

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Via GoToWebinar

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11:31 a.m.

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[11:31 a.m.]

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DR. CHERNEW: Hi, everybody, and welcome to our March MedPAC meeting. We're excited to be here and excited to have you here with us. We're going to jump right in.

This first session is focused on our focus groups, so we get a lot of material, some quantitative, some through focus groups, and we are going to hear a report from Ledia on those focus groups. So, Ledia, you are up.

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

Each year the Commission conducts focus groups in different locations around the country to hear firsthand beneficiary and clinician experiences with the Medicare program.

Given the Commission's interest in better understanding access to care and general experiences with the program, we present these more detailed findings from our latest focus groups. After the presentation I can

1 answer questions you have about the groups, and we can  
2 consider any suggestions for future groups.

3 I would like to thank our contractor team from  
4 NORC at the University of Chicago for their work on this  
5 project and Bhavya Sukhavasi for her help with this  
6 presentation.

7 Understanding the experiences and perspectives of  
8 Medicare beneficiaries and providers is central to MedPAC's  
9 work.

10 Although our focus group participants do not  
11 reflect a perfectly representative sample of beneficiaries  
12 or clinicians, what we hear from them can supplement our  
13 claims and survey analysis by providing information on how  
14 beneficiaries and clinicians are using the program.

15 What we hear can also help us identify emerging  
16 trends in access to care and the organization of care that  
17 are not yet detectable through claims data.

18 Hearing from the participants in these smaller  
19 groups allows us to gain real-time knowledge of Medicare  
20 beneficiary and clinician experiences and perspectives.

21 Each year during our focus groups, we  
22 traditionally cover the following topics: Medicare

1 coverage options, access to care, the changing organization  
2 of care, and prescription drugs. The specific questions we  
3 ask during the sessions may change year to year, but the  
4 topics are broadly the same. The structure of today's  
5 presentation will follow the list of topics in the blue  
6 box.

7           Each year we also incorporate topics of interest  
8 to the Commissioners or emerging trends in health care.  
9 For example, the past two years we have asked both  
10 beneficiaries and clinicians about their use of and  
11 experiences with telehealth and whether patients have  
12 delayed care due to the COVID-19 pandemic. We have  
13 incorporated findings from these topics (in the green box)  
14 into various Commissioner presentations and reports to the  
15 Congress, so I will not cover them today.

16           From May through July 2021, we conducted a total  
17 of 21 virtual focus groups with participants residing in or  
18 around San Francisco, Houston, New York City, and selected  
19 rural areas. Each year we select three new cities in  
20 different regions of the country.

21           The groups are typically conducted in-person each  
22 year, but because of the coronavirus pandemic, they were

1 conducted via virtual platforms. There were on average  
2 about five to six participants in each group.

3 In each location, we conducted virtual  
4 discussions with different groups of participants. We held  
5 groups with Medicare beneficiaries age 65 years or older  
6 and separate groups with dual-eligible beneficiaries. We  
7 also spoke with clinicians that regularly see Medicare  
8 patients in an outpatient setting, including separate  
9 groups of primary care physicians, specialists, and nurse  
10 practitioners and physician assistants predominantly  
11 practicing primary care.

12 Now I'll review key findings from the recent  
13 focus groups and highlight some trends we have seen over  
14 the years. First, I'll review findings around Medicare  
15 coverage options.

16 We heard that almost all beneficiaries knew they  
17 needed to sign up for Medicare upon turning 65 years old.  
18 Beneficiaries received information in the mail, on  
19 television, by their employers, and learned from family or  
20 friends. Similar to previous years, beneficiaries said  
21 they sometimes felt overwhelmed by the information  
22 presented.

1           We also heard that most beneficiaries signed up  
2 for Medicare at 65, except for those who were previously  
3 eligible due to disability or had other comparable  
4 coverage, for example through a spouse's employer. Most  
5 beneficiaries described having help signing up for Medicare  
6 either through brokers, family members, employers, online  
7 tools, calling 1-800-Medicare, or visiting their local  
8 Social Security office.

9           Similar to previous years, while most focus group  
10 participants generally understood that MA and original  
11 Medicare were different, some beneficiaries expressed  
12 confusion or answered the question about their coverage  
13 inconsistently with their remarks in the discussion that  
14 followed.

15           We also heard that some beneficiaries were  
16 confused about the different parts of Medicare, including  
17 the difference between Part D and supplemental coverage.

18           When choosing between original Medicare and MA  
19 plans, beneficiaries considered cost, health status, and  
20 choice of doctors.

21           The beneficiaries who selected MA cited reasons  
22 including cost, provider acceptance of the insurance, and

1 inclusiveness. Some beneficiaries with MA explained that  
2 they felt relatively healthy and wanted to avoid a co-pay  
3 for their limited prescriptions and doctors' visits. When  
4 choosing between MA plans, access to providers and  
5 supplemental benefits were the biggest considerations for  
6 many beneficiaries.

7 Beneficiaries who preferred original Medicare  
8 felt that it was more flexible, familiar, and that  
9 supplemental coverage fit their needs. Some explained that  
10 original Medicare felt more flexible and they are allowed  
11 to see any doctor that takes Medicare and avoid pre-  
12 approvals or referrals.

13 We conducted a poll at the beginning of the focus  
14 groups in which we asked beneficiaries to rate their  
15 insurance coverage. Consistent with previous years, most  
16 beneficiaries 65 years or older were satisfied with their  
17 overall insurance coverage, rating it excellent or good.  
18 The percent of dual-eligible participants who reported  
19 excellent or good coverage was slightly lower than the over  
20 65 years old beneficiaries.

21 The majority of beneficiaries in the 65 years or  
22 older groups rated their prescription drug coverage as



1 excellent or good.

2 I'll now switch to presenting findings around  
3 access to care starting with what we heard during clinician  
4 groups.

5 We asked clinicians about their acceptance of new  
6 patients and specific types of insurance.

7 Most clinicians were accepting new patients,  
8 including Medicare patients. Among those who were not, the  
9 reason was full patient panels, and generally their  
10 practices would open to new patients again when they had  
11 capacity.

12 Several clinicians reported preferences in their  
13 practice for MA over original Medicare and in some cases  
14 were not accepting original Medicare patients. Clinicians'  
15 preference over MA varied by location. The clinicians  
16 primarily cited reimbursement for this preference, but also  
17 the ability to provide coordinated care under MA.

18 Nearly all beneficiaries reported having a usual  
19 source of primary care. Most beneficiaries had a physician  
20 as their designated PCP, but a few had a nurse practitioner  
21 or a physician assistant.

22 Across focus groups, beneficiaries generally

1 reported having timely access to primary care.  
2 Beneficiaries said that for acute issues, they could  
3 usually be seen quickly, sometimes the same day, and  
4 usually within a few days. Several beneficiaries said they  
5 often saw an NP or PA in their doctor's practice when they  
6 had an emergent health issue and wanted to be seen quickly.  
7 These findings are consistent with what we hear in our  
8 annual beneficiary survey.

9           Many beneficiaries in our focus groups had used  
10 urgent care or the ED. Some beneficiaries described the  
11 circumstances in which they had used these alternative  
12 sites of care because it was not feasible to see their PCP  
13 first. In some cases, however, beneficiaries went directly  
14 to urgent care or the ED because they found it easier,  
15 faster, or more convenient than making a primary care  
16 appointment.

17           Several beneficiaries in the focus groups had  
18 sought a new source of primary care in recent years. They  
19 cited several techniques to identify a new PCP including  
20 looking online, calling new practices to try to make an  
21 appointment, asking a current provider for referrals, and  
22 asking their insurance company for their provider

1 directory. Beneficiary experiences varied when obtaining a  
2 new PCP with some reporting no challenges with the process.  
3 Several beneficiaries reported challenges finding providers  
4 who are accepting new patients and accept Medicare. This  
5 is different than what we heard from the clinicians in our  
6 groups, where most of them were accepting new patients.

7           In addition to asking about beneficiaries' access  
8 to primary care, we also asked about their access to  
9 specialty care, including experiences getting in to see a  
10 new specialist. Beneficiaries' experiences varied, with  
11 wait times ranging from a few days to months. In some  
12 cases, a referral to a specialist was facilitated by the  
13 patient's primary care physician, though this did not  
14 guarantee quick access.

15           I'll now turn to findings around changes in the  
16 organization of care.

17           We asked physicians whether and how they worked  
18 with NPs and PAs, their roles, and what they thought of  
19 working with them.

20           About half of physicians -- both primary care and  
21 specialty -- reported working with NPs and slightly fewer  
22 worked with PAs.

1           Most physicians said the NPs or PAs they work  
2 with function fairly independently and in a variety of  
3 roles.

4           As the Commission has previously discussed,  
5 investments into health care businesses, such as physician  
6 practices, has led to changes in the organization of care,  
7 as well as more physicians becoming employed by health  
8 systems.

9           Several clinicians in each location reported  
10 situations in which they had been approached by various  
11 organizations to buy their practices.

12           Hospital systems and private equity firms were  
13 among the organizations that wanted to acquire practices.

14           The majority of these physicians that denied an  
15 offer expressed a desire to maintain a certain level of  
16 autonomy in making practice decisions about the structure  
17 and function of the office.

18           In the groups where we asked about ACOs, more  
19 than half of physicians were aware of the concept. Some  
20 physicians indicated they were participating or had  
21 participated in an ACO. We also noted a slight increase in  
22 clinician awareness of ACOs over time.

1           Consistent with previous years, there was very  
2 limited to no awareness of ACOs among beneficiaries. This  
3 year no beneficiaries were familiar with the term.

4           We asked clinicians about experiences reporting  
5 quality data and payment tied to that data. A small number  
6 of clinicians knew with confidence that they were  
7 participating in the Merit-based Incentive Payment System,  
8 or MIPS. In the groups where we asked, many clinicians  
9 were not sure which Medicare Quality Payment Program path  
10 they participated in. For most clinicians who knew they  
11 participated in MIPS, the extent of their knowledge of the  
12 program was an awareness of reporting specific quality  
13 measures in their EHR.

14           A few clinicians who had a deeper understanding  
15 of their participation in MIPS described challenges.  
16 Several described the difficulties and challenges,  
17 especially for the smaller practices. One clinician noted  
18 that it was "impossible for a small private practice," due  
19 to the reporting requirements of all the different  
20 insurance companies. Another clinician spoke about a sense  
21 of broken promises regarding the potential financial  
22 upside.

1           I'll now switch to findings related to  
2 prescription drugs.

3           Regarding prescription drug costs, few  
4 beneficiaries reported having conversations with their  
5 clinician about the cost of prescription drugs. The  
6 majority of beneficiaries' information about out-of-pocket  
7 medication costs came from their own research.

8           Most beneficiaries knew what their prescriptions  
9 would cost before going to the pharmacy and reported that  
10 their drugs were affordable. However, a minority of  
11 beneficiaries, who likely did not have the low-income  
12 subsidy, reported facing high out-of-pocket drug costs and  
13 described how that affected them including relying on drug  
14 samples, leveraging patient assistance foundations, and not  
15 filling prescriptions when costs were too high.

16           We also heard from both clinicians and  
17 beneficiaries that they use the website GoodRx to compare  
18 out-of-pocket prices for prescriptions drugs. If  
19 beneficiaries are using GoodRx to purchase their medicines  
20 with cash rather than through the Part D benefit, this  
21 implies that some unknown share of prescriptions is not  
22 being recorded within Part D claims data.

1           Turning to clinicians' access to prescription  
2 drug information, clinicians reported unreliable access to  
3 comprehensive electronic medication lists for their  
4 patients. Most clinicians noted how siloed EHRs do not  
5 allow them to see what providers in other health systems  
6 using different EHRs have prescribed to their patients.

7           When asked about their ability to access  
8 formularies and prescription drug costs when they are  
9 prescribing medication for a patient, most clinicians  
10 responded that they do not have access. A few clinicians  
11 also lamented the promise of specific EHR functionalities  
12 to provide cost information, saying that positive changes  
13 have not materialized. Across groups, several clinicians  
14 noted that the formulary content in the EHR is not  
15 accurate.

16           That brings us to the end of our presentation. I  
17 can answer any questions that you have, and then we can  
18 discuss suggestions that we can consider for our future  
19 focus groups.

20           Thank you and I'll turn it over to Mike.

21           DR. CHERNEW: Great, Ledia. That was terrific.  
22 It is amazing to see how much work really gets done, and

1 doing this during the pandemic must have been unbelievably  
2 challenging. So kudos to you all.

3 I'm going to turn it over to Dana to manage the  
4 queue. I know we have at least three people in the Round 1  
5 queue, so, Dana?

6 MS. KELLEY: Okay. We are going to start with  
7 Jonathan Jaffery.

8 DR. JAFFERY: Yeah, thanks, Dana, and thanks,  
9 Ledia. Great presentation. A ton of information, of  
10 course, in the chapter.

11 One of the things that was in the report talked  
12 about some of the difficulties with access to psychiatric  
13 services, which, of course, is something that I think we're  
14 all aware of in lots of different sectors. You know, I  
15 wondered if you know anything about the history of why  
16 licensed counselors, professional counselors, aren't  
17 eligible Medicare providers and if that's something that  
18 limits access. I don't know if that's a statutory thing or  
19 if that's something that CMS or Congress should think about  
20 and if we have any information about what -- you know, you  
21 talked about the issues around people getting medications  
22 through GoodRx and us not being able to track it -- if we



1 have information about when people are -- beneficiaries are  
2 getting services outside of Medicare because of the  
3 shortage of eligible providers and that particular  
4 limitation.

5 MS. TABOR: We haven't asked specifically about  
6 the licensed professional counselors, and I am personally  
7 not familiar with kind of the history regarding Medicare  
8 payment. I don't know if any of my colleagues are, but  
9 kind of thinking about being able to track their use, you  
10 know, kind of cash payments for mental health services. It  
11 would be difficult for us to do so because it's outside of  
12 claims data.

13 I will say that we have thought in the past about  
14 asking beneficiaries about mental health issues, and we  
15 have done so in the past, but it is a hard thing to talk  
16 about because of privacy concerns and wanting to make  
17 beneficiaries feel comfortable. So it's something that we  
18 unfortunately hear year after year about the shortage of  
19 psychiatrists and mental health providers, so it's not a  
20 new fact for this year. But I think how to solve that  
21 issue is a larger discussion for the Commission.

22 DR. JAFFERY: Yeah, absolutely, and I appreciate

1 you wouldn't have that history and that's a sensitive  
2 thing. But that's exactly why it seems striking that with  
3 such a shortage that that group of providers is excluded.  
4 I'm struggling with other examples of when we see that  
5 happening in the Medicare program. But thank you.

6 MS. KELLEY: Okay. Jaewon?

7 DR. RYU: Yeah, thanks. I just had a quick  
8 process question. I know that we do these surveys every  
9 year, but year to year, does the survey instrument or, I  
10 should say, the conversation topics in the focus groups, do  
11 they stay pretty consistent? I was just wondering about  
12 that year-to-year consistency.

13 MS. TABOR: Yeah, for the protocols, I would say  
14 there are parts of them that stay pretty consistent; for  
15 example, signing up for Medicare and choosing between fee-  
16 for-service and MA and general access questions stay the  
17 same. I think because we've been more interested in access  
18 to care, we have tweaked those questions to kind of better  
19 get at, you know, different fine points of how  
20 beneficiaries are accessing care, and other topics. Like  
21 over the past five years we've been asking about ACOs, for  
22 example, that's consistent. But then we have these new

1 topics like telehealth, which we just started asking about  
2 two years ago because of the expansions due to the public  
3 health emergency. So it's a mix.

4 MS. KELLEY: Bruce.

5 MR. PYENSON: Thanks, Ledia. Terrific report. A  
6 question on Medigap. I know there was a little bit of  
7 reference to Medigap in the focus group discussion, and I'm  
8 wondering if you think this would be a useful instrument to  
9 identify the induced utilization of Medigap relative to  
10 what utilization would be without Medigap. Do you think  
11 that could be obtained from this kind of process?

12 MS. TABOR: Off the cuff I would be hesitant to  
13 use it, because I will say that the majority of the  
14 beneficiaries who participate in our groups do have  
15 supplemental coverage, so we wouldn't really have much of a  
16 comparison group. And I think that's, you know, by nature  
17 of who chooses to participate in groups. So that's a  
18 question I can kind of take back to other analysts about  
19 looking into, but I don't think that the focus groups is  
20 probably the right place.

21 DR. MATHEWS: Yeah, I would agree with that,  
22 Ledia. Spot-on, Bruce. Recall that, you know, this is

1 more of a convenience sample. We are talking to  
2 beneficiaries to, you know, add some context, add some  
3 color around our quantitative analyses. But given the size  
4 of the focus groups, the limited number of people that we  
5 were are able to talk with, we would need to be very, very  
6 hesitant about, you know, reading too much into their  
7 responses as indicative of trends. And if we were to  
8 embark on another round of work on the inducement effect of  
9 Medigap and supplemental coverage, which we've done in the  
10 past, I think there are more robust quantitative ways of  
11 doing that rather than trying to tease that out of  
12 responses from a handful of focus group participants.

13 MS. KELLEY: Okay. Larry.

14 DR. CASALINO: Yeah, two quick things. One is  
15 just to compliment Ledia. I love how, even on the slides  
16 and almost always when you were speaking, you gave a  
17 quantitative, quote-unquote, sense of was this one or two  
18 people who you heard from or was it everybody or was it  
19 almost everybody or a lot of people or nobody. That's very  
20 useful. You can read a lot of articles based on focus  
21 groups in the literature where you have no idea really. It  
22 will say, "Beneficiaries thought that..." and there's no

1 sense of was it most, all, some, so you really don't know  
2 if it's the writers', the authors of the articles' opinion,  
3 or if it's the focus group people opinion. So I love that  
4 you did that, and I would encourage you to keep doing that  
5 on slides and when you discuss things.

6           Then my suggestion is maybe to push a little --  
7 maybe you already do, but if possible, push a little harder  
8 on the access question, too. Now, Jim, it may be that the  
9 survey is still the best place to get at this, but in terms  
10 of access, when you have a problem, sometimes a few days,  
11 as it said on the slide, is no big deal. You know, "Gee, I  
12 think my blood pressure has gone up a bit. Could you check  
13 it?" Okay, three days is probably reasonable. The other  
14 thing, if you have a fever and an abscess, you know, three  
15 days isn't reasonable; you really need to be seen the same  
16 day. So maybe pushing a little bit more on that and  
17 pushing maybe a little bit more, too, on what it took to  
18 get a new primary care physician. My sister lives near an  
19 academic medical center. She's trying to get a primary  
20 care physician there. She's on Medicare. And the first  
21 appointment available to her is August 15th, which doesn't  
22 speak well for the access there. It may be different

1 because it's an academic center.

2           Anyway, maybe push a little more on those things  
3 in the focus groups, but I love the way you did it, really.

4           MS. KELLEY: All right. Amol?

5           DR. NAVATHE: Thank you.

6           So I think this was really very helpful to get a  
7 chance to go through and read some of the quotes, Ledia,  
8 that you put in. I think they're just really revealing and  
9 give us a stronger connection to the beneficiaries that  
10 this whole program is obviously trying to benefit.

11           I wanted to ask a couple of questions, so --  
12 actually really one main question here, which is I realize  
13 that there's a limited number of beneficiaries here, but in  
14 some cases, you were able to actually pull out some quotes  
15 and some differences and inferences about dual eligibles,  
16 for example, relative to other beneficiaries, and you  
17 talked about this and the report talked about it in the  
18 context of primary care quite well.

19           There were some examples of quotes in general  
20 around specialty care that seemed to imply that there could  
21 be some issues with access, multiple weeks and months  
22 required. I was wondering if there is any additional

1 information that you've discerned regarding the dual  
2 eligibles versus the other non-dual eligible beneficiaries  
3 with respect to specialty access.

4 MS. TABOR: I will say, you know, as you had said  
5 at the beginning, there were kind of numbers issues we  
6 wouldn't be able to describe, but I think for specialists,  
7 we did hear the same kind of issues that we heard with the  
8 over-65 group, that waiting anywhere from a few days to a  
9 few months, the duals seem more able to talk about issues  
10 with primary care and finding a new primary care provider.  
11 But I will say the specialists kind of felt the same as the  
12 age 65.

13 DR. NAVATHE: Okay.

14 MS. TABOR: We are planning for this summer to  
15 have duals groups, and we can kind of continue to  
16 differentiate if there is a difference between primary care  
17 versus specialty experience.

18 DR. NAVATHE: Just for some context for my  
19 question real quick, so the empirical literature is some  
20 work that I've done, but others have done more of, suggests  
21 that when you look at duals access -- I shouldn't say  
22 access -- dual visits or utilization with primary care,

1 they tend to actually be quite similar in quantity  
2 distribution as non-duals.

3           You really see a huge gap when it comes to  
4 specialty care, and so that's one of the reasons I'm  
5 curious about this is because on the primary care side, I  
6 think the perceptions or our understanding what's happening  
7 to get to access might be harder to get those visits,  
8 although they may be successful at doing it.

9           On the specialty side, there's actually objective  
10 information that suggests that there's less utilization,  
11 which is why I think it might be even more helpful to tease  
12 it out there if we can in follow-up work.

13           MS. TABOR: That's a good point, and we'll  
14 definitely work on that this summer.

15           DR. NAVATHE: Great.

16           MS. TABOR: Thanks.

17           DR. NAVATHE: Thanks.

18           MS. KELLEY: I have Dana with a Round 1 question.

19           DR. SAFRAN: Thank you.

20           Ledia, just adding my compliments for this. It's  
21 always such a valuable part of our work and so really  
22 appreciate it.



1           I think my dog is excited about it too. You can  
2 hear her in the background.

3           My question for you was about one of the findings  
4 related to the clinician focus group and in particular  
5 around the reported preference for MA over traditional  
6 Medicare, and I was just interested to know whether that  
7 represents a change, whether you have any recollection of  
8 the data and how that particular item has changed over  
9 time, if it has.

10           MS. TABOR: Yeah. I will say that this finding  
11 was newer this year, and I think that there wasn't very  
12 much of a regional focus.

13           We heard this predominantly in the San Francisco  
14 area where there's been kind of news clippings over the  
15 past of physicians taking Medicare Advantage over fee-for-  
16 service just because of reimbursement being the biggest  
17 cause. We did hear a few physicians in Texas also mention  
18 a preference, but I will say the strongest commentary  
19 definitely came from the California groups.

20           So I think we'll kind of continue to track this,  
21 but I think the finding is there is a lot of variation  
22 across the country on this issue.

1 DR. SAFRAN: Yeah. It does seem worth just  
2 keeping an eye on that, and I do -- you know, recognizing  
3 the limitations in a focus group setting, I do think the  
4 extent that we can find some ways to report trends that we  
5 see, I think that's really interesting and valuable.

6 Thanks for the great work.

7 MS. KELLEY: All right. That's the end of the  
8 queue for Round 1. I'll just pause in case anyone wants to  
9 jump in.

10 DR. CHERNEW: Well, now they're going to be  
11 transitioning to Round 2, anyway, and we have a pretty full  
12 Round 2 queue, if I've kept track of all of this. So we  
13 should jump into our Round 2, and if I have this right --  
14 this is always fun for me -- I'm thinking Brian was first  
15 in the queue. How did I do, Dana?

16 MS. KELLEY: Very well, Mike. Brian is first.

17 DR. CHERNEW: Brian, you're first.

18 DR. DeBUSK: All right. Well, thanks to staff.  
19 Thank you, Ledia. Really fascinating survey, and it is  
20 comforting to see that there's generally good access and  
21 satisfaction across the beneficiaries.

22 But I do want to point something out. On the

1 table in Exhibit 1, on page 1 of the report, if I'm reading  
2 that correctly, all the clinicians, all the NPs, PAs, PCPs,  
3 specialists, everyone came from either San Francisco,  
4 Houston, or New York City. So just one recommendation,  
5 just a comment in passing, especially when these meetings  
6 are virtual, it would be nice to see some outreach to  
7 clinicians in non-metropolitan areas.

8           Again, that just sort of jumped off the report  
9 that we really didn't talk to any rural clinicians here,  
10 and I realize this sample group is small. So I'm not being  
11 critical. This is more of a suggestion.

12           The other thing that really stood out for me were  
13 the questions around ACOs. I mean, I know in the report,  
14 we said, well, a majority of the clinicians had heard of  
15 ACOs. Well, the thing that really jumped out at me is that  
16 3 out of 30 had been in an ACO. With 10 percent, 3 out of  
17 30 were still in -- were actively in an ACO, which is only  
18 10 percent, and looking at that other statistic backwards,  
19 what that really means is that 11 out of 30 positions had  
20 never even heard of an ACO. And that's a program that's  
21 been around for 12 years.

22           And the only reason I point that out is I think -

1 - and sometimes in MedPAC, we collectively lose sight of  
2 this. I think there's a very significant number of people  
3 who are very, very passionate about ACOs and are  
4 contributing and trying to expand them and make them  
5 better, and I think all that works very laudable.

6           But I think this is a bit of a reality check here  
7 in that physicians in general -- I mean, when 3 out of 30  
8 are participating in ACOs -- and again, these aren't  
9 obscure markets. I mean, this is New York. This is  
10 Houston. This is San Francisco. These are not small  
11 Medicare markets.

12           So I hope that grounds us a little bit on the  
13 need to really get ACOs more broadly accepted and develop  
14 models that are more appealing to a broader population.

15           The other thing I was really fascinated with --  
16 and Dana touched on it -- was that some clinicians cited a  
17 preference for MA based on reimbursement, yet other  
18 clinicians cited not wanting to participate in MA due to  
19 reimbursement.

20           I have a working hypothesis here, Ledia, and  
21 maybe this would be interesting to ferret out in future  
22 surveys. I think when the MA plan is working purely off a

1 discounted fee schedule, that's when you're going to see  
2 the dissatisfaction, the nonparticipation in MA.

3 I think the ones who are citing reimbursement  
4 aren't citing reimbursement at the fee schedule level. I  
5 think what they're probably citing are some of the  
6 additional incentives that MA plans may be providing, and  
7 unfortunately, some of those incentives may be in the way  
8 of paying for coding or, you know, again, over-coding,  
9 upcoding, however you want to put it.

10 So I think what we may have found there is a  
11 delineation between fee-for-service-based MA plans versus  
12 ones that are paying for more -- paying under more  
13 sophisticated models.

14 Those are my comments. Thank you.

15 DR. CHERNEW: So let me just react quickly  
16 because I think we're going to go to Lynn next, if I'm  
17 right, Dana.

18 I agree with that, Brian, although I'll say  
19 something that struck me from your comment is,  
20 increasingly, physicians are working for large  
21 organizations, and I'm not 100 percent convinced that  
22 physicians that are in ACOs understand that they're in ACOs

1 for a whole bunch of reasons. And I've been thinking  
2 through how we survey and what we learn when we think about  
3 the broader organizational structures that the physicians  
4 are practicing in. These are important because often we  
5 have an orientation that physicians are sort of solo and  
6 doing what they're doing and engaging the way they're  
7 engaging, where increasingly, I think, what's happening  
8 with physicians is they're moving along where their  
9 organization is moving in a bunch of particular ways.

10 I'm not sure that's true. I don't want to  
11 belabor it now, but --

12 DR. DeBUSK: Well, on that point, Michael -- on  
13 that point, in the reading materials too, I saw that JAMA  
14 article that looked at hospital-employed physicians, and 84  
15 percent of the primary care docs, 93 percent of the  
16 specialists cited that their compensation was tied to  
17 productivity. And in both populations, it was about 70  
18 percent of their total cost.

19 And I do agree with you. I think a lot of  
20 physicians don't know that they're in ACOs. The problem is  
21 that 70 percent of the pay for the vast majority of those  
22 employed physicians are tied to sheer volume, not

1 necessarily to some of the things we would want to see from  
2 ACOs.

3 DR. CHERNEW: So that's a longer conversation  
4 that we're just not going to have time to have now, but  
5 luckily, we'll be able to continue this discussion.

6 But I agree in understanding the compensation and  
7 what it means in systems is a big deal. Just the role  
8 systems broadly, I think, is a big deal.

9 But we should move on. I don't want to take up  
10 too much time. I did already.

11 Lynn.

12 MS. BARR: Oh, thank you, Michael. So, Ledia,  
13 wonderful, wonderful report. This is my favorite part of  
14 the year is looking at the beneficiaries and how they're  
15 reacting to the program.

16 The big thing that jumped out at me was the Med  
17 supp issue, and I think there's a couple things going on.  
18 One of them is that Part D is such a big incentive for  
19 people to sign up for MA. They don't know or care about  
20 anything else.

21 So the fact that if they enter into Medicare  
22 Advantage and then they want to get back out and their Med

1    supp costs can go way, way up and become completely  
2    unaffordable, I believe that that is not understood.

3                   And I don't know where you get towards  
4    recommendations here, but I think it would be important  
5    that CMS creates a plain language explanation of the Med  
6    supp issue and requires that it's signed by people, because  
7    I can't tell you -- like in rural communities, this is  
8    really a big deal. This is why we have more Med supp in  
9    rural communities. So a much higher percentage of patients  
10   have more Med supp in rural communities because they end up  
11   paying up to 50 percent of the fee schedule in coinsurance  
12   on outpatient. So they have to have Med supp or they  
13   cannot afford to use their rural community and then have to  
14   drive by if they ever get out of that MA plan.

15                   So I feel like this is a major issue that has not  
16   been addressed, and that your comments in this focus group  
17   said it beautifully. They don't understand the financial  
18   risk that they take, and we need to do a better job to make  
19   sure they do it.

20                   Thank you.

21                   MS. KELLEY: Marge.

22                   MS. MARJORIE GINSBURG: Lynn, just a quick



1 comment to your suggestion. Of course, I think most of you  
2 know I'm a SHIP counselor, and my response to all the  
3 problems is to tell people to call their SHIP counseling in  
4 their area, because that's what we do -- we help them work  
5 through this. But, anyway, this was not a promotion for my  
6 volunteer work.

7           Great job, Ledia. I always -- like Lynn, I  
8 always love reading about particularly what beneficiaries  
9 are saying.

10           It occurred to me; I think for the first time in  
11 -- how many years? -- four years I've been on this to ask  
12 whether MedPAC has ever considered using its public input  
13 dollars to do deliberative discussion groups rather than  
14 focus groups. And I think many of you, maybe most of you,  
15 understand what a deliberative discussion is, and I'm not  
16 going to take our time to talk about it now.

17           But it really feels like we may be at a time  
18 we're using public to get input into policy decisions,  
19 which, of course, is what we do, and it can be done with  
20 the public in a much narrower way on much more narrower  
21 subjects. But for any of you who have done any readings  
22 about the results of deliberative discussions, it can be

1 incredibly helpful in understanding how the public responds  
2 to policy issues. For MedPAC, I would think it would be  
3 tremendous.

4           This is a bit of an apology. I don't know why it  
5 took me this long to say, gee, maybe we ought to consider,  
6 and I also realize it's not our role to tell MedPAC how to  
7 spend its money -- well, maybe a little bit. But I hope  
8 this might be something that you'd consider in the future.

9           So that's all. Just a suggestion. Obviously,  
10 Ledia, I'd welcome any comments or thoughts you have about  
11 this now, but this might end up being something that needs  
12 a much longer discussion.

13           Thank you.

14           MS. TABOR: This was a new idea, and it's  
15 different than the focus groups, and I agree there could be  
16 value. But, you know, thinking about sort of how we can  
17 best produce work for the Congress, we can take this back  
18 and discuss it. It's a good idea. Thanks.

19           MS. KELLEY: David.

20           DR. GRABOWSKI: Great. Thanks, Ledia, for this  
21 work. It's just super. I would start by saying these  
22 focus groups are important, and, Ledia, as you suggested

1 during your presentation, they really allow us to learn  
2 about a set of issues that aren't observable or obtainable  
3 in claims.

4 I just wanted to make kind of three brief  
5 comments. Let me start with one that's probably a bit  
6 picky and annoying. You have this great sort of line in  
7 the text on page 3 about due to the small sample size, we  
8 caution against drawing any general conclusions. And then  
9 it's always hard not to behave, given that constraint.

10 But then even during the presentation -- once  
11 again, sorry for being picky and annoying, but I'd just  
12 caution us not to over-interpret differences. So you had  
13 something on Slide 8: duals slightly less satisfied. That  
14 may be true, but this is not the place to kind of draw  
15 those sorts of conclusions. That's the picky and annoying  
16 comment.

17 Comment two and very much picking up on kind of  
18 the duals here, there were 64 beneficiaries total in the  
19 focus groups, 15 of whom were dually eligible. Given the  
20 vulnerability of this group and their high cost, I just  
21 wondered about larger sampling, and I know that's always an  
22 issue to recruit duals, but there's such, I think,

1 importance to this group and a lot to be learned, and so  
2 that would be a comment.

3           Final comment. I was really fascinated by this  
4 difference in what physicians and beneficiaries told us,  
5 about whether the doctors were accepting new patients. And  
6 no offense to Larry and the other clinicians in the group,  
7 but I trust the beneficiaries here. I think trying to  
8 unpack that a little bit more is kind of interesting about  
9 why physicians report this kind of difference. That  
10 disconnect is really interesting. It's something we've  
11 talked about as a Commission before. I know Jon Perlin and  
12 others have commented on this at prior meetings. How do we  
13 know that physicians are truly accepting new Medicare  
14 beneficiaries?

15           So I'll stop there. Ledia, once again, really  
16 glad we do this work every year, and I learned a lot from  
17 this work. Thanks.

18           MS. KELLEY: Betty?

19           DR. RAMBUR: Thank you very much. I really  
20 enjoyed this as well. It was wonderful to hear the voices  
21 of the beneficiaries and also the providers.

22           But I was struck by the comments about the ease

1 of care coordination in MA, which was very interesting.

2 I want to make a comment that I think builds a  
3 bit on Jonathan's comment about how we think about  
4 contemporizing who is a provider in Medicare payment.

5 I notice on page 67, one physician noted that  
6 they have 60 providers and from whom six are nurse  
7 practitioners who basically see, according to what is  
8 reported here, she reported 50 percent of the patients.  
9 You can bet that they don't receive 50 percent of the  
10 revenue, and this has a lot of implications, I think, this  
11 type of situation, not only for our conversation that's  
12 coming up about the general workforce but also GME and  
13 other things.

14 On the next page, I was also struck by the nurse  
15 practitioner who has to pay someone to be her supervisor,  
16 her or his, even though the contribution for that payment  
17 is dinner once a year or something like that.

18 And it was in, I think, 2014 that the Federal  
19 Trade Commission actually cautioned states against limiting  
20 scope of practice of providers, of nurse practitioners in  
21 particular.

22 And so it just seems like one of the pieces of

1 work ahead might be to think about what it means to have a  
2 contemporary workforce, given that when Medicare started in  
3 1965, I think the average life span was between 68 and 70,  
4 and so we're seeing a whole plethora of new kinds of  
5 additions where people have cognitive disorders or  
6 whatever.

7           So that was my big takeaway here, and I think  
8 that's it. Thanks.

9           MS. KELLEY: Larry and Paul, I did not get your  
10 notes until after Betty had started speaking. Both of you  
11 had something that you wanted to respond to that David had  
12 said. Do you want to go ahead, Larry?

13           DR. CASALINO: Yeah. Thanks. Just very quickly  
14 on what David said about the contrast between what  
15 physicians say and what a patient says -- no, David, I  
16 wasn't offended at all, and I think it is worth paying some  
17 explicit attention when there's a contradiction.

18           We published an article in JAMA years ago based  
19 on a pretty small survey of clinicians and patients, and I  
20 don't think JAMA would have really taken the article,  
21 publish an article using such a small survey. But I think  
22 the findings were so striking, that's why they published

1 it.

2           We were asking about patient-physician  
3 communication, about out-of-pocket costs, and the patients  
4 almost universally said they would like to talk -- they  
5 would like their physician to talk to them about their  
6 likely out-of-pocket costs, and they mostly said their  
7 physician didn't talk to them about that. But the  
8 overwhelming majority of physicians said, "We do talk to  
9 our patients about their out-of-pocket costs." I don't  
10 think anybody is lying here, but there's a kind of self-  
11 serving perception.

12           So it is worth it, definitely, keeping this line  
13 in probing, I think, during the focus groups and then also  
14 in thinking about what people have said to look for those  
15 kind of contradictions.

16           That's it.

17           MS. KELLEY: Paul?

18           DR. PAUL GINSBURG: Sure. This may actually not  
19 be on David's point but on something that came up earlier.  
20 You know, as the Medicare Advantage share of Medicare  
21 beneficiaries keeps growing so rapidly -- and I guess we  
22 know that it will be half nationally serving -- you know,

1 this distinction between the access experiences of MA  
2 enrollees versus non-MA enrollees is probably pretty  
3 important. And I think for future surveys warrants some  
4 real -- I mean our focus groups warrants some real  
5 stratification and, you know, a separate cataloging of the  
6 responses to the access questions.

7 MS. KELLEY: Okay. Stacie.

8 DR. DUSETZINA: Thanks. Ledia, great report. I  
9 really enjoyed reading it. I have a couple of quick  
10 thoughts related to some of the other comments that were  
11 made in Round 1 and then also a thought about the  
12 prescription drug space.

13 So one of them is about the question of asking  
14 more about the mental health services received, and I  
15 wonder -- you know, I realize that there tends to be stigma  
16 attached to this, and it can be a difficult question to  
17 ask. But I wonder if it would be worth considering an  
18 opportunity to ask about other cash pay services that  
19 beneficiaries are receiving it and including it along with  
20 things like physical therapy, occupational therapy,  
21 prescription drugs that might be paid in cash, and mental  
22 health or therapy being included among those.



1           I think we are really interested in a lot of  
2 things that beneficiaries are getting outside of the system  
3 and how that's changing, so that might be one way to do it.

4           Another thing that I, like others -- I think Dana  
5 mentioned this one previously. I was really surprised by  
6 the MA patients having potentially greater access based on  
7 those physician reports and realized that it's hard to  
8 generalize what does that mean. Is it just, you know,  
9 based on who was answering? And I wonder if there's an  
10 opportunity to think about something like a secret shopper  
11 type of experiment to do -- where you get a little bit more  
12 geographic variation and just see, you know, do you have  
13 barriers to traditional Medicare relative to Medicare  
14 Advantage for getting appointments, especially for things  
15 like primary care?

16           Along the drug part, you know, I think it's also  
17 really noteworthy the extent to which people are using  
18 coupon sites and things like that, so we do worry a little  
19 bit about missing information in the claims. But I think  
20 one of the things that was really, I would say, not  
21 surprising because I think I anticipated this to be the  
22 case, but physicians talking about not having access to

1 information about the beneficiaries' costs, partly because  
2 by now they're supposed to have access to real-time benefit  
3 tools. It's a requirement that Part D plans have these  
4 available and partner with EHRs to make them accessible and  
5 available for Medicare beneficiaries by now. And so I  
6 think that maybe providing a little bit of context around,  
7 you know, these are not working well and not available  
8 despite the fact that they're, you know, supposed to be  
9 existing and working today.

