MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

The Horizon Ballroom
Ronald Reagan Building
International Trade Center
1300 Pennsylvania Avenue, NW
Washington, D.C. 20004

-and-

Via GoToWebinar

Thursday, November 3, 2022
10:17 a.m.

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1 P R O C E E D I N G S

2 [10:17 a.m.]

3 DR. CHERNEW: Hello, everybody, and welcome. We
4 are not getting feedback, although we are wanting your
5 feedback later so send messages. In any case, hello,
6 everybody, and welcome to the November MedPAC meeting.
7 Again, I think we have a terrific agenda, as always. I'm
8 not going to spend time summarizing it. I'm just going to
9 jump right in.

10 I'm going to start with Ledia and Evan, talking
11 about issues related to quality measurement across
12 different Medicare populations, a topic of great interest
13 to us, broadly speaking, and I think Ledia, you are going
14 to start it off. Take it away.

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

19 The Commission recognizes that health outcomes
20 can be influenced by social risk factors such as income,
21 housing, social support, and race/ethnicity. At the April
22 meeting, the Commission supported analyzing some of our

1 payment adequacy indicators across groups of beneficiaries.
2 Today we will present some quality measure
3 results for different groups of the Medicare population.
4 We do not anticipate any other agenda items on this
5 material this meeting cycle, however we will continue to
6 explore the topic. Today's meeting materials and material
7 from the April meeting will be included in an informational
8 June 2023 report chapter.
9 I would like to thank Carol Carter, Betty Fout,
10 Kathryn Linehan, and Lauren Stubbs for their input on this
11 project.
12 For today's presentation, I'll spend time
13 discussing some background on the topic. Then I'll review
14 the Commission's work to date to address social risk.
15 Next, Evan and I will present results of our examination of
16 differences in quality measure results across Medicare
17 populations. I'll also present some ideas for other
18 policies that could be implemented in the Medicare program
19 to encourage providers to address health disparities.
20 After the presentation, we would like your
21 feedback on the presentation, which we can incorporate into
22 the June chapter.

1 There is a growing recognition of the importance
2 of social risk and social determinants of health for health
3 outcomes. This recognition of health disparities has
4 prompted many organizations in the public and private
5 sectors to prioritize social determinants as a key
6 component of health care quality improvement. For example,
7 many health systems are making sizable investments in
8 addressing social determinants of health, in particular
9 housing-focused interventions.
10 Also, CMS has recently prioritized advancing
11 health equity across all its programs. For example,
12 improving health equity is being incorporated into models
13 tested at the Centers for Medicare and Medicaid Innovation,
14 and CMS released a number of requests for information on
15 how to close health equity gaps in Medicare quality
16 reporting programs.
17 The uneven COVID-19 outcomes have further
18 elevated the role social determinants of health play in
19 health disparities. Black and Hispanic Medicare
20 beneficiaries have been disproportionately impacted by the
21 disease.
22 The Commission's work recognizes differences in

1 patient social risk factors and aims to improve incentives
2 to deliver high-quality and efficient care to all
3 beneficiaries. Over the past several years, the Commission
4 has implemented a principle to account for differences in
5 providers' patient populations using peer grouping in
6 quality payment programs. Over the past year, the
7 Commission has been revisiting payment policies to support
8 safety net providers.
9 Last April, we presented results of a literature
10 review and interviews with various organizations about
11 interventions that address social determinants of health
12 and whether those interventions are associated with
13 improvements. We found that organizations are working to
14 address social determinants of health, but objective
15 evaluations of their effectiveness are limited and findings
16 are often mixed.
17 Now, I'll move to discussing our new analysis
18 where we calculated quality measure results across
19 different Medicare populations.
20 Examining quality measure results for different
21 groups of Medicare beneficiaries is an important step to
22 implementing strategies to decrease disparities. Reporting

1 disparities in quality measure results among groups of
2 Medicare beneficiaries allows for greater transparency
3 regarding where gaps in care exist.
4 For this analysis, we grouped beneficiaries by
5 two social risk factors that are readily available in the
6 claims data.
7 Race and ethnicity categories capture social
8 disadvantage, inequality in the distribution of resources
9 and psychosocial exposures. We present results for four
10 race/ethnicity groups: Non-Hispanic White, Black,
11 Hispanic, and Asian/Pacific Islander.
12 Income is a social risk because it captures
13 access to material and social resources, as well as
14 relative status. Consistent with our work revisiting
15 payment policies for safety net providers, we define
16 beneficiaries as low income if they received full or
17 partial Medicaid benefits or the Part D low-income subsidy,
18 LIS, versus non-LIS.
19 We have developed several claims-based outcome
20 measures that we use in our payment adequacy analyses and
21 in our development of redesigned quality payment programs.
22 For this analysis, we calculated five of those measures for

1 the different groups of beneficiaries.
2 We have developed two population-based outcome
3 measures. Within a population of interest, we calculate
4 the rates of hospitalizations and emergency department
5 visits that are tied to certain ambulatory care sensitive
6 acute and chronic conditions. In determining the final
7 measure result we take into account the clinical risk
8 factors of that populations such as age and comorbidities.
9 These are important measures because both
10 hospitalizations and ED visits have adverse impacts on
11 beneficiaries and increase the cost of care. Conceptually,
12 an ACS hospitalization or ED visit could have been
13 prevented with timely, appropriate, high-quality care.
14 Let's review the risk-standardized rates of
15 ambulatory care sensitive hospitalizations across different
16 groups of beneficiaries.
17 To orient you to the slide format, on the X-axis
18 we have three groups of bars: All beneficiaries on the
19 left, LIS beneficiaries in the middle, and beneficiaries
20 not receiving the LIS on the right side. These groups of
21 beneficiaries are divided into race/ethnicity categories
22 which are displayed as various colors.

1 Looking at the All-beneficiaries group, Black and
2 Hispanic beneficiaries -- the green and yellow bars -- had
3 the highest, or worse, rates of ambulatory care sensitive
4 hospitalizations. These rates were higher than the
5 national average of 46.2 per 1,000 beneficiaries. The rate
6 for Black beneficiaries were substantially higher than the
7 rate of the lowest group, the Asian/Pacific Islander
8 beneficiaries, or the grey bar.
9 Comparing the LIS and non-LIS groups, we can see
10 the rates of ambulatory care sensitive hospitalization were
11 higher for beneficiaries with LIS than those not receiving
12 LIS. Among these groups of beneficiaries, we see that the
13 differences across the race/ethnicity categories persisted.
14 Among the non-LIS group, Black beneficiaries had a rate of
15 ambulatory care sensitive hospitalizations that was almost
16 two times higher than that of Asian/Pacific Islander
17 beneficiaries.
18 Now turning to risk-standardized rates of
19 ambulatory care sensitive ED visits across different
20 groups.
21 Looking at the All-beneficiaries group, we see
22 that Black and Hispanic beneficiaries had the highest, or

1 worst, rate of ambulatory care sensitive ED visits. These
2 rates were higher than the national mean of 70.9 per 1,000
3 beneficiaries. This rate is two times higher than the rate
4 of the lowest group, the Asian/Pacific Islander
5 beneficiaries.
6 Comparing LIS and non-LIS beneficiaries, we see
7 that beneficiaries receiving the LIS had rates that were
8 substantially higher than the those not receiving LIS.
9 Consistent with the previous measure, we see that
10 the differences across the race/ethnicity categories
11 persisted in the income groups. Among the non-LIS group,
12 Black beneficiaries had a rate of ambulatory care sensitive
13 ED visits that was almost two times higher than that of
14 Asian/Pacific Islander beneficiaries.
15 Now, I'll switch to our analysis of hospital
16 readmissions, which is an outcome measure we use to assess
17 the quality of care provided by hospitals. The measure is
18 a rate of beneficiaries returning to the hospital within 30
19 days of discharge from an inpatient stay. The measure
20 calculation takes into account clinical risk factors.
21 Hospital readmissions are disruptive to patients
22 and caregivers and costly to the health care system.

1 Measuring readmissions and including the measures in
2 payment programs holds hospital accountable for ensuring
3 that patients have discharge information and encourages
4 hospitals to coordinate with other providers.
5 We calculated risk-adjusted all condition
6 hospital readmission rates using 2019 data across different
7 groups of beneficiaries.
8 Looking at the All-beneficiaries group, we see
9 that Black and Hispanic beneficiaries had the highest, or
10 worst, rate of hospital readmissions, which were above the
11 national average of 15.3 percent.
12 Comparing LIS and non-LIS beneficiaries, we see
13 that beneficiaries receiving the LIS had an average
14 readmission rate of 17.6 percent which was notably higher
15 than the average of the non-LIS beneficiaries rate of 14.6
16 percent.
17 We see that the differences across the
18 race/ethnicity categories persisted in the income groups.
19 Among the non-LIS group, Black beneficiaries had a rate of
20 readmissions that was higher in both groups.
21 I'll now turn to Evan to discuss post-acute care.
22 MR. CHRISTMAN: Next we will look at the

1 experience of beneficiaries in post-acute care. This
2 analysis will focus on SNF and home health care, as these
3 are the two most frequently used PAC settings.
4 The Commission has developed a successful
5 discharge to the community quality measure for assessing
6 quality in skilled nursing facilities and home health
7 agencies. We report these measure results in our March
8 payment adequacy chapters for SNF and home health.
9 This measure defines successful discharge to the
10 community as beneficiaries who were discharged from the
11 post-acute care provider to the community and did not have
12 an unplanned hospitalization or die in the following 30
13 days. Higher rates indicate better outcomes for a
14 provider.
15 This is a cross-sector measure with a common
16 definition across settings, though results are computed
17 separately for SNF and home health care. For this
18 analysis, we will examine the rates of successful discharge
19 to community across groups of Medicare beneficiaries, for
20 combinations of LIS status, race/ethnicity category, and
21 PAC setting.
22 Turning first to SNF, this slide shows the rate

1 of community discharge for skilled nursing facilities
2 across different groups of beneficiaries. Looking at the
3 group of bars on the left, we see that for the overall
4 population of SNF patients, Black and Hispanic
5 beneficiaries had the lowest rates of successful discharge,
6 but the differences were relatively small. Whites and
7 Asian or Pacific Islander beneficiaries had a rate that was
8 at or 48 percent, the average for all beneficiaries.
9 In the middle groups of bars we can see the
10 results for LIS beneficiaries. Non-Hispanic whites, which
11 is the red bar, had the lowest rate of 34 percent, while
12 Asian or Pacific Islander had the highest rate of 44
13 percent. Note that all categories in the LIS group had
14 rates that were below the 48 percent overall average,
15 indicating that LIS patients had worse than average
16 outcomes.
17 On the right side are the rates for the non-LIS
18 beneficiaries. All of these rates exceed the 48 percent
19 overall average, indicating that these beneficiaries
20 typically had better than average outcomes. There is not
21 much difference between the groups, though Black and
22 Hispanic beneficiaries had slightly higher rates than white

1 and Asian and Pacific Islander beneficiaries.
2 Overall, the rates of successful discharge
3 differed the most when we compare LIS and non-LIS
4 beneficiaries. For non-LIS beneficiaries, there were not
5 significant differences across the race/ethnicity and
6 income groups we looked at, while within the LIS category,
7 there was a 10 percentage point difference between the
8 lowest and highest performing groups.
9 We also calculated rates for home health care.
10 Overall, 75 percent of beneficiaries were discharged from
11 home health care successfully in 2019.
12 Looking at the overall rates on the left side of
13 the slide, you can see that there is not much variation
14 across the subcategories, though the rates are slightly
15 lower for Black and Hispanic beneficiaries.
16 For LIS, overall these beneficiaries had slightly
17 lower rates of discharge to community, but again there was
18 not much variation across the subgroups.
19 And finally on the right side, for the non-LIS
20 you can see that the rates are fairly uniform across the
21 subgroups. Overall, while social determinants of health
22 may have some impact on outcomes in home health care, on

1 these measures we do not see much variation across these
2 subgroups.
3 The relatively narrow variation may reflect that
4 to receive PAC services beneficiaries have to meet the same
5 benefit eligibility criteria, and the Medicare services
6 covered in each setting do not vary by race or ethnicity.
7 This does not mean that outcomes do not vary for these
8 groups in SNF and home health care, but that the range of
9 the variation in outcomes across the groups may be more
10 limited compared to measures that assess outcomes at a
11 population level or over a broader level of time.
12 MS. TABOR: This analysis has certain
13 limitations. First, our analysis is limited to the social
14 risk factors that can be measured using administrative
15 data. Second, there are limitations in the variables we
16 used in our analysis. For example, the race/ethnicity data
17 is partially self-reported but also based on some imputed
18 values. Another approach to capture beneficiary social
19 risk more comprehensively would be to use area-level
20 measures of social risk. However, these are not
21 beneficiary-specific and have other limitations with the
22 variables we used in our analysis.

