MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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International Trade Center
1300 Pennsylvania Avenue, NW
Washington, D.C. 20004

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9:45 a.m.

COMMISSIONERS PRESENT:

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AGENDA PAGE

P R O C E E D I N G S

[9:45 a.m.]

DR. CROSSON: Maybe we could sit down and let's begin.

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

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

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

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

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

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

examples.

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

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

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

acquisitions.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

I turn things back to Jay for questions and discussion.

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

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

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

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

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

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

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

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

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

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

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

[Laughter.]

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

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

DR. CROSSON: David.

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

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

DR. STENSLAND: Yes.

DR. ZABINSKI: And I agree.

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

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

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

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

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

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

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

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

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

DR. STENSLAND: Concentration of physician offices or --

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. THOMAS: Sure.

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

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

DR. CROSSON: Jon.

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

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

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

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

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

to buy.

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

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

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

MS. CAMERON: We relied on the AHA data and

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

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

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

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

DR. PERLIN: Thanks.

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

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

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

DR. CROSSON: On this note?

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

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

MS. WANG: No.

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

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

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

DR. CROSSON: Thank you --

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

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

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

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

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

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

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

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

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

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

DR. STENSLAND: That was a little bit outside the

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

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

[Laughter.]

DR. CROSSON: Pat.

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

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

DR. CROSSON: Dana.

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

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

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

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

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

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

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

DR. SAFRAN: Mm-hmm.

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

DR. SAFRAN: That's very interesting.

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

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

you see any evidence of that happening.

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

DR. SAFRAN: Thanks.

DR. CROSSON: Jaewon?

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

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

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

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

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

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

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

DR. CROSSON: On this point?

DR. NAVATHE: Yeah.

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

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

Brian?

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

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

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

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

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

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

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

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

infrastructure as a proxy for quality.

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

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

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

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

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

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

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

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

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

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

Thank you.

DR. CROSSON: Warner?

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

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

looked at and/or commented on in the report.

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

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

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

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

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

DR. CROSSON: Thank you, Warner.

Larry?

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

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

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

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

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

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

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

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

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

can really harm provider and insurer risk contracting.

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

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

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

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

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

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

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

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

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

[Laughter.]

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

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

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

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

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

When the hospitals consolidated, then they could

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DR. RYU: Hospital outpatient.

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

Dana?

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

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

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

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

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

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

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

DR. CROSSON: Thank you, Dana. Bruce.

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

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

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

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

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

MR. PYENSON: Right. Good point.

DR. DeBUSK: On that point, outside of code

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

MR. PYENSON: I was agreeing with Paul.

DR. CROSSON: Warner, on this point?

MR. THOMAS: No.

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

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

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

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

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

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

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

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

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

DR. CROSSON: David.

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

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

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

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

DR. CROSSON: On this point, Marge?

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

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

Congress, but it is not separate from our report.

MS. MARJORIE GINSBURG: So it will be incorporated.

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

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

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

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

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

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

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

DR. PERLIN: On this point, Jay?

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

well.

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

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

DR. CROSSON: Thank you. Paul.

DR. PAUL GINSBURG: Yeah, the issue that Warner

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

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

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

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

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

much.

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

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

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

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

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

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

So why are we concerned about the primary care pipeline?

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

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

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

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

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

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

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

To better understand how to attract more

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

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

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

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

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

primary care physicians.

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

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

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

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

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

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

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

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

from actors, including Medicare.

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

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

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

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

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

share of their graduates who practice primary care.

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

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

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

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

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

the program has been uneven.

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

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

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

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

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

major impact on income disparities between specialties.

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

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

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

DR. PAUL GINSBURG: Thank you, Rachel and Ariel.

Open for clarifying questions. Kathy.

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

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

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

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

MS. BUTO: Go ahead.

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

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

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

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

family practice and internal medicine practices that are in danger.

DR. PAUL GINSBURG: That's right.

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

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

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

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

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

DR. PAUL GINSBURG: Marge.

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

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

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

DR. PAUL GINSBURG: Yes, Amol.

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

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

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

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

DR. PAUL GINSBURG: Sue and then Bruce.

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

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

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

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

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

DR. CROSSON: Bruce.

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

MR. WINTER: Demand by patients and

beneficiaries?

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

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

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

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

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

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

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

DR. CROSSON: Karen.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

And with that I'm done.

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

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

MR. WINTER: Yeah.

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

DR. CROSSON: Larry, Karen, Jonathan.

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

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

[Laughter.]

DR. CASALINO: So thank you. All these years

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

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

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

In my institution, for example, 100 percent

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

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

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

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

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

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

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

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

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

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

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

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

and practice in the next 30 years?

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

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

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

DR. CROSSON: Thank you, Larry.

Okay. Karen.

DR. DeSALVO: Terrific. Well, favorite topic of

mine.

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

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

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

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

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

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

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

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

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

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

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

DR. CROSSON: Thank you, Karen.

Jonathan?

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

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

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

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

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

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

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

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

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

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

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

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

So those are my comments. Thank you.

DR. CROSSON: Thank you, Jonathan.

Kathy?

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

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

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

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

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

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

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

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

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

DR. CROSSON: Thank you, Kathy.

Jon is next. Jon and then Bruce.

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

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

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

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

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

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

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

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

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

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

Thanks.

DR. CROSSON: Thank you, Jon.

Bruce?

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

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

DR. CROSSON: Bruce?

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

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

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

DR. CROSSON: Thank you, Bruce.

Warner?

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

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

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

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

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

DR. CROSSON: Thank you, Warner. David.

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

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

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

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

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

Jon, do you want to comment on that?

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

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

Thanks.

DR. CROSSON: Good point. Pat.

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

[Laughter.]

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

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

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

DR. CROSSON: Thank you, Pat. Jaewon.

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

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

[Laughter.]

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

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

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

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

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

[Laughter.]

DR. CROSSON: Karen.

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

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

right? Huh?

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

DR. CROSSON: Okay. Sue.

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

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

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

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

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

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

[No response.]

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

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

AFTERNOON SESSION

[1:48 p.m.]

DR. CROSSON: Okay. I think we can get going. We welcome our guests for the afternoon. This afternoon, we are going to be spending some time on the Medicare Advantage program. The first topic is going to be the Medicare quality bonus program, and Carlos, Ledia, and Andy Johnson are here.

Carlos is going to begin.

MR. ZARABOZO: Thank you.

Good afternoon. Ledia, Andy, and I are here to continue the discussion that we have had over several public meetings regarding the current Medicare Advantage quality bonus program and options for an alternative, redesigned value incentive program for MA.

We would like to thank Sam Bickel-Barlow for his contributions to this work.

Reforming the current quality bonus program is a matter of urgency. Although one-third of Medicare beneficiaries are now enrolled in Medicare Advantage and Medicare Advantage plans are viewed as having the potential to be more efficient than fee-for-service while providing

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

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

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

In response to a congressional mandate, in 2010,

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

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

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

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

The star system that is the basis of bonus

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

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

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

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

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

recommended is the local market area, not the contract.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

With about one-third of the Medicare population

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

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

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

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

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

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

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

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

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

The MA–VIP measure set should continue to evolve as better data becomes available.

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

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

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

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

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

For both of these measure calculations, we used

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

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

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

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

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

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

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

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

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

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

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

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

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

I will now turn it over to Andy.

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

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

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

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

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

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

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

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

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

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

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

DR. PAUL GINSBURG: I got the first two.

[Laughter.]

DR. CROSSON: Okay. Hands again.

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

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

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

[Laughter.]

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

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

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

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

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

DR. CROSSON: Okay. Brian.

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

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

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

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

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

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

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

MR. ZARABOZO: [Off microphone.]

DR. DeBUSK: Got it. Totally there.

DR. CROSSON: Let me just make one clarification

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

DR. DeBUSK: Okay.

MR. ZARABOZO: Yeah, 82 percent of beneficiaries.

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

MR. ZARABOZO: Right. It's about half of plans. Right. So if you look at the contract level --

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

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

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

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

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

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

DR. DeBUSK: -- extra benefits or --

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

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

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

DR. DeBUSK: Okay.

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

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

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

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

MS. TABOR: That's correct.

MR. ZARABOZO: Strictly based on their status.

DR. DeBUSK: Strictly based on their dual status. So you're going to see through the plan itself.

MR. ZARABOZO: Correct.

DR. DeBUSK: Okay. Now quick question with that. Wouldn't that mean, though, that you could have dramatically different outcomes? I mean, if I'm in a C-SNP because I have a very specific chronic condition, I might do a lot better than if I'm in the regular MA plan and don't have some of the special features of that C-SNP.

MR. ZARABOZO: Which is sort of one of the

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

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

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

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

[Laughter.]

DR. DeBUSK: Nice. Thank you.

DR. CROSSON: Karen.

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

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

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

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

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

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

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

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

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

DR. DeSALVO: Great.

DR. CROSSON: Thank you, Karen. Jon.

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

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

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

[Laughter.]

MR. ZARABOZO: On first base or third base?

[Laughter.]

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

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

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

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

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

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

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

MA-VIP is actually implemented.

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

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

DR. CROSSON: Pat.

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

MR. ZARABOZO: Parent organization is, for

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

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

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

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

MR. ZARABOZO: Right.

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

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

MR. ZARABOZO: That's the 2020 number.

MS. WANG: The 2020 number?

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

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

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

MS. WANG: Okay.

MR. ZARABOZO: -- which were just released.

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

MR. ZARABOZO: Right, from 2018.

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

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

MS. WANG: Twenty percent of the total?

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

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

perpetuate that thing?

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

MS. WANG: Right.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

distinctions.

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

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

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

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

MS. TABOR: We haven't.

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

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

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

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

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

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

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

MS. TABOR: Correct.

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

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

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

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

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

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

MS. TABOR: Correct.

MS. WANG: Okay, so it would --

MS. TABOR: It is contained within the --

MS. WANG: -- scale, I guess.

MS. TABOR: Yeah.

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

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

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

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

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

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

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

DR. CROSSON: Okay. Bruce.

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

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

including those process measures in the payment system.

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

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

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

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

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

DR. SAFRAN: Thanks.

DR. CROSSON: I confused the two of you.

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

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

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

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

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

DR. SAFRAN: Okay.

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

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

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

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

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

DR. SAFRAN: Okay.

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

DR. SAFRAN: Okay.

MS. TABOR: But we can talk, yeah.

DR. SAFRAN: Okay. No problem.

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

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

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

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

DR. PERLIN: On this point?

DR. CROSSON: Yeah.

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

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

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

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

DR. JOHNSON: Yes.

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

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

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

DR. SAFRAN: Okay -- well --

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

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

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

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

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

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

DR. CROSSON: One sec. You have --

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

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

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

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

How much of what I said is --

DR. SAFRAN: Yeah, and I --

DR. MATHEWS: All right.

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

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

DR. CROSSON: Okay.

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

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

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

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

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

MS. TABOR: Like stratification.

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

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

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

MS. TABOR: Exactly, exactly.

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

Yes? No?

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

DR. DeBUSK: Okay.

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

DR. CROSSON: Larry?

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

[Laughter.]

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

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

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

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

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

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

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

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

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

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

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

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

DR. JOHNSON: Sure.

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

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

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

DR. JOHNSON: Correct.

DR. CASALINO: Okay.

DR. JOHNSON: And I think the other point that

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

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

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

DR. CASALINO: Right.

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

DR. CROSSON: Okay. Marge?

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

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

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

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

So those are the two questions.

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

I think we have been thinking about this as a

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

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

MS. MARJORIE GINSBURG: [Speaking off microphone.]

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

going to see more variation. Yeah.

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

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

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

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

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

DR. NAVATHE: Thank you.

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

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

DR. CROSSON: No, unfortunately.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

And some of these outcomes, while they may, in part, reflect those measures, they may imperfectly reflect a lot of those processes that we know are high value in a broad sense, and I am thinking about vaccination measures. I'm thinking about the sub-measures in diabetes, some of which are intermediate outcomes like A1c. I think those are actually very valuable, and so I hesitate to get rid of them, in some sense.

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

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

Another point is around the measures. The readmission measure, generally speaking, supportive of the concept, I think one piece here is that it's effectively double-counting readmissions because readmissions show up

in the cost performance piece too, and so are readmissions so important that we really want to double down on them? It's already a part of the cost incentive, and that we also want to double-count it on the quality side. Ideally, our quality set would reflect purely quality and not be related necessarily to cost. So it's something to think about. The other measures, I thought were very good.

The peer group piece, I think we've heard a lot about. I'll just echo the points that we might want to think about, more peer groups in terms of the continuity of the different types of socioeconomic disadvantaged-ness, et cetera, recognizing that we have this challenge of sample size. So it's hard to slice and dice one market into so many different layers and then still achieve sample size requirements.

One thought I had is, Would there be a way to create a peer set of markets that have similar characteristics that would allow us to group and get more sample size, a little bit more fidelity on that matching, in some sense, of the peer groups?

And that would also have another potential benefit to think about, which is -- one thing I am worried

about when I look at the scaling is if you have the scenarios that Jonathan was sort of playing out, multiple, quote/unquote, low-quality or low-performing plans in one market, we might find a lot of clustering around the same numbers, which we may then allocate dollars relatively imperfectly, because there's actually not a lot of variation there that we're able to measure when from a beneficiary perspective, it actually could be quite meaningful.

And so if we're able to stratify a little bit more by grouping peer markets, quote/unquote, "peer markets," that might give us a little bit more variation there that would be closer to the reflecting truth. So it's something to think about that could perhaps integrate many of the comments that folks have mentioned.

Let me also help, to some extent, with the small areas that we have, where we have less than three plans. So we could also combine kind of based on like markets.

The budget-neutral concept, I think I'm very supportive of, particularly the consistency across MA and fee-for-service and the other programs that we've been talking about, and I think it's very important, I think,

from an economic perspective to highlight that if what we're really seeking out of the kind of rebate concept of supplemental benefits, if what we're really seeking is to transfer to the beneficiary, we should find a directly way to transfer to the beneficiary. Using a bonus/rebate indirect mechanism is intrinsically going to be inefficient to do that. So if we want to reward beneficiaries for it, we should just go straight out and do that, would be the -- at least economic view on it.

And definitely, I also echo Karen's point about applauding the -- including the patient-reported outcomes in this. I think while there may not as much variation here, I think if we can figure out some of these sample size issues, it could all become particularly important and be a right step in the long-term direction.

So I will stop my comments there. Thank you.

DR. CROSSON: Thank you, Amol. Comments? I see Jaewon, Dana, Bruce, Brian, Pat, Jon.

DR. RYU: Thanks, Jay. So I'll rifle through just some thoughts here. Migrating from contract-based to market-based, I think that's exactly right. Process-oriented measures, migrating to MA-VIP, I think that makes

a lot of sense.

On the budget neutrality, I do pause there, and the reason why is I know that the readings talked quite a bit about plans when they've lost bonus status, they've still maintained their benefits. I think that's isolated plans here and there. I do wonder what happens when the entire program loses a whole swatch of dollars. What happens to those benefits?

I think when an isolated plan loses the bonus status, they still have to compete and maintain a certain benefit offering versus when an entire industry loses a certain pool of dollars, I do think benefits would come out. So that gives me a little pause.

On the local versus national, I actually do like the local, and maybe this is a little bit of my bias based on the geography that I'm coming from. But I think there is something that's different for each market area and, in particular, I think rural. And maybe it is just a rural phenomenon, but I think about, you know, a few things that are very different about rural that I think wouldn't be equitable if you compared it on a national level. You know, transportation is one. Wide distances. There's no

train, there's no public bus, there's no Uber. It's a very different set of circumstances to hit on various quality measures.

Second is literacy level and education level, and I think those are very different in rural environments versus, you know, urban or suburban areas.

I think the third is structural, you know, largely around the delivery system itself, just the prevalence of things like primary care, which may be in a heavily urban area every couple blocks; in a suburban area every couple miles, in a rural area every couple hours. And so I think there is something to looking at the market level.

And then the last point I wanted to make was just around Pat's comment earlier around heterogeneity. Specifically when you get to states that have very stringent Medicaid criteria, if you had non-duals, non-dual eligible in those populations, I think the heterogeneity is potentially huge. And so I don't know if there's another gradation that you add there somehow, another pool of cohorts. And I guess the other question I would have is, you know, the market areas, are there any market areas that

span state borders? Because -- okay. But, yeah, those are the comments.

DR. CROSSON: Thank you, Jaewon. Dana.

DR. SAFRAN: Thanks. Okay, so, number one, I think that the measure set that you've defined is really superb. It's parsimonious but really stands for true value. So I really like it a lot. I'm really thrilled with the addition of the health outcome measures, patient-reported outcome measures.

There was something I saw in the paper that said something about a sample size of 30 is enough in CMS' mind. I just sent you an article while we were talking on that topic, but it's not. But that's okay because plans will have sufficient membership to be able to measure this, and all the better that we will be incentivizing that you need a robust way to collect this information across your population and track it. So I think it's great.

I like the readmission measures. You know, when I was doing this for a living in the commercial sector, I did face that hard choice of did I want to double down on something that's already on the cost side. And there were a couple places, and readmissions is one of them where it's

both big enough quality issue, safety issue, cost issue, and actionable that I think it's a good thing to do.

The second point is that these are hard, these are going to be hard measures to perform well on. I sort of indicated this in one of my questions at the beginning, so I do think we have to think really carefully about how we structure the benchmarks, who you're measured against, the incentives, and everything else, because we don't want to demoralize folks and have them throw up their hands.

However, that said, you know, I land in a different place from Jaewon on the local versus larger, for a couple reasons. One is it's hard for us to face certain markets and just say we have a lower standard of care for you. You know, your providers are really not nearly as good as these other ones, but we pay them handsomely for whatever they can do. And I think we want to push folks to innovate. You know, this is Medicare Advantage where they can use telehealth; they can be creative in solving some of the problems that Jaewon rightly points us to. And I think we want to encourage them to do that.

So for that reason, plus the sample size and other issues, I'd just like us to take another look. And

that doesn't stop us, by the way, from reporting locally, right? So we can measure, you know, to benchmarks nationally, compare peer groups nationally, but still give people information about their local plan in terms of performance.

Two last things. One is that -- I think Marge was commenting on this as I had to step out. There is a difference in how much variation you have from the 2nd to the 98th percentile across these measures. That's okay. I think for now there's enough to work with. But you have to plan for the fact that as improvement happens, especially in the patient experience, you may have too narrow a range to split it ten ways, and you ought to be thinking ahead to that scenario.

And last is, as has been mentioned, I'd love to see us come up with another methodology for the social risk stratification that isn't just tied to duals. Thanks.

DR. CROSSON: Thank you, Dana. Bruce.

MR. PYENSON: I support all four structural changes. I think they're important and a big improvement.

I would like to see a fifth domain in the measure set, which is a small group of what we're calling "process

measures" that can be obtained through claims. And I think many of those, although they're process measures, have a very solid evidence base supporting them -- vaccinations, cancer screenings, a handful of others. And some of those measures, some of the current measures, I believe, could be changed to get more of them from claims than currently.

So that's the only change I'd like to see. Thank you.

DR. CROSSON: Thank you, Bruce. Brian.

DR. DeBUSK: First of all, yes to moving from contracts to markets. I think that's great.

Yes to narrowing the measures down with the caveat, to Bruce's point, which I do think if there's some claims -- you know, not all process measures are the same. You know, some are truly useless and some may have some merit. And if we can preserve some of the claims-based ones and create a fifth domain, I think that would work.

As far as is it budget neutral or is a cut? I think the cut is a separate conversation. I would love to see us have the discussion about the cut, but, you know, it's quality, it's benchmarks, it's coding adjustments. MA has so many different facets to how you would adjust that

overall payment that I would love to see that as a separate discussion.

The final point, a number of people talked about -- pointed out the limitations of confining everything to a market area. But I think the point that one of you two made right at the very end really outweighs a lot of those limitations, which is any redistribution we do that goes beyond the local market area, you know, national or whatever, you're going to run the risk of creating these MA deserts where in any given area, if there's poor health care overall, these plans are so fluid they're just going to simply move out of that area. And you're going to create these areas that the plans just can't afford to move into.

So it is somewhat unsavory to have to keep everything at a market level and in theory reward people who have mediocre performance just because they're, you know, the best mediocre performed among the mediocre. I mean, that's distasteful, but, you know, the alternative I think is worse, which is the idea of an MA desert where no one wants to go.

So thank you, and great work. I hope you keep it

going.

DR. CROSSON: Thank you, Brian. Pat.

MS. WANG: I'm in favor of the local markets and hopefully that -- I really think that it's very appropriate, and I hope that the issues that people have raised with, you know, not enough plan sponsors, not enough -- can be dealt with by doing some expansions, because right now it sounds like the vast majority of people are in what you're defining as local market, and I do think that quality is local, so it's very important to measure and reward that way.

On the measure set, I appreciate the effort to reduce the number of measures and to make them all capable of reporting through administrative data. But I don't actually think that they are the right universe. Fifty percent of the measures have to do with avoidable admissions; 50 percent of the measures have to do with, you know, patient satisfaction, self-reported outcomes. So those have a place in any quality measurement system, but I think that we're missing a lot by restricting to that.

I kind of agree with Amol about readmissions, and there's noise in the measure, too. It can be addressed,

but how do you deal with observation stays? How do you deal with payment denial? Did it happen? Did it not happen? It's a display measure now in stars because the specifications keep changing to try to get at some of this squishyness. So I actually -- I also think that with the emphasis on moving care outside of the hospitals, there needs to be -- to capture things that I think are very, very important to many more people than an avoidable readmission, which, you know, medication adherence, they're terrible difficult measures, but I really believe that they're important, some of the control measures, blood pressure controlled, blood sugar controlled, the cancer screenings, and some of these are hybrid measures. They require medical records review. But plans are doing it today, and providers are supplying that information today. It's not a new burden.

I think that, you know, pulling back on the administrative functions and those kinds of things, as you had suggested will relieve a lot from people's plates, but I think that including impactful HEDIS measures is really quite important, whether they're claims-based or medical records review-based.

People talked about the peer groups. I totally endorse like really kind of doing a deeper dive in trying to do much better than this binary you're a dual/you're not a dual.

On the tournament model, I actually think that -- and I'm just speaking from my own perspective. It stimulates more competition and more initiative on the part of plans and their providers when they don't know exactly where they need to get. Like you can eke out some incremental improvements in quality that I think are really important.

As far as the budget neutrality or the savings is concerned, I am -- I think that Jaewon's comment and Brian's comments are good in terms of using this as a vehicle to do a cut to the MA program. I would really try to separate those two things. We have an upcoming discussion about benchmarks, so this is all -- those things are sort of tied together. Budget neutrality sounds really good in principle, but budget neutrality based on what? You know, what's the underlying payment system that you're taking money out of and giving back.

The final thing that I would say is the aggregate

observations about what plans do and don't do when they go into bonus status, they come out of bonus status, I was really surprised by the observation that plans don't make any changes in extra benefits when they don't have the bonus. Again, this is just local experience. That doesn't even seem possible to me, and I think that there are some plans -- just so that people appreciate how important the bonus programs are to focus -- so some plans take quite a bit of that money and turn them into provider quality incentive programs that are quite focused at specific activities and really hitting and trying to do better and better and better. The power of that reward is bigger than the underlying payment and contract because it's like you're doing the right thing for the member, the person's patient, what have you, and I just think it's just a really critical program to maintain as something special.

DR. CROSSON: Okay. Sue, remember, I cut you off. Do you want to come in at this point.

MS. THOMPSON: The comment's been made [off microphone].

DR. CROSSON: Comment made. I'm sorry. Okay. So I've got Jon, Paul, and Larry, and Kathy and Warner.

And then that's it. Sorry. Only because we're not done with this, right? Okay, Jon.

DR. PERLIN: Thank you. There's clearly an interplay between these four structural elements, so I think it's hard to think of them entirely separately. I'll come back to why I say that.

But to the first question, should the consumer be able to have insight into the performance of a plan that's going to affect them in their local area? Absolutely.

Where I get into a little trouble and see a bit of the interplay is that I think you may need a larger sample size for a variety of reasons. It gets to this question of simplify the measures, I think is the wrong question. Improve the measures is, I think, the better question there.

The reason I want to get to improve the measures as opposed to simply simplify the measures is that there could be some very unintended consequences. You want the measures to actually predict the performance the beneficiary is apt to receive from the plan in the market.

What do I mean by that? You know, I'm going to use readmissions as the example. If you have either by a

low-frequently event or a limited sample size or a limited sampling frame, an inadequate number of events in the particular year, say 2019, but instead say, okay, I'm going to look back 2014 to 2017, that creates a number of derivative effects.

