MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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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
BRUCE PYENSON, FSA, MAAA
BETTY RAMBUR, PhD, RN, FAAN
WAYNE J. RILEY, MD, MPH, MBA
JAEWON RYU, MD, JD
DANA GELB SAFRAN, ScD
PAT WANG, JD

B&B Reporters
29999 W. Barrier Reef Blvd.
Lewes, DE 19958
302-947-9541
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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
answer questions you have about the groups, and we can consider any suggestions for future groups.

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

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

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

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

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

Each year during our focus groups, we traditionally cover the following topics: Medicare
coverage options, access to care, the changing organization of care, and prescription drugs. The specific questions we ask during the sessions may change year to year, but the topics are broadly the same. The structure of today's presentation will follow the list of topics in the blue box.

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

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

The groups are typically conducted in-person each year, but because of the coronavirus pandemic, they were
conducted via virtual platforms. There were on average
about five to six participants in each group.

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

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

We heard that almost all beneficiaries knew they
needed to sign up for Medicare upon turning 65 years old.
Beneficiaries received information in the mail, on
television, by their employers, and learned from family or
friends. Similar to previous years, beneficiaries said
you sometimes felt overwhelmed by the information
presented.
We also heard that most beneficiaries signed up for Medicare at 65, except for those who were previously eligible due to disability or had other comparable coverage, for example through a spouse's employer. Most beneficiaries described having help signing up for Medicare either through brokers, family members, employers, online tools, calling 1-800-Medicare, or visiting their local Social Security office.

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

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

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

The beneficiaries who selected MA cited reasons including cost, provider acceptance of the insurance, and
inclusiveness. Some beneficiaries with MA explained that they felt relatively healthy and wanted to avoid a co-pay for their limited prescriptions and doctors' visits. When choosing between MA plans, access to providers and supplemental benefits were the biggest considerations for many beneficiaries.

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

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

The majority of beneficiaries in the 65 years or older groups rated their prescription drug coverage as
I'll now switch to presenting findings around access to care starting with what we heard during clinician groups. We asked clinicians about their acceptance of new patients and specific types of insurance. Most clinicians were accepting new patients, including Medicare patients. Among those who were not, the reason was full patient panels, and generally their practices would open to new patients again when they had capacity.

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

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

Across focus groups, beneficiaries generally
Beneficiaries said that for acute issues, they could usually be seen quickly, sometimes the same day, and usually within a few days. Several beneficiaries said they often saw an NP or PA in their doctor's practice when they had an emergent health issue and wanted to be seen quickly. These findings are consistent with what we hear in our annual beneficiary survey.

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

Several beneficiaries in the focus groups had sought a new source of primary care in recent years. They cited several techniques to identify a new PCP including looking online, calling new practices to try to make an appointment, asking a current provider for referrals, and asking their insurance company for their provider.
directory. Beneficiary experiences varied when obtaining a new PCP with some reporting no challenges with the process. Several beneficiaries reported challenges finding providers who are accepting new patients and accept Medicare. This is different than what we heard from the clinicians in our groups, where most of them were accepting new patients.

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

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

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

About half of physicians -- both primary care and specialty -- reported working with NPs and slightly fewer worked with PAs.
Most physicians said the NPs or PAs they work with function fairly independently and in a variety of roles.

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

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

Hospital systems and private equity firms were among the organizations that wanted to acquire practices. The majority of these physicians that denied an offer expressed a desire to maintain a certain level of autonomy in making practice decisions about the structure and function of the office.

In the groups where we asked about ACOs, more than half of physicians were aware of the concept. Some physicians indicated they were participating or had participated in an ACO. We also noted a slight increase in clinician awareness of ACOs over time.
Consistent with previous years, there was very limited to no awareness of ACOs among beneficiaries. This year no beneficiaries were familiar with the term.

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

A few clinicians who had a deeper understanding of their participation in MIPS described challenges. Several described the difficulties and challenges, especially for the smaller practices. One clinician noted that it was "impossible for a small private practice," due to the reporting requirements of all the different insurance companies. Another clinician spoke about a sense of broken promises regarding the potential financial upside.
I'll now switch to findings related to prescription drugs.

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

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

We also heard from both clinicians and beneficiaries that they use the website GoodRx to compare out-of-pocket prices for prescriptions drugs. If beneficiaries are using GoodRx to purchase their medicines with cash rather than through the Part D benefit, this implies that some unknown share of prescriptions is not being recorded within Part D claims data.
Turning to clinicians' access to prescription drug information, clinicians reported unreliable access to comprehensive electronic medication lists for their patients. Most clinicians noted how siloed EHRs do not allow them to see what providers in other health systems using different EHRs have prescribed to their patients.

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

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

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

DR. CHERNEW: Great, Ledia. That was terrific.

It is amazing to see how much work really gets done, and
doing this during the pandemic must have been unbelievably challenging. So kudos to you all.

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

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

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

One of the things that was in the report talked about some of the difficulties with access to psychiatric services, which, of course, is something that I think we're all aware of in lots of different sectors. You know, I wondered if you know anything about the history of why licensed counselors, professional counselors, aren't eligible Medicare providers and if that's something that limits access. I don't know if that's a statutory thing or if that's something that CMS or Congress should think about and if we have any information about what -- you know, you talked about the issues around people getting medications through GoodRx and us not being able to track it -- if we
have information about when people are -- beneficiaries are getting services outside of Medicare because of the shortage of eligible providers and that particular limitation.

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

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

DR. JAFFERY: Yeah, absolutely, and I appreciate
you wouldn't have that history and that's a sensitive thing. But that's exactly why it seems striking that with such a shortage that that group of providers is excluded. I'm struggling with other examples of when we see that happening in the Medicare program. But thank you.

MS. KELLEY: Okay. Jaewon?

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

MS. TABOR: Yeah, for the protocols, I would say there are parts of them that stay pretty consistent; for example, signing up for Medicare and choosing between fee-for-service and MA and general access questions stay the same. I think because we've been more interested in access to care, we have tweaked those questions to kind of better get at, you know, different fine points of how beneficiaries are accessing care, and other topics. Like over the past five years we've been asking about ACOs, for example, that's consistent. But then we have these new
topics like telehealth, which we just started asking about two years ago because of the expansions due to the public health emergency. So it's a mix.

MS. KELLEY: Bruce.

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

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

DR. MATHEWS: Yeah, I would agree with that, Ledia. Spot-on, Bruce. Recall that, you know, this is
more of a convenience sample. We are talking to beneficiaries to, you know, add some context, add some color around our quantitative analyses. But given the size of the focus groups, the limited number of people that we were are able to talk with, we would need to be very, very hesitant about, you know, reading too much into their responses as indicative of trends. And if we were to embark on another round of work on the inducement effect of Medigap and supplemental coverage, which we've done in the past, I think there are more robust quantitative ways of doing that rather than trying to tease that out of responses from a handful of focus group participants.

MS. KELLEY: Okay. Larry.

DR. CASALINO: Yeah, two quick things. One is just to compliment Ledia. I love how, even on the slides and almost always when you were speaking, you gave a quantitative, quote-unquote, sense of was this one or two people who you heard from or was it everybody or was it almost everybody or a lot of people or nobody. That's very useful. You can read a lot of articles based on focus groups in the literature where you have no idea really. It will say, "Beneficiaries thought that..." and there's no
sense of was it most, all, some, so you really don't know if it's the writers', the authors of the articles' opinion, or if it's the focus group people opinion. So I love that you did that, and I would encourage you to keep doing that on slides and when you discuss things.

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

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

MS. KELLEY: All right. Amol?

DR. NAVATHE: Thank you.

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

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

There were some examples of quotes in general around specialty care that seemed to imply that there could be some issues with access, multiple weeks and months required. I was wondering if there is any additional
information that you've discerned regarding the dual eligibles versus the other non-dual eligible beneficiaries with respect to specialty access.

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

DR. NAVATHE: Okay.

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

DR. NAVATHE: Just for some context for my question real quick, so the empirical literature is some work that I've done, but others have done more of, suggests that when you look at duals access -- I shouldn't say access -- dual visits or utilization with primary care,
they tend to actually be quite similar in quantity
distribution as non-duals.

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

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

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

DR. NAVATHE: Great.

MS. TABOR: Thanks.

DR. NAVATHE: Thanks.

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

DR. SAFRAN: Thank you.

Ledia, just adding my compliments for this. It's
always such a valuable part of our work and so really
appreciate it.
I think my dog is excited about it too. You can hear her in the background.

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

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

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

So I think we'll kind of continue to track this, but I think the finding is there is a lot of variation across the country on this issue.
DR. SAFRAN: Yeah. It does seem worth just keeping an eye on that, and I do -- you know, recognizing the limitations in a focus group setting, I do think the extent that we can find some ways to report trends that we see, I think that's really interesting and valuable.

Thanks for the great work.

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

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

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

DR. CHERNEW: Brian, you're first.

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

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

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

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

And the only reason I point that out is I think -
and sometimes in MedPAC, we collectively lose sight of this. I think there's a very significant number of people who are very, very passionate about ACOs and are contributing and trying to expand them and make them better, and I think all that works very laudable.

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

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

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

I have a working hypothesis here, Ledia, and maybe this would be interesting to ferret out in future surveys. I think when the MA plan is working purely off a
discounted fee schedule, that's when you're going to see the dissatisfaction, the nonparticipation in MA.

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

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

Those are my comments. Thank you.

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

I agree with that, Brian, although I'll say something that struck me from your comment is, increasingly, physicians are working for large organizations, and I'm not 100 percent convinced that physicians that are in ACOs understand that they're in ACOs
for a whole bunch of reasons. And I've been thinking through how we survey and what we learn when we think about the broader organizational structures that the physicians are practicing in. These are important because often we have an orientation that physicians are sort of solo and doing what they're doing and engaging the way they're engaging, where increasingly, I think, what's happening with physicians is they're moving along where their organization is moving in a bunch of particular ways.

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

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

And I do agree with you. I think a lot of physicians don't know that they're in ACOs. The problem is that 70 percent of the pay for the vast majority of those employed physicians are tied to sheer volume, not
necessarily to some of the things we would want to see from ACOs.

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

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

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

Lynn.

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

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

So the fact that if they enter into Medicare Advantage and then they want to get back out and their Med
supp costs can go way, way up and become completely unaffordable, I believe that that is not understood. And I don't know where you get towards recommendations here, but I think it would be important that CMS creates a plain language explanation of the Med supp issue and requires that it's signed by people, because I can't tell you -- like in rural communities, this is really a big deal. This is why we have more Med supp in rural communities. So a much higher percentage of patients have more Med supp in rural communities because they end up paying up to 50 percent of the fee schedule in coinsurance on outpatient. So they have to have Med supp or they cannot afford to use their rural community and then have to drive by if they ever get out of that MA plan.

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

Thank you.

MS. KELLEY: Marge.

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

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

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

But it really feels like we may be at a time we're using public to get input into policy decisions, which, of course, is what we do, and it can be done with the public in a much narrower way on much more narrower subjects. But for any of you who have done any readings about the results of deliberative discussions, it can be
incredibly helpful in understanding how the public responds to policy issues. For MedPAC, I would think it would be tremendous.

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

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

Thank you.

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

MS. KELLEY: David.

DR. GRABOWSKI: Great. Thanks, Ledia, for this work. It's just super. I would start by saying these focus groups are important, and, Ledia, as you suggested
during your presentation, they really allow us to learn about a set of issues that aren't observable or obtainable in claims.

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

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

Comment two and very much picking up on kind of the duals here, there were 64 beneficiaries total in the focus groups, 15 of whom were dually eligible. Given the vulnerability of this group and their high cost, I just wondered about larger sampling, and I know that's always an issue to recruit duals, but there's such, I think,
importance to this group and a lot to be learned, and so
that would be a comment.

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

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

MS. KELLEY: Betty?

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

But I was struck by the comments about the ease
of care coordination in MA, which was very interesting.

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

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

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

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

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

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

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

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

We published an article in JAMA years ago based on a pretty small survey of clinicians and patients, and I don't think JAMA would have really taken the article, publish an article using such a small survey. But I think the findings were so striking, that's why they published
We were asking about patient-physician communication, about out-of-pocket costs, and the patients almost universally said they would like to talk -- they would like their physician to talk to them about their likely out-of-pocket costs, and they mostly said their physician didn't talk to them about that. But the overwhelming majority of physicians said, "We do talk to our patients about their out-of-pocket costs." I don't think anybody is lying here, but there's a kind of self-serving perception.

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

That's it.

MS. KELLEY: Paul?

DR. PAUL GINSBURG: Sure. This may actually not be on David's point but on something that came up earlier. You know, as the Medicare Advantage share of Medicare beneficiaries keeps growing so rapidly -- and I guess we know that it will be half nationally serving -- you know,
this distinction between the access experiences of MA enrollees versus non-MA enrollees is probably pretty important. And I think for future surveys warrants some real -- I mean our focus groups warrants some real stratification and, you know, a separate cataloging of the responses to the access questions.

MS. KELLEY: Okay. Stacie.

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

So one of them is about the question of asking more about the mental health services received, and I wonder -- you know, I realize that there tends to be stigma attached to this, and it can be a difficult question to ask. But I wonder if it would be worth considering an opportunity to ask about other cash pay services that beneficiaries are receiving it and including it along with things like physical therapy, occupational therapy, prescription drugs that might be paid in cash, and mental health or therapy being included among those.
I think we are really interested in a lot of things that beneficiaries are getting outside of the system and how that's changing, so that might be one way to do it.

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

Along the drug part, you know, I think it's also really noteworthy the extent to which people are using coupon sites and things like that, so we do worry a little bit about missing information in the claims. But I think one of the things that was really, I would say, not surprising because I think I anticipated this to be the case, but physicians talking about not having access to
information about the beneficiaries' costs, partly because by now they're supposed to have access to real-time benefit tools. It's a requirement that Part D plans have these available and partner with EHRs to make them accessible and available for Medicare beneficiaries by now. And so I think that maybe providing a little bit of context around, you know, these are not working well and not available despite the fact that they're, you know, supposed to be existing and working today.

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

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

MS. KELLEY: Pat.

MS. WANG: Thank you. You know, somebody mentioned that there are small numbers in the survey, which is absolutely true, but I do want to just compliment the
sort of like the comprehensiveness of the structure and the layout of the description, and particularly the use of full quotations of folks' or participants' comments. I thought it was really, really interesting.

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

The other thing that struck me -- and, you know, David Grabowski's comment about, you know, being nitpicky, you can't generalize these results. On the other hand, I couldn't help but be struck by the geographic variation in the responses. And so, you know, reporting them out as
this is what the focus group findings were I think obscures
the richness of and the interesting fact that I really do
think there were different responses in different areas of
the country.

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

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

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

The final thing that I'll say that just really struck me, again, about the regional differences in access, some places saying, "Yes, we have full" -- you know, "We're
taking Medicare and Medicaid; other doctors saying, "I don't want to take any Medicare and Medicaid," and sort of, you know, those differences. The beneficiaries' experience of care is different, I think, on this issue in different parts of the country, which underscores to me sort of the validity of the MedPAC approach to measuring quality at one local level. And I think that that includes the beneficiary experience of care. I think it's very hard -- and I'm speaking as an MA plan -- to have like a national standard about how long it takes to schedule an appointment, how long you have to wait in the waiting room, and compare plans against each other where they may be located. When I read the results of these focus groups, I thought, wow, it just -- it to me speaks why that doesn't make a lot of sense.

Thank you.

MS. KELLEY: Amol?

DR. NAVATHE: Thank you. Ledia, great work. I wanted to pick up on a couple of threads, particularly pertaining to access, and I think Pat has touched on variability; I think others have kind of highlighted access to care as obviously an important dimension. And these
focus groups give us a somewhat unique look under the hood, if you will. I think oftentimes we're using claims data as objective data, but it's really important if you actually look under the hood and see what might be driving -- or hidden underneath the averages, if you will.

When I reflect upon the slides in the report and the presentation, it strikes me that there seems to be a number of different areas where it seems like what is underneath those averages may actually be an area of concern. What do I mean by that? So, for example, there was a quote about, you know, needing multiple weeks, three weeks plus to get access to a primary care doctor in Texas. We already talked a little bit in my Round 1 question about the large variability and large number of months it can take to get access to specialty care, and there were some pretty striking examples of quotations of having to go thousands of miles to get to an orthopedist or what have you. Some of those we don't want to overinterpret, as David said, but I think if you take them in totality across the specialists, across the urgent care pieces, I think Larry has mentioned that around urgent care being kind of an interesting -- there's so much urgent care that that
implies something about our belief that beneficiaries get timely primary care access. There were several quotes, several observations around emergency department care as well and use.

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

I bring up to some extent the payment adequacy
piece also, just the chapter, not the concept, the chapter because we outline there that we do a telephone survey as one of the key sources of inputs. And I know over this entire year's cycle we have talked about that many times, and to I guess kind of borrow a page out of Marge's comments, I would say, you know, the Commission -- I would submit that the Commission should consider if we should actually direct more resources towards upsampling, increasing the sampling size basically for the telephone surveys to be able to look at specific groups like dual eligibles in as geographically a representative way as possible because of these concerns. I think there's multiple different areas that we worry about. We worry about dual eligibility. We might also worry about other things like priorities. But I think it's worth taking stock of whether we really need to do more, largely, again, because of the red flags, the seeming red flags that seem to be in this work, and the fact that it doesn't reconcile with the other inferences that we've made that have supported a wide variety of the work that we do at MedPAC. So I want to just submit that and see if other Commissioners might also support that, and that might be
something that we could do. Thank you.

MS. KELLEY: Jaewon?

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

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

I do wish -- and I understand that there's a striking the balance dynamic between making sure we can't draw definitive conclusions or wide-reaching kind of generalizations. But I do think calling out some of the thematic observations just around trends and what are the emerging things that maybe we didn't hear in years past that we are hearing now, I thought that might be kind of a helpful add to the chapter. I think two of the items that I think Pat and some others have spoken about were the
things that kind of left me wanting to dig in a little more
-- one around access, the other, it seems like there's this
common theme around the lack of awareness or the lack of
education on the various programs, the options, the
process, whether it's on the provider side or on the
beneficiary side. I think those were a couple of the areas
where at least for me I was wondering, well, have we heard
these things before? Is it kind of accelerating and
gaining momentum? I thought that would really help round
out the chapter.

MS. KELLEY: I have Dana last.

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

On the issue around, I will call it, methods and
generalizability that I think David was the first to bring
up and a few have touched on, an idea comes back to me that
I think we talked about last time -- but I'm not 100
percent sure -- of whether given that the focus groups are
incredibly valuable and will always be limited in the
numbers that we've got, we could triangulate our findings
with other findings that are out there and, in particular,
with the Medicare Current Beneficiary Survey, MCBS, and, you know, all the better if MCBS data are available by market. I don't remember if they are, but, wow, wouldn't that be interesting if we could triangulate a little bit whether some of the differences we see by geography are more noise than signal or not.

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

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

And then my other quick comment was something I have on my notes for tomorrow's discussion around ACOs, but given this discussion, I thought I would throw it in here, you know, that the finding of physician unawareness, if
that's a word, about ACOs was really interesting. I have
had a thought, as I was reading the chapter we'll discuss
tomorrow, about whether we would ever convene ACO leaders
in particular to talk with them about some of the ideas,
and specifically some of the options that we were looking
at, I felt it would be really valuable to understand how
ACO leaders might think about this.

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

Thank you very much.

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

[No response.]

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

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

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

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

So it is -- and someone has sent me this message
separately. I won't name them. It is always useful to see
this work to help remind us of the beneficiaries we serve
and the providers that serve them and understand the
environment that they're in. And just that touchstone I think is an important exercise, and I appreciate all the work we do to do that, and it's very useful to have that material sent out so we all see a snippet of the stuff that everybody has learned.

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

DR. MATHEWS: No. All good.

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

With that, barring any other comments, I'm going to adjourn us for lunch and just say to those listening we will be reconvening after lunch at 1:45 to talk about an
issue that has been incredibly important to us and will continue to be for cycles to come, which is how we support safety net providers. And we are at the beginning of that important topic, so I really encourage those interested to please tune in after lunch at 1:45.

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

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

AFTERNOON SESSION

[1:46 p.m.]

DR. CHERNEW: Great. Hello, everybody. Welcome back. We're going to jump right into this next session, which is on a topic that is going to appear again and again over the next several cycles. This is the beginning of
what I think is a very important and I think multi-cycle
set of analyses and actions, so that's how we're going to
support safety-net providers, one of our generally big
concerns. So I'm going to turn it over now. Brian, are
you kicking it off?