1 Third, Medicare does not systematically collect
2 clinical data that can be used to study differences in
3 clinical outcomes across different groups of Medicare
4 beneficiaries.
5 Even with these limitations, we think there is
6 value in reporting out disparities we see in outcomes
7 across different groups of Medicare beneficiaries.
8 As I spoke about earlier, policymakers in some
9 areas and certain health care systems are implementing
10 strategies and interventions to reduce health disparities.
11 Some of these efforts to address social risks such as food
12 insecurity, transportation, and housing needs are generally
13 beyond Medicare's scope.
14 However, there are other policies Medicare could
15 implement to encourage providers to focus on reducing
16 health disparities. First, Medicare could publicly report
17 of quality results stratified by social risk factors, to
18 increase accountability and competition. Second, Medicare
19 could add a focus on reducing disparities in quality
20 payment programs, for example by adding health equity
21 measures to quality payment programs.
22 In summary, reporting differences in quality

1 across Medicare populations is an important step for
2 transparency around disparities. For all the measures we
3 examined, we found that both income level and
4 race/ethnicity contributed to differential outcomes.
5 Beneficiaries with low incomes were more likely to have
6 worse outcomes across race/ethnicity categories.
7 For most of the measures, Black and Hispanic
8 Medicare beneficiaries were more likely to have worse
9 outcomes compared to Asian/Pacific Islander and Non-
10 Hispanic White beneficiaries.
11 This leads us to your discussion. After
12 answering any questions, we would like your feedback on the
13 results and the others ways the Medicare program can use
14 quality measures to help reduce disparities in care.
15 I'll now turn it back to Mike and look forward to
16 the discussion.
17 DR. CHERNEW: Ledia and Evan, thanks. That was
18 terrific. I know we have growing queues, so I think we'll
19 start. And if I've got this down right Kenny is first. Is
20 that right, Dana? Dana, you can manage the queue, but
21 Kenny, we'll start with you.
22 MR. KAN: Thanks, Mike. I'm wildly enthusiastic

1 about this body of disparities work and its application to
2 improve overall population health. So a couple of
3 questions.
4 Number one, on page 15, as race indicator is
5 self-reported and some values have to be imputed, can you
6 shed some color on how reliable the race indicator is in
7 the data?
8 MS. TABOR: Yes. We use the RTI Race Code
9 categories, which are based on OMB categories of
10 race/ethnicity. The data comes from self-reported data
11 through Social Security Administration, when people enroll
12 in Social Security, and then where there is not self-
13 reported data there are some imputation models that use
14 last name and address to impute probability of being mainly
15 Asian or Pacific Islander or Hispanic.
16 And the RTI code hasn't been around for a while
17 and it has good specificities, especially for the four
18 categories that we looked at.
19 There are improving models. CMS and RAND have
20 been developing a Medicare Bayesian improvement surname
21 grouping, and the ISG, which we have recently gotten access
22 to the data, so we'll be looking at it in the future.

1 So I would say the RTI code is reliable and
2 sensitive and specific, especially for the four categories
3 we used. There are improved methods that we will be
4 looking into.
5 MR. KAN: As a follow up to that, in your
6 prepared remarks, you mentioned that Medicare does not
7 systematically require this data, so don't wish to go down
8 this rabbit hole, but is it -- I don't know whether it's
9 the Round 1 or Round 2 questions, but could we ponder
10 possibly requiring race data by beneficiaries at the point
11 of enrollment, if you have any color on?
12 MS. BARR: I think that's probably a Round 2
13 comment, I guess.
14 [Laughter.]
15 DR. CHERNEW: Yes, I agree.
16 MR. KAN: And final question --
17 [Laughter.]
18 MS. KELLEY: Amol, did you have something on this
19 point?
20 DR. NAVATHE: Yeah. I just wanted to simply ask
21 for the categories, since you're asking about the
22 categories. Are they mutually exclusive here, or can

1 people be in multiple categories at once?

2 MS. TABOR: They are mutually exclusive.

3 So I guess I will say that there is -- these

4 categories are good but they're broad. You know, as we can

5 all think of, for example, for Hispanics, there are lots of

6 different types of Hispanics and Latinos, and we're not

7 getting at the level of specificity.

8 So could there be an improvement in the

9 race/ethnicity data and kind of the level of collection?

10 Yes. Round 2 would be if this is Medicare's role or not.

11 MR. KAN: And, hopefully, this is the Round 1

12 question. Does the data exist for overall MA? Was this

13 fee-for-service for this disparities data, and should it be

14 covered in this chapter as part of the MA chapter?

15 MS. TABOR: We focused on fee-for-service because

16 for Medicare Advantage -- the issues we've been identifying

17 over the years about MA coding intensity and the

18 completeness of the encounter data, we would be limited on

19 what we could look at. It's something, if the Commission

20 would like, we can think about for some of the measures.

21 I know for the ambulatory care-sensitive ED

22 visits, we wouldn't feel confident calculating that right

1 now with the state of the encounter data, but perhaps some
2 of the other hospital measures.
3 MS. KELLEY: Cheryl.
4 DR. DAMBERG: Thanks.
5 So, first of all, thank you for such an
6 informative chapter, and I think the statistics that you've
7 shared with us serve as an important reminder of the work
8 that needs to be done to reduce disparities and improve
9 health equity in the U.S.
10 I have two questions. So the first was, in terms
11 of the presentation, the data displayed focused on overall
12 nationally versus trying to do any teasing out. That would
13 be by provider setting-specific. And I wasn't clear in
14 terms of this chapter, as well as ongoing work, whether we
15 would see more of that breakout by setting, whether it's by
16 hospital, home health, and so on.
17 And the reason I bring this up is because as we
18 progress -- and I think the focus is on the latter in terms
19 of provider-specific -- is I didn't see any discussion
20 about some of the issues with moving in that direction.
21 Kenny identified one of them in terms of, you know,
22 standardized measurement of social risk factors but also

1 the larger issue of small sample sizes and trying to get to
2 reliable estimates.
3 And then my second question was, in terms of the
4 focus on outcomes, you know, wholeheartedly support that,
5 but I also didn't see -- and I'm kind of curious whether
6 you considered this any discussion of measures that can be
7 derived from electronic health record data. EHRs are
8 ubiquitous, and they have the advantage of enabling
9 reporting on the full population, not just on small
10 samples, which I think would help with the earlier issue
11 that I had identified about small sample sizes. And I
12 think that the Commission has gone on record as wanting to
13 be able to do measurement in smaller geographic areas.
14 MS. TABOR: So I'll take the first question. So
15 I believe the question is, is the goal for this work to
16 eventually focus on provider-level disparities? And I
17 would say that that is a question I would have for all of
18 you -- we started at this national level and raise the
19 question of should provider-level disparities also be
20 looked at. So that would be something I would definitely
21 be interested in your feedback on.
22 We do see that CMS is moving towards some

1 provider-level reporting. Again, I would like your
2 feedback on whether that's the, you know, pros and cons or
3 limitations of that.
4 And then with the second question about focusing
5 on electronic health record measures, I have not thought
6 about that. Perhaps you and I could talk offline about how
7 we could do that.
8 MS. KELLEY: Lynn.
9 MS. BARR: Thank you very much for a terrific
10 chapter. I really, really enjoyed reading this.
11 I have two Round 1 questions. So I love the fact
12 that you're looking at income and ethnicity, but you also
13 have the data to determine rurality. And since we have,
14 you know, much published evidence of growing disparities in
15 health outcomes in rural versus urban and we don't
16 currently require quality reporting in rural America, this
17 would be our only view we could possibly get. And I know
18 this would be a tremendous lift for you, but if you could
19 potentially add rural as a subcategory, I would be very
20 interested in that.
21 My second question is around the home health
22 agency results on page 20, and I think we're all like, "Oh,

1 wow. No disparities in home health. Isn't that
2 interesting?" It would be very interesting if we could
3 look at utilization rates, because this may be an adverse
4 selection issue and that quality is equal, because we're
5 not seeing those patients, so if you could perhaps inform
6 us in that chapter about a potential of different
7 utilization rates for those populations.
8 Thank you.
9 MS. KELLEY: Amol?
10 DR. NAVATHE: Thanks, Evan and Lydia. Very
11 compelling work.
12 So I apologize for the somewhat granular nature
13 of these questions, but I was just kind of curious about a
14 couple of things about the modeling. So, one, I was
15 curious in the risk-standardized and risk-adjusted models,
16 what are we risk standardizing and adjusting for?
17 And, secondly, the second piece that I was
18 curious about is we used the word "risk standardized" for
19 some models and "risk adjusted" for other models, and in
20 fact, I think between the PowerPoint and our mailing
21 materials, one of them switched, I think, for the
22 successful discharge for the SNF. So I was curious if you

1 can just clarify how we should be thinking about the
2 difference between those two modeling approaches.
3 MS. TABOR: So we can take a look to make sure we
4 have consistent terminology. I will say that for all the
5 measures, the idea is you calculate an observed divided by
6 an expected and then multiply it by the national mean to
7 create the scores. And then expected is based on different
8 models that take into account the age, comorbidities, and
9 other clinical factors of the patients.
10 DR. NAVATHE: So, when you say clinical factors,
11 we're talking about HCC specifically?
12 MS. TABOR: Yes.
13 DR. NAVATHE: Okay.
14 MS. KELLEY: Jonathan.
15 DR. JAFFERY: Thanks.
16 So, Ledia and Evan, this is great work, and I
17 think it's super important to be seeing these things
18 stratified with both income and race ethnicity. I've heard
19 a lot of folks over the years sometimes distill these
20 differences and disparities down to try to gloss over,
21 frankly, the race issue and chalk it up to poverty. So
22 it's clear that there's both those things going on, and we

1 need to pay attention to it.

2 My Round 1 one question is, have you thought

3 about or looked for data sources that would -- to try and

4 identify language in addition to race and ethnicity?

5 MS. TABOR: I'm not aware of any beneficiary-

6 level sources on language spoken -- at the federal level,

7 that is.

8 MS. KELLEY: Marge.

9 MS. GINSBURG: Great report. Fascinating,

10 fascinating work.

11 But I was under the impression that the terms

12 "health equity" and "health care equity" are quite

13 distinct, quite different, but it doesn't seem like this

14 has identified those differences and what they mean. And,

15 ultimately, it comes down to can any of these changes which

16 are looking to impact health care equity, actually affect

17 health equity, and it feels to me like a little bit more

18 needs to be written about how these two, in fact, are quite

19 different. It feels as if the term "health equity" is

20 being used kind of universally to apply to everything, but

21 it's my impression that that's not the case.

22 So I guess maybe there are two comments. One is

1 to -- unless I've totally got this wrong -- make a really
2 clear distinction about what "health equity" means and what
3 "health care equity" means, and then the issue of can these
4 interventions that we're proposing, we do expect to affect
5 health care equity, but can they also, which I'm doubtful,
6 have an impact on health equity? Is that clear?
7 MS. TABOR: Yeah. I understand your point, and
8 we can take a look in the chapter and see where we can add
9 more.
10 MS. KELLEY: Dana.
11 DR. SAFRAN: Okay. A couple of questions. One,
12 building on the question that Kenny asked, I didn't see in
13 the written materials or hear you say in your presentation
14 here, what percent of race is self-reported for Medicare
15 versus imputed.
16 MS. TABOR: I don't know off the top of my head,
17 but I can look and get back to you.
18 DR. SAFRAN: Yeah. That would be helpful to
19 know.
20 I mean, if a lot is self-reported through the
21 Social Security system, that would be really powerful to
22 know, because that would really make Medicare unique in its

1 ability to study these questions relative to other
2 populations. So that would be really good to know.
3 A second is kind of related to the question that
4 Amol was asking, though I think I might now know the
5 answer. In your risk stratification or risk
6 standardization or adjustments, are you accounting in any
7 way for data you have that would let you see if there is a
8 primary care relationship in place? So, in other words,
9 are you using the claims data? You're computing a lot of
10 measures: ambulatory care-sensitive admissions and so
11 forth. Are you also computing, using the data, whether
12 there seems to be an attributed relationship to a primary
13 care provider?
14 MS. TABOR: We have not included that as a risk -
15 - as a variable in our risk adjustment model.
16 DR. SAFRAN: Either way --
17 MS. TABOR: It's an interesting idea, though.
18 I'd have to kind of think about that some more, but I know
19 for sure it's not included --
20 DR. SAFRAN: Okay, great.
21 MS. TABOR: -- in our model.
22 DR. SAFRAN: We'll come back to that.