First, a consumer, a beneficiary is trying to make a prediction about what will happen to me in 2020 based on the performance report I read in 2019. But here's the problem: It's not 2019 that's predicting 2020, which is the extrapolation they make. You actually have a three-year sampling frame, 2014 to 2017, that probably has more predictive value for 2015 through 2018 than the year-to-year. The math just doesn't work, otherwise, and Rich Blatt and others have written on that, so it's got two structural flaws.

That suggests two things. One, you know, go to a larger area that's part of the same plan, but also go to higher-frequency events or find a way to get higher-frequency data. Process measures are really good in that regard.

Patient experience is a wonderful indicator, but when you have 26 percent, as the HCAHPS does -- and I don't

know what the CAHPS analog is here -- you don't have a representative sample. What if you actually included a general member satisfaction question or two in every annual enrollment period based on their last? You'd have 100 percent response actually and data that actually predicts the next year.

So I think this balanced approach is absolutely terrific but would really encourage that we have data to predict, you know, prospectively for the period that the beneficiary is going to enroll for.

The point came up earlier as to why a frustrated plan might exit the market. It's not just that they can't get the dollars. It's that they can't control the variables that are the key to the dollars. What do I mean by that? It gets back to that readmissions as the example. If you have a 12-month trailing average that's in arrears by at least a year, they can't overcome the tail of that for a long period of time. They've got to actually focus in on other measures.

That obviously identifies the second issue, that if you have a balance sheet and scorecard of measures and you can't do anything about one of the measures, you're

going to write that measure off regardless so it's actually no longer viable as a performance improvement opportunity.

Then, finally, let me come to this notion of conflation, as Brian pointed out, between, you know, the dollars and the structure here. If we do go to this model, I would encourage that we consider building the equivalent of the excess into the first year so it's not a hit. Why do I say that? For all the reasons that have been mentioned, but one thing that hasn't come up is that there's also a downstream effect on the providers there, and I think you want to make sure, particularly in markets that may be more challenged, that the assets are there. And why is that important in turn?

You know, one thing we never talk about here -- and I don't know if the data are available or I don't know the data, but we've talked about the average losses on Medicare beneficiaries in hospitals, for example. But I would bet you that there's a difference between the MA losses per beneficiary and the fee-for-service losses per beneficiary. And if, in fact, MA is propping up fee-for-service, then you're going to actually impair access for a variety of other reasons.

So for all those reasons, I think we're absolutely on the right track here, but I would suggest these amendments, particularly this last one. We need to think about the downstream impacts in its linkage to the benchmark setting as well. But the intent of this, allowing consumers to be able to have visibility into what their likely experience is absolutely right.

And, finally, you know, I don't think it's an either/or, either I can reference my local market performance between different competitors, or I can reference it with respect to a national. It's really both/and. Let me give you a concrete example of that. If I am buying a car, I might think about the national -- or the performance of the vehicles overall, and that's one factor. The second is what is the service in my environment, and I think the consumers can make that sort of determination when presented with data that ordinally ranks within a market and simultaneously gives them the understanding of how that compares against a broader reference rank.

Thanks.

DR. CROSSON: Thank you, Jon. Paul.

DR. PAUL GINSBURG: Okay. Yes, like others I certainly think moving from contracts to markets is the way to go.

I had a couple of thoughts about new measures. We have a lot of interesting thoughts about how perhaps we need to be more nuanced, new measures we need to draw, selected careful, process measures. But, you know, we need to think about, you know, it's one thing to need to choose the measures to model, but on the other hand we don't want to attract Congress to come up with 40 measures or 20 measures when it writes legislation. So it's really important to talk about, you know, directions, examples, illustrations, but not actually get tied up in exactly what should the measures be.

As far as budget neutrality, I think that -- and, of course, this could be phased in, Pat, but I think that we are overpaying for quality, in the sense we have, you know, a case of everyone succeeding and we're giving everyone a bonus. And, you know, where still Medicare MA payments are above fee-for-service, and that's an unhealthy thing. So I don't think there's really any justification for continuing this quality stars as an add-on.

Final thought is that I was glad to hear some of the concerns about, you know, the MedPAC has been against tournament models ever since I've been on the Commission. I've never been convinced. I like the arguments about how tournament models keep everyone focusing, rather than saying, "Oh, we already achieved that. I don't have to work this year, because I know I can do it."

DR. CROSSON: Thank you, Paul. Larry.

DR. CASALINO: I'm just going to comment on the local versus national as a place for comparison and reward. I think we've heard really compelling arguments for both sides, early on from several people for national and then Jaewon, it's pretty had to refute what he said for local. So I don't know what to do about that. There might be an opportunity to reconcile things by thinking more deeply about peer groups.

We have had surprisingly little discussion, or none, really, about the concept of having these two separate pools, one for non-dual eligible, one for dual eligible, or whatever social risk factor you want to use, or a combination of factors. The fact we haven't had much discussion about that worries me a little -- this is an

aside -- because God knows what unintended consequences could come out of that. So I think more thinking needs to probably be done about that.

But let's suppose we could create peer groups that would be national but would help take care of some of the concerns, for example, like the rural concern that Jaewon mentioned. So, for example, what if a peer group -- and I'm not suggesting this as a best example but just for conceptually a way of thinking about it -- what if the peer groups were based on rural plus some social risk factor -- dual eligible or whatever -- and you could have however many categories you wanted based on that.

It seems to me if those peer groups could be well designed that way, first of all we get away from having to do something that we're not doing anywhere else, I don't think, in Medicare, these two separate pools of payment for dual eligible and non-duals. But secondly, we could do national tournament, if you want to call it that, but still hopefully be addressing the concerns about what happens if you ignore local market conditions. So again, rural dual would be a kind of crude first cut at that.

DR. CROSSON: Thank you, Larry. Kathy.

MS. BUTO: So I want to support moving from contract to area. I want to also add my voice to others who have said the measure set looks really good but it would be, from a perspective of a beneficiary, I think it's missing a big piece of what kind of care am I going to get through this organization. So I think if we can add some process measures that are aimed at some of the highest-cost conditions, I think that would be a place, and we ought to have some criteria around the measures that we think ought to be added so that Congress doesn't come along and willy-nilly add 30 more.

I feel strongly that we should go to budget neutrality, but I liked Jon's suggestion that you add the $6 billion into the base and then go from there, as opposed to approaching it as a $6 billion cut or something like that. I think it's fair to put quality dollars in, but I also think it's fair to look at it not being sort of a one-sided reward system, if you will.

So other than that I think this is terrific work, and I think -- oh, the other one is national versus local. I don't have a strong opinion on that, although my gut tells me we tend to want to do everything nationally in

Medicare, and I just -- as long as I worked in Medicare at the national level I found there are so many flaws in trying to impose a one size fits all on each area. Delivery systems are different. MA plans are going to be structured differently. Challenges are different. And we ought to find a way to accommodate that, and I don't know if it's the new care grouping that you were suggesting, Larry. But I fear that going total national doesn't make a lot of sense, and it's hard to explain. People don't understand why they're being compared to plans in California if they're in rural Pennsylvania. So I just think we need to think more about that.

DR. CROSSON: Kathy, let me just ask you one clarification. So when you said the highest cost issues, I heard that in two ways, focused on the highest-cost patients or in the case of --

MS. BUTO: Conditions, highest-cost --

DR. CROSSON: -- cancer prevention, there's a difference in the level of investment required. So, for example, I can't think of it -- like, for example, colorectal cancer screening requires a high level of investment in order to get to a significant portion. So

when you were using the term "cost," which way were you using it -- highest-cost patients or highest-cost investment, which is a little different?

MS. BUTO: Highest cost --

DR. CROSSON: Because one is up front --

MS. BUTO: -- if something isn't done, the highest cost to the system, in terms of generating high-cost care.

DR. CROSSON: Okay. So that -- anyway.

MS. BUTO: So this could be uncontrolled diabetes, it could be -- I don't know.

DR. CROSSON: Yeah. So that's downstream and the other is upstream.

MS. BUTO: I would look at that.

DR. CROSSON: Yeah. Thanks. Okay. Warner.

MR. THOMAS: I will be brief. Just two comments. I agree with Pat, and I think Bruce made a comment as well. I mean, the process, your screening measures, I think are really important, and just going to Kathy's point, I mean, I think whether it is hypertension or diabetes or major cancer screenings, I think those are really important and need to be included in this as a significant part of what

we do.

And the last piece, I know we're trying to -- there's been a lot of discussion on national versus local and whatnot. I come back to I'd like to make sure we have alignment between these quality measures and what we're trying to do in the ACO world that we're in, you know, the fee-for-service world. We've got to make sure that those are aligned. I didn't see a lot about that in here. I know that's probably the intent, but I'm a little concerned that we're so concerned about the tournament model and national versus local that, you know, to me it's like are the measures the same across the population, which ultimately, if we want to do a good job taking care of people we've got to have that consistency.

DR. CROSSON: Okay. Rich discussion. Almost, not the end.

DR. SAFRAN: Very, very fast, but I think this is important. I think we're conflating the use of the term "tournament" with the idea of having absolute versus relative performance targets. And so I just wanted to say that. Like I think there is a tournament -- when you have absolute performance targets, I think the value is

providers know what they are trying to accomplish, and we aren't stuck rewarding mediocrity just because that's -- you know, that's the best anybody has been able to do.

So I think having absolute performance target and then letting folks have at it, competing to achieve those, is language maybe we can work on. But we're not against tournaments. We're against setting benchmarks in a way where they're relative and so you don't really know what good is. Thanks.

DR. CROSSON: Yeah. So there's -- well, I'm going to violate my own rule here.

Good discussion. More to come. That's the good news and the bad news. Thanks Carlos, Ledia, and Andrew.

[Pause.]

DR. CROSSON: Okay. I assume more of the other Commissioners will be back soon, but I think we do need to get going. For our guests, we have now had one issue for the afternoon, which went a little longer than we thought, related to Medicare Advantage, and we're going to have a second presentation on Medicare Advantage here, the issue ore forming the system that creates the payment benchmarks. And Scott Harrison is here for this.

DR. HARRISON: Good afternoon. Today, I will describe the current MA payment system and present some alternatives for you to consider.

The MA program gives Medicare beneficiaries the option of receiving benefits from private plans rather than from the traditional fee-for-service Medicare program. The Commission strongly supports the inclusion of private plans in the Medicare program -- beneficiaries should be able to choose between the traditional fee-for-service Medicare program and alternative delivery systems that private plans can offer. Because Medicare pays private plans a risk-adjusted per person rate rather than a per service rate, plans have greater incentives than fee-for-service providers to innovate and use care-management techniques to deliver more efficient care.

Unfortunately, much of the growth in MA enrollment over the past 20 years has been subsidized by high payments, payments well in excess of what it would have cost the Medicare fee-for-service program.

Recent legislation, namely the ACA, has lowered MA payments relative to fee-for-service Medicare. There are still a couple of percentage points worth of risk-coding

that is not accounted for, but other than that payments have reached rough parity over the past few years.

But there are opportunities for further reductions that will allow the Medicare program to achieve savings to help the long-term sustainability of the Medicare program. Plans bid an overall average 89 percent of fee-for-service, yet because of the still-too-high benchmarks, the Medicare program realizes no overall savings from the MA program.

The Commission has emphasized the importance of imposing fiscal pressure on all providers of care to improve efficiency and reduce Medicare program costs and beneficiary premiums. For MA, the Commission previously recommended that payments be brought down.

Over the past few years, plan bids and payments have come down in relation to fee-for-service spending while MA enrollment continued to grow. The pressure of lower benchmarks has led to improved efficiencies and more competitive bids that enable MA plans to continue to increase enrollment by offering benefits that beneficiaries find attractive.

If we expect that MA plans will become a more and

more important part of the overall Medicare program, it is essential that plans contribute more and more savings to sustain the program.

Back in the 1980s, Medicare managed care plans were paid at a set rate of 95 percent of the county risk-adjusted average per capita fee-for-service spending. The 5 percent differential recognized the presumed greater efficiency of private plans through their ability to reduce program expenditures using tools such as closed provider networks, prior authorization, and value-based cost-sharing that the fee-for-service system generally cannot use.

A series of legislation beginning in 1997, running through the MMA in 2003, established the MA program and expanded the role of private plans in Medicare. The MA payment system we have today, based on plan bids and county benchmarks, became effective in 2006.

MA enrollment and payments increased throughout this period. By 2009, benchmarks averaged 118 percent of fee-for-service spending and payments averaged 114 percent.

In response to the excessive payments, the ACA changed and reduced the benchmarks substantially. The ACA also introduced the quartile system, which I will describe

shortly, and quality bonuses, which you just heard about in the last presentation. The changes were designed to save the Medicare program over $100 billion dollars over a 10-year period, by reducing the average MA benchmark to about 102 to 103 percent of fee-for-service spending by the end of a seven-year transition.

There was a lot of concern about reducing the benchmarks that much and CBO and CMS forecast that those lower benchmarks would lead to a substantial decrease in MA enrollment.

While the benchmarks did decline as expected, the fiscal pressure did not lead to decreased MA enrollment. Instead, MA plans were able to find efficiencies and lower their bids in response to the benchmark reductions. By 2019, the average MA bid was down to 89 percent of fee-for-service, down from 100 percent in 2010.

Those lower bids allowed plans to offer generous benefits, which have been increasing, and in 2019 were a record high of $107 per month. These benefits are funded by rebates, which are a feature of the bidding process I will explain shortly. Amendment these extra benefits encouraged enrollment, which has doubled since 2010.

Now let's look at how the ACA sets benchmarks using quartiles of fee-for-service spending. Under the ACA, each county's benchmark, excluding quality bonuses, is a certain percentage of the average per capita spending for the county's fee-for-service Medicare beneficiaries. Each county's benchmark percentage is determined by organizing the counties into quartiles based on their fee-for-service spending.

Counties are ranked by average fee-for-service spending. The lowest-spending quartile of counties has benchmarks set at 115 percent of local fee-for-service spending. The next lowest-spending quartile is set at 107.5 percent, followed by the third-lowest, or second-highest on here, set at 100 percent, and the highest-spending quartile has benchmarks set at 95 percent of fee-for-service.

Low fee-for-service spending counties have benchmarks higher than fee-for-service to help attract plans and high fee-for-service spending counties have benchmarks lower than fee-for-service to generate Medicare savings.

I'll note here that the benchmarks are adjusted higher for plans that were deemed high quality, but we are

assuming that plan quality payments will be made outside the benchmark structure, and for the remainder of this session, all references to the benchmarks will be to the base benchmarks; that is, benchmarks that do not include any quality bonuses.

Now let's step back and look at the mechanics of how the bids and benchmarks work. Medicare payments to MA plans are determined by the plan bid, which represents the dollar amount that the plane estimates will cover the Part A and Part B benefits for beneficiary and the benchmark for the county in which the beneficiary resides.

The benchmark is a bidding target that is based on the average expected fee-for-service spending in a county.

If a plan's bid is below the benchmark, as is the case for almost all plans, its payment rate is its bid plus a share -- and that's between 50 percent and 70 percent, depending on a plan's quality ratings -- of the difference between the plan's bid and the benchmark.

The added payment based on the difference between the bid and the benchmark is referred to as the rebate. Plans must use the rebate to provide additional benefits to

enrollees in the form of lower cost sharing, lower premiums, or supplemental benefits. Plans can devote some of the rebate to administrative costs and margins.

In the rare event that a plan's bid is above the benchmark, Medicare pays the plan its benchmark, and the enrollees have to pay a premium equal to the difference.

Returning to the benchmarks, we see a couple of problems with the quartile system.

One problem is that the quartile structure creates discontinuities, or cliffs, at the three borders or cut-points between the quartiles. The differences in the quartile factors are large enough to make the cliffs significant.

For example, assume County A has average fee-for-service spending of $741 and County B has average spending of $1 more or $742. Further, assume that the cut-point between the two lowest spending quartiles is just under $742 so that County A is in the 115 percent quartile and County B is in the 107.5 percent quartile.

County A's benchmark would be set at 115 percent of $741, or $852, and County B's benchmark would be set at 107.5 percent of $742, yielding a benchmark of $798.

So the $1 difference in fee-for-service spending would produce a negative $54 difference in benchmarks.

There are two other cliffs, one between the second and third quartiles and one between the third and fourth quartiles, and each of the drops off these cliffs are also in the $50 neighborhood.

Another fundamental problem with the system is that the benchmarks are simply too high on average for the Medicare program to realize any savings. The primary argument for setting benchmarks above fee-for-service is to promote plan availability in low fee-for-service areas.

When the quartile structure began in 2012, there was concern that low fee-for-service spending areas would have trouble attracting MA enrollment if plans were not paid more than fee-for-service.

The goal of this policy was to promote wide access to managed care plans in Medicare, so the ACA included the quartile system that set higher benchmarks in low-spending areas. The relatively high benchmarks made it easier for plans in those areas to offer relatively generous benefits to attract enrollment.

This strategy has been very successful, and

currently 37 percent of beneficiaries living in low-spending areas have enrolled in MA plans. That 37 percent penetration rate is higher than the national average of 34 percent. Unfortunately, the Medicare program pays 11 percent more for MA enrollment than for fee-for-service enrollment in those areas.

This means that, currently, MA enrollment from areas in the lowest-spending quartile -- and to a lesser extent in the second lowest-spending quartile -- increases the cost for the Medicare program which both weakens the Hospital Insurance Trust Fund and produces taxpayer, state, and beneficiary costs in the Part B program, which is financed by general revenues and Part B premiums.

More generally, the ACA benchmarks have been fully phased in and stable for the last three years, and if we ignore the excess MA risk coding, the aggregate payments to MA plans have been about the same as fee-for-service in each of the last three years.

This equilibrium suggests it is unlikely that MA plans will ever provide any meaningful savings to the Medicare program, absent changes in the benchmarks. However, the Commission believes that the Medicare program

should share in the efficiencies currently being enjoyed only by the plans and their enrollees.

The Commission has seen that plans can provide extra benefits more efficiently than fee-for-service Medicare, and again, they are currently bidding 89 percent of fee-for-service on average. We believe that the increased fiscal pressure would prod plans to find additional efficiencies and lower their bids further. Thus, we consider potential alternatives to the current benchmark system.

So we have a few issues with the current benchmarks. First is the cliffs. They introduce an almost random factor in the determination of the county benchmarks.

Second is that the Medicare program is not realizing any savings from the MA program because of the level of the benchmarks.

And lastly, there is a tradeoff between treating all areas of the country the same relative to their local fee-for-service spending, which for this session, we will "geographic equity," and the desire to promote or subsidize plan participation in low fee-for-service spending areas.

I will present three alternatives for the current benchmarks and examine how they address the three issues above.

All three alternatives have been designed to realize savings by lowering the average benchmark to 98 percent of fee-for-service.

We chose 98 percent of fee-for-service for the average benchmarks in order to claim a modest share of plan efficiencies for the program and to match the shared savings threshold in some of the Medicare ACO models. In some of those models, ACOs are paid shared savings only after they meet a 2 percent savings threshold.

There could be many other alternatives, including some more comprehensive approaches that could include competitive bidding. These three, however, were chosen as relatively simple approaches that could be implemented almost immediately after legislation was passed. Also, these alternatives would not preclude Congress from working on more comprehensive approaches that may take more time to implement.

Alternative 1 would set all benchmarks at 98 percent of local fee-for-service spending. There would be

no cliffs, as all areas would have the same relationship between their fee-for-service spending and their MA benchmark. The relationship also means that this alternative would be geographically equitable.

Alternative 1 would not promote plan participation in the low fee-for-service areas, but that does not mean that all the plans would necessarily leave those areas.

In 2019, plans bid an average of 99 percent of fee-for-service in low-spending areas. Modest bid improvement might allow wide plan availability even under Alternative 1.

Alternative 2 would reduce each of the four quartile factors by 3 percentage points. The four factors would change to 112 percent, 104.5 percent, 97 percent, and 92 percent. These would increase fiscal pressure across all plans and areas of the country. The increase in pressure would be uniform across the country and would be likely to cause little disruption as all the areas would see a relatively small decrease in benchmarks.

It is likely under this alternative that plans serving areas in the three highest-spending quartiles could

contribute savings to the Medicare program. In 2019, we estimate that savings generally came from just the two highest-spending quartiles.

Under Alternative 2, the quartile structure remains, so there would still be cliffs, and high spending areas are treated differently than low-spending areas relative to local fee-for-service. The 112 percent for low-spending areas should be more than adequate to support plan participation in those areas.

Alternative 3 is a hybrid that combines some concepts from the other alternatives. The hybrid would set benchmarks above fee-for-service in low fee-for-service spending areas to promote plan availability. It would also set a benchmark limit, or ceiling, for the highest-spending areas to avoid paying excessive rates in those areas. Most areas would lie between the low-spending areas and the ceiling. As the fee-for-service spending in these areas increases, so would the benchmarks but at a much slower rate, about 40 cents on the dollar, if you were to follow the line-up.

Alternative 3 was designed without any cliffs. The benchmarks would range from 112 percent for the lowest

half of the lowest-spending quartile to promote plan participation in those areas, and it would decrease by the time you got to the very highest-spending counties, to about 8 percent of fee-for-service.

This alternative does not treat all areas equally and does promotes plan participation in low-spending areas.

All of the alternatives were calibrated to produce the same average benchmark equal to 98 percent of fee-for-service, so they would all produce an increase in fiscal pressure and should yield savings for the Medicare program.

Both the 98 percent of fee-for-service in all areas, alternative and the hybrid, eliminate cliffs while the lower quartiles alternative keeps them. Only the 98 percent of fee-for-service alternative produces benchmarks where all areas are treated equally compared with local fee-for-service spending.

The quartile and hybrid alternatives promote plan participation by subsidizing low-spending areas.

An ideal benchmark system should try to support several principles: promote financial neutrality between MA and fee-for-service Medicare, while applying fiscal

pressure on MA plans; support payment fairness across geographic areas; and support wide availability of plans without paying excessive rates. These principles will usually involve tradeoffs, but I hope that this chart can help start a discussion about the Commission's preferences for a revised benchmark system.

In summary, there is an urgent need to reform the MA benchmarks. Medicare is not realizing savings from MA plan efficiency, nor is it likely to without reform.

I look forward to your discussion, where you may begin to prioritize potential reforms to the benchmarks. I just presented three alternatives, but I'm sure you may think of others that we can examine in the coming months.

Staff will build out any alternatives which interest you. At the January meeting, we aim to present payment simulations stemming from your guidance during this meeting.

DR. CROSSON: Thank you, Scott.

We will now take clarifying questions. I saw Jonathan, Sue, Marge, talking slowly, Dana, Bruce, and Brian.

MS. WANG: And Pat.

DR. CROSSON: Oh, I missed you.

DR. JAFFERY: So, Scott, great chapter. Thanks. I absolutely agree that this is an important area to explore.

Two questions. First, did I hear you say that MA plans can provide extra benefits more efficiently than fee-for-service? And if that's what you said --

DR. HARRISON: So they can provide the regular benefit package more efficiently, which then allows them to include extra benefits in their package.

DR. JAFFERY: Okay. That's what I was trying to clarify.

DR. HARRISON: Sorry. I misspoke.

DR. JAFFERY: Others can't provide extra benefits at all, right?

DR. HARRISON: Right.

DR. JAFFERY: Okay. And then a separate question, do we know how ACO availability is distributed across the low- and high-spend areas?

DR. HARRISON: My sense is that they're more prevalent in the high-spend areas.

I'm looking for help. A little bit.

DR. JAFFERY: So there is some. There are some.

DR. HARRISON: My sense was they were more successful in the high-spend areas. Excuse me. High utilization.

DR. JAFFERY: Okay. Right. So we've seen that a bunch of times.

Okay. I'll come back in Round 2. Thanks.

DR. CROSSON: Sue?

MS. THOMPSON: Thanks, Jay, and thank you, Scott.

What can you tell us about the four quartiles, characteristics of them? Urban, rural, or anything else that kind of differentiates them?

DR. HARRISON: So you might have thought -- and maybe in the beginning, they were more rural. They're not anymore -- oh, I'm sorry. The low-spending area is.

There are some counties that don't have any plans now. They're not in the 115 quartile. They're in the 95 quartile, more likely to be in the 95 than the 100 and the 115. So it's like Alaska doesn't have -- yes, they're rural, but they're also high-spending.

The other thing we've seen is that higher-population counties have started to spend less, and lower-

population counties have started to spend more. So you've had some crossing, just by population, not by necessarily MA penetration, but you've seen some crossing.

We've seen an increase in the population of the 115 counties, I would say.