MR. O'DONNELL: I am indeed.

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

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

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

First, the House Committee on Ways and Means
submitted a bipartisan request for the Commission to
examine access to care for vulnerable beneficiaries. We
presented our preliminary results of this work to the
Commission this past October. We concluded that some
measures of vulnerability, such as living in a medically
underserved area, where not immediately useful for the Commission's work. However, for dual-eligible beneficiaries, we concluded that further work was needed to better understand potential access issues and the providers who care for them.

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

Our presentation today focuses on three main topics.

First, we discuss our revised framework for identifying safety-net providers and deciding whether new Medicare funding is warranted to support them.
Second, we'll discuss our expanded definition of low-income beneficiaries.

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

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

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

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

In this section of the presentation, I will discuss our revised framework for identifying safety-net providers and deciding whether new Medicare funding is warranted to support them. While today we only discuss how this framework applies to hospitals, our goal is to be able to apply this framework across multiple sectors in the
future. And as you've seen in your mailing materials, our framework has evolved substantially since you've last seen it. Most notably, we've broken it up into a two-part test.

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

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

In the first step of our framework, we identify safety-net providers as those who treat a disproportionate share of Medicare beneficiaries who have low incomes and
are less profitable than the average beneficiary or the uninsured or those with public insurance that is not materially profitable. The underlying premise of defining safety-net providers this way is that providers who treat a disproportionate share of such patients could be financially challenged because their patients cost more to treat or they receive lower revenues for treating similar patients.

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

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

First, there is a risk of negative effects on beneficiaries without new funding, such as trouble accessing care.
Second, Medicare is not a materially profitable payer in the sector. If Medicare profit margins are already high in a given sector, it suggests other solutions beyond adding new Medicare funding are likely more appropriate.

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

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

In November, we defined low-income Medicare beneficiaries as those eligible for full Medicaid benefits in the state in which they live. In response to Commissioner feedback about this definition potentially being too narrow or creating variation across states, we expanded our definition to include beneficiaries eligible for full Medicaid benefits, partial Medicaid benefits -- meaning Medicaid pays for their Medicare premiums or cost.
sharing through one of the Medicare savings programs -- or those eligible for the Part D low-income subsidy, or LIS, which provides assistance with Part D premiums and cost sharing to beneficiaries who are eligible for full or partial Medicaid benefits or have incomes below 150 percent of the federal poverty level and have limited assets. Because both full and partial benefit dual-eligible beneficiaries automatically receive the LIS, we collectively refer to our full low-income population as "LIS beneficiaries."

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

These figures demonstrate that while safety-net providers are defined based on serving patients with low incomes or relatively unprofitable types of insurance, providers who disproportionately treat certain other types of beneficiaries will also likely benefit from the safety-
Moving on to the issue of variation across states, we found that expanding our low-income definition reduced but did not eliminate variation across states. The exact magnitude of the changes are detailed in your mailing materials.

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

Beyond the benefits we've already discussed, identifying low-income beneficiaries using LIS eligibility has additional benefits. First, relying on this measure would be less administratively burdensome compared with creating new measures. In addition, if funds are allocated based on treating LIS beneficiaries, providers would have an incentive to make their patients aware of and help them
enroll in Medicaid, the Medicare savings programs, and the LIS. Such a woodwork effect whereby previously eligible but unenrolled beneficiaries gain access to the benefits of these programs could improve access to care beyond any positive effects of financially supporting safety-net providers. This is especially true given that research has shown that enrollment in these programs is often low.

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

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

As Brian indicated, the safety-net framework has two steps. The first is to identify safety-net providers. In the case of hospitals, this means identifying hospitals with a disproportionate share of low-income Medicare beneficiaries or hospitals with a poor payer mix. In our prior work, we found that low-income beneficiaries tended
to have higher risk-adjusted costs. Payer mix also matters. High uncompensated care shares and high Medicare shares are associated with lower non-Medicare and total margins. The details of all this are in your paper.

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

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

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

Before we talk about potential redistributions, I want to familiarize you with the current DSH and uncompensated care payments, which are Medicare's main
mechanisms for supporting safety-net hospitals. To be eligible for the DSH program, the sum of the hospital's Medicaid share of patient days plus the hospital's share of Medicare patients who receive SSI must exceed 15 percent. This means the hospital must either serve at least a moderate share of Medicaid patients or serve at least a moderate share of low-income Medicare patients. About 80 percent of hospitals meet this threshold.

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

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

First, the DSH shares are primarily driven by hospitals' Medicaid share of inpatient days. That means that as Medicaid shares increase, the size of the DSH add-
on payment to Medicare rates increases. Medicare ends up indirectly subsidizing Medicaid. In addition, Medicare shares are inversely correlated with Medicaid shares. Therefore, hospitals with high Medicare shares tend to get less DSH payments per discharge.

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

There may also be a concern with uncompensated care payments.

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

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

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

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

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

This graphic illustrates an option for distributing support to safety-net hospitals. In this
illustrative example, 95 percent of hospitals would qualify for the add-on payment. But the amount of the add-on would increase as the SNI increases. The maximum SNI payment in the illustrative example is about 20 percent for hospitals with an SNI above the 95th percentile.

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

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

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

The second row states that the driving factor behind DSH payments are the share of inpatient days where Medicaid is the primary payer. Uncompensated care payments, in contrast, are driven by uncompensated costs at
each hospital. The SNI is a composite measure that increases when the hospital has a larger share of Medicare patients that qualify for LIS, a larger share of Medicare patients in general, and uncompensated care costs that are large relative to the hospital's total revenues.

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

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

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

The first two rows in this slide divides hospitals into quartiles based on their DSH patient percentage. This is the current metric used to distribute DSH funds. We see that the low DSH hospitals tend to have a moderate rate of closures and relatively high Medicare
shares. In contrast, high DSH hospitals tend to have slightly higher rates of closures and low Medicare shares. The DSH program appears to moderately target funds toward hospitals at risk of closure. But it may be of concern that hospitals with high Medicare shares are likely to receive lower DSH adjustments.

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

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

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

Look at the top row which shows Medicare margins. It shows that hospitals with the lowest SNI had a Medicare margin of negative 13 percent. The hospitals with the highest SNI had a Medicare margin of negative 2 percent. This difference is because the high SNI hospitals currently
get greater DSH and uncompensated care payments and have lower costs.

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

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

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

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

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

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

Now we shift to potential discussion questions.

First, we'd like your feedback on the framework that Brian presented including Step 1, identifying safety net providers, and Step 2, deciding whether new funds are warranted for safety-net providers.

Second, we'd like your feedback on applying the framework to safety-net hospitals. Specifically, do you agree with the ideas that Medicare shares should influence safety-net payments and that reforming or replacing the current safety-net policies should be explored further, and also that an SNI-type metric should be explored as a way to improve on the current DSH and uncompensated care payments?
As you can see, the SNI has evolved substantially since our last meeting, and we expect it to evolve further based on your discussion today.

I'll turn it back to Mike.

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

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

MS. KELLEY: Yes, Bruce, go ahead.

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

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

DR. STENSLAND: That's correct. We could shift it to beds. The number or the percentage of IPPS hospitals closing is pretty similar in rural and urban areas, so I...
think there's a fairly reasonable distribution of beds across that. But we can check on it.

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

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

DR. CHERNEW: I think one of the challenges, just to jump in, is there's a measure called the Altman index, which is used in the finance literature to measure financial distress. It has some of those things that Jeff just mentioned. I do think we have to be careful to avoid
getting into a situation where higher costs makes it look
like you're distressed and, therefore, we have to give you
more money or you should get more money in varying ways.
We're trying to find sort of external things. But I do
acknowledge that the relationship isn't always perfect.
I don't know what you think about that, Jeff.

DR. STENSLAND: No further comment.

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

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

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

MS. KELLEY: Okay. I have Larry next.

DR. CASALINO: Thanks, Dana. Brian and Jeff, I
can't say enough about this work. The presentation was
beautifully done. The chapter and the written materials are very informative. The analyses are great. And at this point at least, I really like what I'll call your recommendations. And your questions on your last slide, at this point at least I would say yes to every one of them. What I'm going to bring up is just a quibble, really a definitional issue, but I think worth clarifying. It comes up repeatedly in the written materials and a bit on the slides as well, so I'll be quick, but I just want to give a couple of examples.

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

So, again, I think what you mean is it takes more time to take good care of low-income beneficiaries and, therefore, since the payment rate is the same for all
Medicare beneficiaries, low-income beneficiaries are less profitable. Is that what that means, that sentence? I'll read it again: "Medicare beneficiaries who have low incomes and are less profitable than the average beneficiary."

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

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

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

Then just the other point I have is the second part of that sentence, "We identify safety-net providers as those that disproportionately serve" -- you know, B is "the uninsured or those with public insurance that is not materially profitable." And "materially profitable" shows
up quite often in the written materials and also showed up in the presentation. By "materially profitable," do you just mean the net margin is negative for the public insurance patients?

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

DR. CASALINO: So I would just say, Brian, in the final product, it would be good to define that more clearly, I think. To me at least, it's kind of a nonstandard term. And I understand what you're saying and I don't particularly disagree with it, but, again, I think
defining it would be helpful. It may sound like I'm crowing, but it is important. It shows up pretty prominently in the algorithm that you have in the written materials in terms of deciding who's a safety-net provider and also, you know, what funds should be disbursed, if any, to them. So I'd just try to clarify the "less profitable" and the meaning of "materially profitable" points.

That's it.

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

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

Brian or Jeff, do you have thoughts on that?

DR. STENSLAND: That may be the case in the commercial world. The last time we looked at it, you know, we went through this big DRGs refinement where we looked at
the relative profitability of different DRGs, and we found that certain DRGs were more profitable back when the relative payment rates were based on charges and not costs. And we shifted it to based on costs, and I think, you know, it took some of the payments away from cardiac hospitals, cardiac DRGs. And I think the relative profitability on the Medicare side now I think is fairly similar between the surgical DRGs and the nonsurgical DRGs. And it may be that the commercial side hasn't shifted over to reflect that. I think that's what our analysis showed, but it also showed, I think, in the marketplace when you saw that after we made those changes in the relative payment rates for different DRGs, you saw not only a stop of the growth in heart hospitals; you saw actually a decline in the number of heart hospitals.

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

DR. STENSLAND: It could be, but I think it's probably not something -- it's certainly something we don't have data on. Like we could have the mix for the Medicare shares, but we don't have the mix for the commercial side.
And if it's really the commercial side that's driving it, I think we might be chasing something that we just wouldn't have enough data to make it any -- add any explanatory power to the model.

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

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

MS. KELLEY: That's right, Mike.

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

Two hopefully quick-ish questions. The first one
is somewhat related to the conversation thus far regarding profitability. It struck me that we are -- we did some work as part of this looking at state-by-state variation based on the LIS -- the definitions, if you will, of Medicaid eligibility. And I thought that was very valuable work and will comment on that in Round 2.

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

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

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

DR. STENSLAND: Correct.

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

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

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

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29999 W. Barrier Reef Blvd.
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302-947-9541
could control all these different levers, we would run into this issue, which is if we wanted to increase Medicaid rates, we would increase their profitability, and does that mean that, you know, it changes the way that we would define safety-net providers or how we might reimburse them in a specific targeted way. But I think to the extent that we don't obviously have all those levers, I think it makes sense to understand that we don't want to solve for that specific piece, it's more of an aggregate point how we use it to identify safety net and then use that to design rational policy downstream of that. So that was very clarifying. Thank you.

A second question I had is on page 31 of the reading material, I think it was Table 5, if I'm correct, when we're calculating Medicare share, in the footnote I notice that we say, "Medicare shares are presented as the share of adult and pediatric inpatient days..." And I was curious why we're including pediatric days here in the calculation. It seemed like potentially a tricky problem because some large hospitals will include pediatric -- will have pediatric units and wards inside them. Idiosyncratically, you could end up a situation where a
hospital, brick and mortar right next door, is pediatric and obviously wouldn't then be included. So I was curious what the thinking was there in terms of including the pediatric piece and hypothetically if it would make sense to, in fact, test the sensitivity to that or pull that out and see if the definition of Medicare share would actually meaningfully change for any hospitals.

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

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

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

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

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

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

DR. STENSLAND: Yeah, so the limit on the
uncompensated care is everybody who is a DSH hospital gets basically about 21 percent of your uncompensated care costs paid for. But that's 21 percent of uncompensated care. In this, what we're talking about is an add-on to both your inpatient and outpatient payments.

MS. BARR: Got it.

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

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

DR. STENSLAND: I don't know. It's going to depend on your overall Medicare revenue, so certainly it's going to be -- you know, if you're a big hospital and you have a big share, you know, it could be, you know, 20 percent of $50 million? Or if you're a small hospital, it would be -- and you're at that upper level, it would be 20 percent of your $2 million of Medicare revenue. The people
that would not gain on this that are currently gaining a
lot are the hospitals that don't have much Medicare
business, but they maybe have uncompensated care from other
kinds of business. And then we give them 20 percent of
their costs on whatever their other kind of business is,
even though they don't have much Medicare business. They
would tend to get less money.

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

My other question is -- well, two more questions.

Brian, in the text you mentioned that if their LIS was
slightly more likely to be rural, but the numbers look
bigger to me than slightly, so just kind of net there. I
didn't really interpret that as "slightly," so maybe we
differ on what "slightly" means. But I thought it was
significant. And, of course, what we really don't know is
about all those patients that should be on LIS that aren't
and how are they distributed. And that really -- I mean, I
had no idea that half the patients basically that are
eligible are not getting the LIS subsidy, and we really
need to do something about that with our providers. So
thank you for bringing that up.

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

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

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

My final comment and concern about this, I mean, I love where this is going, but my final concern about this -- and I'm sure you'll hear this from the industry -- is
what is going to be the effect of this on 340B. And so
there's no kind of thinking about like what is the impact
of 340B in these hospital closures and keeping these doors
open. And the dollar amounts have grown tremendously since
MedPAC last looked at the amount of 340B that's out there.
And so I think it's much more substantial than it has been
in the past and gets more and more so every day. And
that's based on DSH percentages and things like that. So
I'm worried that there's some unintended consequences of,
A, not accounting for 340B in this analysis and, B, how
this new metric could potentially affect 340B. And so I
have no answers to that. That is just a concern and a
question.

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

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

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

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

[Pause.]

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

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

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

MS. MARJORIE GINSBURG: My question actually
probably was answered with Larry's question about what is it about the components of the low-income beneficiaries that make them low income, that it's not just that the reimbursement for Medicare is lower on admission, but they get far more services, and that means additional services that cost less than what the actual cost of the service is and that sort of thing.

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

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

The other piece is that since we're looking at LIS who are not part of Medicaid, then what do we know about the cost-sharing patterns for those folks? Do they
simply not have Medigap plans? Is anybody filling in that 20 percent, or is that what makes them a challenge for the hospitals financially?

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

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

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

MS. KELLEY: Pat, I have you next.

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

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

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

DR. STENSLAND: Yeah, right now somewhat over 80 percent of hospitals qualify for DSH payments, and they all -- if you're a DSH hospital, you all get that uncompensated
care payment, too, that flat line, it applies to everybody.

MS. WANG: Okay.

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

MS. WANG: Okay. The other question that I had was just can you help me at least understand how to think about GME revenue in these equations? You know, when I look at the table, Table 5 on page 30, I guess I'm struck, if I'm reading this correctly, that the percentage of teaching hospitals in the highest DSH quartile drops pretty significantly under the SNI quartile, similar for Medicaid
share. I think I'm reading that correctly, Q4 being the highest quartile. Why would that be? Does it have to do with having more revenue? I don't know how to think about that.

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

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

MS. WANG: Hmm.

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

MS. WANG: I see, okay. Last question. This has
been clear throughout, and MedPAC's position on Medicare
not subsidizing Medicaid is very clear and understandable.
It's just a question, I guess. When you look at Table 16,
for example, at least for the fee-for-service, and the
difference in the proportion of beneficiaries who are full
dual-eligible beneficiaries, which is an indication of
Medicaid eligibility standards in the state, and then
partial and LIS only, is there any concern that switching
to sort of an all-LIS metric you maybe reduce the cross-
subsidization of Medicaid but increase the cross-
subsidization of localities that have very skinny
eligibility criteria for Medicaid or perhaps have not
expanded Medicaid. You're subsidizing -- Medicare's
subsidizing something, and I just wonder if that's
something to keep in mind from a policy perspective, who it
is you're subsidizing.

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

MS. WANG: That makes sense, Jeff, and thank you
for that explanation. It's less about the correlation and
whether Medicaid is a good metric. I guess it's just sort
of like something to keep in mind, that as we are
determined to stop cross-subsidizing state Medicaid
programs because they don't pay enough, by expanding the
definition to include all LIS, which might be the right
thing to do, that we are perhaps expanding our subsidy to
states that are not paying anything for their low-income
populations, which is it's just a different form of cross-
subsidy that Medicare would be engaging in. Maybe it's the
right thing to do, but I just -- it's kind of interesting.

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

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

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

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

DR. NAVATHE: Yeah, I think I wanted to add a comment to this point, and I think, Brian, your response actually was super helpful. But if I understand the way you're thinking about this correctly, it might be worth
just testing this out. The idea, to some extent, is that, sure, we're absolutely going to have correlation with Medicaid subsidization to some extent, because at the end of the day there's so much overlap between definitions of low income and what's -- the safety-net eligible populations or what have you are intrinsically overlapping with Medicaid. So it's going to be impossible to get a correlation to zero, because that's probably not what we want in the first place.

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

MR. O'DONNELL: Yes.

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

DR. NAVATHE: Okay. Great. Thank you.

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

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

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

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

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

Jeff, do you have any thoughts?

DR. STENSLAND: No, I think that's it. It just kind of implies that the other -- that the people that we picked up, because we got a lot more people when moving from full dual to LIS, were just distributed relatively
similarly to the full dual in terms of Black, White, Hispanic, you know, disabled, nondisabled, that type of thing. And there could be some variation within the individual states, but on aggregate, it was fairly balanced with the prior distribution.

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

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

DR. CHERNEW: And I know, Larry, you want to say something in a minute, but there are other things, the continuousness of it, for example, and those types of
things that I think are also important. So I'm not sure --
I would have said we are trying to solve -- and, again,
I'll defer to you, Jeff and Brian -- somewhat of a
targeting improvement kind of strategy, and I think it's
clear if you look at some of the data that this is -- I'm
sure folks can do better. We're going to have a whole
Round 2 for you to tell us how. But I think this is a
reasonable way to have a somewhat simple, better targeted
approach. And I just will emphasize -- and I say this
before we get into Round 2 -- we aren't even at the policy
option stage of our work now. We are sort of presenting an
idea, and what is going to come out of this is sort of a
sense of how you feel big picture about pursuing and
refining it and your concerns and not much have been
raised. So we are well before the end of all of this work.
There are some principles that people seem okay with, and
that's nice to hear, and I think several people have made
comments and have used the words "tweaks," "quibbles,"
"considerations," all of which are great. But I think our
basic goal is to kind of have a targeted -- a better
targeted approach that's less sensitive to some of the
things we've wanted to be less sensitive to.
If Jeff or Brian disagrees with that summary, you should let me know. But hopefully that's my response to Dana.

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

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

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

DR. CASALINO: It might be good to provide a very
clear list of the advantages -- you do this to some extent, I think -- of this proposal, so to speak, and that would be a prominent one, I think.

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

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

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

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

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

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

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

MS. BARR: But you made some comments about how
rurality wasn't important, you know, as a -- so could you
do that analysis as well and say, yeah, we added rurality
and it didn't matter? Because as I've said before, the
ADI, although, you know, we do have lower ADI scores -- or
higher ADI scores in our rural areas, it's more of an urban
metric. And so I just -- and given the issues we have with
rural, I think it would be important to either rule it in
or rule it out as being helpful specifically.

DR. STENSLAND: We can look at that.

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

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

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

DR. DUSETZINA: Great, thanks. Jeff and Brian,
this is excellent work, and I really appreciate the
chapter. I am very enthusiastic for these questions about
should we keep going? Absolutely, yes. I think that the
history that you put in the chapter about how we got the
measures we currently have and how, you know, a lot of
those decisions were based on a lack of data and now we
have that information, yes, we should let our policies
evolve to match what we actually want to measure and not,
you know, these very poor proxies. So kudos to the
excellent chapter.

