

1 the hospital consolidations that have gone on for decades.  
2 It's much newer, and I think it could be very problematic.

3 I mean, imagine when we have the same people who  
4 issue Medigap plans are issuing MA plans, are doing PBP  
5 plans, are running the PBM, are running the specialty  
6 pharmacy. There's already a lot of money flowing in every  
7 direction there. Unwinding this when these were stand-  
8 alone entities was virtually impossible, and I think having  
9 these as fully integrated, vertically integrated entities  
10 really presents a challenge for us in transparency and  
11 really in just trying to figure out what's going on behind  
12 the scenes.

13 We can have this debate over does this vertical  
14 integration increase the coordination between, say, the  
15 plan and the physician practice and the PBM, but right now,  
16 that's really just a philosophical question. Does it  
17 reduce cost, or does it ultimately increase prices?

18 The frustrating thing there, by the time the  
19 economists have the data, it's going to be too late. So I  
20 do think there's a little bit of a paradoxical situation  
21 here because what we have is a philosophical issue, that by  
22 the time it becomes a concrete issue, the door will be

1 closed on being able to do anything about it.

2           The one last thing that I want to mention about  
3 this whole thing, imagine all the underpinnings of what we  
4 do with administered rates in Medicare. I mean, think of  
5 the mechanisms that we rely on. We rely on things like  
6 risk corridors, medical expense ratios, margins.

7           Here's just an interesting statistic that I did  
8 preparing for this chapter. In the June 2020 report, we  
9 used the word "corridor" 30 times. We used the word  
10 "ratio" 133 times. But here's my favorite part. In the  
11 March report if this year, 2020, we used the word "margin"  
12 836 times in that publication. What happens in a  
13 vertically integrated environment, the concept of margin  
14 goes away? It's all internal transfer pricing.

15           So really the last thing I want to leave us with  
16 is, short of not doing anything here, just mechanically,  
17 how would we even publish? What does the next March report  
18 look like? Are we going to say relatively efficient  
19 providers reported an internal transfer price margin of 3  
20 percent? I mean, what would that even mean?

21           So I do just want to challenge everyone here. I  
22 do think we need to pay close attention to this because I

1 do think this could interrupt the entire -- disrupt the  
2 entire foundation for administered rates.

3 Thank you.

4 DR. CHERNEW: And now Bruce.

5 MR. PYENSON: Thank you.

6 I wanted to thank Larry for mentioning the  
7 potential role of antitrust in this and some of the issues  
8 around that and also Brian for using the word "transfer  
9 pricing" because I think that's quite relevant.

10 Paul, I agree with -- I'm glad Paul said what he  
11 did, and one of the terms he used was "virtual integration"  
12 as a potential alternative to the corporate integration  
13 that we're seeing as perhaps a solution in the future and  
14 certainly potential competition to the vast enterprises  
15 that we're seeing.

16 I think one of the additional elements of  
17 vertical integration that I'd like the staff to pursue is  
18 to look at the accounting and financial issues that I  
19 believe are driving some of the integration that we're  
20 seeing, especially on the insurance side and the corporate  
21 side.

22 Let's keep in mind that just like provider

1 organizations are complex and have internal conflicts and  
2 people going in different directions, the same is certainly  
3 true of insurance companies, whether they're large or  
4 small. In fact, many insurance entities make sure to have  
5 a diversity of things going on. It's a way of managing  
6 risk. It's a way of encouraging new ideas and potential  
7 solutions.

8 In the reading material, there's certainly  
9 elements of here's some things that could be beneficial in  
10 vertical integration. I don't think I'm in a position to  
11 say, "No. That's not true." For sure, there's people  
12 working very hard on all of those things.