DR. CROSSON: Marge?

MS. MARJORIE GINSBURG: I have two questions. Let me state them, and then you can answer them.

The first one is very general. It says in the opening statement of what we were sent that it's consistent with the Commission's support of equity between the two programs. We've always talked a lot about maintaining equity. Do we assume, then, that that meant that we were obligated -- the Commission was committed to equality in what they are paid? That's the first question.

And the second is very specific. In reading about MA plans and how they -- I was under the assumption that the only time an MA plan could have a monthly premium for their enrollees was if they had bid over the benchmark. Then they were justified, and all I see in Sacramento County is -- with one or two exceptions, are MA plans with not small monthly premiums.

So I wonder if you could clarify that.

DR. HARRISON: Yeah. So there's a monthly premium that would only be paid for the Medicare benefit, Part A and Part B benefit. That's only if you bid above the benchmark.

So if you bid below the benchmark, you're going to have enough so that you can offer a zero premium plan if you want to, but you may be offering extra benefits in that package that you -- so you submitted a bid, and it includes not just the A and B benefit. It includes extra benefits.

So you're going to end up getting some money back from Medicare to provide some of them, but maybe you're providing even more than that in your benefit package, and so there's a premium. But that's mostly for extra benefits.

DR. CROSSON: Pat?

MS. MARJORIE GINSBURG: Could you answer the other one, please?

DR. HARRISON: Oh. We've had a longstanding principle where we've tried to maintain what we call "financial neutrality" between the two programs. One of them is so that the beneficiaries have the right incentives

and they're not trying to pick one or the other that's going to have different costs for the Medicare program, and the other reason is a sense of fairness.

MS. MARJORIE GINSBURG: So then this really might suggest that we'll drop that language?

DR. HARRISON: We'll have to see, yeah.

DR. CROSSON: Pat?

MS. WANG: So going back to the average bid, it is now 89 percent of fee-for-service. Do you know what it is in the different quartiles? Does it differ much?

DR. HARRISON: It does, and it's in our reports each year. The average bid in the 115 quartile was 99 percent, and by the time you get to the 95 percent quartile, it's maybe 80, maybe in the 70s. So, yes, it changes quite a bit.

MS. WANG: Okay. And, again, I'm confused. This came up in the last discussion. The average $107 supplemental benefit, does that include the quality bonus? It must, right? It has to because that would --

DR. HARRISON: Yes, the quality benchmarks are in there. Yes.

MS. WANG: Okay. So that elevates the benchmark,

and then there's more money available.

DR. HARRISON: Right.

MS. WANG: Okay. Final, just small question, is there any correlation between plans that charge a premium and what quartile they're doing -- what quartile they're in for those products?

DR. HARRISON: That's not something we've looked at.

MS. WANG: Okay.

DR. HARRISON: But the rebates are of different sizes, right? So, in the 115 quartile, I think the rebate was around $69, and in the 95 percent quartile, it was like 150.

MS. WANG: How many people live in the 115 quartile? I know that they're split by numbers of counties.

DR. HARRISON: It's getting fairly close to evenly distributed.

MS. WANG: Okay.

DR. HARRISON: Between the four quartiles.

MS. WANG: Thanks.

DR. HARRISON: It's not exactly there, but --

DR. CROSSON: Dana?

DR. SAFRAN: Thanks.

Sue asked my main question, but my other two questions are -- number one, have you got any analysis of the financial impact to MA plans of these three different alternatives?

DR. HARRISON: So that's what I would come back in January with.

DR. SAFRAN: Got it. Okay. And then do we know -- these quartiles are based on the fee-for-service spending so I'm trying to get a handle on just how big is the MA population in the low fee-for-service spending quartile, and how big is the number of MA plans?

DR. HARRISON: All right. So you are not talking about the penetration rate. You want to know where the people are coming from?

DR. SAFRAN: Yeah, for the plans.

DR. HARRISON: Yeah. So it was almost an even split, again. It wasn't exactly there, but you're talking at least in the 20s for each of the four quartiles. It may not all be 25 but they're in that range. And I can get it for you.

DR. SAFRAN: Okay. Thanks.

DR. CROSSON: Bruce.

MR. PYENSON: Thank you very much, Scott. I'm wondering if we could include information on Medigap in the four quartiles when we consider the impact on beneficiaries. It strikes me that for the non-duals that Medicare Advantage is competing against fee-for-service plus Medigap, and a fair comparison from the standpoint of beneficiaries would look at that perhaps.

DR. HARRISON: So the quick datasets that we have area all Medigap by state. To do it at an individual level would take a little while. There is some data that we think is trustworthy, but it's a challenge to work with. So maybe by January we could at least do a run and see that.

MR. PYENSON: Or an approximation. I mean, pick an average age or something for states that are age rated. I mean, it gets complicated, of course.

DR. HARRISON: Let's talk, yeah. I think we can come up with something.

MR. PYENSON: A different question. I know in the past I think three years ago, maybe two years ago,

MedPAC recommended that it would be fairer if the benchmark were based on people who had both A and B, not everybody. And I don't recall if that made sense from a perhaps equity or fairness basis. Was that also a statutory -- was there some legal basis for that?

DR. HARRISON: I think that probably CMS could do that without it. There might be some debate -- I'm not a lawyer, but, yeah, it's possible that that might be done just through CMS.

MR. PYENSON: And likewise from a benchmark standpoint, since the presence of Medigap inflates, through induced utilization, inflates the benchmark, would it be feasible to unwind that impact from the benchmark?

DR. HARRISON: I'm not sure. It's possible but I'm not sure. I think that would be -- and I'm not sure -- again, not being a lawyer, I'm not sure what the statute would say about that. It might be that CMS could do that.

MR. PYENSON: Okay. What are your thoughts on MedPAC, the staff calculating that, in fact?

DR. HARRISON: So we did sponsor a study a few years ago where we said what the gross impact was. It was coordinated with our work on redesigning the fee-for-

service benefit package back -- I have a hard time with time -- six, seven years ago. And there we found quite a significant increase due to Medigap. People who had Medigap spent a lot more money in fee-for-service.

DR. CROSSON: Thank you, Bruce. Brian?

DR. DeBUSK: Great report. Great topic. What I wanted to clarify, and you're not the only person I've heard say this, but when they talk about rebates being paid back, people will always say, "And these rebates have to be spent on extra benefits," and then under their breath they say, "And a portion of the proceeds can be applied toward administrative costs and plan profits." And then they just keep going. So can you help me --

DR. HARRISON: All right. So this is like fully loaded -- they have to spend it on fully loaded -- the benefits can be fully loaded. So how you value those benefits can include profit and administrative costs.

DR. DeBUSK: Okay. So you can build -- because we know about the bonus thing where you can reprice your -- you know, we talked about that in the last session.

DR. HARRISON: The bonus is different --

DR. DeBUSK: It's different.

DR. HARRISON: -- where you don't actually know.

DR. DeBUSK: You get to reprice your bids, sort of.

DR. HARRISON: You don't know what --

DR. DeBUSK: You get to reprice your bid. I got that one. That one's clever, and I did not know that until the last session. So what you're saying is when you guys are saying administrative and plan profits, what they're saying is you get to load administrative cost and plan profits onto the extra benefits.

DR. HARRISON: Right, just as you do onto the basic.

DR. DeBUSK: You don't get to just -- okay. Good, good, good. I just wanted to make sure there wasn't some back door where they could just generate profit out of thin air rebate dollars.

DR. HARRISON: No.

DR. DeBUSK: Okay. Good, good, good.

The second thing -- at first this is going to sound like a Round 2. I promise it isn't. It's Round 1. It's legit. If I look at this rebate -- you know, hand me the rebate. You know, Bruce alluded to this -- a portion

of my rebate is going to go toward really just achieving parity with Medigap, you know, toward --

DR. HARRISON: Buying down the cost-sharing.

DR. DeBUSK: -- buying down the cost-sharing.

DR. HARRISON: Mm-hmm.

DR. DeBUSK: And then I would think that there's this tranche of probably decent benefits, you know, of transportation services and telemedicine, which now can be built into the bid. But anyway, it was a good example up until a year ago. But sort of the genuine, the bona fide benefits.

But then I would think that there's this tranche of things where the plans are just looking to dump the money somewhere. I mean, it's the lower-value benefits. And this is my question: Has anyone explored trying to gauge how much of that are low-value benefits? Do the plans really want to spend the money in the first place? Could we just split the money and give half of it to CMS and let them keep half of it and profit?

[Laughter.]

DR. DeBUSK: I mean, is there -- again, I get it. Medigap tranche, good tranche, but I keep being left with

this impression that there's some noise out there that I don't think anybody really wants.

DR. HARRISON: So most of the rebate has been used to lower cost-sharing. Another big chunk goes to pay down the Part D premium, and then they also supplement Part D. So that's where the bulk of the money is, but then there are other extra benefits. I think dental and vision and hearing aids are becoming more popular, so those are, you know, real supplemental benefits that they would provide. And then, you know, some of these other things -- gym memberships, et cetera -- I don't know how much money is going for those.

DR. DeBUSK: So we don't, and again, to be a Round 1 question we don't really have a feel, even if it's a qualitative feel, for sort of how that money -- how those rebate dollars are being distributed into those three broad categories.

DR. HARRISON: Once you're in the supplemental benefits, no, I don't think we know that much about what's in there.

DR. DeBUSK: Okay. Thanks.

DR. CROSSON: Okay. I've got Kathy, Amol,

Warner.

MS. BUTO: I have four I hope kind of quick questions. So one of them is, do you know, Scott, whether the bids tend to cluster around the benchmarks, or do they tend to cluster around each other? I'm just curious if we know that.

DR. HARRISON: So when we've looked in the past, what we've found is that the bids do not tend to track fee-for-service spending. Instead, they track the benchmarks. And so I think that, for instance, the rebate percentage, what percent of your bid is rebate, is similar in all four quartiles.

MS. BUTO: Okay.

DR. HARRISON: The thought here is that, you know, MA plans have a different production function, so to speak, than fee-for-service, and so their production function might look pretty similar across the country, and so they're a little immune to fee-for-service changes. But they track the benchmark because that's what they need to -- that's what they're competing on.

MS. BUTO: Right. What I'm trying to do is understand -- and you can also help me with this second

question, which is, is our alternative one similar to the old competitive pricing approach that CMS was trying to experiment with, where essentially the only benchmark, if you will, was fee-for-service spending, and then plans were competing with each other against what the A and B benefits were worth or were valued at? Do you know that your alternative one and that approach are similar? I know their benefits were constructed at a local level, depending on what they considered the standard benefit in the area.

DR. HARRISON: By happenstance, it used to be that you get 95 percent of fee-for-service and there were proposals to add a 3 percent package as a supplement to bid on. So I guess it does kind of look like that.

MS. BUTO: Yeah. I was actually talking about the competitive bidding demonstration, where, you know, we only know a little bit about how much would have been saved when plans were allowed to compete for what the cost would be and what they would charge to provide the Part A and B benefits, with a small drug benefit.

DR. HARRISON: I don't necessarily -- well, I guess we had been thinking about this more as like going back in time when it was 95 percent --

MS. BUTO: Oh.

DR. HARRISON: -- and we were just going to have 98 percent.

MS. BUTO: Okay. All right. And we know very little about what that result would have been, because they were never allowed to actually get underway.

My third question is about the extra benefits. I know that plans are required to provide them under the statute. I cannot remember whether that includes a cash rebate to the beneficiary or even reductions in the Part B premium.

DR. HARRISON: It definitely --

MS. BUTO: Are those allowed?

DR. HARRISON: Yeah, so you can definitely reduce the Part B premium, and it seems like more plans have been doing that. I haven't seen the latest bids but you may find out next month.

Now one thing about giving back the Part B premium is you don't get to load that. That's straight cash, so that's probably a little less popular among plans.

MS. BUTO: Right. Okay. Thank you.

DR. CROSSON: Amol.

DR. NAVATHE: Thanks, Scott. So I have one question, which is I think perhaps a redux of Marge's question. But on page 3 of the writeup -- so her, I guess, second question which you answered first, which was about the premiums -- so it says, "If a plan's bid is above the benchmark, Medicare pays the plan's benchmark amount for each enrollee, and enrollees have to pay a premium." And then in parentheses it says, "In addition to the usual Part B premium," close parenthesis, "equals the difference." Can you explain that part?

DR. HARRISON: So it's even a separate thing.

DR. NAVATHE: Okay.

DR. HARRISON: To be eligible to join an MA plan you have to be enrolled in Part A and Part B. The Part B premium you have to pay, so that's one premium. There could be another premium if the plan bids below the benchmark. That usually doesn't happen but, you know, once in a while maybe. But normally the premium you are paying, you're paying your Part B premium unless it's rebated to you, but you're paying that plus you're paying a premium if the plan provides a package and they ask for a premium, and that would include generally a good bid of extra benefits.

DR. NAVATHE: Correct. Got it. Okay. So when we say zero premium we are referring specifically to the MA portion, and we're not saying that the rebate is offsetting the Part B premium.

DR. HARRISON: Correct. That's right.

DR. NAVATHE: It may, in part, do that, but not fully. Okay. Got it. So that was question one.

Question two is, does this -- does the fee-for-service, the percentages under rates apply similarly to SNPs?

DR. HARRISON: SNPs are paid just like --

DR. NAVATHE: Same thing, so the benchmarks are just for those specific populations than the fee-for-service.

DR. HARRISON: Right.

DR. NAVATHE: Got it. Okay. And then the last question I have is, so it seems like the cliffs that we're observing are at the county level.

DR. HARRISON: Correct.

DR. NAVATHE: So are we seeing plans respond to those cliffs? Because you would see potentially that they should be looking at where they can offer plans and,

quote/unquote, "gaming that" or at least responding to that incentive.

DR. HARRISON: So --

DR. NAVATHE: It sounded like you were saying that the distribution is actually pretty even across.

DR. HARRISON: Yeah. So plans -- I don't know if I want to say rarely, but they usually are serving more than one county, and so their benchmark is going to be a mashup of the different counties. Well, the weird thing is that you would think that a county would complain that their rate, you know, fell off a cliff, but we haven't heard from any, so I don't know what to say about that. Yeah, I don't know how much of a reaction there is to the cliffs. It could be that the plans are -- it all comes out in the wash to the plans.

DR. NAVATHE: So last question is -- sorry. Last question is on Slide 4 you say in 2019, the average plan bid was 89 percent of fee-for-service, which is substantially lower than the fee-for-service markup in each of those tiers. But then we also said that the rebate is pretty similar across the different --

DR. HARRISON: Right. So, well, it averages 89

but it varies from 99 to maybe 80, depending on the quartile.

DR. NAVATHE: Okay. So the margin is still pretty constant.

DR. HARRISON: It seems like the margin is fairly constant, yeah.

DR. CROSSON: Okay, Kathy.

MS. BUTO: Very quick. Scott, are there low-spending counties that have high penetration?

DR. HARRISON: Yes. And in general they have high --

MS. BUTO: So they're getting sort of, if you will, overpaid, because the idea behind paying more than fee-for-service was to encourage more participation in MA, right?

DR. HARRISON: I would agree with that, yeah.

DR. CROSSON: Warner.

MR. THOMAS: Two questions. How often do counties, or do counties move between the various --

DR. HARRISON: They move a good bit. Now if you are a county and you move across a threshold, you actually will get the average factor for the following year. So

let's say in 2015, you were 115, and then you moved to -- oh, math is tougher. Let's do you move from 107 ½ to 100 in '15 and '16. In '17, you would get 103 ½ percent.

MR. THOMAS: For that county.

DR. HARRISON: For that county, yeah.

MR. THOMAS: And do you see any differential in, or do you have information for medical trend by county? Is there any major difference based upon low- or high-cost areas, on trend?

DR. HARRISON: I do not have that.

MR. THOMAS: Okay.

DR. CROSSON: Okay. Seeing no questions we will come to the discussion period. Let's put up Slide 13, which are the alternatives on the table, and we're going to go to Paul to begin.

DR. PAUL GINSBURG: Thanks, Jay. Scott, you've done a really good job in the presentation and you answered the questions so efficiently that we're talking at 4:30 instead of 5:30, as far as the discussion.

[Laughter.]

DR. PAUL GINSBURG: So, yeah, I have two thoughts to share with the Commission. I have never been a fan of

the quartile approach that I guess came into the Affordable Care Act. My sense is if the origin of Medicare Advantage, or its predecessors really, was that, you know, there was more potential in some areas for, you know, private plans to deliver better value to the beneficiaries and the program, and so, you know, the penetration was much greater, particularly in the areas that were fairly expensive and fee-for-service. And I guess South Florida stood out as the extreme.

Then I think when Congress was then the Balanced Budget Act of 1997, cut the payments a lot, I think, anyway, there was real concern in Congress about Medicare Advantage or predecessors not being viable. So there were floors put in, and ultimately, in a sense, the payments, as you noted from the paper, got much higher than fee-for-service Medicare.

And in Congress it started to be perceived as "This is a wonderful thing. I want to make sure my constituents get their share," and I think that led to the quartile as things are being squeezed down in the Affordable Care Act.

I think it makes more sense to say that where a

private plan can, you know, serve a beneficiary more efficiently and perhaps with better quality, that's where the reward should be greatest rather than seeing this spread around everybody. So I'm that one of your options is, you know, a 98 percent without quartiles.

The other point I want to make is that, you know, there's been a lot of thinking in a group at Brookings and other organizations that I was part of, did a paper last year on competitive bidding for Medicare Advantage, not premium support because this bidding would be only within Medicare Advantage. I think others have written on it, and I'd like to be able to consider that as one of the alternatives to the three that you've put up on the table. It has the virtue of the structure of what the benchmark is in various areas, is market-based rather than policy decision. And so I'll just stop there.

DR. CASALINO: Just describe what the alternative would be [off microphone].

DR. PAUL GINSBURG: Okay. The alternative would be that each plan makes a bid as to what -- the benchmark it would require or, you know, what I can do Medicare Advantage for in an area, which would be larger than a

county, presumably MedPAC areas or something, it would be -- an average or some other measure would be taken of the bids, and that would determine the Medicare -- the benchmark. So in a sense, it's a way of exploring the potential for, you know, could Medicare pay less and still do well, still have participation? And I think that's the essence of it.

DR. CASALINO: So do rebates go away then? Or you get your rebate?

DR. PAUL GINSBURG: No, there's still rebates, because if you're really a low-cost plan, your bid is likely to be under the benchmark for your area.

DR. CASALINO: Just one shot at it.

DR. PAUL GINSBURG: Well, you do set a bid, and you have to stick to the bid.

MS. MARJORIE GINSBURG: A clarifying question about this. So from my previous question, you might tell that I'm a little annoyed by what I think are high monthly premiums that so many MA-PDs are applying to this.

With your model, if they submit the bid and they win the contract, does that mean that they can no longer then attach another $98 a month as premium in order to make

up for extra benefits or, in fact, to basically improve the bottom line?

DR. PAUL GINSBURG: Well, if the plan believes that there's a demand in the area for Part D and other benefits like buying down the cost sharing, just like today, it would set a premium for this enhanced plan at higher than the benchmark. So in a sense, it wouldn't be -- to the degree that people are demanding richer plans, in many cases they don't have to pay a premium for that.

DR. NAVATHE: Would they be required to offer the base plan, though, as the bid?

DR. PAUL GINSBURG: Yes. Actually, one of the other aspects of it is that we thought it was valuable to have some standardization, so every plan would submit a bid for the base plan. There would be an enhanced plan that would be also standardized, and they would set a bid for that. And then they could come up with their own further enhanced version and set a bid for that.

MS. BUTO: Paul, a question about the extra benefits, though. If the plan is below the benchmark, can the plan offer whatever extra benefits it wants to for no additional cost? That would still be in play, right?

DR. PAUL GINSBURG: I think so. Now, I'm not sure if --

MS. BUTO: And when you say standardization extra benefits, I start to think, well, there's go the innovation opportunity.

DR. PAUL GINSBURG: Oh, yeah. Actually, it depends on how you describe it. What I would prefer is standardizing it as an actuarial value. So say it's 105 percent of the basic Medicare benefit would be that second level. And then the third level of further enhanced would be whatever the plan wants to do.

DR. CROSSON: So let me just suggest here that perhaps the paper that you wrote, participated in writing, or some other summary of this proposal would be available to the Commissioners.

DR. PAUL GINSBURG: Oh, certainly, yes.

DR. CROSSON: Okay. So let's go on with further discussion. We're going to start over this side. Brian, Dana, Pat, David. Who did I miss? Bruce, Pat, Kathy, David, Jonathan. Brian.

DR. DeBUSK: Scott, again, great paper, great work. I do think anything that linearizes the benchmark I

think is a good thing. So the hybrid, I like the hybrid, but, you know, the specifics of that aren't as important to me as the fact that you do avoid the cliffs.

You know, as per the previous discussion, the overall idea of do you do it, do you build the cut into this, or do you make it budget neutral, I do think that's a completely separate discussion on what do we want to do with MA. And I would hate, again, to see good technical work get caught up with, you know, the policy decision over is MA paid adequately, overpaid, underpaid, whatever. So, again, separate discussions, but I do like the linearization.

One thing that I've always been suspicious of when I first learned about MA is this idea that you get a rebate back and tell somebody, "You have to spend this money." And I wish there was some way to discover how much of that money -- you know, sort of a thought experiment here. If I give them a $120 rebate, if the plan could just pocket the money and not, say, buy down and, you know, basically effectively compete with Medigap, they'd probably have what could be a wildly profitable that nobody wants. You know, great margins on zero sales are still zero.

At the same time, you have to wonder, if there was a mechanism -- because we're trying to think about how -- you know, the problem we're trying to solve is not cut, cut, cut. It's how do you generate genuine savings to the Medicare program. Has anyone explored -- and I'd love to see us explore -- when that rebate comes back, giving the plan some flexibility to say, okay, you can use a portion of this rebate for administrative costs and profit, but you're going to do it at, say a 1:1 or a 2:1 ratio. You're going to return some of that money to CMS as well.

I wonder if, given the option, you know, there's $100 in their plan, let's say they've got to spend $50 of it to get parity with Medigap. If you took that $50 that was left over and said, okay, you can go buy a gym membership, you know, 20 miles from the patient's house that's never going to get used, or you can take that $40, let's split it 50/50. You return $20 of it to Medicare, $25 of it to Medicare; you can keep -- and it doesn't have to be 1:1.

I'm just wondering if we could somehow discover what that rebate dollar is really worth to the plan because right now we don't know. We just hand them a crisp $100

bill and tell them they have to go spend it. Let's figure out how much of that they'd really spend and how much of that they could genuinely return to Medicare.

Anyway, that was just my thought.

DR. CROSSON: Great. Dana -- sorry, I missed Bruce. I missed you twice.

MR. PYENSON: I agree with Paul's sentiment, though I'm thinking there's a multiphase goal here. One is to look at something that could be implemented very quickly, and I think, Scott, you mentioned that as a goal at the beginning. And if we agree with that, I think the three alternatives on the table are -- or some variations of that is what we have to do. But I think longer term the issue that Paul raised and the question of Medigap is going to be really essential to get this to the right place.

I'd suggest a hybrid of the hybrid approach would be compelling because the idea of paying more than fee-for-service in some areas is of questionable merit from the standpoint of the Medicare program. So I hate to ask for a fourth option on the short-term proposals, but I think the graph -- I think it was Figure 5 in your presentation, in the writeup, that was a particularly good illustration of

the different options. And that might be --

DR. HARRISON: So are you suggesting like maybe 100 percent of fee-for-service at the low end and then some savings at the high end?

MR. PYENSON: Something like that. I don't have an opinion on the precise numbers.

DR. HARRISON: But you're not concerned too much about attracting plans in the low end with extra money?

MR. PYENSON: Correct, for the reasons that Paul mentioned.

DR. HARRISON: Okay.

DR. CROSSON: Dana.

DR. SAFRAN: Thanks. Thanks for this work, Scott.

I'm not concerned based on what you've told us about attracting plans in the lower spending area. It sounds like that might have been a worthwhile goal before, but that it might have outlived its useful purpose. But in any case, I would say that I don't fully want to cast a vote until we see the impact analysis that you're bringing us in January. But without seeing that, I do find Alternative 1 really attractive. The only thing that

concerns me about it is -- well, two things concern me about it. One is that you've got the high-spending folks -- or the folks in the highest-spending market get a raise out of the deal --

DR. HARRISON: Suggest something else [off microphone].

DR. SAFRAN: Yeah, so -- but I do like just having it be the same regardless of geography, and so we may have to just deal with that pain point one time and get over it.