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

I think it is important to maybe try to tease out
what that means for uncompensated care because, obviously,
the nonexpansion states still have a higher burden of
uncompensated care because of decisions of not expanding.
But that's not necessarily for Medicare beneficiaries. But I think it's important to tease out those pieces, and I think on the other side of that, the states that have chosen to offer much more generous thresholds for who qualifies, you know, I think that that seems like something that we would not want to discourage states from doing, because it provides, you know, more beneficiaries with coverage. But I think that that's kind of the other side of the coin of, you know, the nonexpansion states versus states that have expanded and also have much more generous income thresholds for who qualifies.

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

MS. KELLEY: Okay. I have Bruce next.

MR. PYENSON: I want to echo Stacie's compliments for this work and other Commissioners' compliments. As I was going through the material, I was asking the decades-
old question of how can we assign profits to a nonprofit, largely nonprofit sector? And, of course, I understand that that's a technical term and you're using it consistently with how many others use that term.

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

I have been an advocate on MedPAC of looking at things on a community basis, crossing ACOs and Medicare Advantage plans, regional bases and obligation to public
health, because I think the evidence is that if any
elements of our society are left out, we all do worse. And
I wouldn't automatically say this is not a role for
Medicare. Maybe it's not, but I think it's worth
investigating, because there's -- this is a very hot issue
that's probably not going to go away, and there's really
two sides to the community. There's the safety net and
then there's others.
Just my suggestion to add that as a possible
solution. Thank you.

MS. KELLEY: Amol?

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

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

I think first this notion of outlining the
principles up front, I think Larry had mentioned it, Stacie
had mentioned it as well. I think that would be a great
idea. It would help to clarify why we're going to need additional efforts, if you will, to define the SNI, and, therefore, when we go through this effort, what the principles are that are guiding us.

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

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

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

So I think we should make the point explicitly
that we are trying to remove the state-by-state variation
that had been removed and that the residual state-by-state
variation is, if you will, acceptable because it's not
seemingly related to the underlying policy question that we
as MedPAC are trying to address.

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

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

MS. KELLEY: Lynn?

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

But the comment that Amol brought up is actually
kind of one concern I had about the paper was if we -- so
we're only talking about a small subset -- we're only
identifying a small subset of the underserved, right? And
so we're still like maybe at 20 percent, so we don't have
everybody in there. And so if we do an add-on payment for
that group of patients, well, we're not doing that on
payment for the other 80 percent. And I'm not sure that
that's going to create any equity. However, something that
incentivizes providers to -- patients for the LIS I think
is critical, so -- but I worry about one of the
recommendations of trying to compensation, you know, to pay
more for these types of patients when we're only
identifying a small percentage of them, and just think it
would have to get to, you know -- I mean, I realize there's
no way we can just get income on all patients from Social
Security and, you know, or affirm the IRS and then, you
know -- and then use that as a way of identifying patients. But maybe there's some way that we should start thinking about connecting social services to Medicare so that we can actually really understand who are the underserved so that we can better serve them.

Thank you.

MS. KELLEY: Brian?

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

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

The other thing I was going to mention, I really like this 1:1 to 0.5 ratio that you used for the SNI. I
think it's really clever because it does balance LIS and uncompensated -- you know, it sidesteps the issue of state Medicaid expansion. But I also like that 50 percent that you're adding for Medicare because I think it really reflects the changing nature of Medicare margins. There was a time that Medicare was the good business for the hospital. And I think blending that 50 percent metric in, the other thing -- the thing I really like about this measure is you can titrate that up if Medicare margins were to continue to sink. I think you could even titrate that up to increase the intensity of the SNI based on just sheer Medicare performance.

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

So, again, there's a lot to like here, and I want to congratulate the authors, Jeff and Brian, on some really nice work.
MS. KELLEY: David?

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

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

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

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

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

MS. KELLEY: Paul.

DR. PAUL GINSBURG: Yes, I need to say that the work is superb and I'm really pleased with it. This is one
of these areas where Medicare has made a policy decades ago and has not returned to it even as things were changing. And so, you know, I think this is one of the areas the Commission is particularly valuable for, is to identify areas like this, where the policy was made so long ago and things have changed.

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

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

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

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

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

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

And then two additional points that I just wanted to touch on. One is, I think it's on Slide 22, where there's the risk of closure as a measure of obviously concerns around access. I actually think, if possible, it
would be nice to have something that reflects maybe an endpoint that's not quite that extreme but suggests that there is distress. I think Bruce's comment earlier, some other measure of distress. And when I think about what that might look like, you know, I think hospitals, before they get to actual closure, there's a deterioration of services. There's deterioration of clinical programs. And to the extent you measured something like -- maybe it's transfers out of the hospital because they don't have certain services available. I just think looking at a measure like that might be helpful, because I think at that point you probably already have problems at that hospital. And I would say that is already down the road of distress. So I'd encourage us to explore that.

And then the last point I'll make is Larry's earlier point on cost and just a clarification between, you know, why are these folks not as profitable, hospitals, and downright unprofitable. I do think fleshing that out, I would totally agree that that would be beneficial. And I think it does get to a lot of what folks were chatting about. You know, it does carry additional cost to invest 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
5 MS. KELLEY: Dana.
6
7 DR. SAFRAN: Thank you. I will be very brief and
8 pile on my enthusiasm for this particular piece of work and
9 for pursuing this area. You know, it is incredibly timely
10 to be focused on how to invest in health equity, and, you
11 know, I think this past week, having seen the CMS
12 announcement about the ACO REACH program and the adjustment
13 there of benchmarks related to social risk factors, this
14 feels to me very in line and synergistic with that. I'm
15 excited about the work.
16
17 I do think the point that was raised in the last
18 round about the fact that what seems to be driving the
19 difference here in the pickup of beneficiaries has more to
20 do with where they live than their individual
21 characteristics, and to that end probably the Medicaid
22 policies in the states they live does just give some pause
23 about that. But, you know, I think that -- I forget who
24 made the point, but I agree with it, after I made my
25 comment -- maybe it was you, Larry -- that it's worth
calling out in the chapter that, you know, doing this
overcomes some of -- I guess we won't use the word
"stinginess," but stinginess of certain state Medicaid
programs to be able to ensure adequate payment to providers
caring for these beneficiaries. It's something worth
emphasizing.

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

DR. CHERNEW: Great. So Dana was last in queue.

As is my normal, I'm going to pause for a second to see if
maybe Brian and Jeff want to add something. I have a brief
summary.

[Pause.]

DR. CHERNEW: Okay, so --

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

DR. CHERNEW: We do, Larry.

DR. CASALINO: One of Brian and Jeff's questions
was deciding whether new Medicare funding is warranted, and
I'm not suggesting we necessarily get into a full-scale
discussion, but we haven't really mentioned it at all.

Looking at the tables, you know, it looks like this would
provide a bit more funding for hospitals that are, let's just say, hardest hit in terms of their share of disadvantaged patients. But the differences aren't huge in terms of the -- it looks like the absolute increase in -- or the in the absolute difference in margins as a function of the [inaudible.]

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

DR. MATHEWS: I'm happy to jump in here if I could. Larry, that is indeed the conversation to be had. What we were looking for here is just general reaction to the framework that we've established, general buy-in to the basic concept as we start rolling it out into other sectors. But you are absolutely correct. The next
question, as we continue to advance this work, will be in each of the sectors, does this framework end up with a need for additional Medicare dollars. So that won't happen this cycle, but I would anticipate that we'll start taking that question on explicitly as early as the fall of next cycle.

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

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

DR. CHERNEW: So let me just say one other thing. I am going to wrap up in a second. There's also this issue of how much we continue down the work on hospitals, which you're absolutely going to do, and when and how we expand to other sectors. So there's this trade-off with our sort of capacity to go through this, but we are -- well, I'm going to blend this into my wrap-up.
I was very happy with the way this chapter was structured and where it ended up when I saw it in the mailing materials, and I'm thrilled with the conversation that we just had, both because it was very constructive and, broadly speaking, very supportive of where we're going, which I was hoping it was where we would be. So I'm happy about all that.

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

I will just emphasize one point. An enormous amount of discussion focused on the role of LIS and why that was helpful, and I agree, that's why it's there. Understand there's other pieces of the formula, things like the Medicare share which capture broad payer-mix issues that end up also being important. And so part of what we're struggling with -- and this came up in the concept of materially profitable and how we deal with that -- is we're also sort of supporting organizations that, for lack of a better word -- I don't know how to say this -- have less favorable case mixes, writ large. And that's not simply serving a lot of LIS patients. There's other aspects of
case mix given the big differences in commercial and noncommercial payment rates. And the Safety-net Index seems to do a pretty good job of blending those types of concept.

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

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

And so we have a lot to do, but the safety net and the issues that are addressed in this chapter are really important, and so we're going to keep doing this work.
So, with that said, it's 3:25. We're a bit ahead of schedule. I think I'm going to call for about a ten-minute break. If we could come back at 3:35, please don't be late because we're just going to pick up at 3:35. You don't have to log off. You can just mute and turn off your camera. I'm going to come back at 3:34, and we're just going to jump into another really important topic about the geriatric workforce.

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

[Recess.]

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

DR. TORAIN: Thank you, Mike.

Today we will be talking about our analysis of the geriatric workforce and potential opportunities to strengthen it, but first, we would like to thank Rachel Burton, Lauren Stubbs, and Alison Binkowski for their help with this work.
At the November 2019 meeting, we presented results from our research on increasing the pipeline of primary care physicians, including geriatricians. At that meeting, Commissioners asked us for more information on the role of geriatricians in Medicare. Since then, Commissioners have also asked us to examine the health care workforce more broadly. This is the first stage of our work on the workforce, which we plan to pursue during the next cycle. The material we are presenting today will be included in the upcoming June report.

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

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

Then Ariel will describe three policy options to
strengthen the geriatric workforce.

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

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

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

After their internal medicine or family medicine residency, physicians must complete a one-to-two-year fellowship in order to specialize in geriatrics.
As described in the paper, there are three federal programs of modest size that aim to expand and enhance the workforce of health care professionals who focus on geriatrics.

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

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

On the other hand, some of the reasons why medical students are not interested in geriatrics include minimal exposure to geriatrics during clerkships, feeling
overwhelmed by the complexity of older adults, the time it takes to assess and manage geriatric patients, and geriatricians have lower compensation than other specialties, which leads us to our next slide.

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

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

Consistent with findings from our interviews, our analysis of Medicare claims data from 2019 highlights that compared with other primary care physicians, geriatricians
were more likely to practice in nursing facilities and less likely to practice in offices. They are also more likely to provide care to Medicare beneficiaries who were older, had more chronic conditions, and were more likely to be institutionalized.

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

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

In terms of health care costs, there is limited research that examines whether care provided by
geriatricians directly affects health care costs. However, several studies look at the indirect impact on costs. These studies find that care from geriatricians indirectly reduces costs due to less prescribing of medications considered inappropriate for older adults and fewer adverse drug reactions.

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

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

Now I will turn things over to Ariel.

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

The elderly population in Medicare is growing,
and we need a health care workforce to care for them. As we've discussed, geriatricians focus on providing care to older patients with complex conditions, but there have never been very many geriatricians, and their numbers are declining.

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

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

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

The first policy option is for CMS to improve payment accuracy by establishing a new billing code for a service called "comprehensive geriatric assessment," or CGA. In this service, a multidisciplinary team provides a comprehensive evaluation of an elderly patient's physical, psychological, and functional capabilities and develops a treatment plan.
The team usually includes a physician, a nurse, a social worker, and other health professionals such as physical and occupational therapists and psychologists.

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

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

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

CMS could create a new code for CGA and set an accurate price for it, which it has done for other services, such as chronic care management. When CMS creates a new code, this process is budget neutral.

Although geriatricians would probably bill for this code, other clinicians could also bill for it; for example, NPs,
PAs, and family physicians. Creating a new code for CGA should improve payment accuracy and increase total payments to geriatricians, but it's unlikely to significantly expand the supply of geriatricians.

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

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

Here are some design questions to think about.

First, how should the program verify that clinicians are
practicing in geriatrics? One option is to require that clinicians receive professional certification in geriatrics, although there is currently no certification program for PAs. In addition, the program could require that clinicians treat a minimum number of elderly patients each year.

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

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

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

Several of the geriatricians we interviewed recommended that all Medicare-funded residents be required to have at least some geriatric training. Because Medicare subsidizes GME and most beneficiaries are elderly, Medicare
has a stake in making sure that physicians are trained to
address the needs of older patients. Under this option,
teaching hospitals that receive direct GME or indirect
medical education payments from Medicare would be required
to provide a minimum amount of residency training in
geriatrics.

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

This option would not increase overall Medicare spending on
GME.

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

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

Third, should the amount of training vary by
specialty? For example, should family medicine residents be required to receive more geriatric training than surgical residents?

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

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

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

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

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

In the chapter, you mentioned a few things that are out there that have been tried and in place to try and address the geriatric training and the workforce, and one, in particular, the Geriatric Workforce Enhancement Program, do you have any analysis or data about the results of that
program since that was something that was specifically targeting this problem in the past?

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

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

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

    DR. TORAIN: So one distinction that I'll make is that what we found, I think, when we went into researching these federal programs, we thought that their goals were to increase the existing workforce, but we found that these
three programs are more so to actually support the existing field of geriatricians and practitioners that are in the field.

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

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

MS. KELLEY: Okay. I have Betty next.

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

But I have one question that's probably really
obvious, but it's not clear to me. You mentioned that half of the fellowships that were offered were not filled. How are those fellowships financed or funded? Is that through GME or some other mechanism or foundations? Where does the money come from?

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

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

DR. RAMBUR: Thank you.

One other quick follow-up question, when a slot is unfilled, does that money go back to the Medicare
MR. WINTER: That's a good question. I'll have to look into that.

DR. RAMBUR: Thank you. Appreciate it.

MS. KELLEY: Brian.

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

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

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

DR. RILEY: Good question. I can help with that.

This is Wayne.

I'm an internist. So I work very closely with geriatricians, and there's not enough of them. But the
geriatrician tends to be better trained in sort of all the sort of chronic, multiple chronic conditions that tend to focus in the elderly age cohort. They get more intensive training in that, even above that of just a regular family physician or general internist like myself. Whereas, palliative care physicians tend to be really at the moment of critical -- a withdrawing of certain lifesaving measures, comfort for death, et cetera.

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

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

DR. RILEY: Correct, correct.

DR. DeBUSK: Okay.

DR. JAFFERY: This is Jonathan. I mean, I think I'm not sure I would characterize it exactly as a gap there. I mean, there are somewhat different purposes in -- and the training.
DR. RILEY: Yeah. More containable, right?

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


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

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

MS. KELLEY: Okay. I have David next.

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

This is great work.

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

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

DR. RILEY: But just relationally, I will tell you that there are some departments of geriatrics which are separate from departments of internal medicine. I'm thinking of Mount Sinai. I'm thinking of University of
Chicago, several other places where they've really
separated it out from internal medicine. Those geriatric
programs tend to be stronger, and they tend to attract
residents -- or fellows, rather, who want to concentrate in
geriatrics because they have a more distinct identity
around the care of geriatric patients and more intensive
training, mentoring, and role modeling, if you will.

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

DR. RILEY: Yeah. Great point.

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

DR. GRABOWSKI: Thanks.

MS. KELLEY: Bruce.

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

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

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

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

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

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

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

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

DR. RILEY: Right.

MR. WINTER: In our interviews, we learned that
one of the roles geriatricians play is in capitated systems
and also the plans that have capitated payment systems,
because they often can -- they're trained in how to manage population health for this segment of the population, and they're focused on holistic care and, therefore, are seen as desirable by these organizations and plans.

MR. PYENSON: Thank you.

MS. KELLEY: Pat, you're next.

MS. WANG: Thank you.

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

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

DR. RILEY: Yes, it does.

MR. WINTER: Yeah. So there might have been -- there might have been when the -- earlier on, maybe in the '70s, before these fellowships became -- before they were introduced, maybe there was a way to get board certified
without having done one, but today, it's required.

MS. WANG: Okay.

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

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

In that regard, did you all have an opportunity to talk to the ACGME and the residency review committees that set requirements for being sort of recognized as having completed, for example, an internal medicine or family medicine residency program? Because I would think
that the most effective way to inject awareness and
expertise in geriatrics would be for the program
requirements to change. The money comes later, but if the
program requirements change, I think that's what really
drives teaching programs. Did you have a chance to talk to
anybody over there to see whether they are thinking about
this problem?

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

MS. WANG: Okay.

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

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

The other question I just wanted to ask you was
other than establishing codes for comprehensive geriatric
payments, you kind of stayed away from recommending changes
to the physician fee schedule, and I just wondered why --
or I'm sure you thought about it -- why you didn't go there, including, you know, things like maybe since geriatricians seem to be playing a very important consultative role, telemedicine codes or different categories of payment for geriatric consultation and telehealth, things of that nature? Can you comment?

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

In terms of creating other specific codes that
would just be for geriatricians, one issue is that a CPT panel and CMS have been reluctant to create codes that would be specific to a specialty. They try to create codes that any specialty can bill.

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

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

MS. WANG: Thank you.

MS. KELLEY: Larry.

DR. CASALINO: Yeah. Jamila and Ariel, nice work. I think really difficult work, and in a two-sentence
preview of some of my Round 2 framework, I think really
difficult work because I think the problem has been mis-
framed. I don't think the problem is how to get more
geriatricians, although that would be nice. I think the
problem is how to get better care in nursing homes, and
nobody wants to talk about that. And, actually,
geriatricians provide a very, very small percentage of care
to the nursing home patients.

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

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

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

MR WINTER: We did not, but that's a good topic
to look into in the future.

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

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

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

DR. TORAIN: Okay. Thank you.

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

MS. KELLEY: Okay. I have Lynn next.

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

According to Kaiser Family Foundation, there's only about 1,500 practicing geriatricians. So is this a
problem we can even solve? I mean, are you really going to
get the 3,000 or 5,000, the 30,000 we need, or are we
looking at things kind of upside-down? That's one question
I have.

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

So, you know, sometimes the market speaks, and we
have to listen to the market and not try to fix it. So I'm
wondering is the market telling us something, and we should
just be listening to it and trying to find the alternatives
to where the care needs -- I mean, what I hear is, you
know, what we need is drugs, better management of drugs and
better management of Alzheimer's and dementia. And so is
that psychiatrists and pharmacists that we need? Is it
really geriatricians? Because they're not engaging in the
work. The ones we're training are leaving. I mean,
there's some real fundamental issues that I don't think
we're getting at here, and I'm concerned about them.
I guess the other question I have is that if we feel like we really need this more advanced care for our geriatricians, are NPs and PAs the answer? I mean, that doesn't seem -- like, that seems like a cognitive disconnect for me that that's how we're going to solve that problem.

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

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

DR. CHERNEW: Ariel, we have about 10 people for
Round 2, and we have about 45 minutes, so maybe not try them all. You can reach out to Lynn if you can, but keep the highlights.

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

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

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

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

How was that, Mike?

DR. CHERNEW: That was good and quick.

I think we have one more. Paul, please be brief.

Our Round 1 is taking up a lot of Round 2 time.

DR. PAUL GINSBURG: Thank you, Mike.

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

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

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

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

DR. CHERNEW: Do you want to kick off Round 2,
and then we'll just jump in to --

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

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

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

DR. CHERNEW: Wayne, did you have more to say?
Was that part of your Round 2 comment? Do you have more you want to say?

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

DR. CHERNEW: Okay. Just making sure.

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

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

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

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

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

As Wayne said, they go into it for particular
reasons. There's a lot of job satisfaction. They're generally noted to have among the highest job satisfaction of specialties. So I think it is important that we keep thinking about this work.

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

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

And so I guess I wonder, rather than -- and these aren't basically exclusive, but I'm not sure that I'm crazy about the idea of just trying to go ahead with this code as a solution for the comprehensive geriatric assessment,
partly because it just feels like it's embedded in our fee-
for-service system that I instinctively want us to move
away from.

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

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

MS. KELLEY: Okay. I have Brian next.

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

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

I want to jump straight to solutions or to
talking about the solutions. I agree with Jonathan on the
code. I'm a little concerned about adding a new CPT code
because we can't -- once a code is out there, you can't
really control who accesses it, how much of it is done
incident-to versus how much of it is actually done by the
physician. You can't even control which specialties access
it.

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

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

I was a little concerned in the chapter when I
saw the GME, talking about changing the GME requirements.
You know, as Wayne mentioned earlier, it's hard to find
geriatricians anyway, and creating this scramble for all of
these residency programs to try to secure geriatricians, if they were added to the core GME requirements, would make a really difficult process, which is GME, even harder. I mean, there are enough specialties out there that are difficult to fill in these programs already. So I would discourage the GME route.