1 And then my last question is it's really striking
2 that the magnitude of the differences that you're showing
3 us on race, even stratified by income, are almost
4 diminished the farther we get from ambulatory care. So
5 they're at their height with the ambulatory measures.
6 They're less for household readmissions, and they're less
7 still for post-acute. And I'm curious whether you have
8 hypotheses about that, that, you know, from having spent
9 the time that you've spent with the data. What do you make
10 of that?
11 MS. TABOR: I think we're still looking into it.
12 I mean, we definitely have the same reaction, and we have
13 some ideas of things that we could look at. Like, for
14 example, like home health, looking at short-stay patients
15 versus longer stay or spell patients. So we'd also be
16 welcome to your ideas about things that we can dive into
17 more.
18 I will say that looking at individual providers
19 for hospital SNFs and home health, there is a lot of
20 variation across providers. So I think that there is more
21 there that, perhaps to Cheryl's point, if we started
22 looking at the provider level, we'd do more.

1 DR. SAFRAN: Okay. Thanks
2 MS. KELLEY: Scott.
3 DR. SARRAN: Yeah. Excellent foundational work.
4 This just feels really important.
5 Two clarifying questions. In the readmission
6 data when we present that, I know there has been a lot of
7 concern expressed about the potential for gaming of
8 readmission data by hospitals who substitute, when
9 possible, an observations stay. Do we control for that in
10 any way?
11 MS. TABOR: We do not for the readmissions
12 measure. That is purely inpatient, but --
13 DR. SARRAN: But purely inpatient to inpatient.
14 MS. TABOR: But I will say for the avoidable --
15 for the ambulatory care-sensitive hospitalizations, we
16 purposely did include observation. So that counts
17 inpatient observation because of this phenomenon, and also
18 for the home health and SNF measures, rehospitalization
19 means inpatient or observation.
20 DR. SARRAN: So the readmission rate does --
21 MS. TABOR: Does not. Just we haven't kind of
22 caught up on our measure specs.

1 DR. SARRAN: Okay.
2 MS. TABOR: So four of the five measures take
3 into account observation stays.
4 DR. SARRAN: Okay. Would it be a lot of work to
5 report?
6 MS. TABOR: I have it on my to-do list.
7 DR. SARRAN: All right. Then when we talk -- in
8 slide 12, when we talk about outcomes for SNFs and we walk
9 about successful discharge to the community, can you
10 clarify? If somebody goes from a SNF to a long-term care
11 bed, SNF stay to long-term care bed in the same facility,
12 that would or would not be considered under our definition
13 here as a successful discharge?
14 MR. CHRISTMAN: If they were a long-term care
15 patient to begin with, then they went back to a long-term
16 care bed, that that's a successful discharge.
17 DR. SARRAN: So the common trajectory of hospital
18 to skill to long-term care, that would be successful?
19 MR. CHRISTMAN: Yes, if the long-term care was
20 their community before going to the hospital and if they go
21 back to the same facility.
22 DR. SARRAN: But if it were not their community

1 it --

2 MS. TABOR: It would not.

3 DR. SARRAN: -- would not be considered

4 successful. So it's successful when they go back to the

5 same long-term setting that they came from.

6 MS. TABOR: Yes.

7 DR. SARRAN: So sorry to belabor this, but the

8 community to hospital to skilled to long-term care, that

9 would be considered a failure in this?

10 MR. CHRISTMAN: Yes.

11 DR. SARRAN: Thanks.

12 MS. KELLEY: Greg.

13 MR. POULSEN: Let me pile on by just saying I

14 think this is great work.

15 I'd particularly second what Jonathan said. I

16 think we've all talked about race, ethnicity, and income,

17 and I haven't seen it presented so nicely before, so thank

18 you for that.

19 I would like to, though, understand if we can add

20 some additional insight on geography because, in many

21 instances, I was just thinking of clear examples, Vermont

22 versus Mississippi, where you've got big differences in

1 health outcomes, but you've also got big differences in
2 race, ethnicity, and to some degree, maybe a lesser degree,
3 income. A similar, dramatic example would be Hawaii versus
4 Louisiana where you've got dramatic differences in both
5 race and ethnicity as well as in health outcomes. And I'm
6 wondering how difficult it would be to factor in some of
7 those where we have differences geographically and don't
8 really fully understand the reasons for that difference.
9 Race and ethnicity could apply. Income could apply, but
10 there could be factors that are different than either of
11 those.
12 So maybe I'm piling on a little bit to Lynn's
13 point about if we were to look at some geographic
14 variables, which may be in some cases correlated or even
15 causally related with the factors we're already looking at,
16 but they could also be additional variables which may give
17 us insight in terms of what the most effective way to
18 attack the underlying issues and improve care everywhere,
19 so thanks.
20 MS. KELLEY: Jaewon?
21 DR. JAEWON: Yeah. I agree as well. I love this
22 body of work. I think it's important work. Thank you for

1 putting it together.

2 My clarifying question gets to the reading

3 materials. I think it's page 20 maybe, make reference to

4 the fact that there's a body of the population that's

5 probably missing and how we've defined and using the LIS

6 measure, and I think it's that sliver of the population

7 that's below 150 percent of FPL, not in Medicaid and also

8 not in Part D. And I was just wondering if we have some

9 ballpark of what percentage is that sliver.

10 MS. TABOR: I don't know off the top of my head,

11 but I bet some of my colleagues do. So we'll go back to

12 you.

13 MS. KELLEY: Wayne.

14 DR. RILEY: Yeah. Lydia, Evan, terrific work. I

15 fully support us as a Commission encouraging further work,

16 and I agree with Jonathan. Sometimes the red herring is

17 income where there's clear racial and ethnic differences in

18 terms of Medicare beneficiaries. And I was just thinking.

19 I can't help but think back to the 1980 Heckler Report by

20 Secretary Heckler, which was the first federal report that

21 sort of laid out disparities in Black and minority health.

22 So I fully support this.

1 In terms of readmissions, I have a sneaky
2 suspicion that Black and Latino Medicare beneficiaries are
3 really getting significantly a disadvantage in the
4 readmission issue. Are there any plans to look at the --
5 because I've charged our people with looking at,
6 quote/unquote, the "David Letterman Top 10" reasons why our
7 patients get readmitted and to focus like a laser beam on
8 those to try to drive some quality improvement. Is there
9 any -- have you guys had any discussion around, you know,
10 slicing and dicing that way?
11 MS. TABOR: As far as activities that hospitals
12 can do to reduce --
13 DR. RILEY: Correct. I mean, you know, the first
14 David Letterman Top Ten of readmission is congestive heart
15 failure. You know, that tends to be one of the key ones
16 that we see across the board, but like I said, my suspicion
17 is because of the high incidence and prevalence of heart
18 failure in Black and Latino patients that it may give us
19 some more information, actionable information.
20 MS. TABOR: I see your point now, and that's a
21 good one. We focused, you know, just starting broad, at
22 the all-condition, but we can dive into the various kind of

1 AMI, COPD categories. Good idea.
2 MS. KELLEY: Amol, you had another Round 1
3 question?
4 DR. NAVATHE: Yeah, I was just wondering when --
5 going back to the modeling question, so when we're getting
6 our estimates for the risk adjuster, risk standardized,
7 there are conference intervals there, right? So I was
8 curious if -- some of the estimates that we have obviously
9 are -- there's large magnitude differences. But the
10 populations that we're looking at oftentimes are smaller
11 populations. So I was curious if our insights would at all
12 be altered if we looked at the confidence intervals roles
13 and whether they're overlapping the average or not.
14 MS. TABOR: The numbers here are all quite large.
15 We did do significance testing, and they're all
16 significant, because the populations are all very big. We
17 specifically did not include two or three of the RTI
18 categories, which is the Alaska Native category or
19 other/unknown because they're smaller numbers and,
20 therefore, the significance is less, and confidence also.
21 So to your point, you know, if we got better data, we could
22 go deeper and deeper into these different categories. We

1 would have to think about the significance and confidence
2 of them.
3 DR. CASALINO: Yeah, this is redundant.
4 Wonderful work and beautifully, clearly written. The
5 presentation of the income versus race is also very helpful
6 to the slides.
7 Two pretty minor points, I think. One is if one
8 looks through the chapter, one can see that I think that
9 you're recommending both showing outcomes by stratified,
10 but also showing them nationally for any given provider
11 organization, say. And so I think that's in there, but I
12 think it maybe could be more explicit. I think culling
13 that out is important because we want to compare whatever
14 kind of provider organization to their peers, but we also
15 want to -- it's not that great if they're best among their
16 peers but worse 10 percent nationally, there's still a lot
17 of room for improvement. So it's in there, but I had --
18 maybe call it out very explicitly that both should be done.
19 You do do that, but it's only the second time I went
20 through that I actually realized that you had done it.
21 The second thing is just the results for
22 successful discharge to the community and the kind of lack

1 of differences for home health discharge and SNF discharges
2 really is interesting. And I'm not really suggesting that
3 this is a line of work that you should pursue right now
4 because there would be a lot of work, but just something
5 for you and Commissioners to think about.
6 I have heard people talk about for discharge to
7 the community, meaning to somebody's home, say, this could
8 have something to do with cost of housing. So in
9 communities where housing is really expensive, people may
10 not have a room to put a relative in, say, when they're
11 discharged, and that could be a factor.
12 MR. POULSEN: Or air conditioning during the
13 summer.
14 DR. CASALINO: Yeah, exactly. On the other hand
15 -- but this could even be wealthy people could have a
16 problem with that in high-cost communities, higher-cost
17 housing communities.
18 The other thing is it could be that certain race
19 and ethnicity groups actually are more likely to have
20 extended families in the same building or nearby, and this
21 could actually make it easier for people who are in general
22 socioeconomically disadvantaged to have better rates of

1 successful discharge to the community because there's more
2 of a culture, whatever, of taking care of your relatives,
3 and so they can be discharged to the community.
4 Anyway, those results certainly bear more looking
5 at, and I think there might be something to learn from
6 them.
7 MS. KELLEY: I think that's the end of Round 1,
8 unless I've missed anyone?
9 DR. CHERNEW: That's what I have, and I then will
10 say Round 2 is going to start, I believe, again with Kenny.
11 MS. KELLEY: Yes.
12 DR. CHERNEW: And we have about an hour, so keep
13 that in mind as you go through your set of comments. It is
14 a long queue. Kenny?
15 MR. KAN: Thanks, Mike. As a data geek, I'm
16 really -- I'm really, you know, excited by this, as I
17 mentioned earlier. So two Round 2 questions.
18 The first observation and question is, echoing
19 what Dana said, you know, it is intriguing that, you know,
20 the ratio of the highest to the lowest in Tables 5 and 6,
21 where it's like 1.1 to 1.3, is a lot lower than in Tables 2
22 and 3, which is at 1.7 to 2.1. So I'm trying to figure

1 out, like what Dana just said, how much of that has to do
2 with intensity of care or possibly what Wayne said, that,
3 you know, the Top Ten David Letterman list, like CHF
4 possibly having a wide clinical range of outcomes. How
5 much could it be due to that, that provider level
6 variation, and -- or can we draw any learnings from Tables
7 5 and 6 in looking at those outcomes measures that you
8 could apply to the higher care intensity, maybe they have
9 like standard SOPs or processes that are more homogeneous
10 that you can actually be applied through the disadvantaged
11 populations? Is that something that can be looked at in
12 the data?
13 MS. TABOR: I mean, we can think about it.
14 Definitely the conditions we could look at easily. As far
15 as structures within the providers, that may be more
16 difficult. But, you know, we'll take it back and take a
17 look.
18 MR. KAN: Okay. And then a second Round 2
19 question. You know, the detailed chapter mentioned about
20 the use of ACS, I believe, in the reading. I believe there
21 is a difference between a well-funded hospital in an
22 affluent district, but somehow gets lots of referrals from