13 But I think there's another side on the corporate  
14 issues. You've got very large organizations that have huge  
15 capital resources. They are active investors in ventures.  
16 In today's low-interest environment, that makes sense to  
17 invest in buying entities. Not all those are going to work  
18 out, but for sure, there's differences in the accounting  
19 practices between insurance entities and other kinds of  
20 entities that I think play a role here and perhaps not so  
21 relevant to Medicare but more to the self-insured accounts  
22 that are much bigger than Medicare in lives and generate

1 potentially large margins for some of the non-insurance  
2 entities involved.

3           So I think an area for staff to pursue is to  
4 understand the differences in accounting perhaps between  
5 for an insurance entity that administers self-insured lives  
6 versus the margins involved in a PBM that seemingly does  
7 something similar, but it perhaps accounts for it  
8 differently -- or a specialty pharmacy.

9           I think the other aspect of this is the  
10 deployment of capital and resources that's an inevitable  
11 part of scale. Brian mentioned some of this in different  
12 lines of business, but a very large organization can move  
13 into a market and sustain losses there if it wants to gain  
14 market share and make life difficult for smaller  
15 competitors, as certainly large organizations can deploy  
16 the resources that we've seen deployed for administrative  
17 roles like risk adjustment.

18           And I think staff put together a remarkable chart  
19 looking at different entities and how risk scores evolved  
20 over time between fee-for-service and the different  
21 entities, and I think the information there suggests that  
22 some large organizations are very effective at optimizing



1 risk scores, but others are not. And it tends to be a  
2 problem when policymakers and even MedPAC look at this and  
3 say, "Well, we're paying too much." Well, when you bring  
4 down the average, you're hurting the start-ups, perhaps the  
5 innovators and the smaller organizations, and if that's the  
6 dynamic we're in, we should think about perhaps other  
7 policies that the future may not have those small entities  
8 and what sort of regulations and policies does Medicare  
9 need for a world where there's only a few large  
10 organizations. So I see that as an implication that I  
11 think staff could address.

12           So I think, overall, the work is very provocative  
13 and really terrific information, but I think a focus on  
14 some of the finance and accounting issues and the  
15 implications, what are we going to be needing to do if we  
16 follow this to its logical conclusion in a few years?

17           Thank you.

18           DR. CHERNEW: Bruce, thank you.

19           In a second, I'm going to let Paul jump in, who I  
20 think has something to say in response to one of Larry's  
21 comments. You're too small on my screen, Paul, to know if  
22 that's exactly true. But then we'll continue with the

1 queue.

2           But I do want to point out the theme from this  
3 is, for all the Commissioners and anyone listening, given  
4 all of these interrelationships and multiple businesses and  
5 organizations are part of and the different accounting  
6 things that I'll rely on Bruce and the staff to educate me  
7 on, it becomes extremely difficult to think about the  
8 weight we put on margins and the cost reports and a whole  
9 slew of other things that we traditionally look at, because  
10 the information we get from them may be capturing only a  
11 part of what is going on. And I think that's a theme of  
12 what some of these comments have been, but that we'll have  
13 to wait for further meetings.

14           For now, I'm going to turn it to Paul.

15           MR. PYENSON: Thanks.

16           I wanted to focus on -- I agree with Larry's  
17 disappointments in the Federal Trade Commission for not  
18 pursuing vertical integration cases involving hospitals and  
19 physicians. I think there are two reasons for that. One  
20 is that the type of the qualitative research that Larry has  
21 done long term and that I until recently did a fair amount  
22 of, that often comes to conclusions about market

1 organization and forces years before quantitative research  
2 does. And unfortunately, I don't think the Federal Trade  
3 Commission thinks it can win a case based on that, but the  
4 bright news is that the quantitative literature on vertical  
5 integration has developed a lot in recent years and has  
6 brought consistent results showing the higher prices that  
7 come from hospital physician integration. So maybe we're  
8 actually ready to bring a case.

9           The other concern, which is a big-picture one, is  
10 that the FTC has long been very underfunded, and when  
11 you're underfunded and have a big job to do, sometimes it's  
12 easier to block a few more horizontal mergers, which are  
13 relatively easy and may have had success, than take on your  
14 challenging first vertical integration case. Hopefully,  
15 that can change.