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

I would argue that the die is cast at the point when the student matriculates to medical school, and even in those rare situations where the die isn't cast and a change does occur during training, it's not a change that's occurring in the direction we would want it to. I would argue that it's probably going away from primary care-based specialties and into the special -- so, again, I don't have a solution for that, but I really think we need to revisit how do we get the composition of our medical school students right, because if you've got a class that's 80 percent specialized the day they show up on campus, the
number or the percentage of specialists is only going to
grow from there. And so I think in a lot of cases, we
start with the wrong mix of students in medical school, and
then it gets worse from there.

Anyway, thank you

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

DR. MATHEWS: If I could, please just because

Brian and a couple of the other Commissioners put forth and
made some comments about the labor market with respect to
geriatricians and whether or not these policies are going
to address kind of market-level issues.

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

And I also completely understand Lynn's
positions. I think that, to some extent, the composition
of physicians and NPs and PAs that we are seeing does
reflect a reaction to a natural market, but the nuance that
I would like to convey here relates to the role of NPs and PAs. We had previously talked about them playing a greater role in the provision of primary care generally for the Medicare population, given some of the trends we've seen in the physician world, and so if they are able to fill a need for not geriatricians, but people who know something about providing care to elderly patients, that income differential that might really influence a physician's decision doesn't seem to be as pronounced with respect to NPs and PAs.

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

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

I would look to Betty for some feedback on this, but I'm willing to bet, at least for PAs, a huge portion of those students receive some type of loan assistance or loan
repayment program, irrespective of the practice that they
join. I think that's pretty commonplace for PAs and at
least for some NPs.

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

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

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

And going on Larry's comment about better care in
nursing homes, absolutely, and there have been some small
studies or some studies that have been somewhat time
limited and geographically limited that have nurse
practitioners in the nursing home, really coordinating that
care, being able to provide things, and keeping that
reflexive impulse to send people to the hospital when it
gets stressed. So I think there's lots of opportunity
here.
I don't know if you want me to make the rest of my comments now or wait until it's my turn.

DR. CHERNEW: Betty, why don't you just go now.

We do have about a half an hour, and if you want to roll --

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

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

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

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

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

Thank you.

DR. CHERNEW: Thank you, Betty.

And if I have this right, we're now to David
Grabowski. Is that right, Dana?

MS. KELLEY: Yes.

DR. GRABOWSKI: Great. Thanks, Mike.

Like other Commissioners, I believe there's real value here in increasing the supply of geriatricians. Ariel said it well during the presentation. As more individuals are reaching age 65, we need more individuals, clinicians that are trying to care for them. This issue is not a new one. There was a very well-known and well-cited 2008 IOM report that outlined this issue and put forward a lot of these same issues that we're batting around today in some of these same solutions. So I think it's safe to say this is a really thorny problem without a simple solution.

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

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

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

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

Final comment. Larry, I just want to react to your Round 1 point about reframing the issue. Nursing homes are a big part of the problem. You don't have to convince me if that, but I think that's not the only
problem. I do think we need geriatricians in other settings as well out in the community across the full
launch and care spectrum.

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

Thanks.

MS. KELLEY: I have Paul next.

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

I'm presuming from -- I was actually going to ask you has anyone tried to make an estimate of the proportion of care for elderly care beneficiaries that should be with a geriatrician but compared to the proportion of care that is, and I'm presuming that that proportion is very small, which got me to thinking about, well, you know, maybe we should be spending more time on, you know -- I mean, it may be things worth doing as far as expanding the supply in
geriatricians, although to me none of these options look
like they're going to move the needle, even though they
might be useful things to do.

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

Well, actually one more thing as far as I realize
that even though increasing the relative payment for visits
in general would probably be a far more powerful tool in
incenting people to become geriatricians, you know, that
would -- it's kind of like the tail wagging the dog. It's
not the way you want to argue for that policy. There are a
lot of other reasons to pursue that.
But the notion of paying some percent bonus to physicians who are board certified in geriatrics could be a useful short-term thing and maybe even stop the erosion of the geriatric workforce.

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

MS. KELLEY: Larry?

DR. CASALINO: Thanks, Dana.

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

I just want to note before I get back to what I think the fundamental problem is and the mis-framing that we have right now is that actually medical students and physicians in any specialty during their training get a ton of experience caring for elderly patients, both in the
outpatient and especially in the inpatient study. That's mostly who people take care of when they're training. That doesn't mean that they're as good at caring for elderly patients as geriatricians. They're clearly not and partly because geriatricians are special people, most likely, and the fact that they are specialists is exactly one reason I think that's going to be hard to drastically increase the supply.

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

So I think the fundamental problem -- they're both problems. We want better geriatric care in outpatient settings, but I think the fundamental problem to me or a fundamental problem is how to get more good clinician care in nursing homes.
As I mentioned -- and I think, by the way, the problem, the reason the problem is, in my view, mis-framed is because it's been completely framed by academic geriatricians. It's very geriatrician-focused. So I'm arguing for a focus on it's great if there's geriatricians who can act as consultants or primary care physicians for some really complex geriatric outpatients, but there's a lot of nursing homes or a lot of patients in nursing homes, and they're not getting good care.

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

So I mentioned earlier this work on so-called "SNF-ists," people who specialize in nursing home care, and that the number of those is increasing rather than
decreasing. There's a question about how good physicians they are, but I think there should be a lot more work on the subject of SNF-ists and to what extent there could be a solution along with PAs and NPs in nursing home care.

There isn't that much work in that, in part, because SNF-ists don't have academic representation for the most part.

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

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

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

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

By the way, most SNF-ists right now are foreign trained medical graduates for better or for worse, and they may be there not so much by choice as by, you know, that's an option that is more easily open to them.
I didn't really realize that I had anything much to say about this topic until I started thinking about it last night. That's it.

DR. CHERNEW: Thanks, Larry.

MS. KELLEY: Okay. I have Bruce next.

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

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

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

MS. KELLEY: Lynn.

MS. BARR: I think I've said a lot of this
already, but I don't think new codes are a good idea.
I do think if the market will -- if there are
half a million primary care physicians and we've got 1,500
geriatricians, more primary care physicians will go into
geriatrics if they got paid more, if they got that
geriatrics fellowship. So I would strongly encourage the
Commission to consider that, and that would for NPs and PAs
as well, so some sort of add-on payment for geriatric board
certification is really the only option that I think would
be helpful.

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

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

MS. KELLEY: Amol.

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

A couple things, I think it's worth just quickly clarifying on what geriatrics training means. I think we conventionally understand what the term or the word in English language -- you know, "geriatric" means elderly,
and as Larry pointed out, a lot of the patients who come
into the hospital are older than 65 or elderly, and so, in
that sense, they're geriatric patients.

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

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

In terms of the options, I thought I would opine
mainly because it seemed like I might have some slightly
different views. I think it is important for us to be very
clear about what our policy objective is, and if we are
very narrow in our policy objective around increasing
clinicians who practice geriatrics, practice geriatric
medicine, then I'm generally of the similar view that
Option 1 with the code and Option 3 with the GME training
are unlikely to really be effective in increasing the
supply of geriatricians.

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

So I for one, for example, although I'm not
generally a fan of let's code it up and let's be all about
fee-for-service, I think adding a code to support these
broader assessments is definitely not unreasonable, in
part, because geriatricians, as we know already, are being
underpaid. And we value in our system the codes that
generate the more RVUs, whether we like it or not. So I
think to some extent, it is recalibrating in a way that
disproportionately benefits geriatricians with very, very
little effect as you spread it out across all the other CPT
codes at E&M visits and such.

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

On the second point, I'm very grateful for the
conversation here and Jim's clarification because I think I
defaulted very much to a loan repayment for physicians kind
of concept, and there was -- that is very different for the
NPs and PAs. And so I am broadly supportive of Option 2 as
something that could be quite effective, recognizing that
this is probably not -- given the gap that we have that I
think Lynn highlighted, this probably would be one part of
a panoply of different policy changes or innovations we'd
have to make to really close this gap.
Option 3 of the GME piece, as I mentioned, I think the geriatric medicine piece is a very specialized portion of the curriculum. I think it would probably be relatively difficult to implement any sort of integrity because of some areas that, I think, Jonathan and others have pointed out that even the availability of geriatricians to teach these types of skills may actually – and these clinical concepts may actually not be very pervasive. If that's the case, we may be creating further disparity between regions that have enough geriatricians and those who don't rather than really correcting some of our issues.

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

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

MS. KELLEY: I think that's right.

DR. CHERNEW: Great. So, Amol, thank you. So, first of all, thanks to all of you for engaging in this material, and thanks to Jamila and Ariel for really a wonderful chapter. This illustrates the
challenges that we face.

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

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

I think what is clear is the basic problem is to make sure we get the best care we can for the beneficiaries we're serving, and some of those beneficiaries are very complicated patients that need the type of care that geriatricians provide, and so that seems clear. Although
it is also clear that other people that might not be
geriatricians by training can provide some of that care,
and that's both physicians and non-physicians.

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

So let me just say thanks to you all. For the
audience at home, we really do want to hear your feedback.
So please send any comments to meetingcomments@medpac.gov
or go on the Web where you can send us meeting comments.
We are always looking forward to that, and for those
interested -- and I know that's all the Commissioners --
join us tomorrow morning. We will be convening at 10:30
with a session on alternative payment models, with a focus
on episode-based payment, and followed up after lunch with
a discussion of some issues related to Medicare Advantage
risk adjustment. So we look forward to seeing you all
tomorrow. Thank you for joining us, and thanks again to
Ariel and Jamila for this wonderful work, and we will see
you then.
[Whereupon, at 4:59 p.m., the meeting was recessed, to reconvene at 10:30 a.m. on Friday, March 4th, 2022.]
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
WAYNE J. RILEY, MD, MPH, MBA
JAEWON RYU, MD, JD
DANA GELB SAFRAN, ScD
PAT WANG, JD
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DR. CHERNEW: Welcome, everybody, to this morning's MedPAC session. We're continuing our discussion of alternative payment models, moving along in anticipation of an APM chapter in the June report, and today we're going to deal with one of the more complicated issues: integrating episode-based payment with population-based payment.

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

MR. GERHARDT: Indeed. Good morning, everybody.

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

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

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

Today's presentation starts with a quick review
of work the Commission has been doing to improve Medicare's portfolio of APMs.

At previous meetings, some Commissioners have expressed support for combining episode-based payments with a population-based payment model, so we will discuss how Medicare's episode models work and how they currently interact with current population-based models.

We'll then present three possible options for integrating episode-based payment approaches with the new population-based payment model being discussed by Commissioners.

Finally, we will raise some questions about the three options and ask Commissioners for their feedback.

At several meetings this cycle, Commissioners have discussed specific ways of implementing the June 2021 recommendation that CMS implement a smaller, more harmonized portfolio of APMs.

At the October meeting, there was broad Commissioner interest in centering CMS' APM strategy around a single, multi-track, population-based payment model. Different tracks of this model would be geared toward different types and sizes of organizations and would
involve different amounts of financial risk.

At the November and January meetings, Commissioners expressed interest in moving away from the current practice of periodically "rebasing" ACO benchmarks to an approach that only uses annual administrative updates.

And at the October meeting, Commissioners also expressed interest in exploring how episode-based payment arrangements could be combined with the core population-based payment model. Today's presentation explores that concept in greater detail.

The April meeting will bring these ideas together in a follow-up chapter in our June 2022 report.

Combining an episode-based payment approach with a population-based payment model presents a number of potential benefits.

In theory, supplementing a population-based model with payments that focus on specific clinical episodes can help ensure that specialists and facilities have strong incentives to provide efficient, high-quality care during those episodes.

There is also evidence that attributing
beneficiaries to both an ACO and episode-based payment model can result in larger reductions in utilization and improvements in quality for certain types of episodes than either model would have achieved individually.

However, there are potential drawbacks as well. For instance, if the market for specialists is consolidated or information about their performance is not transparent, the presence of an episode-based approach may not be effective in bringing down costs.

And depending on the specific payment arrangements, ACOs may be reluctant to engage with episode-based providers because they don't want to share potential bonus payments.

In Medicare's episode-based payment models, episodes are triggered by a defined clinical event, such as knee replacement surgery or congestive heart failure. Medicare pays providers on a fee-for-service basis but tracks all spending for a beneficiary once an episode has been triggered. Medicare then compares actual spending during the episode period against a target spending amount.

In Medicare's two largest episode models, the
target amount is a risk-adjusted average of all Part A and Part B costs that occur 90 days following a triggering event, minus a discount factor. The discount factor is the mechanism CMS uses to generate program savings from the model.

If actual spending is less than the target amount, the accountable entity receives payment for the difference. If actual spending is above the target, the entity must pay Medicare for the difference. The maximum amount providers can receive in bonuses or pay in penalties is usually capped at 20 percent of their spending target.

CMS currently uses inconsistent model overlap policies when a beneficiary is in an ACO and triggers an episode in one of the episode-based payment models, as shown in Table 2 of the paper.

In some combinations of models, beneficiaries in an ACO can be concurrently attributed to an episode-based payment model while in other models they cannot.

In scenarios where a beneficiary can be concurrently attributed, participants in both models are eligible to receive bonus payments for any savings. In some of these cases, any bonus payments earned by an ACO or
episode-based provider are not included in tallies of total spending for the other.

For instance, beneficiaries in an MSSP ACO can be concurrently attributed to the BPCI Advanced model, and any bonus payments a BCPI provider receives for those beneficiaries is not counted toward the ACO's total spending.

In this situation, Medicare is essentially double-paying bonuses because CMS allows participants in both models to earn bonuses with no adjustment to account for the other's bonus payments. The same phenomenon can occur for penalties incurred by model participants.

Given the potential benefits of combining ACOs and episode-based payment, Medicare should seek to apply more consistent overlap policies that avoid double-paying bonuses.

I will now hand things over to Rachel.

MS. BURTON: At the October meeting, there was Commissioner interest in exploring whether and how to integrate episode-based payment with a population-based payment model.

The rest of this presentation outlines three
options for doing this, which would all avoid paying double bonuses to providers.

All three of the options I'll be describing assume Medicare would operate a new episode-based payment model, but our options vary in terms of which types of beneficiaries would be attributable to this new model, which I'll say more about in a minute.

The Medicare episode model would only include a few types of clinical episodes that have been proven to save money for the Medicare program, such as hip and knee replacements, other hip and femur procedures, and urinary tract infections.

To prevent Medicare from double-paying bonuses, in options that call for concurrently attributing some beneficiaries to both an ACO and this episode model, any bonus or penalty incurred by episode providers would be included in the ACO's annual spending tally.

We assume this episode model would be mandatory, to avoid the selection issues that can arise when a model is voluntary, and to be consistent with Commissioners' views at the October meeting.

If Commissioners would instead prefer that this
episode model be voluntary, we would look for Commissioner input on how to mitigate selection issues.

In all three of the options I will describe, ACOs could enter into their own arrangements with providers for episodes not covered by Medicare's episode-based payment model.

This would give ACOs flexibility to experiment with payment arrangements for dozens of types of episodes, but we caution that it doesn't necessarily mean that ACOs would choose to set up such arrangements.

ACOs might not bother if they don't have data on the cost and quality of episode providers in their area or if they can't get episode providers to agree to enter into arrangements with them or if they think they can more reliably generate shared savings through other approaches.

I'll now describe the key difference between our three options.

Our options vary in terms of which types of beneficiaries would be attributed to a new Medicare episode-based payment model.

In Option 1, all fee-for-service beneficiaries would be attributed to the Medicare episode model if they
had a triggering episode. This would include beneficiaries in two-sided ACOs, one-sided ACOs, and beneficiaries who are not in an ACO.

In Option 2, only beneficiaries in a one-sided ACO or who are not in an ACO would be attributed to the Medicare episode model, since this option assumes two-sided ACOs would already have a sufficient incentive to ensure episodes are delivered efficiently.

In Option 3, only beneficiaries who are not in an ACO would be attributed to the Medicare episode model, since this option assumes both two-sided and one-sided ACOs would already have a sufficient incentive to ensure episodes are delivered efficiently.

In all three of our options, ACOs would always have an incentive to ensure care is delivered efficiently in the types of episodes not covered by Medicare's episode model, and ACOs would always have an incentive to keep beneficiaries healthy to prevent episodes from occurring, since episodes can be quite costly.

In Option 1, all fee-for-service beneficiaries would be attributable to Medicare's episode model. An advantage of this option is that providers delivering care
during the types of episodes included in Medicare's model would always have an incentive to deliver that care efficiently, since they would always be paid on an episode basis.

In addition, episode providers would be paid using a single, consistent, payment model for these episodes, thus reducing complexity for these providers.

A drawback of Option 1 is that ACOs would have only a weak incentive to manage episodes once they had begun, since the difference between an inefficient episode and an efficient episode would have only a minimal impact on an ACO's spending, as the examples in our paper show.

ACOs would also be limited in their ability to design their own payment arrangements for the episodes covered by Medicare's episode model.

In Option 2, only beneficiaries in one-sided ACOs or who are not in an ACO would be attributed to Medicare's episode model. The advantage of this option is it would give two-sided ACOs a stronger incentive to ensure episodes are delivered efficiently. Two-sided ACOs would be able to design their own payment arrangements to use with their episode providers.
A disadvantage of Option 2 is that two-sided ACOs might not choose to operate their own episode arrangements with providers, since these arrangements can be administratively complex.

If two-sided ACOs did choose to each set up their own episode-based payment arrangements, episode providers could end up being paid using multiple episode payment models, thus creating complexity for these providers.

We also note that under this option, episode providers would have no incentive to deliver efficient episodes if a beneficiary in a two-sided ACO sought care from episode providers who were not in her ACO, since these episode providers would be paid on a purely fee-for-service basis.

A final con is that one-sided ACOs would have only a weak incentive to manage episodes once they had begun and would not be able to design their own payment arrangements to use with episode providers.

In Option 3, only beneficiaries who are not in an ACO would not be attributed to Medicare's episode model. The advantage of this option is it would give all ACOs an incentive to ensure episode care is delivered efficiently.
A disadvantage of Option 3 is that ACOs might not choose to operate their own episode arrangements with providers, since these arrangements can be administratively complex.

If ACOs did choose to each set up their own episode-based payment arrangement, episode providers could end up being paid using multiple episode payment models, thus creating complexity for these providers.

In addition, episode providers would have no incentive to deliver efficient episodes if a beneficiary in an ACO sought care from episode providers who were not in her ACO, since these episode providers would be paid on a purely fee-for-service basis.

As we turn to Commissioners' discussion of this material, we'll leave you with four questions:

Which of the three options do Commissioners prefer?

Are there other pros and cons that our options should note?

Are there modifications that would improve these options?

And are there other options for integrating
episode-based payment with population-based payment that
Commissioners wish to consider?

If during today's discussion many commissioners
support a particular option, we will include it in the APM
chapter of our June report to the Congress.

We'll leave you with a slide summarizing the
differences and commonalities of our three options and turn
things back over to Mike.

DR. CHERNEW: Great. Rachel, thank you, and,
Geoff, thank you.

I'm about to open it up to the Round 1 queue. I
do want to make one comment on context. This material
really focuses on these three options, and I do think it's
important to discuss these three options. But I'm very
aware that your choices may be reflective of a bunch of
other things related to the episode program: how many
episodes, whether they're mandatory, maybe something about
benchmarks. So I'm torn as to sort of the instructions to
the Commission. On the one hand, please make your comments
about these known, to the extent that you have them. On
the other hand, I'm interested in other aspects of the
programs you might want to comment on and how they interact
with these options, recognizing that the time between now and when we see this again in April -- and that is actually much shorter than it seems, so there's only going to be so much we're going to be able to do. But it is always useful to hear your thinking even if we can't incorporate it all at this stage. We have other cycles and other times to be able to get that into account.

So I guess what I'm saying is thoughts on this is obviously important, and to Geoff and Rachel, I think this graphic is just outstanding. But if you want to say more about how it interacts with your feelings about other aspects of the episode program, don't hold back.

So, with that, Dana, let's go into the queue, and I think Round 1 is going to start with Jonathan.

MS. KELLEY: I think that's right.

DR. JAFFERY: Great. Thanks, Mike and Dana.

Thanks, Rachel and Geoff. Indeed, it's a fantastic chapter, and the presentation was clear and great, and the way you've laid out the pros and cons is really wonderful for this discussion. And as you know, I'm very excited about this topic.

I'm not sure if this is two questions or a single
two-part question, but when you listed the cons for Option 1, you said the one con is that ACOs couldn't design their own payment arrangements, something like that. And so I'm curious if that's actually true. And why couldn't ACOs maybe design some of their own payment arrangements, even for mandatory episodes?