10           So I think that maybe couching that language a  
11 little bit along the lines of, you know, this isn't just  
12 functionality that is optional, that is should exist. And  
13 I think looking forward, there is an effort to make real-  
14 time benefit tools available to patients directly, Medicare  
15 beneficiaries directly. And so I think maybe keeping an  
16 eye on that for future surveys would be great.

17           But, again, wonderful report. Thank you very  
18 much.

19           MS. KELLEY: Pat.

20           MS. WANG: Thank you. You know, somebody  
21 mentioned that there are small numbers in the survey, which  
22 is absolutely true, but I do want to just compliment the

1 sort of like the comprehensiveness of the structure and the  
2 layout of the description, and particularly the use of full  
3 quotations of folks' or participants' comments. I thought  
4 it was really, really interesting.

5           There are a couple of things. So, you know, one  
6 is this issue about the docs in California preferring  
7 Medicare Advantage to traditional Medicare. I really think  
8 that that has to do with the form of payment that MA plans  
9 utilize in that part of the country, which I assume in this  
10 case includes capitation and risk sharing. And it might be  
11 an area -- when I read that, I thought, oh, that's got to  
12 be what it is. But there really wasn't any more  
13 information about that, and so I would suggest that when  
14 folks in the future hear that kind of response, they dig in  
15 a little bit more to the nature of the payment. And it  
16 seems pretty -- it seems logical to me, but it would be  
17 good to get confirmation about that.

18           The other thing that struck me -- and, you know,  
19 David Grabowski's comment about, you know, being nitpicky,  
20 you can't generalize these results. On the other hand, I  
21 couldn't help but be struck by the geographic variation in  
22 the responses. And so, you know, reporting them out as

1 this is what the focus group findings were I think obscures  
2 the richness of and the interesting fact that I really do  
3 think there were different responses in different areas of  
4 the country.

5           On the issue of access, which I think is a key  
6 thing to come out of the discussion here, just going back  
7 to David Grabowski and Larry's discussion about docs saying  
8 that they're accepting new patients, but beneficiaries  
9 saying they're not, I do think -- I don't know if this is  
10 for a future focus group question, but I do think that one  
11 has to consider the role of the front office staff in  
12 turning potential new patients away simply because they  
13 manage -- a doctor may think that they are open to new  
14 patients, but their front office staff, who sees their  
15 actual schedules, is telling folks, you know, "We're  
16 closed." And that has certainly been our experience.  
17 Sometimes, you know, the doctors are not in that level of  
18 detail, unsurprisingly so. I think you have to look a  
19 little further at who's actually talking to the beneficiary  
20 and what that experience is based on.

21           The other things that I think were interesting  
22 about access, again, it's very different in different parts

1 of the country. I think it's very hard to generalize. The  
2 use of urgent care centers in some densely populated areas  
3 of the country where there's a lot of supply of urgent  
4 care, it reveals an access issue. People are going to  
5 urgent care because they don't want to wait for an  
6 appointment, especially something that might require a  
7 specialist. They just go into urgent care and get it done  
8 with when that supply exists. And in other areas, it's  
9 less of a problem.

10 I want to just also give a caution to the  
11 conversation that folks were having about PCPs accepting --  
12 or preferring Medicare Advantage as translating into that  
13 Medicare Advantage members have greater access. That could  
14 be true of primary care practices, which I think were the  
15 ones that were being discussed in the San Francisco area,  
16 and have absolutely nothing to do with specialist access.  
17 So I'd be very careful while sort of translating that  
18 observation into that means broader access for  
19 beneficiaries for all services. I don't think it does.

20 The final thing that I'll say that just really  
21 struck me, again, about the regional differences in access,  
22 some places saying, "Yes, we have full" -- you know, "We're

1 taking Medicare and Medicaid"; other doctors saying, "I  
2 don't want to take any Medicare and Medicaid," and sort of,  
3 you know, those differences. The beneficiaries' experience  
4 of care is different, I think, on this issue in different  
5 parts of the country, which underscores to me sort of the  
6 validity of the MedPAC approach to measuring quality at one  
7 local level. And I think that that includes the  
8 beneficiary experience of care. I think it's very hard --  
9 and I'm speaking as an MA plan -- to have like a national  
10 standard about how long it takes to schedule an  
11 appointment, how long you have to wait in the waiting room,  
12 and compare plans against each other where they may be  
13 located. When I read the results of these focus groups, I  
14 thought, wow, it just -- it to me speaks why that doesn't  
15 make a lot of sense.

16 Thank you.

17 MS. KELLEY: Amol?

18 DR. NAVATHE: Thank you. Ledia, great work. I  
19 wanted to pick up on a couple of threads, particularly  
20 pertaining to access, and I think Pat has touched on  
21 variability; I think others have kind of highlighted access  
22 to care as obviously an important dimension. And these

1 focus groups give us a somewhat unique look under the hood,  
2 if you will. I think oftentimes we're using claims data as  
3 objective data, but it's really important if you actually  
4 look under the hood and see what might be driving -- or  
5 hidden underneath the averages, if you will.

6           When I reflect upon the slides in the report and  
7 the presentation, it strikes me that there seems to be a  
8 number of different areas where it seems like what is  
9 underneath those averages may actually be an area of  
10 concern. What do I mean by that? So, for example, there  
11 was a quote about, you know, needing multiple weeks, three  
12 weeks plus to get access to a primary care doctor in Texas.  
13 We already talked a little bit in my Round 1 question about  
14 the large variability and large number of months it can  
15 take to get access to specialty care, and there were some  
16 pretty striking examples of quotations of having to go  
17 thousands of miles to get to an orthopedist or what have  
18 you. Some of those we don't want to overinterpret, as  
19 David said, but I think if you take them in totality across  
20 the specialists, across the urgent care pieces, I think  
21 Larry has mentioned that around urgent care being kind of  
22 an interesting -- there's so much urgent care that that

1 implies something about our belief that beneficiaries get  
2 timely primary care access. There were several quotes,  
3 several observations around emergency department care as  
4 well and use.

5           And so I think if we take that in totality, it  
6 should make us concerned about the access to care piece for  
7 beneficiaries, and also to reconcile -- I, in fact, went  
8 back when I read this -- it was really interesting because  
9 I remember in December when we had our payment adequacy  
10 conversation where we do a bunch of the beneficiary access  
11 to care under physician services, for example, you know, we  
12 were using largely I think the objective data and to some  
13 extent our telephone survey, coming to the conclusion that  
14 there weren't any differential challenges between fee-for-  
15 service benes and privately insured individuals. Yet here,  
16 as Pat is highlighting, there are some examples where we  
17 might be seeing differences in access between MA  
18 beneficiaries and fee-for-service beneficiaries. And that  
19 doesn't quite reconcile itself, and so I think that that to  
20 me feels like an area that we need to do some additional  
21 work.

22           I bring up to some extent the payment adequacy



1 piece also, just the chapter, not the concept, the chapter  
2 because we outline there that we do a telephone survey as  
3 one of the key sources of inputs. And I know over this  
4 entire year's cycle we have talked about that many times,  
5 and to I guess kind of borrow a page out of Marge's  
6 comments, I would say, you know, the Commission -- I would  
7 submit that the Commission should consider if we should  
8 actually direct more resources towards upsampling,  
9 increasing the sampling size basically for the telephone  
10 surveys to be able to look at specific groups like dual  
11 eligibles in as geographically a representative way as  
12 possible because of these concerns. I think there's  
13 multiple different areas that we worry about. We worry  
14 about dual eligibility. We might also worry about other  
15 things like priorities. But I think it's worth taking  
16 stock of whether we really need to do more, largely, again,  
17 because of the red flags, the seeming red flags that seem  
18 to be in this work, and the fact that it doesn't reconcile  
19 with the other inferences that we've made that have  
20 supported a wide variety of the work that we do at MedPAC.

21           So I want to just submit that and see if other  
22 Commissioners might also support that, and that might be

1 something that we could do. Thank you.

2 MS. KELLEY: Jaewon?

3 DR. RYU: Thanks, Dana. And thank you, Ledia. I  
4 really enjoyed the chapter as well. For whatever reason, I  
5 don't seem to recall in prior years, you know, the summary  
6 of the focus groups, but I thought this was really helpful  
7 for me.

8 It also just felt like -- you know, I think it's  
9 probably pretty obvious on its face, but I'll say it. I  
10 actually found it kind of refreshing to have sort of this  
11 qualitative view versus the things that we normally do,  
12 which is so quantitative. And so I felt like there was a  
13 lot here.

14 I do wish -- and I understand that there's a  
15 striking the balance dynamic between making sure we can't  
16 draw definitive conclusions or wide-reaching kind of  
17 generalizations. But I do think calling out some of the  
18 thematic observations just around trends and what are the  
19 emerging things that maybe we didn't hear in years past  
20 that we are hearing now, I thought that might be kind of a  
21 helpful add to the chapter. I think two of the items that  
22 I think Pat and some others have spoken about were the

1 things that kind of left me wanting to dig in a little more  
2 -- one around access, the other, it seems like there's this  
3 common theme around the lack of awareness or the lack of  
4 education on the various programs, the options, the  
5 process, whether it's on the provider side or on the  
6 beneficiary side. I think those were a couple of the areas  
7 where at least for me I was wondering, well, have we heard  
8 these things before? Is it kind of accelerating and  
9 gaining momentum? I thought that would really help round  
10 out the chapter.

11 MS. KELLEY: I have Dana last.

12 DR. SAFRAN: Thank you very much, Dana. So  
13 really just two comments for me, other than re-emphasizing  
14 my appreciation for this work.

15 On the issue around, I will call it, methods and  
16 generalizability that I think David was the first to bring  
17 up and a few have touched on, an idea comes back to me that  
18 I think we talked about last time -- but I'm not 100  
19 percent sure -- of whether given that the focus groups are  
20 incredibly valuable and will always be limited in the  
21 numbers that we've got, we could triangulate our findings  
22 with other findings that are out there and, in particular,

1 with the Medicare Current Beneficiary Survey, MCBS, and,  
2 you know, all the better if MCBS data are available by  
3 market. I don't remember if they are, but, wow, wouldn't  
4 that be interesting if we could triangulate a little bit  
5 whether some of the differences we see by geography are  
6 more noise than signal or not.

7           And then also I think that for the work that the  
8 team does annually to inform our own discussions about what  
9 to recommend for rate increases, that there are some  
10 claims-based indicators that could be used as well to help  
11 triangulate some of our findings. In particular, I'm  
12 thinking of some of the indicators around access.

13           So that's just a thought that given we will  
14 always be limited, but it would be helpful to be able to  
15 say something about how robust these are, and that maybe  
16 being able to say where they align or differ from other  
17 types of indicators like MCBS or claims-based would be  
18 helpful.

19           And then my other quick comment was something I  
20 have on my notes for tomorrow's discussion around ACOs, but  
21 given this discussion, I thought I would throw it in here,  
22 you know, that the finding of physician unawareness, if

1 that's a word, about ACOs was really interesting. I have  
2 had a thought, as I was reading the chapter we'll discuss  
3 tomorrow, about whether we would ever convene ACO leaders  
4 in particular to talk with them about some of the ideas,  
5 and specifically some of the options that we were looking  
6 at, I felt it would be really valuable to understand how  
7 ACO leaders might think about this.

8           So I just throw that idea on the table as  
9 something for us to think about. My idea for tomorrow is  
10 really very targeted around, you know, the different  
11 optionality for how to incorporate episodes. But it could  
12 be very interesting to do a focus group with ACO leaders.

13           Thank you very much.

14           DR. CHERNEW: Okay. I think, Dana, you were the  
15 last in the queue. I'm going to pause for a minute to see  
16 if anyone wants any last thoughts. Otherwise, I will have  
17 some wrap-up ones.

18           [No response.]

19           DR. CHERNEW: Okay. So this is a wonderful body  
20 of work and a really rich discussion of what it is. I'm  
21 just going to make a few quick bullets.

22           The first one, which I think is clear, is this

1 analysis is intended to help us both know where to look and  
2 give some sense of reasonableness to things that we've  
3 found, but it's certainly not designed to tell us what to  
4 conclude. And comments like the one you just made, Dana,  
5 about finding other sources, or like Amol said about the  
6 survey and how we think about that, I think is actually  
7 very important. So we are balancing, as David said, really  
8 rich information but from a small, non-randomly selected  
9 group of folks. So that's Point 1.

10 Point 2 -- and I think it's getting more and more  
11 clear every year -- we have a fee schedule and a system and  
12 things about like physicians and beneficiaries who I want  
13 to emphasize are really the crux of what goes on. I don't  
14 mean to imply otherwise, but there's an incredibly  
15 important role of systems, the policies that the systems  
16 put in place, the administrators that work in those  
17 systems, and insight that those people might have that may  
18 transcend what we can get from the people that we have  
19 traditionally talked to because of their important role.  
20 And I think through everything we do, including this  
21 broadly, we need to think about the organizations in which  
22 the physicians and other clinicians are working as well as

1 the places where beneficiaries are getting care, and I  
2 think that matters.

3           The third and sort of last thing I will say about  
4 a lot of these is -- I might say this in every meeting. I  
5 am really excited next year as we begin to do more work on  
6 workforce, because I don't think it's the case that, for  
7 example, you could solve any problems that are identified  
8 simply by a tweak one way or another to payment models or  
9 payment levels of anything like that. I think there's  
10 really broad issues that arise in the workforce that is  
11 fundamental to how the health care system functions, and  
12 we're not quite there yet, but we are on the cusp, based in  
13 part to Betty's prodding, of doing even more workforce work  
14 than we do -- we've always done, just to be clear for those  
15 in the system, we've been interested in the workforce,  
16 we've also understood the importance of clinicians of all  
17 types in delivering care. But I think we're going to have  
18 even more of a focus on that as we go forward next cycle.

19           So it is -- and someone has sent me this message  
20 separately. I won't name them. It is always useful to see  
21 this work to help remind us of the beneficiaries we serve  
22 and the providers that serve them and understand the

1 environment that they're in. And just that touchstone I  
2 think is an important exercise, and I appreciate all the  
3 work we do to do that, and it's very useful to have that  
4 material sent out so we all see a snippet of the stuff that  
5 everybody has learned.

6           So, with that, I will say thank you to everybody.  
7 Another pause to see if anyone wants to add anything. Jim,  
8 if you want to add anything about this going forward,  
9 please do.

10           DR. MATHEWS: No. All good.

11           DR. CHERNEW: Okay. So then to the public, I  
12 will remind you that we really do value your comments, so  
13 please, if you have any thoughts on this morning's session,  
14 reach out to us. There are many ways to do it. On the  
15 website you can find a link or you can send an email to  
16 meetingcomments@medpac.gov, and we will get those comments,  
17 and we look forward to hearing them. One way to get a  
18 bigger sample is to have people that listen to us at these  
19 meetings tell us what they think. So please do.

20           With that, barring any other comments, I'm going  
21 to adjourn us for lunch and just say to those listening we  
22 will be reconvening after lunch at 1:45 to talk about an



1 issue that has been incredibly important to us and will  
2 continue to be for cycles to come, which is how we support  
3 safety net providers. And we are at the beginning of that  
4 important topic, so I really encourage those interested to  
5 please tune in after lunch at 1:45.

6           So, with that, thank you. We will see you all  
7 soon.

8           [Whereupon, at 12:41 p.m., the meeting was  
9 recessed, to reconvene at 1:45 p.m. this same day.]

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AFTERNOON SESSION

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[1:46 p.m.]

19

DR. CHERNEW: Great. Hello, everybody. Welcome  
20 back. We're going to jump right into this next session,  
21 which is on a topic that is going to appear again and again  
22 over the next several cycles. This is the beginning of

1 what I think is a very important and I think multi-cycle  
2 set of analyses and actions, so that's how we're going to  
3 support safety-net providers, one of our generally big  
4 concerns. So I'm going to turn it over now. Brian, are  
5 you kicking it off?

6 MR. O'DONNELL: I am indeed.

7 DR. CHERNEW: Okay. Brian, you're up.

8 MR. O'DONNELL: Good afternoon. In this  
9 presentation we'll discuss Medicare's payment policies to  
10 support safety-net providers. Before I begin, I'd like to  
11 remind the audience that they can download a PDF version of  
12 these slides in the handout section of the control panel on  
13 the right-hand side of the screen.

14 Before we get into the substance of the  
15 presentation, I'd like to take a second to review the big-  
16 picture motivations for examining safety-net providers.

17 First, the House Committee on Ways and Means  
18 submitted a bipartisan request for the Commission to  
19 examine access to care for vulnerable beneficiaries. We  
20 presented our preliminary results of this work to the  
21 Commission this past October. We concluded that some  
22 measures of vulnerability, such as living in a medically

1 underserved area, where not immediately useful for the  
2 Commission's work. However, for dual-eligible  
3 beneficiaries, we concluded that further work was needed to  
4 better understand potential access issues and the providers  
5 who care for them.

6           Second, while some providers experienced record-  
7 high profits in the years before the pandemic, some  
8 stakeholders have had ongoing concerns about the financial  
9 stability of safety-net providers, suggesting a growing  
10 disparity between providers within a sector. When thinking  
11 about how to address this issue, the Commission strives to  
12 balance supporting providers with being a responsible  
13 fiscal steward of Medicare resources. Given these  
14 competing priorities, large, across-the-board payment  
15 updates would be costly and potentially poorly targeted.  
16 Instead, targeting new funding to safety-net providers may  
17 be a more efficient use of resources.

18           Our presentation today focuses on three main  
19 topics.

20           First, we discuss our revised framework for  
21 identifying safety-net providers and deciding whether new  
22 Medicare funding is warranted to support them.

1           Second, we'll discuss our expanded definition of  
2 low-income beneficiaries.

3           Third, to demonstrate how our framework applies  
4 to one sector, we'll present updated analyses of safety-net  
5 hospitals and an illustrative example of how current  
6 supplemental safety-net payments could be redistributed.

7           We'll wrap up this presentation by soliciting  
8 feedback from the Commission about next steps.

9           As you can see in your mailing materials, our  
10 work has evolved based on feedback from the Commission, and  
11 we anticipate it will further evolve as the work continues  
12 into the 2022-2023 Commission cycle.

13           Also, one last programming note for the audience.  
14 Safety-net clinicians are not covered in this presentation,  
15 but we plan on coming back to the Commission in April to  
16 discuss these providers.

17           In this section of the presentation, I will  
18 discuss our revised framework for identifying safety-net  
19 providers and deciding whether new Medicare funding is  
20 warranted to support them. While today we only discuss how  
21 this framework applies to hospitals, our goal is to be able  
22 to apply this framework across multiple sectors in the

1 future. And as you've seen in your mailing materials, our  
2 framework has evolved substantially since you've last seen  
3 it. Most notably, we've broken it up into a two-part test.

4           Based on Commissioner feedback from our meetings  
5 last October and November, our framework is based on the  
6 premise that safety-net providers should be defined on the  
7 characteristics of their patients rather than the type of  
8 facility they are, where they are located, or other  
9 criteria.

10           As I mentioned, our revised framework now has two  
11 distinct steps. In the first step, our goal is to identify  
12 safety-net providers. The second step is deciding whether  
13 new Medicare funding is warranted to support the safety-net  
14 providers identified in the first step. The goal of having  
15 a two-step framework is to allow us to broadly identify  
16 safety-net providers while recognizing that new Medicare  
17 funding is not warranted in all situations. This balances  
18 the desire to support safety-net providers with the reality  
19 that Medicare has limited financial resources.

20           In the first step of our framework, we identify  
21 safety-net providers as those who treat a disproportionate  
22 share of Medicare beneficiaries who have low incomes and

1 are less profitable than the average beneficiary or the  
2 uninsured or those with public insurance that is not  
3 materially profitable. The underlying premise of defining  
4 safety-net providers this way is that providers who treat a  
5 disproportionate share of such patients could be  
6 financially challenged because their patients cost more to  
7 treat or they receive lower revenues for treating similar  
8 patients.

9 In turn, the concern is that these financial  
10 challenges could lead to negative outcomes for  
11 beneficiaries, such as having difficulty accessing care if  
12 providers close or choose not to treat certain types of  
13 patients.

14 Having identified safety-net providers, the  
15 second step of our framework is deciding whether new  
16 Medicare funding is warranted to support safety-net  
17 providers. Because Medicare faces substantial financial  
18 challenges, Medicare should only spend additional funds to  
19 support safety-net providers if three criteria are met:

20 First, there is a risk of negative effects on  
21 beneficiaries without new funding, such as trouble  
22 accessing care.

1           Second, Medicare is not a materially profitable  
2 payer in the sector. If Medicare profit margins are  
3 already high in a given sector, it suggests other solutions  
4 beyond adding new Medicare funding are likely more  
5 appropriate.

6           And, third, new Medicare funding is only  
7 warranted if current Medicare payment adjustments cannot be  
8 redesigned to better support safety-net providers.

9           One key issue in terms of identifying, as Jeff  
10 will discuss later, paying safety-net providers is defining  
11 low-income beneficiaries. In this part of the  
12 presentation, we'll discuss how we expanded our definition  
13 of low-income beneficiaries in response to Commissioner  
14 feedback.

15           In November, we defined low-income Medicare  
16 beneficiaries as those eligible for full Medicaid benefits  
17 in the state in which they live. In response to  
18 Commissioner feedback about this definition potentially  
19 being too narrow or creating variation across states, we  
20 expanded our definition to include beneficiaries eligible  
21 for full Medicaid benefits, partial Medicaid benefits --  
22 meaning Medicaid pays for their Medicare premiums or cost

1 sharing through one of the Medicare savings programs -- or  
2 those eligible for the Part D low-income subsidy, or LIS,  
3 which provides assistance with Part D premiums and cost  
4 sharing to beneficiaries who are eligible for full or  
5 partial Medicaid benefits or have incomes below 150 percent  
6 of the federal poverty level and have limited assets.  
7 Because both full and partial benefit dual-eligible  
8 beneficiaries automatically receive the LIS, we  
9 collectively refer to our full low-income population as  
10 "LIS beneficiaries."

11           In addition to having relatively low incomes, LIS  
12 beneficiaries differed from the full Medicare fee-for-  
13 service population in other regards, including being three  
14 times as likely to be currently disabled; twice as likely  
15 to be Black or Hispanic; nearly three times as likely to  
16 have ESRD; and slightly more likely to be female or live in  
17 a rural area.

18           These figures demonstrate that while safety-net  
19 providers are defined based on serving patients with low  
20 incomes or relatively unprofitable types of insurance,  
21 providers who disproportionately treat certain other types  
22 of beneficiaries will also likely benefit from the safety-



1 net adjustment.

2           Moving on to the issue of variation across  
3 states, we found that expanding our low-income definition  
4 reduced but did not eliminate variation across states. The  
5 exact magnitude of the changes are detailed in your mailing  
6 materials.

7           While some variation across states remained, it  
8 is important to note that some variation across states is  
9 appropriate and driven by differences in the rates of  
10 beneficiaries living at or near the federal poverty level.  
11 For example, the poverty rate in New Hampshire is about 5  
12 percent compared to more than 18 percent in Mississippi.  
13 So even if their Medicaid eligibility criteria were equally  
14 generous, we'd expect substantial variation across these  
15 two states.

16           Beyond the benefits we've already discussed,  
17 identifying low-income beneficiaries using LIS eligibility  
18 has additional benefits. First, relying on this measure  
19 would be less administratively burdensome compared with  
20 creating new measures. In addition, if funds are allocated  
21 based on treating LIS beneficiaries, providers would have  
22 an incentive to make their patients aware of and help them

1 enroll in Medicaid, the Medicare savings programs, and the  
2 LIS. Such a woodwork effect whereby previously eligible  
3 but unenrolled beneficiaries gain access to the benefits of  
4 these programs could improve access to care beyond any  
5 positive effects of financially supporting safety-net  
6 providers. This is especially true given that research has  
7 shown that enrollment in these programs is often low.

8 I'll now hand it over to Jeff who will discuss  
9 how our expanded low-income definition and revised safety-  
10 net provider framework applies to hospitals.

11 DR. STENSLAND: Brian just presented a framework  
12 for identifying and paying safety-net providers. I'll now  
13 provide an illustrative example of how this could be  
14 applied to IPPS hospitals, and this only applies to IPPS  
15 hospitals because critical access hospitals are paid on the  
16 basis of their costs.

17 As Brian indicated, the safety-net framework has  
18 two steps. The first is to identify safety-net providers.  
19 In the case of hospitals, this means identifying hospitals  
20 with a disproportionate share of low-income Medicare  
21 beneficiaries or hospitals with a poor payer mix. In our  
22 prior work, we found that low-income beneficiaries tended

1 to have higher risk-adjusted costs. Payer mix also  
2 matters. High uncompensated care shares and high Medicare  
3 shares are associated with lower non-Medicare and total  
4 margins. The details of all this are in your paper.

5 Step 2 asks whether these hospitals serving a  
6 disproportionate share of low-income beneficiaries need  
7 assistance, and the answer is yes. We see that even with  
8 current safety-net payments, hospitals serving lower-income  
9 populations are more likely to close.

10 In addition, Medicare patients are not materially  
11 profitable, suggesting Medicare is not currently overpaying  
12 for hospital services. This contrasts with post-acute  
13 sectors where Medicare may be overpaying.

14 Therefore, some safety-net funds are justified  
15 under Step 2. A remaining question is whether existing  
16 safety-net funds are enough. One option is to simply  
17 redistribute existing funds. A second option is to  
18 redistribute existing safety-net funds and direct  
19 additional funds to safety-net hospitals.

20 Before we talk about potential redistributions, I  
21 want to familiarize you with the current DSH and  
22 uncompensated care payments, which are Medicare's main

1 mechanisms for supporting safety-net hospitals. To be  
2 eligible for the DSH program, the sum of the hospital's  
3 Medicaid share of patient days plus the hospital's share of  
4 Medicare patients who receive SSI must exceed 15 percent.  
5 This means the hospital must either serve at least a  
6 moderate share of Medicaid patients or serve at least a  
7 moderate share of low-income Medicare patients. About 80  
8 percent of hospitals meet this threshold.

9           In 2022, these hospitals will receive about \$3.5  
10 billion of DSH add-on payments. They will also receive  
11 \$7.2 billion of payments to help cover their uncompensated  
12 care costs. In 2022, fee-for-service Medicare pays over 20  
13 percent of hospitals' expected uncompensated care costs to  
14 each DSH hospital. The combination of fee-for-service  
15 Medicare and Medicare Advantage plans, which also make DSH  
16 and uncompensated care payments, together pay for about a  
17 third of DSH hospitals' uncompensated care costs.

18           There are two main concerns with the way DSH  
19 funds are currently distributed.

20           First, the DSH shares are primarily driven by  
21 hospitals' Medicaid share of inpatient days. That means  
22 that as Medicaid shares increase, the size of the DSH add-

1 on payment to Medicare rates increases. Medicare ends up  
2 indirectly subsidizing Medicaid. In addition, Medicare  
3 shares are inversely correlated with Medicaid shares.  
4 Therefore, hospitals with high Medicare shares tend to get  
5 less DSH payments per discharge.

6 Second, DSH payments are driven by the share of  
7 inpatient days. Inpatient was the dominant site of care in  
8 1985 when the program was started, but that is no longer  
9 the case.

10 There may also be a concern with uncompensated  
11 care payments.

12 You can see from this chart that hospitals do not  
13 qualify for any uncompensated care payments until their DSH  
14 patient percentage reaches 15 percent. At that point, and  
15 for all points to the right on the graphic, the hospitals  
16 receive Medicare payments equal to just over 20 percent of  
17 their uncompensated care costs. For the average hospital,  
18 this is about \$2.6 million and increases the hospital's  
19 total revenue by almost 1 percent. If a hospital has more  
20 uncompensated care costs, it get higher payments, but the  
21 share of those uncompensated care costs paid by fee-for-  
22 service Medicare is always just over 20 percent for all DSH

1 hospitals.

2           The point of the slide is that the uncompensated  
3 care payments are not highly focused on hospitals serving  
4 low-income patients.

5           The alternative metric is called the Safety-net  
6 Index, which we continue to refine. It combines the  
7 hospital LIS share. It then adds in uncompensated care  
8 costs as a share of revenue and one-half of the Medicare  
9 share of inpatient days. The rationale for this particular  
10 formulation of the SNI is discussed in your mailing  
11 materials.

12           The purpose of adding Medicare share days is to  
13 acknowledge that Medicare profit margins are substantially  
14 below where they were when the DSH program was enacted in  
15 1985. So in 1985, high Medicare shares were not a concern.  
16 Today they may be.

17           In this illustrative example, we allow 95 percent  
18 of hospitals to receive some SNI payments. However, as we  
19 show on our next slide, hospitals serving more low-income  
20 patient will receive a larger adjustment.

21           This graphic illustrates an option for  
22 distributing support to safety-net hospitals. In this

1 illustrative example, 95 percent of hospitals would qualify  
2 for the add-on payment. But the amount of the add-on would  
3 increase as the SNI increases. The maximum SNI payment in  
4 the illustrative example is about 20 percent for hospitals  
5 with an SNI above the 95th percentile.

6           The point of this graphic is to contrast it with  
7 the earlier slide showing the share of uncompensated care  
8 paid was flat and did not increase as the safety-net metric  
9 increased. The implication is that the SNI is more focused  
10 on safety-net providers than the uncompensated care metric.

11           Now, this table provides kind of a high-level  
12 comparison of the current safety-net metrics and contrasts  
13 them with the alternative SNI metric.

14           The first line shows that fee-for-service  
15 Medicare will spend about \$3.5 billion on DSH and about  
16 \$7.2 billion on uncompensated care in 2022. If we  
17 redistribute the money to an SNI metric, there would be  
18 about \$10.7 billion available for redistribution.

19           The second row states that the driving factor  
20 behind DSH payments are the share of inpatient days where  
21 Medicaid is the primary payer. Uncompensated care  
22 payments, in contrast, are driven by uncompensated costs at

1 each hospital. The SNI is a composite measure that  
2 increases when the hospital has a larger share of Medicare  
3 patients that qualify for LIS, a larger share of Medicare  
4 patients in general, and uncompensated care costs that are  
5 large relative to the hospital's total revenues.

6 The DSH and SNI are distributed as add-on  
7 payments to Medicare claims. The uncompensated care  
8 payments are different. Hospitals with small Medicare  
9 revenues can still receive large uncompensated care  
10 payments from the Medicare program.

11 The bottom row shows that uncompensated care is  
12 also different from DHS and SNI payments in that the  
13 magnitude of the uncompensated care adjustment does not  
14 change as the safety-net metric increases.

15 So how well are these DSH and uncompensated care  
16 payments working? How focused on financially vulnerable  
17 hospitals are they compared to the new SNI metric?

18 The first two rows in this slide divides  
19 hospitals into quartiles based on their DSH patient  
20 percentage. This is the current metric used to distribute  
21 DSH funds. We see that the low DSH hospitals tend to have  
22 a moderate rate of closures and relatively high Medicare



1 shares. In contrast, high DSH hospitals tend to have  
2 slightly higher rates of closures and low Medicare shares.  
3 The DSH program appears to moderately target funds toward  
4 hospitals at risk of closure. But it may be of concern  
5 that hospitals with high Medicare shares are likely to  
6 receive lower DSH adjustments.

7 In contrast, the bottom two rows look at  
8 characteristics of hospitals with low and high SNI shares.  
9 We see that low SNI hospitals are very unlikely to close  
10 and high SNI hospitals were historically more likely to  
11 close. And unlike the DSH example, Medicare shares do not  
12 decline as the SNI increases.

13 Now, this slide looks at actual historical data,  
14 but next we'll shift to a simulation.

15 In this slide, we simulate what would happen if  
16 DSH and uncompensated care payments were replaced with  
17 safety-net payments determined by the SNI.

18 Look at the top row which shows Medicare margins.  
19 It shows that hospitals with the lowest SNI had a Medicare  
20 margin of negative 13 percent. The hospitals with the  
21 highest SNI had a Medicare margin of negative 2 percent.  
22 This difference is because the high SNI hospitals currently

1 get greater DSH and uncompensated care payments and have  
2 lower costs.

3 But what if we redistributed those payments using  
4 the SNI? This simulation is shown in the second row. It  
5 shows that under the SNI, high SNI hospitals' Medicare  
6 margins would increase from an average of negative 2  
7 percent to 0 percent.

8 The last row, we see that the SNI policy would  
9 have increased hospitals' all-payer margins by about 1  
10 percent for that group of hospitals in the highest SNI  
11 quartile. Essentially, hospitals that are at higher risk  
12 of closure would have received a slight increase in their  
13 total profit margins.

14 In conclusion, Brian illustrated how using LIS  
15 helps address variation across state Medicaid policies.  
16 The use of the LIS could also have the added benefit of  
17 encouraging providers to help Medicare beneficiaries enroll  
18 in programs that assist them with Medicare premiums and  
19 cost sharing.

20 I illustrated how Medicare currently provides  
21 substantial support to DSH hospitals, but there are some  
22 aspects of the current DSH program that are less than

1 ideal.

2 DSH patient percentages are negatively correlated  
3 with Medicare shares, and that may have been okay when the  
4 DSH program was started and Medicare margins were 10  
5 percent. But now that may be more troubling.

6 DSH is also an inpatient-centric metric, which  
7 can be of concern as hospitals continue to move away from  
8 inpatient as a site of care. And we also noted the  
9 uncompensated care payments are not highly focused on  
10 safety-net hospitals.

11 Now we shift to potential discussion questions.  
12 First, we'd like your feedback on the framework that Brian  
13 presented including Step 1, identifying safety net  
14 providers, and Step 2, deciding whether new funds are  
15 warranted for safety-net providers.

16 Second, we'd like your feedback on applying the  
17 framework to safety-net hospitals. Specifically, do you  
18 agree with the ideas that Medicare shares should influence  
19 safety-net payments and that reforming or replacing the  
20 current safety-net policies should be explored further, and  
21 also that an SNI-type metric should be explored as a way to  
22 improve on the current DSH and uncompensated care payments?

1           As you can see, the SNI has evolved substantially  
2 since our last meeting, and we expect it to evolve further  
3 based on your discussion today.

4           I'll turn it back to Mike.

5           DR. CHERNEW: Great. It is always impressive how  
6 much gets done at the beginning of this journey, so thank  
7 you for that.

8           I know we have some Round 1 questions. If I have  
9 this right, Bruce was the first one to ask for a Round 1  
10 question. I'm not sure, but, Dana, I'm turning it over to  
11 you to make sure this goes smoothly.

12           MS. KELLEY: Yes, Bruce, go ahead.

13           MR. PYENSON: Thank you very much. This is  
14 terrific work. I have a couple of questions on some of the  
15 metrics used and whether you've considered certain  
16 alternatives.

17           In particular, the metric of hospital closing, is  
18 that -- that's independent of beds, like we don't know if  
19 that hospital had 20 beds or 1,000 beds. Is that right?

20           DR. STENSLAND: That's correct. We could shift  
21 it to beds. The number or the percentage of IPPS hospitals  
22 closing is pretty similar in rural and urban areas, so I

1 think there's a fairly reasonable distribution of beds  
2 across that. But we can check on it.

3 MR. PYENSON: Have you considered, is there a  
4 metric such as distressed hospitals or -- and what I'm  
5 thinking about is from the importance of stability and over  
6 a time frame of several years, that is, are hospitals -- is  
7 this an issue of cyclical stresses on a business? Or is it  
8 persistent stresses on business? So I think a metric of  
9 this financial distress might be -- would show different  
10 things than closures.

11 DR. STENSLAND: Yeah, we could do something like  
12 that, like the financial pressure metric we used to use,  
13 which had -- it looked at consistency of losses of the  
14 hospital over several years and also a lack of growth in  
15 equity at the hospital. So we could use that metric and  
16 see what it's going to say. I'm pretty sure it's going to  
17 say the same thing, but we can look.

18 DR. CHERNEW: I think one of the challenges, just  
19 to jump in, is there's a measure called the Altman index,  
20 which is used in the finance literature to measure  
21 financial distress. It has some of those things that Jeff  
22 just mentioned. I do think we have to be careful to avoid

1 getting into a situation where higher costs makes it look  
2 like you're distressed and, therefore, we have to give you  
3 more money or you should get more money in varying ways.  
4 We're trying to find sort of external things. But I do  
5 acknowledge that the relationship isn't always perfect.

6 I don't know what you think about that, Jeff.

7 DR. STENSLAND: No further comment.

8 MR. PYENSON: Along those lines, is it your sense  
9 that -- is there a cyclical issue? You know, in the  
10 Medicaid world, there's a concept that Medicaid is  
11 countercyclical for economies for states. And to what  
12 extent is this a cyclical issue where -- or is it a chronic  
13 issue? Do you have a feel for that?

14 DR. STENSLAND: I'm pretty sure it's a chronic  
15 issue. I would lay heavy odds on that. But we can put  
16 some more data behind that.

17 MR. PYENSON: Okay. I think that might have some  
18 bearing on some of the answers to the questions you posed  
19 about funding. Thank you very much.

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

21 DR. CASALINO: Thanks, Dana. Brian and Jeff, I  
22 can't say enough about this work. The presentation was

1 beautifully done. The chapter and the written materials  
2 are very informative. The analyses are great. And at this  
3 point at least, I really like what I'll call your  
4 recommendations. And your questions on your last slide, at  
5 this point at least I would say yes to every one of them.

6           What I'm going to bring up is just a quibble,  
7 really a definitional issue, but I think worth clarifying.  
8 It comes up repeatedly in the written materials and a bit  
9 on the slides as well, so I'll be quick, but I just want to  
10 give a couple of examples.

11           On the written materials, on the second page, the  
12 first page of the executive summary, it says, "We identify  
13 safety-net providers as those that disproportionately  
14 serve, number 1, Medicare beneficiaries who have low  
15 incomes and are less profitable than the average  
16 beneficiary." So that sentence kind of made me stop. How  
17 can a Medicare beneficiary be less profitable than the  
18 average beneficiary? They're paid at the same rate. And  
19 how do low incomes come into that?

20           So, again, I think what you mean is it takes more  
21 time to take good care of low-income beneficiaries and,  
22 therefore, since the payment rate is the same for all

1 Medicare beneficiaries, low-income beneficiaries are less  
2 profitable. Is that what that means, that sentence? I'll  
3 read it again: "Medicare beneficiaries who have low  
4 incomes and are less profitable than the average  
5 beneficiary."

6 MR. O'DONNELL: So, Larry, that's right.  
7 Basically the payment rate's the same, but there might be  
8 higher costs for treating low-income beneficiaries. So in  
9 the hospital world, this might be, you know, longer length  
10 of stays. But, also, even though the payment rate is the  
11 same for all beneficiaries, the revenue realized by  
12 providers might be less for low-income folks. And so in  
13 the clinician world, there's a big issue with not being  
14 able to collect cost sharing. So even though the payment  
15 rate on paper is the same, the revenue realized might be  
16 lower.