16           MS. KELLEY: I have Pat next.

17           MS. WANG: Thanks.

18           I love that this is the last session of the day,  
19 and I think it's such an important chapter. And it's great  
20 work because what it does is it links a lot of the  
21 discussions that we've been having, and I think it provides  
22 a broader context that Bruce was talking about towards the

1 end of his comments that we need to keep in mind.

2 I guess a question that I would have for some of  
3 the hospital systems in MedPAC in particular -- we talked  
4 about private equity and the role of private equity. I  
5 actually think private equity has a role in stimulating  
6 some of the system-ness that is happening on the provider  
7 consolidation side. Private equity is essentially taking  
8 advantage of the disorganization of the system and picking  
9 stuff out that they can make money on, and I've always  
10 wondered whether the response of the provider system has  
11 been to try to get more as a system to response to that. I  
12 was curious about that. I would throw that into the mix.

13 Important discussion. I think to the extent that  
14 we are talking about convergence of payer and provider,  
15 however that happens, there's some very positive aspects of  
16 that. I think that there are examples, for example, of  
17 organizations that have skipped the ACO step and gone  
18 straight to full risk when they have found an MA plan  
19 partner that they can really align with and pool resources  
20 like huge information analytics, care management, and that  
21 that's where they're going. And I think you see examples  
22 of provider organizations that are trying to start MA plans

1 around the country for that reason, to try to integrate  
2 better. The examples in the paper were more on the health  
3 plan side, acquisition of providers, and, you know, people  
4 have talked about some of the reasons that that has  
5 happened, and, you know, to the extent that there is better  
6 integration of EMR data, et cetera, I think it can be a  
7 good thing for beneficiaries.

8           On the down side and the danger side, you know,  
9 everybody has been mentioning what happens to competition,  
10 especially when you look at the MA market and how  
11 consolidated it is today, I think that this is a really big  
12 deal. I also think that some of the acquisitions of  
13 physician practices by health plans can actually lead to  
14 predatory behavior, in local markets in particular, where  
15 you can really affect your local competitor if you dominate  
16 their physician network by, you know, jacking prices up,  
17 and it's a bit of a danger.

18           As far as the -- both Brian and Bruce talked  
19 about transfer pricing, and I want to bring it home to  
20 implications for Medicare Advantage. Whatever we decide to  
21 do with benchmarks for payment to MA plans, there is just  
22 something to keep a big watch out about is that plans that

1 are vertically integrated, along the lines of the slide  
2 that we were shown earlier, have such a greater ability,  
3 through transfer pricing, to get in there, be it however  
4 they want, make their bids look a certain way, that will be  
5 very hard to discern.

6           It is a big disadvantage for regional plans, a  
7 big disadvantage for regional plans who do not have the  
8 means at their disposal to engage in that sort of financial  
9 flexibility, if you will. And so if it is a priority to  
10 maintain competition in MA, as well as heterogeneity of the  
11 type of plans that are available, I think it's a big watch  
12 out and I really -- I think it's an important thing to keep  
13 on the radar screen. There may be other things we want to  
14 think about. Thanks.

15           MS. KELLEY: David.

16           DR. GRABOWSKI: Great. Thanks. I'm, like  
17 others, very excited that we are doing this work. I just  
18 wanted to speak briefly about vertical integration between  
19 health plans and post-acute care providers.

20           I think it's really important here that we  
21 consider the context regarding Medicare Advantage and post-  
22 acute care. Three quick observations from the literature.

1 The first, and Rachel did a great job of reviewing this, we  
2 have really strong evidence that MA plans use less post-  
3 acute care, especially skilled nursing facility care. Some  
4 of that, as Rachel noted, may be favorable selection. But  
5 even after conditioning on particular health events like  
6 stroke or hip fracture, and controlling for lots of patient  
7 covariates, it does seem like MA plans are just better at  
8 limiting utilization, and especially utilization of  
9 institutional PAC. So that's kind of the first part about  
10 this.