So, for example, could an ACO provide care coordination support or create a strong affiliation with some groups of specialist providers and then in return maybe receive a portion of any shared savings that they get from that episode payment?

And then, again, maybe this is a two-part question or maybe it's a separate question, but I just want to make sure that I'm thinking about this correctly. Again, in the chapter, you have an example, walking through some of the dollars under Option 1 that probably could apply in the other options as well. And so in that example, all the episode savings and losses go to the episode provider, not the ACO, and then they're counted toward the ACO spending. But in that scenario, is the ACO more or less guaranteed to get the CMS discount? That was sort of my read on how the dollars would flow. So let me
ask those, and thanks for -- looking forward to the rest of the discussion, too.

MS. BURTON: I think I'd have to mull your second question. So let me take that back and see if any tweaks need to be made to our dollar example in the paper.

And for your first point, I think you're right that ACOs could potentially layer on some other type of arrangement with episode providers, even in Option 1. You certainly have more experience than I would on, you know, what type of thing might be possible and acceptable to episode providers.

MR. GERHARDT: But I think to expound on that a little bit more, we were trying to create some clear demarcations, and one of the demarcations was for the episodes that are covered by the Medicare model, would the participants in a given type of ACO be allowed to do their own arrangements for those, or would essentially their providers that triggered those kinds of episodes be in the Medicare model? Rather than having sort of the choice to go one way or another, these options envision more of a clean demarcation. So for those episodes that are covered by the Medicare model that apply to a specific ACO, the
ACO's participants would go into the Medicare model.

DR. CHERNEW: I think -- so because the queue is long, I'm going to move us along, but I think, Jonathan, the way to think about this is organizations can always build contractual arrangements outside of what Medicare does. But if they were going to do that in Option 1, they would have to build whatever they build around an episode model that exists that people would be in; whereas, the others they wouldn't. So they could in some sense undo or modify what that is, but it's just a completely different framework for how that plays out when you have the episode existing. So think about that as people just working around the underlying Medicare foundation, which in this case would include the episode.

Since I see you nodding your head, Rachel, I think we're going to move on to the next person in the queue.

DR. NAVATHE: This is Amol. May I just add a quick point? I think to some extent it also impacts how the funds are flowing. So if you have a mandatory episode model, then in some ways the savings are accruing to the episode provider, and then, Jonathan, the ACO would be
contracting to sort of bring the savings from the episode provider into the ACO rather than vice versa if it were in the other opposite informal arrangement.

DR. CHERNEW: Yes. Good point.

MS. KELLEY: Okay. I have Dana next.

DR. SAFRAN: Thank you so much. Okay. We're in Round 1, just to get myself organized here. So a couple of questions.

One is I'm curious what we know about the extent to which patients who are receiving procedural care in Medicare are doing so with guidance or advice on who to go to for that care from another provider, either a PCP or potentially a specialist. I know that's hard to discern, but I think it's very relevant to our thinking about the three options, because to understand the leverage that the ACO has with respect to referrals and, therefore, the leverage they have for the episode provider in terms of concern that their market share can dry up if they aren't performing in a way that the ACO feels is adding value, it's really helpful to understand those referral dynamics, even in a model that doesn't require a referral in terms of benefits.
I hope that's a clear question, but my question is really what we know about those patterns in fee-for-service Medicare.

MS. BURTON: I think Luis and Jeff might be the best people to answer that question. If they're available to pop on, that's great. And if not, we'll just consult with them offline and add some information about that in our paper.

DR. STENSEL: We can look into that, but I don't think we have any data off the shelf that's going to say what share of the fee-for-service, say, surgeries were driven by a primary care referral.

DR. SAFRAN: Yeah, I'd be happy to chat offline. There's some ideas I have for how you might model it with claims data, but I recognize that you may not have the time or bandwidth to do that.

So just two other questions to clarify. One is, you know, your point at the early part of the chapter around the very small number of episodes today for which there's sufficient evidence of effectiveness that they be rolled into this model got me curious about how we ever filled out the portfolio of episodes to do this. So, you
know, you suggested that CMS can be still doing some
testing, which, of course, is right. How else would we
build out the portfolio? I just was curious about your
thoughts around how that comports with the recommendations
we're making and have made about parsimony in the models,
because if CMS is continuing to need to test a whole lot of
episodes in order to build out the episode portfolio, that
just -- I wondered how that fits together.

And then I'll just add my third question and then
go off mic. The third one was just a point of confusion
for me. On page 12 of the reading material, when you're
sharing the evidence from the BPCI Advanced, you note that
there were significant impacts on costs for surgical
episodes but not for medical. My understanding was that
the paper of Amol's that you cite had the absolute opposite
findings, that the impact was for medical episodes, not
surgical. I could be wrong, but I just wanted to ask that
question.

Thank you.

MS. BURTON: Well, Amol might be in the best
position to answer your last question. I wonder if he can
chime in.
DR. NAVATHE: Sure. So the paper, I think, that you're referencing, Dana, looked at overlap between ACOs and bundles. So this is when an ACO beneficiary goes to a bundled payment provider where there are additive benefits, those additive benefits accrue to both surgical and medical condition patients in the context of lower readmissions.

But there were greater savings -- you remembered this correctly. There were greater savings in the medical group, and the higher acuity of the patient, the stronger the effect within the medical group.

DR. CHERNEW: Incremental. Incremental.

DR. NAVATHE: Incremental, yeah.

DR. SAFRAN: Thanks.

MS. BURTON: And then to your first question, Dana, this presentation is trying to kind of capture some of the Commissioners' views from the October meeting and sort of present them back in like here are some ways to implement what you guys were thinking. So in October, there was a preference expressed for an episode model that only focuses on a few episodes. But it did seem like there was interest in continuing to not give up on episodes but continue to try to see what else might work in an episode
sort of arrangement. But if you would prefer that CMMI
rein it in and not test further episodes, that's certainly
something that you guys could talk about.

DR. CHERNEW: Can I say something in that regard?
This issue about how many episodes or how to build it out,
those type of things, is a very important issue, and I'm
interested -- people can say something about this in Round
2. I will say that we're not going to resolve that
particularly for this chapter. My personal view is
building out episodes should not be done for the sake of
building out episodes. Building out episodes should be
done when we think adding any particular episode helps
promote the objectives we have of better care, lower
spending, et cetera. And we have to be worried not just
about what's happening in the particular episode that we're
building but how it influences all that's going on in the
population-based payment model or, for that matter, with
the other episodes. And I think it is likely that where we
may get in this chapter -- and, Dana, I hear your statement
as a call for us to do this. I'm not sure how we
operationalize. To say something about the considerations
one would use in doing that, because I can pretty much tell
you, at least for this cycle, we're not going to get to a point where we're going to resolve that issue. I think as a Commission we would have to be much further along, and I just don't see us getting there in the time frame we have. But I do think we can say something about the issue and how to think about it.

I don't know if that was helpful, but I fear this issue -- not fear. I expect this issue may be running through a lot of people's minds, so I want to emphasize where I think we may end up on that. Others may comment, but --

DR. SAFRAN: That's helpful, Michael. Thanks.

DR. CHERNEW: Yeah. Let's go on. I think Paul is next.

DR. PAUL GINSBURG: Sure. I have a question about the relationships of ACOs to their physician members, and, you know, particularly, Dana, we know that if a primary care physician is a member of an ACO, that really defines the ACO because that attributes beneficiaries to it. But, you know, on the specialists, it's something where an ACO could steer patients to a specialist whether they're a member of the ACO or not. And, you know, in a
sense it seems as though whether specialists are in ACOs is very much endogenous in this world we're talking about. So the question is: Is there anything you could tell us about, you know, what proportion of the primary care physicians and specialists who treat Medicare beneficiaries are now members of ACOs? And is there any norm for what the relationship is for a specialist? And if they become a member of an ACO, what actually is their relationship to the ACO?

MR. GERHARDT: That might be something that Jeff or Luis know more about, but I will tell you there are more specialists that participate in ACOs in total than PCPs, which, of course, largely affects the breakdown in the overall specialty of physicians. So there are a significant number of specialists already participating in ACOs, but the make-up of a given ACO is going to vary very highly between different ACOs, so maybe almost exclusively PCPs and no specialists while others are clearly weighted more heavily towards the specialist side.

I don't know if Jeff or Luis have anything more to add.

DR. STENSLAND: Yeah, I have nothing else to add.
to that.

DR. PAUL GINSBURG: Okay. Well, let's keep going forward to Round 2, and I'll come back to this later. You know, think in terms of whether specialists are members of ACOs is very endogenous, you know, very subject to the details in different situations, and presumably would be very affected by the decisions we make on overlap.

DR. MATHEWS: Paul, if I could jump in here, this is always something fraught with risk when I do this kind of thing. But, you know, everything that Geoff said about representation of specialists in ACOs is correct insofar as the data permit us to evaluate, so we can say things like, you know, the share of physicians receiving a 5 percent bonus payment is roughly commensurate with the share of specialists in the environment. But what we don't know -- and here, Geoff or Jeff or Rachel, you know, if I'm heading out on a limb, stop me. What we don't know is the degree to which specialists are actively involved in the governance of any given ACO and making decisions about how to manage the patients or things like that. And that's a much harder issue than just evaluating the flow of dollars.

DR. CHERNEW: Related to that is oftentimes you
could have a large health care system that has an ACO and a specialist that works for that health care system where the specialist is neither on the list nor self-identifies with being part of the ACO, but is subject to the rules of the system, that they would be affected by the fact that the system is in the ACO. So this notion about whether or not a specialist is in or is not in an ACO or how the specialist is or isn't compensated or how they are or aren't engaged is actually much more complicated than just simply are they getting bonuses through the ACO or are they on the ACO list or some other type of thing.

I'm not sure we're going to resolve all of that given the heterogeneity in the country, but that's my take on this very complex issue.

DR. PAUL GINSBURG: Yeah, excellent, because I think the actual takeaway is that, you know, as we go through these issues, we need to recognize that they could very much influence the degree to which specialists are members of ACOs or which ACO they're in.

When I was on the board of an ACO as a Medicare beneficiary, they made a decision once to remove all of the hospital-employed specialists from the ACO because Milliman
told them they'd do better, which was correct. I won't push it any further.

DR. CHERNEW: I think Bruce is next in the queue.

Sorry, Dana, I should let you run this. I'm just --

MS. KELLEY: No, that's fine. Bruce is next.

MR. PYENSON: Thank you. Perhaps a follow-up question to Paul's and then I have another -- I've got actually two questions. I was struggling to think about how the options interact with governance of two entities, one entity being the ACO and the other entity being the sponsor of an episode-based model. And, in particular, you know, if you have a community hospital ACO, what happens when a community hospital is also the sponsor of a bundled payment program and there's overlap, a different kind of overlap than we're talking about with patients, but it's really the same entity? And how's that defined? So there's -- that's one question. How do we think about that? Because as we know, often the kinds of organizations that sponsor ACOs might be also sponsoring bundled payment programs.

My second question is about the statement that we have to avoid double payment, and I'm wondering what the
origin of that is. Is that a principle? Is it empirically based because it's material or something else? I'm just curious about what's the rationale for saying double payment is a bad thing. So two questions there.

MS. BURTON: Our paper focused on beneficiary overlap rather than provider overlap, so I think we'd be curious to hear your thoughts on what you think would make sense on the provider overlap front.

And then in terms of double payment, maybe I'll ask Jim if he wants to take that.

DR. MATHEWS: Sure, absolutely. I mean, from our perspective, as we were putting together this paper, this seemed to be, you know, something innately fiscally prudent that the Medicare program would have a vested interest in doing, avoiding paying out double bonuses for basically the same care provided to a single patient during the course of a single episode. And so if I were in an argumentative mood -- which I'm not -- you know, I might ask: Well, what would be the competing rationale for paying out double payments?

MR. PYENSON: Well, is that a Round 1 question, Jim?
DR. CHERNEW: Remember, he would say that if he was in an argumentative mood, but he's not in an argumentative mood, so he actually didn't say that. That's the way to interpret that complicated set of semantics.

Actually, let me just say this, just for the purposes. Jim, I think you answered the clarifying question of which you were thinking. Bruce, in Round 2, if you want, you can comment on what Jim said. I personally think a lot of the issue depends on how big the program is, writ large. I could probably get you to agree that there's a certain amount of double payment that would not be good. You would never be able to save money totally if every time someone saved a dollar you paid back two. But it might be I could design some set where some limited amount of overlap or some limited amount of episodes might not be disastrous. This is, I think, much simpler than that level of nuance and I think what motivated it. That's my take on what Jim said.

But, Bruce, you get to comment on all of that --

MR. PYENSON: But just --

DR. CHERNEW: -- all of that in Round 2.

MR. PYENSON: So I understand Jim's answer, I
asked if it was based on materiality or principle or
something else, and I think what I heard is it's based on
principle.

   DR. MATHEWS: That's correct.

   MR. PYENSON: Okay. Thank you.

   MS. KELLEY: All right. That's the end of Round
1, I think, Mike, unless anyone else wants to jump in.

   DR. CHERNEW: No, that's what I have, too, and so
I think now Amol, who I will tell everybody was in the
queue last night at around 10:00, is going to be the first
participant in Round 2. Amol.

   DR. NAVATHE: Great. Thanks, Mike. So as you
can tell, I can barely contain my enthusiasm for this work.
Geoff and Rachel, I think you did an outstanding job of
taking a very complicated subject and making it digestible
and distillable and not 300 pages long, so congratulations
on that.

   I have a number of different suggestions,
thoughts on the policies but also suggestions for potential
improvement of the chapter and the work in general. So
what I'm going to try to do here to be as tractable as
possible is to categorize this into short-term feedback in
terms of what we might be able to actually change in a practical, feasible way by April or by the June chapter deadline, and then some longer-term suggestions for the work where there might be some analytic components that we could do but not for this cycle given the time constraints that we have.

I think one thing that's important to just outline is a general principle -- and I think we embody this, but it's good to remember sometimes -- that what we're trying to do here is not per se advocate any particular program or type of provider or what have you, but really design policy that's following what the best evidence suggests to do what's best for the Medicare program writ large. And I think that's important, and I'll come back to a couple of areas where I think that might be helpful.

So in terms of short-term pieces, I have four points. I'll try to outline them as crisply and cleanly as possible.

The first point is I think there may be some opportunities for us to just improve the characterization, in some sense the balance of the way that we describe the
evidence in the chapter. I won't get into it now because I
don't think it's that helpful, but I will follow up with
some comments by email that will be hopefully much more
targeted and well-scoped in some sense.

Alongside this comment, I think one thing that
might be helpful is, as I went through the chapter, it felt
a little bit backwards in sequence, and I recognize that
this is part of a broader chapter to be married with the
other ACO model discussion. But we sort of dive head first
into the overlap considerations and then have a paragraph
or two after that to say, well, here are the design
considerations that one might think about in bundled
programs going forward.

And I think that made it cognitively very
difficult to follow because when we're reading the parts
about the options, we haven't really pre-committed in any
fashion to what the general design of the bundle looks
like. Are we talking about chronic condition bundles like
the oncology care model? Are we talking about only
exclusively acute condition bundles or surgical bundles? I
think it would actually help if we could have some preamble
discussion around here's the broad structure of a bundled
program; there are number of considerations which we don't have time to get into now that would be a part of further work and that would need to be specified either in part by MedPAC or by CMS if it were to implement these. And so I think that would require a little bit of reorganization, but I don't think it would be too onerous to do that, maybe with just a little bit more language to contextualize.

Second main short-term point is discussion around episode choices and to some extent episode design. One of the reasons I'm coming back to this point around balancing or improving the discussion of the evidence to some extent is we are -- on one hand, we have the benefit of looking back at three or four different episode programs that CMMI has put out. On the other hand, there's only three or four programs that were implemented in a very particular way, and we know, for example, that the CGR program, when it went voluntary, introduced a rate goal. We know the BPCI Advanced program has had some issues with the way that the benchmarks were designed, et cetera.

And so if we stick our litmus test peg to this notion of net savings, I think we may actually be doing a disservice to the program, much in the same way I think in
part the ACO conversation we followed where the gross
savings, where the practice change is happening. And so
there's an opportunity here as part of this work to
probably just flag, not do the work in the short run. In
the long term we could potentially do some work on how do
we improve the design of bundles or episodes such that they
can be the best they can be, and then we can integrate them
in with ACOs as best as possible. But it's hard to do this
-- I recognize -- and I'm not saying this as a
Commissioner. I'm saying this as staff or as a Commission
overall. It's hard to parallel process this a little bit,
but I think it's worth putting it out there, that this
parallel processing does need to happen, whether MedPAC
does it or CMS does it or both try to do it.

Another sub-point on episode choice is we have a
smaller set of medical -- I think we mentioned UTI, urinary
tract infection, is the only medical bundle. I think the
evidence that Dana was alerting us to earlier are these
that there may be better evidence, in fact, for some
medical conditions. It seems to me conceptually we need to
have some foundation here that where we have a lot of
conceptual care overlap between ACOs and episodes, we may
worry more. So what I'm talking about here are chronic medical conditions may not be as suitable to overlap because you may actually be creating conflict in the structure. But acute medical episodes -- I'm thinking things like sepsis or pneumonia or acute myocardial infarction -- may actually function and do, in fact, if you look at the spending patterns function a lot more like procedural episodes. And so this may be a concrete place, again, that we might want to widen our aperture of how we think about this. And then also, again, I think important to just flag out there that we're going to hear some dimensions of consideration.

Third short-term point is I found it a little -- I tussled with this point of mandatory bundles a fair amount, and I think in part the reason is I'm fully in support of the concept of mandatory bundles. It's just that the way that we read it in the context of the options, we're kind of playing both sides. We're saying, yes, mandatory, but, no, not mandatory. It feels a little bit inconsistent. And so I think if we really want to push and say we support mandatory bundles -- and I think there's a lot of good reasons to do that selection and other issues.
that you outlined -- then I think we should probably highlight that it really does start to push us more towards Option 1. And that is, you know, generally in keeping; otherwise, it does create some significant complexity to have a mandatory bundle where you have some groups that aren't really factored into the benchmarks or they're opted out in some way. It actually in a circulate way comes back and undercuts the whole benefit of the mandatory design to some extent.

So I think we should just be explicit about those points, and, yeah, I'll stop there.

DR. CHERNEW: Amol -- sorry. I thought you were actually going to stop there, but now I realize you're not.

DR. NAVATHE: Fourth shorter-term point, again, I think we can leave some of the specifics for the future. I think a yearly redesign policy incentives here to really prioritize ACOs to refer to efficient bundle providers. I think this can be done. Jonathan's questions I think were highlighting that the ACOs take a 3 percent haircut. There's a discount on total cost of care for the ACOs. The bundle providers also take a 3 percent haircut on the episode. And so even if we took the 3 percent haircut, for
example, from the episode and gave that directly to the ACO
for referring to an efficient bundle provider, we could
directly create kind of steerage incentives that don't end
up creating this double-pay concept if we're really worried
about that. I think here as far as the short term it might
be nice to just state that, that we want to consider
supporting those policy designs without having to specify
the range of options.

Two points on longer-term work, and then I
promise I will stop. So I think that there might be some
analytic work that can really help here to support the
longer-term work. One of the areas is in quantifying the
significance of overlap. One of the things that we have
put out in the chapter presently is that we will have a
select set of episodes, be they acute medical or surgical
or what have you, not the expansive list of 30, 40 episodes
in current Medicare bundled voluntary programs. And I
think if that's the case, then the significance of overlap
quantitatively is going to dissipate pretty rapidly. And
if we're worried about siphoning off savings from the ACOs,
it may be quantitatively a lot less important.

So if you think about a $12,000 or $13,000 per
beneficiary per year payment for an ACO and the portion that happens for a hip and knee replacement surgery to an episode, we're talking maybe $700, $800 of savings total for a beneficiary and only 3 to 4 -- maybe maximum 3 to 4 percent of beneficiaries will have a hip or knee replacement in a year. So, conceptually, I think it may be problematic. Quantitatively, it may not be, and I think it's incumbent upon the Commission to do some work there to help us really to understand that quantitatively in the long term, not for April or June, again.

The last point is really relevant to these options. There's a lot of discussion of this idea of can ACOs just do the informal contracts themselves out of the Medicare program? I will register to say that I am skeptical about that, and I think that would lead me to recommend Option 1 in some sense. Part of that is in conversations that we've had as part of the Commission, I was stimulated to basically go talk to a bunch of organizations, and they all actually highlighted very much so the administrative complexity. And so I think before we make a recommendation that is in part hinging on this "under the waterline" type of subcontracting that might
occur, it is again incumbent upon us to maybe do so some
focus groups with ACOs and episode-based providers to
really understand if they feel it's feasible in the next
two, three, or five years.