1 LIS population versus, you know, a real community hospital
2 that is, like, right in the middle of, say, the Bronx that
3 gets a lot of LIS folks. I mean, it's different dynamics
4 here. Can you help me understand, like, why we in MedPAC
5 believe that ACS is an appropriate measure to use it for
6 this body of work, while in the safety-net chapter that we
7 will discuss tomorrow, I believe, you know, we didn't
8 really consider ACS, or maybe we felt that it wasn't as
9 good as maybe the other data source that we're using?
10 MS. TABOR: Let me make a few statements, and let
11 me ask Jim to step in here, too. So when we looked at the
12 ambulatory care sensitive rates of hospitalizations for a
13 population of beneficiaries who are dually eligible for
14 Medicare and Medicaid or received the Part D LIS subsidy,
15 and that's how we defined income -- low income, and that's
16 the same indicator for low income that is being used in the
17 safety-net work. So we are using the same indicators
18 across both analyses.
19 MR. KAN: Okay. I guess I was just inquiring
20 what is the difference about one being a population health
21 data measure versus one being more -- was there some
22 beneficiary data that we got in the safety-net work or --

1 or maybe you can put to tomorrow. I didn't mean to go down
2 a rabbit hole on this.
3 [Laughter.]
4 MS. TABOR: We are using consistent indicators
5 across.
6 MR. KAN: Okay.
7 DR. CHERNEW: I think, Jim, you're going to say
8 something, then I'll say something.
9 DR. MATHEWS: Go ahead.
10 DR. CHERNEW: I think there's a theme that has
11 emerged in these comments as both some combination of
12 enthusiasm -- actually, there's clear enthusiasm, so let's
13 start with that. And then it's tempered by a bunch of sort
14 of analytic questions about things that sometimes blend
15 into, well, how are we going to use these things, which
16 then blends into, for example, how we do our VIP work and
17 how we risk-adjust in our VIP work.
18 I think the way that I would think about this for
19 now is more limited, although it doesn't have to stay more
20 limited, which is we are simply reporting variations in
21 quality across different populations. There are a series
22 of legitimate analytic questions. Is that because they

1 live -- people live in places are treated by different
2 providers? Amol has shown some work that the providers --
3 you know, is it a provider quality issue? Is it an
4 underlying context of their environment issue? There's a
5 lot of hypotheses one might have about what gives rise to
6 these disparities.
7 We can control for some things. We can discuss -
8 - I'm sure there will be other comments -- I know there's a
9 long queue -- about what we can control for. But we are
10 not going to get, in my opinion, towards a really unpacking
11 of all of the causal connections that may give rise to
12 these things.
13 I think our key point here is to really point out
14 some very troubling findings, but we're going to save all
15 of our actions, what we should do in the quality reporting,
16 to the quality reporting kind of VIP peer grouping stuff
17 where we do things or some of the other kind of issues.
18 Right now I think you should view this
19 fundamentally as a highlighting of a problem issue,
20 although there are certain things, some of the reporting
21 stuff, that may flow through here. But I'd give some
22 caution of trying to push folks to doing really causal

1 disentangling of the complicated relationships that give
2 rise to these things that we observe, because I just think
3 that's going to be analytically particularly challenging,
4 although we can go -- geographic controls, for example, is
5 something that is probably an easier lift than some of the
6 other things that have been mentioned.
7 Anyway, I don't want to belabor this because I
8 know how long the queue is, so I think, if I have this
9 right, Cheryl is next. Is that right, Dana? It's so nice
10 when I'm on top of what's happening.
11 DR. DAMBERG: Okay, Mike, you're going to tell me
12 I'm in left field then. So I do think it would help to
13 clarify sort of the intent of this chapter, which I think
14 is both looking nationally but also signaling that we want
15 to be able to measure these disparities at the provider
16 level. So I would support the chapter moving in that
17 direction.
18 And I do think that we need to potentially
19 comment on other sources of quality information that would
20 allow, you know, a better understanding of disparities
21 other than the limited data set that you have to work with
22 today.

1 But I think my bigger set of comments focuses on,
2 you know, whether what we're trying to do here is create
3 some kind of road map or to try to link it to other
4 chapters and other work that the Commission is involved in,
5 because I think we probably collectively agree that we need
6 a multifaceted approach to reducing disparities, and I'm
7 going to lay out four of the areas that I see as needing
8 attention. A couple of these you've discussed in the
9 chapter.
10 You know, clearly one is measuring and
11 stratifying performance. And none of these should be
12 viewed as mutually exclusive. Two, you know, working to
13 develop and see implemented measures of health equity,
14 because I think we want to create the incentives in the
15 marketplace to improve care, and I think we can do that
16 through measurement.
17 Something that wasn't measured is risk adjusting
18 the performance measures for social risk factors to try to
19 reduce measurement bias to avoid unintended consequences
20 associated with providers avoiding these patient
21 populations.
22 And then the last thing ties back to something

1 that MedPAC has already come out with, which is, you know,
2 the peer groupings, and I would wholeheartedly support that
3 work.
4 MS. KELLEY: Lynn.
5 MS. BARR: This is almost a Round 1 question, but
6 I assume that you did not include swing beds in the
7 analysis. Is that correct? SNF is SNF and not swing beds?
8 MS. TABOR: We'll have to look at the specs and
9 get back to you. I don't want to misspeak.
10 MS. BARR: Okay. But I would like to see an
11 inclusion of swing beds in this. I mean, this is a really
12 great opportunity for us to get a couple looks at quality
13 we've never seen before, and there's no source of data, and
14 there's a lot of possibly wishful thinking out there, you
15 know, but possibly right, that swing beds, you know, have
16 tremendous quality so they're worth the price, you know,
17 and it would be really nice to have data to say, well, yes
18 or no. So if that would be possible, that would be great.
19 If you do include rural, of course, you know, and
20 we do some sort of comparison, there could be some really
21 bad unintended consequences of that, so I'm going to argue
22 the other side of the coin, which is then we're going to be

1 comparing how rural patients do in rural hospitals versus
2 how rural patients do in urban hospitals, and they may not
3 be the same in many ways, right? And so I worry about the
4 -- the peer grouping piece of it concerns me that there
5 could be very unintended consequences. So I am arguing
6 against myself, but I just thought I'd bring that up.
7 [Laughter.]
8 DR. CHERNEW: And you win. We just agree with
9 you.
10 MS. BARR: Thank you.
11 MS. KELLEY: Stacie.
12 DR. DUSETZINA: Thank you for such a great
13 chapter in this really important work. I've been kind of
14 working through mentally how this fits in with the safety-
15 net work. I do appreciate very much the measurement, and
16 as Jon Jaffery mentioned earlier, you know, separating out
17 the race and the low-income subsidy is, I think, very
18 important.
19 I want to reemphasize a couple of points that
20 have previously been made. One is Lynn's point about who's
21 getting access to services in the first place, and I think
22 that in the health disparities literature, we often fall

1 into this trap of saying, oh, you know, everybody, there's
2 no disparities because we've already conditioned on access
3 in some ways that are really important. And so I think to
4 whatever extent we can try to discern that there is this
5 similar baseline of access to these different sites of
6 care, like the entry is the same, the exit is different,
7 that would, I think, be really important.
8 Another thing that I kept trying to think through
9 is, like -- and I think the chapter kind of points to this,
10 and the presentation as well, is this mechanisms issue.
11 How do we start to think about improving the quality of
12 care or these outcomes? And it seems like a lot of these
13 measures are really related to whether or not you have a
14 usual source of care. And I don't know whether we can
15 explicitly try to measure that and think about how that
16 interplays between your low-income subsidy and your race,
17 and, you know, is that really a factor where we could do a
18 better job of incentivizing, you know, having a usual
19 source of care as one way of thinking about payment or some
20 of the tools we have. And I think it would marry in nicely
21 with some of the ways we're thinking about safety-net
22 payments in a way that -- and also in primary care and

1 trying to encourage, you know, kind of better access to
2 primary care.
3 The last thing -- and this I think goes to one of
4 Cheryl's points -- is thinking about in the health
5 disparities literature there is a lot about whether or not
6 you're getting different care at the same site or whether
7 you're going to different sites. And I really think that
8 it's important to try to tease those out.
9 You know, the different sites of care feels like
10 in some ways we can do more from a payment perspective, and
11 that's where we're heading with the safety-net work, is
12 like how to make sure we level the playing field for places
13 that treat a larger group of people of low income, for
14 example, but differences within a site of care is very,
15 very problematic and concerning and I think is a place
16 where maybe we could think about quality measures or ways
17 to think about either penalties or rewards for doing better
18 within the same site of care for different people.
19 But I'm really, really enthusiastic about this
20 work, and thank you both for such an excellent chapter and
21 presentation.
22 MS. KELLEY: Jonathan.

1 DR. JAFFERY: Great, thank you. So, again, great
2 chapter. A couple things.
3 One, going back to my Round 1 question, it would
4 be wonderful to start thinking about how we could
5 incorporate language. I don't have -- I'm not an expert.
6 I don't have a data source in mind, but I do maybe have
7 some people I know who might have some ideas. So I'll
8 think about that. But it would be great if we could
9 broadly.
10 Some of the other things -- I really like some of
11 the policies around public reporting of things are
12 stratified for the reasons we've talked about and adding
13 that focus on reducing disparities in the various quality
14 payment programs. I think that's, you know, a key step to
15 getting us to those outcomes we want.
16 I think some other things that have come up in
17 this morning's discussion around provider level reporting
18 are going to be important, and, of course, strongly related
19 to our ability to put these things into payment programs.
20 And I think just, you know, reinforcing Wayne's
21 comment about thinking about different clinical situations
22 is an important idea. Certainly the causes of and the

1 potential opportunities to mitigate things like
2 readmissions are going to vary for things like, you know,
3 medical conditions that are chronic, like congestive heart
4 failure, and have all sorts of inputs that might relate to
5 access to food, healthy food, versus, you know, after a hip
6 replacement that may have some other factors, too, and that
7 could go in different ways.
8 My last comment is sort of, I think, the biggest
9 point that we haven't talked about yet. So in the chapter
10 it states -- and you said this, Ledia. You know, some of
11 the efforts to address social risks and things like food
12 insecurity and transportation and housing needs are
13 generally beyond Medicare's scope. And I get that.
14 However, that's sort of what you hear health care providers
15 say continuously, and there's some truth there, too. But I
16 worry that that's reinforcing this separation between
17 health and health care.
18 You know, we now have MA that has some
19 permissions to invest and pay for some of social
20 determinants of health care. You know, I'm not sure how
21 successful that's been or how disseminated that's been yet.
22 I believe there's some hope that population-based payments

1 in ACOs will allow providers in those situations to do this
2 as well.
3 I do worry that just expecting ACOs to do this is
4 not a really viable strategy. It's complicated. ACOs, you
5 know, don't really have the obvious means to sort of, you
6 know, quote-unquote, purchase these services, and, in
7 particular, smaller ones, that's going to be more
8 difficult. So I think if we push in that direction and
9 expect ACOs and other providers to do that, we're probably
10 reinforcing or we have the risk to reinforce things like
11 more consolidation and other groups like MA or other types
12 of commercial organizations consolidating and sort of
13 organizing around our population-based payment work, which
14 I think gets away from the provider-driven approach that
15 we've seen could be most successful.
16 So I recognize this is -- you know, we're not
17 ready in this chapter to do this, although if you want to,
18 I'm happy to entertain it. But thinking about how do we
19 get to some policy proposals where maybe Medicare does
20 start to purchase those services directly, and I recognize
21 we'd have to put some pretty hard guardrails on that, which
22 could be based on beneficiaries that meet certain criteria

1 around these things we're talking about here -- income,
2 race, ethnicity, and maybe language. They very much could
3 be within the context only of two-sided risk, advanced
4 alternative payment models where there would be some
5 protections against that. But I think that, you know, we
6 do want to think about that at least in the future, and for
7 the purposes of this chapter, you know, maybe we could even
8 have some language that signals that that's something that
9 could be considered by the Medicare program, but certainly
10 not what we have, which is the opposite direction, which is
11 to say this is not something Medicare does, it's beyond our
12 scope.
13 So that's kind of my big sort of burning takeaway
14 that I wanted to emphasize, and, otherwise, you know, great
15 chapter, fantastic, and for all the reasons we've talked
16 about, I think this is really moving us in a great
17 direction.
18 Thank you.
19 MS. KELLEY: David.
20 DR. GRABOWSKI: Great. Thanks, Dana. Evan and
21 Ledia, this is terrific. I'm very enthusiastic about this
22 work. I wanted to offer kind of one idea and then make two