17 DR. CASALINO: Okay. So both harder to collect  
18 cost sharing and possibly take more time and effort to  
19 provide good care for low-income beneficiaries. Actually,  
20 an additional point I would say is that insofar as a  
21 provider isn't participating in a value-based payment  
22 program, he might be less likely to get bonuses and more



1 likely to get penalties as well.

2           So I don't think -- at one point, at least, in  
3 the written materials, I think you do refer to it might  
4 take more effort to care for disadvantaged patients, lower-  
5 income patients. But I think that's the only place -- and  
6 the issue you just referred to about collecting and what I  
7 just said about value-based payment programs I don't think  
8 appear anywhere. But in any case, none of that appears  
9 here where you're talking about less profitable, and I  
10 think it might just be -- even though this is the executive  
11 summary, I think it might be -- wherever you think best to  
12 define once and for all very clearly why beneficiaries who  
13 are paid at the same rate are "less profitable." Everybody  
14 knows Medicare beneficiaries are less profitable than  
15 commercially insured patients, generally speaking, but --  
16 so, anyway, I just think it would -- that kept making me  
17 stop, and it showed up in the presentation a bit, too.

18           Then just the other point I have is the second  
19 part of that sentence, "We identify safety-net providers as  
20 those that disproportionately serve" -- you know, B is "the  
21 uninsured or those with public insurance that is not  
22 materially profitable." And "materially profitable" shows

1 up quite often in the written materials and also showed up  
2 in the presentation. By "materially profitable," do you  
3 just mean the net margin is negative for the public  
4 insurance patients?

5 MR. O'DONNELL: Yes, so I'll say some things, and  
6 I'll let Jeff jump in if he wants to. I think we went back  
7 and forth on the wording of what "materially profitable"  
8 meant. So I think we're comfortable with, you know, if you  
9 have a Medicare margin of 15 percent, we're comfortable  
10 sorting you on one side of the ledger; if you have negative  
11 10 percent perhaps, we're comfortable sorting on the other  
12 side of the ledger. But there is some Commissioner  
13 judgment on some provider types in between, and so I think  
14 that's what that language conveys, is that the framework is  
15 trying to give an overall vibe of how to think about a  
16 sector. But there could be sectors where you have kind of  
17 judgment calls, I would say.

18 DR. CASALINO: So I would just say, Brian, in the  
19 final product, it would be good to define that more  
20 clearly, I think. To me at least, it's kind of a  
21 nonstandard term. And I understand what you're saying and  
22 I don't particularly disagree with it, but, again, I think

1 defining it would be helpful. It may sound like I'm  
2 crowing, but it is important. It shows up pretty  
3 prominently in the algorithm that you have in the written  
4 materials in terms of deciding who's a safety-net provider  
5 and also, you know, what funds should be disbursed, if any,  
6 to them. So I'd just try to clarify the "less profitable"  
7 and the meaning of "materially profitable" points.

8 That's it.

9 MS. KELLEY: Bruce, did you have something on  
10 this point?

11 MR. PYENSON: I did. I'll perhaps -- I want to  
12 thank Paul for identifying -- recognizing that issue of  
13 less profitable, and I'm wondering if that is connected  
14 with -- if that's connected to issues in the DRG  
15 reimbursement where it's been identified that surgical  
16 patients are more profitable than medical patients, and so  
17 that hospitals without a large surgical service line may be  
18 less profitable.

19 Brian or Jeff, do you have thoughts on that?

20 DR. STENSLAND: That may be the case in the  
21 commercial world. The last time we looked at it, you know,  
22 we went through this big DRGs refinement where we looked at

1 the relative profitability of different DRGs, and we found  
2 that certain DRGs were more profitable back when the  
3 relative payment rates were based on charges and not costs.  
4 And we shifted it to based on costs, and I think, you know,  
5 it took some of the payments away from cardiac hospitals,  
6 cardiac DRGs. And I think the relative profitability on  
7 the Medicare side now I think is fairly similar between the  
8 surgical DRGs and the nonsurgical DRGs. And it may be that  
9 the commercial side hasn't shifted over to reflect that. I  
10 think that's what our analysis showed, but it also showed,  
11 I think, in the marketplace when you saw that after we made  
12 those changes in the relative payment rates for different  
13 DRGs, you saw not only a stop of the growth in heart  
14 hospitals; you saw actually a decline in the number of  
15 heart hospitals.

16 MR. PYENSON: I'm wondering if you would consider  
17 that mix in the models that you build, whether that's a  
18 predictor of financial results.

19 DR. STENSLAND: It could be, but I think it's  
20 probably not something -- it's certainly something we don't  
21 have data on. Like we could have the mix for the Medicare  
22 shares, but we don't have the mix for the commercial side.

1 And if it's really the commercial side that's driving it, I  
2 think we might be chasing something that we just wouldn't  
3 have enough data to make it any -- add any explanatory  
4 power to the model.

5 DR. CHERNEW: So let's save some of this for  
6 Round 2 because it gets into what we should do. I'll say  
7 that we do have to be careful because adjustments in the  
8 DRG rates could then change how this works out, and I think  
9 we have to be careful of trying to undo whatever is  
10 happening in the DRGs or redo it, you know, how we set it  
11 up. But that's a valid point of discussion, and I think  
12 we'll save it for Round 2.

13 I think, if I have this right, Amol is next. Is  
14 that right, Dana?

15 MS. KELLEY: That's right, Mike.

16 DR. NAVATHE: Thank you. I wanted to certainly  
17 offer support for this line of work. It's incredibly  
18 important. I'm very, very happy that we're taking on some  
19 of the foundational pieces around safety-net provider  
20 definition, patient definition, and going forward, how to  
21 support a sector.

22 Two hopefully quick-ish questions. The first one

1 is somewhat related to the conversation thus far regarding  
2 profitability. It struck me that we are -- we did some  
3 work as part of this looking at state-by-state variation  
4 based on the LIS -- the definitions, if you will, of  
5 Medicaid eligibility. And I thought that was very valuable  
6 work and will comment on that in Round 2.

7           What I was curious about is, is there any -- or  
8 what is and to what extent is there state-by-state  
9 variation on the payment rate side that would also affect  
10 profitability that here would get smoothed out across all  
11 of the averages in terms of looking at Medicare share,  
12 Medicaid share, and the other kind of associations that  
13 we're looking at? But what is -- intrinsically, on the  
14 payment side, what is the variability that exists for these  
15 beneficiaries through the Medicaid programs?

16           DR. STENSLAND: There's lots of variation in the  
17 payment rates they have for the Medicaid patients, and  
18 there's also a lot of variation in how much of the cost  
19 sharing that they pay for dual eligibles. In some states  
20 they're paying for almost all of it, in some states less of  
21 it. The only thing conceptually, I think, we're trying to  
22 avoid doing is we're trying to avoid having a situation

1 where, if they lower Medicaid rates, we end up paying them  
2 more.

3 DR. NAVATHE: I see. That's a good point. So it  
4 sounds like in some sense we want to get to get to  
5 aggregate profitability, if you will, but we're not trying  
6 to tune this at all toward what the Medicaid rate variation  
7 might be or even aggregate what it is. Is that correct?

8 DR. STENSLAND: Correct.

9 DR. NAVATHE: That's a very good point. Thank  
10 you.

11 MR. O'DONNELL: The thing that I would add to it,  
12 Amol, is it does vary by sector. So if you're concerned of  
13 losing some cost sharing for duals in hospitals, there's a  
14 little bit of a backstop because of the bad debt policies.  
15 In the clinician world, there's really not -- that really  
16 doesn't exist so much. So it does vary by sector, too,  
17 what the effects of actually payment rates are.

18 DR. NAVATHE: Yeah, it's interesting. I mean,  
19 these issues are always deeper and more sophisticated, I  
20 think, as you dig more and more into them. So it creates  
21 this interesting circularity problem to the logic if you  
22 start to think -- if as a central planner hypothetically we

1 could control all these different levers, we would run into  
2 this issue, which is if we wanted to increase Medicaid  
3 rates, we would increase their profitability, and does that  
4 mean that, you know, it changes the way that we would  
5 define safety-net providers or how we might reimburse them  
6 in a specific targeted way. But I think to the extent that  
7 we don't obviously have all those levers, I think it makes  
8 sense to understand that we don't want to solve for that  
9 specific piece, it's more of an aggregate point how we use  
10 it to identify safety net and then use that to design  
11 rational policy downstream of that. So that was very  
12 clarifying. Thank you.

13           A second question I had is on page 31 of the  
14 reading material, I think it was Table 5, if I'm correct,  
15 when we're calculating Medicare share, in the footnote I  
16 notice that we say, "Medicare shares are presented as the  
17 share of adult and pediatric inpatient days..." And I was  
18 curious why we're including pediatric days here in the  
19 calculation. It seemed like potentially a tricky problem  
20 because some large hospitals will include pediatric -- will  
21 have pediatric units and wards inside them.  
22 Idiosyncratically, you could end up a situation where a



1 hospital, brick and mortar right next door, is pediatric  
2 and obviously wouldn't then be included. So I was curious  
3 what the thinking was there in terms of including the  
4 pediatric piece and hypothetically if it would make sense  
5 to, in fact, test the sensitivity to that or pull that out  
6 and see if the definition of Medicare share would actually  
7 meaningfully change for any hospitals.

8 DR. STENSLAND: Yeah, I see what you're saying  
9 theoretically. I think just the way the data is shown, it  
10 just lists the line as adult and pediatric days. I don't  
11 know if we're able to pull the pediatric days out. We can  
12 look at that. But it might just be a data limitation.  
13 There's only certain columns where we have data for MA and  
14 fee-for-service, and we wanted to have both MA and fee-for-  
15 service volumes in that Medicare share.

16 DR. NAVATHE: Right. Yeah, I did see that. It  
17 also includes Medicare Advantage days, which seemed very  
18 important, so I agree with you on that. And to the extent  
19 that there's a trade-off, I guess we make the trade-off  
20 that we have to make. But thanks. I think if we can look  
21 into it more, that would be helpful.

22 MS. KELLEY: Lynn?

1 MS. BARR: Thank you. Brian, Jeff, great  
2 chapter. I'm really excited about the progress in terms of  
3 identifying the underserved patients and love, you know,  
4 kind of the correlation of your Safety-net Index with  
5 closures. I have a couple of questions, though.

6 One of them is, Jeff, did I understand this  
7 correctly that when you went to the Safety-net Index, that,  
8 you know, previously it was -- you know, once they got to  
9 the threshold, everybody got about 20 percent, and with  
10 your proposal only the top -- you know, 20 percent is still  
11 the top reimbursement that you're anticipating. So is this  
12 a net savings for the trust fund that you're proposing in  
13 that graph, or did I misunderstand?

14 DR. STENSLAND: The way it was done for this  
15 illustrative example is it was all budget neutral, so we  
16 just took all the money that they currently are spending on  
17 DSH and uncompensated care and then redistributed it to  
18 everybody. So in that 20 --

19 MS. BARR: But it seemed like the limit was still  
20 20 percent, and I thought everybody got 20 percent. That  
21 was the part I couldn't figure out.

22 DR. STENSLAND: Yeah, so the limit on the

1 uncompensated care is everybody who is a DSH hospital gets  
2 basically about 21 percent of your uncompensated care costs  
3 paid for. But that's 21 percent of uncompensated care. In  
4 this, what we're talking about is an add-on to both your  
5 inpatient and outpatient payments.

6 MS. BARR: Got it.

7 DR. STENSLAND: So your inpatient and outpatient  
8 payments is a much bigger pool than your uncompensated  
9 care, so 20 percent of that becomes a much bigger number,  
10 and that's how we spend all the money.

11 MS. BARR: Got it. Do you know roughly what that  
12 number is? Because you were saying on average it was about  
13 \$2.5 million, I believe. So like when somebody's up in the  
14 95th percentile, what are we talking about there? Is that  
15 \$4 million, \$10 million?

16 DR. STENSLAND: I don't know. It's going to  
17 depend on your overall Medicare revenue, so certainly it's  
18 going to be -- you know, if you're a big hospital and you  
19 have a big share, you know, it could be, you know, 20  
20 percent of \$50 million? Or if you're a small hospital, it  
21 would be -- and you're at that upper level, it would be 20  
22 percent of your \$2 million of Medicare revenue. The people

1 that would not gain on this that are currently gaining a  
2 lot are the hospitals that don't have much Medicare  
3 business, but they maybe have uncompensated care from other  
4 kinds of business. And then we give them 20 percent of  
5 their costs on whatever their other kind of business is,  
6 even though they don't have much Medicare business. They  
7 would tend to get less money.

8 MS. BARR: Okay. So that could be concerning  
9 for, you know, our county hospitals that really have super-  
10 high Medicare shares.

11 My other question is -- well, two more questions.  
12 Brian, in the text you mentioned that if their LIS was  
13 slightly more likely to be rural, but the numbers look  
14 bigger to me than slightly, so just kind of net there. I  
15 didn't really interpret that as "slightly," so maybe we  
16 differ on what "slightly" means. But I thought it was  
17 significant. And, of course, what we really don't know is  
18 about all those patients that should be on LIS that aren't  
19 and how are they distributed. And that really -- I mean, I  
20 had no idea that half the patients basically that are  
21 eligible are not getting the LIS subsidy, and we really  
22 need to do something about that with our providers. So

1 thank you for bringing that up.

2 I don't know if you have more -- if you can kind  
3 of -- will you be able to sort of tell us more about who's  
4 not getting that subsidy?

5 MR. O'DONNELL: Yeah, I think it's going to be  
6 hard, but you're right that the LIS kind of builds a floor,  
7 but that floor has a lot of holes in it. I think we have  
8 some gut sentiment as to where there might be bigger holes  
9 than others, but I don't think we have any great data on  
10 it, to be honest.

11 MS. BARR: Awesome. Well, maybe if we did a real  
12 push to get everybody enrolled in LIS, then we could plug  
13 the holes, and that seems like a really good  
14 recommendation. I mean, right off the top, I had no idea  
15 about that. I'm like, okay, we need to get with our  
16 providers because those are our patients, you know, that  
17 probably aren't getting the LIS and aren't taking their  
18 drugs, and that's very dangerous for them. So I really  
19 want to do something about that.

20 My final comment and concern about this, I mean,  
21 I love where this is going, but my final concern about this  
22 -- and I'm sure you'll hear this from the industry -- is

1 what is going to be the effect of this on 340B. And so  
2 there's no kind of thinking about like what is the impact  
3 of 340B in these hospital closures and keeping these doors  
4 open. And the dollar amounts have grown tremendously since  
5 MedPAC last looked at the amount of 340B that's out there.  
6 And so I think it's much more substantial than it has been  
7 in the past and gets more and more so every day. And  
8 that's based on DSH percentages and things like that. So  
9 I'm worried that there's some unintended consequences of,  
10 A, not accounting for 340B in this analysis and, B, how  
11 this new metric could potentially affect 340B. And so I  
12 have no answers to that. That is just a concern and a  
13 question.

14 DR. STENSLAND: I don't think -- we haven't done  
15 any modeling on 340B, and the working assumption in all our  
16 modeling is that nothing happens to 340B. Like even if  
17 you're not distributing DSH and uncompensated care  
18 payments, you can still compute your DSH percentage and see  
19 if you would qualify for 340B. And so to keep it  
20 manageable, we haven't integrated that at all into this,  
21 assuming that it can still run independently, even if the  
22 DSH and uncompensated care payments were changed.

1 MS. BARR: Okay. Thank you. That's it for me.

2 MS. KELLEY: Paul, did you have something on this  
3 point?

4 DR. PAUL GINSBURG: Yes. On Lynn's point about  
5 the low enrollment in LIS, I can't think of a more powerful  
6 tool to promote LIS enrollment than including it in the  
7 formula, as Jeff and Brian are proposing.

8 MS. KELLEY: Larry, did you have something on  
9 this?

10 [Pause.]

11 MS. KELLEY: Larry, I'm sorry. We can't hear  
12 you.

13 DR. CASALINO: Sorry. Thanks, Dana. Just to  
14 reiterate Lynn's point, this might be Round 2, but I'll be  
15 quick. I think in the final product probably 340B does  
16 have to -- we can't just kind of ignore it. Either there  
17 should be no more 340B and it should all come out of this  
18 pool of funds that we're talking about for safety-net  
19 providers, or we have to think about consequences for 340B  
20 and how that would interact with whatever proposal we make.

21 MS. KELLEY: All right. I have Marge next.

22 MS. MARJORIE GINSBURG: My question actually

1 probably was answered with Larry's question about what is  
2 it about the components of the low-income beneficiaries  
3 that make them low income, that it's not just that the  
4 reimbursement for Medicare is lower on admission, but they  
5 get far more services, and that means additional services  
6 that cost less than what the actual cost of the service is  
7 and that sort of thing.

8           So, yes, same question, and you answered it  
9 beautifully, and so I think more information about what is  
10 it about this population that has such a financial impact  
11 on hospitals.

12           So the other part of that then has to do with the  
13 LIS folks, because I'm not sure, I couldn't tell whether  
14 staff have been able to dig deep into LIS admissions, LIS  
15 only not Medi-Medi, and the impact they have on the  
16 financial well-being of the hospital, or was it an  
17 assumption that because they are low-income, they are very  
18 likely to follow the same pattern of others who fit that  
19 criteria?

20           The other piece is that since we're looking at  
21 LIS who are not part of Medicaid, then what do we know  
22 about the cost-sharing patterns for those folks? Do they



1 simply not have Medigap plans? Is anybody filling in that  
2 20 percent, or is that what makes them a challenge for the  
3 hospitals financially?

4 So a little bit more information about what we  
5 know about the LIS admissions and, again, more information  
6 about understanding why they represent such a financial  
7 hardship for hospitals.

8 Great work, great report, and I'm really excited  
9 about it going forward.

10 MR. O'DONNELL: Yeah, and, Marge, I agree with  
11 what you said, and you could see in the report, we did  
12 disaggregate our LIS beneficiaries a little bit, and I  
13 think your instinct is right that different kind of buckets  
14 within that population will have differential effects,  
15 although in our modeling we did kind of lump them together  
16 to look at the financial impacts. In our future work for  
17 clinicians, there certainly will be differential impact  
18 depending on whether you're a full dual or a part dual or  
19 even a QMB within the part dual. So we hear you, and I  
20 think you'll see some of that going forward.

21 MS. KELLEY: Pat, I have you next.

22 MS. WANG: Thank you. Can you hear me? Okay.

1 I was wondering, on the data that is shown, for  
2 example, in Table 2 on page 16 is fee-for-service  
3 population, similar to Table 1. Do you all have access to  
4 all the Medicare population including those who are  
5 enrolled in MA plans?

6 MR. O'DONNELL: So, absolutely, we do a table  
7 that is all beneficiaries, if you'd like that.

8 MS. WANG: Yeah, I think that would be more --  
9 yeah, because MA plans are in this as well. And I may have  
10 missed it, but is there anything in here that actually has  
11 a count of hospitals that qualify, you know, currently  
12 under the DSH formula, perhaps you add on the additional  
13 hospitals who qualify as a result of the uncompensated care  
14 pool program compared to the numbers that might qualify  
15 under the SNI. And I realize it depends on where you set  
16 the levels, but just to get a sense of, like, are we  
17 expanding the number of hospitals eligible for the program?  
18 Shrinking the number of hospitals eligible? I wondered if  
19 that's feasible or if it makes sense to you.

20 DR. STENSLAND: Yeah, right now somewhat over 80  
21 percent of hospitals qualify for DSH payments, and they all  
22 -- if you're a DSH hospital, you all get that uncompensated

1 care payment, too, that flat line, it applies to everybody.

2 MS. WANG: Okay.

3 DR. STENSLAND: You know, it's actually a  
4 decision that could be made later, but when we modeled it,  
5 we had 95 percent of hospitals giving something. But if  
6 you just -- you know, if you have a very low SNI ratio,  
7 meaning you don't have a lot of low-income patients, you  
8 get a very small adjustment. But as you move up, having  
9 more and more poor folks, your adjustment goes up from, you  
10 know, half of 1 percent up to 21, 22 percent as you move up  
11 the line. So actually the SNI, the way we modeled it, has  
12 more hospitals in the pool, but the differential of how  
13 much you get grows more. So there's a greater differential  
14 in the amount of the add-on for those at the upper end  
15 versus the lower end than there was before.

16 MS. WANG: Okay. The other question that I had  
17 was just can you help me at least understand how to think  
18 about GME revenue in these equations? You know, when I  
19 look at the table, Table 5 on page 30, I guess I'm struck,  
20 if I'm reading this correctly, that the percentage of  
21 teaching hospitals in the highest DSH quartile drops pretty  
22 significantly under the SNI quartile, similar for Medicaid

1 share. I think I'm reading that correctly, Q4 being the  
2 highest quartile. Why would that be? Does it have to do  
3 with having more revenue? I don't know how to think about  
4 that.

5 DR. STENSLAND: I think it has more to do with  
6 the Medicare share and the Medicaid share. Like under the  
7 current system, Medicaid plays a big role in your DSH  
8 percentage, so if you have a lot of Medicaid patients,  
9 you're more likely to be in the high DSH quartile. But  
10 under the current system, Medicare doesn't affect you at  
11 all. So maybe a lot of Medicare patients, but then you  
12 don't do obstetrics and so you don't have a lot of Medicaid  
13 patients, you are not going to do as well under the current  
14 DSH program where you would do better under the SNI.

15 So you see in the SNI, the people in the top  
16 quartile are more likely to have more Medicare patients;  
17 actually, the teaching share there of hospitals across the  
18 four SNI quartiles is more flat, but it goes down a little  
19 at the end. And I think that's more a fact that they're  
20 not quite as Medicare dependent.

21 MS. WANG: Hmm.

22 DR. STENSLAND: And you see the opposite thing

1 happening with rural. So, you know, you have a lot of --  
2 you kind of can think of a lot of the rural hospitals,  
3 small rural hospitals, maybe they don't do so much  
4 obstetrics; maybe they have a lot of old people. So for  
5 them, putting Medicaid -- Medicare as part of the equation  
6 moves them up. And as they move up, then somebody else is  
7 going to have to go down because we're just moving  
8 everybody in the quartiles, and that would be the other  
9 folks.

10 MS. WANG: I see, okay. Last question. This has  
11 been clear throughout, and MedPAC's position on Medicare  
12 not subsidizing Medicaid is very clear and understandable.  
13 It's just a question, I guess. When you look at Table 16,  
14 for example, at least for the fee-for-service, and the  
15 difference in the proportion of beneficiaries who are full  
16 dual-eligible beneficiaries, which is an indication of  
17 Medicaid eligibility standards in the state, and then  
18 partial and LIS only, is there any concern that switching  
19 to sort of an all-LIS metric you maybe reduce the cross-  
20 subsidization of Medicaid but increase the cross-  
21 subsidization of localities that have very skinny  
22 eligibility criteria for Medicaid or perhaps have not

1 expanded Medicaid. You're subsidizing -- Medicare's  
2 subsidizing something, and I just wonder if that's  
3 something to keep in mind from a policy perspective, who it  
4 is you're subsidizing.

5 DR. STENSLAND: We can do that, and I should say  
6 just to be clear on the data, you know, we ran this without  
7 Medicaid explicitly being in the SNI formula. But what is  
8 in the SNI formula is the share of your patients that are  
9 LIS, meaning the share that -- because a lot of them that  
10 are those that qualify for Medicaid or basically when  
11 they're old. And so those hospitals that tend to have a  
12 lot of old people who are poor also tend to have a lot of  
13 young people who are poor. So there's a correlation  
14 coefficient between your Medicaid share and your LIS share  
15 is about 0.55. So we're not directly putting the Medicaid  
16 share in there, but there tends to be still some help for  
17 those places that have higher Medicaid shares because when  
18 you have a lot of poor old folks, you also tend to have a  
19 lot of poor young folks.

20 MS. WANG: That makes sense, Jeff, and thank you  
21 for that explanation. It's less about the correlation and  
22 whether Medicaid is a good metric. I guess it's just sort

1 of like something to keep in mind, that as we are  
2 determined to stop cross-subsidizing state Medicaid  
3 programs because they don't pay enough, by expanding the  
4 definition to include all LIS, which might be the right  
5 thing to do, that we are perhaps expanding our subsidy to  
6 states that are not paying anything for their low-income  
7 populations, which is it's just a different form of cross-  
8 subsidy that Medicare would be engaging in. Maybe it's the  
9 right thing to do, but I just -- it's kind of interesting.

10 MR. O'DONNELL: So can I say a little bit there?  
11 And I think we ran into a couple of these issues as we were  
12 thinking through how to define things, and I think one  
13 thing to make clear is that whether a state has expanded  
14 Medicaid under the ACA or not does not affect the R metric  
15 at all. The LIS metric that we use on page 16 or 17, it  
16 doesn't affect it. So because if you're in a state -- the  
17 expansion really applies to folks without insurance, and so  
18 what we're talking about are Medicare beneficiaries who  
19 have Medicaid as wrap-around. So that's one nugget.

20 I think the other thing to think about is that,  
21 as we expanded from full dual to all LIS, we actually  
22 weakened the correlation of state Medicaid policies,

1 because the LIS, the criteria, it creates a national floor,  
2 and this gets back to what Lynn was talking about. So we  
3 kind of went away from a purely state-based and went more  
4 towards a national floor. So still not quite a national  
5 ceiling so some states can, if they're more generous with  
6 their full or partial Medicaid benefits, some states might  
7 get a little bit higher LIS share. But I do think -- and  
8 the evidence to this is you can see when you sort states  
9 based on having really high LIS beneficiaries as a share of  
10 their population, you see states like Mississippi and West  
11 Virginia and Kentucky and even D.C. So it's really -- it's  
12 correlated with state policies for sure, but it's really  
13 strongly correlated with how many poor folks you have in  
14 your state.

15 MS. WANG: Okay. Thank you. That's very  
16 helpful.

17 MS. KELLEY: Amol, did you have something on this  
18 point?

19 DR. NAVATHE: Yeah, I think I wanted to add a  
20 comment to this point, and I think, Brian, your response  
21 actually was super helpful. But if I understand the way  
22 you're thinking about this correctly, it might be worth



1 just testing this out. The idea, to some extent, is that,  
2 sure, we're absolutely going to have correlation with  
3 Medicaid subsidization to some extent, because at the end  
4 of the day there's so much overlap between definitions of  
5 low income and what's -- the safety-net eligible  
6 populations or what have you are intrinsically overlapping  
7 with Medicaid. So it's going to be impossible to get a  
8 correlation to zero, because that's probably not what we  
9 want in the first place.

10 But the metrics that you're picking here and the  
11 way we're structuring this is trying to actually create a  
12 conceptual and pragmatic disconnect between what a state  
13 chooses to do on its Medicaid policy, so whether I increase  
14 eligibility, whether I increase or decrease payment rates,  
15 that should not affect whether hospitals in that state get  
16 paid more directly because of a result of the Medicaid  
17 policy but, rather, we're taking a national view; there is  
18 going to be positive correlation, but we're trying to  
19 remove some of the direct link, if you will, between  
20 Medicaid policy and then the payments that might be  
21 covering it through the safety net. Is that a correct way  
22 to think about sort of the conceptual basis of what we're

1 after here, Brian and Jeff?

2 MR. O'DONNELL: Yes.

3 DR. CHERNEW: Yes. I'm sorry. I'm not Brian or  
4 Jeff.

5 DR. NAVATHE: Okay. Great. Thank you.

6 MS. KELLEY: Okay. I have Dana with a Round 1  
7 question.

8 DR. SAFRAN: Yes, thank you. So just adding my  
9 appreciation for this work, it really is timely and  
10 important. I'll save any additional comments about that  
11 for Round 2.

12 But the question I have relates to the Table 1  
13 results that you have in the mailing materials, and in  
14 looking at that, the only difference that I saw from the  
15 previous definition of "full dual" to the current all-LIS  
16 beneficiary is geographic location. That's the only one  
17 that really jumped out as being a big difference between  
18 them. And, in fact, it didn't seem to be race; it didn't  
19 seem to be disability status, et cetera. I just found it  
20 sort of surprising, and I wondered what you make of that  
21 relative to the differences that you show and that you  
22 spoke to today in the presentation in terms of hospital

1 closures and, you know, inpatient days and so forth.

2 Does it really come down primarily to geography,  
3 or is Table 1 kind of missing some important variables?

4 MR. O'DONNELL: So I'll say a few things about  
5 Table 1, and then, Jeff, you can talk about closures if you  
6 want. So I think we gave you Table 1 just to give you a  
7 feel for what the population looks like. I think when  
8 you're talking about geography, you know, when you look at  
9 the folks who were not included in our full dual but they  
10 were included in the ones we moved up to the all LIS, you  
11 did see, as you mentioned, greater increases for kind of  
12 some rural states, and that could be, again, moving away  
13 from state Medicaid policies and states that are  
14 potentially more rural had kind of less generous Medicaid  
15 policies. So we picked more of them up as we went up to  
16 the LIS threshold. So that could be one explanation, but  
17 we can dig a little bit further there.

18 Jeff, do you have any thoughts?

19 DR. STENSLAND: No, I think that's it. It just  
20 kind of implies that the other -- that the people that we  
21 picked up, because we got a lot more people when moving  
22 from full dual to LIS, were just distributed relatively

1 similarly to the full dual in terms of Black, White,  
2 Hispanic, you know, disabled, nondisabled, that type of  
3 thing. And there could be some variation within the  
4 individual states, but on aggregate, it was fairly balanced  
5 with the prior distribution.

6 DR. SAFRAN: Yeah, so I guess it does then just -  
7 - it's really what's driving the power of this new  
8 modeling, is that we're overcoming state Medicaid policies  
9 that are hurting duals. That's just good to know. You  
10 know, it puts us in a somewhat different light than what I  
11 at least might have assumed we were solving for, which was  
12 more, you know, beneficiary characteristics, not the  
13 characteristics of the states or markets in which they  
14 live.

15 DR. STENSLAND: I think it does go back to kind  
16 of what Amol said and what Mike commented on in that it is  
17 now less connected to the states' decisions regarding  
18 Medicaid policy than it was before, and we are moving,  
19 trying to not have it as connected to that.

20 DR. CHERNEW: And I know, Larry, you want to say  
21 something in a minute, but there are other things, the  
22 continuousness of it, for example, and those types of

1 things that I think are also important. So I'm not sure --  
2 I would have said we are trying to solve -- and, again,  
3 I'll defer to you, Jeff and Brian -- somewhat of a  
4 targeting improvement kind of strategy, and I think it's  
5 clear if you look at some of the data that this is -- I'm  
6 sure folks can do better. We're going to have a whole  
7 Round 2 for you to tell us how. But I think this is a  
8 reasonable way to have a somewhat simple, better targeted  
9 approach. And I just will emphasize -- and I say this  
10 before we get into Round 2 -- we aren't even at the policy  
11 option stage of our work now. We are sort of presenting an  
12 idea, and what is going to come out of this is sort of a  
13 sense of how you feel big picture about pursuing and  
14 refining it and your concerns and not much have been  
15 raised. So we are well before the end of all of this work.  
16 There are some principles that people seem okay with, and  
17 that's nice to hear, and I think several people have made  
18 comments and have used the words "tweaks," "quibbles,"  
19 "considerations," all of which are great. But I think our  
20 basic goal is to kind of have a targeted -- a better  
21 targeted approach that's less sensitive to some of the  
22 things we've wanted to be less sensitive to.

1           If Jeff or Brian disagrees with that summary, you  
2 should let me know. But hopefully that's my response to  
3 Dana.

4           Okay. So we have about 50 minutes left for Round  
5 2. I think Dana was the last one -- oh, I'm sorry. Larry  
6 had something on this point. Larry? Then we'll go to  
7 Round 2.

8           DR. CASALINO: Very quickly for Jeff and Brian.  
9 The point that -- in the LIS beneficiaries in the narrow  
10 LIS sense, the ones we include just because they have LIS  
11 and not other things, Amol and Dana have both stated very  
12 clearly that this reduces the effect of the state variation  
13 in Medicaid policies. Was it a strategic decision not to  
14 really emphasize that or it just didn't happen? Because it  
15 does seem like -- although it certainly will be a  
16 controversial point, it's pretty basic to trying to  
17 understand the implications of what you guys have come up  
18 with.

19           MR. O'DONNELL: Yeah, I don't think there's any  
20 qualms on our end of emphasizing it a little bit more than  
21 we did.

22           DR. CASALINO: It might be good to provide a very

1 clear list of the advantages -- you do this to some extent,  
2 I think -- of this proposal, so to speak, and that would be  
3 a prominent one, I think.

4 MS. KELLEY: Lynn, did you want to add something  
5 here?

6 MS. BARR: Yeah, I just had one final Round 1  
7 question for you, Brian and Jeff. Since, you know, adding  
8 the LIS, it really made this so much more powerful. Were  
9 there other metrics that you looked at adding that you  
10 discarded? Or is there any way to -- you know, we're still  
11 only talking about a subset of the patients that we're  
12 trying to identify, right? And so are there other things  
13 that you've considered adding onto this to further define?  
14 Have you discarded other things or can you talk a little  
15 bit more about that?

16 So, for example, you said, okay, we're not going  
17 to look at location. But if you added location, did that  
18 improve or did it worsen the results?

19 MR. O'DONNELL: Jeff, you can talk about we  
20 modeled the ADI, which we included and then excluded. Do  
21 you want to mention any other ones, Jeff?

22 DR. STENSLAND: We also looked at Medicaid share.

1 So in the appendix, we were trying to say, well, if we  
2 added some more variables, could we do any better job of  
3 predicting margins or predicting closures and adding the  
4 Area Deprivation Index, which is basically kind of the  
5 characteristics of people living in that zip code, how  
6 crowded is the neighborhood, [inaudible.] That didn't  
7 really add explanatory power beyond what we were already  
8 getting just looking at the actual patient characteristics.  
9 And, surprisingly, the Medicaid share didn't really add any  
10 explanatory power to the model either.

11           The third thing we looked at just because some  
12 Commissioners had suggested it was the difference in the  
13 LIS from the state average, and that didn't seem to add  
14 anything either.

15           So when we looked through the explanatory models,  
16 those weren't adding a lot into the explanation of how much  
17 financial struggle a hospital would have; whereas, the  
18 other variables that were left in there, certainly the LIS  
19 share had a fairly big explanatory power, and the Medicare  
20 share also had some explanatory power, as did the share of  
21 revenue spent on uncompensated care.

22           MS. BARR: But you made some comments about how



1 rurality wasn't important, you know, as a -- so could you  
2 do that analysis as well and say, yeah, we added rurality  
3 and it didn't matter? Because as I've said before, the  
4 ADI, although, you know, we do have lower ADI scores -- or  
5 higher ADI scores in our rural areas, it's more of an urban  
6 metric. And so I just -- and given the issues we have with  
7 rural, I think it would be important to either rule it in  
8 or rule it out as being helpful specifically.

9 DR. STENSLAND: We can look at that.

10 MS. BARR: Thank you. That's my last point.

11 DR. CHERNEW: Okay. Well, I don't know if that's  
12 true, Lynn. My guess is you're going to be in the queue  
13 for Round 2, so that's your last Round 1, which is fine, by  
14 the way. I'm looking forward to Round 2.

15 So we are going to get into Round 2, and if I  
16 have this right, Stacie, you are number one in Round 2.  
17 And then I'm going to leave it to Dana to manage the rest  
18 of the queue.

19 DR. DUSETZINA: Great, thanks. Jeff and Brian,  
20 this is excellent work, and I really appreciate the  
21 chapter. I am very enthusiastic for these questions about  
22 should we keep going? Absolutely, yes. I think that the

1 history that you put in the chapter about how we got the  
2 measures we currently have and how, you know, a lot of  
3 those decisions were based on a lack of data and now we  
4 have that information, yes, we should let our policies  
5 evolve to match what we actually want to measure and not,  
6 you know, these very poor proxies. So kudos to the  
7 excellent chapter.

8           Some of my questions actually got resolved to  
9 some extent with the conversations around Medicaid  
10 expansion and the extent to which that doesn't factor into  
11 your formulas. But I agree with what has been said, that  
12 that should be really explicit, and I think trying to tease  
13 apart the extent to which -- you know, Medicaid expansion  
14 actually changed the DSH formula for a lot of states, and  
15 so I think you could build in the history of how the  
16 Medicaid expansion modified DSH and maybe also isn't what  
17 we wanted specifically for the Medicare beneficiaries and  
18 their payments.

19           I think it is important to maybe try to tease out  
20 what that means for uncompensated care because, obviously,  
21 the nonexpansion states still have a higher burden of  
22 uncompensated care because of decisions of not expanding.

1 But that's not necessarily for Medicare beneficiaries. But  
2 I think it's important to tease out those pieces, and I  
3 think on the other side of that, the states that have  
4 chosen to offer much more generous thresholds for who  
5 qualifies, you know, I think that that seems like something  
6 that we would not want to discourage states from doing,  
7 because it provides, you know, more beneficiaries with  
8 coverage. But I think that that's kind of the other side  
9 of the coin of, you know, the nonexpansion states versus  
10 states that have expanded and also have much more generous  
11 income thresholds for who qualifies.

12           So teasing those pieces out would be, I think,  
13 incredibly helpful for this work moving forward and being  
14 really explicit about what these changes might mean for  
15 states that have more or less generous thresholds. But I  
16 am a very enthusiastic yes on pursuing this work. I think  
17 you all have done an excellent job getting this started,  
18 and I'm really glad to see how it's evolved so far.

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

20           MR. PYENSON: I want to echo Stacie's compliments  
21 for this work and other Commissioners' compliments. As I  
22 was going through the material, I was asking the decades-

1 old question of how can we assign profits to a nonprofit,  
2 largely nonprofit sector? And, of course, I understand  
3 that that's a technical term and you're using it  
4 consistently with how many others use that term.

5           But across my desk in recent months has been a  
6 flood of literature about how the other side of the  
7 nonprofit sector -- not the safety-net hospitals, but the  
8 hospitals that have -- the nonprofits that are generating  
9 enormous profits and are not making the charitable  
10 contributions that they were thought to or ought to be  
11 making. And as an out-of-the-box suggestion, in addition  
12 to the options that you have here, which I think are  
13 excellent, I would suggest that, rather than Medicare  
14 funding the safety-net hospitals and ensuring their  
15 stability, that we look to the charitable obligations of  
16 the hospitals that are not safety-net hospitals and create  
17 funding or a pooling mechanism that will use those funds to  
18 meet their obligations and help the safety-net hospitals as  
19 a result.

20           I have been an advocate on MedPAC of looking at  
21 things on a community basis, crossing ACOs and Medicare  
22 Advantage plans, regional bases and obligation to public

1 health, because I think the evidence is that if any  
2 elements of our society are left out, we all do worse. And  
3 I wouldn't automatically say this is not a role for  
4 Medicare. Maybe it's not, but I think it's worth  
5 investigating, because there's -- this is a very hot issue  
6 that's probably not going to go away, and there's really  
7 two sides to the community. There's the safety net and  
8 then there's others.

9           Just my suggestion to add that as a possible  
10 solution. Thank you.

11           MS. KELLEY: Amol?

12           DR. NAVATHE: Thank you. I also echo a lot of  
13 the comments of support for this work, incredibly important  
14 and I'm probably going to be a little bit less provocative  
15 than the prior comments.