Again, I am skeptical, but I am happy to be
overturned if the ACO and bundled payment leadership
themselves turn around and say, "No, we can do this." Then
I think that's a totally different issue.

So thank you so much for listening. I apologize
for being a little long-winded here. I agree. I mean, in
general, Rachel and Geoff, you've done a phenomenal job
with this chapter. I think there's a lot of great work
here. I'm really enthusiastic about it, and thank you very
much.

All right, Mike. I'm done.

MS. KELLEY: Okay. I have Brian next.

DR. DeBUSK: First of all, I'll start with the
positive. I really enjoyed the chapter, and I was really
excited to see us take on episodic payments.

As far as the chapter goes, I do think we need to
underscore the support in the literature for the efficacy
of bundled and episodic payments, specifically very narrow
bundles such as lower joint replacement. There is no question that episodes drive specialist behavior and drive specialist change. And this is in a program that desperately needs engagement, being APMs.

I do question where we chose to start on the chapter. APMs face a number of challenges, and I'm really unconvinced that double payments or stolen savings are one of those major issues. You know, I still remember the survey results from yesterday. Three out of 30 physicians in three major metropolitan markets were even in ACOs, and 11 out of 30 of those physicians didn't even know what an ACO was, which is, again, 12 years into a statutory program. Again, APMs need engagement.

So for now, I would support an all-of-the-above strategy that maximizes the appeal of both ACOs and episodes. And for now, when in doubt, double payment won't hurt, at least until, to Amol's point, we can quantify not only how much double payment is currently occurring, but how much could theoretically occur based on the base of episodes that we define.

To Bruce's earlier comment, by the way, I would want to ensure that we aren't double-paying the same
entity. I think we should take care there. But for now, I think ACOs and episodes need encouragement, not containment.

Now, specifically with the options presented in the chapter, I think if I'm forced to choose, I would choose Option 1. You know, I think 100 percent of the savings should go to specialists when no ACO is present or in a one-sided ACO. I do think if I could choose an Option 1.5, I would, which is when a two-sided ACO co-attributes with an episodic model, I think at least 50 percent of the savings should be retained by the episode. But we may be able to make up the difference by giving the ACO and episode provider some really sweeping anti-kickback, historic, and CMP relief so that they could get really creative with some new agreements, you know, well beyond gain-sharing, on how they could interact and work together, because I think then we could help them find some mutual value that might be able to make up in that split or shared savings gap.

The final point I want to make is that I think none of these shared savings, whether they come from episodes or ACOs, should count toward MA benchmarks. It
makes no sense to me why we would inflate MA benchmarks by crediting them with payments for providers that are using services more efficiently.

Thank you.

MS. KELLEY: Lynn?

MS. BARR: Good morning, everyone, and thank you for an excellent chapter. This is a lot to think about, and it's hard to come up with the right answer.

My general feeling on this is to not overburden ACOs. I know that was my position this summer -- it hasn't really changed -- that, you know, taking organizations that are taking downside risk and then forcing more administrative burden on them is not the way to encourage people to take more downside risk. You know, the purpose of moving into two-sided ACOs is to reduce your administrative burden, and I think it's not the right way to be thinking about this, is to force additional administrative burden on those that are taking downside risk.

I'm not sure it's really that hard to differentiate between a beneficiary that is in an ACO and is not in an ACO. I mean, they're all on a list, right?
And so I don't know, is there really huge complexity in identifying whether a patient is in a two-sided ACO, a one-sided ACO, or not in an ACO? That doesn't seem like it should be, given that they're all on a list.

And then, you know, I think that we need to think about carrots and sticks. I mean, I do believe that mandatory bundles is smart. I'm mixed on whether or not one-side ACOs should take mandatory bundles. I could probably go along with that. But I don't think we should be penalizing two-sided ACOs by imposing bundles on them. However, I think we should think about incentives, because I agree that there isn't enough attention paid to specialty care. So what kind of incentives could we give two-sided ACOs? Maybe more along the lines like of what the REACH Model is doing and saying, hey, if you're in a two-sided ACO, you can contract with preferred providers. They get the benefit of being part of your ACO and you can contract differential fees and create a preferred provider network.

So I think I would be more in favor of trying to figure out incentives for at-risk ACOs than to make that mandatory.

Thank you for a great chapter.
DR. CHERNEW: Lynn?

MS. BARR: Yes?

DR. CHERNEW: Thank you. Yes, I keep going on and off mute because I'm muting too rapidly. What I took from what you said -- I want to make sure I understood -- is that you loosely favor Option 2.

MS. BARR: That's right.

DR. CHERNEW: Okay. Thanks. You don't need to say more. Just thanks.

MS. BARR: You're welcome.

MS. KELLEY: All right. I have Jonathan next.

DR. JAFFERY: Great, thanks. So, again, I really like the direction that we're taking here. I'll try to be brief because I know that a lot of people want to talk.

I like the idea of focusing on a limited set of episodes up front where we have evidence. I think thinking through and maybe building on some of Amol's comments, thinking through what that means for evidence and actually thinking about some of Dana's comments in previous meetings around some of the accountable care type change, when we have evidence of practice change that's happening, that actually is significant, and it doesn't necessarily need to
rise to the level that we've seen through CMMI demonstrations or something like that. So I think that's something we should think about.

I agree that making episodes mandatory is going to be a really key component in any of these options, so we struggle to get specialists engaged in value-based care in a meaningful way, and it becomes very difficult to do without these being mandatory for all the reasons that have already been said regardless of -- you know, irrespective of which option we choose.

In terms of options, I strongly favor Option 1. You know, from the ACO perspective, some episodes are more avoidable than others, right? So I think the incentives become different depending on the episode. For some avoidable episodes, let's say UTI, it's really analogous to ambulatory care-sensitive conditions. The ACO not only has the incentive here but the capability to prevent them altogether. In that situation, we clearly had the best outcome. We've avoided a hospitalization. You've saved as much money as possible when it's better for patients and for everybody.

For unavoidable or less avoidable episodes,
putting the risk and reward on the episode provider to me here makes more sense, as these are the providers that have the ability to impact episode outcomes, and, again, building on some of Amol's comments and some of my question in Round 1. So if the ACO has the sophistication and the capabilities and the inclination to contract with episode providers, then that would be fine. But I think trying to build a policy around that assumption like we might see in 2 and 3 is a problem, because I think we'd have to do a lot more work to understand if ACOs can really do that, and I'm pretty confident that many, if not most, don't have those capabilities now.

So, again, I'll leave it at that. I think Option 1 to me is the strong preference, and even the cons that you laid out in the chapter -- or in the presentation, as you heard from Round 1, my Round 1 question, I'm not even sure that I think that the con is even there. I think ACOs could contract potentially with episode providers if they have that inclination and sophistication.

And then, finally, a couple other things that came out in the chapter. I think moving forward that administratively set benchmarks for episodes would make
sense for the same reasons we talked about for population-based payments. And there was also some discussion about episode-level cost and transparency, which I think is absolutely something we should shoot for, actually irrespective of this whole question of ACO and episode alignment.

So thanks, and I'm looking forward to hearing others' comments for the rest of the discussion.

MS. KELLEY: Dana.

DR. SAFRAN: Yeah, thank you. So, Rachel, Geoff, really exciting work and really clear, very well laid out, including the presentation here. These visuals are very helpful.

I have just a few comments to add to what others have said. First, just adding my voice that, you know, as I read this chapter, the logic for why these episodes in particular need to be mandatory as opposed to voluntary became very clear, the potential for, you know, providers selecting in and out with greater knowledge of how they're going to perform because of the narrowness, it just seems like it's much more important to have it be mandatory when we're talking of episodes.
Second is that I do agree that if we're going to go to the effort to build this and put this in place, we need more episodes to be part of the program. So we can return to that issue of how that occurs, you know, and what level of evidence do we need, et cetera. I think that's an important issue, but I understand Michael's point that that's out of scope of what we're talking about today.

Third, just adding my voice that, you know, the emphasis on avoiding double payment here just really jumped out at me, and my own experience, first of all, in leading a program that was population-based, ultimately we had originally avoided having measures that had a cost component to them in our quality measure set because we felt that would be double-paying, right? We were sharing savings, and we were going to give a payment, but ultimately began to incorporate some of those because it was clear that the added incentives to change behavior was helpful. And so I think it comes down -- you know, is it really double-paying if two different entities have incentives? I would argue it's not unless, you know, what's getting paid is more than the overall savings. So I think we should not be so dogmatic on that issue of double
payment. It's a matter of how much is being paid cumulatively.

Then, finally, I would say I do overall favor Option 1. I would say I least prefer Option 2. I could actually get my mind around Option 3, particularly if [inaudible/audio interference] more and more providers in an ACO model. And the reason for that really is that I do think that the ACOs can play a very important role with respect to driving the performance of the episode providers. Even if they don't create their own arrangements for value-based payment and episode payment with those providers, their lever of market share, that was what motivated my earlier question, I think is a quite important one. But that said, the reason that I favored Option 1 over 3 is that I think it can get very messy to have different episode models from your different payers, and we've seen that with respect to the conversation in value-based payment overall, and providers' objection to different quality measures used by different payers and the push for alignment.

Now, I do think CMS could -- if we were in an Option 3 world -- have standardized episodes the way we
have standardized measures for value-based payment, and then the differences could be in the financial incentives the different parties are placing on those episodes when they're contracting with the episode provider. But, nonetheless, I do kind of like the simplicity of the Option 1 world for the episode provider.

I'll just take a quick look.

Oh, one final thing from my notes. I'll just mention that having the shared savings included in and charged against the budget of the ACO I know is the right thing to do. That is a total cost of care view. So I'm not arguing it's the wrong thing to do. I just want to flag that it does create a little bit of a counterincentive for that ACO in that they could direct their referrals to lower-cost episode providers and do better on their budget. So I just would call that out as something for us to think a little bit about, but I do recognize that we can't carve out from their budget the true costs that we are spending when we're paying that episode provider shared savings.

So those are my comments. Great work, and I really appreciate this conversation. Thanks.

MS. KELLEY: Betty?
DR. RAMBUR: Thank you so much. Great work on the chapter, and I really appreciate the comments of the other Commissioners.

In the interest of time, I'm going to just focus on a few points. I very much support episode-based payments, and I certainly support them for both surgical conditions but also medical. And I'm wondering if when we talk about proven as merely saving expenditures rather than sparing suffering, we're sort of missing the mark. And I thought Amol's comment about acute versus chronic is important, but I'm also -- and I support that. But I'm also wondering, is there some way we should think about chronic medical differently? If I may just bring this down to the working surface, I know there's the problem of the tyranny of the antidote, but once you've seen it you can't look away.

I'm recalling a community hospital in the State of Vermont that had a high community burden of congestive heart failure and accepted a bundle arrangement under SIM, and they immediately had the kind of practice changes that Jonathan mentioned. Immediately they had a nurse in the emergency department do an intake when people came in with
CHF and start a care coordination process. They quickly really needed to think about these differently and really pulled in hospice, palliative care, different kinds of supports, home care, different kinds of long-term services and support. And in talking to the chief nursing officer, they were actually able to decant their ICU and nurses transitioned to other roles in transitional care in the model that Mary Naylor from the University of Pennsylvania, former Commissioner, has talked to them about.

So when I think about that example and I think about having congestive heart failure, that is absolutely the model I would want to be in. Now, whether or not they save money in the end, I don't know. But I'm wondering, how can we think about chronic condition bundles, because there is so much disease burden, and I know it can be very difficult to do risk adjustment in things like Alzheimer's, but I think that could be really important.

So I'm very supportive of bundles being a condition of participation, sometimes called "mandatory." I support both acute and potentially chronic if that can be worked out for medical. And I am most supportive of Option 1. I appreciated Dana's explanations or explication of
Option 3, which I could live with. I'm not very supportive of Option 2 for a number of reasons I won't go into.

And, finally, for some other time, I'm wondering if we can think about surgical episodes in terms of what they cost and what they should cost. I continue to think about an article that was in the Wall Street Journal that was what does a hip replacement or knee replacement cost, no one knows and that's a problem. And it was someplace in Wisconsin that actually traced it out, and basically their perceived cost was actually five times what it actually cost. So what's the base? What's the trend? What do things cost and what should they cost?

I know that's not something that can be done in this scope of work, but I do very much like the direction that we're going, and I do feel very comfortable with a hierarchical model with bundles nested inside ACOs.

Thank you.

DR. CHERNEW: Let me just jump in for one second. I think we're going to go in a minute to Paul and then Larry. I just want to make one point as this goes on in response to what you said, Betty.

The challenge here -- and I've written this in
another context -- is the amount of waste is in some ways an asset, and we make these decisions between ACOs and episodes. We're deciding who gets it. So imagine that we had -- and I'm not saying we should or shouldn't. I'm just making a mathematical point. Imagine we had a chronic care episode, and we decided to give the savings associated with treating a patient with that chronic condition to some entity that controlled the episode, which is a feasible thing to do.

If we were to do that, those potential savings would be taken away from the ACO or double-counted, but the way, but for now let's assume taken away from the ACO. That might be fine if you think you can get more from giving into an episode, but eventually, you get to the point where who wants to be in ACO. All the savings you get have been given to somebody else, and then you're left with a poor bunch of episodes, which is a bigger issue.

And so that's, I think -- we're not going to resolve that now, by the way. I think the issue is ultimately going to be to give CMS some guidance whether to or not to think about that. So that --

DR. RAMBUR: Right. But -- I'm sorry.
DR. CHERNEW: No, I'm done.

DR. RAMBUR: Can I just comment? I think it also illustrates the whole issue of the voluntary nature of risk-bearing arrangements. I mean, that's really the heart of the problem.

MS. BARR: Amen, sister.

[Laughter.]

DR. CHERNEW: We're going now to Paul and then Larry.

MS. KELLEY: I'm sorry. We have Stacie next.

DR. CHERNEW: Oh, I'm sorry. My queue is all screwed up.

DR. DUSETZINA: Thank you. This is a really great chapter, and I really appreciate all the comments from the other Commissioners. I think that there's a lot of work ahead.

I will just say briefly that I was most supportive of Option No. 1, as presented. It seems to do a good job of aligning incentives for ACOs without necessarily requiring more formal relationships with the episode providers.

I totally agree with comments by Amol, Jon
Jaffery, and Betty around these issues of acute and chronic
and then distinguishing between avoidable and unavoidable
related issues. So I think that's an important area to
maybe try to explore or distinguish.

But, you know, I'd say like ideally, just
thinking about trying to solve this problem and aside from
the chapter, it seems to me that trying to figure out a way
to reward participants for the act of referring to
efficient or high quality, or however we define it, episode
providers, you know, and trying to distinguish like what is
the activity that the ACOs have under their control and
trying to prevent these episodes from happening in the
first place really seems core to this.

But I think, in general, Option 1 seems to do the
best job of that, and I look forward to seeing this work as
it continues to evolve.

MS. KELLEY: Bruce.

MR. PYENSON: This is a terrific discussion which
reflects the terrific nature of the chapter.

I think there is a real materiality issue here.
The non-double payment of savings strikes me as not
essential at this point. It's not a particularly important
issue. I think we could easily quantify it. In my back-of-the-envelope, and ACO might have a per -- attributed beneficiary per year amount of 10- or $12,000, and the biggest bundle is perhaps 13 per 1,000. And even if it were hips and knees and even if it were $30,000, you do the PM, per member per year equivalent to that, and it's really very small.

That further gets deluded because perhaps two-thirds of fee-for-service beneficiaries aren't in an ACO. It further gets deluded when members leak out of an ACO to perhaps non-bundle providers unless bundles are mandatory. So there's a whole series of decrements there.

I think so the materiality -- frankly, I wish Medicare did avoid double payment. There's lots of examples we can look at and find in the Medicare system where, arguably, there's double payment.

So, all of that said, I've certainly advocated for mandatory ACOs and mandatory systems. That doesn't seem to be on the horizon, but in the short run, I would support Option 1. As Lynn said, let's not overcomplicate things. Let's do a serious analysis of what's really involved in the overlap, quantify that, and move ahead with
models that hopefully are going to have success. Thank you.

MS. KELLEY:  Paul.

DR. PAUL GINSBURG:  Yes. This has been a great session, both because of the great chapter that we're reading and because there's so many good comments from my colleagues.

I want to start by saying I think episodes should be an important part of alternative payments. When you think of it, to the degree that improvements in efficiency and quality can come in episodes of care, it's likely to come from the specialists that provide the episode. So, if we think of knee replacements, I think there's a lot of room for improvements, but it's not going to come from ACOs. The ACO's role should be steering beneficiaries to the more capable specialty groups that do the knee replacements rather than being relied on to somehow directly increase the efficiency and the quality.

So I believe we should have more episodes over time. I think they should be developed by CMMI. I think some of the real potential is in chronic disease.

We've all known that we don't want to focus on
chronic diseases where coordination across different specialties is important or where we have real risk adjustment problems. I think there are many chronic conditions that are very much within a particular specialty, where fragmentation and coordination is not that big an issue, where we could do episode payments. And I would say the innovation center going forward, continuing to test new models because it's okay to add a new episode into the mix as opposed to a new twist on ACO designs, which we know can be very disruptive.

Given the endogeneity of whether specialists are members of the ACO, I think this makes me lean towards Option 1, because otherwise you're just going to drive the specialists at the ACO if the ACOs get all the savings and the specialists don't.

So getting back to how will the ACOs, the ACOs should benefit from good steering decisions, and I think they can through the discounts. I think just since we're sharing savings rather than giving all the savings, even just steering to a group that has 10 percent lower cost, I think it will benefit the ACO. So that, this way the specialists who provide the services for the bundle can get
substantial shared savings from it.

I'll stop there.

MS. KELLEY: Larry.

DR. CASALINO: Thanks, Dana.

Well, I have one eye on my notes and one eye on the clock. Amol and I have a bet over whether or not I can stay under five minutes.

So I'm in substantial agreement with these points, but I want to emphasize some points that I think are important and haven't been mentioned very much or haven't had the attention I think they may deserve during the discussion so far.

I think that the chapter as written or the section as written is framed too narrowly in part because of its focus on double payment, which I agree with some other Commissioners is an issue but not the most fundamental issue by any means.

I think the broad framing with regard to episodes and with regard to integrating, this discussion with the discussion of ACOs is -- I think it should be explicitly questioned whether emphasizing bundles is likely to slow or to hasten or not affect movement to population-based care,
assuming that the latter is the fundamental call. So I think that question at least needs to be posed, and if it is posted, I think everyone would agree at least that we would want our bundled programs to be designed in a way that would hopefully not slow the evolution of population-based care. So that's one thing that I think should be emphasized and to frame.

The second thing is this question is implicit in what we've been discussing, but I think it should be explicit. How can specialists be more involved in the population-based care? I mean, that's really critical. It's not the case that the only thing that specialists do that's important is deal with things that are susceptible to bundling. There are all kinds of things specialists can do to help other specialists and primary care physicians manage care better across the spectrum and not just in episodes.

So anything that would bring specialists into closer collaboration broadly, not just about bundles, with ACOs, I think, would be important, and things that are likely to keep specialists so that they don't care what goes on in population-based care, which I think bundles can
do, I think, is not something we want to do. So that's the second thing that I think should be in the fundamental framing, one emphasizing bundles. How are bundles going to likely affect and move to population-based care? And the correlate question, how can specialists become more involved in population-based care, and how can we dissolve episode-based payment programs that would speed, not slow the evolution of successful population-based care?

On policy options, the alternative policy options, I very much like the idea of presenting alternative policy options rather than choosing one. I'm not sure we have consensus within the group of Commissioners and staff about which would be the most desirable.

I actually like all three of the options. Like Dana, I would probably favor No. 1 and No. 3 over No. 2 if pushed, but I do think that we need a more detailed discussion of the pros and cons of each option. I think the pros in this kind of discussion are narrower than it needs to be, and it could be expanded, including to discuss the possible effects of each on the evolution of population-based models.
The third point I want to make, without discussing the pros and cons of a national mandatory program, I think that making the options dependent on there being such an option, which Options 1 and 2 are, they really limit the usefulness of any discussion we would have. There's likely to be very heavy resistance to a national mandatory program.

Also, advocating implicitly at least the national mandatory episode-based program would be -- someone might say, well, why not a mandatory ACO one? Why should we have one and not the other?