1 points, reacting to the ideas you put forward about how we
2 could use this information.
3 My idea, we've seen very similar disparities in
4 our work on skilled nursing facilities in terms of duals
5 versus non-duals, and looking at whether or not they are
6 successfully discharged to the community. Scott, to your
7 earlier point, not surprisingly duals are much more likely
8 to get stuck and transition into long-stay status. And we
9 did something very similar to what you did. You used LIS,
10 which is better. We used duals.
11 The comparison you're making is national, so it
12 encompasses some within area, within provider, but also
13 cross-area. And so what we did was we looked across areas
14 but we also used a ZIP code fix effect where then you can
15 look within a very narrow area. And guess what? These
16 disparities persist.
17 I think that would be really powerful here to not
18 just look kind of nationally but also to sort of zero in.
19 And that gets to Greg's earlier point and I think some of
20 Lynn's points about rural areas. And I bet you're going to
21 see a lot of these disparities persist in local areas.
22 So that's a potential extension of this work, and

1 I don't think it would be too hard to kind of extend your
2 existing framework to look within areas, and whether it's
3 ZIP codes or some other area level.
4 To then react to your two points, first this idea
5 to publicly report measures stratified by social risk
6 factors. I like this idea of reporting quality for
7 providers by race, ethnicity, and LIS status. I worry a
8 little bit for SNFs about sample size, and we've gotten
9 into this previously, and Dana knows this well. We've
10 thought about can you do this in a single year, do you have
11 to look back kind of multiple years?
12 For example, colleagues at Brown publish data
13 every year on the racial mix in nursing homes, and they
14 have to censor a lot of facilities. Nursing homes are
15 incredibly segregated, so you have lots of facilities with
16 high numbers of minority residents but lots of facilities
17 with very few. So how we think about this measure and
18 sample size is going to be really important, less of a
19 problem for LIS but still something to think about there.
20 And then finally, on reducing disparities in
21 quality payment programs, I also like the idea of
22 incorporating equity into these programs. There's been

1 prior work in long-term care, and I'll send you some
2 references here, that value-based payment, quality payment
3 programs, if they don't account for disparities can
4 actually magnify the problem and widen the gap between the
5 haves and the have-nots. And that's both true, to Lynn and
6 Stacie's earlier comment, both in terms of disparities and
7 access and in quality, in that it kind of widens who gets
8 access to services but also conditional on admission, the
9 quality of care they receive.
10 So I really like the idea of bringing equity in
11 directly because it's not something we've always thought
12 about or used in kind of evaluating our different quality
13 payment programs.
14 Once again, great work. I'm very enthusiastic
15 about this. Thanks.
16 MS. KELLEY: Dana.
17 DR. SAFRAN: Thank you. And I'll just pile on
18 about the importance of the work that you're doing here and
19 my appreciation for it.
20 I have four main comments to make. The first one
21 is that I'm a bit concerned. This is, as you're hearing
22 around the table, a very timely, very sensitive, very hotly

1 debated topic right now, how to deal with social risk in
2 performance measurement. And, in fact, NQF has been
3 working on this for close to a decade, and most recently in
4 a two-year technical expert panel that CMS commissioned,
5 and the report will be out either this month or next month
6 from that. I think it will bring some good insight that we
7 can leverage in this.
8 But I think that I'd like to see this chapter
9 reflect more recognition of that, so that we don't sound
10 kind of academic and like isn't this an interesting thing
11 and aren't these interesting findings. Like this is a very
12 heated, heated topic right now, and I think we have to
13 acknowledge that.
14 The second point is something that Jonathan was
15 pointing to, and I'll just underscore. I really would urge
16 that we not describe this as something that's beyond
17 Medicare's scope, because, you know, even as recently as 10
18 years ago, when I was involved with creating a payment
19 model, the thinking was that asking providers to be
20 accountable for control of blood pressure in patients with
21 hypertension or hemoglobin A1C in patients with diabetes,
22 let's be honest. We can be accountable for testing for

1 those things but not for control, because we're not the
2 ones making dinner and making sure people take the
3 medicines we have prescribed.
4 And so what's in somebody's control and what is
5 in the purview of care is really changing, and I would
6 argue that value-based payment is part of what's changing
7 it and causing us to be so aware of the impact of social
8 drivers of health. And so we shouldn't row in the opposite
9 direction right as those things are starting to be
10 considered and even address this part of value-based
11 payment model that part of health providers in those models
12 are responding, starting to look outside their four walls
13 at what they can do.
14 Kind of related to that, before I move to the
15 fourth point, and this might be a little bit of a nit, but
16 I think I heard you refer to the literature search as
17 literature on whether there are interventions to address
18 social determinants, as opposed to literature on whether to
19 address health in spite of social determinants, right?
20 Like how do you actually get to good results for patients
21 regardless of their circumstances? You might not be able
22 to fix their housing situation, but how do you make their

1 health outcomes better in spite of their housing situation,
2 be knowledgeable about their housing situation?
3 So I think that's an important issue, and related
4 to that, I'd urge you to look at the evolving lingo here,
5 to social drivers, not determinants of health, and maybe
6 adopt that for our use. That may sound like a silly thing
7 to focus on, but it actually comes from patient and
8 consumer reactions and this notion that, like, is it really
9 deterministic or is it something we can affect, which is
10 why I lump that under this it's not beyond Medicare's
11 scope.
12 Third point, really importantly, and Stacie
13 really started to get at some of this, you know, we don't
14 understand these results very well yet. We don't
15 understand, are these the results of discrimination? Are
16 these the result of access differences? Are they a result
17 of seeing different providers, something Stacie pointed to,
18 seeing different providers, or getting different quality of
19 care at a given provider, which maybe brings us back to a
20 discrimination result. For some outcomes is there some
21 physiologic basis for differences? Like we just don't
22 know.

1 So I'd argue that if we can in this work -- and I
2 think Stacie was the one that also touched on this and I
3 did in my Round 1 question -- I think at a minimum,
4 especially given the differences we're seeing for the
5 ambulatory versus the hospital versus the post-acute
6 measures, we should take a look at usual source of care.
7 So attribution model to see is there evidence of patients
8 having a primary care relationship and what does that do.
9 Because we've got to start to at least have some
10 hypotheses, I think, for what's behind these differences
11 that we're seeing. And I think with the claims data that
12 you have you have the ability to do that.
13 I also would argue that the lack of a difference
14 in the post-acute care finding could very much be a kind of
15 selection effect, that is, those people who are able to get
16 home care are not the same as everybody might have needed
17 home care, and so that mute the differences that we see?
18 My last points are on methods, and they're just a
19 couple of small things. I would say, number one, before
20 moving to provider-level reporting and provider-level
21 accountability -- people might be surprised I'm saying this
22 -- before moving to that, I would say we'd have to

1 understand this much better what's behind it. And so I do
2 like the idea of incorporating work on equity in
3 accountability programs, but not accountability for
4 performance. Let's start, for example, with accountability
5 for making sure you have self-reported data for every
6 patient in your population on race, ethnicity, and the
7 other social driver variables that we need to understand.
8 So let's have providers be part of helping us
9 answer those questions I was just talking about before,
10 before we move to accountability for performance.
11 A second methods point is I wouldn't advise the
12 area-level indices. I think that moves us away from
13 understanding these issues.
14 And then finally, on Cheryl's point about
15 clinical measures, that would be really helpful. I'm
16 pretty sure that we talked about that last conversation we
17 had about this, in that because you have claims data those
18 are kind of out of your reach. But if there's some partner
19 you can work with who has them, that would bring a lot of
20 insight here.
21 So thank you again for the great work. I hope
22 these comments are helpful to moving it to be even stronger

1 than it already is. Thanks.

2 MS. KELLEY: Amol.

3 DR. NAVATHE: Thanks, Ledia and Evan. I want to
4 add to the chorus of compliments from the Commissioners
5 about the really high importance and high quality of this
6 work. So thank you for pushing us in that direction.

7 I have five comments. I think many of them are
8 reinforcing what other Commissioners have said so I'll try
9 to be brief but kind of add what I can.

10 First, I think we've heard from David and Dana
11 and others that it's vitally important for us to understand
12 what's going on here, and I think a really important piece
13 of understanding is understanding the geographic
14 differences. So I wanted to make sure to support that
15 point very strongly.

16 I think in part it would be interesting to
17 understand and decompose whether these relationships that
18 we're seeing, in terms of the disparities, are cross-
19 geography or if they're highly consistent within geography.
20 And especially if we're starting to think about going down
21 the providing reporting, those kind of avenues, we have to
22 understand this first. I think it's just a must for us to

1 be able to decompose what's between geography and within
2 geography, and I think David and others have highlighted
3 ZIP or county, you know, the different kinds of ways that
4 we could do that.
5 The second point I want to make, I don't think
6 others have made but maybe I missed it. I think it was
7 quite striking to look at some of the results and see, for
8 example, there does seem to be some interaction between
9 race and LIS on some measures and not others. And at the
10 same time I think the non-LIS group is actually fairly
11 heterogeneous when it comes to income.
12 And so I don't know if we have the data to do
13 this, but I think it would be quite interesting if we could
14 actually stratify within the non-LIS group as well, based
15 on some sort of income bands, to understand a little bit
16 more of what might be happening there or if we're losing
17 some heterogeneity that's just being captured in a large
18 average, basically. And we might reveal some other
19 differences that we're right now not finding.
20 Third point is I think it's, to some extent,
21 conceptually challenging or maybe even troubling that we're
22 seeing a lack of consistency across the results when we

1 look at ambulatory condition sensitive conditions, when we
2 look at readmissions, fairly consistent, and then we get to
3 the post-acute world and it looks really different. And so
4 I think David and Dana, Lynn, and I think others have
5 pointed out to reasons we might worry about that.
6 I think at a minimum using the data it might be
7 interesting to look at specific conditions, like congestive
8 heart failure, other specific reasons for home health use,
9 for example, or discharge to SNF, to see if we narrowed the
10 groups to make them a little bit more similar can we
11 actually reveal that there is some disparity that we're not
12 detecting. Because the reasons, hypothetically, that Black
13 beneficiaries are using home health may differ from non-
14 Black beneficiaries.
15 And I think that goes to the bucket of Dana's
16 point of we have to understand this more. But I think we
17 should really try to push this a little further rather than
18 accept that it just looks this way for ACSs and it doesn't
19 look that way for post-acute care. Because the conceptual
20 basis of what we're worried about here shouldn't actually
21 vary in this way, and so I think the onus is on us to push
22 to that greater level of depth.

1 The next point I wanted to touch on is this
2 notion of provider reporting. I'm very broadly supportive
3 of this idea that we should be using equity measures as
4 part of our quality reporting, very generally. I'm very
5 concerned that we're not ready for prime time to do this at
6 the provider level, for the reasons that I outlined earlier
7 in my comments and other have made, which is there is a lot
8 to understand here regarding geography and what's really
9 driving it. When we start to report it by provider, I
10 think whether we mean it or not it has this implication
11 that the provider has a role in really producing those
12 results. And while we may want to pull some accountability
13 for them in, I'm not sure that we're quite ready to imply
14 that. So I think we should be thoughtful and careful and
15 see when the right time is to do that.
16 The last point I wanted to make is just to come
17 back and say you outlined in the paper a number of
18 different potential avenues. I think the idea that we're
19 incorporating these stratifications into quality
20 measurement as kind of a foundational step is really
21 fundamentally important. And I agree that we could even be
22 stronger in making the point about why it's so important.