The other, which kind of relates to my comment about waiting until January, is until we really know how much pain this inflicts on those in the lower-spending areas who are going to take a bigger hit, it's a little hard to know. But for now, that's the model that I prefer. Thanks.

DR. CROSSON: Okay. Where are we? Pat.

MS. WANG: I'm also in favor of Alternative 1 or something that groups much more tightly that way. I sort of would -- I think Dana stated it well, that maybe it was a good idea at the time, but at this point the idea of paying that much more than fee-for-service seems --

especially since the counties like flow back and forth. I don't know. Maybe it's not necessary anymore.

The one thing I just want to -- the way that this is presented and, therefore, what frames the discussion, you know, the way that you put it was there's an urgent need for reform for increased efficiency and the realization of savings. I would kind of try to maybe shift the discussion to value as opposed to savings. There is a statutorily mandated use of rebate dollars, which, Bruce, they are already split with CMS. I don't know if that was clear. But if you bid below the benchmark, if you're not in star bonus, you're giving 70 percent of that delta back. So there's a built-in savings in there. If you're in star, you get to keep more of it, but, you know, I just wanted to make sure, because you were doing that kind of at the end like another split. There's a split at the front end.

But there's an explicit expectation, I guess, that part of the thing for MA, even if they're being paid at the equivalent of Medicare Advantage, is that they are trying to deliver some extra value to beneficiaries by the mandated use of the rebate. So I just want to be careful about saying -- kind of getting into that by saying, no,

no, that money should instead be spent on savings.

So I think the value issue is important. I know that there have always been concerns echoed, like, well, how come only MA beneficiaries, enrollees, are getting the dental, the hearing, the transportation, you know, the eyeglasses, you know, for poorer folks, they're getting other things that support their health care, and why shouldn't that be available to the whole program? You know, that's a more philosophical questions, I guess. But somehow or other these market dynamics have made it possible for MA plans to, in many, many cases, deliver, I think, a superior-quality product to fee-for-service and make room for valuable benefits that are meaningful to beneficiaries.

Bruce, to your question, I would love to meet the plan who says at the table when they are kind of looking at their bid and how things are shaping up, "Oh, my gosh, we have too much money to spend on supplemental benefits. We should just give some" -- there's always --

DR. DeBUSK: But I'm back to -- sorry to interrupt. But one thing, I still, when I learned, I saw a paper once on the number of gym memberships that these

plans were buying, and there were like 10 and 20 and 30 miles from these people's homes. I won't go two miles to get to a gym.

[Laughter.]

DR. DeBUSK: And I just -- again, I agree with you. I don't think these people are swimming in dollars. But I think if we look through the program, there's clearly some money being spent on marginal activities.

MS. WANG: You know, it's an interesting question and part of, I think, what plans go through, is this actually being utilized? Because that gym membership is so important to so many people. I just have to tell you, they want it. And maybe they don't have any other options for exercise, but the gym membership is -- there's certain things, and that's what the market kind of does, is it pushes towards meeting actual demand in the community as opposed to something that somebody thinks is a good idea. So it does, it flexes, you know, year by year, and different populations want different things at different stages of their lives. That's a very interesting feature, I think, about MA, and it goes to the innovation.

So this idea of, like, with the reform it gets

savings out, we have to be kind of careful, I think is the point that Kathy was making. I think the program is set up with rebates being spent on supplemental benefits for a reason. Maybe it's not savings, but it's value. So I'd just be a little careful there.

But, otherwise, I'm also -- I feel like there should be -- it's time to kind of look at -- there's a simplicity to sort of saying everybody's getting paid at the same percentage of fee-for-service and then it opens up a better baseline discussion, for example, for how you pay for a quality bonus.

DR. CROSSON: Are you on this point also, Marge?

MS. MARJORIE GINSBURG: Yes.

DR. CROSSON: All right. I saw Marge first, and then, Bruce on this point.

MS. MARJORIE GINSBURG: My comment is relevant because of the reference to the gym memberships, and I have to tell you this whole topic area, I am wearing my taxpayer advocate hat. And the gym membership one, particularly, brings to mind a project that we did. I ran a nonprofit that worked on health policy issues with the public.

We did 1,000-person phone survey. It was done by

whoever those big survey people are in California. They're all Californians, and people responded to, I think, 20 different vignettes. And they were told to answer two questions for each vignette. How important is insurance covering this on a scale of 1 to 10, and should it be part -- then a yes or no. Should it be part of a health plan? And we had every interesting, you know, short two-sentence scenario possible.

The lowest scoring was gym membership, and this was 2009, and I don't know if anybody was actually paying for it then, but somehow we included it.

I went and looked up the results in anticipation. Twenty-six percent said, "yes, they'd cover it."

Now, they were told, in responding to this, "You are answering these questions knowing that the more things that are covered, the more that it costs you and others. So you are wearing both your consumer hat and your taxpayer hat."

I'll get off my soapbox, but I guess what troubles me is that at the end of the day, it is the taxpayer. It is the Medicare budget that's being impacted every time new extra benefits are added. These are not

free. The health plans are not paying for them. The taxpayers are paying for them.

That's all. Thank you.

DR. CROSSON: Bruce? Asked.

Okay. David?

DR. GRABOWSKI: Great. First, thanks, Scott. I'm once again very excited that we're going down this path, and I'm very supportive of reforming the benchmark.

I like how Bruce framed this. There's a two-stage process here. First, we want to fix this, and I think we have some good options on the table here. I think if I had to choose among these options, I'd go with kind of a flat 98 percent of fee-for-service spending.

I very much view that, hopefully, as a first part to our agenda here, and I wanted to go down the same path in a second stage that Paul took us. And that's to think about competitive bidding here. There's a lot written on this. We can share some of that, but it basically uses the bids that all these different plans offer as a way of helping shape the adjusted benchmark.

As Paul said, you have a geographic area, and potentially, you take the mean kind of bid within that area

and use that as the new benchmark. Some of these plans put an inflation factor on top of that, maybe a buffer, if you will, 5 percent, just to make certain there's greater rebates.

I really like this approach, and CBO costed it out a couple of years ago, the 10-year window here with a 5 percent buffer, and they came up with savings of about $77 billion. So it's a big number, and there's a lot of money on the table. I really like going down this path.

I think the limitations -- and we can get more into these downstream, but obviously, you're taking benefits off the table. You're taking dollars off the table, and there are strong incentives for selection as you begin to kind of ratchet that down and finding certain types of beneficiaries. I think you magnify some of the incentives that are present in the current system. But I really like that and hope we'll continue to talk about it.

Jim, I don't know how this fits in that current chapter scope of work. Is that a text box? Is there sort of a second part to this? You don't have to answer that. But just as a way of sort of framing this, I really hope we'll talk more about that and think more about it.

Thanks.

DR. CROSSON: On this point? Just on the list? Sorry. Larry?

DR. PAUL GINSBURG: I think on this point.

DR. CROSSON: On this point? Oh, you're in line.

MS. BUTO: I think I'm in line.

DR. CROSSON: You are, yes.

Is there anybody who wants to talk on this point?

DR. NAVATHE: On this point.

DR. CROSSON: Okay.

DR. NAVATHE: I would strongly echo that. I think the current system is actually pretty weird in the sense that it's sort of a double regulatory system, where we're regulating fee-for-service prices in the first place, and then we're regulating on top of that. So there's kind of a two-phase movement away from markets, and then we're presumably doing it in the name of competition because we think MAs -- the privatization or private option around Medicare. I think that's very incongruous. It actually doesn't make a lot of sense, except that we need to short fix that. I would vote 1 here as well. Again, I think it would help, per Dana's points, to see the actual program

impact.

I think there's a lot to be said for going to a competitive bidding lottery-type system, and I think there's probably a lot of options, David, that could work because to deal with that 5 percent inflation factor, you can find a portion of the bid, the top quartile or top tertile or something and exclude them from even participating as a way to constrain the inflation piece of it,

There's a lot of subtlety to that as well, but I think it's certainly worth -- I would strongly encourage the Commission to continue exploring that as the long-run view around MA benchmarks.

DR. CROSSON: On his point? On our point?

MS. WANG: Yeah, on this point, generally, about competitive bidding.

So I'm really interested that so many Commissioners are kind of really interested in pursuing this. The one thing that I would ask is we do this, and maybe it's in the paper and the literature, is whether -- I mean, don't forget. An MA plan is delivering the benefit through providers. So whatever happens at this level

trickles down into providers, is whether there's any literature or studies on how to prevent sort of redlining higher-cost providers. That might be academic medical centers, and it's not a race to the bottom, because that's always the fear with competitive bidding. So I'm sure that people have thought about that. I would just personally appreciate knowing more about that.

DR. PAUL GINSBURG: I just wanted to say one thing. I think those are really good thoughts.

One thing we can't do is contemplate doing an experiment because that was attempted in the 1980s and the 1990s, and Congress shut down the experiment each time. I think this is an area where we're just going -- as we have in a lot of other Medicare payment policies, just jump in, like we did with DRGs, if we decide to go forward with this.

DR. CASALINO: On this point, the competitive bidding point, I realize that I'm not -- I'm confused about what people -- I'm not sure we all are thinking about the same thing when we say competitive bidding, or at least I don't understand.

I don't think you used the phrase "competitive

bidding." To me, competitive bidding means you submit your bids, and some people get contracts, and some don't. But that's not what we're saying here, just to be clear.

DR. PAUL GINSBURG: Yeah. This is competitive bidding in health care financing, which has always been that nobody loses.

[Laughter.]

DR. PAUL GINSBURG: But some people get paid less than they had hoped they would.

DR. CROSSON: It's competitive bidding to set the benchmark.

Kathy:?

MS. BUTO: Yeah. Competitive pricing is what it --

DR. CROSSON: Right.

MS. BUTO: I look back at Brian Dowd's article trying to summarize the four or five demos that tried to get started on this, and the last one, which I was involved in, was killed in 1999. So we're at the 20-year mark, and in 2000, Mark McClellan actually laid out a framework that was under consideration on the Hill by Breaux and Thomas and others, a bipartisan group looking at two different

ways to do competitive pricing for Medicare Advantage plans.

So, to your point, Pat, yes, a lot of work has been done, but a lot of it has been stymied, if you will, because the experiments were never allowed to go forward.

So I think I just want to -- having said that as a preamble, I think this is really a good idea and one to pursue. Of the options that are laid out, Scott, in your paper, I would choose the first one, but I know, without any question, that it will overpay in a lot of areas. If you set a rate at 98 percent of fee-for-service, that's going to overpay, maybe in most areas.

So the appeal of the benchmark being set through a competitive approach, I think it's the competitive benchmark setting as much as anything else. It's that you get some of the savings, just from the competition.

To Pat's point, I think one of the things that we have to face -- and really Marge's point too -- face up to is maybe we don't want to necessarily require that all or most of the savings go back into extra benefits. We should think about that. I mean, we haven't revisited that. That was always the sweetener to make it more appealing, but

maybe there is a happy medium there, more flexibility for the plans, you figure to be competitive with other plans. Plans are going to offer additional benefits, either at a supplemental premium or from whatever savings they can get by bidding against the benchmark.

But I would let them keep a lot of the money if they can bid under the benchmark that's competitively set and not have to put all that back into extra benefit.

I mean, I just think there's a lot of stuff for us to talk about, but to the benchmark issue itself, I think I like Alternative 1, but I think it's going to badly overpay. It's just a lot simpler to administer. There won't be cliffs, but I think it's just a baby step.

DR. CROSSON: Okay. Good discussion.

Oh, Jonathan.

DR. JAFFERY: Sorry. I can do this in under 20 minutes, I premise.

[Laughter.]

DR. JAFFERY: I'll be quick. First of all, I am also supportive. I think I like to see modeling. I think that getting rid of cliffs is going to be beneficial and, in general, feel like you don't need to encourage people to

participate in the way that maybe we did in the past.

I think the point I want to make that I don't think we've talked about is one that actually is true. It was true in the previous discussion as well, and I think we're not just talking about things, changes or recommendations that could impact the MA program anymore. We're not just talking about MA versus everybody else in traditional fee-for-service.

We're now in a situation where we've got ACOs, and we're talking about a couple different models. And I think we just -- whatever we're doing, I think we want to be mindful that that's another part of the conversation, and we shouldn't be totally thinking about all these policies completely in isolation.

We've got high-cost or high-spend areas right now where ACOs operate, and they're coming in below their benchmark and getting a lot of money back, even though maybe we're overspending in those areas, which are very different from the low-spend areas.

So I just wanted to bring that piece into the conversation we had, actually both conversations this afternoon.

Thanks.

DR. CROSSON: Okay. Again, thank you. Good discussion.

Scott, we'll be hearing from you again.

We now have time for a public comment period, if there are any of our guests who would like to make a public comment based on the material that has been discussed this afternoon. Please come forward to the microphone.

[No response.]

DR. CROSSON: Seeing no one, we are adjourned until 8:30 tomorrow morning.

[Whereupon, at 5:00 p.m., the meeting was recessed, to reconvene at 8:30 a.m., Friday, November 8, 2019.]

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MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

The Horizon Ballroom
Ronald Reagan Building
International Trade Center
1300 Pennsylvania Avenue, NW
Washington, D.C. 20004

Friday, November 8, 2019
8:31 a.m.

COMMISSIONERS PRESENT:

FRANCIS J. CROSSON, MD, Chair
PAUL GINSBURG, PhD, Vice Chair
KATHY BUTO, MPA
LAWRENCE P. CASALINO, MD, PhD
BRIAN DeBUSK, PhD
KAREN B. DeSALVO, MD, MPH, Msc
MARJORIE E. GINSBURG, BSN, MPH
DAVID GRABOWSKI, PhD
JONATHAN B. JAFFERY, MD, MS, MMM
AMOL S. NAVATHE, MD, PhD
JONATHAN PERLIN, MD, PhD, MSHA
BRUCE PYENSON, FSA, MAAA
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AGENDA PAGE

P R O C E E D I N G S

[8:31 a.m.]

DR. CROSSON: Okay. I think we can begin to get started here.

I'd like to welcome our guests to the Friday morning session of the November MedPAC meeting. This morning we're going to be discussing two issues, the first of which is part of our continuing work on Medicare drug policy, specifically Medicare Part D, and the role of low-income beneficiaries, and Eric is here. I think Shinobu is riding shotgun. So, Eric, you can start.

MR. ROLLINS: Thank you. Good morning.

At our meeting last month, Rachel and Shinobu spoke about the shortcomings of the Part D drug benefit and outlined some potential reforms that would give plans better incentives to manage drug costs. Today I'm going to continue our work on this topic by taking a closer look at the implications of restructuring Part D for plans that serve beneficiaries who receive the program's low-income subsidy, or LIS. We plan to make recommendations on Part D reform during this work cycle and include those recommendations in the Commission's June 2020 report.

Let me start by giving you a little bit of background. The LIS was created to ensure that low-income Medicare beneficiaries have access to Part D drug coverage by helping them pay their premiums and out-of-pocket costs. As of April 2019, almost 13 million beneficiaries receive the LIS, and they account for 28 percent of overall Part D enrollment. Most LIS beneficiaries qualify automatically because they receive both Medicare and Medicaid benefits, but the program also covers beneficiaries who have income below 150 percent of the federal poverty level and limited assets.

LIS beneficiaries tend to be in poorer health than other Part D enrollees and have higher drug costs. As you can see here, gross drug spending for LIS beneficiaries is more than two times higher than spending for non-LIS beneficiaries. The spending for LIS beneficiaries is higher because they fill more prescriptions, and those prescriptions are, on average, more expensive. Because of their higher spending, you'll also notice that LIS beneficiaries are much more likely to reach the catastrophic phase of the Part D benefit. In 2017, 19 percent of LIS beneficiaries reached the catastrophic

phase, compared to only 3 percent of non-LIS beneficiaries.

As I mentioned earlier, the LIS covers both premiums and cost sharing. For premiums, the LIS tries to encourage beneficiaries to enroll in lower-cost plans by putting a dollar limit on the amount it will cover, known as the benchmark. As a result, the LIS covers the entire premium for only about a quarter of the stand-alone Part D plans, or PDPs, that are being offered this year.

For cost sharing, the LIS eliminates the deductible and the coverage gap and limits the amount that beneficiaries pay for prescriptions to nominal copayments. The copayment amounts are set in law and updated annually. This year, most LIS beneficiaries pay no more than $3.40 for a generic and $8.50 for a brand-name drug. If the regular copayment for a drug is lower than those amounts, LIS beneficiaries pay the regular copayment. In addition, as we discuss in the mailing materials, the copayments for many LIS beneficiaries are even lower. The LIS also covers all cost sharing in the catastrophic phase for most beneficiaries.

The LIS helps ensure access to coverage, but its limits on cost sharing also weaken incentives for

beneficiaries to use lower-cost drugs. This table shows how cost sharing in stand-alone Part D plans differs for LIS and non-LIS beneficiaries. The cost sharing for non-LIS beneficiaries varies depending on where a drug appears on the plan's formulary. Almost all PDPs now use formularies with five tiers: two tiers for generic drugs and three tiers that are largely for brand-name drugs. In contrast, the cost sharing for LIS beneficiaries varies depending only on whether a drug is generic or brand. I'd like to highlight two ways that cost sharing for these groups differ.

First, non-LIS beneficiaries have strong incentives to use generics. As you can see in the yellow box on the left, the two generic tiers have significantly lower cost sharing than the other tiers. A beneficiary who uses a generic on Tier 2 instead of a brand drug on Tier 3 can save $35. If you look at the yellow box on the right, you'll see that LIS beneficiaries also pay less when they use generics, but the savings are much smaller -- about $5 at most.

Second, the cost sharing for brand drugs differs significantly from tier to tier. It's a little hard to see

here because Tier 3 usually has copayments while Tiers 4 and 5 have coinsurance, but as we note in the mailing materials, the coinsurance for Tier 4 can be as high as $100 and the 26 percent coinsurance for Tier 5 is at least $174. So a beneficiary who uses a preferred drug on Tier 3 can save as much as $60 compared to a non-preferred drug on Tier 4 and more than $130 compared to a specialty drug on Tier 5. Plans use this differential cost sharing as leverage to negotiate rebates from manufacturers that want their products placed on the preferred tier. However, LIS beneficiaries pay the same amount for drugs on all three tiers and thus have no financial incentive to use a preferred drug.

The distinctive features of the LIS population make it more difficult for plans to manage their drug spending, but these challenges are magnified for plans that have large numbers of LIS enrollees. Both Part D and Medicare Advantage have features that encourage LIS beneficiaries to cluster in certain types of plans. In Part D, the LIS only covers the entire premium when beneficiaries enroll in lower-cost benchmark plans, plus Medicare automatically enrolls LIS beneficiaries in

benchmark plans when they do not pick a plan on their own. In MA, many sponsors operate special needs plans for dual eligibles, who all receive the LIS. As a result, LIS beneficiaries account for a majority of the enrollees in about a quarter of all Part D plans. These majority-LIS plans together cover about 65 percent of the entire LIS population.

Given the differences between LIS and non-LIS beneficiaries, we interviewed several Part D sponsors to learn about their experience with the LIS population. These sponsors were a mix of large, for-profit companies that operate both PDPs and MA-PDs and smaller, nonprofit companies that operate regional MA-PDs. Each sponsor had at least one plan where a majority of the enrollees are LIS beneficiaries.

Every sponsor said it was more difficult to manage drug costs for the LIS population, primarily because their basic strategy for managing drug costs -- tiered formularies and differential cost sharing -- is relatively ineffective because the LIS covers most cost sharing. For example, many sponsors pointed out that LIS beneficiaries are less likely to use generics. Some sponsors said they

used somewhat narrower formularies for their majority-LIS plans, but the differences from the formularies for their other plans were not viewed as significant. Finally, although sponsors said it was more difficult to manage drug costs for the LIS population, they nonetheless felt that Medicare's payment rates for these beneficiaries were adequate because of the adjustments that CMS makes to account for differences in beneficiaries' health status. We'll return to this issue again later.

This brings us to our work on restructuring the Part D drug benefit. As we discussed last month, the Commission has been examining several changes to Part D that would require plans to bear more risk and would give them stronger incentives to manage drug costs.

First, we would equalize the benefit structure for LIS and non-LIS enrollees by making plans responsible for 75 percent of costs between the deductible and the catastrophic phase. We would do this by expanding the basic benefit to fill in the coverage gap for LIS beneficiaries and eliminating the coverage gap discount program for non-LIS beneficiaries.

Second, we would add an annual cap on beneficiary

out-of-pocket costs.

And, third, we would change the financing of the catastrophic phase by reducing the use of Medicare reinsurance, creating a new program of manufacturer discounts on brand-name drugs, and increasing the share of spending covered by capitated payments where plans bear risk.

We wanted to demonstrate the effect that these kinds of reforms would have on payments for LIS versus non-LIS beneficiaries, so we put together an illustrative example that makes the following changes. Under this illustrative package, plans would cover 75 percent of costs between the deductible and the catastrophic phase for all beneficiaries. The catastrophic phase would start when a beneficiary had about $7,500 in total drug spending. We chose $7,500 because we used 2017 data for this exercise, and that was roughly where the catastrophic threshold was in that year. There would be no beneficiary cost sharing in the catastrophic phase. Finally, in the catastrophic phase, plans would pay for 50 to 60 percent of drug costs, Medicare reinsurance would pay for 20 percent, and manufacturer discounts would cover the remaining 20 to 30

percent.

This graphic shows the impact that this illustrative package of reforms would have on payments for LIS and non-LIS beneficiaries. The figures here show gross drug spending in 2017 on a per enrollee per month basis. The two columns on the left show spending for LIS beneficiaries, while those on the right show spending for non-LIS beneficiaries for comparison. The columns that show spending under the illustrative package of reforms do not incorporate any behavioral responses by plans or beneficiaries.

Looking at the left-most column, you can see that, for LIS beneficiaries, the capitated payments where plans bear risk -- that's the red segment -- are $139 per month, which is less than 30 percent of total spending. Most spending for LIS beneficiaries is financed by Medicare reinsurance -- which is the orange segment -- and the LIS -- which is the green segment -- which are both cost-based forms of reimbursement. Out-of-pocket spending plays a minimal role because the LIS covers most beneficiary cost sharing.

Under our illustrative package of reforms,

capitated payments would play a much larger role, increasing to $314 per month, or about 60 percent of total spending. The share of spending financed by Medicare reinsurance and the LIS would decrease to about 25 percent combined. You can also see that some costs would be financed by manufacturer discounts, which isn't the case now.

As we've noted already, you can see that the average spending for non-LIS beneficiaries is much lower. Here, too, the reforms would increase the role of capitated payments and reduce the use of reinsurance.

Under our illustrative reforms, risk adjustment would play an important role in ensuring that the capitated payments are adjusted for differences in beneficiaries' health status. As we showed on the previous slide, capitated payments for LIS beneficiaries will need to be much higher than the payments for non-LIS beneficiaries -- $314 per month versus $135 per month, on average. We believe that CMS can recalibrate its risk adjustment model, known as the RxHCC model, to provide an adequate overall level of risk adjustment. One key feature of the model that makes this possible is the use of separate risk

adjusters for LIS and non-LIS beneficiaries. CMS added separate adjusters to the model in 2011, and the plan sponsors and actuaries we interviewed said that this change had made payments for LIS beneficiaries more accurate.

However, some sponsors expressed concern that the recalibrated model might underestimate costs for certain types of beneficiaries, such as those who use very high-cost drugs. These high-cost outliers might pose a greater risk for smaller, regional plans that have lower enrollment, but the Part D risk corridors would provide some protection against unexpected losses, and plans might also be able to buy private reinsurance, as we discussed last month.

The Commission has long believed that if Part D plans are going to be required to bear more risk, there should also be reforms that make it easier for them to control drug spending and thus manage the added risk. With respect to LIS beneficiaries, there was wide agreement among the sponsors we interviewed that Part D could be modified in ways that make it easier to manage drug costs while still ensuring access to coverage.

One policy change that the Commission could

consider is requiring LIS beneficiaries to pay higher cost sharing for non-preferred drugs. This would make it easier for plans to manage costs by giving LIS beneficiaries stronger incentives to use lower-cost brands and generics. Under this approach, the cost sharing for preferred drugs would not change. Since CMS requires plans to include at least one drug in each therapeutic class on a preferred tier, LIS beneficiaries would still have good access to coverage. The sponsors we interviewed believed that the cost sharing for non-preferred drugs would need to be $10 to $20 higher to encourage LIS beneficiaries to use a preferred product.