11 The second is there's some really strong research  
12 suggesting MA plans use lower-quality skilled nursing  
13 facilities and home health agencies, even within markets,  
14 based on the CMS star rating. MA plans are directing to  
15 lower-quality SNFs and HHAs. And then the final results or  
16 thread from the research literature won't surprise anyone,  
17 at least when it comes to skilled nursing facilities and  
18 home health agencies, MA pays below traditional Medicare.

19 And so they pay less, they get less, in the sense  
20 that they're working with lower-quality places, but then  
21 they're also, kind of at least on individual beneficiary  
22 basis, using less services and using different services.

1           And so I want to sort of put that on the table as  
2 we think about vertical integration, these MA plans that  
3 are acquiring post-acute care providers can now do in-  
4 network management of these services. How does that impact  
5 the incentives that were already in place in terms of  
6 utilization and quality? I thought Rachel did a really  
7 nice job in the draft of outlining the possible  
8 implications here. In some regards it may not have any  
9 impact. In other ways it's definitely worth monitoring.

10           I just wanted to make certain we keep our eyes on  
11 the idea that beneficiaries in these plans may have  
12 obviously fewer options, but what is this going to do to  
13 their utilization and ultimate quality? I think this is  
14 something we want to pay attention to. It may be a good  
15 thing that they're using less institutional post-acute  
16 care. That may be consistent with their preferences and it  
17 may not have any implications for their health. But this  
18 idea that plans are often contracting with lower-quality  
19 providers is definitely something we want to keep our eyes  
20 on.

21           There's obviously some upside to this  
22 integration. Brian mentioned that it's largely been



1 philosophical or theoretical to date, the idea that you  
2 could better manage care within a network as these plans  
3 have their own post-acute providers. That could actually  
4 improve outcomes, of course. On the other side, we have to  
5 really examine what's going to happen to care at the  
6 margins.

7           So I really hope this is something we will  
8 continue to monitor as we think about implications of  
9 vertical integration. Thank you.

10           MS. KELLEY: Jaewon?

11           DR. RYU: Yeah. Thanks, Dana. Just a few  
12 thoughts to add to the mix. I think a lot of different  
13 actors and a lot of different combinations. It dawns on me  
14 that there are probably different motivations for each of  
15 those. I think Jon Perlin illustrated some good  
16 considerations that we see as well on the provider side  
17 that I do think comes into play, in addition to all the  
18 things that folks mentioned around what might motivate  
19 hospitals, what might motivate health plans. But I do  
20 think there are a lot of combinations out there.

21           I also think, in the reading there was payer  
22 actions and provider actions. It seems to me like there's

1 a chicken-and-egg kind of dynamic there. It's unclear to  
2 me, at least, is it the provider actions in this space that  
3 are motivating the payer actions, or vice versa? In  
4 reality it's probably both feeding off each other. But I  
5 think that is something I wanted to call up.

6           The other is I think there is a dynamic, and  
7 perhaps this is more pronounced on the payer action side,  
8 around easier channels for growth. If you have a fairly  
9 competitive market, I think there's a growth channel here  
10 that might be easier for them to tap into by vertically  
11 getting into other lines of business. I think there is a  
12 diversification component, which I think either Bruce or  
13 somebody else had also mentioned, but I think if you can't  
14 grow, or maybe it's easier to grow share of wallet, I guess  
15 you could say, when it becomes really tough to grow more  
16 wallets. So I think that may also be feeding into this.