16           So a couple things. One, I largely want to echo  
17 and articulate support for a few different things that  
18 other Commissioners have said and also for the work,  
19 generally speaking.

20           I think first this notion of outlining the  
21 principles up front, I think Larry had mentioned it, Stacie  
22 had mentioned it as well. I think that would be a great

1 idea. It would help to clarify why we're going to need  
2 additional efforts, if you will, to define the SNI, and,  
3 therefore, when we go through this effort, what the  
4 principles are that are guiding us.

5           A second point is I think it's a little bit --  
6 "confusing" may not be the right word, but on page 17 of  
7 the reading materials, for example, Brian and Jeff, there  
8 is a discussion about the variability at the state level  
9 and the fact that switching to LIS gives us a reduction in  
10 state variability, state-by-state variability, but then you  
11 point out that doesn't eliminate it. And I think we want  
12 to be careful in outlining explicitly that there are two  
13 types of state-by-state variability that we care about.

14           There's state-by-state variability that is driven  
15 by state-by-state Medicaid policy differences. Those are  
16 the types of definitions that we don't want for defining  
17 our population of interest.

18           There's natural variability, if you will, that's  
19 going to exist based on the other types of factors that you  
20 mentioned, such as income level of the population, for  
21 example, or other policies.

22           So I think we should make the point explicitly

1 that we are trying to remove the state-by-state variation  
2 that had been removed and that the residual state-by-state  
3 variation is, if you will, acceptable because it's not  
4 seemingly related to the underlying policy question that we  
5 as MedPAC are trying to address.

6           Along those lines, I wanted to just very clearly  
7 state support for the Safety-net Index. I think the way  
8 that it's been constructed, the tables and the associations  
9 and relationships that you described I think are very  
10 sensible and they support a sensible policy for supporting  
11 the safety net.

12           I also, alongside that, wanted to articulate  
13 support for this idea of designing the payment policy here  
14 for supporting safety-net institutions that it is one that  
15 is kind of pro-access. So the idea of having the  
16 percentage add-on to every beneficiary who meets this  
17 definition, who's cared for by an institution, by linking  
18 the payments to a metric like that that is promoting access  
19 for these groups I think is a fundamentally important piece  
20 and, in fact, if we could pull that forward into the  
21 principles or the objectives of the policy redesign, I  
22 think that would actually be really helpful.

1 Thank you.

2 MS. KELLEY: Lynn?

3 MS. BARR: So, again, thank you, guys, and really  
4 great work. I look forward to seeing how rurality might  
5 affect the index in the future.

6 But the comment that Amol brought up is actually  
7 kind of one concern I had about the paper was if we -- so  
8 we're only talking about a small subset -- we're only  
9 identifying a small subset of the underserved, right? And  
10 so we're still like maybe at 20 percent, so we don't have  
11 everybody in there. And so if we do an add-on payment for  
12 that group of patients, well, we're not doing that on  
13 payment for the other 80 percent. And I'm not sure that  
14 that's going to create any equity. However, something that  
15 incentivizes providers to -- patients for the LIS I think  
16 is critical, so -- but I worry about one of the  
17 recommendations of trying to compensation, you know, to pay  
18 more for these types of patients when we're only  
19 identifying a small percentage of them, and just think it  
20 would have to get to, you know -- I mean, I realize there's  
21 no way we can just get income on all patients from Social  
22 Security and, you know, or affirm the IRS and then, you



1 know -- and then use that as a way of identifying patients.  
2 But maybe there's some way that we should start thinking  
3 about connecting social services to Medicare so that we can  
4 actually really understand who are the underserved so that  
5 we can better serve them.

6 Thank you.

7 MS. KELLEY: Brian?

8 DR. DeBUSK: First of all, I'd like to echo  
9 previous Commissioner comments. I think this is fantastic  
10 work. I think it's very important work. You find yourself  
11 reading these chapters critically, you know, looking for  
12 what's wrong, and, you know, this chapter was a real page-  
13 turner. I mean, the more you read, the more you liked it.  
14 So, again, congratulations on good -- great work.

15 I'm really intrigued by this move from the full  
16 eligibles to the LIS beneficiaries, and as I was reading  
17 the chapter, I wondered if we should also consider that for  
18 some of our peer grouping mechanisms, because, again, I  
19 think, as others have said, there's some real novelty and  
20 utility in using this broader measure.

21 The other thing I was going to mention, I really  
22 like this 1:1 to 0.5 ratio that you used for the SNI. I

1 think it's really clever because it does balance LIS and  
2 uncompensated -- you know, it sidesteps the issue of state  
3 Medicaid expansion. But I also like that 50 percent that  
4 you're adding for Medicare because I think it really  
5 reflects the changing nature of Medicare margins. There  
6 was a time that Medicare was the good business for the  
7 hospital. And I think blending that 50 percent metric in,  
8 the other thing -- the thing I really like about this  
9 measure is you can titrate that up if Medicare margins were  
10 to continue to sink. I think you could even titrate that  
11 up to increase the intensity of the SNI based on just sheer  
12 Medicare performance.

13           The other thing I wanted to mention, I really  
14 like the gradual payment. I think that's a really nice  
15 mechanism. You know, again, this is not a situation where  
16 we would want to use a cliff to influence anyone's  
17 behavior. So this proportional payment I think is great.  
18 I think spreading it over the inpatient and outpatient  
19 procedures as well is really good policy.

20           So, again, there's a lot to like here, and I want  
21 to congratulate the authors, Jeff and Brian, on some really  
22 nice work.

1 MS. KELLEY: David?

2 DR. GRABOWSKI: Great. Thanks, Dana. I'll be  
3 brief. Brian, Jeff, great work. Just let me echo everyone  
4 else. I'm really excited we're pursuing this line of work.

5 I've been one of the Commissioners that's  
6 discussed this variability in Medicaid eligibility and  
7 issues that could raise here, so using the LIS is a very  
8 elegant solution, so kudos. This is just tremendous. I  
9 think it's -- I really like the way this is headed.

10 Similar to Brian, that's a great application,  
11 Brian, of using this for the peer groupings as well. I  
12 think this is a really nice solution because the same sets  
13 of problems with the variability in Medicaid come up there  
14 as well.

15 Finally, I think smoothing this out and  
16 eliminating the cliffs there, I thought that was also a  
17 nice innovation.

18 So, overall, great work, and I'm excited to see  
19 where we go with this. Thanks.

20 MS. KELLEY: Paul.

21 DR. PAUL GINSBURG: Yes, I need to say that the  
22 work is superb and I'm really pleased with it. This is one

1 of these areas where Medicare has made a policy decades ago  
2 and has not returned to it even as things were changing.  
3 And so, you know, I think this is one of the areas the  
4 Commission is particularly valuable for, is to identify  
5 areas like this, where the policy was made so long ago and  
6 things have changed.

7           So I very much support defining eligibility for  
8 these additional payments on the basis of patients rather  
9 than on areas because we all know how so many prominent,  
10 wealthy hospitals are located in areas with very low  
11 income, usually it's downtown or close to a downtown.

12           I think the SNI is really good and, you know, I'm  
13 really glad Lynn pointed out this thing about encouraging  
14 LIS. Another virtue -- I mean encouraging LIS enrollment.  
15 Another virtue of it is that since you're including  
16 outpatient care as well as inpatient care, it means that  
17 hospitals will get many opportunities to enroll or  
18 encourage patients to enroll in LIS because it will touch  
19 so many more patients in the outpatient department than the  
20 inpatient departments.

21           And so I think that covers what I had to say.

22           MS. KELLEY: Jaewon?

1 DR. RYU: Yes, so I'll pile on a little bit as  
2 well. I also like the approach of focusing on who folks  
3 are treating versus where they happen to be, Paul's point.  
4 I thought the chapter does a good job illustrating some  
5 examples of why the focus on the where doesn't quite make  
6 sense.

7 I also have to say I really like the SNI LIS  
8 approach, and something that I had not thought about was  
9 Lynn's point. I think the chapter mentioned that, and it's  
10 sort of -- a nice tangential benefit is creating better  
11 enrollment of folks who may be eligible for LIS. I think  
12 that's something that continues to be a challenge for any  
13 kinds of programs along those lines. So I thought that was  
14 a nice win as well.

15 I also like how the framework of the step-by-step  
16 was laid out. I thought that was very clear in terms of  
17 setting forth the criteria to even determine whether action  
18 is necessary.

19 And then two additional points that I just wanted  
20 to touch on. One is, I think it's on Slide 22, where  
21 there's the risk of closure as a measure of obviously  
22 concerns around access. I actually think, if possible, it

1 would be nice to have something that reflects maybe an  
2 endpoint that's not quite that extreme but suggests that  
3 there is distress. I think Bruce's comment earlier, some  
4 other measure of distress. And when I think about what  
5 that might look like, you know, I think hospitals, before  
6 they get to actual closure, there's a deterioration of  
7 services. There's deterioration of clinical programs. And  
8 to the extent you measured something like -- maybe it's  
9 transfers out of the hospital because they don't have  
10 certain services available. I just think looking at a  
11 measure like that might be helpful, because I think at that  
12 point you probably already have problems at that hospital.  
13 And I would say that is already down the road of distress.  
14 So I'd encourage us to explore that.

15           And then the last point I'll make is Larry's  
16 earlier point on cost and just a clarification between, you  
17 know, why are these folks not as profitable, hospitals, and  
18 downright unprofitable. I do think fleshing that out, I  
19 would totally agree that that would be beneficial. And I  
20 think it does get to a lot of what folks were chatting  
21 about. You know, it does carry additional cost to invest  
22 in whether it's social workers, discharge coordination,

1 financial counselors, of course, greater costs to collect  
2 on whatever applicable co-pays exist. I think those or  
3 some mention of that in the chapter would be beneficial.

4 MS. KELLEY: Dana.

5 DR. SAFRAN: Thank you. I will be very brief and  
6 pile on my enthusiasm for this particular piece of work and  
7 for pursuing this area. You know, it is incredibly timely  
8 to be focused on how to invest in health equity, and, you  
9 know, I think this past week, having seen the CMS  
10 announcement about the ACO REACH program and the adjustment  
11 there of benchmarks related to social risk factors, this  
12 feels to me very in line and synergistic with that. I'm  
13 excited about the work.

14 I do think the point that was raised in the last  
15 round about the fact that what seems to be driving the  
16 difference here in the pickup of beneficiaries has more to  
17 do with where they live than their individual  
18 characteristics, and to that end probably the Medicaid  
19 policies in the states they live does just give some pause  
20 about that. But, you know, I think that -- I forget who  
21 made the point, but I agree with it, after I made my  
22 comment -- maybe it was you, Larry -- that it's worth

1 calling out in the chapter that, you know, doing this  
2 overcomes some of -- I guess we won't use the word  
3 "stinginess," but stinginess of certain state Medicaid  
4 programs to be able to ensure adequate payment to providers  
5 caring for these beneficiaries. It's something worth  
6 emphasizing.

7           So I really appreciate the work and the  
8 opportunity to have this discussion. Thanks.

9           DR. CHERNEW: Great. So Dana was last in queue.  
10 As is my normal, I'm going to pause for a second to see if  
11 maybe Brian and Jeff want to add something. I have a brief  
12 summary.

13           [Pause.]

14           DR. CHERNEW: Okay, so --

15           DR. CASALINO: I do have one comment if we have  
16 time.

17           DR. CHERNEW: We do, Larry.

18           DR. CASALINO: One of Brian and Jeff's questions  
19 was deciding whether new Medicare funding is warranted, and  
20 I'm not suggesting we necessarily get into a full-scale  
21 discussion, but we haven't really mentioned it at all.  
22 Looking at the tables, you know, it looks like this would



1 provide a bit more funding for hospitals that are, let's  
2 just say, hardest hit in terms of their share of  
3 disadvantaged patients. But the differences aren't huge in  
4 terms of the -- it looks like the absolute increase in --  
5 or the in the absolute difference in margins as a function  
6 of the [inaudible.]

7           Going forward, I think we do need to explicitly  
8 consider whether just reallocating existing funding is  
9 enough or whether there does need to be additional funding,  
10 because if I understood the tables correctly, it's hard to  
11 believe that going from, you know, minus 1 percent to plus  
12 1 percent or plus 2 percent in margin -- I mean, I  
13 understand hospitals operate, a lot of them, on a thin  
14 margin, so that's not like trivial. But is it enough?  
15 There are probably other Commissioners who are better  
16 equipped to speak to that than I am.

17           DR. MATHEWS: I'm happy to jump in here if I  
18 could. Larry, that is indeed the conversation to be had.  
19 What we were looking for here is just general reaction to  
20 the framework that we've established, general buy-in to the  
21 basic concept as we start rolling it out into other  
22 sectors. But you are absolutely correct. The next

1 question, as we continue to advance this work, will be in  
2 each of the sectors, does this framework end up with a need  
3 for additional Medicare dollars. So that won't happen this  
4 cycle, but I would anticipate that we'll start taking that  
5 question on explicitly as early as the fall of next cycle.

6 DR. CASALINO: You mean that there will be an  
7 analysis that will be presented to the Commissioners along  
8 those lines, or just that the Commissioners will discuss  
9 it?

10 DR. MATHEWS: No, I'm going to commit Jeff and  
11 Brian to some work here, so maybe some blowback offline.  
12 But, yes, we will do analytic work that would start to  
13 evaluate the impacts at different categories of hospitals  
14 and our usual block and tackle of that kind of financial  
15 analysis.

16 DR. CHERNEW: So let me just say one other thing.  
17 I am going to wrap up in a second. There's also this issue  
18 of how much we continue down the work on hospitals, which  
19 you're absolutely going to do, and when and how we expand  
20 to other sectors. So there's this trade-off with our sort  
21 of capacity to go through this, but we are -- well, I'm  
22 going to blend this into my wrap-up.

1           I was very happy with the way this chapter was  
2 structured and where it ended up when I saw it in the  
3 mailing materials, and I'm thrilled with the conversation  
4 that we just had, both because it was very constructive  
5 and, broadly speaking, very supportive of where we're  
6 going, which I was hoping it was where we would be. So I'm  
7 happy about all that.

8           I have about half a page of notes that I won't  
9 run through. That's probably about a third of the notes  
10 that Jim and the staff have, so we are going to regroup.

11           I will just emphasize one point. An enormous  
12 amount of discussion focused on the role of LIS and why  
13 that was helpful, and I agree, that's why it's there.  
14 Understand there's other pieces of the formula, things like  
15 the Medicare share which capture broad payer-mix issues  
16 that end up also being important. And so part of what  
17 we're struggling with -- and this came up in the concept of  
18 materially profitable and how we deal with that -- is we're  
19 also sort of supporting organizations that, for lack of a  
20 better word -- I don't know how to say this -- have less  
21 favorable case mixes, writ large. And that's not simply  
22 serving a lot of LIS patients. There's other aspects of

1 case mix given the big differences in commercial and  
2 noncommercial payment rates. And the Safety-net Index  
3 seems to do a pretty good job of blending those types of  
4 concept.

5           So while I hear the points about presentation and  
6 what problems we're trying to solve and the principles, all  
7 of which I think are well taken, and a few of the other  
8 things, I did want to emphasize that there were more things  
9 there than simply the LIS part or the interaction with  
10 Medicaid or the things we were talking about there.

11           So, in summary, I really am happy for the words  
12 of support from all of you. We have a lot of regrouping.  
13 As I think I said at the beginning, we were only at the  
14 beginning, and so this is going to be a multi-cycle thing,  
15 not just for hospitals but as we move it out to other  
16 sectors. We have to think about complicated issues like  
17 how this interacts with the updates, for example. No one  
18 asked that. Thank you very much.

19           And so we have a lot to do, but the safety net  
20 and the issues that are addressed in this chapter are  
21 really important, and so we're going to keep doing this  
22 work.

1           So, with that said, it's 3:25. We're a bit ahead  
2 of schedule. I think I'm going to call for about a ten-  
3 minute break. If we could come back at 3:35, please don't  
4 be late because we're just going to pick up at 3:35. You  
5 don't have to log off. You can just mute and turn off your  
6 camera. I'm going to come back at 3:34, and we're just  
7 going to jump into another really important topic about the  
8 geriatric workforce.

9           So, again, let's take a ten-minute break. I  
10 could use one, and we'll see you all at 3:35.

11           [Recess.]

12           DR. CHERNEW: Okay. Welcome back, everybody.  
13 We're going to talk about a really important project,  
14 strengthening the geriatric workforce, and I am turning it  
15 over to Jamila, who is going to lead us through this.  
16 Jamila, you're up.

17           DR. TORAIN: Thank you, Mike.

18           Today we will be talking about our analysis of  
19 the geriatric workforce and potential opportunities to  
20 strengthen it, but first, we would like to thank Rachel  
21 Burton, Lauren Stubbs, and Alison Binkowski for their help  
22 with this work.

1           At the November 2019 meeting, we presented  
2 results from our research on increasing the pipeline of  
3 primary care physicians, including geriatricians. At that  
4 meeting, Commissioners asked us for more information on the  
5 role of geriatricians in Medicare. Since then,  
6 Commissioners have also asked us to examine the health care  
7 workforce more broadly. This is the first stage of our  
8 work on the workforce, which we plan to pursue during the  
9 next cycle. The material we are presenting today will be  
10 included in the upcoming June report.

11           Today I'll start by providing some background  
12 information. Next, I'll talk about the role of  
13 geriatricians in the health care system. We examined the  
14 number of these clinicians who specialize in treating  
15 geriatric patients, their training, factors that influence  
16 medical students and residents to choose geriatrics,  
17 geriatricians' practice patterns, and evidence of the  
18 impact of geriatricians on outcomes and costs.

19           I'll also talk about the role of nurse  
20 practitioners and physician assistants in treating elderly  
21 patients.

22           Then Ariel will describe three policy options to

1 strengthen the geriatric workforce.

2           As the baby-boom generation continues to age into  
3 the Medicare program, Medicare will have an increasing need  
4 for a variety of clinicians with expertise in caring for  
5 elderly patients with complex conditions. To learn more  
6 about the workforce of geriatricians and other clinicians  
7 who treat elderly patients, we analyzed Medicare claims  
8 data, reviewed the literature, and conducted 11 interviews  
9 with experts in geriatrics between 2019 and 2022.

10           Some of the interviewees were nurse  
11 practitioners. Most were physicians who research the  
12 geriatric workforce, run geriatric fellowship programs, or  
13 lead provider organizations and professional associations.

14           The number of geriatricians in the U.S. has never  
15 been large and has been shrinking in recent years. Since  
16 1996, the number of geriatricians has declined from about  
17 9,000 to about 7,000 in 2020. Meanwhile, the Medicare  
18 population grew from 38 million to 63 million during the  
19 same time period.

20           After their internal medicine or family medicine  
21 residency, physicians must complete a one-to-two-year  
22 fellowship in order to specialize in geriatrics.

1           As described in the paper, there are three  
2 federal programs of modest size that aim to expand and  
3 enhance the workforce of health care professionals who  
4 focus on geriatrics.

5           However, academic medical programs still struggle  
6 to fill the small number of geriatric fellowship positions  
7 they offer, with only about half of positions filled each  
8 year.

9           After reviewing the literature and conducting  
10 interviews with experts in the field, we found several  
11 factors that influence physicians to pursue or avoid a  
12 career in geriatrics. The main factors that motivate  
13 medical students and residents to pursue geriatrics include  
14 a desire to fill society's need for more physicians to care  
15 for the elderly, an interest in focusing on the entire  
16 patient instead of organ systems, the intellectual  
17 challenge of treating older adults,  
18 and because of the influence of having a strong connection  
19 with an older adult in their youth, such as a grandparent.

20           On the other hand, some of the reasons why  
21 medical students are not interested in geriatrics include  
22 minimal exposure to geriatrics during clerkships, feeling



1 overwhelmed by the complexity of older adults, the time it  
2 takes to assess and manage geriatric patients, and  
3 geriatricians have lower compensation than other  
4 specialties, which leads us to our next slide.

5           Geriatricians are one of the lowest-paid  
6 specialties. Their annual compensation is lower than that  
7 of other primary care physicians. In 2020, the median  
8 compensation for geriatricians was \$232,000, compared with  
9 \$250,000 for other primary care physicians and \$348,000 for  
10 specialists. The reasons for these disparities are  
11 described in the paper.

12           We learned from interviewees that geriatricians  
13 often wear multiple hats. They provide direct patient care  
14 and consult on other clinicians' patients, train future  
15 geriatricians, conduct research, and take on leadership  
16 roles in organizations and health plans. For example,  
17 geriatricians set up geriatric fellowship programs, launch  
18 hospital units for elderly patients, and serve as chief  
19 medical officers of nursing homes.

20           Consistent with findings from our interviews, our  
21 analysis of Medicare claims data from 2019 highlights that  
22 compared with other primary care physicians, geriatricians

1 were more likely to practice in nursing facilities and less  
2 likely to practice in offices. They are also more likely  
3 to provide care to Medicare beneficiaries who were older,  
4 had more chronic conditions, and were more likely to be  
5 institutionalized.

6           For example, 30 percent of beneficiaries treated  
7 by geriatricians had Alzheimer's disease or dementia,  
8 compared with 12 percent of those treated by other primary  
9 care physicians.

10           We also reviewed the literature on the impact of  
11 geriatricians on health outcomes and health care costs.  
12 There is limited evidence describing the impact of  
13 geriatricians when they deliver primary care, and the  
14 evidence is mixed. There are more studies describing the  
15 impact when geriatricians consult on patient care. Most of  
16 them show that care is associated with improved health  
17 outcomes. For example, geriatricians were associated with  
18 decreased length of stay in the hospital, fewer emergency  
19 department visits, lower in-hospital mortality, and lower  
20 risk of acute care hospitalization.

21           In terms of health care costs, there is limited  
22 research that examines whether care provided by

1 geriatricians directly affects health care costs. However,  
2 several studies look at the indirect impact on costs.  
3 These studies find that care from geriatricians indirectly  
4 reduces costs due to less prescribing of medications  
5 considered inappropriate for older adults and fewer adverse  
6 drug reactions.

7           In addition to geriatricians, some nurse  
8 practitioners and physician assistants focus on geriatric  
9 care. The overall number of NPs and PAs has been growing  
10 rapidly. But, according to a survey from 2020, only 3.5  
11 percent of NPs said that geriatrics is their main clinical  
12 focus area. Similarly, only 0.8 percent of PAs reported  
13 that geriatrics was their principal area of practice in  
14 2018.

15           According to these studies, median income for NPs  
16 and PAs who focus on geriatrics was about the same as  
17 median income for other NPs and PAs.

18           Now I will turn things over to Ariel.

19           MR. WINTER: I am going to take a moment to  
20 restate the problem and set the stage for some policy  
21 options.

22           The elderly population in Medicare is growing,

1 and we need a health care workforce to care for them. As  
2 we've discussed, geriatricians focus on providing care to  
3 older patients with complex conditions, but there have  
4 never been very many geriatricians, and their numbers are  
5 declining.

6           We've developed some ideas to address this issue.  
7 The first is to improve payment accuracy for a key service  
8 provided mainly by geriatricians.

9           The second option acknowledges that we're  
10 unlikely to ever have enough geriatricians and is,  
11 therefore, aimed at increasing the number of nurse  
12 practitioners and physician assistants who focus on  
13 geriatrics.

14           The third option would ensure that all physicians  
15 have at least some training in geriatrics.

16           The first policy option is for CMS to improve  
17 payment accuracy by establishing a new billing code for a  
18 service called "comprehensive geriatric assessment," or  
19 CGA. In this service, a multidisciplinary team provides a  
20 comprehensive evaluation of an elderly patient's physical,  
21 psychological, and functional capabilities and develops a  
22 treatment plan.

1           The team usually includes a physician, a nurse, a  
2 social worker, and other health professionals such as  
3 physical and occupational therapists and psychologists.

4           The assessment often focuses on geriatric  
5 syndromes, such as cognitive impairment and trouble  
6 balancing. It can occur in a variety of settings, such as  
7 hospitals, nursing homes, and ambulatory settings.

8           Empirical studies have found that CGA improves  
9 health outcomes, such as quality of life, cognition, the  
10 ability to live at home, and functional status.

11           Medicare's physician fee schedule does not  
12 currently have a billing code for comprehensive geriatric  
13 assessment. As a result, geriatricians use other codes to  
14 bill for CGA, such as a Level 4 or 5 E&M office visit, but  
15 geriatricians claimed that these other codes don't account  
16 for the time and resources involved in providing CGA.

17           CMS could create a new code for CGA and set an  
18 accurate price for it, which it has done for other  
19 services, such as chronic care management. When CMS  
20 creates a new code, this process is budget neutral.  
21 Although geriatricians would probably bill for this code,  
22 other clinicians could also bill for it; for example, NPs,

1 PAs, and family physicians. Creating a new code for CGA  
2 should improve payment accuracy and increase total payments  
3 to geriatricians, but it's unlikely to significantly expand  
4 the supply of geriatricians.

5           The second option is to establish a scholarship  
6 or loan repayment program for clinicians, including NPs and  
7 PAs, who focus on geriatrics in clinical practice. There  
8 are some existing scholarship and loan repayment programs,  
9 but they are not targeted to clinicians who provide  
10 geriatric care.

11           In our June 2019 report, we discussed creating a  
12 new program for primary care physicians, in particular,  
13 geriatricians, but there was skepticism from some  
14 Commissioners and some geriatricians that it would attract  
15 more physicians to geriatrics because of the large income  
16 gap between geriatrics and other specialties. But such a  
17 program could be more attractive to NPs and PAs than to  
18 physicians because compensation for NPs and PAs who focus  
19 on geriatrics is about the same as compensation for other  
20 NPs and PAs.

21           Here are some design questions to think about.  
22 First, how should the program verify that clinicians are

1 practicing in geriatrics? One option is to require that  
2 clinicians receive professional certification in  
3 geriatrics, although there is currently no certification  
4 program for PAs. In addition, the program could require  
5 that clinicians treat a minimum number of elderly patients  
6 each year.

7           Second, should the program provide scholarships  
8 to clinicians when they enter a graduate program, such as  
9 medical school, or provide loan repayment to clinicians  
10 after they complete their training or offer both options?

11           Third, how many years would clinicians need to  
12 provide geriatric care to qualify for a scholarship or loan  
13 repayment? This could vary based on the amount of the  
14 subsidy that a clinician receives.

15           The third option is to require teaching hospitals  
16 that receive graduate medical education payments from  
17 Medicare to provide training in geriatrics to their  
18 residents.

19           Several of the geriatricians we interviewed  
20 recommended that all Medicare-funded residents be required  
21 to have at least some geriatric training. Because Medicare  
22 subsidizes GME and most beneficiaries are elderly, Medicare

1 has a stake in making sure that physicians are trained to  
2 address the needs of older patients. Under this option,  
3 teaching hospitals that receive direct GME or indirect  
4 medical education payments from Medicare would be required  
5 to provide a minimum amount of residency training in  
6 geriatrics.

7           This should include locations outside of an  
8 inpatient hospital setting because elderly patients also  
9 receive care in other settings, such as nursing homes and  
10 ambulatory clinics.

11 This option would not increase overall Medicare spending on  
12 GME.

13           Here are some key design questions. First, how  
14 should Medicare define geriatrics training? For example,  
15 would clinical rotations in geriatrics need to be  
16 supervised by geriatricians? In addition to clinical  
17 rotations, should there be a formal curriculum, such as  
18 lectures?

19           Second, what is the minimum amount of geriatric  
20 training that should be required? For example, how many  
21 hours or weeks?

22           Third, should the amount of training vary by



1 specialty? For example, should family medicine residents  
2 be required to receive more geriatric training than  
3 surgical residents?

4 Fourth, how should such a requirement be  
5 enforced? For example, should there be an adjustment to  
6 GME payments if a teaching hospital doesn't comply?

7 For your discussion, we'd like to get your  
8 feedback on these three policy options, and please let us  
9 know if there other options you would like us to explore.

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

12 DR. CHERNEW: Jamila and Ariel, thanks. We're  
13 going to jump right into Round 1, and Dana is going to run  
14 the queue, but I believe Jonathan Jaffery will kick us off.

15 DR. JAFFERY: Great. Thanks, Mike, and thanks.  
16 It was a great chapter and a really great report, and I've  
17 got a number of comments I'll bring up in Round 2.

18 In the chapter, you mentioned a few things that  
19 are out there that have been tried and in place to try and  
20 address the geriatric training and the workforce, and one,  
21 in particular, the Geriatric Workforce Enhancement Program,  
22 do you have any analysis or data about the results of that

1 program since that was something that was specifically  
2 targeting this problem in the past?

3 DR. TORAIN: So this program, the Geriatric  
4 Workforce program, is actually evaluated each year, and  
5 they do produce a report each year where they have to  
6 basically cite all of their publications and anything that  
7 they're doing in the community. But, in terms of an actual  
8 evaluation of the program and survey for the actual  
9 participants in the actual program, we didn't have any  
10 information on that.

11 GACA, we did find an actual evaluation of the  
12 program where they interviewed almost half of the GACA  
13 recipients as of the current cohort where they were  
14 actually able to say what are the outcomes of the program  
15 and how did the awardees actually benefit from the program.

16 DR. JAFFERY: So we don't know if any of the  
17 programs had any impact on increasing the actual number of  
18 geriatricians or people going into it anyway?

19 DR. TORAIN: So one distinction that I'll make is  
20 that what we found, I think, when we went into researching  
21 these federal programs, we thought that their goals were to  
22 increase the existing workforce, but we found that these

1 three programs are more so to actually support the existing  
2 field of geriatricians and practitioners that are in the  
3 field.

4           Some of the programs in interviews with Hopkins,  
5 for example, we did find that they can use the funds to  
6 encourage medical students to go into geriatrics, but it's  
7 not necessarily the mission or the goal of the program  
8 overall. It's more so to support the existing field. For  
9 example, with the Geriatric Academic Career Award, those  
10 funds are really dedicated to helping the physician or  
11 practitioner better themselves as leaders in the fields,  
12 clinicians, and researchers. So the funds that they  
13 receive give them protected time to develop themselves.

14           DR. JAFFERY: Thanks. I was familiar with the  
15 other two programs, and that was my understanding of their  
16 goals, but I wasn't sure about the other ones. So thanks.  
17 That's really helpful.

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

19           DR. RAMBUR: Thank you. I'm very excited that  
20 we're taking this on, and I will have a lot more to say in  
21 Round 2.

22           But I have one question that's probably really

1 obvious, but it's not clear to me. You mentioned that half  
2 of the fellowships that were offered were not filled. How  
3 are those fellowships financed or funded? Is that through  
4 GME or some other mechanism or foundations? Where does the  
5 money come from?

6 MR. WINTER: It's probably -- I would guess that  
7 Medicare GME provides most of the funding, and direct GME  
8 is calculated more favorably for fellowships, for geriatric  
9 fellowships than for other kinds of fellowships. So --  
10 sorry. Direct GME is determined based on number of FTEs,  
11 FTE residents at each hospital, and once you get to the  
12 fellowship stage, most fellowships count as half an FTE for  
13 that purpose. But geriatric fellowships and a couple of  
14 others like preventative medicine count as a full FTE. So  
15 they are treated a little more favorably.

16 In terms of the overall -- where the overall  
17 funding comes from, my hunch is that most of it is Medicare  
18 GME, but I'll look into that a little bit more and see if I  
19 can find some more for that.

20 DR. RAMBUR: Thank you.

21 One other quick follow-up question, when a slot  
22 is unfilled, does that money go back to the Medicare

1 program, or how does that work?

2 MR. WINTER: That's a good question. I'll have  
3 to look into that.

4 DR. RAMBUR: Thank you. Appreciate it.

5 MS. KELLEY: Brian.

6 DR. DeBUSK: I have one question, and actually,  
7 this could be open to other fellow Commissioners as well as  
8 the staff. Could you compare and contrast or at least  
9 speak to geriatricians versus primary care physicians  
10 versus palliative care specialists or physicians? How do  
11 all of those interrelate?

12 MR. WINTER: In terms of training or their roles  
13 in the health care system or the kinds of beneficiaries?

14 DR. DeBUSK: Yeah. I'm sorry. I should have  
15 asked more. Not necessarily in terms of training. Just  
16 what does a day's work look like? Help me compare and  
17 contrast, again, primary care, geriatricians, and  
18 palliative care specialists.

19 DR. RILEY: Good question. I can help with that.  
20 This is Wayne.

21 I'm an internist. So I work very closely with  
22 geriatricians, and there's not enough of them. But the

1 geriatrician tends to be better trained in sort of all the  
2 sort of chronic, multiple chronic conditions that tend to  
3 focus in the elderly age cohort. They get more intensive  
4 training in that, even above that of just a regular family  
5 physician or general internist like myself. Whereas,  
6 palliative care physicians tend to be really at the moment  
7 of critical -- a withdrawing of certain lifesaving  
8 measures, comfort for death, et cetera.

9           Some geriatricians do palliative care. Some  
10 palliative care physicians are geriatricians but not  
11 always. So there are some bright lights between them,  
12 Brian, that play out in terms of the workforce challenge.

13           DR. DeBUSK: That's really helpful. So what  
14 you're saying is there's a clear space between a primary  
15 care physician and a palliative care physician. There's a  
16 gap there that needs to be filled.

17           DR. RILEY: Correct, correct.

18           DR. DeBUSK: Okay.

19           DR. JAFFERY: This is Jonathan. I mean, I think  
20 I'm not sure I would characterize it exactly as a gap  
21 there. I mean, there are somewhat different purposes in --  
22 and the training.

1 DR. RILEY: Yeah. More containable, right?

2 DR. JAFFERY: Yeah. And geriatricians, some do  
3 some or a lot of primary care and some do more consultative  
4 work for an older population, and then palliative care is  
5 sort of a very different set of training that can deal with  
6 all sorts of care conditions and actually isn't necessarily  
7 an end of life, either.

8 DR. RILEY: That's right. That's right. Chronic  
9 pain issues, et cetera, et cetera. Correct.

10 DR. RAMBUR: So this is Betty. If I could just  
11 leap in as well.

12 For example, one of my colleagues who was an  
13 internist at one point in his life decided he wanted to  
14 really focus on just palliative care, but I also wanted to  
15 mention geriatric nurse practitioners. So, for example,  
16 some of my colleagues as geriatric nurse practitioners  
17 really focus on memory and cognitive issues working with  
18 patients with Alzheimer's. Sometimes they work to augment  
19 the expertise of primary care providers because they're  
20 really in that space deeply. Sometimes they are working in  
21 memory clinics, and then there's a whole other group that  
22 sort of works in sort of geropsych. So sometimes -- so

1 that's at least my experience of what I've seen.

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

3 DR. GRABOWSKI: Great. Thanks, Jamila and Ariel.

4 This is great work.

5 I wanted to ask about the third policy option in  
6 this requirement or requiring teaching hospitals that  
7 receive GME payments to provide training in geriatrics.  
8 Are there examples of hospitals that do that well? Are  
9 there other examples of kind of leveraging GME in this?  
10 I'm just trying to get a handle on this and whether this is  
11 kind of more -- I'm worried. I guess I'll save that for  
12 Round 2, but I'm a little worried this feels more like box  
13 checking than something that's meaningful. Can you help me  
14 there? Thanks.

15 MR. WINTER: Yeah. We did not do research into  
16 whether there are hospitals that do this better than  
17 others. That's something we can think about doing for the  
18 future.

19 DR. RILEY: But just relationally, I will tell  
20 you that there are some departments of geriatrics which are  
21 separate from departments of internal medicine. I'm  
22 thinking of Mount Sinai. I'm thinking of University of



1 Chicago, several other places where they've really  
2 separated it out from internal medicine. Those geriatric  
3 programs tend to be stronger, and they tend to attract  
4 residents -- or fellows, rather, who want to concentrate in  
5 geriatrics because they have a more distinct identity  
6 around the care of geriatric patients and more intensive  
7 training, mentoring, and role modeling, if you will.

8 DR. GRABOWSKI: Yeah. That's helpful, Wayne, and  
9 I wonder if like having those stronger programs, if that  
10 spills over to nongeriatric fellows in those institutions.

11 DR. RILEY: Yeah. Great point.

12 MR. WINTER: David, one thing I'll add is that  
13 one of the federal programs that Jonathan asked about  
14 earlier, the Geriatric Workforce Enhancement Program, is  
15 awarded to health professional schools, primarily medicine  
16 or -- I think primarily medicine, and one of the main goals  
17 is to integrate geriatrics with primary care. So they are  
18 really focused on -- they are focused on training medical  
19 students and residents in geriatrics and integrating  
20 geriatrics in primary care. So that's a place we could  
21 look to. We could look to those kinds of institutions as  
22 examples for how to -- as places that do a good job,

1 perhaps. I mean, that's the goal of training students and  
2 residents more broadly in geriatric care.

3 DR. GRABOWSKI: Thanks.

4 MS. KELLEY: Bruce.

5 MR. PYENSON: Thank you very much for this  
6 chapter.

7 My question is about the policy options here, and  
8 given that about half of Medicare beneficiaries are covered  
9 by Medicare Advantage and probably more than that in the  
10 future, how would these operate in Medicare Advantage?  
11 Would they have any effect on the care for those that half  
12 of beneficiaries?

13 MR. WINTER: Can you clarify? When you say how  
14 would these operate, what are you referring to?

15 MR. PYENSON: Well, the assumption here, I think  
16 is that if we create more people with training or specialty  
17 or geriatricians or geriatric nurse practitioners that that  
18 will benefit the population, but that seems to be a fee-  
19 for-service. I can see how that might work in fee-for-  
20 service. It's less clear to me how that would work for  
21 Medicare Advantage or those beneficiaries.

22 MR. WINTER: So we came at this issue from the

1 perspective of Medicare as a whole, not trying to  
2 distinguish between fee-for-service versus MA. What frames  
3 the problem for me at least is that you've got a growing  
4 number of elderly beneficiaries and a shrinking supply of  
5 geriatricians, and so how do we deal with that issue going  
6 forward? And I think that issue affects beneficiaries,  
7 whether they're on Medicare Advantage or fee-for-service.

8           Now, the first policy option I described, that is  
9 more targeted to a fee-for-service payment system, but if  
10 Medicare covers that service, then MA plans would have to  
11 cover it as well because they might pay for it differently.

12           MR. PYENSON: So it's your thinking that Medicare  
13 Advantage plans would be happy to have geriatricians join  
14 their networks? They would invite geriatricians to join  
15 their networks? I'm asking a question.

16           DR. CHERNEW: If they're effective in some of the  
17 things that Jamila presented, they would probably want to  
18 do that anyway.

19           DR. RILEY: Right.

20           MR. WINTER: In our interviews, we learned that  
21 one of the roles geriatricians play is in capitated systems  
22 and also the plans that have capitated payment systems,

1 because they often can -- they're trained in how to manage  
2 population health for this segment of the population, and  
3 they're focused on holistic care and, therefore, are seen  
4 as desirable by these organizations and plans.