So I think if we don't think that there are good options for episode-based payments, unless they are national mandatory bundles, then I think we need to explicitly make that argument. If we think there are good options, if they aren't mandatory bundles, then I think those options should be presented as well as the options that we are presenting. So maybe present the options that we have based on the assumption that there is a national mandatory program, at least the first two options, and then what options are there if there isn't a national mandatory program, which is the most likely thing?
And the last point I'd make -- and I may lose my bet here -- I'm very strongly opposed to adding a lot more bundles, and I'm really opposed to adding a lot more medical bundles, especially chronic illness bundles. The most costly medical patients are likely to have very many things wrong with them. Congestive heart failure patients often have diabetes and COPD and hypertension and hypercholesterolemia, and lots of bad things happen to them.

So I've never talked to a practicing physician who doesn't throw up their hands at the idea of chronic medical bundles, but I'm not opposed what Amol recommended to acute medical bundles. I think it would be very complex to add chronic medical bundles as more adding is for gaming, confusion, and complexity and will, I think, be -- make especially primary care physicians very unhappy. It would be very easy for episodes to multiply, multiply. We don't want that to happen.

And that's it.

Amol, I think we need a stopwatch. I'm at five minutes, but I don't know if I was over or under, just by the crude minute clock.
DR. NAVATHE: Five minutes, 57 seconds.

DR. CASALINO: Okay. You win.

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

DR. GRABOWSKI: Thanks. Thanks. I will definitely be under five minutes. I'm going to be brief. This has been a great discussion. Thanks, Jeff and Rachel, for this work.

So I really like where Amol started us with this overarching general principle. Let's do its best for the Medicare program, not what's best for a particular model or program, and I think based on the existing evidence to date, I believe what's best for the Medicare program is having a balance of bundles and ACOs.

The evidence today has really supported a strong role for bundles. Amol made a really important point. I've been very kind of centered in the ACO literature. I have done a little bit of bundles work as well, but we talk a lot about all the flaws in ACO design, and I think we sort of assume that the bundles are fine, but there's been a lot of flaws there too.

We did an evaluation of CJR. Our paper was quite favorable, but we recognized, as Amol said, that we had
this shift from mandatory to voluntary. And I think it made it really challenging going forward to kind of show the results that we achieved early on in that program.

Similar to Bruce, I do believe mandatory solves a lot of problems, but I'm not going to hold my breath on that one.

I like Larry's idea of trying to think through the options of kind of conditional on there being a mandatory program, what does that entail, and if we don't, I think we're probably, unfortunately, going to end up with something that isn't mandatory.

So, bottom line, I'm supportive of Option 1, similar to others. I think that's the option that kind of best balances the incentives across ACOs and the bundles, and I look forward to kind of taking this work and incorporating it into the bigger chapter. Thanks.

MS. KELLEY: Jaewon.

DR. RYU: Yeah. A lot of similar themes. I think I worry about delusion of accountability and value as a result or maybe one feeds the other, and I worry about complexity. And I think a lot of the comments that have been made, I don't think we want to make life tougher for
those that are in ACOs. I think you really want somebody, some entity to take accountability over the totality of care in an ideal setting.

That being said, I'm a big believer, and I think much like everybody else that the role of episodes and bundles is absolutely critical. It's a very important arrow in the APM quiver if you want to think of it that way, and I think the other reason why I think it's important is because it also extends beyond the Medicare program, and to the extent you create that capability, I think it does help to have a halo effect beyond Medicare, which I think is important.

But, as far as how those things shake out in the balance, I would probably gravitate more towards Option 2, although I could see a strong argument for Option 1. And I think in my mind at least, it kind of depends on whether the episode is avoidable or unavoidable. If it's something that's avoidable, I think it's better left with the two-sided ACOs to manage and try to avoid the triggering of the episode altogether, but if it's unavoidable, then I think it makes total sense to have it roll right into Option 1.

So I'm probably split between the two, but if
pushed between those two, I'd lean towards Option 2.

MS. KELLEY: I have reached the end of my list.

I don't know if I -- I hope I haven't missed anyone.

DR. CHERNEW: Good. Well, we're just at time.

So I'm going to go if you haven't, although I'm going to talk for a little bit and watch what happens if anyone raises their hand or whatever.

But I feel like I've been drinking from a firehose with 6,000 different pieces of information that's all going to have to be digested.

Let me say a few broad summary points, and then I'm going to -- we'll move on to lunch and come back to talk about MA risk adjustment.

So, first, there is a clear interest in this question of how many and which episodes and which considerations. The chapter will try and say something more about that. I am not sure how much more about that. There's been a lot of discussion of that, and I certainly hear that.

The other thing that I think is important to acknowledge is that when any decisions about episodes are made -- and it's sort of chronological to say that when we
have episodes, we want the best designed episodes as possible. Yes, that's true. The key point is when we make those decisions, it should be done understanding that they will be implemented in an environment that has ACOs, and we must at least consider what that means.

So, for example, one reason why I think there's been some — like for Jaewon's recent point, Option 1 versus Option 2, it depends on the episode, how broad the episodes are. There's a lot of "it depends" in this. Since we're not going to answer all the various "it depends," we're going to sort of raise those considerations and leave it for CMMI to sort out how to move forward in what particular cases.

So I could see a world in which we say there's a lot of support for Option 1. There might be some episodes in which you would do Option 23. We'll leave it at that. I think that's the type of thing we will say.

I hear loud and clear, this notion about double payment. We will think about that more in detail. There's been a lot of discussion. Maybe we can take some of it offline, but other than that, it's noon. So I'm going to thank you all for all of your comments. This will not be
the last time we see this. We are going to have a version of this integrated chapter reappear in April. We will leave six hours for the discussion.

And for the public, thank you for joining. As always, please send us your feedback.

You can go to meetingcomments@medpac.gov to send us an email or go on the website, and you will find ways to reach out to us and give us your thoughts.

So, again, thank you, everybody. We're going to come back to talk about an aspect of Medicare Advantage risk adjustment after lunch, so we will be returning at one o'clock. So are we good?

[No response.]

DR. CHERNEW: All right. Thanks, everybody.

[Whereupon, at 12:01 p.m., the meeting was recessed, to reconvene at 1:00 p.m. this same day.]
AFTERNOON SESSION

[1:01 p.m.]

DR. CHERNEW: Hi, everybody, and welcome to our afternoon MedPAC session. We are going to focusing on risk adjustment in Medicare Advantage. This is neither the first and will certainly not be the last time we do this, and, in fact, you will see a lot of other material related to Medicare Advantage program and risk adjustment in the Medicare Advantage chapter. This is a somewhat specific topic, and I'm going to turn it over to Dan to walk us through it. Dan, you're up.

DR. ZABINSKI: Thank you, Mike. I just want to say, to start, that the audience can download a PDF version of these slides in the Handout section. That is on the Control Panel on the right-hand side of your screen.

At the October 2021 meeting we presented a modification to Medicare Advantage risk adjustment that would improve payment accuracy by limiting the influence of large prediction errors that occur under the standard risk adjustment model. Today, we will revisit the model improvements that we discussed in October 2021, with the addition of a sensitivity analysis that is discussed in
your paper. Also in your paper, we added a discussion of how payment accuracy improves within specific condition categories, but we will not present those results today.

After responding to feedback from Commissioners, our intent is to publish this analysis in the upcoming June 2022 Report to the Congress.

To start, MA plans receive a unique payment for each enrollee that is the product of two factors. There is a base payment amount that is calculated for each plan and a risk score, which is the ratio of a beneficiary's expected costliness to the average fee-for-service spending. CMS uses those risk scores from the CMS-HCC model to adjust MA payments.

These risk scores increase payment for beneficiaries who are expected to be more costly than average and decrease payment for beneficiaries who are expected to be less costly than average. The CMS-HCC model uses demographic information and certain medical conditions that are identified by diagnosis codes and grouped into hierarchical condition categories, or HCCs. Each demographic and HCC variable in the model has a coefficient that represents the expected cost
associated with that variable. A risk score for a beneficiary is the sum of the relevant coefficients for the beneficiary. To determine the size of the coefficient for each variable, CMS conducts a regression using fee-for-service data that essentially distributes the medical costs for each beneficiary to the coefficients that apply for that beneficiary. This regression includes all fee-for-service beneficiaries, so each coefficient reflects the average fee-for-service cost associated with the variable.

To use risk scores for payment, CMS divides the sum of dollar-valued coefficients by the average fee-for-service spending to create an index value, so the average risk score is always 1.0.

The purpose of risk adjustment is to predict costs accurately on average for a group of people who have similar health attributes rather than to predict costs accurately for each individual beneficiary.

CMS chooses the demographic variables and the HCCs for the model, in large part, on their ability to predict medical costs. However, no set of model components, based on commonly observed information, that can explain all the variation in individual medical costs.
Instead, a large share of the cost variation is unexplained by the risk adjustment model, and this provides opportunities for improvement.

The benefits of the modification that we're presenting is that it would improves the accuracy of payments to MA plans, increases payment equity among plans, and counter incentives for favorable selection in which plans may seek to attract and retain beneficiaries who contribute to plan profits and to avoid beneficiaries that contribute to plan losses.

We know that since CMS fully implemented the CMS-HCC model in 2007, the agency has improved the model several times. These improvements include a revised mapping of diagnosis codes within the HCCs; adding and deleting HCCs based on which HCCs improve model performance the most; added a count of the number of HCCs for each beneficiary; and stratifying Medicare populations by beneficiaries' institutional status, eligibility status defined by being aged or disabled, and Medicaid status defined by full benefits, partial benefits, or no benefits. And CMS now has distinct versions of the CMS-HCC model for
seven populations defined by these characteristics.

One risk adjustment feature common in many health insurance markets that CMS has not implemented is a system of reinsurance and repayments that redistributes the original premium payments to plans from enrollees for whom plans are highly overpaid to enrollees for whom plans are highly underpaid. However, in Medicare Advantage, cost data are not sufficient to support such a system of financial transfers.

So the modification to the model that we are considering today, which was developed by McGuire, Schillo, and van Kleef, seeks to improve the model's accuracy by limiting the influence of outliers when estimating the model coefficients. The method essentially simulates a system of reinsurance and repayments in the data used to estimate model coefficients. To evaluate the modification, we consider metrics assessing the model's accuracy overall and for certain groups of beneficiaries.

We view the benefit of this approach as being the combination of two factors. First, it would improve the performance of the CMS-HCC model by increasing the accuracy of MA payments through the limitation of the influence of
beneficiaries who have outlier costs on the HCC coefficients. Second, this improvement would place no additional burden on plans and minimal burden on CMS, as there would be no need to collect additional data, and CMS can continue to use a risk adjustment method that is straightforward and easy to understand. This contrasts with some other ways to improve MA risk adjustment that could be difficult to understand and viewed as a black box by many.

We want to emphasize that there would be no actual reinsurance or repayments, but, instead, we simply redistribute costs during model estimation.

We used five steps to implement this method. In step one, we estimated coefficients for the current CMS-HCC model. Second, we used the estimated coefficients to predict costs for each beneficiary and calculate a prediction error that is the difference between the predicted cost for a beneficiary and the beneficiary's actual cost.

In step 3 we simulate reinsurance by applying a loss limit on the actual costs for the beneficiaries with the largest underpredictions. When the prediction error is
larger than the loss limit, we reduce the beneficiary's actual cost in the data by 80 percent of the difference between the prediction error and the loss limit, which simulates reinsurance.

In step 4 we simulate repayments by applying a gain limit on the actual costs for beneficiaries who have the largest overpredictions. When the prediction error is larger than the gain limit, we increase the beneficiary's actual cost in the data by the difference between the prediction error and the gain limit, which simulates repayment.

By adjusting the actual cost data in steps 3 and 4, we generate a new data set in which the fee-for-service costs have been redistributed to simulate reinsurance and repayments. Then, in the fifth and final step, we use the new data set to estimate the CMS-HCC model coefficients that would be used to calculate risk scores for paying MA plans.

Now we'll talk about putting into practice the steps from the previous slide.

A vital part of that analysis was identifying the loss limit and the gain limit, which we used to calculate
cost adjustments to simulate reinsurance and repayment. We estimated the standard CMS-HCC model using a sample of 10.2 million fee-for-service beneficiaries, which is described in your paper. We then used the estimated standard model to calculate predicted costs and a prediction error for each beneficiary on our analytic file. That is, we calculated the underpredictions and overpredictions.

Through an iterative process, we used the prediction errors to determine the loss limit and the gain limit. We determined the loss limit so that the aggregate reduction in actual costs across all beneficiaries affected by the simulated reinsurance equals 2 percent of total costs. Likewise, we determined the gain limit so that the aggregate increase in actual costs across all beneficiaries affected by the simulated repayments equals 2 percent of total costs.

Under this 2 percent simulation, the resulting loss limit was $106,500, and the resulting gain limit was $25,300.

We then used the loss limit and gain limit to adjust actual costs for underprediction and overprediction errors. If a beneficiary had an underprediction greater
than the loss limit, we trimmed the beneficiary's costs by
80 percent of the difference between underprediction and
the loss limit. But if a beneficiary had an overprediction
greater than the gain limit, we augmented the beneficiary's
costs by the difference between the overprediction and the
gain limit.

This decrease in actual costs offsets the
increase in actual costs, so that this modification to the
model is revenue neutral. We then used these redistributed
costs to re-estimate the CMS-HCC model. We call this re-
estimated model the modified model.

We found that the modified model that limits the
effects of outliers would substantially improve how well
beneficiaries' predicted costs match their actual costs.
To evaluate the performance of the modified model, we used
the R-squared statistic, which indicates how well
beneficiaries' costs predicted by the model match their
actual costs. The R-squared is always between 0 and 1, and
the closer to 1.0, the better the model has performed.

We found that the standard model had an R-squared
of 0.13 while the modified model had an R-squared of 0.19,
a 43 percent increase. This tells us that the modified
model explains 43 percent more of the variation in costs than the standard model. This improved predictive accuracy under the modified model would reduce the likelihood that plans would experience substantial financial gains or losses based on which beneficiaries choose to enroll in their plans.

To illustrate how substantial the improvement is from limiting the outliers, on slide 6 we discussed several changes that CMS has implemented since 2007, and these changes have increased the R-squared from about 0.11 to about 0.13.

We also found that the modified model would improve the predictions for beneficiaries with the largest prediction errors. We evaluated the beneficiaries who under the standard model had the 1 percent largest underpredictions and 1 percent largest overpredictions, and we used predictive ratios, or PRs, to measure payment accuracy for these groups in which a PR is the aggregate predicted costs for a group divided by the aggregate actual costs for the group. The closer a PR is to 1.0, the better the model has performed for the group.

For both these populations, the PR improved under
the modified model. For beneficiaries who had the 1 percent largest underpredictions, the PR improved from 0.13 to 0.16. Also, for the beneficiaries who had the 1 percent largest overpredictions, the PR improved from 6.4 to 2.0.

By predicting costs more accurately for both the largest underpredictions and largest overpredictions, the modified model would reduce the likelihood that plans experience large financial gains or losses.

Finally, at the October meeting, a few Commissioners asked how our results would change if we used different amounts of costs being redistributed in our re-estimation. So, in addition to the simulation that we've already discussed in which we redistributed 2 percent of aggregate costs, we estimated the effects of a system in which we redistribute 1 percent of aggregate costs and 3 percent of aggregate costs.

On this table, we show the R-squared values from the standard CMS-HCC model and from versions of the modified model under which we redistributed 1, 2, and 3 percent of aggregate costs. This table shows that increasing the redistributed costs has an appreciable effect on the model's R-squared, indicating greater
predictive power as you increase the magnitude of the redistributed costs.

However, as we redistribute more costs, the coefficients on the HCCs in the model will change. As we increase the redistribution of costs, we increase the possibility that the HCC coefficients won't reflect the actual cost of care for that group. This trade-off between higher R-squared and how accurately we predict costs for HCCs is an issue that must be addressed if any system of simulated reinsurance and repayment is to be effectively administered.

The conclusions that we draw from this analysis is that limiting the influence of outliers would improve how well predicted costs and plan payments would match actual costs, which reduces incentives for plans to use beneficiaries' costs to identify favorable risks. The extent of substantial underpredictions and overpredictions would be reduced so plans would face less risk from substantial losses.

We realize that we face many issues regarding risk adjustment in the MA program, such as the coding of conditions, and we have documented these issues extensively.
and have recommended fixes to those problems. The approach we have discussed today would improve MA risk adjustment, independent of those well-documented problems, and adopting an approach like this would not impede nor negate other more comprehensive approaches to addressing problems with MA risk adjustment.

So for today's discussion, we will address the Commissioners' questions and concerns about the method and content of this analysis. Then, we will address the feedback that we receive and complete this analysis for publication in the June 2022 report.

Now I will turn it back to Mike.

DR. CHERNEW: Great. Dan, thank you. I'm going to start with a clarifying question of my own, which I hope will set some of the stage, and then we'll jump into Round 1 where I think, actually -- well, I'll let Dana say it -- from my view here Larry is the first in Round 1.

But in any case, Dan, you did this using split-sample approach. In other words, you did a lot of this work on half of the sample and then at the very end when you were doing the evaluations you were doing it on an evaluation sample. Is that basically right?
DR. ZABINSKI: Yes, that's right.

DR. CHERNEW: And when you did your statistics, that means the R-square improvements and the predicted ratios, those are all based on the evaluation sample for which there was actually no redistribution of costs. It was just the actual data in the evaluation sample. Is that also right?

DR. ZABINSKI: Yes.

DR. CHERNEW: Okay. I am now clarified, and again I guess it goes to Larry.

DR. CASALINO: Yeah, Dan, really elegant work and nicely presented. The chapter could be a kind of a primer on someone who doesn't understand the CMS-HCC method and wants to. So really, nice work.

I have just one question. In the presentation you mentioned a couple of times that this improved method would reduce the incentive for plans to try to get local patients, and I agree with that. You don't mention, I don't think, in the presentation but you do several times in the chapter that using reinsurance would decrease the incentive of plans to control the costs of beneficiaries who they did have enrolled.
So my question gets to looking at the sensitivity analyses, and do we like 3 percent, 2 percent, 1 percent? It is certainly true that reinsurance changes incentives, but do you have any sense of the extent to which moving from 2 percent to 3 percent, for example, would reduce plans' efforts to control the cost of care for their members?

DR. ZABINSKI: I don't have a firm sense, but my inclination is to say at that stage probably not a lot. And I'm not really sure at what level it would become a problem to be concerned about.

DR. CHERNEW: Dan, I'm sorry. I need to ask another clarifying question. Because you're doing all of this on the evaluation sample and actually not proposing to shift money, the actual incentives in any plan, the redistributions that you showed us aren't actually real redistributions, if I understand correctly. So once you have this new equation, I don't think there would be any incentive effects to control costs, because whatever you do isn't going to affect your payment at the margin. You're not actually being reinsured.

And again, I may still be confused. This might
be Michael's confused session of the month. Am I confused?

    DR. ZABINSKI: I don't think you are. I might be overstepping my bounds. I think a lot of the discussion, when we talk about incentives of reinsurance, when we talk about it it's like in the purest sense of reinsurance. And Andy, please correct me if I'm wrong, because he really is deep into this and knows it even better than I do. But when we talk about reinsurance in that sense we're talking the actual redistribution.

    I think the bigger concern here is the extent to which you're going to start affecting the coefficients on the HCCs. And then the HCCs coefficients won't accurately reflect the actual cost of treating beneficiaries with those conditions if you start monkeying around too much with the levels.

    DR. CASALINO: Dan, if I can interrupt, do you mean the coefficients as a whole won't accurately reflect the total cost of care predicted for the beneficiary or do you mean that the total predicted cost might be accurate but the individual coefficients will no longer be as precise as they were?

    DR. ZABINSKI: The latter. So this is completely
hypothetical. Suppose that you do this simulator
reinsurance and repayment, and the coefficient on, say,
diabetes with complications changed a lot. It might be to
the extent that the coefficient doesn't really reflect the
ture cost of treating those patients.

DR. CASALINO: So do you think there would be --
and this will be my last question, I think -- do you think
there would be practical implications? If the total
predicted cost is more or less as accurate as we can get
it, reasonably, but the individual coefficients are a
little off, would there be any practical negative
implications to that?

DR. ZABINSKI: I'm not sure. Andy, do you have
any feeling on that?

DR. JOHNSON: Dan, your analysis looking in the
chapter at individuals with a specific HCC I think suggests
that there wouldn't really be any negative implications,
because a plan still has to pay for the total cost of care
for the whole beneficiary. Even if theoretically a single
HCC coefficient is a little off, the cost for that whole
beneficiary for -- and Dan looked at the top 15 HCCs --
that cost was always improved under the modified model.
DR. CHERNEW: I think -- I'm sorry, Larry.

DR. CASALINO: No, go ahead.