1 So thank you so much.
2 MS. KELLEY: Jaewon.
3 DR. RYU: Yeah, thank you for the work as well.
4 I think it was really an informative chapter.
5 I have two comments. One echoes Stacie and
6 Lynn's comments around access, and this may be a hypothesis
7 around Amol's point of why you see this difference between
8 the ambulatory sensitive condition measure and what you see
9 with the post-acute measures.
10 I actually like the ambulatory sensitive
11 condition measure because I think it somewhat mitigates or
12 at least neutralize, partially, the question of access.
13 Because what you're measuring are people who land in
14 emergency rooms and hospitals, or you have other
15 structures, i.e., EMTALA, that sort of take the access
16 questions off the table.
17 And then everywhere else, I think, in health care
18 you have significant access questions that play out
19 differently across different populations, and so I think
20 using those kinds of measures become a lot trickier. So
21 that's my first point.
22 The second point is around, and I think Dana

1 touched on this, Amol touched on it, I think Cheryl touched
2 on it, and there is some mention when you shift in the
3 chapter to the how to use this information and you throw
4 out some suggestions, and I think one of them is in the MA
5 space, and you have some other places where it is public
6 reporting, could it become a quality measure around P4P
7 kinds of programs.
8 I think that's where I would still be very
9 cautious. I think it's one thing, and I think absolutely
10 we should start incorporating risk adjustment of these kind
11 of factors to make sure that whether providers or plans are
12 not disadvantaged as a result of taking on populations we
13 absolutely want and need them to take on. But when the
14 level of disparity itself becomes the measures, I think we
15 have serious problems, because the easiest way to have
16 fewer disparities is just not take on populations that
17 drive disparities. And I think that would be the wrong
18 outcome, and probably gets into the whole realm of
19 unintended consequences and so forth.
20 And then just as an aside, I think when we do
21 that, and as we think about how do you use this
22 information, I think how we use it in the provider space is

1 probably very nuanced and different from how you might use
2 it in the MA space. On the provider side, you know, if you
3 think of hospitals or even physicians, to some degree,
4 their geography is the geography. Those populations are
5 who they're going to get coming in the door. Health plans,
6 very different. MA plans could choose to just exit certain
7 counties if that drives disparities, and so forth. So I
8 think the dynamics play out differently.
9 MS. KELLEY: Scott.
10 DR. SARRAN: Three brief comments, all in the
11 family of teeing up next work and placeholders and all
12 that.
13 First, I reinforce Kenny's earlier comment about
14 the critical importance of our sourcing over time
15 comparable data for MA. That's just such a huge, I think,
16 take-home issue that we've got to be able to look side by
17 side at the fee-for-service system and the MA system and
18 how they perform.
19 Second, in the post-acute space, the measure of
20 successful discharge to the community. The framework I
21 have for thinking about that is there are really two things
22 we all want from the post-acute sector. We want it to be a

1 safe place, as the first thing, the second thing is within
2 which someone completes their recovery, whether it’s a
3 medical end or if they're a rehabilitative recovery.
4 So we get at the safe part pretty well, the
5 avoidance of death or hospital discharge. I mean, it's a
6 great proxy for it. The problem is in terms of
7 successfully completing their rehab or recovery, while on
8 the surface successful discharge to the community may be
9 considered to be a good proxy for it, it's a confounded
10 variable because, as people have been expressing, it mixes
11 in the reality of differential resources available in the
12 community to support that particular beneficiary after
13 discharge.
14 And so it's just a placeholder for saying we've
15 got to get more granular and expert on understanding and
16 measuring how well the post-acute provider is, in fact,
17 completing the person's recovery or rehab. This measure,
18 while a good step, is not nearly far enough.
19 And the third comment I have is when I think
20 about addressing the avoidable outcomes of social
21 determinants, the first thought that pops in my mind is it
22 takes a village, right? And although it's not to negate

1 the importance of each player's responsibility for working
2 to address, it would be ideal if there is a way over time
3 of capturing and subsequently incenting providers and MA
4 plans and ACOs, participation in multi-stakeholder
5 initiatives to address the outcomes -- the avoidable
6 outcomes of social determinants. I know that's way out of
7 the box for how we think about measuring and incenting, but
8 part of why we are where we are in U.S. health care is we
9 have a competitive -- well, imperfectly competitive
10 business environment, which is the exact opposite of a
11 collaborative environment, which is what's needed to
12 address the impacts of social determinants. And I'd at
13 least, again, plant a seed that we find a way of measuring
14 and incenting providers and plans, et cetera, participation
15 in solid multi-stakeholder initiatives.
16 MS. KELLEY: Betty.
17 DR. RAMBUR: Thank you so much for this fabulous
18 chapter and the great comments from fellow Commissioners.
19 I just have a few comments. The chapter opens by
20 just say something we all know, that there's little
21 incentive for quality and addressing disparities and fee-
22 for-service, and so anything -- as Cheryl said, anything we

1 can do to align economics and quality so we're not relying
2 on altruism -- I think that's what you said -- is really
3 essential.
4 One thing that no one has mentioned was the
5 socioeconomic position, which I thought was actually a
6 brilliant inclusion, because it looks at absolute and
7 relative position, and just briefly, showing my age, Paul
8 Wachtel's book in 1980s brilliantly dissected how the more
9 wealthy person in a poor community is in a very different
10 position than a poorest person in a wealthy community. So
11 it goes to culture, and I don't know how we get at that,
12 but I haven't thought about that for a long time. I
13 thought it was really important.
14 Both Jon and Dana and perhaps others talked about
15 traditional fee-for-service and how we perceive that as not
16 within our purview. This has always troubled me because if
17 we let it go long enough, people get sick enough, that we
18 actually do quite well financially. So I think we have an
19 accountability for that much broader view. And I sometimes
20 wonder if we could shift the thought from social risk to
21 social complexity and financial reward, taking care of
22 social complexity, as we do medical complexity. We have

1 all kinds of ways of measuring and paying for medical
2 complexity, but what about social complexity?
3 And if we could really grab onto that, maybe we
4 would -- I hate this expression, but I'll use it -- not
5 have the cherry-picking and lemon-dropping, but that
6 everything becomes a welcome situation that can work for
7 us. So I think it's really important that we grab hold of
8 that and take that as our accountability as providers.
9 For that reason, I am really -- I think we really
10 need to set the groundwork for provider-level reporting but
11 not yet. I think there's a lot that has to happen, but I
12 think that we need to set the groundwork for that.
13 I have to comment on the rural. Yes. No. If we
14 do include rural, it would be really important to include
15 frontier. As you know, that's less than six individuals
16 per square mile. Vermont and North Dakota have the same
17 population. Vermont's population density is 60 people per
18 square mile. North Dakota's is 10. So there's not just
19 red/blue differences. And in that particular county,
20 state, North Dakota 36 of 52 are frontier, with less than
21 six individuals per square mile. So you're talking about
22 an entirely different area, and then the point that was

1 made, I think, by Greg about the regional differences.
2 And then, finally, I can't help but comment on
3 Larry's comment on family culture. I've come to believe
4 that no people - no two people are discharged to the same
5 world, and I see it so graphically in my own family. The
6 Northern European branch versus the Filipino branch, it is
7 entirely different in terms of what is expected as we age.
8 And so I don't know how these metrics are included, and I
9 don't know that we can get that level of granularity. But
10 it's a really important thing.
11 So thank you for this hard work, and I look
12 forward to continuing to row on this with you all. Thank
13 you.
14 MS. KELLEY: Larry.
15 DR. CASALINO: Yeah. I want to comment a little
16 bit on the brief mention in the report of Medicare. I was
17 looking for the exact word, and I couldn't find it just
18 now, but basically it's been a reaction from a few
19 Commissioners to the report saying Medicare's not
20 responsible for social determinants or whatever. And I
21 think, honestly, that there's been a lot of -- it's a
22 complex issue, and I think there's -- because it's a kind

1 of a progressive issue, I think there's been some certain
2 amount of not very specific thinking about it in general.
3 So I think we need to think more carefully about
4 what Medicare can do, what health care providers can do in
5 relation to social drivers.
6 Medicare can make sure that providers aren't
7 penalized for taking care of disadvantaged populations
8 through reward programs like, say, for reducing disparities
9 through public reporting, with all the caveat that
10 Commissions have raised about that. Medicare can and
11 should do that, and organizations that provide care, they
12 can and should be sure that they have information for every
13 patient on social drivers of health for that patient and
14 then develop very systematic ways of trying to help those
15 patients and help the physicians and nurses who take care
16 of them to somehow deal with those social drivers, if they
17 don't have good housing, whatever.
18 That's very different than saying that Medicare
19 or a health system should have responsibility for fixing
20 housing problems in the community or fixing the
21 transportation system in the community or making sure
22 there's food in food deserts. I know that some big health

1 systems are investing some money in doing those kind of
2 things. That's fine. But the idea that Medicare or
3 organizations that provide care can fix these deep social
4 problems and should fix them, to me, it doesn't make sense.
5 There's not enough money for it. Medicare
6 doesn't have the money. Health systems don't have the
7 money, and I don't think we want Medicare or health systems
8 to have the enormous amounts of money it would take to make
9 a fundamental change in social drivers.
10 The health care system already has too much
11 money, and too much of the federal government goes into
12 health care system. Too much of the state government
13 budgets goes into health care, and to say either with the
14 current budget, the health care system can fix these deep
15 problems, or there should be a much bigger budget that
16 would enable them to do it, to me doesn't make sense.
17 Neither Medicare nor health systems have the -- they don't
18 have the resources, and they don't have the expertise to
19 fundamentally fix housing or transportation, for example.
20 So that's not to say that we shouldn't try to
21 help patients who have those problems, and there needs to
22 be much, much more of that. And any physician, nurse

1 practitioner, whatever, who all day long takes care
2 patients with social drivers, knows how hopeless you feel
3 on your own to try to do anything about that. So that
4 needs to be done.
5 I liked what you had to say in the report,
6 although now maybe it should be clarified, because I think
7 the language about the health system in relation to social
8 drivers is kind of a loose -- and it's not clear whether
9 people are really thinking, "Aha. New York Presbyterian is
10 going to fix the housing problem in Upper West Side" -- I
11 don't think so -- "or Montefiore is going to fix the
12 housing problem in the Bronx."
13 So, anyway, that's my spiel.
14 DR. CHERNEW: Dana, I think you have a comment
15 from Robert.
16 MS. KELLEY: I think --
17 DR. CHERNEW: And I think Dana wants to say one
18 more thing.
19 MS. KELLEY: I also think Amol and Betty, maybe,
20 had a comment on something Larry said. Am I getting that
21 right?
22 DR. CHERNEW: We have to go really quickly, so --

1 MS. KELLEY: Yes.
2 DR. CHERNEW: -- just understand.
3 DR. CASALINO: I do want to say I asked Dana to
4 say what I just said for me, but she wouldn't do it.
5 [Laughter.]
6 DR. CHERNEW: All right. Very quickly, Amol.
7 DR. NAVATHE: Yes, very quickly.
8 So I just wanted to really echo Larry's point. I
9 think it's really fundamentally important, because there's
10 a really important balancing act that we have to do on
11 framing this.
12 I don't think we want to suggest that we should
13 be addressing social services through health services or
14 through any health program, because then we start to think
15 if you think about the extreme world here, then we're
16 motivating people to only get housing support if it's going
17 to reduce their health spending or improve their health
18 outcomes, which is probably not the right way to think
19 about social services at a broad level.
20 So I think we should be careful. I think that's
21 different, and Larry made this distinction, which is really
22 important. That's different than saying we should be

1 delivering care as we should be developing care delivery
2 models to deliver the same health outcomes for people,
3 regardless of what their social situation is, and
4 motivating that type of innovation may very well be within
5 the purview of the Medicare program.
6 So I think this is a really, really fundamentally
7 important distinction that we should be mindful of as we do
8 any reframing around this.
9 DR. RAMBUR: I was just going to briefly say we
10 can't expect that Medicare payment reform can fix every ill
11 of the world at all, and I totally agree with that.
12 So I see this -- and maybe this is just semantics
13 -- as being the difference between responsible for or being
14 responsible to.
15 So, if I'm working with a patient who has
16 diabetes and they're homeless or whatever, I can't be
17 responsible for all of that, but I can embrace the
18 responsiveness to that situation.
19 And I have seen things like nurses going into
20 homeless encampments and doing home care to prevent people
21 from going to the emergency department, et cetera. So, to
22 me, that's where you broaden the lens and you think, you

1 know, how can I really think about the social complexity?
2 So I agree we cannot fix the world. So thank you.
3 MS. KELLEY: Okay. I have a comment to read from
4 Robert. He says, "Thank you for the excellent report.
5 Well done and directionally correct.
6 "One of the underappreciated aspects of quality
7 improvement programs is that care is improved for those
8 patients who have access to a provider's services and are
9 able to benefit from their performance improvement
10 opportunities. Health care disparities, therefore, becomes
11 exacerbated when access remains limited due to
12 socioeconomic factors, and patients are unable to take
13 advantage of services that provide high quality of care.
14 "I believe it is critical that we emphasize
15 access as a quality measure and would nicely complement
16 readmissions and ambulatory care-sensitive ED visits.
17 "In addition, the report underscores our
18 continued efforts in defining safety net providers and
19 removing barriers to access, including the higher costs
20 associated with vulnerable populations due to higher acuity
21 and disease burden.
22 "Thank you again for an excellent report."