5 MR. PYENSON: Thank you.

6 MS. KELLEY: Pat, you're next.

7 MS. WANG: Thank you.

8 Ariel and Jamila, you had mentioned the unfilled  
9 rate for geriatric fellowships. Of the total very small  
10 number of geriatricians left in the country, do you know  
11 roughly what proportion have come to a fellowship program  
12 like that or later; for example, general internists who  
13 later became board certified in geriatrics?

14 MR. WINTER: I'd have to look at whether the  
15 requirements today on -- whether board certification  
16 requires having done a fellowship. My understanding is it  
17 does on --

18 DR. RILEY: Yes, it does.

19 MR. WINTER: Yeah. So there might have been --  
20 there might have been when the -- earlier on, maybe in the  
21 '70s, before these fellowships became -- before they were  
22 introduced, maybe there was a way to get board certified

1 without having done one, but today, it's required.

2 MS. WANG: Okay.

3 DR. RILEY: To the point that was back in the  
4 '90s, geriatric fellowships were anywhere from two to three  
5 years, and that was shortened for this very reason that  
6 there just weren't enough. And they shortened it to a  
7 minimum of one year post-residency training in either  
8 internal medicine or family medicine as a means to try to  
9 catalyze the pursuit of more geriatric residency training,  
10 and it's not had as good an effect as we had all hoped.

11 MS. WANG: Thank you, Wayne. That's helpful, but  
12 it kind of -- it segues to my next question which is I  
13 think it's really important to be talking about training  
14 programs and just even -- without even focus so much on  
15 geriatrics, just producing more geriatricians, but  
16 producing more knowledge of geriatrics among physicians who  
17 will take care of the Medicare population.

18 In that regard, did you all have an opportunity  
19 to talk to the ACGME and the residency review committees  
20 that set requirements for being sort of recognized as  
21 having completed, for example, an internal medicine or  
22 family medicine residency program? Because I would think

1 that the most effective way to inject awareness and  
2 expertise in geriatrics would be for the program  
3 requirements to change. The money comes later, but if the  
4 program requirements change, I think that's what really  
5 drives teaching programs. Did you have a chance to talk to  
6 anybody over there to see whether they are thinking about  
7 this problem?

8 MR. WINTER: We have not talked to those folks  
9 yet, but that's a good idea.

10 MS. WANG: Okay.

11 MR. WINTER: We have looked at their requirements  
12 for internal medicine and family medicine residencies, but  
13 we have not talked to them.

14 MS. WANG: Okay. Maybe it's more like a  
15 roundtable, but just to put a period at the end of the  
16 sentence. That's where the change is going to come from in  
17 my view, and the other physicians and educators can comment  
18 on that.

19 The other question I just wanted to ask you was  
20 other than establishing codes for comprehensive geriatric  
21 payments, you kind of stayed away from recommending changes  
22 to the physician fee schedule, and I just wondered why --

1 or I'm sure you thought about it -- why you didn't go  
2 there, including, you know, things like maybe since  
3 geriatricians seem to be playing a very important  
4 consultative role, telemedicine codes or different  
5 categories of payment for geriatric consultation and  
6 telehealth, things of that nature? Can you comment?

7 MR. WINTER: Yeah. So that's a really good  
8 question, and we should have cross-referenced the prior  
9 work we've done, extensive prior work we've done on  
10 improving accuracy in the fee schedule, which is focused on  
11 properly valuing ambulatory E&M codes. CMS, as you know,  
12 recently increased RVUs significantly for E&M office and  
13 outpatient visit codes, which are a huge amount of E&M  
14 volume in payments. We supported that change, and that  
15 would certainly improve Medicare revenue for geriatricians  
16 because they bill for a lot of these E&M codes. So we  
17 should definitely -- but we kind of thought -- I thought of  
18 that work as separate because that has much broader  
19 implications for primary care physicians, other kinds of  
20 clinicians, and here we are focused on geriatricians. But  
21 we should definitely cross-reference our work in that area.

22 In terms of creating other specific codes that

1 would just be for geriatricians, one issue is that a CPT  
2 panel and CMS have been reluctant to create codes that  
3 would be specific to a specialty. They try to create codes  
4 that any specialty can bill.

5           With comprehensive geriatric assessment, you  
6 could argue, well, but this is, you know -- it would really  
7 be billed by geriatricians, and it would probably be the  
8 main specialty that goes for it, but it could also be  
9 billed by NPs, PAs, family physicians, and other clinicians  
10 who are doing the same kind of service.

11           We try to be cautious about encouraging CMS and  
12 CPT panel to create lots of new codes that increase the  
13 complexity of the fee schedule. So we're trying to kind of  
14 take a middle ground here between, you know, creating lots  
15 of new codes versus not -- versus providing a way for  
16 geriatricians and other clinicians to get paid for doing  
17 this service, which seems to be -- which does not seem to  
18 be captured by the existing set of E&M codes.

19           MS. WANG: Thank you.

20           MS. KELLEY: Larry.

21           DR. CASALINO: Yeah. Jamila and Ariel, nice  
22 work. I think really difficult work, and in a two-sentence



1 preview of some of my Round 2 framework, I think really  
2 difficult work because I think the problem has been mis-  
3 framed. I don't think the problem is how to get more  
4 geriatricians, although that would be nice. I think the  
5 problem is how to get better care in nursing homes, and  
6 nobody wants to talk about that. And, actually,  
7 geriatricians provide a very, very small percentage of care  
8 to the nursing home patients.

9           So my question is, there's been a fair amount of  
10 attention in the last five years or so to so-called "SNF-  
11 ists," intended to be analogous to hospitalists and usually  
12 defined as physicians who are -- at least 90 percent of  
13 those E&M claims are for visits to nursing home patients.

14           Unlike geriatricians, you know, SNF-ists have  
15 been increasing and provide about a third of nursing home  
16 visits. The geriatricians provide about 3 percent of  
17 nursing home visits, I believe.

18           So my question is, did you guys talk to people at  
19 all about these non-geriatricians who, nevertheless, are  
20 almost completely focused or completely focused on nursing  
21 home care?

22           MR WINTER: We did not, but that's a good topic

1 to look into in the future.

2 DR. CASALINO: Okay. I can get back to you  
3 offline about that, about good people to talk to, and I'll  
4 have a little more substantive to say about it in Round 2.  
5 Thanks.

6 DR. TORAIN: Yeah. That would be helpful.  
7 When you say non-geriatricians, do you mean  
8 physicians? They are physicians, these SNF-ists.

9 DR. CASALINO: They are physicians. They're  
10 mostly primary care physicians, mostly family physicians  
11 and general internists who spend almost all their time in  
12 nursing homes.

13 DR. TORAIN: Okay. Thank you.

14 DR. CASALINO: But the recent work has data on  
15 who they are, and I can refer you to the people who do it.

16 MS. KELLEY: Okay. I have Lynn next.

17 MS. BARR: Thanks. This was a really interesting  
18 chapter. We don't see very many geriatricians. The only  
19 geriatrician I know is no longer a geriatrician, and I was  
20 curious about that.

21 According to Kaiser Family Foundation, there's  
22 only about 1,500 practicing geriatricians. So is this a

1 problem we can even solve? I mean, are you really going to  
2 get the 3,000 or 5,000, the 30,000 we need, or are we  
3 looking at things kind of upside-down? That's one question  
4 I have.

5           Have you talked to geriatricians and asked them  
6 are they satisfied with their work? I mean, what do the  
7 geriatricians say about why there are not geriatricians?  
8 I'm curious about that because what I heard from my  
9 colleague that left the work was it was very difficult  
10 work, and she really didn't enjoy it.

11           So, you know, sometimes the market speaks, and we  
12 have to listen to the market and not try to fix it. So I'm  
13 wondering is the market telling us something, and we should  
14 just be listening to it and trying to find the alternatives  
15 to where the care needs -- I mean, what I hear is, you  
16 know, what we need is drugs, better management of drugs and  
17 better management of Alzheimer's and dementia. And so is  
18 that psychiatrists and pharmacists that we need? Is it  
19 really geriatricians? Because they're not engaging in the  
20 work. The ones we're training are leaving. I mean,  
21 there's some real fundamental issues that I don't think  
22 we're getting at here, and I'm concerned about them.

1           I guess the other question I have is that if we  
2 feel like we really need this more advanced care for our  
3 geriatricians, are NPs and PAs the answer? I mean, that  
4 doesn't seem -- like, that seems like a cognitive  
5 disconnect for me that that's how we're going to solve that  
6 problem.

7           And then, you know, kind of the final question I  
8 have is if it's a market issue, I can tell you that  
9 creating new codes doesn't solve market issues because the  
10 adoption of new codes by providers and their embracement of  
11 it or their belief that they can do it or that they're  
12 going to actually get paid for their work is pretty small.  
13 So have you considered -- I mean, we pay NPs and PAs 15  
14 percent less than the fee schedule. Couldn't you pay  
15 geriatricians 15 percent more? I mean, there's going to  
16 have to be a more market -- I don't think the approach of,  
17 you know -- I was just wondering whether you've thought  
18 about something that's just more compelling than more  
19 codes.

20           MR. WINTER: Okay. That's a lot of questions  
21 there. Let me see if I get them all. The first one --

22           DR. CHERNEW: Ariel, we have about 10 people for

1 Round 2, and we have about 45 minutes, so maybe not try  
2 them all. You can reach out to Lynn if you can, but keep  
3 the highlights.

4 MR. WINTER: Highlights are, first one, can we  
5 get enough geriatricians? We raised that question  
6 ourselves, which is why we put down the second two policy  
7 options to get at that. Why do geriatricians choose this  
8 work? Why do they like it? Based on interviews and the  
9 literature, geriatricians actually enjoy very high levels  
10 of satisfaction because they view the work as rewarding,  
11 and geriatricians are people who enjoy -- they enjoy the  
12 work because they enjoy building long-term relationships  
13 with the patient to providing holistic care.

14 Are NPs and PAs the answer? Can they replace the  
15 specialized expertise of a geriatrician? I think that's an  
16 open question, but there are certainly NPs and PAs who take  
17 care of this population, and we can look more into that.

18 In terms of new codes, geriatricians have been  
19 trying for many years to get this comprehensive geriatric  
20 assessment code adopted. I think they would bill for it,  
21 but I can't predict that with certainty.

22 Your last suggestion, which was to pay

1 geriatricians a certain percentage increase over other  
2 clinicians, was an idea we heard from geriatricians. We  
3 did not -- and it's something you can all decide if you  
4 want to pursue. We did not put it on the table because  
5 there are lots of complexities with how clinicians define  
6 their -- list their specialty, report their specialty to  
7 Medicare, that can make that kind of policy very deem-able  
8 and hard to target.

9 How was that, Mike?

10 DR. CHERNEW: That was good and quick.

11 I think we have one more. Paul, please be brief.  
12 Our Round 1 is taking up a lot of Round 2 time.

13 DR. PAUL GINSBURG: Thank you, Mike.

14 I'm just going to add my Round 1 and 2 when I  
15 speak on Round 2.

16 MS. KELLEY: Mike, I'm sorry. I had -- I think  
17 Wayne might have had a question.

18 DR. CHERNEW: Oh. Wayne, yes, you do. But I  
19 wasn't sure if it was a Round 1 or Round 2 question, Wayne.

20 DR. RILEY: Yeah. I can wait until Round 2. No  
21 worries.

22 DR. CHERNEW: Do you want to kick off Round 2,

1 and then we'll just jump in to --

2 DR. RILEY: Well, yeah. Just a quick one, and  
3 Jamila -- first of all, Jamila and Ariel, great work. But  
4 you mentioned the other -- you did an environmental scan  
5 for other agencies within the federal government that  
6 support geriatric training. I keep thinking that HRSA used  
7 to do something around geriatrics. Has that wound down?

8 DR. TORAIN: Yeah. So HRSA has two programs. So  
9 the GACA, the Geriatric Academic Career Award, and they  
10 also are part of the GWEB, so the Geriatric Workforce  
11 Enforcement Program. So those are both HRSA programs.

12 DR. RILEY: I see. And then just a comment about  
13 geriatricians in general, I tried to find a geriatrician  
14 for a family member, and it's sort of like trying to find a  
15 psychiatrist. Just anecdotally, every geriatrician I've  
16 ever worked with, I wanted them to be my doctor. They are  
17 just fantastic people, and they go into it for the same  
18 reason that pediatricians like taking care of kids. So  
19 they are a breed apart that we desperately need more, but  
20 this is a very nubby, you know, GME workforce issue that  
21 hopefully we can keep at it.

22 DR. CHERNEW: Wayne, did you have more to say?

1 Was that part of your Round 2 comment? Do you have more  
2 you want to say?

3 DR. RILEY: No. I'm done. Yep, I'm good.

4 DR. CHERNEW: Okay. Just making sure.

5 So we're going to transition now to Round 2, and  
6 if I have my Round 2 organizing right, it's going to kick  
7 off again with Jonathan.

8 DR. JAFFERY: Yeah. Great. Thanks, Mike.

9 And, again, Ariel and Jamila, it's a great  
10 report. I think this is a really robust discussion, and  
11 you can see that there's a lot of questions, and they're  
12 pretty broad, key questions.

13 I'm glad Wayne made his comments then because  
14 that really segued nicely because I very much am along the  
15 same lines as his thinking that I see a lot of value that  
16 geriatricians bring to individual patient interactions, to  
17 the health system as a whole.

18 I know Lynn mentioned that it's hard to find one  
19 in practices, and I can appreciate that. I'm fortunate.  
20 We have a training program, where we have a GRECC. So I  
21 work with them a lot, and I think they bring a lot to this.

22 As Wayne said, they go into it for particular



1 reasons. There's a lot of job satisfaction. They're  
2 generally noted to have among the highest job satisfaction  
3 of specialties. So I think it is important that we keep  
4 thinking about this work.

5           When I look at the report, you cite these three  
6 major reasons why or main reasons that you found why  
7 medical students wouldn't come to geriatrics medical  
8 exposure. They were less, and that they have more complex  
9 patients with more comorbidities, which I think are all  
10 spot on.

11           But then it feels like the conclusion sort of  
12 moves into that there will be more interest if compensation  
13 is better, and I certainly think that compensation could be  
14 a barrier. And even if it's not, it should be better for  
15 this group, but I don't know that that totally addresses  
16 all the underlying things that really dissuade people from  
17 working -- or from wanting to care for these more complex  
18 patients.

19           And so I guess I wonder, rather than -- and these  
20 aren't basically exclusive, but I'm not sure that I'm crazy  
21 about the idea of just trying to go ahead with this code as  
22 a solution for the comprehensive geriatric assessment,

1 partly because it just feels like it's embedded in our fee-  
2 for-service system that I instinctively want us to move  
3 away from.

4           But I do wonder if rather than that kind of  
5 approach to increasing the funding for geriatricians and  
6 geriatric services, that if there was a way that CMS could  
7 provide a payment and perhaps even some technical  
8 assistance, specifically to support the development of the  
9 care team that they need, because that's one of the things  
10 that makes it so hard to care for a population that's  
11 complex with lots of comorbidities is you don't have the  
12 support around you to adequately care for a geriatric  
13 population. And you could base this on how many Medicare  
14 beneficiaries, a group, take care of or an absolute number  
15 or a percentage, but I think rather than think about, okay,  
16 if I take care of this one patient and do this assessment,  
17 I'll get X number of dollars more, if you knew that you had  
18 money coming in that was specifically designed to create  
19 that support system -- and I think there's probably  
20 something analogous here to some of the primary care  
21 transformation dollars that have come out -- that might be  
22 a useful approach. And, again, that might not have to be

1 specifically to -- or exclusively to geriatricians, but it  
2 could be designed to support the geriatric practice  
3 overall.

4           So, again, great, great report, I think a really  
5 important topic, and I just would want to think about a way  
6 to support geriatricians through real practice  
7 transformation as opposed to just a fee-for-service code  
8 add-on. Thank you.

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

10           DR. DeBUSK: Well, thank you. There seems to be  
11 a lot of interest in this area.

12           I was really excited to see a chapter come  
13 through or another chapter come through on workforce  
14 development. I mean, I think for Medicare, workforce  
15 development is going to be a major issue for at least the  
16 next decade because it's going to take at least a decade  
17 just to work through the backlog of doctors and nurses that  
18 we're going to have, so, again, love to see this topic come  
19 through.

20           I want to jump straight to solutions or to  
21 talking about the solutions. I agree with Jonathan on the  
22 code. I'm a little concerned about adding a new CPT code

1 because we can't -- once a code is out there, you can't  
2 really control who accesses it, how much of it is done  
3 incident-to versus how much of it is actually done by the  
4 physician. You can't even control which specialties access  
5 it.

6           So I do think there's a potential for some  
7 unintended consequences and program integrity issues if you  
8 just created this large deluxe GCA-style code.

9           You know, Jonathan, I did like where I think you  
10 were going, though, with how to pay the geriatricians. You  
11 know, I think of the old primary care incentive payment,  
12 where you're paying a per-member-per-month fee. I do think  
13 there could be some novel ways to get these guys paid, and  
14 I think maybe it's a -- you know, instead of a primary care  
15 incentive payment fee, maybe it's a geriatric care  
16 incentive payment fee. But, again, I think there's some  
17 real novelty there in doing something outside of fee-for-  
18 service.

19           I was a little concerned in the chapter when I  
20 saw the GME, talking about changing the GME requirements.  
21 You know, as Wayne mentioned earlier, it's hard to find  
22 geriatricians anyway, and creating this scramble for all of

1 these residency programs to try to secure geriatricians, if  
2 they were added to the core GME requirements, would make a  
3 really difficult process, which is GME, even harder. I  
4 mean, there are enough specialties out there that are  
5 difficult to fill in these programs already. So I would  
6 discourage the GME route.

7           The final thing I wanted to talk about was the  
8 loan forgiveness approach, and I've said this over the  
9 years in previous meetings. I don't know that loan  
10 forgiveness or scholarship are really going to drive the  
11 mix of physicians that we train.

12           I would argue that the die is cast at the point  
13 when the student matriculates to medical school, and even  
14 in those rare situations where the die isn't cast and a  
15 change does occur during training, it's not a change that's  
16 occurring in the direction we would want it to. I would  
17 argue that it's probably going away from primary care-based  
18 specialties and into the special -- so, again, I don't have  
19 a solution for that, but I really think we need to revisit  
20 how do we get the composition of our medical school  
21 students right, because if you've got a class that's 80  
22 percent specialized the day they show up on campus, the

1 number or the percentage of specialists is only going to  
2 grow from there. And so I think in a lot of cases, we  
3 start with the wrong mix of students in medical school, and  
4 then it gets worse from there.

5           Anyway, thank you

6           MS. KELLEY: Jim, did you want to hop in here?

7           DR. MATHEWS: If I could, please just because  
8 Brian and a couple of the other Commissioners put forth and  
9 made some comments about the labor market with respect to  
10 geriatricians and whether or not these policies are going  
11 to address kind of market-level issues.

12           So, Brian, you are absolutely correct with  
13 respect to characterizing our prior discussion of the  
14 potential impact of a loan repayment program with respect  
15 to physicians where, as you said, even in med school, you  
16 know, students are cognizant of the income differentials  
17 that accrue if they choose one path versus another. So I  
18 completely understand that.

19           And I also completely understand Lynn's  
20 positions. I think that, to some extent, the composition  
21 of physicians and NPs and PAs that we are seeing does  
22 reflect a reaction to a natural market, but the nuance that

1 I would like to convey here relates to the role of NPs and  
2 PAs. We had previously talked about them playing a greater  
3 role in the provision of primary care generally for the  
4 Medicare population, given some of the trends we've seen in  
5 the physician world, and so if they are able to fill a need  
6 for not geriatricians, but people who know something about  
7 providing care to elderly patients, that income  
8 differential that might really influence a physician's  
9 decision doesn't seem to be as pronounced with respect to  
10 NPs and PAs.

11           There is somewhat more homogeneity in income  
12 here, and in that regard, if NPs and PAs can fill a role  
13 here, the notion of a loan repayment program may have more  
14 value to those kinds of professionals than it might be to a  
15 physician who is looking at huge income gaps if they make  
16 one choice versus another.

17           DR. DeBUSK: On that one point, Jim, first of  
18 all, I totally agree with you, and I see where you're going  
19 with the nurse practitioner and the PA thing.

20           I would look to Betty for some feedback on this,  
21 but I'm willing to bet, at least for PAs, a huge portion of  
22 those students receive some type of loan assistance or loan

1 repayment program, irrespective of the practice that they  
2 join. I think that's pretty commonplace for PAs and at  
3 least for some NPs.

4 DR. RAMBUR: Well, I can briefly comment now, if  
5 you want.

6 I, first of all, have to address Lynn's comment.  
7 I think it's important to remember -- I'm speaking  
8 specifically about nurse practitioners. I would say  
9 they're not necessarily less. They are different.

10 Remember that many of the people who go on to  
11 become geriatric nurse practitioners have years of  
12 experience in nursing and often with geriatric populations,  
13 and so they want to expand that.

14 And going on Larry's comment about better care in  
15 nursing homes, absolutely, and there have been some small  
16 studies or some studies that have been somewhat time  
17 limited and geographically limited that have nurse  
18 practitioners in the nursing home, really coordinating that  
19 care, being able to provide things, and keeping that  
20 reflexive impulse to send people to the hospital when it  
21 gets stressed. So I think there's lots of opportunity  
22 here.



1 I don't know if you want me to make the rest of  
2 my comments now or wait until it's my turn.

3 DR. CHERNEW: Betty, why don't you just go now.  
4 We do have about a half an hour, and if you want to roll --

5 DR. RAMBUR: I'll be very quick. There is  
6 actually a lot of data about nurses' effectiveness in  
7 managing chronicity and some of the kinds of challenges  
8 that elders have, and I just want to make a comment about  
9 the critical role of loan repayment.

10 In my previous life as a dean, I found both  
11 scholarships and loan repayment effective, but loan  
12 repayment almost the most effective because students had  
13 already committed to a track at that time.

14 The American Association of Colleges of Nursing  
15 has this data, and I can forward it to you. This was done  
16 in 2017. Seventy-six percent of nurses who go to graduate  
17 school have undergraduate loans. Fifty-one percent have  
18 one or more dependents. Sixty-nine percent took out  
19 federal loans, and the biggest worry is being able to pay  
20 off that federal loan. So that is one of the things that  
21 can pull people away from primary care.

22 I want to just also mention this view of

1 preceptors. Just in January, there was an article that was  
2 led by the University of Pennsylvania group, Linda Aiken  
3 and others, about revisiting graduate nurse education.  
4 There was a pilot of graduate nurse education, because  
5 remember there is a real challenge for educating graduate  
6 nurses because we don't pay those preceptors, and  
7 increasingly, the preceptors are not able to take on  
8 students. PA programs pay them. There's GME for  
9 physicians. And so the solution to that is to have an  
10 additional fee for the students, which then you pay the  
11 preceptor, which actually just increases the amount of  
12 their debt.

13           So revisiting the article that was in Health  
14 Affairs in January, I think, would be very important, and I  
15 do think it's -- yeah. I think it's really important that  
16 we look at the whole long-term care and elder workforce  
17 that includes these opportunities but also the direct care  
18 workers and others that we'll be talking about in other  
19 settings.

20           Thank you.

21           DR. CHERNEW: Thank you, Betty.

22           And if I have this right, we're now to David

1 Grabowski. Is that right, Dana?

2 MS. KELLEY: Yes.

3 DR. GRABOWSKI: Great. Thanks, Mike.

4 Like other Commissioners, I believe there's real  
5 value here in increasing the supply of geriatricians.  
6 Ariel said it well during the presentation. As more  
7 individuals are reaching age 65, we need more individuals,  
8 clinicians that are trying to care for them.

9 This issue is not a new one. There was a very  
10 well-known and well-cited 2008 IOM report that outlined  
11 this issue and put forward a lot of these same issues that  
12 we're battling around today in some of these same solutions.  
13 So I think it's safe to say this is a really thorny problem  
14 without a simple solution.

15 So let me just go through the kind of policy  
16 options. Similar to other Commissioners, I'm not a big fan  
17 of Policy Option 1 with the new codes. I don't think this  
18 addresses the problem we're trying to solve here, and I  
19 think, Ariel, you said that during your remarks. It  
20 doesn't actually grow the supply of geriatricians. It may  
21 be something we want to consider, and other Commissioners  
22 have already kind of spoken about why we probably don't

1 want to do this. But I don't actually think it solves the  
2 problem at hand.

3 Policy Option 3, I sort of began to push at this  
4 in my first-round question. I don't know that this is  
5 actually going to move the needle in terms of expanding  
6 geriatrics. I have the sense that it's more box checking  
7 than actually true kind of training.

8 So that sort of leaves with the final option,  
9 Policy Option 2. Similar to Betty, I actually like this.  
10 I'm really glad, Jim, that you clarified this issue. I  
11 totally agree we're not going to recruit new physicians to  
12 geriatrics with this program, but I think there's great  
13 potential to expand the supply of NPs and PAs.

14 Betty is the real expert here. So I'm glad I'm  
15 speaking after her, but I think there's ways to do this  
16 that we could actually really put a lot of highly trained  
17 individuals out in the workforce caring for individuals in  
18 different long-term care settings.

19 Final comment. Larry, I just want to react to  
20 your Round 1 point about reframing the issue. Nursing  
21 homes are a big part of the problem. You don't have to  
22 convince me if that, but I think that's not the only

1 problem. I do think we need geriatricians in other  
2 settings as well out in the community across the full  
3 launch and care spectrum.

4           There's a well-known paper saying that clinicians  
5 in nursing homes are missing in action, and I think the  
6 SNF-ist movement, Larry, has helped with that. But I still  
7 think we have a ways to go. So I wonder if that's kind of  
8 a similar but separate problem, but I think they're both  
9 problems here that need to be addressed.

10           Thanks.

11           MS. KELLEY: I have Paul next.

12           DR. PAUL GINSBURG: Yes. Well, thanks again,  
13 Jamila and Ariel, for a really good chapter. It really set  
14 up our discussion well.

15           I'm presuming from -- I was actually going to ask  
16 you has anyone tried to make an estimate of the proportion  
17 of care for elderly care beneficiaries that should be with  
18 a geriatrician but compared to the proportion of care that  
19 is, and I'm presuming that that proportion is very small,  
20 which got me to thinking about, well, you know, maybe we  
21 should be spending more time on, you know -- I mean, it may  
22 be things worth doing as far as expanding the supply in

1 geriatricians, although to me none of these options look  
2 like they're going to move the needle, even though they  
3 might be useful things to do.

4           But, you know, the question I have generally is  
5 what about, you know, getting more training for physicians  
6 who are in residencies or even in maintaining their  
7 certification to actually take some geriatrics instruction,  
8 not monitored by the number of hours they do, but really  
9 providing an incentive for specialty boards to include some  
10 geriatrics questions in their initial certification exams  
11 and maybe even their maintenance certification as far as  
12 this incentive to have a lot of people invest a modest  
13 amount of time in becoming more capable of dealing with  
14 these very elderly patients with complex disease? So  
15 that's just the idea I wanted to throw in here.

16           Well, actually one more thing as far as I realize  
17 that even though increasing the relative payment for visits  
18 in general would probably be a far more powerful tool in  
19 incenting people to become geriatricians, you know, that  
20 would -- it's kind of like the tail wagging the dog. It's  
21 not the way you want to argue for that policy. There are a  
22 lot of other reasons to pursue that.

1           But the notion of paying some percent bonus to  
2 physicians who are board certified in geriatrics could be a  
3 useful short-term thing and maybe even stop the erosion of  
4 the geriatric workforce.

5           I know Ariel mentioned the issues that physicians  
6 tell Medicare what specialty they're in, but this could be  
7 a separate thing like applying for the ability to get this  
8 bonus and submitting evidence of board certification in  
9 geriatrics.

10           MS. KELLEY: Larry?

11           DR. CASALINO: Thanks, Dana.

12           So I'm going to focus on physicians, but I  
13 recognize that physician assistants and nurse practitioners  
14 may well turn out to be the most important solution to this  
15 problem. I would certainly encourage that any further work  
16 on this topic focuses quite a lot of attention specifically  
17 on NPs and PAs.

18           I just want to note before I get back to what I  
19 think the fundamental problem is and the mis-framing that  
20 we have right now is that actually medical students and  
21 physicians in any specialty during their training get a ton  
22 of experience caring for elderly patients, both in the

1 outpatient and especially in the inpatient study. That's  
2 mostly who people take care of when they're training. That  
3 doesn't mean that they're as good at caring for elderly  
4 patients as geriatricians. They're clearly not and partly  
5 because geriatricians are special people, most likely, and  
6 the fact that they are specialists is exactly one reason I  
7 think that's going to be hard to drastically increase the  
8 supply.

9           But getting to why I think the problem is mis-  
10 framed -- and if it's mis-framed, it's unlikely to be  
11 resolved, or if it's resolved, it's not going to solve what  
12 I think is the main underlying problem. I think the main  
13 underlying problem is care in nursing homes where an awful  
14 lot of people or an increasing number of people are going  
15 to be, including, unfortunately, many of us, it's not --  
16 care is quite bad in nursing homes, and to me, it's worse  
17 than the care of geriatric patients in outpatient settings.

18           So I think the fundamental problem -- they're  
19 both problems. We want better geriatric care in outpatient  
20 settings, but I think the fundamental problem to me or a  
21 fundamental problem is how to get more good clinician care  
22 in nursing homes.



1           As I mentioned -- and I think, by the way, the  
2 problem, the reason the problem is, in my view, mis-framed  
3 is because it's been completely framed by academic  
4 geriatricians. It's very geriatrician-focused. So I'm  
5 arguing for a focus on it's great if there's geriatricians  
6 who can act as consultants or primary care physicians for  
7 some really complex geriatric outpatients, but there's a  
8 lot of nursing homes or a lot of patients in nursing homes,  
9 and they're not getting good care.

10           There are these SNF-ists, and by the way,  
11 exposing -- in terms of suggestions about training,  
12 exposing physicians to nursing homes during their training  
13 as nursing homes are now, it's not going to induce more  
14 physicians to become geriatricians or to work in nursing  
15 homes. It's going to make them run the other way. Believe  
16 me, if you've ever spent much time in a nursing home,  
17 especially a nursing home that cares for a high percentage  
18 of Medicaid patients, which is a lot of nursing homes, it's  
19 not an attractive environment.

20           So I mentioned earlier this work on so-called  
21 "SNF-ists," people who specialize in nursing home care, and  
22 that the number of those is increasing rather than

1 decreasing. There's a question about how good physicians  
2 they are, but I think there should be a lot more work on  
3 the subject of SNF-ists and to what extent there could be a  
4 solution along with PAs and NPs in nursing home care.  
5 There isn't that much work in that, in part, because SNF-  
6 ists don't have academic representation for the most part.

7           So just to finish up, why don't more physicians  
8 want to go into -- let me just say nursing home care. Some  
9 of this is also true for geriatrics. There's no prestige  
10 to it whatsoever. It influences your specialty choice a  
11 lot when you're in your third and fourth year of medical  
12 school and during training and residency training when  
13 people ask you what you're going to do. If you say, oh,  
14 I'm going to work in nursing homes, people will look at you  
15 like wow. So not only is there a lack of compensation  
16 which is, of course, important, but there's a real lack of  
17 respect and prestige.

18           It's also very isolating, I think, for most  
19 people who work in nursing homes. You're not really  
20 working with a multi-physician specialty group. You're  
21 there by yourself really in a tough environment.

22           So I think that more research on care in nursing

1 homes might be helpful, attention to PAs and nurse  
2 practitioners, potential role there, better pay for sure.  
3 It doesn't have to be better pay for geriatricians. As  
4 Ariel suggested, Medicare is not big on specialty-specific  
5 compensation, but there could be better pay for  
6 compensation for nursing home visits, which I think we  
7 actually cut the compensation for that a year ago -- or two  
8 ago, if I'm not mistaken. Building more respect for doing  
9 that, I think -- this is kind of a wonky policy solution,  
10 but funding -- certainly devoting more joint training to  
11 geriatrics would help, but better funding for nursing home  
12 care would also help, I think, over time get more respect  
13 for it.

14           So I do think there's two separate policies. One  
15 is how to get more geriatricians. That would be great. In  
16 my mind, the much more pressing problem is how to get more  
17 people who take care of patients in nursing homes and how  
18 to make those people be good doctors.

19           By the way, most SNF-ists right now are foreign  
20 trained medical graduates for better or for worse, and they  
21 may be there not so much by choice as by, you know, that's  
22 an option that is more easily open to them.

1           I didn't really realize that I had anything much  
2 to say about this topic until I started thinking about it  
3 last night. That's it.

4           DR. CHERNEW: Thanks, Larry.

5           MS. KELLEY: Okay. I have Bruce next.

6           MR. PYENSON: A terrific discussion, and I really  
7 enjoyed the ideas about NPs and PAs and SNF-ists and  
8 geriatricians.

9           But I want to present an option for demand side  
10 rather than supply side, and since half of the Medicare  
11 beneficiaries are or about to be in Medicare Advantage, one  
12 approach to creating a bigger supply is to require Medicare  
13 Advantage plans to have in their network, availability of  
14 certain resources. For example, the Medicare Advantage  
15 plan is not allowed to sell in a county that doesn't meet  
16 certain standards, and putting into those standards a  
17 certain availability, whether it's geriatricians or  
18 geriatric nurse practitioners or SNF-ists or what have you  
19 and creating a timeline for that that's perhaps reasonable  
20 over the future years would send a strong signal that there  
21 is going to be demand for these professionals.

22           This is, I think, a tool that hasn't been

1 available up until now because Medicare Advantage was not a  
2 big piece of the Medicare program, but approaching this  
3 from a demand side, since MA is likely to continue to grow,  
4 I think is an option worth exploring. And, frankly, it  
5 would be relatively simple to have that put into the rules  
6 that Medicare promulgates each year for Medicare Advantage  
7 plans. It wouldn't require dealing with the GME and all  
8 these other details that we're working with. Let the MA  
9 plans, which are some of the biggest corporations in the  
10 country, figure out how to get it done. So I would like to  
11 present that as an option worth considering.

12 MS. KELLEY: Lynn.

13 MS. BARR: I think I've said a lot of this  
14 already, but I don't think new codes are a good idea.

15 I do think if the market will -- if there are  
16 half a million primary care physicians and we've got 1,500  
17 geriatricians, more primary care physicians will go into  
18 geriatrics if they got paid more, if they got that  
19 geriatrics fellowship. So I would strongly encourage the  
20 Commission to consider that, and that would be for NPs and PAs  
21 as well, so some sort of add-on payment for geriatric board  
22 certification is really the only option that I think would

1 be helpful.

2 I think your points about the scholarship program  
3 -- it's great to give the scholarships, but then what's  
4 going to make them actually practice? How many patients  
5 are they going to see? Look at the dropout rates we have  
6 already, and so I think that that can just end up not  
7 getting us where we need to go, and it won't be enough.

8 Like you say, you've got to get them at medical  
9 school to make that decision to go into geriatrics, to make  
10 that additional. So there's got to be more money. I don't  
11 think there's any other way to get at it, and those are my  
12 comments. Thank you.

13 MS. KELLEY: Amol.

14 DR. NAVATHE: Thank you. So I'm very supportive  
15 of this line of work. I think as Betty and the others have  
16 highlighted, I think workforce is a broad bucket of work  
17 that MedPAC should certainly consider doing more work in,  
18 and I know that's a priority.

19 A couple things, I think it's worth just quickly  
20 clarifying on what geriatrics training means. I think we  
21 conventionally understand what the term or the word in  
22 English language -- you know, "geriatric" means elderly,

1 and as Larry pointed out, a lot of the patients who come  
2 into the hospital are older than 65 or elderly, and so, in  
3 that sense, they're geriatric patients.

4           That is very different than geriatric medicine as  
5 a specialty. Caring for older people in the hospital or  
6 even in the primary care setting in a general way is not  
7 geriatric medicine. Geriatric medicine is a very specific  
8 training dealing with specific issues like -- and I think a  
9 few people mentioned this -- around memory, cognition.  
10 There's a whole area of intersection between geriatrics and  
11 psychiatry called geropsych. They're very -- they're  
12 subspecialty type of issues that come up.

13           And yes, geriatricians provide primary care, but  
14 they also have a very specific clinical skill set that is  
15 extending beyond just taking care of general medicine for  
16 older people. I think that's very important to recognize,  
17 particularly in the context of the GME piece of this, where  
18 it might feel otherwise like, well, isn't that what we're  
19 already doing? So that was one point I wanted to make sure  
20 we clarify.

21           In terms of the options, I thought I would opine  
22 mainly because it seemed like I might have some slightly

1 different views. I think it is important for us to be very  
2 clear about what our policy objective is, and if we are  
3 very narrow in our policy objective around increasing  
4 clinicians who practice geriatrics, practice geriatric  
5 medicine, then I'm generally of the similar view that  
6 Option 1 with the code and Option 3 with the GME training  
7 are unlikely to really be effective in increasing the  
8 supply of geriatricians.

9           That being said, if our goal is to recognize that  
10 there is a demographically older, aging population over  
11 time and that the issues that geriatric specialists take  
12 care of are only going to become more prevalent, then I  
13 think we might think about this differently.

14           So I for one, for example, although I'm not  
15 generally a fan of let's code it up and let's be all about  
16 fee-for-service, I think adding a code to support these  
17 broader assessments is definitely not unreasonable, in  
18 part, because geriatricians, as we know already, are being  
19 underpaid. And we value in our system the codes that  
20 generate the more RVUs, whether we like it or not. So I  
21 think to some extent, it is recalibrating in a way that  
22 disproportionately benefits geriatricians with very, very



1 little effect as you spread it out across all the other CPT  
2 codes at E&M visits and such.

3           So I would actually submit that if we're not  
4 exclusively looking at the policy question with blinders on  
5 around expanding supply, then it would not be unreasonable  
6 at all. In fact, it would be kind of a great equity move  
7 from the perspective of geriatric medicine and  
8 incentivizing geriatricians and hopefully, I think, to  
9 Brian's point, as long as you can have some program  
10 integrity pieces to this, the provision of this assessment,  
11 which is otherwise almost like a loss-leader for  
12 geriatricians in general.

13           On the second point, I'm very grateful for the  
14 conversation here and Jim's clarification because I think I  
15 defaulted very much to a loan repayment for physicians kind  
16 of concept, and there was -- that is very different for the  
17 NPs and PAs. And so I am broadly supportive of Option 2 as  
18 something that could be quite effective, recognizing that  
19 this is probably not -- given the gap that we have that I  
20 think Lynn highlighted, this probably would be one part of  
21 a panoply of different policy changes or innovations we'd  
22 have to make to really close this gap.

1           Option 3 of the GME piece, as I mentioned, I  
2 think the geriatric medicine piece is a very specialized  
3 portion of the curriculum. I think it would probably be  
4 relatively difficult to implement any sort of integrity  
5 because of some areas that, I think, Jonathan and others  
6 have pointed out that even the availability of  
7 geriatricians to teach these types of skills may actually -  
8 - and these clinical concepts may actually not be very  
9 pervasive. If that's the case, we may be creating further  
10 disparity between regions that have enough geriatricians  
11 and those who don't rather than really correcting some of  
12 our issues.