Policymakers could also apply this approach to high-cost specialty drugs by allowing plans to have separate preferred and non-preferred tiers for these products. CMS currently limits plans to one specialty tier. This would be a broader change that would apply to all Part D enrollees, not just those receiving the LIS.

This next slide provides an illustrative example of how this policy might work. In this example, the plan has added a preferred tier for specialty drugs, so its formulary has six tiers instead of the five-tier structure

that is typically used now.

The first three tiers that we have listed here would be the preferred tiers -- with one tier for generics, a second for brands, and a third for specialty drugs. When LIS beneficiaries used drugs on these formulary tiers, they would have the same nominal copayments as they do now -- in this example, $3.40 for a generic and $8.50 for a brand.

The last three tiers would be the non-preferred tiers, and again you'd have one tier for generics, one for brands, and one for specialty drugs. Under this policy, when LIS beneficiaries used drugs on these tiers, their copayments would be higher than they are now. These higher copayments would give LIS beneficiaries a financial incentive to use a preferred drug. Policymakers would need to decide how much higher the copayments for non-preferred drugs would be, but presumably the differential would be smaller than what plans use for non-LIS beneficiaries.

One potential concern about this policy would be its impact on out-of-pocket spending. As we discuss in the mailing materials, the vast majority of LIS beneficiaries now spend less than $200 annually on Part D drugs. The policy's impact on out-of-pocket spending would depend

heavily on how LIS beneficiaries respond to the higher copayments. If beneficiaries switch to preferred drugs, the impact on out-of-pocket spending would be minimal. If beneficiaries continue to use non-preferred products, their out-of-pocket spending would increase. However, it is worth noting that beneficiaries would have access to a preferred drug in every therapeutic class, and that any increases in out-of-pocket spending would reflect beneficiaries' choices about which drugs to use. Policymakers could also limit any increase in out-of-pocket spending by allowing beneficiaries to request exceptions from the higher cost sharing if their physician believes that a non-preferred drug is the more appropriate treatment.

That brings us to the discussion portion of our session. We'd like to get your feedback on whether LIS beneficiaries should be required to pay somewhat higher cost sharing when they choose non-preferred drugs. We'd also like to know if there are other tools that you think Part D plans should be able to use to manage drug costs for LIS beneficiaries while preserving access for this important population. For example, we touched briefly on a

few other possibilities in the mailing materials, such as requiring LIS beneficiaries to pay higher cost sharing when they use a non-preferred pharmacy and giving plans more flexibility to manage drugs in Part D's six protected classes.

Finally, in terms of next steps, we -- and by "we" I mean Rachel and Shinobu -- will return to you in January to give our annual Part D update and discuss the parameters of a redesigned benefit.

That concludes my presentation. I will now be happy to take your questions.

DR. CROSSON: Thank you, Eric.

We are now open for clarifying questions. Paul and David and Bruce and Jonathan.

DR. PAUL GINSBURG: Sure. I've got two.

Eric, any comment about how well the exceptions process works today for either LIS or non-LIS?

MR. ROLLINS: I think that's going to depend partly on who you talk to. I think the beneficiary advocates would say that the exceptions process does not work terribly well, partly because a lot of beneficiaries are not very aware that it exists.

MS. SUZUKI: But I also think we heard in stakeholder interviews that when there are drugs that a beneficiary wants and it is not on the formulary that the plan ended up covering them through formulary exceptions, and because they were not getting rebates on those drugs, it ended up costing them. And so that makes us think that exceptions processes do work in some cases.

DR. MATHEWS: Can I jump in?

Shinobu, a couple years back, we actually did an evaluation of starting with the number of exceptions that were actually initiated. We tracked in a given year how many went through the first process, the second process. Can you say a little bit more about that?

MS. SUZUKI: So I don't remember the exact statistics on this, but there are very few drugs that actually went through the exceptions process.

The one data point we don't have is the denominator that people could have gone through the exceptions process but did not and either went and got another medication or did not fill that prescription. So we don't have that information to say whether or not the process is easy for beneficiaries and prescribers to

maneuver or not.

But we also think that we've heard from plans, like I said, that the process has provided access to many of the medications that are either not on the plan's formulary or on higher tiers.

DR. CROSSON: Shinobu, remind me now, because I remember going over this, particularly when Jack Hoadley was on the Commission. What's the process to notify either physicians or beneficiaries that the exception process exists, or is there a process?

MS. SUZUKI: So the claim is rejected at the pharmacy, and I believe the pharmacist will see that there needs to be a process. And pharmacists may reach out to the prescriber to get a different drug, or they may contact the prescriber or beneficiary may contact the prescriber to start the exceptions process, but I believe they find that out usually at the pharmacy counter.

And we had talked about how a better system would be if prescribers could have access to that information prior to prescribing a medication.

DR. CROSSON: And that could be electronic, for example?

MS. SUZUKI: Yes.

DR. CROSSON: Thank you.

Okay. David?

MR. ROLLINS: Paul, did you have -- you said you had two questions.

DR. CROSSON: Oh, I'm sorry.

DR. PAUL GINSBURG: I am halfway withdrawn. The second question was going to be about is there a literature about the sensitivity to cost sharing of low-income people, but I am suspecting there isn't because of the uniform national benefit design for low-income people.

MR. ROLLINS: That is correct, yes. There have been a number of studies done that look at how responsive Part D beneficiaries are to sort of tiered cost sharing and their incentives to move from a brand to a generic, for example, but the studies I have seen routinely exclude the LIS population because, as you say, there really just isn't much variation in what they pay.

DR. CROSSON: David. I'm sorry. Kathy, on this point?

MS. BUTO: Isn't there, Eric, some literature analysis using Medicaid copay policies? In other words,

some states use more drug copays than others, and I wondered if there was anything there or not. I thought there was an effect on beneficiary access.

MR. ROLLINS: We can look into that, but again, the Medicare copayments are very tightly constrained. They are, in some way, lower than the limits we've been talking about here. It's usually $1 or $2 or $3.

I think even we can look at that literature, but this specific policy that we're talking about, there's also this element of how much do they move to the substitute product, and I'm not sure that the research that's been done will sort of focus on that question specifically. But we can look.

DR. CROSSON: David?

DR. GRABOWSKI: Great. Thanks. I'm super excited we're working on this.

Help me understand. I'm auto-assigned to a benchmark plan. Am I totally indifferent as a beneficiary as to which of those plans I'm assigned to? For example, do they all have uniform formularies? I get the zero premium part.

MR. ROLLINS: They do not have uniform

formularies, but all of the plans will meet CMS's requirements for formularies. So, for example, they cover two products in each therapeutic class. They cover all drugs in the protected classes, things like that.

So it's possible that depending on the mix of drugs that an individual beneficiary takes, you could potentially be auto-enrolled in a plan, that one of your drugs is on the formulary, is not on the formulary.

That being said, historically, the LIS population was allowed to switch plans on a month-to-month basis. CMS has tightened that recently. They can now switch once a quarter, but there's also that option as well.

DR. GRABOWSKI: This will not surprise Amol, who does a lot of behavior economics work, but very few people switch is my understanding.

[Laughter.]

DR. GRABOWSKI: There's a real stickiness in the program. So you're sort of stuck with what you're initially assigned.

MR. ROLLINS: Most of them accept their initial assignment, and as we discussed in the paper, CMS will periodically reassign people to new plans if the premium

goes up. And in most of those cases, the people will accept reassignment to a new plan.

DR. CROSSON: On this point?

DR. NAVATHE: So if there's multiple benchmark plans, how do they get auto-enrolled? Do they get distributed across them, the ones who auto-enroll? How does it work?

MR. ROLLINS: So what CMS does is it will take the lineup of benchmark plans in a particular region, and then it divvies people up based at the parent organization level. So, for example, if you've got three plans and they're offered by three different parent organizations, each of them is going to get a third of the auto-assigned population, and you can get this right now, like what we have now, with the mergers that have been going on.

If you had four benchmark plans in a region, but there were still only three parents, one of the companies had two products, each parent is still going to get a third of the LIS assignment. But the one that has two plans, they will be sort of split. Its third is going to be split evenly across its two products.

DR. CROSSON: Warner.

Hold on one second.

Warner, were you on this point or just in the queue?

MR. THOMAS: [Speaking off microphone.]

DR. CROSSON: Karen?

DR. DeSALVO: Just for the auto-assignment, so there are beneficiaries auto-assigned without any risk adjustment taken into account? Is it basically just one, two, three, four, five, six assignment, or are they stratified and then assigned in that way?

MR. ROLLINS: It's completely random.

DR. DeSALVO: Thank you.

DR. CROSSON: Okay. Bruce?

MR. PYENSON: Yeah. A couple of questions. I think an important group of LIS patients are those who are institutionalized, and they have other types of benefits that are expensive; for example, transitional scripts and dispense, mechanisms for dispensing drugs that also add cost.

Have you been able to subset that group out or have a sense of how much spending is associated with them or some of the options for dealing with those?

MR. ROLLINS: We didn't do it specifically for these mailing materials.

As we noted, roughly 20 percent of your LIS population pays no copays at all because they receive long-term services and supports. Now, that includes both people who are in nursing homes and people who are receiving like home- and community-based waiver services. The nursing home population is a subset of that. We could look more to see what their spending profile looks like, but I would certainly expect it to be high.

MR. PYENSON: Another question. On Slide 10, the assumption about behavioral change of the beneficiary as well as the behavioral change of the plan, I think that, of course, reflects lots of numbers here, that there's no behavioral change on either part. How do you think behavioral change would affect any of this; for example, the top line numbers?

MR. ROLLINS: Well, I think certainly the hope would be that by having plans have stronger incentives to manage drug costs, the hope would be that the total drug spending might be lower under the illustrative package that it is now, but that's the policy goal. We don't know

exactly how that would play out, and to what degree it would play out is not easy to know.

MR. PYENSON: That's the plan behavior. How about the member behavior, beneficiary behavior?

MR. ROLLINS: I think the two would be sort of interlinked. The plans would make different decisions about which drugs they cover, how they structure their formularies. The beneficiaries would face a different set of decisions about what prices they're getting charged for the drugs on the different tiers. So I think they would sort of work in tandem.

DR. CROSSON: Kathy, are you on this point?

MS. BUTO: No.

DR. CROSSON: Okay. Jonathan?

DR. JAFFERY: Thanks, Jay.

Going back to Paul's question about literature on the impact on low-income individuals or their behavior based on these things, I know you said a couple times that we don't have literature, but I wonder if there's any literature in non-Medicare spending, just related to behavioral change in low-income individuals based on taxes of different things?

MR. ROLLINS: So to the extent that I'm aware of it, it's sort of more general research on what's the effect of cost sharing or co-insurance for health care services generally, and the thing I had in my mind is that -- and I think this kind of, sort of makes sense, an intuitive sense, that if you charged, let's say, a fixed-dollar amount, a $20 copayment for a particular service, that a lower-income population is going to be more responsive to that than a middle-income or a higher-income population.

But, again, in this particular case, it's not simply a matter of charging potentially somewhat higher cost sharing for certain drugs. It's also the extent to which you want them to move to another product as opposed to some of the broader literature on sort of use of co-insurance or cost sharing for health care which is sort of to what extent do they just use fewer services generally.

So there's an element of substitution here that I'm not sure we're getting.

DR. JAFFERY: Yeah. I was sort of thinking of things that aren't even in the health insurance realm, but I think you'd have the same issues where some of those things, people just are choosing not to do, certain

behaviors.

My second question is around actually the exceptions issue. Have you considered the feasibility or the cost of an exception process that would grandfather people into preferred drugs or specialty drugs that they had?

MR. ROLLINS: That's not something that we've considered. If that's the Commission's interest, that's something we could look at.

Certainly, to the extent that you are grandfathering in the medications that the current beneficiaries are taking, the impact of the policy would probably be substantially reduced, at least in the near term.

DR. CROSSON: Thank you.

Warner?

MR. THOMAS: Just a couple of questions. On the various tiers, do you have information on the spending in the different tier levels, like the percentage of spending between the tiers? And if it was in the report, I missed it.

MR. ROLLINS: It's not in the report. I don't

think we have that.

MR. THOMAS: Was there any discussion in your interviews about the cost sharing on LIS just being zero for lower tiers and the impact that may have on compliance?

MR. ROLLINS: There was some discussion of having lower cost sharing particularly for generics, like should there be generics where essentially they're free and there's no cost sharing, and there have been some efforts to sort of experiment with that, as you say, with the goal of promoting it here for certain classes where we think that it would be very beneficial.

But there wasn't any sort of structured, I think, takeaway that we got from the sponsor in terms of Medicare should really consider doing X or Y.

MR. THOMAS: Okay. On Slide 10, where you have the manufacturer discounts, exactly how would you see that working? Are there opportunities to do more in that area, especially around LIS plans or beneficiaries?

MR. ROLLINS: So, again, the keyword on this slide is "illustrative." What we have in the figures that you --

MR. THOMAS: Not even fiction?

[Laughter.]

MR. ROLLINS: Illustrative in the sense of that decision is going to be made by the 17 of you and not the 2 of us.

MR. THOMAS: Okay.

MR. ROLLINS: If the Commission is interested in pursuing higher discounts, that's an option, or lower discounts. That's going to be a decision that you all are going to have to make.

MR. THOMAS: So, basically, it's a possibility that some way it could be considered.

MR. ROLLINS: It's something that could be dialed up or down, depending on the collective judgment.

MR. THOMAS: Okay. Thanks.

DR. CROSSON: Larry?

DR. CASALINO: Yeah. At the first pass, at least, it's not the patient or the beneficiary who chooses the medication. It's the physician, and the patient, in my experience at least, gets involved when they get to the pharmacy. They see what it's going to cost, and the physician gets a call, "How come you prescribed this drug that is going to cost me so much money?"

Did you have any information on what information is readily available to physicians at the point of care that would make it possible for them to be aware of what the cost to the patient is going to be? If they're dealing with beneficiaries who are in multiple Part D plans -- I know this is already the case, but this would actually potentially add to it and also make it less desirable to take care of LIS patients because of more hassle in dealing with the pharmacists.

Right now, how is it done? Is there any systematic way that makes it easy for physicians at the point of care to understand what copays their patients are going to be paying?

MR. ROLLINS: I don't know that it rises to the level of being systematic yet, but we did talk to some sponsors that have developed systems that allow clinicians sort of like Jay was referring to, sort of at the point where they're getting ready to write a prescription, they can consult and see sort of which for your patient's plan, which drugs are the preferred drugs, what are sort of the differences in cost sharing that he or she would pay.

DR. CASALINO: Software?

MR. ROLLINS: It's like an online portal they can look at.

DR. CASALINO: Online portal for a particular plan or for all the plans?

MR. ROLLINS: Well, it would be for that beneficiary's particular plan, and they would have to navigate more than one plan. But keep in mind at least for the LIS population, they're often concentrated in only four or five plans.

So I think one thing we heard is these systems are very useful, but for an LIS beneficiary, all they show is the two different cost sharing amounts -- the generic amount and the brand amount -- and that for a non-preferred drug, if you had the system, that would show the cost sharing for one of those drugs would be somewhat higher. That would be very helpful.

DR. CASALINO: Do you have a sense of how often a particular plan makes changes in its formulary, which would change the copay for beneficiaries?

MR. ROLLINS: Well, they are very limited in what they can do during a plan year. They have more flexibility from one plan year to the next.

DR. CROSSON: Kathy?

MS. BUTO: I know it is only illustrative here on Slide 10, but have we thought about the increase in premiums now that the capitated payments would go up in the illustration? Have you looked at that at all? Because I think that as we look at the policy, we'd want to consider how big a jump in premiums we're going to be dialing up or down.

MR. ROLLINS: We have not looked at that specifically, but again, that's going to be a question that you all have to wrestle with starting next month. There are a lot of sort of moving pieces here that we're talking about for the reforms. So holding all other things equal, if you took the coverage gap for LIS beneficiaries, which is now the LIS covers this drug spending there, if you move that into the basic benefit, all other things being equal, that would tend to increase premiums.

Similarly, again, all other things being equal, if you had a beneficiary out-of-pocket cap roughly at where it is now, plans would be covering spending that they're not covering now, and that would also put upward pressure on premiums.

But, again, where that out-of-pocket cap starts is a decision you will need to make. What the level of manufacturer discounts are, that's also a decision you will need to make. So there's a lot of considerations that would go into what's going to be the effect on the premium.

DR. CROSSON: Amol.

DR. NAVATHE: So picking up on Warner's first question -- and I think this may have been, at least in part, in a previous report that you guys have done -- do we have a sense, so in addition to sort of spending by tier for LIS beneficiaries, a dollar amount and a percent of spend that is presumably modifiable? So this idea that we could move from branded to generic or from non-preferred to preferred, and what that sort of size of opportunity is here that we're trying to affect, potentially?

MR. ROLLINS: In terms of a dollar figure I don't think we have that. We touched at a couple places in the mailing materials where we noted that even within therapeutic classes where there are a lot of generics available, you will see that the generic usage rate for the LIS beneficiaries is a few points lower than for the non-LIS, and that's been, at least across all drug classes,

that's been something we've seen for many years in Part D. So that would at least give you a sense.

Specifically on the issue of brands and sort of how much is potentially achievable on sort of taking a preferred brand versus a non-preferred brand, that's not something we've generated.

DR. CROSSON: Brian.

DR. DeBUSK: If I remember correctly, there is a skew in the way DIR is allocated back to plans -- how much of it goes to the capitated payments versus so much of it goes back to reinsurance. And I just made a mental note that if we ever got a chance we should fix that. Could you guys speak to that misallocation, and does this move us a step closer to having that misallocation fixed, or is there an opportunity here to do something there as well?

MS. SUZUKI: So the issue we discussed a couple of years back is that the way CMS currently allocates the DIR is using the gross spending, and above the gross spending 80 percent is Medicare's reinsurance. So they figure out how much Medicare keeps for that portion of the benefit, using the shared spending that's covered by reinsurance, which means the plan portion is everything

else, including the rebates they receive during all the phases, gap phase and LIS.

So in looking at how much the DIR offsets the cost to the Medicare versus plans, it looked like offsets for the plan costs are much higher than reinsurance offset. This would move in a direction of fixing that issue, primarily because plans would be responsible for all the costs below the out-of-pocket threshold, all the benefit costs below the out-of-pocket threshold. So they're not keeping greater share than their benefit covers currently.

DR. DeBUSK: That was what I was thinking, is if you go from the skew impacting 80 percent to saying we're like 20 percent, you know, because some of the illustrative things have had you at 20 percent. Is that correct?

MS. SUZUKI: Mm-hmm.

DR. DeBUSK: The other question I had, and this touches on what Warner was asking about, I'm assuming at some point then you guys are going to bring us, here's the coverage gap discount program, you know, how much is paid into that, here's what we would propose, go into, now the reinsurance, basically transformed into reinsurance, and then I would assume the Medicare payment, the catastrophic

phase, would still -- would be the difference, basically. I mean, are we going to see a model like that at some point?

MR. ROLLINS: I'm not going to commit to a model per se, but in terms of like -- I think that's the right way to think about the catastrophic phase is sort of three buckets that are going to play a role in financing. One is the Medicare reinsurance, one is manufactured discounts, consistent with what you have discussed, and the remainder would be sort of capitated payments for the plan's bare risk, and sort of it's up to you all to decide what mix you want those three to play.

DR. DeBUSK: Okay. So at some point in the upcoming work you're going to have three buckets and fill in the blank, basically.

MS. SUZUKI: The thing I'll caution is we may, for example, prior to the meeting, we may try to think about, in the static sense, what the current data shows. That would be different from cost estimates that CBO would provide. So for recommendations we usually come up with parameters and have CBO provide us with cost estimates. So if we chose 20 percent, they would provide one-year, five-

year estimate for that.

DR. CROSSON: On this point?

MR. PYENSON: Brian, correct me if I'm wrong. On the percent retained by the plan of DIR rebates, as Federal reinsurance shrinks, that percentage is going to go up, assuming the total drug spend doesn't change, the Federal reinsurance, which is the numerator, is going to go down from 80 percent to something smaller. So the plan portion of retained rebates goes up. However, the plan liability for expensive drugs goes up also, from 15 percent to, say, 60 percent. So the incentives will turn so that it will be hard for a rebate to meet -- harder for the rebate to meet profitability.

DR. DeBUSK: That's what I was thinking, is that the theoretical rebate you would need to still defeat the system I think goes down by a factor of four, if you're dropping from 80 percent to 20 percent. Because, you know, in theory there's always a theoretical rebate that will defeat the system.

MR. PYENSON: I think the rebate has to go up --

DR. DeBUSK: Yeah, that's what I'm saying. Yes, I'm sorry. I said that backwards.

MR. PYENSON: Yeah.

DR. DeBUSK: It's going to get much harder to find -- I mean, you're going to need a 90 percent rebate instead of a 40 percent.

MR. PYENSON: It also depends on the other corridors as well.

DR. DeBUSK: Okay.

DR. CROSSON: Okay. Karen.

DR. DeSALVO: I'll wait for them.

DR. CROSSON: Okay. Sorry. I have Jon.

DR. PERLIN: Thanks. On Chart 5, could you roughly allocate where you see the proportions of the dollars that potentially could be saved if we went from generic to preferred generics from non-preferred to preferred branded, and just extrapolating to the ultimate six, your table, from preferred specialty to specialty? In other words, I'm going to assume most of the money is at the lower end of the table. Is that correct? In other words, where do you get the bang for the buck in terms of making changes here?

MR. ROLLINS: I think it's difficult to say exactly how this would play out because it would depend on,

sort of, again, you would need to figure out what is the differential in cost-sharing that we are going to use that we don't have now. And as we've discussed, we don't have a great research base in terms of sort of what effect that would have on patient behavior.

DR. PERLIN: In a sense, you know what drugs are prescribed and you know the behaviors of the non-LIS population, and so there's a hypothesis that if the LIS beneficiaries behaved more like the non-LIS beneficiaries then there would be a better set of utilization of the drugs and that would result in lower expenditures while retaining the quality of care, because the drugs are interchangeable.

MR. ROLLINS: Yes. I mean, the hope would be that in response to the higher cost-sharing for the non-preferred drugs you could have beneficiaries who, instead of the non-preferred drugs switch to a preferred brand, which would be less expensive for the program, or potentially move all the way down to a generic.

DR. PERLIN: The reason I'm getting at this, I wanted to clarify, where we think the dollars are, is that really sensitive to Larry's issue, it's not the patient

that comes in and says, "Hey, this is the drug I need," and it's the physician to make a choice. And the challenge for the physician is this workflow issue, is that, you know, you've got not only Medicare beneficiaries with different plans but you've got all these commercial formularies. What happens is it's impossible to go outside of your workflow, go to a portal, look something up, and back to your workflow. You know, it's Miller, not Budweiser -- please, a metaphor.

[Laughter.]

DR. PERLIN: It just doesn't happen, and that means it gets arbitrated at the point of the pharmacist. And in terms of not adding, you know, burden into the process, if we know most precisely where we think the savings are, that means that we can focus down on the particular tier exchange where the dollars are, in a way that's as efficient as possible. Because I think the piece that I'm trying to understand is, you know, what can we do most precisely that retains the benefit for the quality of prescribing for the beneficiary while also not adding inordinate additional work load to this sort of arbitration process, which ultimately, you know, will exist at the back

end, from a patient who is concerned about the cost interacting with the pharmacist and going back to the physician's office.

MR. ROLLINS: Again, I don't think we have a great sense of that because right now this is just kind of a concept that we're putting in front of you. I think, you know, your concerns about sort of the physician workflow, they deal with this for the non-LIS population, and even if you do this on a more targeted basis for the LIS population, you're still going to have them deal with sort of the same hassles.

DR. PERLIN: Thanks.

MS. SUZUKI: Can I just add one thing?

DR. CROSSON: Go ahead.

MS. SUZUKI: So I think we talked a little bit about this at the last meeting, but EHR and real-time benefit checks are things that are supposedly is going to help the prescribers make this easier. And the other thing to note is this policy layers on top of the current plan structure, so the prescribers already do this for their non-LIS beneficiaries. They have seen the same kind of drug, and beneficiaries probably would ask for the cheaper

option, and they have had to do similar kind of transactions.

DR. PERLIN: So, Shinobu, absolutely terrific point. So whatever a policy option, it would seem fit the degree to which that can be inserted into standard EHR capacities would be the best approach. Thanks.

DR. CROSSON: Bruce, you had --

MR. PYENSON: But, Jonathan, on some of the socioeconomic differences in populations are such that I've seen lower adherence by LIS than non-LIS in a category of drug. So there are things other than cost-sharing that drive -- so the behavior of non-LIS is not always useful completely. But a question on that process. I think the state-level dispense has written laws and other things like that that probably take precedence over Medicare rules, or how does that, the mandatory substitution laws, how does that interact with Part D?