1 Now I think Dana and Greg both wanted to jump
2 back into the queue for a quick second.
3 DR. SAFRAN: Okay, thanks.
4 I just wanted to get a comment on the record
5 here, because a couple of Commissioners have made a point
6 about the fact that if we don't risk-adjust performance
7 scores for these social risk variables, we jeopardize
8 access for vulnerable populations, and I wanted to
9 highlight that there is a hot debate about that and, in
10 fact, kind of have-your-cake-and-eat-it-too solution that
11 says if you adjust payment for social risk -- and I love,
12 Betty, your idea of social complexity -- and you can adjust
13 the payment by either or both of the following, you can add
14 additional funding or payments for those who have a more
15 socially complex population that they're caring for,
16 knowing that to get to good outcomes for those populations
17 will require something different and/or you can amplify
18 rewards for a given level of performance, knowing that
19 maybe it takes something more to achieve good performance,
20 but either way, by doing that, you then blunt that urge
21 maybe to avoid those populations, and you avoid the really
22 bad consequence.

1 If we adjust on the score side, we hide the
2 disparities that exist. We accept the status quo and fail
3 to invest in health equity, which I think is what happens
4 when you adjust on the financial side. So just a couple of
5 thoughts to get that in there.
6 If we're going to address that in the chapter,
7 you know, that we should point to adjusting for these
8 things could happen on either side, and there are pros and
9 cons in both.
10 MR. POULSEN: So I'll make this really, really
11 quick. My 10-minute diatribe is going to be 10 seconds and
12 basically boiled down to prepayment is -- or a holistic
13 prepayment is by far the most effective way to incentivize
14 people to undertake the complexity that this requires, and
15 in a fee-for-service world, this will always be difficult
16 and, in many cases, ineffective.
17 DR. CHERNEW: Thank you. I've been holding my
18 tongue for a lot of discussion. So let me say a few broad
19 things.
20 Again, to repeat what I said earlier, there's a
21 ton of enthusiasm for this. There's a lot of ways we can
22 take it. I just want to echo two core points.

1 The first one is I would like most of the
2 relevant policy discussions to be included in the relevant
3 places where we have those policy discussions, like the
4 MIPs, for example, and how we deal with that. Some of
5 them, it gets litigated there. This chapter will weigh
6 certain issues of things we might do. A good example would
7 be the reporting, the reporting things or using equity as a
8 measure of itself. Those might come up in this chapter.
9 That's true.
10 I think the key challenge here is to really think
11 carefully about the unintended consequences. It's very
12 easy to quickly jump to we should do this for various
13 reasons, but there's a lot of different types of unintended
14 consequences ranging from small sample sizes, noise in the
15 data, data reporting burdens, interfering with aspects of
16 the patient provider relationship when you're trying to
17 measure various things. There's a lot of complexities when
18 you deal with issues that are this sensitive.
19 I'm not claiming that those are determinant in
20 what happens. I'm just saying across the board, I think
21 it's important for us to consider a range of unintended
22 consequences where we jump in for recommending a range of

1 things.

2 A few other issues that came up here that are

3 relevant, one of them is there's been a lot of discussion

4 about what to control for. I think that's a reasonable

5 discussion. We will think about that, but understand that

6 some of this is to just point out broad aspects of where

7 the disparities are existing, not to say something causally

8 about why they exist.

9 And the challenge, for example, is you don't want

10 to control for things that may causally result in the

11 disparities. If you do that perfectly, the disparity will

12 go away, and all the disparity will be in access to say

13 having source of care or whatever it is. So, if you're

14 very careful about what it is one decides to control for

15 and how that's treated -- and we will take some of those

16 into consideration.

17 Obviously, geography is important. That's come

18 up a lot.

19 Controlling for specific providers, a little bit

20 more challenging, because there's conceptual differences

21 about how you think about disparities in a provider versus

22 people are going to different providers, just a whole other

1 issue.

2 And the last thing, which I'll say we'll just

3 leave it at that, is all of this hinges on the quality of

4 the quality measures, and we are limited as to the quality

5 measures we could have. From Round 1, people tried to make

6 a bunch of Round 2 comments like, "Do you observe these

7 better measures?" which is fine, and the answer is it is

8 hard to get the right measures, and while some places might

9 do a good job of measuring, a lot of places don't, and

10 trying to force them to measure things may have a bunch of

11 other unintended consequences. So we will continue to

12 think through how to do all of those various things.

13 But I very much resonate with what Dana said,

14 which is there is a whole lot of people spending a whole

15 lot of time, more than we could possibly do, trying to

16 address how some of the measurements and other related

17 issues are, and I think we just need to be cognizant. We

18 are cognizant of that, and we'll continue to think through

19 what we can do in our limited -- with our limited resources

20 to do this.

21 But I think in terms of shedding light on some

22 really important findings, this has been exceptional, and I

1 think the discussion has been really very rich. And I
2 appreciate that.
3 So we are now going to go grab lunch. I say to
4 everybody at home, thank you for listening. I hope you
5 found it as interesting as I did. If you want to send us
6 feedback or just general compliments, send messages to
7 MeetingComments@MedPAC.gov, or you can reach out to the
8 staff or go on the website, and you will find ways to let
9 us know.
10 In any case, we are going to be adjourning. I
11 guess we're readjourning at 1:15. We're going to be
12 talking about primary care, which we'll dovetail nicely
13 with this. And then we have a few other topics.
14 [Whereupon, at 12:02 p.m., the meeting was
15 adjourned, to reconvene at 1:15 p.m. on this same day.]
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1 AFTERNOON SESSION

2 [1:19 p.m.]

3 DR. CHERNEW: Welcome, everybody, to our
4 afternoon session. We're going to start off now with some
5 work that continues of broad interest in paying primary
6 care physicians. And I'm going to turn it over to Rachel
7 to start. Rachel.

8 MS. BURTON: Good afternoon. In this
9 presentation, I will describe two policy options for
10 increasing Medicare payments to primary care clinicians,
11 with the goal of attracting more clinicians to primary
12 care.

13 This presentation is in response to last
14 December's meeting, where a number of Commissioners
15 expressed interest in increasing payment rates for primary
16 care clinicians.

17 For those watching online, a PDF of these slides
18 is available from the webinar's control panel on the right
19 side of your screen.

20 I'd like to thank my co-author, Ariel Winter, and
21 my colleague, Geoff Gerhardt, for several claims analyses
22 used in this presentation.

1 I'll start by presenting some findings about the
2 primary care physician workforce, and note some prior
3 Commission recommendations and discussions on this topic.
4 I'll recap a recent action taken by CMS, and then describe
5 two options for increasing payments to primary care
6 clinicians.
7 I'll start with a trend we've reported on in our
8 recent physician update chapters. The Commission has found
9 that the number of primary care physicians billing Medicare
10 for at least 15 beneficiaries has declined slightly in
11 recent years, while the number of specialists has steadily
12 grown.
13 Although the number of nurse practitioners and
14 physician assistants has grown rapidly in recent years, the
15 Commission is concerned that NPs and PAs may not fully
16 substitute for primary care physicians, and believes that
17 there continues to be a role for primary care physicians,
18 for example, to direct the care of more complex patients
19 and to supervise NPs and PAs in states that require this.
20 I also note that our analyses of 2021 Medicare claims data
21 suggest that only a quarter of NPs and PAs are choosing to
22 practice as primary care clinicians.

1 A number of factors influence physicians'
2 specialty choice, as demonstrated by a survey of 2022
3 graduates of U.S. medical schools. A few of these factors
4 can be affected by Medicare payment policy, which therefore
5 presents a lever that policymakers could use to attract
6 more physicians to primary care.
7 Specifically, income expectations was cited by
8 half of medical school graduates as a factor that
9 influenced their specialty choice. In addition, work-life
10 balance influenced 80 percent, and amount of educational
11 debt influenced 23 percent. If payments to primary care
12 clinicians were increased, it could raise their income
13 expectations, allow them to hire more support staff to
14 improve their work-life balance, and/or enable them to
15 repay student loans more quickly.
16 The Commission monitors compensation disparities
17 between physicians of different specialties, due to their
18 potential to influence the composition of the physician
19 workforce. At $264,000, median annual compensation for
20 primary care physicians in 2021 was well below that of
21 various types of specialists, such as non-surgical
22 procedural specialists, who made a median of $450,000 that

1 year.

2 Part of the reason for this compensation
3 disparity has to do with the nature of the services
4 different types of clinicians perform. Specialists are
5 more likely to provide procedures, imaging, and tests,
6 services that can often be performed more efficiently over
7 time, as clinicians become more adept at using a new
8 technology or technique.

9 By contrast, primary care clinicians tend to
10 provide more evaluation and management, or E&M, services.
11 These services do not lend themselves to efficiency gains
12 because they involve activities that cannot be performed
13 more quickly with practice, such as talking to patients,
14 physically examining them, and reading medical records.

15 Billing codes for services are assigned a certain
16 number of work relative value units, or RVUs, when a
17 technology or technique is relatively new. Work RVUs
18 capture how much time and effort is involved in delivering
19 a service. As clinicians become more experienced at
20 delivering non-E&M services and can deliver them in less
21 time, the RVUs for these service should decline
22 accordingly. If this were to happen, it would cause

1 payment rates for all other services to increase, since
2 changes to the physician fee schedule's codes are required
3 to be budget neutral.
4 However, the RVUs for many procedures are not
5 reduced over time, resulting in some non-E&M services
6 becoming overvalued. For example, a recent analysis of all
7 Medicare procedures involving anesthesia found that these
8 procedures took 27 percent less time to conduct than the
9 billing codes in Medicare's physician fee schedule assumed.
10 Studies have also found that payment rates for 10- and 90-
11 day global surgical codes are overvalued, since clinicians
12 often do not provide the post-operative visits that these
13 codes assume are occurring.
14 When non-E&M services become overvalued, it
15 results in E&M services becoming undervalued, since these
16 services miss out on payment increases they would have
17 otherwise received.
18 Over the years, the Commission has made several
19 recommendations aimed at rebalancing Medicare's physician
20 fee schedule from specialty care to primary care, which are
21 recapped on this slide.
22 More recently, other work has included a 2018

1 chapter that discussed an option to increase payments for
2 ambulatory E&M services, which would be paid for by
3 reducing payments for all other services.
4 In 2019, we interviewed two dozen stakeholders
5 and identified additional policy ideas to attract
6 clinicians to primary care. And last March, we presented
7 three options for attracting more clinicians to careers as
8 geriatricians.
9 CMS is aware of issues with the physician fee
10 schedule, and in 2019 the agency announced it would
11 increase payment rates for E&M visits in office and
12 outpatient settings starting in 2021. For example, CMS
13 increased the payment rate for a Level 3 visit with an
14 established patient in a freestanding office by 21 percent,
15 from $75 to $92.
16 Since office and outpatient E&M visits make up a
17 quarter of all clinician spending, increasing payment rates
18 for these codes required a 10 percent reduction to all fee
19 schedule services' payment rates, to maintain budget
20 neutrality.
21 To avoid a sharp decline in non-E&M payment rates
22 happening in a single year, Congress increased the fee

1 schedule's payment rates by 3.75 percent in 2021, and by 3
2 percent in 2022, which increased Medicare spending by
3 billions of dollars. These increases only applied for one
4 year each, and were not built into future years' payment
5 rates. As a result, fee schedule payment rates for all
6 services will decline in 2023.
7 I will note that increasing payment rates for
8 office and outpatient E&M visits did not fully address the
9 overvaluation of non-E&M services, which continues to be an
10 issue.
11 The first of the two policy options we'll discuss
12 today would address the overvaluation of non-E&M services
13 by splitting the physician fee schedule into two fee
14 schedules. The 272 codes for E&M services would be
15 included in an E&M fee schedule, and codes for all other
16 services, such as procedures, tests, and imaging, would be
17 included in a non-E&M fee schedule.
18 Changes to codes in one fee schedule would have
19 no effect on payment rates in the other fee schedule. For
20 example, if a new procedure code were added to the non-E&M
21 fee schedule, it would result in a slight decrease to the
22 payment rates for that fee schedule, but the payment rates

1 for the E&M fee schedule would be unaffected.