13           But thank you so much for this work. I think  
14 it's fundamentally very important.

15           DR. CHERNEW: Okay. Dana, if I followed, Amol  
16 had the penultimate word. I guess I have the ultimate or  
17 the last word, anyway. Is that right, Dana?

18           MS. KELLEY: I think that's right.

19           DR. CHERNEW: Great. So, Amol, thank you.

20           So, first of all, thanks to all of you for  
21 engaging in this material, and thanks to Jamila and Ariel  
22 for really a wonderful chapter. This illustrates the

1 challenges that we face.

2 I'm not going to give a big wrap-up here as a  
3 general point. I will say that the concerns and the issues  
4 that you all raised, we will ponder. I think, again, this  
5 tradeoff for all of these is what is it going to cost, what  
6 are the unintended consequences, and will it achieve the  
7 goals that we want, what exactly are the goals we want, and  
8 there's some discussion therein.

9 There were a few new ideas that arose, and we'll  
10 think through them. We are early in this process. The  
11 other thing, just so you all know, is, as I mentioned  
12 earlier, we will have a workforce focus to some extent next  
13 cycle. There's an extent to which this can fit into that.  
14 We do some stuff on GME overall. This could fit into that.  
15 So there's some broad notion of what we get for the way we  
16 do training. So there's a lot of moving pieces that relate  
17 to this.

18 I think what is clear is the basic problem is to  
19 make sure we get the best care we can for the beneficiaries  
20 we're serving, and some of those beneficiaries are very  
21 complicated patients that need the type of care that  
22 geriatricians provide, and so that seems clear. Although

1 it is also clear that other people that might not be  
2 geriatricians by training can provide some of that care,  
3 and that's both physicians and non-physicians.

4           So we're going to ponder. We will come back at  
5 some point and decide what to do with this. This has been  
6 useful. I know Jim has to hop off, and I think also with  
7 Hope and Stephanie, they have a meeting at 5:00 because  
8 their days never end.

9           So let me just say thanks to you all. For the  
10 audience at home, we really do want to hear your feedback.  
11 So please send any comments to [meetingcomments@medpac.gov](mailto:meetingcomments@medpac.gov)  
12 or go on the Web where you can send us meeting comments.  
13 We are always looking forward to that, and for those  
14 interested -- and I know that's all the Commissioners --  
15 join us tomorrow morning. We will be convening at 10:30  
16 with a session on alternative payment models, with a focus  
17 on episode-based payment, and followed up after lunch with  
18 a discussion of some issues related to Medicare Advantage  
19 risk adjustment. So we look forward to seeing you all  
20 tomorrow. Thank you for joining us, and thanks again to  
21 Ariel and Jamila for this wonderful work, and we will see  
22 you then.

1                   [Whereupon, at 4:59 p.m., the meeting was  
2 recessed, to reconvene at 10:30 a.m. on Friday, March 4th,  
3 2022.]

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MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Via GoToWebinar

Friday, March 4, 2022  
10:31 a.m.

COMMISSIONERS PRESENT:

MICHAEL CHERNEW, PhD, Chair  
PAUL B. GINSBURG, PhD, Vice Chair  
LYNN BARR, MPH  
LAWRENCE P. CASALINO, MD, PhD  
BRIAN DeBUSK, PhD  
STACIE B. DUSETZINA, PhD  
MARJORIE E. GINSBURG, BSN, MPH  
DAVID GRABOWSKI, PhD  
JONATHAN B. JAFFERY, MD, MS, MMM  
AMOL S. NAVATHE, MD, PhD  
JONATHAN PERLIN, MD, PhD, MSHA  
BRUCE PYENSON, FSA, MAAA  
BETTY RAMBUR, PhD, RN, FAAN  
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P R O C E E D I N G S

[10:31 a.m.]

1  
2  
3 DR. CHERNEW: Welcome, everybody, to this  
4 morning's MedPAC session. We're continuing our discussion  
5 of alternative payment models, moving along in anticipation  
6 of an APM chapter in the June report, and today we're going  
7 to deal with one of the more complicated issues:  
8 integrating episode-based payment with population-based  
9 payment.

10 So, with that in mind, I'm going to turn it over  
11 to Geoff and Rachel, and, Geoff, I think you are kicking us  
12 off.

13 MR. GERHARDT: Indeed. Good morning, everybody.

14 In this session, Rachel Burton and I will discuss  
15 ways in which to combine episode-based payment approaches  
16 with a population-based payment model.

17 We want to thank Jeff Stensland, Luis Serna, and  
18 Betty Fout for their input.

19 The audience can download a PDF of these slides  
20 from the webinar's control panel under the "Handouts"  
21 section on the right-hand side of the screen.

22 Today's presentation starts with a quick review



1 of work the Commission has been doing to improve Medicare's  
2 portfolio of APMs.

3 At previous meetings, some Commissioners have  
4 expressed support for combining episode-based payments with  
5 a population-based payment model, so we will discuss how  
6 Medicare's episode models work and how they currently  
7 interact with current population-based models.

8 We'll then present three possible options for  
9 integrating episode-based payment approaches with the new  
10 population-based payment model being discussed by  
11 Commissioners.

12 Finally, we will raise some questions about the  
13 three options and ask Commissioners for their feedback.

14 At several meetings this cycle, Commissioners  
15 have discussed specific ways of implementing the June 2021  
16 recommendation that CMS implement a smaller, more  
17 harmonized portfolio of APMs.

18 At the October meeting, there was broad  
19 Commissioner interest in centering CMS' APM strategy around  
20 a single, multi-track, population-based payment model.  
21 Different tracks of this model would be geared toward  
22 different types and sizes of organizations and would

1 involve different amounts of financial risk.

2           At the November and January meetings,  
3 Commissioners expressed interest in moving away from the  
4 current practice of periodically "rebasings" ACO benchmarks  
5 to an approach that only uses annual administrative  
6 updates.

7           And at the October meeting, Commissioners also  
8 expressed interest in exploring how episode-based payment  
9 arrangements could be combined with the core population-  
10 based payment model. Today's presentation explores that  
11 concept in greater detail.

12           The April meeting will bring these ideas together  
13 in a follow-up chapter in our June 2022 report.

14           Combining an episode-based payment approach with  
15 a population-based payment model presents a number of  
16 potential benefits.

17           In theory, supplementing a population-based model  
18 with payments that focus on specific clinical episodes can  
19 help ensure that specialists and facilities have strong  
20 incentives to provide efficient, high-quality care during  
21 those episodes.

22           There is also evidence that attributing

1 beneficiaries to both an ACO and episode-based payment  
2 model can result in larger reductions in utilization and  
3 improvements in quality for certain types of episodes than  
4 either model would have achieved individually.

5           However, there are potential drawbacks as well.

6           For instance, if the market for specialists is  
7 consolidated or information about their performance is not  
8 transparent, the presence of an episode-based approach may  
9 not be effective in bringing down costs.

10           And depending on the specific payment  
11 arrangements, ACOs may be reluctant to engage with episode-  
12 based providers because they don't want to share potential  
13 bonus payments.

14           In Medicare's episode-based payment models,  
15 episodes are triggered by a defined clinical event, such as  
16 knee replacement surgery or congestive heart failure.

17           Medicare pays providers on a fee-for-service  
18 basis but tracks all spending for a beneficiary once an  
19 episode has been triggered. Medicare then compares actual  
20 spending during the episode period against a target  
21 spending amount.

22           In Medicare's two largest episode models, the

1 target amount is a risk-adjusted average of all Part A and  
2 Part B costs that occur 90 days following a triggering  
3 event, minus a discount factor. The discount factor is the  
4 mechanism CMS uses to generate program savings from the  
5 model.

6           If actual spending is less than the target  
7 amount, the accountable entity receives payment for the  
8 difference. If actual spending is above the target, the  
9 entity must pay Medicare for the difference. The maximum  
10 amount providers can receive in bonuses or pay in penalties  
11 is usually capped at 20 percent of their spending target.

12           CMS currently uses inconsistent model overlap  
13 policies when a beneficiary is in an ACO and triggers an  
14 episode in one of the episode-based payment models, as  
15 shown in Table 2 of the paper.

16           In some combinations of models, beneficiaries in  
17 an ACO can be concurrently attributed to an episode-based  
18 payment model while in other models they cannot.

19           In scenarios where a beneficiary can be  
20 concurrently attributed, participants in both models are  
21 eligible to receive bonus payments for any savings. In  
22 some of these cases, any bonus payments earned by an ACO or

1 episode-based provider are not included in tallies of total  
2 spending for the other.

3           For instance, beneficiaries in an MSSP ACO can be  
4 concurrently attributed to the BPCI Advanced model, and any  
5 bonus payments a BCPI provider receives for those  
6 beneficiaries is not counted toward the ACO's total  
7 spending.

8           In this situation, Medicare is essentially  
9 double-paying bonuses because CMS allows participants in  
10 both models to earn bonuses with no adjustment to account  
11 for the other's bonus payments. The same phenomenon can  
12 occur for penalties incurred by model participants.

13           Given the potential benefits of combining ACOs  
14 and episode-based payment, Medicare should seek to apply  
15 more consistent overlap policies that avoid double-paying  
16 bonuses.

17           I will now hand things over to Rachel.

18           MS. BURTON: At the October meeting, there was  
19 Commissioner interest in exploring whether and how to  
20 integrate episode-based payment with a population-based  
21 payment model.

22           The rest of this presentation outlines three

1 options for doing this, which would all avoid paying double  
2 bonuses to providers.

3 All three of the options I'll be describing  
4 assume Medicare would operate a new episode-based payment  
5 model, but our options vary in terms of which types of  
6 beneficiaries would be attributable to this new model,  
7 which I'll say more about in a minute.

8 The Medicare episode model would only include a  
9 few types of clinical episodes that have been proven to  
10 save money for the Medicare program, such as hip and knee  
11 replacements, other hip and femur procedures, and urinary  
12 tract infections.

13 To prevent Medicare from double-paying bonuses,  
14 in options that call for concurrently attributing some  
15 beneficiaries to both an ACO and this episode model, any  
16 bonus or penalty incurred by episode providers would be  
17 included in the ACO's annual spending tally.

18 We assume this episode model would be mandatory,  
19 to avoid the selection issues that can arise when a model  
20 is voluntary, and to be consistent with Commissioners'  
21 views at the October meeting.

22 If Commissioners would instead prefer that this

1 episode model be voluntary, we would look for Commissioner  
2 input on how to mitigate selection issues.

3           In all three of the options I will describe, ACOs  
4 could enter into their own arrangements with providers for  
5 episodes not covered by Medicare's episode-based payment  
6 model.

7           This would give ACOs flexibility to experiment  
8 with payment arrangements for dozens of types of episodes,  
9 but we caution that it doesn't necessarily mean that ACOs  
10 would choose to set up such arrangements.

11           ACOs might not bother if they don't have data on  
12 the cost and quality of episode providers in their area or  
13 if they can't get episode providers to agree to enter into  
14 arrangements with them or if they think they can more  
15 reliably generate shared savings through other approaches.

16           I'll now describe the key difference between our  
17 three options.

18           Our options vary in terms of which types of  
19 beneficiaries would be attributed to a new Medicare  
20 episode-based payment model.

21           In Option 1, all fee-for-service beneficiaries  
22 would be attributed to the Medicare episode model if they

1 had a triggering episode. This would include beneficiaries  
2 in two-sided ACOs, one-sided ACOs, and beneficiaries who  
3 are not in an ACO.

4 In Option 2, only beneficiaries in a one-sided  
5 ACO or who are not in an ACO would be attributed to the  
6 Medicare episode model, since this option assumes two-sided  
7 ACOs would already have a sufficient incentive to ensure  
8 episodes are delivered efficiently.

9 In Option 3, only beneficiaries who are not in an  
10 ACO would be attributed to the Medicare episode model,  
11 since this option assumes both two-sided and one-sided ACOs  
12 would already have a sufficient incentive to ensure  
13 episodes are delivered efficiently.

14 In all three of our options, ACOs would always  
15 have an incentive to ensure care is delivered efficiently  
16 in the types of episodes not covered by Medicare's episode  
17 model, and ACOs would always have an incentive to keep  
18 beneficiaries healthy to prevent episodes from occurring,  
19 since episodes can be quite costly.

20 In Option 1, all fee-for-service beneficiaries  
21 would be attributable to Medicare's episode model. An  
22 advantage of this option is that providers delivering care



1 during the types of episodes included in Medicare's model  
2 would always have an incentive to deliver that care  
3 efficiently, since they would always be paid on an episode  
4 basis.

5 In addition, episode providers would be paid  
6 using a single, consistent, payment model for these  
7 episodes, thus reducing complexity for these providers.

8 A drawback of Option 1 is that ACOs would have  
9 only a weak incentive to manage episodes once they had  
10 begun, since the difference between an inefficient episode  
11 and an efficient episode would have only a minimal impact  
12 on an ACO's spending, as the examples in our paper show.

13 ACOs would also be limited in their ability to  
14 design their own payment arrangements for the episodes  
15 covered by Medicare's episode model.

16 In Option 2, only beneficiaries in one-sided ACOs  
17 or who are not in an ACO would be attributed to Medicare's  
18 episode model. The advantage of this option is it would  
19 give two-sided ACOs a stronger incentive to ensure episodes  
20 are delivered efficiently. Two-sided ACOs would be able to  
21 design their own payment arrangements to use with their  
22 episode providers.

1           A disadvantage of Option 2 is that two-sided ACOs  
2 might not choose to operate their own episode arrangements  
3 with providers, since these arrangements can be  
4 administratively complex.

5           If two-sided ACOs did choose to each set up their  
6 own episode-based payment arrangements, episode providers  
7 could end up being paid using multiple episode payment  
8 models, thus creating complexity for these providers.

9           We also note that under this option, episode  
10 providers would have no incentive to deliver efficient  
11 episodes if a beneficiary in a two-sided ACO sought care  
12 from episode providers who were not in her ACO, since these  
13 episode providers would be paid on a purely fee-for-service  
14 basis.

15           A final con is that one-sided ACOs would have  
16 only a weak incentive to manage episodes once they had  
17 begun and would not be able to design their own payment  
18 arrangements to use with episode providers.

19           In Option 3, only beneficiaries who are not in an  
20 ACO would not be attributed to Medicare's episode model.  
21 The advantage of this option is it would give all ACOs an  
22 incentive to ensure episode care is delivered efficiently.

1           A disadvantage of Option 3 is that ACOs might not  
2 choose to operate their own episode arrangements with  
3 providers, since these arrangements can be administratively  
4 complex.

5           If ACOs did choose to each set up their own  
6 episode-based payment arrangement, episode providers could  
7 end up being paid using multiple episode payment models,  
8 thus creating complexity for these providers.

9           In addition, episode providers would have no  
10 incentive to deliver efficient episodes if a beneficiary in  
11 an ACO sought care from episode providers who were not in  
12 her ACO, since these episode providers would be paid on a  
13 purely fee-for-service basis.

14           As we turn to Commissioners' discussion of this  
15 material, we'll leave you with four questions:

16           Which of the three options do Commissioners  
17 prefer?

18           Are there other pros and cons that our options  
19 should note?

20           Are there modifications that would improve these  
21 options?

22           And are there other options for integrating

1 episode-based payment with population-based payment that  
2 Commissioners wish to consider?

3           If during today's discussion many commissioners  
4 support a particular option, we will include it in the APM  
5 chapter of our June report to the Congress.

6           We'll leave you with a slide summarizing the  
7 differences and commonalities of our three options and turn  
8 things back over to Mike.

9           DR. CHERNEW: Great. Rachel, thank you, and,  
10 Geoff, thank you.

11           I'm about to open it up to the Round 1 queue. I  
12 do want to make one comment on context. This material  
13 really focuses on these three options, and I do think it's  
14 important to discuss these three options. But I'm very  
15 aware that your choices may be reflective of a bunch of  
16 other things related to the episode program: how many  
17 episodes, whether they're mandatory, maybe something about  
18 benchmarks. So I'm torn as to sort of the instructions to  
19 the Commission. On the one hand, please make your comments  
20 about these known, to the extent that you have them. On  
21 the other hand, I'm interested in other aspects of the  
22 programs you might want to comment on and how they interact

1 with these options, recognizing that the time between now  
2 and when we see this again in April -- and that is actually  
3 much shorter than it seems, so there's only going to be so  
4 much we're going to be able to do. But it is always useful  
5 to hear your thinking even if we can't incorporate it all  
6 at this stage. We have other cycles and other times to be  
7 able to get that into account.

8           So I guess what I'm saying is thoughts on this is  
9 obviously important, and to Geoff and Rachel, I think this  
10 graphic is just outstanding. But if you want to say more  
11 about how it interacts with your feelings about other  
12 aspects of the episode program, don't hold back.

13           So, with that, Dana, let's go into the queue, and  
14 I think Round 1 is going to start with Jonathan.

15           MS. KELLEY: I think that's right.

16           DR. JAFFERY: Great. Thanks, Mike and Dana.  
17 Thanks, Rachel and Geoff. Indeed, it's a fantastic  
18 chapter, and the presentation was clear and great, and the  
19 way you've laid out the pros and cons is really wonderful  
20 for this discussion. And as you know, I'm very excited  
21 about this topic.

22           I'm not sure if this is two questions or a single

1 two-part question, but when you listed the cons for Option  
2 1, you said the one con is that ACOs couldn't design their  
3 own payment arrangements, something like that. And so I'm  
4 curious if that's actually true. And why couldn't ACOs  
5 maybe design some of their own payment arrangements, even  
6 for mandatory episodes?

7           So, for example, could an ACO provide care  
8 coordination support or create a strong affiliation with  
9 some groups of specialist providers and then in return  
10 maybe receive a portion of any shared savings that they get  
11 from that episode payment?

12           And then, again, maybe this is a two-part  
13 question or maybe it's a separate question, but I just want  
14 to make sure that I'm thinking about this correctly.  
15 Again, in the chapter, you have an example, walking through  
16 some of the dollars under Option 1 that probably could  
17 apply in the other options as well. And so in that  
18 example, all the episode savings and losses go to the  
19 episode provider, not the ACO, and then they're counted  
20 toward the ACO spending. But in that scenario, is the ACO  
21 more or less guaranteed to get the CMS discount? That was  
22 sort of my read on how the dollars would flow. So let me

1 ask those, and thanks for -- looking forward to the rest of  
2 the discussion, too.

3 MS. BURTON: I think I'd have to mull your second  
4 question. So let me take that back and see if any tweaks  
5 need to be made to our dollar example in the paper.

6 And for your first point, I think you're right  
7 that ACOs could potentially layer on some other type of  
8 arrangement with episode providers, even in Option 1. You  
9 certainly have more experience than I would on, you know,  
10 what type of thing might be possible and acceptable to  
11 episode providers.

12 MR. GERHARDT: But I think to expound on that a  
13 little bit more, we were trying to create some clear  
14 demarcations, and one of the demarcations was for the  
15 episodes that are covered by the Medicare model, would the  
16 participants in a given type of ACO be allowed to do their  
17 own arrangements for those, or would essentially their  
18 providers that triggered those kinds of episodes be in the  
19 Medicare model? Rather than having sort of the choice to  
20 go one way or another, these options envision more of a  
21 clean demarcation. So for those episodes that are covered  
22 by the Medicare model that apply to a specific ACO, the

1 ACO's participants would go into the Medicare model.

2 DR. CHERNEW: I think -- so because the queue is  
3 long, I'm going to move us along, but I think, Jonathan,  
4 the way to think about this is organizations can always  
5 build contractual arrangements outside of what Medicare  
6 does. But if they were going to do that in Option 1, they  
7 would have to build whatever they build around an episode  
8 model that exists that people would be in; whereas, the  
9 others they wouldn't. So they could in some sense undo or  
10 modify what that is, but it's just a completely different  
11 framework for how that plays out when you have the episode  
12 existing. So think about that as people just working  
13 around the underlying Medicare foundation, which in this  
14 case would include the episode.

15 Since I see you nodding your head, Rachel, I  
16 think we're going to move on to the next person in the  
17 queue.

18 DR. NAVATHE: This is Amol. May I just add a  
19 quick point? I think to some extent it also impacts how  
20 the funds are flowing. So if you have a mandatory episode  
21 model, then in some ways the savings are accruing to the  
22 episode provider, and then, Jonathan, the ACO would be



1 contracting to sort of bring the savings from the episode  
2 provider into the ACO rather than vice versa if it were in  
3 the other opposite informal arrangement.

4 DR. CHERNEW: Yes. Good point.

5 MS. KELLEY: Okay. I have Dana next.

6 DR. SAFRAN: Thank you so much. Okay. We're in  
7 Round 1, just to get myself organized here. So a couple of  
8 questions.

9 One is I'm curious what we know about the extent  
10 to which patients who are receiving procedural care in  
11 Medicare are doing so with guidance or advice on who to go  
12 to for that care from another provider, either a PCP or  
13 potentially a specialist. I know that's hard to discern,  
14 but I think it's very relevant to our thinking about the  
15 three options, because to understand the leverage that the  
16 ACO has with respect to referrals and, therefore, the  
17 leverage they have for the episode provider in terms of  
18 concern that their market share can dry up if they aren't  
19 performing in a way that the ACO feels is adding value,  
20 it's really helpful to understand those referral dynamics,  
21 even in a model that doesn't require a referral in terms of  
22 benefits.

1 I hope that's a clear question, but my question  
2 is really what we know about those patterns in fee-for-  
3 service Medicare.

4 MS. BURTON: I think Luis and Jeff might be the  
5 best people to answer that question. If they're available  
6 to pop on, that's great. And if not, we'll just consult  
7 with them offline and add some information about that in  
8 our paper.

9 DR. STENSLAND: We can look into that, but I  
10 don't think we have any data off the shelf that's going to  
11 say what share of the fee-for-service, say, surgeries were  
12 driven by a primary care referral.

13 DR. SAFRAN: Yeah, I'd be happy to chat offline.  
14 There's some ideas I have for how you might model it with  
15 claims data, but I recognize that you may not have the time  
16 or bandwidth to do that.

17 So just two other questions to clarify. One is,  
18 you know, your point at the early part of the chapter  
19 around the very small number of episodes today for which  
20 there's sufficient evidence of effectiveness that they be  
21 rolled into this model got me curious about how we ever  
22 filled out the portfolio of episodes to do this. So, you

1 know, you suggested that CMS can be still doing some  
2 testing, which, of course, is right. How else would we  
3 build out the portfolio? I just was curious about your  
4 thoughts around how that comports with the recommendations  
5 we're making and have made about parsimony in the models,  
6 because if CMS is continuing to need to test a whole lot of  
7 episodes in order to build out the episode portfolio, that  
8 just -- I wondered how that fits together.

9           And then I'll just add my third question and then  
10 go off mic. The third one was just a point of confusion  
11 for me. On page 12 of the reading material, when you're  
12 sharing the evidence from the BPCI Advanced, you note that  
13 there were significant impacts on costs for surgical  
14 episodes but not for medical. My understanding was that  
15 the paper of Amol's that you cite had the absolute opposite  
16 findings, that the impact was for medical episodes, not  
17 surgical. I could be wrong, but I just wanted to ask that  
18 question.

19           Thank you.

20           MS. BURTON: Well, Amol might be in the best  
21 position to answer your last question. I wonder if he can  
22 chime in.

1 DR. NAVATHE: Sure. So the paper, I think, that  
2 you're referencing, Dana, looked at overlap between ACOs  
3 and bundles. So this is when an ACO beneficiary goes to a  
4 bundled payment provider where there are additive benefits,  
5 those additive benefits accrue to both surgical and medical  
6 condition patients in the context of lower readmissions.  
7 But there were greater savings -- you remembered this  
8 correctly. There were greater savings in the medical  
9 group, and the higher acuity of the patient, the stronger  
10 the effect within the medical group.

11 DR. CHERNEW: Incremental. Incremental.

12 DR. NAVATHE: Incremental, yeah.

13 DR. SAFRAN: Thanks.

14 MS. BURTON: And then to your first question,  
15 Dana, this presentation is trying to kind of capture some  
16 of the Commissioners' views from the October meeting and  
17 sort of present them back in like here are some ways to  
18 implement what you guys were thinking. So in October,  
19 there was a preference expressed for an episode model that  
20 only focuses on a few episodes. But it did seem like there  
21 was interest in continuing to not give up on episodes but  
22 continue to try to see what else might work in an episode

1 sort of arrangement. But if you would prefer that CMMI  
2 rein it in and not test further episodes, that's certainly  
3 something that you guys could talk about.

4 DR. CHERNEW: Can I say something in that regard?  
5 This issue about how many episodes or how to build it out,  
6 those type of things, is a very important issue, and I'm  
7 interested -- people can say something about this in Round  
8 2. I will say that we're not going to resolve that  
9 particularly for this chapter. My personal view is  
10 building out episodes should not be done for the sake of  
11 building out episodes. Building out episodes should be  
12 done when we think adding any particular episode helps  
13 promote the objectives we have of better care, lower  
14 spending, et cetera. And we have to be worried not just  
15 about what's happening in the particular episode that we're  
16 building but how it influences all that's going on in the  
17 population-based payment model or, for that matter, with  
18 the other episodes. And I think it is likely that where we  
19 may get in this chapter -- and, Dana, I hear your statement  
20 as a call for us to do this. I'm not sure how we  
21 operationalize. To say something about the considerations  
22 one would use in doing that, because I can pretty much tell

1 you, at least for this cycle, we're not going to get to a  
2 point where we're going to resolve that issue. I think as  
3 a Commission we would have to be much further along, and I  
4 just don't see us getting there in the time frame we have.  
5 But I do think we can say something about the issue and how  
6 to think about it.

7 I don't know if that was helpful, but I fear this  
8 issue -- not fear. I expect this issue may be running  
9 through a lot of people's minds, so I want to emphasize  
10 where I think we may end up on that. Others may comment,  
11 but --

12 DR. SAFRAN: That's helpful, Michael. Thanks.

13 DR. CHERNEW: Yeah. Let's go on. I think Paul  
14 is next.

15 DR. PAUL GINSBURG: Sure. I have a question  
16 about the relationships of ACOs to their physician members,  
17 and, you know, particularly, Dana, we know that if a  
18 primary care physician is a member of an ACO, that really  
19 defines the ACO because that attributes beneficiaries to  
20 it. But, you know, on the specialists, it's something  
21 where an ACO could steer patients to a specialist whether  
22 they're a member of the ACO or not. And, you know, in a

1 sense it seems as though whether specialists are in ACOs is  
2 very much endogenous in this world we're talking about.

3           So the question is: Is there anything you could  
4 tell us about, you know, what proportion of the primary  
5 care physicians and specialists who treat Medicare  
6 beneficiaries are now members of ACOs? And is there any  
7 norm for what the relationship is for a specialist? And if  
8 they become a member of an ACO, what actually is their  
9 relationship to the ACO?

10           MR. GERHARDT: That might be something that Jeff  
11 or Luis know more about, but I will tell you there are more  
12 specialists that participate in ACOs in total than PCPs,  
13 which, of course, largely affects the breakdown in the  
14 overall specialty of physicians. So there are a  
15 significant number of specialists already participating in  
16 ACOs, but the make-up of a given ACO is going to vary very  
17 highly between different ACOs, so maybe almost exclusively  
18 PCPs and no specialists while others are clearly weighted  
19 more heavily towards the specialist side.

20           I don't know if Jeff or Luis have anything more  
21 to add.

22           DR. STENSLAND: Yeah, I have nothing else to add

1 to that.

2 DR. PAUL GINSBURG: Okay. Well, let's keep going  
3 forward to Round 2, and I'll come back to this later. You  
4 know, think in terms of whether specialists are members of  
5 ACOs is very endogenous, you know, very subject to the  
6 details in different situations, and presumably would be  
7 very affected by the decisions we make on overlap.

8 DR. MATHEWS: Paul, if I could jump in here, this  
9 is always something fraught with risk when I do this kind  
10 of thing. But, you know, everything that Geoff said about  
11 representation of specialists in ACOs is correct insofar as  
12 the data permit us to evaluate, so we can say things like,  
13 you know, the share of physicians receiving a 5 percent  
14 bonus payment is roughly commensurate with the share of  
15 specialists in the environment. But what we don't know --  
16 and here, Geoff or Jeff or Rachel, you know, if I'm heading  
17 out on a limb, stop me. What we don't know is the degree  
18 to which specialists are actively involved in the  
19 governance of any given ACO and making decisions about how  
20 to manage the patients or things like that. And that's a  
21 much harder issue than just evaluating the flow of dollars.

22 DR. CHERNEW: Related to that is oftentimes you



1 could have a large health care system that has an ACO and a  
2 specialist that works for that health care system where the  
3 specialist is neither on the list nor self-identifies with  
4 being part of the ACO, but is subject to the rules of the  
5 system, that they would be affected by the fact that the  
6 system is in the ACO. So this notion about whether or not  
7 a specialist is in or is not in an ACO or how the  
8 specialist is or isn't compensated or how they are or  
9 aren't engaged is actually much more complicated than just  
10 simply are they getting bonuses through the ACO or are they  
11 on the ACO list or some other type of thing.

12 I'm not sure we're going to resolve all of that  
13 given the heterogeneity in the country, but that's my take  
14 on this very complex issue.

15 DR. PAUL GINSBURG: Yeah, excellent, because I  
16 think the actual takeaway is that, you know, as we go  
17 through these issues, we need to recognize that they could  
18 very much influence the degree to which specialists are  
19 members of ACOs or which ACO they're in.

20 When I was on the board of an ACO as a Medicare  
21 beneficiary, they made a decision once to remove all of the  
22 hospital-employed specialists from the ACO because Milliman

1 told them they'd do better, which was correct. I won't  
2 push it any further.

3 DR. CHERNEW: I think Bruce is next in the queue.  
4 Sorry, Dana, I should let you run this. I'm just --

5 MS. KELLEY: No, that's fine. Bruce is next.

6 MR. PYENSON: Thank you. Perhaps a follow-up  
7 question to Paul's and then I have another -- I've got  
8 actually two questions. I was struggling to think about  
9 how the options interact with governance of two entities,  
10 one entity being the ACO and the other entity being the  
11 sponsor of an episode-based model. And, in particular, you  
12 know, if you have a community hospital ACO, what happens  
13 when a community hospital is also the sponsor of a bundled  
14 payment program and there's overlap, a different kind of  
15 overlap than we're talking about with patients, but it's  
16 really the same entity? And how's that defined? So  
17 there's -- that's one question. How do we think about  
18 that? Because as we know, often the kinds of organizations  
19 that sponsor ACOs might be also sponsoring bundled payment  
20 programs.

21 My second question is about the statement that we  
22 have to avoid double payment, and I'm wondering what the

1 origin of that is. Is that a principle? Is it empirically  
2 based because it's material or something else? I'm just  
3 curious about what's the rationale for saying double  
4 payment is a bad thing. So two questions there.

5 MS. BURTON: Our paper focused on beneficiary  
6 overlap rather than provider overlap, so I think we'd be  
7 curious to hear your thoughts on what you think would make  
8 sense on the provider overlap front.

9 And then in terms of double payment, maybe I'll  
10 ask Jim if he wants to take that.

11 DR. MATHEWS: Sure, absolutely. I mean, from our  
12 perspective, as we were putting together this paper, this  
13 seemed to be, you know, something innately fiscally prudent  
14 that the Medicare program would have a vested interest in  
15 doing, avoiding paying out double bonuses for basically the  
16 same care provided to a single patient during the course of  
17 a single episode. And so if I were in an argumentative  
18 mood -- which I'm not -- you know, I might ask: Well, what  
19 would be the competing rationale for paying out double  
20 payments?

21 MR. PYENSON: Well, is that a Round 1 question,  
22 Jim?

1 DR. CHERNEW: Remember, he would say that if he  
2 was in an argumentative mood, but he's not in an  
3 argumentative mood, so he actually didn't say that. That's  
4 the way to interpret that complicated set of semantics.

5 Actually, let me just say this, just for the  
6 purposes. Jim, I think you answered the clarifying  
7 question of which you were thinking. Bruce, in Round 2, if  
8 you want, you can comment on what Jim said. I personally  
9 think a lot of the issue depends on how big the program is,  
10 writ large. I could probably get you to agree that there's  
11 a certain amount of double payment that would not be good.  
12 You would never be able to save money totally if every time  
13 someone saved a dollar you paid back two. But it might be  
14 I could design some set where some limited amount of  
15 overlap or some limited amount of episodes might not be  
16 disastrous. This is, I think, much simpler than that level  
17 of nuance and I think what motivated it. That's my take on  
18 what Jim said.

19 But, Bruce, you get to comment on all of that --

20 MR. PYENSON: But just --

21 DR. CHERNEW: -- all of that in Round 2.

22 MR. PYENSON: So I understand Jim's answer, I

1 asked if it was based on materiality or principle or  
2 something else, and I think what I heard is it's based on  
3 principle.

4 DR. MATHEWS: That's correct.

5 MR. PYENSON: Okay. Thank you.

6 MS. KELLEY: All right. That's the end of Round  
7 1, I think, Mike, unless anyone else wants to jump in.

8 DR. CHERNEW: No, that's what I have, too, and so  
9 I think now Amol, who I will tell everybody was in the  
10 queue last night at around 10:00, is going to be the first  
11 participant in Round 2. Amol.

12 DR. NAVATHE: Great. Thanks, Mike. So as you  
13 can tell, I can barely contain my enthusiasm for this work.  
14 Geoff and Rachel, I think you did an outstanding job of  
15 taking a very complicated subject and making it digestible  
16 and distillable and not 300 pages long, so congratulations  
17 on that.

18 I have a number of different suggestions,  
19 thoughts on the policies but also suggestions for potential  
20 improvement of the chapter and the work in general. So  
21 what I'm going to try to do here to be as tractable as  
22 possible is to categorize this into short-term feedback in

1 terms of what we might be able to actually change in a  
2 practical, feasible way by April or by the June chapter  
3 deadline, and then some longer-term suggestions for the  
4 work where there might be some analytic components that we  
5 could do but not for this cycle given the time constraints  
6 that we have.

7           I think one thing that's important to just  
8 outline is a general principle -- and I think we embody  
9 this, but it's good to remember sometimes -- that what  
10 we're trying to do here is not per se advocate any  
11 particular program or type of provider or what have you,  
12 but really design policy that's following what the best  
13 evidence suggests to do what's best for the Medicare  
14 program writ large. And I think that's important, and I'll  
15 come back to a couple of areas where I think that might be  
16 helpful.

17           So in terms of short-term pieces, I have four  
18 points. I'll try to outline them as crisply and cleanly as  
19 possible.

20           The first point is I think there may be some  
21 opportunities for us to just improve the characterization,  
22 in some sense the balance of the way that we describe the

1 evidence in the chapter. I won't get into it now because I  
2 don't think it's that helpful, but I will follow up with  
3 some comments by email that will be hopefully much more  
4 targeted and well-scoped in some sense.

5           Alongside this comment, I think one thing that  
6 might be helpful is, as I went through the chapter, it felt  
7 a little bit backwards in sequence, and I recognize that  
8 this is part of a broader chapter to be married with the  
9 other ACO model discussion. But we sort of dive head first  
10 into the overlap considerations and then have a paragraph  
11 or two after that to say, well, here are the design  
12 considerations that one might think about in bundled  
13 programs going forward.

14           And I think that made it cognitively very  
15 difficult to follow because when we're reading the parts  
16 about the options, we haven't really pre-committed in any  
17 fashion to what the general design of the bundle looks  
18 like. Are we talking about chronic condition bundles like  
19 the oncology care model? Are we talking about only  
20 exclusively acute condition bundles or surgical bundles? I  
21 think it would actually help if we could have some preamble  
22 discussion around here's the broad structure of a bundled

1 program; there are number of considerations which we don't  
2 have time to get into now that would be a part of further  
3 work and that would need to be specified either in part by  
4 MedPAC or by CMS if it were to implement these. And so I  
5 think that would require a little bit of reorganization,  
6 but I don't think it would be too onerous to do that, maybe  
7 with just a little bit more language to contextualize.

8           Second main short-term point is discussion around  
9 episode choices and to some extent episode design. One of  
10 the reasons I'm coming back to this point around balancing  
11 or improving the discussion of the evidence to some extent  
12 is we are -- on one hand, we have the benefit of looking  
13 back at three or four different episode programs that CMMI  
14 has put out. On the other hand, there's only three or four  
15 programs that were implemented in a very particular way,  
16 and we know, for example, that the CGR program, when it  
17 went voluntary, introduced a rate goal. We know the BPCI  
18 Advanced program has had some issues with the way that the  
19 benchmarks were designed, et cetera.

20           And so if we stick our litmus test peg to this  
21 notion of net savings, I think we may actually be doing a  
22 disservice to the program, much in the same way I think in



1 part the ACO conversation we followed where the gross  
2 savings, where the practice change is happening. And so  
3 there's an opportunity here as part of this work to  
4 probably just flag, not do the work in the short run. In  
5 the long term we could potentially do some work on how do  
6 we improve the design of bundles or episodes such that they  
7 can be the best they can be, and then we can integrate them  
8 in with ACOs as best as possible. But it's hard to do this  
9 -- I recognize -- and I'm not saying this as a  
10 Commissioner. I'm saying this as staff or as a Commission  
11 overall. It's hard to parallel process this a little bit,  
12 but I think it's worth putting it out there, that this  
13 parallel processing does need to happen, whether MedPAC  
14 does it or CMS does it or both try to do it.

15 Another sub-point on episode choice is we have a  
16 smaller set of medical -- I think we mentioned UTI, urinary  
17 tract infection, is the only medical bundle. I think the  
18 evidence that Dana was alerting us to earlier are these  
19 that there may be better evidence, in fact, for some  
20 medical conditions. It seems to me conceptually we need to  
21 have some foundation here that where we have a lot of  
22 conceptual care overlap between ACOs and episodes, we may

1 worry more. So what I'm talking about here are chronic  
2 medical conditions may not be as suitable to overlap  
3 because you may actually be creating conflict in the  
4 structure. But acute medical episodes -- I'm thinking  
5 things like sepsis or pneumonia or acute myocardial  
6 infarction -- may actually function and do, in fact, if you  
7 look at the spending patterns function a lot more like  
8 procedural episodes. And so this may be a concrete place,  
9 again, that we might want to widen our aperture of how we  
10 think about this. And then also, again, I think important  
11 to just flag out there that we're going to hear some  
12 dimensions of consideration.

13 Third short-term point is I found it a little --  
14 I tussled with this point of mandatory bundles a fair  
15 amount, and I think in part the reason is I'm fully in  
16 support of the concept of mandatory bundles. It's just  
17 that the way that we read it in the context of the options,  
18 we're kind of playing both sides. We're saying, yes,  
19 mandatory, but, no, not mandatory. It feels a little bit  
20 inconsistent. And so I think if we really want to push and  
21 say we support mandatory bundles -- and I think there's a  
22 lot of good reasons to do that selection and other issues

1 that you outlined -- then I think we should probably  
2 highlight that it really does start to push us more towards  
3 Option 1. And that is, you know, generally in keeping;  
4 otherwise, it does create some significant complexity to  
5 have a mandatory bundle where you have some groups that  
6 aren't really factored into the benchmarks or they're opted  
7 out in some way. It actually in a circulate way comes back  
8 and undercuts the whole benefit of the mandatory design to  
9 some extent.