17           The last is, and this I would have liked to see a  
18 little more of in the chapter, but I think there is a  
19 consumer expectation dynamic that's feeding this as well.  
20 It's this notion of end-to-end integrated, easy experience,  
21 know what I want, anticipate what I need, when I go here I  
22 want it to be this way and then when I go somewhere else, I

1 want that information to follow me. I think it's not  
2 unlike what we see with whether it's cellphones or  
3 streaming services. I do think there's a consumer  
4 expectation component that may be feeding into some of  
5 this, in terms of stickiness and a longstanding  
6 longitudinal relationship with patient members, and having  
7 that ability to end-to-end integrate, whether it's your  
8 payer, how you interact with the pharmacy and the PBM, how  
9 you even get your care. I think there is something to  
10 that.

11           There was mention in the readings about data, and  
12 I think that's also a very powerful driver, data and  
13 analytics, and understanding that consumer becomes  
14 tremendously more powerful when you have a full end-to-end  
15 experience.

16           MS. KELLEY: The last person I have in the queue  
17 is Betty.

18           DR. RAMBUR: Thank you so much. I'll be very  
19 brief. First of all I just wanted to underscore and share  
20 my support for the comments that Larry and others had about  
21 antitrust and the FTC. As a private citizen, I've been  
22 very concerned that the reach of the FTC has not really

1 included vertical integration in the same way it has  
2 horizontal, and I understand why now better than I did.

3 But at least from my perspective the data are  
4 increasingly clear, and to the extent that however it might  
5 be appropriate for us to make some statement about that, I  
6 would feel very comfortable, even though I know it's not in  
7 our wheelhouse.

8 Second, I was very intrigued by what Paul said  
9 about virtual integration. I would like us to think about  
10 that more and think about that tangibly, what that might  
11 mean. And finally, I just want to underscore that although  
12 site-neutral payments have been unpopular with hospital  
13 providers, I think that -- I just want to voice my support  
14 for that as an approach to this particular issue as well as  
15 others. Thank you.

16 DR. CHERNEW: Great. So I am going to make a  
17 comment now on this chapter, simply because there's time,  
18 and then I'll see if anyone else wants to add something.  
19 But the first thing I'll say is I think it's important,  
20 through Medicare policy, to avoid exacerbating our problem  
21 with vertical integration, and I think it's something we  
22 need to be aware of. Betty, you raised site neutral. I

1 agree with that. This has been an issue that MedPAC has  
2 addressed for a long time.

3           The other thing I'd like to emphasize is that  
4 this affects a lot of what we do. One of my personal  
5 concerns, for example, is we've built alternative payment  
6 models off of tax identification numbers, TIN. The TINs  
7 are related in organizations in complex ways. There is a  
8 MedPAC recommendation on that aspect to this point, but we  
9 need to think through how the integration affects a lot of  
10 what we do, particularly in the A-APM space, because we  
11 often think of the TINs as the actual organizations, but as  
12 has been pointed out it's really not.

13           Several folks have spoken eloquently about the  
14 impact in relationship between Medicare Advantage plans and  
15 providers. David spoke about the impacts of SNFs and  
16 different plans and providers.

17           So the direction we go in terms of  
18 recommendations is really unclear to me. I will be  
19 interested in what people's thoughts are. But I think more  
20 importantly, and I think the value of this chapter is to  
21 point out that increasingly we, MedPAC, work in a set of  
22 siloed payment models overlaid to a very, very complex and

1 very integrated delivery system with a plethora of  
2 interconnections between the types of organizations. And  
3 while I don't have any particular insight about how we  
4 address that -- in fact, I think Paul started us off by  
5 saying some of that is beyond MedPAC -- it is important for  
6 us to track it and monitor it and take the information we  
7 learn in chapters like this into our deliberations, I  
8 think, across the board.

9           So that's sort of where my head is on the  
10 vertical integration chapter, and I really did appreciate  
11 all of the work and the insight there.

12           I'm looking to see if anyone else is getting in  
13 the queue. It jumps by quickly so I don't see that easily  
14 enough.