MR. ROLLINS: They generally apply to Part D. So a Part D beneficiary could also get a mandatory dispensing of a generic product in a state that had that law.

MR. PYENSON: Or likewise, do we know if there is a way for Federal rules to supersede state rules for Part

D? Is that a CMS rule or is that Federal?

MR. ROLLINS: To supersede what specifically?

MR. PYENSON: So, for example, the mandatory generic substitution.

MR. ROLLINS: That can be overwritten if the prescriber says "dispense as written" on the script.

MR. PYENSON: Only in certain states?

MR. ROLLINS: I think that's going to take precedence everywhere. I don't know that. We can double-check, but that's my guess.

MR. PYENSON: But does that seem like a viable solution to the problem?

DR. PAUL GINSBURG: Bruce, I don't see how that solves it at all, because if the pharmacist can add substitutes then it just goes back to the beneficiary, here's how much more you're left to pay, and then I guess the beneficiary can get the doctor to change. So, in a sense, it's really something about how smoothly the process works rather than the ultimate outcome.

MR. PYENSON: Well, I'm thinking of circumstances where manufacturers may have encouraged physicians to write DAW, which is not in the interest of the Medicare program.

DR. CROSSON: Okay. All right. I think we're done with that. Warren, you have a separate issue?

MR. THOMAS: Separate. On the chart here, I assume that, is the total cost here illustrative as well, or is that the actual cost?

MR. ROLLINS: So this is 2017 data and this is actual for their gross drug spending. It doesn't include manufacturer rebates and discounts, so it doesn't have sort of the net. This is just sort of the gross payments at the pharmacy counter.

MR. THOMAS: And do we have a handle on the -- that's a pretty substantial differential, and do we have a good handle -- I know in Table 1 we had, you know, I guess it's 19 percent of the LIS enrollees are above the catastrophic versus 3 on the non-LIS. Do we have a decent handle on the differential in that cost, like what's driving -- is it all just the catastrophic or are there other pieces that are driving that differential?

MR. ROLLINS: I think generally probably across most -- I'm not going to go so far as to say every single drug class, but generally speaking, across the board, the LIS population is going to use more of a particular type of

medication. They are particularly likely to use certain types of medications -- behavioral health medications, things like that. But generally speaking they are going to use more of just about everything.

DR. CROSSON: Okay, Sue, last question.

MS. THOMPSON: Well, I want to go back to the interviews that were conducted. Can you talk just a little more -- I mean, you talk about interviewing several Part D plan sponsors. How many? What was their geography? How many of the LIS beneficiaries lived in urban versus rural communities? Can you just describe that complement of who you interviewed?

MR. ROLLINS: We talked to, all told, I'm going to say about a half dozen plan sponsors. Most of them were national sponsors that are operating sort of across the country, so we didn't get specifically into sort of urban versus rural issues. But to the extent that they are operating nationally they are in all of those areas. And then we also talked to some regional sponsors that had MA-PDs in like certain areas.

MS. THOMPSON: And did you visit with any clinical pharmacists in terms of the impact from a clinical

perspective these policies might have, from their viewpoint?

MR. ROLLINS: No, we did not.

MS. THOMPSON: And in relation to the idea of preferred pharmacies, any thoughts about, or did the plans have any thoughts about the impact to rural communities if we moved towards preferred pharmacy?

MR. ROLLINS: They did not voice those concerns, but I don't want to make it sound like it's something that we probed deeply on. I think before sort of that policy would be kind of ready for prime time, if you will, I think we would want to dig a little bit more deeply and sort of see what that means, because a lot of times the preferred pharmacies are sort of the chain pharmacies or your grocery stores or things like that, and we have heard some plans say that the LIS population is much more likely to use independent pharmacies, things like that.

So I think we would want to get a better picture of sort of what's going on there before sort of really moving forward with higher cost sharing for the non-preferred pharmacies.

MS. THOMPSON: Thank you.

DR. CROSSON: Okay. So we will move forward to the discussion. Could you put up Slide 15, the last slide? We would like to focus the discussion on a fundamental question, and that is, is there support for moving forward with changing the benefit structure, payment structure for LIS beneficiaries. Are there any thoughts about a different way to go about reducing perhaps excess expenditures by LIS beneficiaries?

And I would add, I think, you know, based on the questions so far, if you have thoughts about the exception process, because I'm going to suggest I think towards the end that maybe if we go forward with this policy we may want to bring back some of our former point about the exception process, ease of use, et cetera, because I think it goes together with this.

And so Paul is going to begin.

DR. PAUL GINSBURG: Thanks. Yeah, you did a really comprehensive job on this question. You know, this comes down to a basic concept behind Part D, which was that rather than the Medicare program taking risk, as it does in Parts A and B, it would have Part D plans take risk, and the reason for shifting the risk would be because to engage

the plans in management activities, designing formularies, negotiating formularies using other utilization management techniques such as prior authorization. And what you're pointing out here is that these techniques, at least the formulary techniques, likely are much more effective with the non-LIS population than the LIS population.

So now that we're contemplating moving to shifting a lot of the risk that should have been on the plans back to the plans through changing the reinsurance, the question you posed is whether, in fact, the plans have adequate tools to handle their very large, very expensive LIS populations.

So I'm really glad that you conducted the interviews. I find in so many MedPAC analyses the interviews are very valuable, and it was very meaningful to me.

I'm generally supportive of the proposal's next steps you put up, and I was going to mention, before Jay did, that I think work on making sure the -- improving the exceptions process, making it more usable, more transparent to the beneficiary, at least aware of their options, I think would be a good thing. And I think some of the

things that we come up with for LIS would be suitable for non-LIS, and we should add that in.

DR. CROSSON: Thank you, Paul. Further discussion? Karen, Bruce, Amol, Pat. Karen -- and Warner.

DR. DeSALVO: Thank you, guys, so much for this follow-up. You know, I don't want to be paternalistic but just realistic that I think asking the beneficiaries to drive the process and trying to use them even would seem like small financial levers to get their behavior to change is not the direction that I would feel comfortable going. I think that the majority of these individuals are living on the edge financially and also don't feel a sense of agency in the conversation with their clinical teams. And often they may have -- you know, folks who are trying to help them navigate the systems, they might be prescribed, you know, a psychotropic medication on a Friday afternoon in clinic and then show up at the pharmacy, and it's not the right pharmacy and it's not the right drug, and then they have to go the next few days until the doctor is able to answer the phone. And so they get caught up in a broken system.

So I think that, harkening back to what Warner

said, I'd almost see, you know, asking them to pay zero, but I'm not really in favor of leveraging them to drive down costs.

On the other hand, I think this conversation that we started having about the use of technology is ripening for an opportunity to drive point-of-care behavior, and I think that helps everybody involved. And I'm not very familiar with how good the literature is that's driving the market to build these kinds of tools, but there may be some that you're familiar with. And, you know, as a couple of examples, Humana and Epic announced a pathway to integrate into the work flow point-of-care decisionmaking using that as sort of a first step into how other electronic health record companies could do this work, Epic having a huge market share. Cerner, another major vendor, announced a pathway partnering with Surescripts, which does most of the trafficking -- the data trafficking, that is -- when you say "trafficking" and "drug" in one sentence.

[Laughter.]

DR. DeSALVO: -- for the country. So those are big moves, especially Epic, Cerner, and Surescripts, to try to free up the marketplace, and there are others, CVS

Caremark from a pharmacy angle.

I think the policy issue -- the market can drive some of that, but the policy issues are already in flow but need to be finalized. So, you know, the 2015 edition of the electronic health record requires open nonproprietary API, which means a doorway to the data that allows easier connectivity and pushing point-of-care decisionmaking about real-time benefits check into the work flow for the clinicians so there's not a separate portal to look at. So the technology exists. The policy has been made. It has to be continued to be acted on and the rules in play right now that I guess are under review at OMB, the interoperability rules from CMS and ONC are a part of that puzzle to keep pushing a more open ecosystem and require the use of a specific technology FHIR-based APIs, which is, you know, not proprietary and inexpensive.

So that policy direction is less about payment and more about keeping that train going that has been around pushing the technology side, and I wouldn't want us to lose sight of that as an opportunity to put some more pressure on the point of care and not on the beneficiary.

Saying that, I think having some evidence about

whether that actually works and what are the results of it for all types of patients and not just commercial patients, but is it going to help particularly those that are low-income, because, for example, my suspicion would be that low-income beneficiaries are less likely to be cared for in practice environments that are using Epic or Cerner, just -- those are the two big first, probably more likely to be smaller -- not smaller but relatively smaller technologies like eClinicalWorks. So not to get too into the weeds here, but I think just the broad policy -- it's not so much about what the market decides to do independently. CMS has a really important role to say the entire market needs to move in this direction, and that sort of ties into all the HIT policy that they already have underway but need to complete.

DR. CROSSON: On this?

DR. CASALINO: Yeah. You know, I don't have anything to contribute on the technology side of it, but I do want to emphasize the issue, basically restating a little bit more strongly what I said and Jonathan said a few minutes ago. It's really -- to talk about the beneficiary making a choice, it's not a trivial use of

language, and I think Karen's right. I think that a lot of these beneficiaries are not in a good place to make a choice. They're likely to wind up as a result paying more, especially if they're seeing physicians who aren't well equipped to even understand what the choices are.

But then I do want to talk about from the physician side of things. Unless this can be done right within the work flow, not having to go to a portal for every different health plan to try to figure this out, it's just very, you know, unfair to physicians and the patients. And it does add cost to the system; it's just not visible immediately to Medicare, because it's a huge cost in physician and staff time and physician morale. Physician morale at this point -- you know, I can't tell you how many times in the last couple of years I've gone to a medical group leader and asked him to ask their physicians to do X, Y, or Z, take a three-minute survey or whatever. And they said, "Larry, I'm sorry. I'd like to do that, but my physicians tell me with gritted teeth, `Not one more thing.'" This is not a trivial thing, so requiring physicians to go through different portals is analogous, or maybe even worse, to the situation, when I left practice,

with pharmaceutical formularies, I had a desk drawer, a large drawer that was full of formulary books from each health plan, which changed each year, and were supplemented by faxes that we'd get from the health plans. I'd get a fax one day from Humana: "You may no longer use lisinopril as your preferred" blah, blah, blah. And from a different health plan the same day, "You must now use lisinopril as your preferred" blah, blah, blah. So there's no rational way for a physician to learn, okay, this is the best drug at the best price for what I want. It takes enormous time, and it's an enormous hassle and creates a lot of cynicism, I think, among physicians and staff, and pharmacists, too.

I think you're going in the right direction, but I do think that -- and this is something I don't understand the technicalities. But insofar as Medicare can put requirements on that would make this, so at the point of care in your work flow you can see this, and physicians will be, you know, happy to do what they can for their patients. But, otherwise, it's just one more burden, and not a trivial one, for physicians and one that will make LIS patients less desirable to exactly the kind of practices we might want to see them have access to.

DR. DeSALVO: Just to respond to that, Larry, that's exactly what the product track is with this API, the doorways to the data. They're not proprietary. They're open source. Then it can allow those data feeds to come right into the work flow and not have to go to a separate portal. The pathway right now is the market's kind of creating different portals, but that's where the more progressive part of the market is and where federal policy, is to make it directly into the work flow.

DR. CASALINO: But, Karen, there's no need for any additional federal policy in relation to --

DR. DeSALVO: There needs to be finalization of rules, but that's going to hopefully be in process now.

DR. CASALINO: But no need to put something into this proposed program specific to that.

DR. DeSALVO: You know, I'm not sure that there has to be anything additional, except unless we find something in the literature that, in addition to just having the information, maybe -- if only 40 percent of clinicians act on information and make change, which is the little bit of literature that I've seen, then that's not as far as you'd want to get. There may be other policy

actions. But to me, starting with a point-of-care decisionmaking that's in your work flow so that it's on the burden of the clinician as the first step would be where I would prefer to start instead of adding -- and let that play out.

DR. CROSSON: I'm sorry. Brian, on this?

DR. DeBUSK: A question on this, and I'm going to show naivete when I ask you both. There seems to be this issue about the physician work flow that you guys were talking about. And then, you know, Karen, you mentioned the patient, you know, what if the patient -- can they deal with the difficulties that may arise, like a non-LIS patient? But I want to focus on the physician perspective. When I'm a practicing physician in the office and I'm about to prescribe something, do I even know if they're a LIS or a non-LIS? I mean, I'm doing this regardless, aren't I?

DR. DeSALVO: Yeah, you may not know, but the system will know. That's sort of the idea of having it embedded into the electronic health record because it will know the benefits of the person. And so when you're doing a real-time benefits check, it's an automated process that augments your decisionmaking at the point of care.

DR. DeBUSK: But I'm coming back to if there's a drug I'm supposed to prescribe or not supposed to prescribe, I mean, I'm doing that right now for the majority of Medicare beneficiaries. I'm asking, by the way. This isn't a lightning rod type question.

DR. DeSALVO: Yeah. Well, and others could probably weigh in, obviously, but these systems exist for formulary checks, but it's just that they tend to be separate and apart from the work flow. And the idea is that all that data lives or is connected to the electronic health record, the formulary for that beneficiary of whatever type, and it supports the decisionmaking. So if you prescribe something, it'll redirect the clinician to the best alternative.

DR. CROSSON: Okay. Let's -- I don't want to spend the whole time just focusing on this, but Jaewon and then Jon on this point.

DR. RYU: I just wanted to throw one other thing that I think Jon raised earlier, which is how much of this lands more appropriately in the pharmacy work flow at the point of distribution. And I don't know, you know, what should land on the physician work flow side, what should

land on the pharmacy side, and how much of these scenarios are actually substitutable situations. But I think that would be useful to know as well.

DR. CROSSON: Jon.

DR. PERLIN: And I think it's incredibly relevant on this point, is that all other things being equal, you want to use the most effective, least expensive medication that's appropriate.

Second, you don't want to have the patient have to be the one to reconcile the deficiencies in the system.

Third, the ideal would be to get it right at the front end. Karen and others, Larry, suggest that the technology be inserted into work flow.

And then, fourth, Jaewon says that ideally if it can't be there, don't -- why burden the beneficiary, especially financially? And I think Bruce's point, there may be other reasons that beneficiaries may be at greater risk for noncompliance and, therefore, worse outcomes. So what can the pharmacist do to reconcile. That is, I think, design principles, but I think it is worth reinforcing in whatever sense of MedPAC, if not a specific statement, that these are the technologies that would optimize both the

expenditure as well as, most importantly, the clinical outcome.

DR. CROSSON: Yeah, this has been a good discussion. I'd just like to point out, though, at least from my point of view, this is anchored in the issue of viability of the exception process, were we to move forward with changing the incentives for LIS beneficiaries. I think the exception process, which is already in place and may or may not be functioning properly, needs to be thought through and perhaps improved. And what we're talking about here is one way to do that, but also perhaps a little bit larger set of questions around work flow for doctors and everything of that sort.

Okay. All right. So I've got Bruce next.

MR. PYENSON: Thank you very much. This has been great work and a terrific discussion. I would recommend, along the lines of the other tools, that we look at whether NDC blocks are being used appropriately. There's certainly instances where Part D plans block generics and require use of brand and things of that sort, and vice versa with respect to the impact of dispense as written and whether that's in the public health -- in the public's interest and

the circumstances under which it is, which also gets to Jay's point about the exception process for exceptions to formularies.

You had suggestions for changing and MedPAC has had suggestions for changing the protected classes, and I think revisiting that would be important, and, again, to Paul's point, not just for LIS but more broadly.

I would also urge us to look at the long-term-care patients who are even more expensive than the regular LIS and whether there's an opportunity to bring better value to both those patients and the Part D program.

That's it. Thank you.

DR. CROSSON: Thank you, Bruce. Amol.

DR. NAVATHE: So thanks for taking this important work on and putting out an illustrative scenario for us to sink our teeth into.

I wanted to actually integrate several of the different points here. First off, just expressing support for the work that you guys are doing and the very general direction that we're going.

I think my initial question in the Q&A phase, I think Jon has done a nice job, I think, of also -- perhaps

said it better in terms of trying to quantify to some extent the opportunity. And I think the reason we need some level of specificity on what the opportunity is, quote-unquote, and where the opportunity is, as Jon described, is really important because it ties into Karen's point, which is we want -- through this change we want to use the design principles that Jon laid out around getting the lowest-cost effective medication for these beneficiaries. That's fundamentally important, but we have to do it in a responsible way where we don't think that we're putting beneficiaries at harm in the process.

And so if we can get a greater level of detail, I think even some examples of where we have therapeutically equivalent medications that are preferred, branded, versus non-preferred and that substitution and what that cost difference is, I think that would give us a greater level of certainty and a sense that truly in the system we can make cost-saving choices or cost-saving design changes to the policy that would still be equivalent for the beneficiary.

So I think that hopefully we can try to dive a little bit deeper in future work to at least give some

illustrative scenarios and size the opportunity in some level of granularity, I think that would actually be very helpful, particularly because at some point we will want to make recommendations on what those differences in cost sharing, for example, would be, or copays would be, between preferred and non-preferred. Right now they're very abstract concepts, and so I think that piece is also important.

The other piece I'd highlight is that the dollar amount that we set for a difference between preferred and non-preferred or brand and generic is also a choice, and so it doesn't necessarily have to be a huge difference, and we still may find that LIS beneficiaries are potentially responsive to that. And I think that we have to internalize that there is a possibility here, recognizing some of the system problems that we have, that we can get to this goal of still effective or equivalently effective medication for an LIS beneficiary for lower cost.

DR. NAVATHE: And that is the goal. There are system barriers, perhaps.

I think one thing to recognize is if we don't have differences in cost sharing, it doesn't matter how

good the health IT is on real-time benefit checks because, if there's no incentive to change, there's going to be on incentive to change, and the real-time benefit check is not going to do anything. So I think that's kind of one important piece that's very broadly supportive of the direction that we're going here, and I think it's important.

I also think we should be reasonably cautious about relying purely on the health IT solution soon. I've had the opportunity to actually see them in practice, actually look at data on engagement and, quote/unquote, "practice change." It's still pretty low. Most people still click around it. There's very few. I would say from the data that I saw, less than a fifth of opportunities are actually for -- therapeutically equivalent changes are actually followed through upon. So we still have some work to do there, and again, I think the policy pieces, design pieces have to be in place.

And the last piece I'll say is I think preserving ideas like "dispense as written" are actually really fundamentally important for patient safety. I think we know that there are cases in some endocrine drugs,

certainly in psychotropic medications and other mental health-oriented medications where branded generic can matter. When you have a patient on a stable dose of a medication that's branded, it's much more predictable for a patient with bipolar or some other mental health disease. You really may not want to switch to a generic, even if it seems cost saving, because of the fact it may be bad for patients, and it may actually be anything but cost saving in the long run.

I think we should certainly espouse the principles around protecting these beneficiaries and recognizing that there is a number of other barriers around them, but if we don't set up the policy in the first place, then the system is not going to adapt to try to drive the right behaviors at the point of the physician, at the point of the pharmacist, and then I think perhaps downstream at the point of the beneficiary.

DR. CROSSON: Thank you, Amol.

Pat?

MS. WANG: Thanks.

Thank you, Eric, for doing this really important work and focusing on this population.

Can you go back to Slide 10 for a second? This, especially in color, is a very impactful slide. Where we start, as you have noted, the beneficiary structure for LIS today is different than it is for non-LIS. This re-depiction follows the goals set out in the initial work of standardizing the beneficiary design between LIS and non-LIS.

But what this shows really is the magnitude of the risk shift to plans from CMS. That's the goal.

In the non-LIS population on the right-hand side, obviously the risk shift is smaller in dollars, and it's also smaller proportionately from current to the plans, like one and a half times.

If you go to the left and you look at the magnitude of the risk shift from an LIS plan today, it's two-plus times, and the magnitude of the dollars is much, much bigger.

So I think that it's really important to just stop and pause and stare at this because the title of this paper was "Implications for Plans Serving LIS Beneficiaries," and so this is the magnitude of the impact on those plans. Let's just start there.

Here, I'm focused on really D-SNPs, MA-PDs, not the freestanding drug plans. I don't know enough about freestanding drug plans, but I know a little bit about D-SNPs, who serve the population. Many of them are Medicaid plans that have kind of gone into this serving duals who have aged in or are from the same community as Medicaid members. Those of the plans that are not-for-profit, regional, provider-sponsored, what have you, I think are very well suited to serving the population because this is a population that is very local.

So hyper-local approaches, their physicians are different. They're not practicing in big group practices with Epic and all this kind of thing, as Karen pointed out. They're onesie-twosies community doctors. Depending on the community that they're in, they may be immigrants. They may be -- because of cultural competence and the need for language competence, it's a different population. It's a different provider workforce. It's a different pharmacy, dispensing pharmacy, community pharmacies, not the big drug chains that are connected to the world through sophisticated technology.

To the extent that those are the plans that are

serving this population today, I think it's very important to understand the implications of the magnitude of the risk shift. So that's number one.

Number two, if you go to Slide 13 -- and this was also in Table 3 on page 9 of the paper -- just to stare at this again, the illustrative middle column, these are six tiers of varying cost-sharing implications for non-LIS populations, and on the right for LIS beneficiaries, this depicts the cost sharing for LIS Category 1, where one-third of LIS beneficiaries fall into that category today. This is their cost sharing.

There are four LIS categories, the third of which, according to the payer, 19 percent of LIS beneficiaries fall into this category. Zero cost sharing, zero generics, zero brand, zero catastrophic. These are duals who are using long-term supports and services. These are the duals in the duals demos. These are the duals who are in I-SNPs and PACE programs. Forty-four percent of the LIS population is in the full-benefit dual population, where the cost sharing is $1.25 for generics and $3.80 for brand.

These are appropriate levels of cost sharing for

the population. This is not a population that has any money. This is a population that is sicker, that has many, many barriers to care, and so this is appropriate cost sharing.

The other thing, I mean, Eric, I appreciate many of the suggestions that you developed in the paper, but I want people to appreciate what the rules around the LIS formulary management is today. If there are six tiers here shown here and those translate into five or so tiers in the non-LIS Part D benefit, for the LIS population, current rule is there's one tier. Every single one of those generic, brand, preferred, non-preferred specialty is required to be in one tier. The only thing that differs is the cost sharing applicable to the beneficiary, which in the case of 20 percent of the population is zero. All of those things by law today are in one tier.

So if you go back to Slide 10 and just stare at the magnitude of the risk shift, I would just suggest that the points that people raised here today may explain why the benefit structure in Part D is different today for LIS than for non-LIS.

I really think that, Amol, the goal is to lower

the cost of drugs, the appropriate life-saving, safe drugs for the LIS population. The question is, How do you get there?

I think the suggestions on cost sharing are appropriate. It's important to try to do what there is where it's possible to, but then on the other hand, there's a desire to make sure that there are good exceptions processes.

There's an expectation that physicians will somehow be able to say, "You don't have any cost sharing, but I'm going to take the time to figure out which brand is preferred and lower cost." I mean, I don't think that's realistic. So you don't want to put the burden on the physician.

The beneficiaries have got a lot going on in their lives. The expectation that they are going to understand, this is better to take a lower-cost brand because it will save the Medicare program money, and that's what they want me to do, even though I have no differential cost sharing or zero cost sharing. It's not realistic either.

So where are we? Where I think we are not, in my

view, without people being really realistic about the implications for plans that predominantly serve this population is on the left-hand side of this box. I think it is very, very impactful and has gigantic implications at least for regional plans that are in a community to continue being able to serve the population.

I think that all of the suggestions, Eric, that were in your paper do need to be adopted. Plans need to have whatever tools they have with whatever restructuring of the Part D benefit there is, but I think that the concerns that have been raised today, there's going to be tugs and pulls on what to impose on beneficiaries, what to expect of the delivery system, what to expect of the beneficiaries themselves, whose health literacy and English literacy may be very, very low and probably is. So I would just be very cautious about that.

Eric, you very correctly pointed out that risk adjustment for the amount of risk that is going to have to shift over to LIS has to be exquisite, but you also pointed out -- and I'm very appreciative -- that your observations are on a national basis, and on an individual plan basis, you could have all kinds of outliers, new drug launches

that could just really spell catastrophe for plans that have a mission to serve this population.

Risk corridor protection, you mentioned maybe in the catastrophic layer, that could help. I would urge that that be modeled.

If you just even look at the 19 percent in the reinsurance layer versus the 3 percent for non-LIS, that's' six times the number of people are going to be -- that an LIS plan is going to be managing and taking risk for in the reinsurance player. The magnitude of these impacts is really big.