10 So I think we should just be explicit about those  
11 points, and, yeah, I'll stop there.

12 DR. CHERNEW: Amol -- sorry. I thought you were  
13 actually going to stop there, but now I realize you're not.

14 DR. NAVATHE: Fourth shorter-term point, again, I  
15 think we can leave some of the specifics for the future. I  
16 think a yearly redesign policy incentives here to really  
17 prioritize ACOs to refer to efficient bundle providers. I  
18 think this can be done. Jonathan's questions I think were  
19 highlighting that the ACOs take a 3 percent haircut.  
20 There's a discount on total cost of care for the ACOs. The  
21 bundle providers also take a 3 percent haircut on the  
22 episode. And so even if we took the 3 percent haircut, for

1 example, from the episode and gave that directly to the ACO  
2 for referring to an efficient bundle provider, we could  
3 directly create kind of steerage incentives that don't end  
4 up creating this double-pay concept if we're really worried  
5 about that. I think here as far as the short term it might  
6 be nice to just state that, that we want to consider  
7 supporting those policy designs without having to specify  
8 the range of options.

9           Two points on longer-term work, and then I  
10 promise I will stop. So I think that there might be some  
11 analytic work that can really help here to support the  
12 longer-term work. One of the areas is in quantifying the  
13 significance of overlap. One of the things that we have  
14 put out in the chapter presently is that we will have a  
15 select set of episodes, be they acute medical or surgical  
16 or what have you, not the expansive list of 30, 40 episodes  
17 in current Medicare bundled voluntary programs. And I  
18 think if that's the case, then the significance of overlap  
19 quantitatively is going to dissipate pretty rapidly. And  
20 if we're worried about siphoning off savings from the ACOs,  
21 it may be quantitatively a lot less important.

22           So if you think about a \$12,000 or \$13,000 per

1 beneficiary per year payment for an ACO and the portion  
2 that happens for a hip and knee replacement surgery to an  
3 episode, we're talking maybe \$700, \$800 of savings total  
4 for a beneficiary and only 3 to 4 -- maybe maximum 3 to 4  
5 percent of beneficiaries will have a hip or knee  
6 replacement in a year. So, conceptually, I think it may be  
7 problematic. Quantitatively, it may not be, and I think  
8 it's incumbent upon the Commission to do some work there to  
9 help us really to understand that quantitatively in the  
10 long term, not for April or June, again.

11           The last point is really relevant to these  
12 options. There's a lot of discussion of this idea of can  
13 ACOs just do the informal contracts themselves out of the  
14 Medicare program? I will register to say that I am  
15 skeptical about that, and I think that would lead me to  
16 recommend Option 1 in some sense. Part of that is in  
17 conversations that we've had as part of the Commission, I  
18 was stimulated to basically go talk to a bunch of  
19 organizations, and they all actually highlighted very much  
20 so the administrative complexity. And so I think before we  
21 make a recommendation that is in part hinging on this  
22 "under the waterline" type of subcontracting that might

1 occur, it is again incumbent upon us to maybe do so some  
2 focus groups with ACOs and episode-based providers to  
3 really understand if they feel it's feasible in the next  
4 two, three, or five years.

5           Again, I am skeptical, but I am happy to be  
6 overturned if the ACO and bundled payment leadership  
7 themselves turn around and say, "No, we can do this." Then  
8 I think that's a totally different issue.

9           So thank you so much for listening. I apologize  
10 for being a little long-winded here. I agree. I mean, in  
11 general, Rachel and Geoff, you've done a phenomenal job  
12 with this chapter. I think there's a lot of great work  
13 here. I'm really enthusiastic about it, and thank you very  
14 much.

15           All right, Mike. I'm done.

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

17           DR. DeBUSK: First of all, I'll start with the  
18 positive. I really enjoyed the chapter, and I was really  
19 excited to see us take on episodic payments.

20           As far as the chapter goes, I do think we need to  
21 underscore the support in the literature for the efficacy  
22 of bundled and episodic payments, specifically very narrow

1 bundles such as lower joint replacement. There is no  
2 question that episodes drive specialist behavior and drive  
3 specialist change. And this is in a program that  
4 desperately needs engagement, being APMs.

5 I do question where we chose to start on the  
6 chapter. APMs face a number of challenges, and I'm really  
7 unconvinced that double payments or stolen savings are one  
8 of those major issues. You know, I still remember the  
9 survey results from yesterday. Three out of 30 physicians  
10 in three major metropolitan markets were even in ACOs, and  
11 11 out of 30 of those physicians didn't even know what an  
12 ACO was, which is, again, 12 years into a statutory  
13 program. Again, APMs need engagement.

14 So for now, I would support an all-of-the-above  
15 strategy that maximizes the appeal of both ACOs and  
16 episodes. And for now, when in doubt, double payment won't  
17 hurt, at least until, to Amol's point, we can quantify not  
18 only how much double payment is currently occurring, but  
19 how much could theoretically occur based on the base of  
20 episodes that we define.

21 To Bruce's earlier comment, by the way, I would  
22 want to ensure that we aren't double-paying the same

1 entity. I think we should take care there. But for now, I  
2 think ACOs and episodes need encouragement, not  
3 containment.

4 Now, specifically with the options presented in  
5 the chapter, I think if I'm forced to choose, I would  
6 choose Option 1. You know, I think 100 percent of the  
7 savings should go to specialists when no ACO is present or  
8 in a one-sided ACO. I do think if I could choose an Option  
9 1.5, I would, which is when a two-sided ACO co-attributes  
10 with an episodic model, I think at least 50 percent of the  
11 savings should be retained by the episode. But we may be  
12 able to make up the difference by giving the ACO and  
13 episode provider some really sweeping anti-kickback,  
14 historic, and CMP relief so that they could get really  
15 creative with some new agreements, you know, well beyond  
16 gain-sharing, on how they could interact and work together,  
17 because I think then we could help them find some mutual  
18 value that might be able to make up in that split or shared  
19 savings gap.

20 The final point I want to make is that I think  
21 none of these shared savings, whether they come from  
22 episodes or ACOs, should count toward MA benchmarks. It



1 makes no sense to me why we would inflate MA benchmarks by  
2 crediting them with payments for providers that are using  
3 services more efficiently.

4 Thank you.

5 MS. KELLEY: Lynn?

6 MS. BARR: Good morning, everyone, and thank you  
7 for an excellent chapter. This is a lot to think about,  
8 and it's hard to come up with the right answer.

9 My general feeling on this is to not overburden  
10 ACOs. I know that was my position this summer -- it hasn't  
11 really changed -- that, you know, taking organizations that  
12 are taking downside risk and then forcing more  
13 administrative burden on them is not the way to encourage  
14 people to take more downside risk. You know, the purpose  
15 of moving into two-sided ACOs is to reduce your  
16 administrative burden, and I think it's not the right way  
17 to be thinking about this, is to force additional  
18 administrative burden on those that are taking downside  
19 risk.

20 I'm not sure it's really that hard to  
21 differentiate between a beneficiary that is in an ACO and  
22 is not in an ACO. I mean, they're all on a list, right?

1 And so I don't know, is there really huge complexity in  
2 identifying whether a patient is in a two-sided ACO, a one-  
3 sided ACO, or not in an ACO? That doesn't seem like it  
4 should be, given that they're all on a list.

5           And then, you know, I think that we need to think  
6 about carrots and sticks. I mean, I do believe that  
7 mandatory bundles is smart. I'm mixed on whether or not  
8 one-side ACOs should take mandatory bundles. I could  
9 probably go along with that. But I don't think we should  
10 be penalizing two-sided ACOs by imposing bundles on them.  
11 However, I think we should think about incentives, because  
12 I agree that there isn't enough attention paid to specialty  
13 care. So what kind of incentives could we give two-sided  
14 ACOs? Maybe more along the lines like of what the REACH  
15 Model is doing and saying, hey, if you're in a two-sided  
16 ACO, you can contract with preferred providers. They get  
17 the benefit of being part of your ACO and you can contract  
18 differential fees and create a preferred provider network.

19           So I think I would be more in favor of trying to  
20 figure out incentives for at-risk ACOs than to make that  
21 mandatory.

22           Thank you for a great chapter.

1 DR. CHERNEW: Lynn?

2 MS. BARR: Yes?

3 DR. CHERNEW: Thank you. Yes, I keep going on  
4 and off mute because I'm muting too rapidly. What I took  
5 from what you said -- I want to make sure I understood --  
6 is that you loosely favor Option 2.

7 MS. BARR: That's right.

8 DR. CHERNEW: Okay. Thanks. You don't need to  
9 say more. Just thanks.

10 MS. BARR: You're welcome.

11 MS. KELLEY: All right. I have Jonathan next.

12 DR. JAFFERY: Great, thanks. So, again, I really  
13 like the direction that we're taking here. I'll try to be  
14 brief because I know that a lot of people want to talk.

15 I like the idea of focusing on a limited set of  
16 episodes up front where we have evidence. I think thinking  
17 through and maybe building on some of Amol's comments,  
18 thinking through what that means for evidence and actually  
19 thinking about some of Dana's comments in previous meetings  
20 around some of the accountable care type change, when we  
21 have evidence of practice change that's happening, that  
22 actually is significant, and it doesn't necessarily need to

1 rise to the level that we've seen through CMMI  
2 demonstrations or something like that. So I think that's  
3 something we should think about.

4 I agree that making episodes mandatory is going  
5 to be a really key component in any of these options, so we  
6 struggle to get specialists engaged in value-based care in  
7 a meaningful way, and it becomes very difficult to do  
8 without these being mandatory for all the reasons that have  
9 already been said regardless of -- you know, irrespective  
10 of which option we choose.

11 In terms of options, I strongly favor Option 1.  
12 You know, from the ACO perspective, some episodes are more  
13 avoidable than others, right? So I think the incentives  
14 become different depending on the episode. For some  
15 avoidable episodes, let's say UTI, it's really analogous to  
16 ambulatory care-sensitive conditions. The ACO not only has  
17 the incentive here but the capability to prevent them  
18 altogether. In that situation, we clearly had the best  
19 outcome. We've avoided a hospitalization. You've saved as  
20 much money as possible when it's better for patients and  
21 for everybody.

22 For unavoidable or less avoidable episodes,

1 putting the risk and reward on the episode provider to me  
2 here makes more sense, as these are the providers that have  
3 the ability to impact episode outcomes, and, again,  
4 building on some of Amol's comments and some of my question  
5 in Round 1. So if the ACO has the sophistication and the  
6 capabilities and the inclination to contract with episode  
7 providers, then that would be fine. But I think trying to  
8 build a policy around that assumption like we might see in  
9 2 and 3 is a problem, because I think we'd have to do a lot  
10 more work to understand if ACOs can really do that, and I'm  
11 pretty confident that many, if not most, don't have those  
12 capabilities now.

13           So, again, I'll leave it at that. I think Option  
14 1 to me is the strong preference, and even the cons that  
15 you laid out in the chapter -- or in the presentation, as  
16 you heard from Round 1, my Round 1 question, I'm not even  
17 sure that I think that the con is even there. I think ACOs  
18 could contract potentially with episode providers if they  
19 have that inclination and sophistication.

20           And then, finally, a couple other things that  
21 came out in the chapter. I think moving forward that  
22 administratively set benchmarks for episodes would make

1 sense for the same reasons we talked about for population-  
2 based payments. And there was also some discussion about  
3 episode-level cost and transparency, which I think is  
4 absolutely something we should shoot for, actually  
5 irrespective of this whole question of ACO and episode  
6 alignment.

7 So thanks, and I'm looking forward to hearing  
8 others' comments for the rest of the discussion.

9 MS. KELLEY: Dana.

10 DR. SAFRAN: Yeah, thank you. So, Rachel, Geoff,  
11 really exciting work and really clear, very well laid out,  
12 including the presentation here. These visuals are very  
13 helpful.

14 I have just a few comments to add to what others  
15 have said. First, just adding my voice that, you know, as  
16 I read this chapter, the logic for why these episodes in  
17 particular need to be mandatory as opposed to voluntary  
18 became very clear, the potential for, you know, providers  
19 selecting in and out with greater knowledge of how they're  
20 going to perform because of the narrowness, it just seems  
21 like it's much more important to have it be mandatory when  
22 we're talking of episodes.

1           Second is that I do agree that if we're going to  
2 go to the effort to build this and put this in place, we  
3 need more episodes to be part of the program. So we can  
4 return to that issue of how that occurs, you know, and what  
5 level of evidence do we need, et cetera. I think that's an  
6 important issue, but I understand Michael's point that  
7 that's out of scope of what we're talking about today.

8           Third, just adding my voice that, you know, the  
9 emphasis on avoiding double payment here just really jumped  
10 out at me, and my own experience, first of all, in leading  
11 a program that was population-based, ultimately we had  
12 originally avoided having measures that had a cost  
13 component to them in our quality measure set because we  
14 felt that would be double-paying, right? We were sharing  
15 savings, and we were going to give a payment, but  
16 ultimately began to incorporate some of those because it  
17 was clear that the added incentives to change behavior was  
18 helpful. And so I think it comes down -- you know, is it  
19 really double-paying if two different entities have  
20 incentives? I would argue it's not unless, you know,  
21 what's getting paid is more than the overall savings. So I  
22 think we should not be so dogmatic on that issue of double

1 payment. It's a matter of how much is being paid  
2 cumulatively.

3           Then, finally, I would say I do overall favor  
4 Option 1. I would say I least prefer Option 2. I could  
5 actually get my mind around Option 3, particularly if  
6 [inaudible/audio interference] more and more providers in  
7 an ACO model. And the reason for that really is that I do  
8 think that the ACOs can play a very important role with  
9 respect to driving the performance of the episode  
10 providers. Even if they don't create their own  
11 arrangements for value-based payment and episode payment  
12 with those providers, their lever of market share, that was  
13 what motivated my earlier question, I think is a quite  
14 important one. But that said, the reason that I favored  
15 Option 1 over 3 is that I think it can get very messy to  
16 have different episode models from your different payers,  
17 and we've seen that with respect to the conversation in  
18 value-based payment overall, and providers' objection to  
19 different quality measures used by different payers and the  
20 push for alignment.

21           Now, I do think CMS could -- if we were in an  
22 Option 3 world -- have standardized episodes the way we



1 have standardized measures for value-based payment, and  
2 then the differences could be in the financial incentives  
3 the different parties are placing on those episodes when  
4 they're contracting with the episode provider. But,  
5 nonetheless, I do kind of like the simplicity of the Option  
6 1 world for the episode provider.

7 I'll just take a quick look.

8 Oh, one final thing from my notes. I'll just  
9 mention that having the shared savings included in and  
10 charged against the budget of the ACO I know is the right  
11 thing to do. That is a total cost of care view. So I'm  
12 not arguing it's the wrong thing to do. I just want to  
13 flag that it does create a little bit of a counterincentive  
14 for that ACO in that they could direct their referrals to  
15 lower-cost episode providers and do better on their budget.  
16 So I just would call that out as something for us to think  
17 a little bit about, but I do recognize that we can't carve  
18 out from their budget the true costs that we are spending  
19 when we're paying that episode provider shared savings.

20 So those are my comments. Great work, and I  
21 really appreciate this conversation. Thanks.

22 MS. KELLEY: Betty?

1 DR. RAMBUR: Thank you so much. Great work on  
2 the chapter, and I really appreciate the comments of the  
3 other Commissioners.

4 In the interest of time, I'm going to just focus  
5 on a few points. I very much support episode-based  
6 payments, and I certainly support them for both surgical  
7 conditions but also medical. And I'm wondering if when we  
8 talk about proven as merely saving expenditures rather than  
9 sparing suffering, we're sort of missing the mark. And I  
10 thought Amol's comment about acute versus chronic is  
11 important, but I'm also -- and I support that. But I'm  
12 also wondering, is there some way we should think about  
13 chronic medical differently? If I may just bring this down  
14 to the working surface, I know there's the problem of the  
15 tyranny of the antidote, but once you've seen it you can't  
16 look away.

17 I'm recalling a community hospital in the State  
18 of Vermont that had a high community burden of congestive  
19 heart failure and accepted a bundle arrangement under SIM,  
20 and they immediately had the kind of practice changes that  
21 Jonathan mentioned. Immediately they had a nurse in the  
22 emergency department do an intake when people came in with

1 CHF and start a care coordination process. They quickly  
2 really needed to think about these differently and really  
3 pulled in hospice, palliative care, different kinds of  
4 supports, home care, different kinds of long-term services  
5 and support. And in talking to the chief nursing officer,  
6 they were actually able to decant their ICU and nurses  
7 transitioned to other roles in transitional care in the  
8 model that Mary Naylor from the University of Pennsylvania,  
9 former Commissioner, has talked to them about.

10           So when I think about that example and I think  
11 about having congestive heart failure, that is absolutely  
12 the model I would want to be in. Now, whether or not they  
13 save money in the end, I don't know. But I'm wondering,  
14 how can we think about chronic condition bundles, because  
15 there is so much disease burden, and I know it can be very  
16 difficult to do risk adjustment in things like Alzheimer's,  
17 but I think that could be really important.

18           So I'm very supportive of bundles being a  
19 condition of participation, sometimes called "mandatory."  
20 I support both acute and potentially chronic if that can be  
21 worked out for medical. And I am most supportive of Option  
22 1. I appreciated Dana's explanations or explication of

1 Option 3, which I could live with. I'm not very supportive  
2 of Option 2 for a number of reasons I won't go into.

3           And, finally, for some other time, I'm wondering  
4 if we can think about surgical episodes in terms of what  
5 they cost and what they should cost. I continue to think  
6 about an article that was in the Wall Street Journal that  
7 was what does a hip replacement or knee replacement cost,  
8 no one knows and that's a problem. And it was someplace in  
9 Wisconsin that actually traced it out, and basically their  
10 perceived cost was actually five times what it actually  
11 cost. So what's the base? What's the trend? What do  
12 things cost and what should they cost?

13           I know that's not something that can be done in  
14 this scope of work, but I do very much like the direction  
15 that we're going, and I do feel very comfortable with a  
16 hierarchical model with bundles nested inside ACOs.

17           Thank you.

18           DR. CHERNEW: Let me just jump in for one second.  
19 I think we're going to go in a minute to Paul and then  
20 Larry. I just want to make one point as this goes on in  
21 response to what you said, Betty.

22           The challenge here -- and I've written this in

1 another context -- is the amount of waste is in some ways  
2 an asset, and we make these decisions between ACOs and  
3 episodes. We're deciding who gets it. So imagine that we  
4 had -- and I'm not saying we should or shouldn't. I'm just  
5 making a mathematical point. Imagine we had a chronic care  
6 episode, and we decided to give the savings associated with  
7 treating a patient with that chronic condition to some  
8 entity that controlled the episode, which is a feasible  
9 thing to do.

10           If we were to do that, those potential savings  
11 would be taken away from the ACO or double-counted, but the  
12 way, but for now let's assume taken away from the ACO.  
13 That might be fine if you think you can get more from  
14 giving into an episode, but eventually, you get to the  
15 point where who wants to be in ACO. All the savings you  
16 get have been given to somebody else, and then you're left  
17 with a poor bunch of episodes, which is a bigger issue.

18           And so that's, I think -- we're not going to  
19 resolve that now, by the way. I think the issue is  
20 ultimately going to be to give CMS some guidance whether to  
21 or not to think about that. So that --

22           DR. RAMBUR: Right. But -- I'm sorry.

1 DR. CHERNEW: No, I'm done.

2 DR. RAMBUR: Can I just comment? I think it also  
3 illustrates the whole issue of the voluntary nature of  
4 risk-bearing arrangements. I mean, that's really the heart  
5 of the problem.

6 MS. BARR: Amen, sister.

7 [Laughter.]

8 DR. CHERNEW: We're going now to Paul and then  
9 Larry.

10 MS. KELLEY: I'm sorry. We have Stacie next.

11 DR. CHERNEW: Oh, I'm sorry. My queue is all  
12 screwed up.

13 DR. DUSETZINA: Thank you. This is a really  
14 great chapter, and I really appreciate all the comments  
15 from the other Commissioners. I think that there's a lot  
16 of work ahead.

17 I will just say briefly that I was most  
18 supportive of Option No. 1, as presented. It seems to do a  
19 good job of aligning incentives for ACOs without  
20 necessarily requiring more formal relationships with the  
21 episode providers.

22 I totally agree with comments by Amol, Jon

1 Jaffery, and Betty around these issues of acute and chronic  
2 and then distinguishing between avoidable and unavoidable  
3 related issues. So I think that's an important area to  
4 maybe try to explore or distinguish.

5 But, you know, I'd say like ideally, just  
6 thinking about trying to solve this problem and aside from  
7 the chapter, it seems to me that trying to figure out a way  
8 to reward participants for the act of referring to  
9 efficient or high quality, or however we define it, episode  
10 providers, you know, and trying to distinguish like what is  
11 the activity that the ACOs have under their control and  
12 trying to prevent these episodes from happening in the  
13 first place really seems core to this.

14 But I think, in general, Option 1 seems to do the  
15 best job of that, and I look forward to seeing this work as  
16 it continues to evolve.

17 MS. KELLEY: Bruce.

18 MR. PYENSON: This is a terrific discussion which  
19 reflects the terrific nature of the chapter.

20 I think there is a real materiality issue here.  
21 The non-double payment of savings strikes me as not  
22 essential at this point. It's not a particularly important

1 issue. I think we could easily quantify it. In my back-of-  
2 the-envelope, and ACO might have a per -- attributed  
3 beneficiary per year amount of 10- or \$12,000, and the  
4 biggest bundle is perhaps 13 per 1,000. And even if it  
5 were hips and knees and even if it were \$30,000, you do the  
6 PM, per member per year equivalent to that, and it's really  
7 very small.

8           That further gets deluded because perhaps two-  
9 thirds of fee-for-service beneficiaries aren't in an ACO.  
10 It further gets deluded when members leak out of an ACO to  
11 perhaps non-bundle providers unless bundles are mandatory.  
12 So there's a whole series of decrements there.

13           I think so the materiality -- frankly, I wish  
14 Medicare did avoid double payment. There's lots of  
15 examples we can look at and find in the Medicare system  
16 where, arguably, there's double payment.

17           So, all of that said, I've certainly advocated  
18 for mandatory ACOs and mandatory systems. That doesn't  
19 seem to be on the horizon, but in the short run, I would  
20 support Option 1. As Lynn said, let's not overcomplicate  
21 things. Let's do a serious analysis of what's really  
22 involved in the overlap, quantify that, and move ahead with



1 models that hopefully are going to have success. Thank  
2 you.

3 MS. KELLEY: Paul.

4 DR. PAUL GINSBURG: Yes. This has been a great  
5 session, both because of the great chapter that we're  
6 reading and because there's so many good comments from my  
7 colleagues.

8 I want to start by saying I think episodes should  
9 be an important part of alternative payments. When you  
10 think of it, to the degree that improvements in efficiency  
11 and quality can come in episodes of care, it's likely to  
12 come from the specialists that provide the episode. So, if  
13 we think of knee replacements, I think there's a lot of  
14 room for improvements, but it's not going to come from  
15 ACOs. The ACO's role should be steering beneficiaries to  
16 the more capable specialty groups that do the knee  
17 replacements rather than being relied on to somehow  
18 directly increase the efficiency and the quality.

19 So I believe we should have more episodes over  
20 time. I think they should be developed by CMMI. I think  
21 some of the real potential is in chronic disease.

22 We've all known that we don't want to focus on

1 chronic diseases where coordination across different  
2 specialties is important or where we have real risk  
3 adjustment problems. I think there are many chronic  
4 conditions that are very much within a particular  
5 specialty, where fragmentation and coordination is not that  
6 big an issue, where we could do episode payments. And I  
7 would say the innovation center going forward, continuing  
8 to test new models because it's okay to add a new episode  
9 into the mix as opposed to a new twist on ACO designs,  
10 which we know can be very disruptive.

11           Given the endogeneity of whether specialists are  
12 members of the ACO, I think this makes me lean towards  
13 Option 1, because otherwise you're just going to drive the  
14 specialists at the ACO if the ACOs get all the savings and  
15 the specialists don't.

16           So getting back to how will the ACOs, the ACOs  
17 should benefit from good steering decisions, and I think  
18 they can through the discounts. I think just since we're  
19 sharing savings rather than giving all the savings, even  
20 just steering to a group that has 10 percent lower cost, I  
21 think it will benefit the ACO. So that, this way the  
22 specialists who provide the services for the bundle can get

1 substantial shared savings from it.

2 I'll stop there.

3 MS. KELLEY: Larry.

4 DR. CASALINO: Thanks, Dana.

5 Well, I have one eye on my notes and one eye on  
6 the clock. Amol and I have a bet over whether or not I can  
7 stay under five minutes.

8 So I'm in substantial agreement with these  
9 points, but I want to emphasize some points that I think  
10 are important and haven't been mentioned very much or  
11 haven't had the attention I think they may deserve during  
12 the discussion so far.

13 I think that the chapter as written or the  
14 section as written is framed too narrowly in part because  
15 of its focus on double payment, which I agree with some  
16 other Commissioners is an issue but not the most  
17 fundamental issue by any means.

18 I think the broad framing with regard to episodes  
19 and with regard to integrating, this discussion with the  
20 discussion of ACOs is -- I think it should be explicitly  
21 questioned whether emphasizing bundles is likely to slow or  
22 to hasten or not affect movement to population-based care,

1 assuming that the latter is the fundamental call. So I  
2 think that question at least needs to be posed, and if it  
3 is posted, I think everyone would agree at least that we  
4 would want our bundled programs to be designed in a way  
5 that would hopefully not slow the evolution of population-  
6 based care. So that's one thing that I think should be  
7 emphasized and to frame.

8           The second thing is this question is implicit in  
9 what we've been discussing, but I think it should be  
10 explicit. How can specialists be more involved in the  
11 population-based care? I mean, that's really critical.  
12 It's not the case that the only thing that specialists do  
13 that's important is deal with things that are susceptible  
14 to bundling. There are all kinds of things specialists can  
15 do to help other specialists and primary care physicians  
16 manage care better across the spectrum and not just in  
17 episodes.

18           So anything that would bring specialists into  
19 closer collaboration broadly, not just about bundles, with  
20 ACOs, I think, would be important, and things that are  
21 likely to keep specialists so that they don't care what  
22 goes on in population-based care, which I think bundles can

1 do, I think, is not something we want to do. So that's the  
2 second thing that I think should be in the fundamental  
3 framing, one emphasizing bundles. How are bundles going to  
4 likely affect and move to population-based care? And the  
5 correlate question, how can specialists become more  
6 involved in population-based care, and how can we dissolve  
7 episode-based payment programs that would speed, not slow  
8 the evolution of successful population-based care?

9           On policy options, the alternative policy  
10 options, I very much like the idea of presenting  
11 alternative policy options rather than choosing one. I'm  
12 not sure we have consensus within the group of  
13 Commissioners and staff about which would be the most  
14 desirable.

15           I actually like all three of the options. Like  
16 Dana, I would probably favor No. 1 and No. 3 over No. 2 if  
17 pushed, but I do think that we need a more detailed  
18 discussion of the pros and cons of each option. I think  
19 the pros in this kind of discussion are narrower than it  
20 needs to be, and it could be expanded, including to discuss  
21 the possible effects of each on the evolution of  
22 population-based models.

1           The third point I want to make, without  
2 discussing the pros and cons of a national mandatory  
3 program, I think that making the options dependent on there  
4 being such an option, which Options 1 and 2 are, they  
5 really limit the usefulness of any discussion we would  
6 have. There's likely to be very heavy resistance to a  
7 national mandatory program.

8           Also, advocating implicitly at least the national  
9 mandatory episode-based program would be -- someone might  
10 say, well, why not a mandatory ACO one? Why should we  
11 have one and not the other?

12           So I think if we don't think that there are good  
13 options for episode-based payments, unless they are  
14 national mandatory bundles, then I think we need to  
15 explicitly make that argument. If we think there are good  
16 options, if they aren't mandatory bundles, then I think  
17 those options should be presented as well as the options  
18 that we are presenting. So maybe present the options that  
19 we have based on the assumption that there is a national  
20 mandatory program, at least the first two options, and then  
21 what options are there if there isn't a national mandatory  
22 program, which is the most likely thing?

1           And the last point I'd make -- and I may lose my  
2 bet here -- I'm very strongly opposed to adding a lot more  
3 bundles, and I'm really opposed to adding a lot more  
4 medical bundles, especially chronic illness bundles. The  
5 most costly medical patients are likely to have very many  
6 things wrong with them. Congestive heart failure patients  
7 often have diabetes and COPD and hypertension and  
8 hypercholesterolemia, and lots of bad things happen to  
9 them.

10           So I've never talked to a practicing physician  
11 who doesn't throw up their hands at the idea of chronic  
12 medical bundles, but I'm not opposed what Amol recommended  
13 to acute medical bundles. I think it would be very complex  
14 to add chronic medical bundles as more adding is for  
15 gaming, confusion, and complexity and will, I think, be --  
16 make especially primary care physicians very unhappy. It  
17 would be very easy for episodes to multiply, multiply. We  
18 don't want that to happen.

19           And that's it.

20           Amol, I think we need a stopwatch. I'm at five  
21 minutes, but I don't know if I was over or under, just by  
22 the crude minute clock.

1 DR. NAVATHE: Five minutes, 57 seconds.

2 DR. CASALINO: Okay. You win.

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

4 DR. GRABOWSKI: Thanks. Thanks. I will  
5 definitely be under five minutes. I'm going to be brief.  
6 This has been a great discussion. Thanks, Jeff and Rachel,  
7 for this work.

8 So I really like where Amol started us with this  
9 overarching general principle. Let's do its best for the  
10 Medicare program, not what's best for a particular model or  
11 program, and I think based on the existing evidence to  
12 date, I believe what's best for the Medicare program is  
13 having a balance of bundles and ACOs.

14 The evidence today has really supported a strong  
15 role for bundles. Amol made a really important point.  
16 I've been very kind of centered in the ACO literature. I  
17 have done a little bit of bundles work as well, but we talk  
18 a lot about all the flaws in ACO design, and I think we  
19 sort of assume that the bundles are fine, but there's been  
20 a lot of flaws there too.

21 We did an evaluation of CJR. Our paper was quite  
22 favorable, but we recognized, as Amol said, that we had



1 this shift from mandatory to voluntary. And I think it  
2 made it really challenging going forward to kind of show  
3 the results that we achieved early on in that program.

4           Similar to Bruce, I do believe mandatory solves a  
5 lot of problems, but I'm not going to hold my breath on  
6 that one.

7           I like Larry's idea of trying to think through  
8 the options of kind of conditional on there being a  
9 mandatory program, what does that entail, and if we don't,  
10 I think we're probably, unfortunately, going to end up with  
11 something that isn't mandatory.

12           So, bottom line, I'm supportive of Option 1,  
13 similar to others. I think that's the option that kind of  
14 best balances the incentives across ACOs and the bundles,  
15 and I look forward to kind of taking this work and  
16 incorporating it into the bigger chapter. Thanks.

17           MS. KELLEY: Jaewon.

18           DR. RYU: Yeah. A lot of similar themes. I  
19 think I worry about delusion of accountability and value as  
20 a result or maybe one feeds the other, and I worry about  
21 complexity. And I think a lot of the comments that have  
22 been made, I don't think we want to make life tougher for

1 those that are in ACOs. I think you really want somebody,  
2 some entity to take accountability over the totality of  
3 care in an ideal setting.

4           That being said, I'm a big believer, and I think  
5 much like everybody else that the role of episodes and  
6 bundles is absolutely critical. It's a very important  
7 arrow in the APM quiver if you want to think of it that  
8 way, and I think the other reason why I think it's  
9 important is because it also extends beyond the Medicare  
10 program, and to the extent you create that capability, I  
11 think it does help to have a halo effect beyond Medicare,  
12 which I think is important.

13           But, as far as how those things shake out in the  
14 balance, I would probably gravitate more towards Option 2,  
15 although I could see a strong argument for Option 1. And I  
16 think in my mind at least, it kind of depends on whether  
17 the episode is avoidable or unavoidable. If it's something  
18 that's avoidable, I think it's better left with the two-  
19 sided ACOs to manage and try to avoid the triggering of the  
20 episode altogether, but if it's unavoidable, then I think  
21 it makes total sense to have it roll right into Option 1.

22           So I'm probably split between the two, but if

1 pushed between those two, I'd lean towards Option 2.

2 MS. KELLEY: I have reached the end of my list.  
3 I don't know if I -- I hope I haven't missed anyone.

4 DR. CHERNEW: Good. Well, we're just at time.  
5 So I'm going to go if you haven't, although I'm going to  
6 talk for a little bit and watch what happens if anyone  
7 raises their hand or whatever.

8 But I feel like I've been drinking from a  
9 firehose with 6,000 different pieces of information that's  
10 all going to have to be digested.

11 Let me say a few broad summary points, and then  
12 I'm going to -- we'll move on to lunch and come back to  
13 talk about MA risk adjustment.

14 So, first, there is a clear interest in this  
15 question of how many and which episodes and which  
16 considerations. The chapter will try and say something  
17 more about that. I am not sure how much more about that.  
18 There's been a lot of discussion of that, and I certainly  
19 hear that.

20 The other thing that I think is important to  
21 acknowledge is that when any decisions about episodes are  
22 made -- and it's sort of chronological to say that when we

1 have episodes, we want the best designed episodes as  
2 possible. Yes, that's true. The key point is when we make  
3 those decisions, it should be done understanding that they  
4 will be implemented in an environment that has ACOs, and we  
5 must at least consider what that means.

6           So, for example, one reason why I think there's  
7 been some -- like for Jaewon's recent point, Option 1  
8 versus Option 2, it depends on the episode, how broad the  
9 episodes are. There's a lot of "it depends" in this.  
10 Since we're not going to answer all the various "it  
11 depends," we're going to sort of raise those considerations  
12 and leave it for CMMI to sort out how to move forward in  
13 what particular cases.

14           So I could see a world in which we say there's a  
15 lot of support for Option 1. There might be some episodes  
16 in which you would do Option 23. We'll leave it at that.  
17 I think that's the type of thing we will say.

18           I hear loud and clear, this notion about double  
19 payment. We will think about that more in detail. There's  
20 been a lot of discussion. Maybe we can take some of it  
21 offline, but other than that, it's noon. So I'm going to  
22 thank you all for all of your comments. This will not be

1 the last time we see this. We are going to have a version  
2 of this integrated chapter reappear in April. We will  
3 leave six hours for the discussion.

4 And for the public, thank you for joining. As  
5 always, please send us your feedback.

6 You can go to [meetingcomments@medpac.gov](mailto:meetingcomments@medpac.gov) to send  
7 us an email or go on the website, and you will find ways to  
8 reach out to us and give us your thoughts.

9 So, again, thank you, everybody . We're going to  
10 come back to talk about an aspect of Medicare Advantage  
11 risk adjustment after lunch, so we will be returning at one  
12 o'clock. So are we good?

13 [No response.]

14 DR. CHERNEW: All right. Thanks, everybody.

15 [Whereupon, at 12:01 p.m., the meeting was  
16 recessed, to reconvene at 1:00 p.m. this same day.]

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1 AFTERNOON SESSION

2 [1:01 p.m.]

3 DR. CHERNEW: Hi, everybody, and welcome to our  
4 afternoon MedPAC session. We are going to focusing on risk  
5 adjustment in Medicare Advantage. This is neither the  
6 first and will certainly not be the last time we do this,  
7 and, in fact, you will see a lot of other material related  
8 to Medicare Advantage program and risk adjustment in the  
9 Medicare Advantage chapter. This is a somewhat specific  
10 topic, and I'm going to turn it over to Dan to walk us  
11 through it. Dan, you're up.

12 DR. ZABINSKI: Thank you, Mike. I just want to  
13 say, to start, that the audience can download a PDF version  
14 of these slides in the Handout section. That is on the  
15 Control Panel on the right-hand side of your screen.

16 At the October 2021 meeting we presented a  
17 modification to Medicare Advantage risk adjustment that  
18 would improve payment accuracy by limiting the influence of  
19 large prediction errors that occur under the standard risk  
20 adjustment model. Today, we will revisit the model  
21 improvements that we discussed in October 2021, with the  
22 addition of a sensitivity analysis that is discussed in

1 your paper. Also in your paper, we added a discussion of  
2 how payment accuracy improves within specific condition  
3 categories, but we will not present those results today.

4 After responding to feedback from Commissioners,  
5 our intent is to publish this analysis in the upcoming June  
6 2022 Report to the Congress.

7 To start, MA plans receive a unique payment for  
8 each enrollee that is the product of two factors. There is  
9 a base payment amount that is calculated for each plan and  
10 a risk score, which is the ratio of a beneficiary's  
11 expected costliness to the average fee-for-service  
12 spending. CMS uses those risk scores from the CMS-HCC  
13 model to adjust MA payments.

14 These risk scores increase payment for  
15 beneficiaries who are expected to be more costly than  
16 average and decrease payment for beneficiaries who are  
17 expected to be less costly than average. The CMS-HCC model  
18 uses demographic information and certain medical conditions  
19 that are identified by diagnosis codes and grouped into  
20 hierarchical condition categories, or HCCs.

21 Each demographic and HCC variable in the model  
22 has a coefficient that represents the expected cost

1 associated with that variable. A risk score for a  
2 beneficiary is the sum of the relevant coefficients for the  
3 beneficiary. To determine the size of the coefficient for  
4 each variable, CMS conducts a regression using fee-for-  
5 service data that essentially distributes the medical costs  
6 for each beneficiary to the coefficients that apply for  
7 that beneficiary. This regression includes all fee-for-  
8 service beneficiaries, so each coefficient reflects the  
9 average fee-for-service cost associated with the variable.  
10 To use risk scores for payment, CMS divides the sum of  
11 dollar-valued coefficients by the average fee-for-service  
12 spending to create an index value, so the average risk  
13 score is always 1.0.

14           The purpose of risk adjustment is to predict  
15 costs accurately on average for a group of people who have  
16 similar health attributes rather than to predict costs  
17 accurately for each individual beneficiary.

18           CMS chooses the demographic variables and the  
19 HCCs for the model, in large part, on their ability to  
20 predict medical costs. However, no set of model  
21 components, based on commonly observed information, that  
22 can explain all the variation in individual medical costs.



1 Instead, a large share of the cost variation is unexplained  
2 by the risk adjustment model, and this provides  
3 opportunities for improvement.

4           The benefits of the modification that we're  
5 presenting is that it would improve the accuracy of  
6 payments to MA plans,  
7 increases payment equity among plans, and counter  
8 incentives for favorable selection in which plans may seek  
9 to attract and retain beneficiaries who contribute to plan  
10 profits and to avoid beneficiaries that contribute to plan  
11 losses.