DR. CHERNEW: I think the issue is to enroll or disenroll. If you get the coefficient on congestive heart failure wrong, there may be an incentive to enroll or disenroll someone with congestive heart failure. I think that would be the ramification, not what to do once you have them.

I saw Andy nod, but maybe there's just like a fly in the room. I'm not sure.

DR. JOHNSON: I think that's right.

DR. CASALINO: Thank you.

MS. KELLEY: Bruce, you have a Round 1 question?

MR. PYENSON: I do. Actually, Mike's question prompted another one. If we go to, I think, Slide 14 or 15, where you talk about the 1 percent and 2 percent alternatives, now my understanding of those alternatives were redistribution -- it has the word "redistributed," and even the draft discusses incentives to not manage care after a certain point. So both of those suggest to me and the last couple of pages of the draft were investigating an actual reinsurance program. Did I read that wrong?
DR. ZABINSKI: You mean in the draft?

MR. PYENSON: Yes.

DR. ZABINSKI: It seems to me that we need to say what we did at the very end of the paper differently. It seems to be confusing.

DR. MATHEWS: Dan, let me jump in here. Just for a conceptual reset here, it is an absolutely true statement that our collective thinking about this idea originated with the work of McGuire and his colleagues where they did look at reinsurance and repayments in a commercial payer setting where there are actual changes, you know, dollars changing hands. But what we are doing here -- and this word punches through in the materials and in the presentation, maybe not enough, but we are coming up with a different way of simulating that effect through truncating outliers, high cost, low cost. And one potential solution here would be to drop any reference at all to reinsurance and repayments and simply treat this as, you know, a stand-alone, narrow policy that would achieve some substantial improvement in the predictive power of the HCC model and just stop talking about reinsurance and repayments. And if that's what's tripping people up, I will take full
responsibility for that confusion.

DR. CHERNEW: And, Bruce, in response to your question, on this slide I believe if they put the word "simulated" redistribution increases, put "simulated" there, that would be more accurate to what they're doing, because there's nothing going on. They're just simulating these different -- I call them -- it's basically about trimming. There's all the trimming regression models to get more accurate coefficients.

MR. PYENSON: So perhaps redistributed to the coefficients or something.

DR. ZABINSKI: Correct.

MR. PYENSON: Okay. Got it. Thank you for that.

I've got a question about the comparison of R-squares. I understand what you did is you did it in two different models -- the current model and the alternate model -- to the 2019 data, and the original model came up with a 0.13 R-square and the refitted model something better than that. I came across the CMS report to Congress on risk adjustment from December 2021, and they describe in there the R-squares that you report for the different versions. But those are R-squares with lags of perhaps
five years. So, for example, B-22 used data from 2010 to 2011, but the R-square -- but it was actually used in 2014 to 2016. And so there's a big lag there.

I'm trying -- you know, it seems like you were comparing your R-squares to their R-squares, but I'm not sure -- I don't understand how that -- since you're in effect measuring a concurrent model and theirs has a lag of five years -- do you know what I'm asking?

DR. ZABINSKI: Yeah, I know what you're asking. Well, let's see. I hope we can connect here. You know, I've had discussions with people at CMS and with people at RTI International who actually do most of the estimating of the CMS HCC model for CMS, and like, say you have the model for 2015, but it used data from 2011 and 2012, they do the R-squared based on the 2011-2012 data. That's the R-squared that you're seeing. But take those coefficients and --

MR. PYENSON: So it's even worse --

DR. ZABINSKI: -- apply them to 2015. That's my understanding. I might be wrong about that, but that's my understanding from my discussion with them.

MR. PYENSON: So I'll send you the footnote. My
impression is the footnote suggests otherwise Table 2.1, I think, in that document, but okay. Those are -- my other question is more general. There's lots and lots of stuff published on improving risk scores. How did you choose the McGuire paper?

DR. ZABINSKI: Andy, do you want to handle that one?

DR. JOHNSON: Sure. I just want to follow up with your first question, Bruce, too. So the slide we're looking at, 14, the R-squareds on this slide, the "None" is calculated from Dan's sample, so it is the same year of data just with the current model implemented by Dan, so there's apples-to-apples comparison about the years on this slide. And you're right. Dan was speaking to earlier when we talked about the prior update to the model and the effect on the R-squared coming from the CMS estimates of R-squares.

But with the McGuire modification to the model, I think we chose that because of its simplicity and easiness of implementation. You know, we weren't coming at this from a framework of trying to think about should we replace the CMS HCC model with another version. I know you sent
along some comments including the DXCG, the ACG, and 3M and several other companies that have an entirely different risk adjustment model, and so we weren't approaching it from that, but that this paper offers a modification to the calibration phase, which I think could be applied to any model. It just happens that, you know, we're using the CMS HCC model now, and so this modification could be implemented with minimal effort, no additional data collection. It doesn't require learning a different model. And I know you've mentioned in the past, too, the potential benefits from machine learning and some AI technologies, improving the accuracy of the predictions in the model. But we were trying to keep it as much as possible the same with how CMS operates the risk adjustment model, though with a little additional modification how they calibrate the coefficient.

MR. PYENSON: Did you consider a very simple approach like instead of least squares, which exaggerates outliers, least absolute differences? That was hard to program when all this stuff started in the 1990s, but that's just a simple, different procedure.

DR. JOHNSON: You're right, we didn't consider
additional types of fitting the model, you know, using the
different -- a nonlinear model of some way, but I think
you're right that that also would offer some improvements,
but I think -- and this is sort of getting into squishier
territory where, you know, people are comfortable with the
current model and understand how the linear regression
works more so than -- the more and more complicated it
gets, I think it's harder for, you know, a good chunk of
people, stakeholders in the industry, to understand. So
we're trying to avoid as many changes as we could.

MR. PYENSON: Thank you.

MS. KELLEY: Okay. I have Dana next.

DR. SAFRAN: Thanks. I appreciate this work and
the conversation so far. I have two -- well, I had two
questions. One I think you've answered through the
presentation here, so I'm only keeping it on my list so
that I can flag that, unless I missed it, the language in
the paper wasn't super clear. When you shared about the 2
percent adjustment that was made, I now understood from
your presentation here that that was across the full
population of beneficiaries that were in your analysis.
When I was reading the chapter, I was trying to understand
whether it had to do with outliers for the individual providers you were penalizing. So I could have just missed that in the tee up, but I'm just flagging it.

The other question I have is I'm sure outside the bounds of what you'll be able to do this in this time frame, but have you looked at how the inclusion of patient-reported outcomes, you know, something simple like the SF-12 from the Health Outcome Survey that Medicare administers improves your risk adjustment model? And I'll just flesh that out. The reason I ask that is know that in, you know, many, many analyses, predicting anything from readmissions to functional improvements to death that it is among the most powerful predictors of outcomes. And while I know that we don't today have universal data on this from our beneficiaries, I think it could be very valuable if it's possible to link data from the Health Outcomes Survey in with claims to test how much of a gain we'd get from that. I guess based on my past experience, you've got even more than what you're seeing here, and that could be really valuable not just for the risk adjustment model, but because of the importance of that information for all kinds of things, from clinical care to, you know, evaluating
differences in health plans and providers. So sorry for the long tee-up of the question, and maybe that foreshadows comments in Round 2, but anything you've done that has already explored that?

DR. JOHNSON: Dan, why don't you start?

DR. ZABINSKI: I was just going to say, looked at it, no, we haven't looked at it. I guess anything that is a powerful predictor is going to be worthwhile to look at. So going forward, yeah, I think it's something to consider.

DR. JOHNSON: So I think here the major limitation is the data in that we don't have the information for all beneficiaries across all of Medicare. It would be a big lift to do that.

In MA, there is a frailty adjuster for PACE contracts and certain D-SNPs where they can conduct a survey of their plan enrollees, and based on some of that information -- I don't know if this gets exactly to what you're speaking to, but it takes into account some of the activities of daily living with patients and adjust the payment based on that. So when the enrollment is more targeted to a population that have more ADLs than there is a frailty adjuster for certain clients.
DR. SAFRAN: Yeah, that's helpful, Andy. And I was pointing specifically to the Health Outcomes Survey that's administered to Medicare Advantage beneficiaries. I just don't know whether that maintains an identifier that could get linked in with claims to do the testing and see how it helps the model, because if it helps as much as I hypothesized that it will, you're right, it's a heavy lift to try to get that on all beneficiaries, but it would have value well beyond this, but potentially very big value here. So I think it's worth exploring.

DR. JOHNSON: Okay. That is a good point about the Health Outcomes Survey in MA. I think the issue is that we don't have that information for the fee-for-service beneficiaries, so to calculate -- to calibrate the model with the fee-for-service population, we'd have to still field that survey to the fee-for-service population first.

DR. CHERNEW: Let me do a little level-setting if I can. I'm sorry, Dana. I didn't mean to interrupt. Go on.

DR. SAFRAN: I was just saying understood, but a test of the model in the MA population, you know, could be fruitful. That's all.
DR. CHERNEW: So, first, Dana, I very much appreciate there's a lot to be done. I want to repeat something I said in my intro. There's a lot of work we need to do and will continue to do on Medicare Advantage, and there's a lot of possible things one could do.

Dan and Andy, correct me if I'm wrong, because this started before I was actually in my current position, or at least before I knew what was going on. But my take on this is this is sort of a relatively simple, quick-hitting, in the spirit of everything that's going on now, small change approach as opposed to what eventually I think we will be discussing, certainly things we do discuss and things we will continue to discuss, what I would call bigger-picture issues about how to resolve issues related to Medicare Advantage coding and, for that matter, fee-for-service coding.

So this is -- I guess all I'm trying to say is I view this as a much more prescribed exercise, and I hear some of the questions as being along the lines of, well, if you start down this, why don't you do this? Why didn't you go further? Or why didn't you -- those are not crazy questions. In many ways we will, and, in fact, I
appreciate those comments very much. But understand this is meant to be a smaller lift, if you will.

Before we go on, I think we have one more Round 1 question. I think it's Stacie. But maybe, if I've got that wrong, Dan or Andy, help level-set us for our comments.

DR. JOHNSON: That's exactly right.

DR. ZABINSKI: Yeah. Go ahead.

MS. KELLEY: Okay. Stacie I believe has taken herself out of the Round 1 queue. I do have two others. Pat first.

[Pause.]

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

MS. WANG: Okay. Thank you very much. I hope that my questions are within the parameters as Mike just described them and that you guys agreed with. You know, the sort of evidence, I guess, for the improvement of this change to the model is reflected on Slide 14. I wonder whether it would make sense to further evidence the benefit of the change by looking at certain subpopulations like duals, partial duals, and LIS, where I think the incidence
of outliers might be greater, just to see whether the
predictive value for those subpopulations also appears to
be better. And I wondered whether you had considered that
or whether you think that that makes any sense.

DR. ZABINSKI: Okay. Well, on the duals and the
partial duals, for this particular model, I mean, we subset
-- you know, CMS has seven different populations right now
for whom they have distinct versions of the model. And
just for practical reasons, we just honed in on the largest
one, the 65 and older non-dual population. So assessing
the effect on duals in this case is not something we could
do directly with this data set that we've been working
with. But there's certainly other subpopulations that we
could consider.

MS. WANG: So this study only reflects over-65
non-dual?

DR. ZABINSKI: Correct.

MS. WANG: Okay.

DR. JOHNSON: And, Pat, I think your point from
last time we talked about this, which we tried to
incorporate, which makes sense, is that to the extent that
there is redistribution in the cost data for the
calibration, that would have to be done for each of the seven populations separately that I mentioned. And I think the point -- if I'm hearing you correctly now, it's that it might be worth considering that the 2 or 3 percent, whatever the share of cost redistribution in the data is, it could be different for some of those different populations because of the --

MS. WANG: Yes.

DR. JOHNSON: -- outliers might differ. So that's a really good point.

MS. WANG: Thank you. And I won't bother with a Round 2 comment because I raised it the first time that you presented the paper, so I guess I am really curious. If the idea is to try to make suggestions to sort of improve the predictive value of the model, where, if at -- you know, what I raised last time was that the current model is based on 2014 costs in the 2015 -- matched to 2015 ICD-9 codes. The cost base has not been updated since then, and while ICD-9 has sort of been matched to ICD-10, there hasn't been a full recalibration of the model to update both costs like on a real ICD-10 base. And I just -- you know, with COVID, just -- is that not worth doing to
improve the predictive value? CMS has updated the model so many times to try to increase predictive value. I just wonder where in the value or order of value of changes is updating stuff to be more current with cost and actually use ICD-10?

DR. JOHNSON: I don't know if I can say where, in order, that value is, but I do agree that that is important and would certainly improve the accuracy. I think that's part of Bruce's comment was earlier too, was the model's base data, the longer that it is [inaudible/audio distortion] it is less likely to be accurate in predicting the costs.

I know this past year, well, the past cycle of rulemaking for 2023, CMS did update the Part D risk adjustment model with the newer data, so possibly it is just a level of effort that maybe next it will be that they will work on the MA model. I'm not entirely sure, but it is definitely getting to the point where I think you are right, using data that incorporates claims where ICD-10 was the actual diagnosis code version that was being used would be a helpful update.

MS. WANG: And again, in the interest of time I
won't get into Round 2, but if you could include a comment like that someplace in your risk adjustment work I just think it would be helpful. Thanks.

MS. KELLEY: Okay, Mike. That's the end of Round 1. Oh, excuse me, Amol, I had you on my page right here.

I'm so sorry. Go right ahead.

DR. NAVATHE: No worries.

DR. CHERNEW: I think just to get the time right, Amol, I think you're the last in Round 1. Then we have two in Round 2, because remember we only have 15 minutes left. Go on, Amol.

DR. NAVATHE: So I had a quick question. I think it's quick. But earlier this year, and I'm not sure of the exact timing, there was a proposed rule, so-called HHS Notice of Benefit and Payment Parameters for 2023, that suggested a revision to the HCC model. I think it was primarily to the HCC model used on exchanges, but it doesn't actually specify that. It just says HCC model. And HHC model proposed rule recommends a two-stage approach to the estimation to try to deal with the underestimation of individuals who don't have HCCs, so zero HCCs.

So I was curious, that is trying to deal with the
bottom end of distribution. As far as I can tell, this is trying to do deal with the top end of the distribution. So one, I guess, is that relevant the HCC model that we're discussing here in the context of fee-for-service programs in MA? I think so, but you should correct me if I'm wrong. And if it is indeed, how can we think about the interaction between what has already been proposed versus this?

DR. JOHNSON: I'm only familiar enough with the two-stage proposal to know that it is part of the ACA marketplace plans and that the names are very similar. It's the HHS-HCC model that's used in that market and it's the CMS-HCC model that's used in the MA world, so it's very similar. But I haven't had a chance to take a closer look to see if that similar approach would be important for MA. I think there are some other complicating factors too, with the marketplace risk adjustment model about reinsurance and risk corridors.

DR. CHERNEW: So just very quickly, the marketplace version, there actually is reinsurance. It's not just a simulated change to the model. It's very much. Tom was actually working at ASPE as a consultant when they did all of that. It's spiritually very similar. It's just
a different place.

The problem we have here is because we don't observe MA spending, there is no proposed actual reinsurance. This is really a chapter on trimming. It's just a very specific way of trimming, two-sided trimming. And assuming it on an evaluation sample -- obviously, trimming makes things look better in the dataset you're estimating on. The point here is trimming makes things look better on the evaluation dataset.

I understand that's not the largest physical point, but I'm going to look at Dan and Andy to see head nodding, to see if I got that right. But that's my understanding of what's going on here.

DR. NAVATHE: Got it. Okay. So in that case what I was raising, the proposal that I raise is not relevant to this conversation. Thank you.

DR. CHERNEW: Yeah. So I think we have Brian and then Bruce in Round 2. Dana, am I right?

MS. KELLEY: Yes, that's correct.

DR. CHERNEW: Brian.

DR. DeBUSK: Thank you, Michael. First of all, I do want to start with a quick apology to Dan and Andy. In
October, I did not recognize that you were using a split sample, so all of my questions around trimming data and L2 norms and how the R-squared got better -- Andy, you even tried to explain it to me, and I just completely missed it. So I apologize to both of you.

I also appreciate your acknowledgment that there are other issues related to risk scores, you know, for example, coding intensity, and that this chapter wasn't meant to address that.

In general, I really am supportive of the work. I'm very supportive of anything that's trying to improve risk adjustment. You know, in this presentation the focus was on overshedding and outliers. But even things like adding other nonlinear terms like account of conditions and some of the things that CMS has recently done, I think those are all good steps, or even a departure from the linear model. I think Andy, you said something really important. You were talking about the linear regression being, I think you used the word "familiar" or "comfortable." I think it's great to have a model that people are familiar with. I think the problem is that it leaves opportunities for better models to produce
consistent and ongoing sources of advantage and savings for MA plans. So I do think that we should embrace more sophisticated models to the extent that it can help us pay more accurately and pay for efficiently in aggregate.

Regarding the specific treatment in this chapter, it does appear that your approach, the modified McGuire approach, was effective, and I think that the results are pretty obvious. There was significant model improvement here. So I do think we -- we, MedPAC -- should encourage CMS to incorporate this or something like this into future HCC model work.

Regarding the future and related work, I am very interested in temporal persistence. You know, the McGuire paper and the paper from today really focused on a single-year snapshot. I'm really interested in which beneficiaries persistently overspend and underspend in some of these plans, because I think persistent residuals are going to play a huge role in Medicare Advantage in the future.

Having said that, I think the overspending and underspending too, I'm really interested to see if those are elastic effects that simply equalize out over a couple
of years or if these are plastic effects where something catastrophic has happened and the average spending over time has shifted upward permanently. But again, that's all for future work.

I really like the paper. I really like the technique. And again, my apologies for not getting the split sample information right in October. Thank you.

MS. KELLEY: Okay, Bruce.

MR. PYENSON: I really think the work is terrific work. However, I would suggest that it not be published in the Report to Congress but adapted as a payment basis on risk adjustment. I think there's a really strong need for an explanation of risk adjustment as it applies to Medicare Advantage and Part D programs, and there's a tiny bit in the paper on MA and the ACO chapter. But we really need to get the basic out there and available to the MedPAC audience. I think that would be the optimal use of the material.

My concern with this going into the June report is that there is a huge body of work that hasn't been addressed of alternative approaches to risk adjustment. There are proprietary systems. I'm very much in favor of
open-source systems. And I think we risk being criticized as taking one point of view when there are many other approaches that would be better or should be considered. So I also don't think we have demonstrated that any of the beneficial effects attributed to the improvement are actually significant from a business standpoint. That is, there is, in my mind, very little connection between Medicare Advantage behavior and a theoretical over- or under-prediction on a population basis of a risk score. And to illustrate that, I would look at the large portion of people who have very low spending in a year, and there's a big overprediction by those people, but it's nothing close to the trim point that you use. If the average is roughly $10,000, and the minimum HCC is, I think, 0.5, you know, just on a demographic factor, the difference there is very attractive to an MA plan. But I don't think that's addressed at all in the construction here.

So I'm not convinced that the improvements in R-square or the predictive ratio has any consequence for plan behavior. So if that's the case, then we have a paper that's just an illustration of an adaption of someone's
paper, and I think it weakens the argument.

So my recommendation is that this is terrific work and again, adapted into a Medicare payment basics which would be incredibly valuable. Having that is overdue. Thank you.

DR. CHERNEW: Okay. Dana, is there anyone else in the queue?

MS. KELLEY: No.

DR. CHERNEW: All right. So sometimes you deal with very conceptual issues. This is one that is sort of unique. It is very, very statistically specific. I don't view -- and I think I've said this in various ways here is -- in the grand scheme of issues that we have to address this is not the biggest one related to MA coding. That said, there does some to be some issue of fit improvement. So Bruce, we will take your comments under advisement, and those of other people, and those that might get sent afterwards, and, in fact, those that get sent afterwards from the public.

So thank you, the public, for attending, and please, if you want to reach us, send an email to meetingcomments@medpac.gov. We will take those into
account along with other comments, and we will make some
decisions about how to move forward here.

Anyway, does anyone else want to have any last
words?

[No response.]

DR. CHERNEW: Okay.

So we have made it to the end of the March
meeting. We very much look forward to seeing you again in
April. We are hoping that that will be in public. So
everybody stay safe, stay happy, stay healthy, send us
comments, and we will continue to do all of this work.

Thanks to the staff, as always, for both the work
today, and the staff yesterday, you've done a tremendous
job and you're going to move all this forward.

So I'm signing off. Thanks, everybody. Meeting
adjourned.

[Whereupon, at 1:57 p.m., the meeting was
adjourned.]