15           MS. KELLEY: I think Larry has a quick comment.

16           DR. CHERNEW: Oh, great. Larry, you're on.

17           DR. CASALINO: Yep, just one quick point, based  
18 on what you just said. You know, I think that Paul gave  
19 some reasons, and then there are more, I think, why  
20 antitrust agencies have been reluctant to bring these  
21 vertical integration cases. I do think that if MedPAC  
22 draws some attention to this phenomenon and also to the

1 failure of antitrust to address it that that might have  
2 some influence on the agencies. At the margins, I'll say,  
3 probably a useful activity.

4 DR. PAUL GINSBURG: I agree.

5 DR. CHERNEW: Okay. Larry, thank you. Bruce, I  
6 see you have a comment you want to get in.

7 MR. PYENSON: Thank you. Several of us noted  
8 Paul's introduction of the vertical integration  
9 opportunity. In the previous MedPAC season someone used  
10 the term that we can't unscramble the eggs. I think that  
11 was referring to integrated delivery systems and physician  
12 and hospital organizations, but it could apply to a lot of  
13 things.

14 But innovation and new technology tends to, you  
15 know, replace the scrambled eggs sometimes. And I think  
16 one of the things that we could think about is making sure  
17 that virtual integration is open-sourced and that it  
18 doesn't need the vertically integrated organizations that  
19 it opens up for everyone, and I think that's something that  
20 Medicare can play a role in and make sure that that's truly  
21 public.

22 So just a thought there to add to the list of

1 things for staff to do, the virtual integration concept.

2 DR. CHERNEW: Thanks, Bruce. Karen, I see you  
3 have a comment.

4 DR. DeSALVO: I do. It's more of a comment about  
5 the ways that CMS policy drives physicians to perhaps  
6 become acquired. And so there are the payment models and  
7 some of the other strategies, but I think it's worth at  
8 least a little more mention and consideration of how  
9 policies like meaningful use or MACRA, that have this  
10 expectation of data infrastructure, not only the first  
11 investment acquisition of the EHR but then the ongoing need  
12 to renew that technology and the costs therein, and how  
13 some of that had been not only a financial challenge for  
14 front-line clinicians but a source of great frustration, to  
15 have to deal with the technology and selectives.

16 So it's not immaterial for the way physicians are  
17 thinking about how to simplify their back office,  
18 basically, and some of the business decisions they have to  
19 make. And that won't stop.

20 So I think there are some other ways that  
21 Medicare policy drives this integration and creates kind of  
22 this push for physicians to want to step out of having to



1 manage their own practice. I just don't want us to lose  
2 sight of that.

3 DR. CHERNEW: Great, Karen. Thanks a lot. I'm  
4 pausing for a second intentionally.

5 [Pause.]

6 DR. CHERNEW: Okay. Well, that was a tremendous  
7 discussion, in fact, I will say I think overall this was a  
8 tremendous meeting. We have had a lot of good discussions,  
9 and I think we have a lot of good directions to go. I will  
10 try to be open to all of your comments, and I will say to  
11 the folks listening I am aware of [inaudible] so I do  
12 appreciate that. Many of these are broader than Twitter  
13 exchanges, but I do appreciate the interest.

14 So to the public, you know there's ways to reach  
15 out to us. We look forward to your comments. To the  
16 Commissioners, I want to thank you again for a really  
17 educational and thoughtful meeting, and as always my  
18 greatest thanks goes to the staff who put a ton of time,  
19 and has continued to put a ton of time into the materials  
20 and the work that they do to prepare for these meetings,  
21 and you will have a lot to do going forward.

22 So I'm going to give everyone a bit of their day

1 back. Thank you all, to the Commissioners. Jim, do you  
2 want to add anything before I say my final thanks?

3 DR. MATHEWS: No. I appreciate everyone's  
4 engagement. You've helped make our latest virtual meeting  
5 a success, and we will do this again in early November.

6 DR. CHERNEW: Great. So, everybody, stay safe  
7 out there and I look forward to seeing you in November.  
8 Thanks all.

9 [Whereupon, at 12:10 p.m., the meeting was  
10 adjourned.]

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