12           We know that since CMS fully implemented the CMS-  
13 HCC model in 2007, the agency has improved the model  
14 several times. These improvements include a revised  
15 mapping of diagnosis codes within the HCCs; adding and  
16 deleting HCCs based on which HCCs improve model performance  
17 the most; added a count of the number of HCCs for each  
18 beneficiary; and stratifying Medicare populations by  
19 beneficiaries' institutional status, eligibility status  
20 defined by being aged or disabled, and Medicaid status  
21 defined by full benefits, partial benefits, or no benefits.  
22 And CMS now has distinct versions of the CMS-HCC model for

1 seven populations defined by these characteristics.

2           One risk adjustment feature common in many health  
3 insurance markets that CMS has not implemented is a system  
4 of reinsurance and repayments that redistributes the  
5 original premium payments to plans from enrollees for whom  
6 plans are highly overpaid to enrollees for whom plans are  
7 highly underpaid. However, in Medicare Advantage, cost  
8 data are not sufficient to support such a system of  
9 financial transfers.

10           So the modification to the model that we are  
11 considering today, which was developed by McGuire, Schillo,  
12 and van Kleeef, seeks to improve the model's accuracy by  
13 limiting the influence of outliers when estimating the  
14 model coefficients. The method essentially simulates a  
15 system of reinsurance and repayments in the data used to  
16 estimate model coefficients. To evaluate the modification,  
17 we consider metrics assessing the model's accuracy overall  
18 and for certain groups of beneficiaries.

19           We view the benefit of this approach as being the  
20 combination of two factors. First, it would improve the  
21 performance of the CMS-HCC model by increasing the accuracy  
22 of MA payments through the limitation of the influence of

1 beneficiaries who have outlier costs on the HCC  
2 coefficients. Second, this improvement would place no  
3 additional burden on plans and minimal burden on CMS, as  
4 there would be no need to collect additional data, and CMS  
5 can continue to use a risk adjustment method that is  
6 straightforward and easy to understand. This contrasts  
7 with some other ways to improve MA risk adjustment that  
8 could be difficult to understand and viewed as a black box  
9 by many.

10           We want to emphasize that there would be no  
11 actual reinsurance or repayments, but, instead, we simply  
12 redistribute costs during model estimation.

13           We used five steps to implement this method. In  
14 step one, we estimated coefficients for the current CMS-HCC  
15 model. Second, we used the estimated coefficients to  
16 predict costs for each beneficiary and calculate a  
17 prediction error that is the difference between the  
18 predicted cost for a beneficiary and the beneficiary's  
19 actual cost.

20           In step 3 we simulate reinsurance by applying a  
21 loss limit on the actual costs for the beneficiaries with  
22 the largest underpredictions. When the prediction error is

1 larger than the loss limit, we reduce the beneficiary's  
2 actual cost in the data by 80 percent of the difference  
3 between the prediction error and the loss limit, which  
4 simulates reinsurance.

5           In step 4 we simulate repayments by applying a  
6 gain limit on the actual costs for beneficiaries who have  
7 the largest overpredictions. When the prediction error is  
8 larger than the gain limit, we increase the beneficiary's  
9 actual cost in the data by the difference between the  
10 prediction error and the gain limit, which simulates  
11 repayment.

12           By adjusting the actual cost data in steps 3 and  
13 4, we generate a new data set in which the fee-for-service  
14 costs have been redistributed to simulate reinsurance and  
15 repayments. Then, in the fifth and final step, we use the  
16 new data set to estimate the CMS-HCC model coefficients  
17 that would be used to calculate risk scores for paying MA  
18 plans.

19           Now we'll talk about putting into practice the  
20 steps from the previous slide.

21           A vital part of that analysis was identifying the  
22 loss limit and the gain limit, which we used to calculate

1 cost adjustments to simulate reinsurance and repayment. We  
2 estimated the standard CMS-HCC model using a sample of 10.2  
3 million fee-for-service beneficiaries, which is described  
4 in your paper. We then used the estimated standard model  
5 to calculate predicted costs and a prediction error for  
6 each beneficiary on our analytic file. That is, we  
7 calculated the underpredictions and overpredictions.

8           Through an iterative process, we used the  
9 prediction errors to determine the loss limit and the gain  
10 limit. We determined the loss limit so that the aggregate  
11 reduction in actual costs across all beneficiaries affected  
12 by the simulated reinsurance equals 2 percent of total  
13 costs. Likewise, we determined the gain limit so that the  
14 aggregate increase in actual costs across all beneficiaries  
15 affected by the simulated repayments equals 2 percent of  
16 total costs.

17           Under this 2 percent simulation, the resulting  
18 loss limit was \$106,500, and the resulting gain limit was  
19 \$25,300.

20           We then used the loss limit and gain limit to  
21 adjust actual costs for underprediction and overprediction  
22 errors. If a beneficiary had an underprediction greater

1 than the loss limit, we trimmed the beneficiary's costs by  
2 80 percent of the difference between underprediction and  
3 the loss limit. But if a beneficiary had an overprediction  
4 greater than the gain limit, we augmented the beneficiary's  
5 costs by the difference between the overprediction and the  
6 gain limit.

7           This decrease in actual costs offsets the  
8 increase in actual costs, so that this modification to the  
9 model is revenue neutral. We then used these redistributed  
10 costs to re-estimate the CMS-HCC model. We call this re-  
11 estimated model the modified model.

12           We found that the modified model that limits the  
13 effects of outliers would substantially improve how well  
14 beneficiaries' predicted costs match their actual costs.  
15 To evaluate the performance of the modified model, we used  
16 the R-squared statistic, which indicates how well  
17 beneficiaries' costs predicted by the model match their  
18 actual costs. The R-squared is always between 0 and 1, and  
19 the closer to 1.0, the better the model has performed.

20           We found that the standard model had an R-squared  
21 of 0.13 while the modified model had an R-squared of 0.19,  
22 a 43 percent increase. This tells us that the modified

1 model explains 43 percent more of the variation in costs  
2 than the standard model. This improved predictive accuracy  
3 under the modified model would reduce the likelihood that  
4 plans would experience substantial financial gains or  
5 losses based on which beneficiaries choose to enroll in  
6 their plans.

7           To illustrate how substantial the improvement is  
8 from limiting the outliers, on slide 6 we discussed several  
9 changes that CMS has implemented since 2007, and these  
10 changes have increased the R-squared from about 0.11 to  
11 about 0.13.

12           We also found that the modified model would  
13 improve the predictions for beneficiaries with the largest  
14 prediction errors. We evaluated the beneficiaries who  
15 under the standard model had the 1 percent largest  
16 underpredictions and 1 percent largest overpredictions, and  
17 we used predictive ratios, or PRs, to measure payment  
18 accuracy for these groups in which a PR is the aggregate  
19 predicted costs for a group divided by the aggregate actual  
20 costs for the group. The closer a PR is to 1.0, the better  
21 the model has performed for the group.

22           For both these populations, the PR improved under

1 the modified model. For beneficiaries who had the 1  
2 percent largest underpredictions, the PR improved from 0.13  
3 to 0.16. Also, for the beneficiaries who had the 1 percent  
4 largest overpredictions, the PR improved from 6.4 to 2.0.

5 By predicting costs more accurately for both the  
6 largest underpredictions and largest overpredictions, the  
7 modified model would reduce the likelihood that plans  
8 experience large financial gains or losses.

9 Finally, at the October meeting, a few  
10 Commissioners asked how our results would change if we used  
11 different amounts of costs being redistributed in our re-  
12 estimation. So, in addition to the simulation that we've  
13 already discussed in which we redistributed 2 percent of  
14 aggregate costs, we estimated the effects of a system in  
15 which we redistribute 1 percent of aggregate costs and 3  
16 percent of aggregate costs.

17 On this table, we show the R-squared values from  
18 the standard CMS-HCC model and from versions of the  
19 modified model under which we redistributed 1, 2, and 3  
20 percent of aggregate costs. This table shows that  
21 increasing the redistributed costs has an appreciable  
22 effect on the model's R-squared, indicating greater



1 predictive power as you increase the magnitude of the  
2 redistributed costs.

3           However, as we redistribute more costs, the  
4 coefficients on the HCCs in the model will change. As we  
5 increase the redistribution of costs, we increase the  
6 possibility that the HCC coefficients won't reflect the  
7 actual cost of care for that group. This trade-off between  
8 higher R-squared and how accurately we predict costs for  
9 HCCs is an issue that must be addressed if any system of  
10 simulated reinsurance and repayment is to be effectively  
11 administered.

12           The conclusions that we draw from this analysis  
13 is that limiting the influence of outliers would improve  
14 how well predicted costs and plan payments would match  
15 actual costs, which reduces incentives for plans to use  
16 beneficiaries' costs to identify favorable risks. The  
17 extent of substantial underpredictions and overpredictions  
18 would be reduced so plans would face less risk from  
19 substantial losses.

20           We realize that we face many issues regarding  
21 risk adjustment in the MA program, such as the coding of  
22 conditions, and we have documented these issues extensively

1 and have recommended fixes to those problems. The approach  
2 we have discussed today would improve MA risk adjustment,  
3 independent of those well-documented problems, and adopting  
4 an approach like this would not impede nor negate other  
5 more comprehensive approaches to addressing problems with  
6 MA risk adjustment.

7           So for today's discussion, we will address the  
8 Commissioners' questions and concerns about the method and  
9 content of this analysis. Then, we will address the  
10 feedback that we receive and complete this analysis for  
11 publication in the June 2022 report.

12           Now I will turn it back to Mike.

13           DR. CHERNEW: Great. Dan, thank you. I'm going  
14 to start with a clarifying question of my own, which I hope  
15 will set some of the stage, and then we'll jump into Round  
16 1 where I think, actually -- well, I'll let Dana say it --  
17 from my view here Larry is the first in Round 1.

18           But in any case, Dan, you did this using split-  
19 sample approach. In other words, you did a lot of this  
20 work on half of the sample and then at the very end when  
21 you were doing the evaluations you were doing it on an  
22 evaluation sample. Is that basically right?

1 DR. ZABINSKI: Yes, that's right.

2 DR. CHERNEW: And when you did your statistics,  
3 that means the R-square improvements and the predicted  
4 ratios, those are all based on the evaluation sample for  
5 which there was actually no redistribution of costs. It  
6 was just the actual data in the evaluation sample. Is that  
7 also right?

8 DR. ZABINSKI: Yes.

9 DR. CHERNEW: Okay. I am now clarified, and  
10 again I guess it goes to Larry.

11 DR. CASALINO: Yeah, Dan, really elegant work and  
12 nicely presented. The chapter could be a kind of a primer  
13 on someone who doesn't understand the CMS-HCC method and  
14 wants to. So really, nice work.

15 I have just one question. In the presentation  
16 you mentioned a couple of times that this improved method  
17 would reduce the incentive for plans to try to get local  
18 patients, and I agree with that. You don't mention, I  
19 don't think, in the presentation but you do several times  
20 in the chapter that using reinsurance would decrease the  
21 incentive of plans to control the costs of beneficiaries  
22 who they did have enrolled.

1           So my question gets to looking at the sensitivity  
2 analyses, and do we like 3 percent, 2 percent, 1 percent?  
3 It is certainly true that reinsurance changes incentives,  
4 but do you have any sense of the extent to which moving  
5 from 2 percent to 3 percent, for example, would reduce  
6 plans' efforts to control the cost of care for their  
7 members?

8           DR. ZABINSKI: I don't have a firm sense, but my  
9 inclination is to say at that stage probably not a lot.  
10 And I'm not really sure at what level it would become a  
11 problem to be concerned about.

12           DR. CHERNEW: Dan, I'm sorry. I need to ask  
13 another clarifying question. Because you're doing all of  
14 this on the evaluation sample and actually not proposing to  
15 shift money, the actual incentives in any plan, the  
16 redistributions that you showed us aren't actually real  
17 redistributions, if I understand correctly. So once you  
18 have this new equation, I don't think there would be any  
19 incentive effects to control costs, because whatever you do  
20 isn't going to affect your payment at the margin. You're  
21 not actually being reinsured.

22           And again, I may still be confused. This might

1 be Michael's confused session of the month. Am I confused?

2 DR. ZABINSKI: I don't think you are. I might be  
3 overstepping my bounds. I think a lot of the discussion,  
4 when we talk about incentives of reinsurance, when we talk  
5 about it it's like in the purest sense of reinsurance. And  
6 Andy, please correct me if I'm wrong, because he really is  
7 deep into this and knows it even better than I do. But  
8 when we talk about reinsurance in that sense we're talking  
9 the actual redistribution.

10 I think the bigger concern here is the extent to  
11 which you're going to start affecting the coefficients on  
12 the HCCs. And then the HCCs coefficients won't accurately  
13 reflect the actual cost of treating beneficiaries with  
14 those conditions if you start monkeying around too much  
15 with the levels.

16 DR. CASALINO: Dan, if I can interrupt, do you  
17 mean the coefficients as a whole won't accurately reflect  
18 the total cost of care predicted for the beneficiary or do  
19 you mean that the total predicted cost might be accurate  
20 but the individual coefficients will no longer be as  
21 precise as they were?

22 DR. ZABINSKI: The latter. So this is completely

1 hypothetical. Suppose that you do this simulator  
2 reinsurance and repayment, and the coefficient on, say,  
3 diabetes with complications changed a lot. It might be to  
4 the extent that the coefficient doesn't really reflect the  
5 true cost of treating those patients.

6 DR. CASALINO: So do you think there would be --  
7 and this will be my last question, I think -- do you think  
8 there would be practical implications? If the total  
9 predicted cost is more or less as accurate as we can get  
10 it, reasonably, but the individual coefficients are a  
11 little off, would there be any practical negative  
12 implications to that?

13 DR. ZABINSKI: I'm not sure. Andy, do you have  
14 any feeling on that?

15 DR. JOHNSON: Dan, your analysis looking in the  
16 chapter at individuals with a specific HCC I think suggests  
17 that there wouldn't really be any negative implications,  
18 because a plan still has to pay for the total cost of care  
19 for the whole beneficiary. Even if theoretically a single  
20 HCC coefficient is a little off, the cost for that whole  
21 beneficiary for -- and Dan looked at the top 15 HCCs --  
22 that cost was always improved under the modified model.

1 DR. CHERNEW: I think -- I'm sorry, Larry.

2 DR. CASALINO: No, go ahead.

3 DR. CHERNEW: I think the issue is to enroll or  
4 disenroll. If you get the coefficient on congestive heart  
5 failure wrong, there may be an incentive to enroll or  
6 disenroll someone with congestive heart failure. I think  
7 that would be the ramification, not what to do once you  
8 have them.

9 I saw Andy nod, but maybe there's just like a fly  
10 in the room. I'm not sure.

11 DR. JOHNSON: I think that's right.

12 DR. CASALINO: Thank you.

13 MS. KELLEY: Bruce, you have a Round 1 question?

14 MR. PYENSON: I do. Actually, Mike's question  
15 prompted another one. If we go to, I think, Slide 14 or  
16 15, where you talk about the 1 percent and 2 percent  
17 alternatives, now my understanding of those alternatives  
18 were redistribution -- it has the word "redistributed," and  
19 even the draft discusses incentives to not manage care  
20 after a certain point. So both of those suggest to me and  
21 the last couple of pages of the draft were investigating an  
22 actual reinsurance program. Did I read that wrong?

1 DR. ZABINSKI: You mean in the draft?

2 MR. PYENSON: Yes.

3 DR. ZABINSKI: It seems to me that we need to say  
4 what we did at the very end of the paper differently. It  
5 seems to be confusing.

6 DR. MATHEWS: Dan, let me jump in here. Just for  
7 a conceptual reset here, it is an absolutely true statement  
8 that our collective thinking about this idea originated  
9 with the work of McGuire and his colleagues where they did  
10 look at reinsurance and repayments in a commercial payer  
11 setting where there are actual changes, you know, dollars  
12 changing hands. But what we are doing here -- and this  
13 word punches through in the materials and in the  
14 presentation, maybe not enough, but we are coming up with a  
15 different way of simulating that effect through truncating  
16 outliers, high cost, low cost. And one potential solution  
17 here would be to drop any reference at all to reinsurance  
18 and repayments and simply treat this as, you know, a stand-  
19 alone, narrow policy that would achieve some substantial  
20 improvement in the predictive power of the HCC model and  
21 just stop talking about reinsurance and repayments. And if  
22 that's what's tripping people up, I will take full



1 responsibility for that confusion.

2 DR. CHERNEW: And, Bruce, in response to your  
3 question, on this slide I believe if they put the word  
4 "simulated" redistribution increases, put "simulated"  
5 there, that would be more accurate to what they're doing,  
6 because there's nothing going on. They're just simulating  
7 these different -- I call them -- it's basically about  
8 trimming. There's all the trimming regression models to  
9 get more accurate coefficients.

10 MR. PYENSON: So perhaps redistributed to the  
11 coefficients or something.

12 DR. ZABINSKI: Correct.

13 MR. PYENSON: Okay. Got it. Thank you for that.

14 I've got a question about the comparison of R-  
15 squares. I understand what you did is you did it in two  
16 different models -- the current model and the alternate  
17 model -- to the 2019 data, and the original model came up  
18 with a 0.13 R-square and the refitted model something  
19 better than that. I came across the CMS report to Congress  
20 on risk adjustment from December 2021, and they describe in  
21 there the R-squares that you report for the different  
22 versions. But those are R-squares with lags of perhaps

1 five years. So, for example, B-22 used data from 2010 to  
2 2011, but the R-square -- but it was actually used in 2014  
3 to 2016. And so there's a big lag there.

4 I'm trying -- you know, it seems like you were  
5 comparing your R-squares to their R-squares, but I'm not  
6 sure -- I don't understand how that -- since you're in  
7 effect measuring a concurrent model and theirs has a lag of  
8 five years -- do you know what I'm asking?

9 DR. ZABINSKI: Yeah, I know what you're asking.  
10 Well, let's see. I hope we can connect here. You know,  
11 I've had discussions with people at CMS and with people at  
12 RTI International who actually do most of the estimating of  
13 the CMS HCC model for CMS, and like, say you have the model  
14 for 2015, but it used data from 2011 and 2012, they do the  
15 R-squared based on the 2011-2012 data. That's the R-  
16 squared that you're seeing. But take those coefficients  
17 and --

18 MR. PYENSON: So it's even worse --

19 DR. ZABINSKI: -- apply them to 2015. That's my  
20 understanding. I might be wrong about that, but that's my  
21 understanding from my discussion with them.

22 MR. PYENSON: So I'll send you the footnote. My

1 impression is the footnote suggests otherwise Table 2.1, I  
2 think, in that document, but okay. Those are -- my other  
3 question is more general. There's lots and lots of stuff  
4 published on improving risk scores. How did you choose the  
5 McGuire paper?

6 DR. ZABINSKI: Andy, do you want to handle that  
7 one?

8 DR. JOHNSON: Sure. I just want to follow up  
9 with your first question, Bruce, too. So the slide we're  
10 looking at, 14, the R-squareds on this slide, the "None" is  
11 calculated from Dan's sample, so it is the same year of  
12 data just with the current model implemented by Dan, so  
13 there's apples-to-apples comparison about the years on this  
14 slide. And you're right. Dan was speaking to earlier when  
15 we talked about the prior update to the model and the  
16 effect on the R-squared coming from the CMS estimates of R-  
17 squares.

18 But with the McGuire modification to the model, I  
19 think we chose that because of its simplicity and easiness  
20 of implementation. You know, we weren't coming at this  
21 from a framework of trying to think about should we replace  
22 the CMS HCC model with another version. I know you sent

1 along some comments including the DXCG, the ACG, and 3M and  
2 several other companies that have an entirely different  
3 risk adjustment model, and so we weren't approaching it  
4 from that, but that this paper offers a modification to the  
5 calibration phase, which I think could be applied to any  
6 model. It just happens that, you know, we're using the CMS  
7 HCC model now, and so this modification could be  
8 implemented with minimal effort, no additional data  
9 collection. It doesn't require learning a different model.  
10 And I know you've mentioned in the past, too, the potential  
11 benefits from machine learning and some AI technologies,  
12 improving the accuracy of the predictions in the model.  
13 But we were trying to keep it as much as possible the same  
14 with how CMS operates the risk adjustment model, though  
15 with a little additional modification how they calibrate  
16 the coefficient.

17 MR. PYENSON: Did you consider a very simple  
18 approach like instead of least squares, which exaggerates  
19 outliers, least absolute differences? That was hard to  
20 program when all this stuff started in the 1990s, but  
21 that's just a simple, different procedure.

22 DR. JOHNSON: You're right, we didn't consider

1 additional types of fitting the model, you know, using the  
2 different -- a nonlinear model of some way, but I think  
3 you're right that that also would offer some improvements,  
4 but I think -- and this is sort of getting into squishier  
5 territory where, you know, people are comfortable with the  
6 current model and understand how the linear regression  
7 works more so than -- the more and more complicated it  
8 gets, I think it's harder for, you know, a good chunk of  
9 people, stakeholders in the industry, to understand. So  
10 we're trying to avoid as many changes as we could.

11 MR. PYENSON: Thank you.

12 MS. KELLEY: Okay. I have Dana next.

13 DR. SAFRAN: Thanks. I appreciate this work and  
14 the conversation so far. I have two -- well, I had two  
15 questions. One I think you've answered through the  
16 presentation here, so I'm only keeping it on my list so  
17 that I can flag that, unless I missed it, the language in  
18 the paper wasn't super clear. When you shared about the 2  
19 percent adjustment that was made, I now understood from  
20 your presentation here that that was across the full  
21 population of beneficiaries that were in your analysis.  
22 When I was reading the chapter, I was trying to understand

1 whether it had to do with outliers for the individual  
2 providers you were penalizing. So I could have just missed  
3 that in the tee up, but I'm just flagging it.

4           The other question I have is I'm sure outside the  
5 bounds of what you'll be able to do this in this time  
6 frame, but have you looked at how the inclusion of patient-  
7 reported outcomes, you know, something simple like the SF-  
8 12 from the Health Outcome Survey that Medicare administers  
9 improves your risk adjustment model? And I'll just flesh  
10 that out. The reason I ask that is know that in, you know,  
11 many, many analyses, predicting anything from readmissions  
12 to functional improvements to death that it is among the  
13 most powerful predictors of outcomes. And while I know  
14 that we don't today have universal data on this from our  
15 beneficiaries, I think it could be very valuable if it's  
16 possible to link data from the Health Outcomes Survey in  
17 with claims to test how much of a gain we'd get from that.  
18 I guess based on my past experience, you've got even more  
19 than what you're seeing here, and that could be really  
20 valuable not just for the risk adjustment model, but  
21 because of the importance of that information for all kinds  
22 of things, from clinical care to, you know, evaluating

1 differences in health plans and providers.

2           So sorry for the long tee-up of the question, and  
3 maybe that foreshadows comments in Round 2, but anything  
4 you've done that has already explored that?

5           DR. JOHNSON: Dan, why don't you start?

6           DR. ZABINSKI: I was just going to say, looked at  
7 it, no, we haven't looked at it. I guess anything that is  
8 a powerful predictor is going to be worthwhile to look at.  
9 So going forward, yeah, I think it's something to consider.

10           DR. JOHNSON: So I think here the major  
11 limitation is the data in that we don't have the  
12 information for all beneficiaries across all of Medicare.  
13 It would be a big lift to do that.

14           In MA, there is a frailty adjuster for PACE  
15 contracts and certain D-SNPs where they can conduct a  
16 survey of their plan enrollees, and based on some of that  
17 information -- I don't know if this gets exactly to what  
18 you're speaking to, but it takes into account some of the  
19 activities of daily living with patients and adjust the  
20 payment based on that. So when the enrollment is more  
21 targeted to a population that have more ADLs than there is  
22 a frailty adjuster for certain clients.

1 DR. SAFRAN: Yeah, that's helpful, Andy. And I  
2 was pointing specifically to the Health Outcomes Survey  
3 that's administered to Medicare Advantage beneficiaries. I  
4 just don't know whether that maintains an identifier that  
5 could get linked in with claims to do the testing and see  
6 how it helps the model, because if it helps as much as I  
7 hypothesized that it will, you're right, it's a heavy lift  
8 to try to get that on all beneficiaries, but it would have  
9 value well beyond this, but potentially very big value  
10 here. So I think it's worth exploring.

11 DR. JOHNSON: Okay. That is a good point about  
12 the Health Outcomes Survey in MA. I think the issue is  
13 that we don't have that information for the fee-for-service  
14 beneficiaries, so to calculate -- to calibrate the model  
15 with the fee-for-service population, we'd have to still  
16 field that survey to the fee-for-service population first.

17 DR. CHERNEW: Let me do a little level-setting if  
18 I can. I'm sorry, Dana. I didn't mean to interrupt. Go  
19 on.

20 DR. SAFRAN: I was just saying understood, but a  
21 test of the model in the MA population, you know, could be  
22 fruitful. That's all.



1 DR. CHERNEW: So, first, Dana, I very much  
2 appreciate there's a lot to be done. I want to repeat  
3 something I said in my intro. There's a lot of work we  
4 need to do and will continue to do on Medicare Advantage,  
5 and there's a lot of possible things one could do.

6 Dan and Andy, correct me if I'm wrong, because  
7 this started before I was actually in my current position,  
8 or at least before I knew what was going on. But my take  
9 on this is this is sort of a relatively simple, quick-  
10 hitting, in the spirit of everything that's going on now,  
11 small change approach as opposed to what eventually I think  
12 we will be discussing, certainly things we do discuss and  
13 things we will continue to discuss, what I would call  
14 bigger-picture issues about how to resolve issues related  
15 to Medicare Advantage coding and, for that matter, fee-for-  
16 service coding.

17 So this is -- I guess all I'm trying to say is I  
18 view this as a much more prescribed exercise, and I hear  
19 some of the questions as being along the lines of, well, if  
20 you start down this, why don't you do this? Why didn't you  
21 go further? Or why didn't you -- those are not crazy  
22 questions. In many ways we will, and, in fact, I

1 appreciate those comments very much. But understand this  
2 is meant to be a smaller lift, if you will.

3 Before we go on, I think we have one more Round 1  
4 question. I think it's Stacie. But maybe, if I've got  
5 that wrong, Dan or Andy, help level-set us for our  
6 comments.

7 DR. JOHNSON: That's exactly right.

8 DR. ZABINSKI: Yeah. Go ahead.

9 MS. KELLEY: Okay. Stacie I believe has taken  
10 herself out of the Round 1 queue. I do have two others.  
11 Pat first.

12 [Pause.]

13 MS. KELLEY: Pat, we can't hear you. Try now,  
14 Pat.

15 MS. WANG: Okay. Thank you very much. I hope  
16 that my questions are within the parameters as Mike just  
17 described them and that you guys agreed with. You know,  
18 the sort of evidence, I guess, for the improvement of this  
19 change to the model is reflected on Slide 14. I wonder  
20 whether it would make sense to further evidence the benefit  
21 of the change by looking at certain subpopulations like  
22 duals, partial duals, and LIS, where I think the incidence

1 of outliers might be greater, just to see whether the  
2 predictive value for those subpopulations also appears to  
3 be better. And I wondered whether you had considered that  
4 or whether you think that that makes any sense.

5 DR. ZABINSKI: Okay. Well, on the duals and the  
6 partial duals, for this particular model, I mean, we subset  
7 -- you know, CMS has seven different populations right now  
8 for whom they have distinct versions of the model. And  
9 just for practical reasons, we just honed in on the largest  
10 one, the 65 and older non-dual population. So assessing  
11 the effect on duals in this case is not something we could  
12 do directly with this data set that we've been working  
13 with. But there's certainly other subpopulations that we  
14 could consider.

15 MS. WANG: So this study only reflects over-65  
16 non-dual?

17 DR. ZABINSKI: Correct.

18 MS. WANG: Okay.

19 DR. JOHNSON: And, Pat, I think your point from  
20 last time we talked about this, which we tried to  
21 incorporate, which makes sense, is that to the extent that  
22 there is redistribution in the cost data for the

1 calibration, that would have to be done for each of the  
2 seven populations separately that I mentioned. And I think  
3 the point -- if I'm hearing you correctly now, it's that it  
4 might be worth considering that the 2 or 3 percent,  
5 whatever the share of cost redistribution in the data is,  
6 it could be different for some of those different  
7 populations because of the --

8 MS. WANG: Yes.

9 DR. JOHNSON: -- outliers might differ. So  
10 that's a really good point.

11 MS. WANG: Thank you. And I won't bother with a  
12 Round 2 comment because I raised it the first time that you  
13 presented the paper, so I guess I am really curious. If  
14 the idea is to try to make suggestions to sort of improve  
15 the predictive value of the model, where, if at -- you  
16 know, what I raised last time was that the current model is  
17 based on 2014 costs in the 2015 -- matched to 2015 ICD-9  
18 codes. The cost base has not been updated since then, and  
19 while ICD-9 has sort of been matched to ICD-10, there  
20 hasn't been a full recalibration of the model to update  
21 both costs like on a real ICD-10 base. And I just -- you  
22 know, with COVID, just -- is that not worth doing to

1 improve the predictive value? CMS has updated the model so  
2 many times to try to increase predictive value. I just  
3 wonder where in the value or order of value of changes is  
4 updating stuff to be more current with cost and actually  
5 use ICD-10?

6 DR. JOHNSON: I don't know if I can say where, in  
7 order, that value is, but I do agree that that is important  
8 and would certainly improve the accuracy. I think that's  
9 part of Bruce's comment was earlier too, was the model's  
10 base data, the longer that it is [inaudible/audio  
11 distortion] it is less likely to be accurate in predicting  
12 the costs.

13 I know this past year, well, the past cycle of  
14 rulemaking for 2023, CMS did update the Part D risk  
15 adjustment model with the newer data, so possibly it is  
16 just a level of effort that maybe next it will be that they  
17 will work on the MA model. I'm not entirely sure, but it  
18 is definitely getting to the point where I think you are  
19 right, using data that incorporates claims where ICD-10 was  
20 the actual diagnosis code version that was being used would  
21 be a helpful update.

22 MS. WANG: And again, in the interest of time I

1 won't get into Round 2, but if you could include a comment  
2 like that someplace in your risk adjustment work I just  
3 think it would be helpful. Thanks.

4 MS. KELLEY: Okay, Mike. That's the end of Round  
5 1. Oh, excuse me, Amol, I had you on my page right here.  
6 I'm so sorry. Go right ahead.

7 DR. NAVATHE: No worries.

8 DR. CHERNEW: I think just to get the time right,  
9 Amol, I think you're the last in Round 1. Then we have two  
10 in Round 2, because remember we only have 15 minutes left.  
11 Go on, Amol.

12 DR. NAVATHE: So I had a quick question. I think  
13 it's quick. But earlier this year, and I'm not sure of the  
14 exact timing, there was a proposed rule, so-called HHS  
15 Notice of Benefit and Payment Parameters for 2023, that  
16 suggested a revision to the HCC model. I think it was  
17 primarily to the HCC model used on exchanges, but it  
18 doesn't actually specify that. It just says HCC model.  
19 And HHC model proposed rule recommends a two-stage approach  
20 to the estimation to try to deal with the underestimation  
21 of individuals who don't have HCCs, so zero HCCs.

22 So I was curious, that is trying to deal with the

1 bottom end of distribution. As far as I can tell, this is  
2 trying to do deal with the top end of the distribution. So  
3 one, I guess, is that relevant the HCC model that we're  
4 discussing here in the context of fee-for-service programs  
5 in MA? I think so, but you should correct me if I'm wrong.  
6 And if it is indeed, how can we think about the interaction  
7 between what has already been proposed versus this?

8 DR. JOHNSON: I'm only familiar enough with the  
9 two-stage proposal to know that it is part of the ACA  
10 marketplace plans and that the names are very similar.  
11 It's the HHS-HCC model that's used in that market and it's  
12 the CMS-HCC model that's used in the MA world, so it's very  
13 similar. But I haven't had a chance to take a closer look  
14 to see if that similar approach would be important for MA.  
15 I think there are some other complicating factors too, with  
16 the marketplace risk adjustment model about reinsurance and  
17 risk corridors.

18 DR. CHERNEW: So just very quickly, the  
19 marketplace version, there actually is reinsurance. It's  
20 not just a simulated change to the model. It's very much.  
21 Tom was actually working at ASPE as a consultant when they  
22 did all of that. It's spiritually very similar. It's just

1 a different place.

2           The problem we have here is because we don't  
3 observe MA spending, there is no proposed actual  
4 reinsurance. This is really a chapter on trimming. It's  
5 just a very specific way of trimming, two-sided trimming.  
6 And assuming it on an evaluation sample -- obviously,  
7 trimming makes things look better in the dataset you're  
8 estimating on. The point here is trimming makes things  
9 look better on the evaluation dataset.

10           I understand that's not the largest physical  
11 point, but I'm going to look at Dan and Andy to see head  
12 nodding, to see if I got that right. But that's my  
13 understanding of what's going on here.

14           DR. NAVATHE: Got it. Okay. So in that case  
15 what I was raising, the proposal that I raise is not  
16 relevant to this conversation. Thank you.

17           DR. CHERNEW: Yeah. So I think we have Brian and  
18 then Bruce in Round 2. Dana, am I right?

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

20           DR. CHERNEW: Brian.

21           DR. DeBUSK: Thank you, Michael. First of all, I  
22 do want to start with a quick apology to Dan and Andy. In



1 October, I did not recognize that you were using a split  
2 sample, so all of my questions around trimming data and L2  
3 norms and how the R-squared got better -- Andy, you even  
4 tried to explain it to me, and I just completely missed it.  
5 So I apologize to both of you.

6 I also appreciate your acknowledgment that there  
7 are other issues related to risk scores, you know, for  
8 example, coding intensity, and that this chapter wasn't  
9 meant to address that.

10 In general, I really am supportive of the work.  
11 I'm very supportive of anything that's trying to improve  
12 risk adjustment. You know, in this presentation the focus  
13 was on overshadowing and outliers. But even things like  
14 adding other nonlinear terms like account of conditions and  
15 some of the things that CMS has recently done, I think  
16 those are all good steps, or even a departure from the  
17 linear model. I think Andy, you said something really  
18 important. You were talking about the linear regression  
19 being, I think you used the word "familiar" or  
20 "comfortable." I think it's great to have a model that  
21 people are familiar with. I think the problem is that it  
22 leaves opportunities for better models to produce

1 consistent and ongoing sources of advantage and savings for  
2 MA plans. So I do think that we should embrace more  
3 sophisticated models to the extent that it can help us pay  
4 more accurately and pay for efficiently in aggregate.

5           Regarding the specific treatment in this chapter,  
6 it does appear that your approach, the modified McGuire  
7 approach, was effective, and I think that the results are  
8 pretty obvious. There was significant model improvement  
9 here. So I do think we -- we, MedPAC -- should encourage  
10 CMS to incorporate this or something like this into future  
11 HCC model work.

12           Regarding the future and related work, I am very  
13 interested in temporal persistence. You know, the McGuire  
14 paper and the paper from today really focused on a single-  
15 year snapshot. I'm really interested in which  
16 beneficiaries persistently overspend and underspend in some  
17 of these plans, because I think persistent residuals are  
18 going to play a huge role in Medicare Advantage in the  
19 future.

20           Having said that, I think the overspending and  
21 underspending too, I'm really interested to see if those  
22 are elastic effects that simply equalize out over a couple

1 of years or if these are plastic effects where something  
2 catastrophic has happened and the average spending over  
3 time has shifted upward permanently. But again, that's all  
4 for future work.

5 I really like the paper. I really like the  
6 technique. And again, my apologies for not getting the  
7 split sample information right in October. Thank you.

8 MS. KELLEY: Okay, Bruce.

9 MR. PYENSON: I really think the work is terrific  
10 work. However, I would suggest that it not be published in  
11 the Report to Congress but adapted as a payment basis on  
12 risk adjustment. I think there's a really strong need for  
13 an explanation of risk adjustment as it applies to Medicare  
14 Advantage and Part D programs, and there's a tiny bit in  
15 the paper on MA and the ACO chapter. But we really need to  
16 get the basic out there and available to the MedPAC  
17 audience. I think that would be the optimal use of the  
18 material.

19 My concern with this going into the June report  
20 is that there is a huge body of work that hasn't been  
21 addressed of alternative approaches to risk adjustment.  
22 There are proprietary systems. I'm very much in favor of

1 open-source systems. And I think we risk being criticized  
2 as taking one point of view when there are many other  
3 approaches that would be better or should be considered.

4           So I also don't think we have demonstrated that  
5 any of the beneficial effects attributed to the improvement  
6 are actually significant from a business standpoint. That  
7 is, there is, in my mind, very little connection between  
8 Medicare Advantage behavior and a theoretical over- or  
9 under-prediction on a population basis of a risk score.

10           And to illustrate that, I would look at the large  
11 portion of people who have very low spending in a year, and  
12 there's a big overprediction by those people, but it's  
13 nothing close to the trim point that you use. If the  
14 average is roughly \$10,000, and the minimum HCC is, I  
15 think, 0.5, you know, just on a demographic factor, the  
16 difference there is very attractive to an MA plan. But I  
17 don't think that's addressed at all in the construction  
18 here.

19           So I'm not convinced that the improvements in R-  
20 square or the predictive ratio has any consequence for plan  
21 behavior. So if that's the case, then we have a paper  
22 that's just an illustration of an adaption of someone's

1 paper, and I think it weakens the argument.

2           So my recommendation is that this is terrific  
3 work and again, adapted into a Medicare payment basics  
4 which would be incredibly valuable. Having that is  
5 overdue. Thank you.

6           DR. CHERNEW: Okay. Dana, is there anyone else  
7 in the queue?

8           MS. KELLEY: No.

9           DR. CHERNEW: All right. So sometimes you deal  
10 with very conceptual issues. This is one that is sort of  
11 unique. It is very, very statistically specific. I don't  
12 view -- and I think I've said this in various ways here is  
13 -- in the grand scheme of issues that we have to address  
14 this is not the biggest one related to MA coding. That  
15 said, there does seem to be some issue of fit improvement.  
16 So Bruce, we will take your comments under advisement, and  
17 those of other people, and those that might get sent  
18 afterwards, and, in fact, those that get sent afterwards  
19 from the public.

20           So thank you, the public, for attending, and  
21 please, if you want to reach us, send an email to  
22 meetingcomments@medpac.gov. We will take those into

1 account along with other comments, and we will make some  
2 decisions about how to move forward here.

3           Anyway, does anyone else want to have any last  
4 words?

5           [No response.]

6           DR. CHERNEW: Okay.

7           So we have made it to the end of the March  
8 meeting. We very much look forward to seeing you again in  
9 April. We are hoping that that will be in public. So  
10 everybody stay safe, stay happy, stay healthy, send us  
11 comments, and we will continue to do all of this work.

12           Thanks to the staff, as always, for both the work  
13 today, and the staff yesterday, you've done a tremendous  
14 job and you're going to move all this forward.

15           So I'm signing off. Thanks, everybody. Meeting  
16 adjourned.

17           [Whereupon, at 1:57 p.m., the meeting was  
18 adjourned.]

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