There was a mention in the paper about plans purchasing private reinsurance, stop-loss insurance. It's very expensive. Maybe CMS could do an at-cost stop-loss program for these programs.

But I think that my fundamental concern here is, number one, I really think that -- I urge that the Commissioners be sober about the fact that this policy could have very unintended and very unknown consequences for what plans in the future serve the population. It could have unintended consequences or unintended consequences for plan consolidation, and so it's sort of

that's what people want because that's the only type of plan that can withstand this sort of risk. It has to be national. It has to be multi, whatever. People should just have that in their minds.

But I think that the other thing that I would like us to keep an open mind about as we go forward with the work is that I don't really know why we think that the benefit structure between non-LIS and LIS must be standard or must be the same. I think there's a reason today that CMS is absorbing more of the cost for this population and that the benefit structure is different, and I think that we should be open to that going forward for LIS.

DR. CROSSON: Thank you, Pat.

Kathy, are you on this point?

MS. BUTO: Yeah, really.

I really appreciate what Pat just said because I came into the conversation thinking I totally support the direction that Eric and Shinobu have laid out, but now after the conversation, I really feel as if, number one, we should make no change in beneficiary cost sharing for the LIS population. And the reason for that is I think the structural change that we're advocating, which I very much

support, will have an impact on the spending that we're seeing that sort of statically reflects the current state.

So I think before we move to looking at changing cost sharing for LIS beneficiaries, it makes sense to see what that structural change will do because it's going to have a big impact.

The second thing is after Pat's --

DR. CASALINO: What do you mean by "structural change"?

MS. BUTO: Just doing away with the coverage gap, this whole restructuring that I think we're coming back to in the next session.

But what Pat's comments really struck me is that I think we do want to protect the plans that serve a larger share of LIS beneficiaries, and we might want to think about in that next go-around on the big structural change, a different structure for those plans that maybe has less plan risk absorbing and more federal manufacturer risk taking for that population.

In my mind, if plans and manufacturers are taking on more risk in the catastrophic phase, there will be a different dynamic in both the technology provided to

physicians and also the behavior of manufacturers. So that's number one.

But, two, if they absorb even more risk, if the federal government and manufacturers absorb more risk vis-a-vis the plans that have less ability to controls pending for that category of patients, then I think you'll see an even different behavior on the part of -- there will be more fair risk sharing in my mind if we do that.

So I hate to think about two different tiers because then you have cliffs, but it just strikes me that this is a different kind of plan. And we don't want to see these disappear.

So I would just say for the next go-round, we ought to think about that.

DR. CROSSON: Thank you for that comment, Kathy.

I just want to make one point, and that is that Pat, quite rightly and intensely, draws a comparison between large plans and plans like hers. It seems to me that were we to make the kind of differentiation that I think both of you are talking about, it takes us into the situation of having to define, how we define the two types of plans.

One case is easy to understand, but then you get into the question of which plan qualifies as having a different structure, or do we have multiple structures, depending on the percentage of LIS beneficiaries and the like? It's important, but it's also complicated.

Amol, did you want to comment on this?

DR. NAVATHE: Yes. Two points on this point. One is I appreciate, Pat, your point that the level of cost sharing that we're seeing on the other table are appropriate levels of cost sharing, and I think the important thing that we have to recognize is that we can still create differentiation in the levels between preferred and non-preferred and still stay within balance there.

There's no differentiation right now, and that may mean we could actually drop the copay for the preferred to create differentiation. So this doesn't necessarily have to be something that's harmful from a financial perspective. I think we just need to create the incentive for cost-conscious behavior.

And then to your point, when you do a real-time benefit check, if there's no variation, the doc is not

going to do it. Why should I do it if it's not going to benefit my patient? I think if there's a benefit, then you might actually do it.

Then the second piece, both to your and Kathy's points -- I'm curious -- is it seems to me that the system change, Kathy, that you're supporting, not the copay side of this, is really what is potentially more challenging for more regional plans like yours, and I think kind of what Jay was getting at. So it's a challenging situation because they're supporting the system change, but it's that system change itself that is actually the most challenging for the regional plans.

MS. BUTO: Yeah. But the systems, I'm modifying my support for the system change to say let's consider whether we need another category for the system change. It has a slightly different structure.

DR. CROSSON: Okay. So Warner has been waiting patiently, and then I think we're going to have to move on.

MR. THOMAS: Thanks, Jay.

[Laughter.]

MR. THOMAS: I think Pat's comments are really important. I really have not thought about it like that,

but I do think this idea of if you do have a plan that has a disproportionate number of -- or higher percentage number of LIS beneficiaries, it sounds like that is a different model that should be thought about.

My comments kind of lean back towards, Pat, I think, your comments about there are a large percentage of folks that are in these programs that are LIS beneficiaries who really do have zero patient responsibility, and I think that's great. I think that's an important point because we want to make sure folks that have -- when you look in the paper, risk scores that are almost 50 percent higher than folks that are in the non-LIS plans, we want to make sure they're taking their medicine and they're getting the right care. So I think that's an important component.

The other thing -- I don't know if this should have been probably in Round 1, but I don't know if we're able to look at the LIS beneficiaries and track them back to either Medicaid or Medicare plans and see what is their cost, trend, and impact on this system there. My guess is folks that are more compliant and have drugs and are taking them in the Part D plan over time have a lower cost structure in the MA plans, I would think, but I'm not sure

if any of the people you interviewed talked about that or not.

I do think the big issue here is -- and it is kind of brought up here -- huge risk transferred to the plans, but right now, I mean, the manufacturers, there's not a lot of manufacturer discount. When you look at the LIS beneficiaries, I kind of equate this back to -- not to throw a wrench in the work, but the 340B program. That is pharma's contribution to Medicare and Medicaid.

And I think in the Part D program, I think we should be looking towards the manufacturers to have a more significant discount for the program overall and a disproportionate significant discount for the program where we have LIS beneficiaries. They win tremendously in these programs, and I think Larry's point about getting the faxes, about use this one, don't use this one, use this one, well, that's because they can set their own prices. And they're changing all the time. If there was a price, you would not get those faxes all the time. You would basically know what you're going to pay for the drug, and you could decide whether it's on the formulary or not. Because we don't do that, therefore, we get faxes every

week, or now emails, about kind of what's going on about this situation.

I think, pushing once again, if you want to play in this program, you ought to set your rates as a manufacturer, and if we can't go that route because we think it's too dramatic, there should be significant discounts from the manufacturers to play in this program because of the tremendous cost and the vulnerable population we have here.

So I would encourage us in our illustrative proposal to have a much higher percentage of that, what's going out of risk share going to the capitated payments to go to manufacturer discounts and to have them have a much higher proportion of the risk in the program, especially with 19 percent of LIS being in over the catastrophic benefit. That to me just seems like it would really lend itself to have a lot more leaning in from the plan.

So maybe I'll just stop there.

DR. CROSSON: Larry?

DR. CASALINO: A quick question for Pat, just a question, not a speech.

DR. CROSSON: Yes.

DR. CASALINO: Since you spoke, several people have referred to identifying the plans. You talk about by percentage of LIS beneficiaries that they provide care for. Is that a definition that's adequate for you, or would you require something more?

MS. WANG: I think if you just describe a dual SNP or the SNP plans, they are by definition all dual or LIS, Eric, right?

I mean, Eric had pointed out in his paper that the concentration of LIS in certain plan types is a result of deliberate federal policy. So a dual SNP is all dual. I don't know if there are other criteria.

I appreciate everybody's sensitivity to the point. I have to say I share Jay's concern about trying to define types of plans. I mean, a D-SNP can be relied on to be all LIS, and there are other types of plans of that nature too.

I think it's difficult to sort of go lower down and say, "Well, you're a standalone regional not-for-profit plan as opposed to you're a D-SNP that is part of a parent organization that is in 45 states. It's hard to make that level of distinction.

I think the most important thing that is important here is the differentiation, I think, about the type of structure of the Part D redesign for plans serving LIS, and I think it's hard to dive below that more.

I like Warner's suggestions and Kathy's suggestion, especially in the reinsurance layer of just getting a little more help in there from the other parties.

And I to think that, frankly, there's a reason that CMS has had a lot of participation in the reinsurance layer for the LIS population, and I don't really want to see it get out completely to the same extent as the non-low income.

Also, I have to say I think that Amol – I know there's a lot of sensitivity to changing cost sharing where it exists, but differentiating between preferred and non-preferred, I think, is an appropriate way to go. Even simple things like allowing plans, even if there's no differentiation in cost sharing, to put the drugs on different tiers, just to show like it's a zero cost share, it's LIS Category 3, just to sort of signal to a prescriber, this is the preferred generic, this is the preferred drug, the preferred brand.

Right now, the requirement, it's one tier. Everything is just jumbled together. These are not huge changes, but they are stubborn to be changed.

MR. THOMAS: Just a quick comment on that.

I think we could be overly complex about trying to say, well, this is a plan that's regional and this sort of thing, or we could just say, you can look at the percentage of the total population that's LIS or not. I mean, that would cover, you know, a regional plan that has a disproportionate amount of LIS would basically potentially qualify. One that's national, that has, you know, a smaller percentage, or maybe has a lot in one pocket but overall does not have a higher percentage of LIS, I think you could, you know, work through that.

But I think this idea of creating some protection of plans that have a disproportionate percentage of LIS beneficiaries I think would be relatively easy to quantify and define in any sort of, you know, structure, or restructure of the plans.

DR. CROSSON: Last point.

DR. RYU: I actually think Pat's point, it was the LIS side but also even on the non-LIS side there's a

significant risk transfer. So if you look at the red bar there, it's going up 60 percent, you know, between the current and the proposed. I wonder if this is just something that could be mitigated through, you know, the reinsurance, and stop loss coverage, and having CMS or others help with that, versus trying to parse out, you know, maybe you do something even above and beyond that for those with significant LIS.

But I think the unintended consequences point is at play, not just for LIS or not -- oh, sorry -- for LIS. I think it's also still in play for the non, where it's going to favor the larger health plans that, you know, are multi-state, perhaps for-profit, to be able to absorb, you know, significantly more risk.

DR. PAUL GINSBURG: Can I just -- it sounds like you are questioning the whole basic approach of changing the, you know, reducing the reinsurance, because of, you know, these reasons.

DR. RYU: I think the idea of the risk transfer resonates. I get that and I think that's correct. I think it's the right way to go. I just wish there was some way to protect the exposure so that we don't have an unintended

consequence by making that move that we're encouraging even more consolidation in the insurance market. And maybe, you know, consolidation to some extent, you know, it's not necessarily a bad thing. It's just I think the playing field may not be even with such a significant transfer.

MS. BUTO: And maybe with playing with the percentages -- as Eric said, this is illustrative -- if you change the percentages it changes that exposure.

DR. CROSSON: Okay. Interesting discussion. Eric, we wish you luck here.

[Laughter.]

DR. CROSSON: We will be looking forward to hearing from you again. And Shinobu, thank you for riding shotgun.

So we will move on to the last November presentation.

[Pause.]

DR. CROSSON: Okay. For the final presentation we are going to focus in on the body of work that we've been doing on ACOs, and specifically the MSSP model, and receive some new information about the impact of those programs, specifically on post-acute care. And it looks

like Evan here, and Evan is going to start. And we've got Luis and Jeff, in this case, is riding shotgun on this presentation.

So, Evan, it is up to you. Go ahead.

MR. CHRISTMAN: Thank you, Jay. As you said, in this session we will be assessing the impact of MSSP ACOs on spending and utilization for post-acute care. And again, as you point out, I would like to acknowledge the many contributions of Luis Serna, Jeff Stensland, and David Glass to this work.

As an overview, today's presentation will have three parts. First, I will review why post-acute care is seen as an opportunity for ACOs to produce savings. Second, I will briefly review prior analyses of MSSP ACOs by MedPAC and others to provide a frame of reference. And finally, I will walk through our new analysis, looking at the impact of MSSP ACOs on PAC and acute care hospital spending.

Starting with the first point, ACOs have sought to address PAC services because they are used frequently and account for a significant share of Medicare expenditures. About 40 percent of hospital discharges are

followed by a stay at a SNF, home health agency, IRF, or LTCH. Payment for these services accounted for $59 billion in Medicare fee-for-service expenditures in 2017.

MedPAC and others have long noted that spending for PAC services varies widely across geographic regions, often demonstrating more variation than other Medicare services. These variations suggest inefficiency and potential overuse. In addition, PAC services may be a good opportunity for ACOs to improve care because these providers overlap in the services they provide and the patients they serve. Medicare operates separate payment systems for each setting, despite these overlaps. These factors raise concerns about whether patients are being served in the most appropriate and lowest cost site of care.

There have been multiple studies of ACOs. Generally they have found that ACOs appear to lower spending growth for acute hospital care and PAC services relative to non-ACO populations. Acute care hospital services and PAC generally account for the majority of ACO spending impacts, and relatively little impact is found in other payment systems.

For example, one study by McWilliams and others found that MSSP ACOs reduced the per beneficiary spending growth by about $197, equal to about 2 percent of 2014 Part A and B spending.

As you may recall, MedPAC also published an examination of MSSP ACOs in our June 2019 report. Our analysis found that expenditures for beneficiaries assigned to an MSSP ACO increased slower than a comparison population. Over a four-year period, the rate of growth in Medicare expenditures was 1 to 2 percentage points lower for the MSSP ACO group.

It is worth noting that the spending impacts measured in these analyses do not include MSSP shared savings payments to ACOs. Including these payments would raise Medicare spending for ACOs and bring their expenditure growth closer to the trend of the comparison populations.

The analysis of PAC spending and utilization I am about to present builds on the analysis of MSSP ACO spending we presented this spring. As we discussed in the last cycle, measuring ACO savings requires caution because assignment to an ACO can change over time. Our analysis

found that assignment could be affected by service use, which, in turn, can be a function of patient health status. As a result, it is appropriate to use an "intent to treat" approach that holds beneficiary assignment constant across the period studied.

In this approach, beneficiaries are assigned to two groups. The first is our treatment group. This consists of beneficiaries who were in an MSSP ACO in 2013. The second is our comparison group. This consists of fee-for-service beneficiaries in the same market as ACOs, and they are weighted to match the ACO population for demographic and clinical factors.

In the intent to treat approach, we follow the same beneficiaries across time. As a result, no new beneficiaries enter our cohort after 2012 and the average age of the beneficiaries in our study increases, and we expect average spending to increase for both groups every year as a result.

This analysis measures the impact of ACOs by comparing the growth in expenditures for these two groups. If the ACO group has a lower growth in expenditures than the control group, than this relative reduction may be

thought of as a savings, while if the reverse is true, ACOs would be more expensive than traditional fee-for-service.

There is more about why we used intent to treat in the paper. We discussed this issue in more detail last spring, and we will gladly take any questions you have about this approach.

I would also note that this analysis, again, does not include the shared savings payments made to ACOs that qualified for them. If they were, the ACO spending growth would be higher.

This slide compares the growth in expenditures for our two groups of beneficiaries for three Medicare services: acute inpatient hospital, skilled nursing facilities, and home health care. The first and second columns in the red box indicate the spending growth for these two groups, and comparing these two columns indicates which group of beneficiaries had a lower growth in expenditures. The third column in the yellow box shows this difference in absolute dollars.

As you can see, for all of these services the MSSP ACO group had lower expenditure growth than the comparison group, suggesting some savings for the MSSP

ACOs.

From the bottom line on the chart, you can see that, across these three services the MSSP ACO population had spending growth that was $98 lower than the comparison group over this period. Of this $98 relative difference, about $69 of it was attributable to lower growth in acute inpatient hospital spending. SNF spending increased by $23 less for the MSSP ACO group, and home health spending increased by $6 less.

The last column on the right gives you a sense of the decrease compared to the average Medicare spending for a beneficiary during the period. They indicate that on average, spending for MSSP ACO beneficiaries was 1 to 2.8 percentage points lower relative to the average spending in each of these categories over this period.

This next slide compares the growth in PAC utilization for our two groups of beneficiaries, and the columns follow a format similar to the previous slide. The unit of measurement here is the number of PAC encounters per 100 beneficiaries, and PAC encounters include a SNF, IRF, or LTCH stay and home health episodes.

As you can see by looking at the third column,

for all of these services the MSSP ACO group again had lower utilization growth than the comparison group. However, the relative difference is fairly small. The overall growth was lower by 0.2 encounters per 100 beneficiaries or less.

The fourth column displays the difference in Column 3 relative to the average number of PAC encounters for these categories. And as you can see, the difference in utilization growth is modest, equaling 1 percent or less of the average utilization in each of these categories.

It is notable that the relative difference in utilization for SNF, the percentage in the last column, is less than the relative decline for SNF spending on the prior slide. This suggests that the frequency of admission to a SNF has not declined much, and that much of the decline in spending on the prior slide is due to fewer days of SNF care under Medicare's per diem PPS for SNFs.

We observe a similar pattern in looking at the change in discharges to PAC from the hospital over time. It appears that MSSP ACOs have not significantly slowed the frequency of PAC use, suggesting the bulk of the savings we showed in the prior slides are due to lower spending per

PAC stay. This slide examines how the rate of hospitalization has changed, and how the incidence of PAC use after hospitalization has changed.

This table shows that all hospitalizations with PAC increased at a slightly lower rate for the MSSP ACO group, by less than 0.1 discharges per 100 beneficiaries, as you can see on the third column of this chart.

In contrast, hospitalization without PAC, experienced a more significant slowdown, as discharges in this category increased by 0.3 hospitalizations per 100 beneficiaries less for the MSSP ACO group.

Overall, this chart suggests that ACOs have modestly reduced the rate of hospitalization for beneficiaries, but most of this reduction is due to a slowdown in hospitalizations that were not followed by PAC. It appears that MSSP ACOs have not reduced the growth in PAC use after hospitalization by a meaningful degree.

To review, our analysis found that MSSP ACOs appear to have slightly slowed spending growth in acute hospital and PAC services over a four-year period relative to a comparison population. Most of any slowdown was in acute hospital services, and PAC spending accounted for a

relatively smaller share of the impact.

To the extent that MSSP ACOs had an impact, they did slightly slow the growth in SNF and home health care. However, the greatest impact for PAC appears to be for SNF, and it appears that most of the savings have come from shorter SNF stays, and not less frequent SNF admission.

Finally, it does not appear that MSSP ACOs had any significant effect on PAC referral patterns after hospitalization. There was a slight decline in PAC use after hospitalizations, but the magnitude of the decline was small and does not suggest that ACOs are aggressively curbing PAC use or moving patients to less costly PAC sites when feasible.

This analysis suggests several questions that Commissioners may want to discuss. First, why have ACOs had such a limited impact on PAC utilization? What change to the MSSP would encourage ACOs to reduce unnecessary PAC utilization? And finally, will the shift to two-sided risk improve incentives for PAC program savings?

This completes my presentation, and we look forward to your discussion.

DR. CROSSON: Thanks, Evan. This is new

information, or relatively new information. I think in the past we've thought that there was a larger impact on PAC spending than this analysis shows, marginally. And so the thinking was like, well, this is low-hanging fruit, if you will, because for an ACO, in effect, particularly one that involves physicians and hospitals and their spending, post-acute care spending is somebody else's money, and therefore might be the first area of focus for an organization with risk, or with just upside.

This data suggests that that may not be as true as we thought in the past. And so the questions you have asked here are good ones, and that has to do with why not?

Jon, do you want to --

DR. PERLIN: Yeah, it is exactly to this point. I think you've framed it up terrifically, and so my question is this: Is it possible that there are some unmeasured factors that might be extraordinarily important? I think there's -- unless I'm reading the research, which I think is absolutely terrific, incorrectly, there's a sort of baseline assumption that the PAC encounters that occur -- or the PAC encounters that occur are distributed to the beneficiaries in an equal and available manner. You know,

is there a way to correct for the availability or unavailability of the best, the right level of care for a particular beneficiary? Just to give it a little more tangible aspect, if I have a patient in a hospital and I'm part of an ACO and I've got a choice between a higher level of care or no post-acute care, I will revert to the higher level of care. And, unfortunately, those resources aren't uniformly distributed.

Similarly, one could imagine a situation in which family supports may vary and a patient doesn't go to the lowest level of care that's appropriate but, in fact, to a higher level of care. So I'm just wondering if there might be unmeasured factors related to the availability or unavailability of certain PAC resources or family resources that, in fact, exert a greater impact on the proactive management within the ACO, so directly to your question.

DR. DeBUSK: On that, actually, I think intent to treat would see through that because you would have -- let's say there is, you know, four LTCHs in a market, so there are all these -- and three IRFs, so there are all these expensive options. In their intent-to-treat model, they take the 2013 ACO member, but then they pull a

clinically equivalent member into the other cohort from that same geography. Is that correct? It's from the same MSA.

DR. PERLIN: That's correct.

DR. DeBUSK: So in theory, those four LTCHs and three IRFs are within that beneficiary's grasp as well.

DR. PERLIN: I wonder if it wouldn't correct for PAC versus no PAC, but not necessarily level of care.

MR. CHRISTMAN: I guess I'm not sure I am entirely following your question, but what I would say is that certainly moving patients out of the higher-cost settings has been something that people have speculated would be something ACOs did. And, you know, I guess we haven't observed much of that, and I think that's been broadly consistent with other studies.

But I guess the other point I would make is in terms of ACOs and post-acute care and whether they're going to make a difference, of the $59 billion that's in PAC, 51 of it is in home health and SNF. So if they're going to get serious dollars out of this, it's going to come out of two categories of providers that are pretty broadly available, or at least as broadly available as any Medicare

service. And I think that, you know, the result we find here is that even for these relatively common, broadly available services, they have not significantly shifted utilization.

DR. CROSSON: Okay. Further questions? David.

DR. GRABOWSKI: On this point, I think, Brian, your response to Jon was correct on sort of the area resources, like the presence of LTCHs and IRFs.

The second part of his question, however, I think is -- he's spot on that there may be real differences there about, you know, family supports, income, resources that are unobserved, and it's unclear to me -- I'll talk more in the second round, but I don't know if the intent to treat, if you're following this individual out over time, if that actually gets at some of those issues. And we can come --

DR. DeBUSK: I think you and I are [off microphone]. I think you and I are going to have a similar -- because I have a similar question about intent to treat along the same line and, Jon, arguably along your line, too. Let's say I have a 75-year-old frequent flyer diabetic and they get attributed to the ACO, obviously, because they're showing up to the doctor's office, showing

up to the hospital.

Now, in their intent-to-treat model -- which I do like overall; I'm on board -- you're going to have to go from that same MSA and get another 75-year-old diabetic who didn't frequent fly enough to be attributed to the ACO, or maybe they did but their pattern was erratic. For some reason or another, they weren't attributed to the ACO. I would argue you've got a little bit of a bias there because the attributed person in that cohort is going to -- even though they're both 75-year-old diabetics, to get attributed you have to have certain characteristics, again, a frequent fly is my example.

I'm wondering if there's a bias where, when you do this calculation, it's going to make the ACO-attributed people look a little bit more expensive just because the non-attributed people gained the benefit of -- in some cases they're ghosts. I mean, we never see them.

DR. STENSLAND: I think our comparison group is all attributed people. They're just attributed to somebody else. So we're comparing attributed to attributed, and if you never saw anybody, you're not in either group.

DR. DeBUSK: Then what if you've got a 2013 ACO

group and then you've got a group that wasn't attributed to an ACO in 2013?

DR. STENSLAND: So they were attributed to non-ACO doctors. They saw a non-ACO --

DR. DeBUSK: Okay. So you still have to have equal levels of attribution or comparable levels of attribution. Okay. So that would save them on that.

DR. PERLIN: And that's where the unobserved variable, such as family characteristics or potentially momentary availability of a particular type of resource, you know, might --

DR. DeBUSK: Large numbers should fix that, though. I would think that would average out, wouldn't it?

MR. CHRISTMAN: I mean, I think it's certainly true that the results might be disturbed by unmeasured factors. But I guess another way to -- the best answer I can come up with your question, you know, is there's 900,000 people in the ACO group and about 4 million in the comparison group. And to the extent that the factors you're talking about are correlated with patient demographics and clinical conditions, we are picking up, you know, differences in family income and living

situation.

And I think one thing that happens with post-acute care is, you know, the pathways aren't -- the clinical pathways aren't as well understood as people think. I appreciate concerns about things like caregiver, but probably the poster child for things not always balancing the way you would think is, you know, in 2006 CMS began enforcing the standards for being an IRF more strictly, and some patients were pushed out. And, you know, people were thinking, well, this is going to push a lot of individuals into SNF because, you know, that's the progression people thought would happen. And there were a surprising number, I think it was, hip and knee patients who ended up in home health, and that was an instance where people might have said, well, can they go home because they don't have -- you know, do they have a caregiver? And I think in that instance at least people were surprised that the jump was not IRF to SNF; it was IRF to home health.

And so I do appreciate your point that some factors like caregiver might affect placement. On the other hand, I think we've seen some things that surprise us about the substitutability of these locations.

DR. CROSSON: Okay. Additional questions? I see Marge, Brian, Bruce, Sue.

MS. MARJORIE GINSBURG: There is such little impact between the ACO and non-ACO that it occurred to me that, you know, maybe the sweet spot has been reached. Maybe, in fact, the levels of use of PAC are appropriate for this population and their medical needs.

So do we have any other -- we always compare ACO versus non-ACO beneficiaries. Do we have this information at all for patients who are part of MA plans? We have these two groups, and we seem to keep them so separate, it's very hard for me to understand what is a desirable level of PAC use.

MR. CHRISTMAN: So, narrowly, about -- what do we know about MA? My colleague, Andy Johnson, covers that work for us, and he's done a lot of work looking at the MA encounter data for SNF and home health. And I think we still struggle with its completeness. We still see a lot of problems. You know, I think there is some work that has been done with the data. I think it suggests, you know, in some instances that it's lower. But I think from, you know, the Commission's perspective, we heavily caveat that

and say that, you know, we're kind of spoiled on PAC because we can compare the assessment data people submit for all their Medicare patients, MA and non-MA, and fee-for-service to this encounter data and sort of use it as a ground truth test of how complete is the data. And when we look at it, we find a lot of stuff is missing from the encounter data.

So there's stuff out there, but, you know, I think our feeling is that it needs to be handled with care, and we're still kind of waiting for the data to get better.

MR. SERNA: And I'll add that we do know that MA plans have more utilization management tools at their disposal so they can push down on rates, they can do things like prior authorization after a certain number of days, things you won't see in fee-for-service.

DR. CROSSON: Brian.

DR. DeBUSK: So I had two questions. First of all, great report. I had two questions.

First of all, you know, when you look at -- and I asked this I guess two years ago. When you look at the pool of ACO participants, you know, we'll come up with a gross number. Well, the savings, we think, using the

intent-to-treat model, is 2 percent. Do we have a feel for the dilution that occurs? I do think there are at least some people in the ACO program who don't really understand what they're getting into. There's more of a novelty approach as opposed to a transformational approach. Have we looked at -- for example, when we look at hospitals, sometimes we'll look at the best performers, and we'll define a criteria. Are the results 2 percent savings plus or minus 1 percent? Or are the results 2 percent savings plus or minus 15 percent where there is maybe a group of 10 or 20 percent that are just outperforming -- you know. Do you have a feel for that?

MR. SERNA: So I think in general we have observed that in high utilization areas there are more ACO savings, so you are going to get more savings in those high-use areas than you are in the low-use areas.

DR. DeBUSK: But, no, I'm asking have you tried -- Jeff knows. You got it.

DR. STENSLAND: My guess is it's probably true because certainly anecdotally we hear some ACOs where the physicians are much more engaged than other ACOs where the physicians might not even know they're in an ACO or not.

And so you would expect there to be some different performance, and we're looking at the average performance. But that is something that we just haven't been able to quantify. Like we don't have any variable we can stick in our model right now that says, oh, you're really a top performer or you're engaged or something like that.

DR. DeBUSK: Well, let's say you came back and 2 percent is the number using intent to treat. How would it color your opinion if I said, okay, the top 20 percent of the performers weren't 2 percent, they were 3.5 percent? Or if I said the top 20 percent of the performers weren't 2 percent, they were 15 percent? How does that color your --

DR. STENSLAND: I don't know. They're not 15 percent, but --

DR. DeBUSK: That might not be what I'm saying. I'm trying to be hyperbolic.

DR. STENSLAND: Part of the difficulty here is a lot of these are small places, like 10,000 or 15,000. So 5 percent of the time you're going to have a 4 percent shift.

DR. DeBUSK: Okay.

DR. STENSLAND: And a 4 percent shift is like

fantastic if you're an ACO, if you can get a 4 percent shift. But you have a 5 percent random chance of getting it anyways.

DR. DeBUSK: Right.

DR. STENSLAND: So that whole --

DR. DeBUSK: Oh, trust me, I feel your pain.

[Laughter.]

DR. STENSLAND: Okay. That makes it difficult.

DR. DeBUSK: I'm just trying to get to if there was some way to systematically push out maybe the people who are in it for the novelty or, you know, for the cocktail party conversation of, yeah, we started an ACO, and maybe find the ones that are really performing. And I realize it's a little bit of a self-defining variable. I just wonder if there's a treatment we could use, you know, analogous to what we do for hospitals. You know, we calculate the top performers, Medicare performers, and try to treat them differently or at least use them in our analysis. Anyway, just a thought, because I've often wondered how much variation is there.

My second question was this: You're not seeing a lot of ACO-PAC rationalization. But if you look at BPCI

and lower joint replacement, the results were dramatic, I mean double-digit PAC utilization.

Is there any way from claims-based data to go back and see did we -- did that actually happen, say, in ACOs with joint replacement, too, and it just got diluted? You know, if you've got double-digit savings and a 10 percent service, all of a sudden you've got single-digit savings.

DR. STENSLAND: I'm deferring this one to Amol, who knows more about lower joint and ACOs than I think anybody else around the table.

DR. NAVATHE: So we've done a few different analyses. I've looked at the overlap and interactions here. And, overall, ACOs don't seem to have tremendous impact on PAC, regardless of condition. In fact, we've also done a study where we looked at hospital ACOs, because you would think that, because of locus of control, hospitals that are in ACOs would have more of an incentive to change their discharge processes. And for non-attributed beneficiaries, they have nil effect, even nil effect on lower extremity joint replacement. We looked specifically at that.

So I think it seems -- my reading of the literature is somewhat similar to what they have here, which is in general it looks like the predominant part of the ACO effect is on avoiding hospitalization as opposed to on managing the hospital-to-PAC transition, which tends to be much more focused on what the hospital is doing and only a subset of ACOs have hospitals in them. And so hospital-targeted programs like bundled payments tend to have much stronger effects on the PAC transition.

DR. DeBUSK: And it's my impression that BPCI for lower joint, that there was a dramatic rationalization in PAC. Is that --

DR. NAVATHE: There's a big difference, right. It's about $1,100 of savings per lower extremity joint replacement.

DR. DeBUSK: Out of a $22,000-ish bill?

DR. NAVATHE: Initial estimates were off a base of $30,000. That was the first Lewin Group study that was done. Since then, the estimates have come down a little bit as the overall spending on joint replacement episodes has come down. So now it's closer to $22,000, and the estimates are probably closer to $500 to $600 per episode.

[Inaudible comment.]

DR. NAVATHE: Total, but the majority of that is shifting SNF to home health.

DR. CROSSON: Okay. I've got Bruce, Sue, and Jonathan. Bruce.

MR. PYENSON: Yeah, just a data question related to CJR and BPCI. In the hierarchy of a bundle versus an ACO, are we including or excluding the PAC from such bundles in our analysis?

MR. CHRISTMAN: I guess I'm -- I'm not sure I'm following your question. This includes all claims for both populations, so we haven't dropped them if they're in BPCI.

MR. PYENSON: Okay.

DR. CROSSON: Sue.

MS. THOMPSON: Thank you. You know, when we say ACO, it's a term that has many definitions. And the data that we're using is from 2012 to 2016, so I just want to clarify how many different ACOs, what kinds of ACOs, geographically how many lives were covered. Just give me a little more description there.

MR. CHRISTMAN: I think the number we have on the paper is there's about 560 ACOs. You know, the sample we

worked with reflected all of the ACOs that were in effect in 2013. So I can't really off the top of my head speak to the geographic distribution of those, but, you know, it was the whole program.

MS. THOMPSON: So in 2013, MSSP, upside risk, downside risk?

MR. CHRISTMAN: I believe most were in upside risk.

MS. THOMPSON: Upside only?

MR. CHRISTMAN: I think there was -- yeah.

MS. THOMPSON: All upside only? Okay. So what do we know about the comparison of ACOs with upside risk only compared to those that have taken upside/downside risk at 80 percent, 100 percent? Do we have any analysis of the differences in performance and utilization of SNF in those two populations?

MR. SERNA: Well, I think we have the -- there's the Next Gen evaluation, which basically is upside and downside risk, and that found savings as well. The magnitude is similar. So there have been different evaluations, including this one, where the magnitudes seem to be directionally consistent. The ACO investment model,

the valuation for the rural ACOs, the Next Gen evaluation, MSSP. So in the neighborhood of 1 to 2 percent seems to be consistent.

MS. THOMPSON: And as we think about utilization of PAC we're talking about admissions to PAC. Have we looked at length of stay, managing the length of stay in PAC, and just talk a little more about that.

MR. CHRISTMAN: Sure. I mean, the big one is when folks have looked at SNF length of stay it's come down a little bit, and that's where it appears to be that the biggest bucket of dollars for PAC are coming from. I mean, the difference is, gosh, I think it's somewhere between half a day and a day in the leverage length of stay, so it's something. But I think, you know, something that's leading to a net reduction, I think that's sort of the biggest thing for PAC.

MS. THOMPSON: Thank you.

DR. CROSSON: Jonathan.

DR. JAFFERY: Yeah, thanks. So, first of all, Brian, I started with an ACO seven years ago and I don't think I've yet found an opportunity to bring that up at a cocktail party.

[Laughter.]

DR. JAFFERY: So in the reading you talk about one of the reasons for thinking about PAC use is that there is a lot of variability across the country. And so I wonder if you looked at this in looking at that cut. Are there ACOs in areas that are high PAC spend at baseline? In fact, going back to this notion that we've seen over and over again, where it's the baseline high cost ACOs that are able to get savings at least early, which is, I would argue, we are still talking about here, even over four years. So were you able to look at that, or could you tier it that way?

MR. CHRISTMAN: I believe in prior analysis -- we haven't looked at specifically in terms of the distribution of PAC spending, but we looked in terms of overall spending, and generally the two are correlated. And I believe it is sort of, in general, when you guys looked at it, there's been a little bit more action in the higher baseline spending areas. And so, you know, I think that would support the idea that, you know, probably the areas with higher PAC spending are doing a little bit better than average.

DR. JAFFERY: I mean, I guess, that seems like a really crucial question, if we're thinking that there's an opportunity here to because of the variability that trying to understand that in the places that vary and are high cost, maybe we actually did come down a significant amount. I'm thinking about the CJR experience.

So I don't think our ACO has had a significant amount of change in PAC spending, but I do know that when we were participating in CHR we went from, you know, 55 percent -- I mean, that's where we made all the savings. We went from 55 percent SNF admission to 20 percent, pretty quickly.

DR. CROSSON: Okay. Seeing no more questions we will move on to the discussion period, and I think, David, you are going to kick it off.

DR. GRABOWSKI: Great. Thanks, Jay. I think the encouraging part about this report is that the results were largely confirmatory. You found there were savings, there were savings in inpatient and post-acute, and the savings were smaller, if I could can use an academic word, modest. We use that when we don't want to confess that our results are small.

[Laughter.]

DR. GRABOWSKI: Something in the 1 to 2 percent range. And think the difference between this work and maybe some of the research in the literature is just the distribution that was in inpatient versus PAC.

So I wanted to do two things with my time. The first was kind of make a policy point and the second was push a little bit on some of the methods.

First, on the policy side, Sue began this kind of line in her round of questioning, but an ACO is not an ACO is not an ACO, and you're looking at the MSSP over the 2012 to 2016. As you note in the chapter, we had this dramatic change in the program with the Pathways to Success. It changed beneficiary assignment. It changed how we set the benchmarks. It changed, you know, going from one-sided to two-sided risk. It's basically we've taken the snow globe and we shook it, and it's a whole new ballgame here.

And so how much can we learn from this model, and I think Sue was already pushing you on that, kind of that has, you know, one-sided risk and we know all the features of MSSP over that period, and apply them to kind of what we have going forward. And I think, as a Commission, we will

need to think about that very critically, of how do we kind of connect the dots. It's not clear to me that the savings we observed under the MSSP are going to necessarily apply going forward. In fact, there might not be savings going forward.

And so I just think we have to acknowledge that. And, yes, we can learn from this but the ability to apply it directly just isn't there.

So the second point, and this will be a little wonky so I apologize in advance, there's a real debate in the literature about kind of the right methods to use in evaluating ACOs. You guys use this intent-to-treat approach, where you take beneficiaries who are attributed and then follow them -- continuously attributed and follow them out over time. And as you note in the chapter, there is real potential for bias here, and that individuals who are continually attributed are going to have health care costs at some point, and potentially die, and we see this kind of increase in their spending. You try to address that in the chapter by taking out the decedents, or including the decedents, and try to run some checks there.

The way that the literature has dealt with this,

and largely the McWilliams work, has been to use a different intent to treat, where they take kind of, at the outset, those physician practices that are in the ACO, kind of assign them at that time, and then, you know, that's the intent to treat, that they're in whether they drop out of the ACO or in the ACO. They are in from the beginning, and that's the intent to treat. And then he uses kind of a repeated or a cross-section each year. Rather than following the same individuals it is a new set of individuals in each year.

And I think the encouraging part is that you're getting similar results, but I'm a little worried -- and there was a nice NBER working paper by McWilliams and Chernew and others in that group, that suggest, you know, there's real potential bias here with the approach we're using. So I don't want MedPAC to get out ahead of this with an approach that I think is real susceptible to bias. And they have a great figure. Jay, you wouldn't let me use overheads for my comments, so I'll just describe it to you and then maybe I could forward it around.

But in the NBER working paper they show Medicare spending over time, and with this repeated cross-sections

or cohort it's very flat, or maybe it increases a little bit with the secular increase in Medicare spending. With this group that's continually attributed, it's flat and then it kicks up right towards the end, and that's kind of what we would expect, you know. As you're sort of continuously attributed at some point you're kind of approaching health care costs.

And so I really worry about this kind of group. It's encouraging you're getting similar results, but I just worry about using this as the MedPAC approach. We know we have a MedPAC approach to measuring markets and we have a MedPAC approach to quality measurement. I wouldn't want this to be the MedPAC approach to evaluating ACOs. Precedent is really important here. And so I don't think there's anything wrong with these current results, but I just worry about us, you know, going forward with a method that I think is going to leave us susceptible to some criticism.

So I will stop there and I will open it up. Thanks.

DR. CROSSON: Thank you, David. I mean, one thing -- we'll get into discussion further, but one thing

that's struck me so far in the conversation is the differential results that appear to accrue from the bundled payment experiments. And the question, in keeping with this first question here, is there something we can learn there? Is this condition-specific or is it something about the payment incentives differential? What do people think?

Brian.

DR. DeBUSK: I think specifically to answer your question, I think there is tremendous power in being able to look at a physician and say, "You're responsible for this orthopedic episode from start to finish." And I do think one of the things we won't measure, that occurred in the lower joint BPCI is the patient selection and the grooming. You know, a patient with a BMI of 50 doesn't typically get to go through a BPCI, but they're going to go through a hospital ACO.

But I do think we shouldn't underestimate the behavioral impact of looking an orthopedic surgeon in the eye and saying, "Your target price is $22,000. If you use PAC responsibly, if you do these other things responsibly, you are going to get $500. You are going to get $750." It does change -- it dramatically changes orthopedic surgeon

behavior, and I think that's what's missing in ACOs. I almost feel like they're too nebulous for a lot of providers to understand, if I do this I gain this benefit. I just don't think there's a connection there.

DR. CROSSON: Jonathan.

DR. JAFFERY: Yeah. So maybe building on that a little bit, I think if you think about a hip and knee and you're working with orthopedic surgeons it is very well defined, and you are not really fundamentally changing what they're doing. There may be something about the patient selection and there may be some things, but if you think about where they're going to find savings it really was -- it was in moving away from SNFs. The main cost to the bundle is the DRG, which didn't really change if they were going to be part of the program. But beyond that, you are not fundamentally changing how they are delivering care.

What we are talking about with the ACO is a completely different thing. We're talking about fundamentally changing an entire care model from one way we're focused on, you see somebody in clinic, you submit a claim, you get paid, you don't repeat. And the entire structure, the entire system is set up, and it's been that

for decades.

I think what we're seeing here is that real change takes time. I'm actually a little encouraged to see that we're seeing some change in admissions. And it may be that the amount of time that we're seeing is not quite enough. I mean, we saw that experience coming from not a high spending area. You know, after four years we're just starting to see some changes -- not enough to get shared savings -- and then year five and year six and year seven starts to increase.

Dana is not here but her experience in Blue Cross Blue Shield of Massachusetts suggests the same thing, that year one had some changes in some low-hanging fruit but it was year four you were starting to see fundamental things, and by year eight you were seeing real changes.

So I don't think we can underestimate the fact that what we're talking about with ACOs, unlike the bundles, is an actual care model change that is hugely fundamental to how we deliver care. And, you know, it goes beyond the physician engagement piece.

I mean, I would guess that there are a bunch of

folks at UW who don't know we're in an ACO and couldn't define what that means. And sometimes that really hurts our ability to do things and sometimes it may not matter so much, because what we're doing is putting in place a team-based care model. And they may not know we're an ACO but they know that now they have behavioral health and primary care and that helps their patients get point of care behavioral health, and that helps improve their quality of care and decrease bad outcomes and lower costs.

So I will stop there.

DR. CROSSON: Thank you. Amol.

DR. NAVATHE: So I have several thoughts and I'm going to try to limit what I say here. I think one thing, just to respond to David, so I think my sense is the reason that they are probably getting the same results is that they are following the same pattern in the comparison group of continuous attribution that will dull some of that effect, which makes the bias probably smaller than it would be otherwise. So I think that helps you guys out, which is good.

That being said, I think the notion of selection here is important, and I think there are a couple of pieces

that are worth probably digging into a little bit in follow-up work. So one thing is I think there's actually mixed literature on whether ACO-attributed populations are sicker or more disadvantaged or less disadvantaged. I think I've seen some stuff that suggests that they are more clinically vulnerable. I have seen other stuff that ACOs seem to locate in places with less low socioeconomic status and beneficiaries are a less disadvantaged population. So how your population shakes out here would be helpful to actually understand the characteristics of your ACO-attributed group and the comparison group, in terms of few of these types of factors. So clinical risk and other SES factors would be helpful.

The other thing I think that we've heard from a lot of folks is some heterogeneity analysis of the ACOs. I think it's kind of interesting, actually. On one hand, this is a voluntary program so we would expect, on average, that ACOs that formed and opted to join would expect to have some impact. And so that, I think, is helpful to size the results or interpret the results.

At the same time, you know, some of the heterogeneity analysis that we've heard around higher-

spending markets versus lower-spending markets, ACOs that include hospitals versus not include hospitals because PAC is a very hospital-centric thing, I would be helpful. Perhaps also exploring areas where you have greater BPCI participation or CJR participation versus probably a little bit more heavily on the BPCI, since CJR is very focused on one condition.

Anecdotally I will tell you, we haven't published this but we are looking at overlap between ACO and bundles in my research group, and we are finding that there seems to be some synergist effect. And so it does probably make sense, actually, to look at that overlap and examine that as a heterogeneity analysis.

The last point I wanted to make is to opine, I guess, on the questions a little bit, in the way that Jay has framed, and I think it's interesting because I'm generally very supportive of ACOs. I think it is true what Jonathan has said, that we are seeing increasing results over time, and that's reassuring. I do think that downside risk will help. It does also, at the same time, seem like ACOs are primarily a non-hospital-based mechanism, and the majority of PAC opportunity seems to be a hospital-based

mechanism.

And so I wonder if ACOs are going to be the right design to attack this problem, relative to complementing them, kind of like, I guess, what CMMI has done to date with both ACOs and bundles, or trying some sort of complementary approach.

I think it's, again anecdotally, notable that if you look in the commercial insurance sector, where there is less PAC to be had in the first place, or PAC opportunity to be had, the majority of the larger insurance companies that we have interacted with seem to be pursuing both paths simultaneously rather than one over another. And so that might be also something to learn from, and we're seeing, even in MA we're seeing more episode-based for bundled payment-based approaches.

That being said, the one cautionary piece I would note is that there is a lot of condition -- so you asked about the conditions, Jay -- there is a lot of variation in results by condition. To date, we don't see bundled payment type approaches really generating benefits at the level of congestive heart failure and pneumonia and sepsis and the medical condition-based episodes, where it seems

like probably there is a lot more opportunity that you see outside.

DR. CROSSON: Okay. Warner and Brian, and that will probably be the last comments.

MR. THOMAS: Just briefly, I mean, I think one of the things is that, I think going to Jonathan's point, is I think you're going to see this continue to change over time. So it would be interesting to see, the next time we look at this, whether there is a change as these organizations continue to get more traction.

I think the other thing is, I would really be interested, you know, going to Brian's point about what are the best reformers and what do they look like, what are they doing? You know, what is the materiality of the impact? I know that, you know, we've seen a pretty big change in our ACO post-acute utilization, but we have set up a structure to deal with it.

We looked at -- when we first started this process we used, you know, about 600 different post-acute care providers that we referred to. We went through a process. We sent out RFPs, narrowed it down to 150, and then we narrowed it down to about 80, and we have seen a

material change in utilization, because we've got better integration with the ones that we work with, and a better kind of feedback mechanism into the rest of the delivery system. And we've seen the same in the CJR. We have seen improvement there.

So I think it really depends on whether that's a focus of the ACO, whether they've set up an infrastructure to deal with it, and it would be interesting to see the ones that -- if any of the ones in your research have seen any materiality beyond 2 percent, because my guess is there are some there. It would be interesting to just identify what are the things they are doing that are driving some of that change.

DR. CROSSON: Thank you. Brian.

DR. DeBUSK: First of all, really nice work. I love your analytics. I do like your intent-to-treat model.

I just wanted to echo what Sue and I think what David and a few other Commissioners mentioned, which is this is 2012 through 2016 data. Let's don't read too much into it.

I think the beauty of this chapter is the treatment and the analytic work and the fact that it could

be applied against future data and not read too much into 2012 through 2016.

The one thing I would ask -- and thank you, Warner, for your comment on that too -- let's at least explore ideas to try to identify maybe the true believers. Even if there is bias in the result, if we start with just the top 20 percent performers, lo and behold, we're going to get better performance. Who would have thought?

But there may still be merit in trying to look at maybe that top 10 or top 20 percent to say are they performing a little better or are they performing a lot better.

The other thing I wanted to mention, again, these results look a little critical of ACOs, and here I am defending the method and defending the data and saying, "Hey, keep going." I do think you're going to hit a wall, though, as we go. I hope you guys will closely follow the economics of an ACO too and try to track down what happens when you shed an inpatient -- let's say I am in an enhanced track now under the new models. What happens when I shed an admission? What are the economics of that? I hope we can follow that really, really closely.

The fact that providers still like our 87-cents-on-the-dollar payment makes me think that we're well exceeding their variable cost and eating into some of their fixed cost. Again, they seem to case their 87 cents on the dollar aggressively. That being the case, it does make me question the variable cost, and I really do worry about the economics of the shared savings model at around the 50 percent point.

So if you guys could help us shed some light on that, I would just hate to set out to create a model where someone has to give up an inpatient admission, shed 50 percent of their cost to get 50 percent savings, because to me that feels like a lot of wheel spin.

So if we could follow that and follow the top performers in future work, I think that would be great. Thanks.

DR. PERLIN: If you believe there is a difference over time and then with the introduction of two-sided risk, it becomes more aggressive in terms of the management, I think it really commends the approach, the McWilliams approach of consecutive cross-sections to be able to detect that difference. So I think the intent-to-treat is fine,

but just a model that will really allow you to follow that consecutively.

DR. DeBUSK: Would it be onerous for them to run it both ways?

You know, I'm willing for them to work as hard as necessary.

[Laughter.]

DR. PERLIN: Well, there's upside and downside risk.

DR. DeBUSK: I never liked you, Jon.

DR. CROSSON: Well, with that closing comment, Evan, Luis, Jeff, thank you so much for the work. We appreciate.

We have come to the end of the prepared presentations and discussion. We now have time for a public comment period. If there are any of our guests who wish to make a public comment on the matters before the Commission this morning, please come to the microphone.

[No response.]

DR. CROSSON: Seeing none, we are adjourned until the December meeting.

Thank you, Commissioners. Good work.

[Whereupon, at 11:12 a.m., the meeting was adjourned.]