2 Similarly, if office and outpatient E&M visits
3 were again revalued to have higher work RVUs, it would not
4 result in a decline in the payment rates for services in
5 the non-E&M fee schedule.

6 Under this option, each fee schedule would have
7 its own separate conversion factor, which could be
8 increased at different rates to achieve desired policy
9 goals. All clinicians could bill under both fee schedules,
10 regardless of their specialty.

11 If Commissioners wish to pursue this option,
12 there are two key design issues to consider. The first is
13 what types of services to include in which fee schedule.
14 The E&M fee schedule could include all of the categories
15 that are typically considered E&M services, which are shown
16 on this slide, or it could be restricted to a subset of
17 these services.

18 Including some E&M services in one fee schedule
19 and other E&M services in another fee schedule, could cause
20 payment rates for similar types of services to diverge over
21 time, since RVUs for these services would continue to be
22 set in relation to each other, but the conversion factors

1 used to calculate payments would vary based on which fee
2 schedule a code was housed within.
3 Then again, if policymakers increase payment
4 rates for services in the E&M fee schedule at a faster rate
5 than services in the non-E&M fee schedule, then reducing
6 the number of codes in the E&M fee schedule would lower the
7 cost of this option.
8 Another design issue has to do with budget
9 neutrality.
10 This option posits that the non-E&M fee schedule would be
11 budget neutral and work the same way the physician fee
12 schedule does today.
13 A question for Commissioners, is whether the E&M
14 fee schedule should also be budget neutral. If part of the
15 goal of this option is to increase payments for E&M
16 services, Commissioners may want to consider waiving budget
17 neutrality for the E&M fee schedule. This would mean that
18 the next time CMS increases payment rates for office and
19 outpatient E&M visits, which constitute half of all E&M
20 spending, the agency would not have to apply a large
21 offsetting reduction to payment rates. Then again, waiving
22 budget neutrality would increase Medicare spending and

1 beneficiary cost sharing, and be inconsistent with other
2 Medicare payment systems.
3 An advantage of Option 1 is it could be used to
4 increase payments for E&M services, which would reduce
5 compensation disparities between primary care clinicians
6 and various types of specialists.
7 Another advantage of this option is it could
8 result in other payers also increasing payments for E&M
9 services, since many payers use Medicare's physician fee
10 schedule as the basis for their fee schedule. This could
11 result in primary care clinicians receiving higher total
12 payments not only from Medicare, but also from other
13 payers.
14 Another implication of Option 1 is that using
15 different conversion factors for the E&M fee schedule and
16 the non-E&M fee schedule would likely result in services
17 with the same RVUs having different payment rates,
18 depending on if they are E&M services or non-E&M services.
19 A rationale for allowing this is the fact that studies
20 suggest that RVUs for E&M and non-E&M services have already
21 lost their comparability, with non-E&M services' RVUs
22 tending to become inflated over time, since they assume

1 more minutes are being spent on a service than is actually
2 the case.
3 I'll now move on to a second policy option to
4 consider, after I have a brief drink of water.
5 [Laughter.]
6 DR. CHERNEW: Was that scripted?
7 MS. BURTON: Under Option 2, Medicare would pay
8 primary care clinicians a monthly amount for each
9 beneficiary who is attributed to them. There would be no
10 beneficiary cost sharing for this payment.
11 Primary care clinicians would continue to bill
12 the physician fee schedule for individual services, meaning
13 that this payment would be on top of their usual fee
14 schedule payments.
15 In 2015, the Commission recommended that Congress
16 establish a per-beneficiary payment for primary care
17 clinicians, which would have started at about $2.35 per
18 beneficiary per month. This payment would have been budget
19 neutral.
20 A per beneficiary payment would need to be much
21 larger than this to meaningfully reduce compensation
22 disparities between primary care clinicians and

1 specialists, so you may want to consider a higher payment.
2 If you want to pursue this option there are
3 several design issues to consider.
4 First, should the per beneficiary payment be risk
5 adjusted? Doing so would provide higher per capita
6 payments to clinicians who treat more complex patients.
7 Under the CPC+ model, for example, there was a
8 monthly participation payment that varied depending on each
9 beneficiary's HCC risk score and the presence of dementia.
10 If we decide that the payment under this option should be
11 risk adjusted, the next question would be what type of risk
12 adjustment model to use.
13 Second, how should CMS attribute beneficiaries to
14 primary care clinicians? A per beneficiary payment
15 requires linking a beneficiary to a single clinician to
16 ensure that only one clinician receives the payment for
17 that beneficiary. Under our 2015 recommendation,
18 beneficiaries would be attributed to the clinician who
19 provided them with a plurality of their primary care visits
20 during the prior year. This attribution would occur at the
21 start of the year so that CMS could make payments
22 throughout the year.

1 But beneficiaries may switch primary care
2 clinicians during the year, which means that clinicians
3 could be paid for beneficiaries who are no longer under
4 their care. To address this issue, CMS could use claims
5 data to verify beneficiary attribution on a quarterly
6 basis.
7 Third, how large should the per beneficiary
8 payment be? Ideally, it would be large enough to
9 meaningfully reduce compensation disparities between
10 primary care physicians and specialists. As guidance, we
11 could consider the size of the per beneficiary
12 participation payments in the CPC+ model, which ranged from
13 $15 per month, on average, in one track, to $28 per month
14 in a more advanced track.
15 A per beneficiary payment of $20 per month would
16 result in total payments of $30,000 per clinician per year,
17 on average. This amount would raise primary care
18 physicians' compensation to a level that is comparable to
19 that of nonsurgical, nonprocedural specialists. We could
20 also consider a payment amount that is larger or smaller
21 than $20/month.
22 The fourth issue is how to define the primary

1 care clinicians who would be eligible for this payment. In
2 our 2015 recommendation, we defined primary care clinicians
3 based on their Medicare specialty designation, which
4 included specialties such as internal medicine and family
5 medicine, and their Medicare billing patterns. if at least
6 60 percent of their allowed charges were for primary care
7 services.
8 But clinicians in non-primary care specialties
9 may also function as a beneficiary's primary care
10 clinician. For example, an endocrinologist may act as the
11 primary care physician for a patient with diabetes.
12 Therefore, we could explore options to define primary care
13 clinicians based solely on their Medicare billing patterns.
14 Here are some key implications of the per
15 beneficiary payment option.
16 If the payment is large enough, it would reduce
17 compensation disparities between primary care physicians
18 and specialists. It would begin to shift payments for
19 primary care clinicians from a fee-for-service system to a
20 population-based payment approach.
21 If the per beneficiary payment is funded in a
22 budget neutral manner, such as by reducing fee schedule

1 payment rates for non-primary care services, there would be
2 no impact on total Medicare spending. However, this could
3 lead to significant reductions in payment rates for fee
4 schedule services, especially if the per beneficiary
5 payment is large.
6 If this policy is not budget neutral, it would
7 increase total Medicare spending.
8 For your discussion, do you have any questions
9 about these options? Are you interested in further
10 exploring either or both of them? If so, we could model
11 the financial impact of various iterations of each option.
12 And finally, are there other ideas you would like us to
13 explore?
14 This concludes our presentation, and I'll turn
15 things back over to Mike.
16 DR. CHERNEW: Rachel, thank you. I'm going to go
17 out on a limb and say there's going to be interest, but
18 we're going to see, so we will go through the queue.
19 If I have this right, Lynn is first in the queue,
20 so Lynn, you're number one, and then Dana will run the
21 queue.
22 MS. BARR: You don't trust yourself after that,

1 right?

2 [Laughter.]

3 DR. CHERNEW: I'm not sure I even trust myself to

4 do that. You noticed the fear on my face when I look at

5 Dana and say who I think is first.

6 MS. BARR: I get it. Yeah.

7 DR. CHERNEW: Right. Exactly.

8 MS. BARR: Thank you so much. I really

9 appreciate the chapter and really am looking forward to the

10 Round 2 discussion.

11 But in Round 1 my question is really related to

12 page 4 of the document, where you have, in Figure 1, and

13 you're talking about the number of primary care physicians

14 billing Medicare, fee schedules decline slightly. And you

15 use a caught-up of 15 patients per PCP, which seems like

16 that would've been really relevant in 1970. I was

17 wondering, when was the last time you've updated that,

18 because the number of Medicare patients has grown

19 tremendously, right? And so 15, we expect 100. You know,

20 for a PCP that's actually seeing a proportionate share of

21 their patients, you'd expect 100 to 200 patients they would

22 be billing for.

1 So where did the 15 come from, and is there any
2 thought about updating that as the threshold?
3 MS. BURTON: I can say a little bit about that,
4 and then Jim might want to jump in. I hear your point, but
5 there's another issue that in some geographic areas MA has
6 a very large share of the market, so you wouldn't want to
7 miss out doctors who are providing a lot of care to a lot
8 of MA benes, but not a lot of fee-for-service benes. So 15
9 would allow you to capture those people.
10 MS. BARR: I guess you could probably adjust it
11 by an MA factor perhaps. I'm just wondering like how --
12 that seems like -- how long have you had that number of 15?
13 Do you know, Jim?
14 DR. MATHEWS: Not off the top of my head, but the
15 notion is we are trying to capture a majority of physicians
16 for whom they are providing more than a nominal amount of
17 care to Medicare patients.
18 MS. BARR: All right. That seems like a very low
19 number to me, but that's my opinion. Thank you.
20 MS. KELLEY: Marge.
21 MS. GINSBURG: I have some questions more about
22 the background of the information here. My first comment I

1 wrote -- this was from page 12 -- did we really dis the
2 geriatrics options? I mean, it said, you know, the
3 Commission was not interested in moving forward on any of
4 the areas that might increase the number of geriatricians.
5 And, of course, I have no memory of that discussion.
6 MS. BURTON: Let me just clarify that.
7 MS. GINSBURG: Okay.
8 MS. BURTON: So a few people liked one option; a
9 few people liked another option; a few people, you know,
10 wanted to go in a different direction. So when we get this
11 like scattered kind of reaction, it's hard for us to move
12 forward.
13 MS. GINSBURG: Okay, so it wasn't necessarily
14 that there was no interest; it's just the interest was so
15 diverse that it was hard to pin anything down, because I'd
16 had to drop that completely in the future. And I realize
17 this was not specific to the content of the chapter, but I
18 think it is important in terms of background.
19 My other area of interest was about medical
20 schools, and there were some good comments here about
21 because often there are specialists who are doing the
22 teaching and that they often influence their students. I

1 guess we can't make them stop, can we? But I wondered, is
2 there any way of tracking -- I'm just very curious about
3 this -- about the number or percent of physicians who
4 graduate from certain medical schools, how many actually go
5 into primary care? And it just -- it seems to me that
6 might be a really -- I don't know how hard it is to track.
7 I don't even know when people go to medical school whether
8 they know at the time that they have an idea about what
9 they want to do. I suspect not. My husband's a
10 neurologist. I asked him once why he didn't go into
11 primary care, and he said, "Because it's too hard. It's
12 much more difficult." Now, that didn't come up on the
13 thing, and I don't know whether, in fact, many people
14 believe primary care is just really challenging, and that's
15 why many don't do it. I'm looking for ways, other than
16 financial, in addition to financial, of bringing more
17 people to it.
18 My last question is: Do we know what -- and
19 maybe you said this and I missed it. Do MA plans have a
20 greater percentage of PCPs available to them than those in
21 fee-for-service? And that may be because -- are they paid
22 better? I'm just very curious whether we know anything

1 about that.

2 MS. BURTON: Okay, I'll take those one at a time.

3 I believe medical schools that prioritize primary care tend

4 to track what percent of their grads go into primary care,

5 but I'm not sure if there's a national source, but I can

6 look into that.

7 DR. JAFFERY: So the people, they are tracked.

8 You know, there may be some issues around people including

9 OB/GYN or also including just people who go into internal

10 medicine or pediatrics getting counted, writ large, as

11 PCPs. And then, of course, many of those people end up,

12 myself included, specializing in the long run. Otherwise,

13 schools report on that pretty routinely.

14 MS. BURTON: Is that collected by AAMC?

15 DR. JAFFERY: Of course.

16 [Laughter.]

17 MS. BURTON: Okay.

18 DR. JAFFERY: In the best possible way.

19 MS. BURTON: Did somebody else have a point on

20 this, or should I move on?

21 [No response.]

22 MS. BURTON: Okay, I'll move on. So the second

1 question, in our interviews back in 2019, we did hear what
2 you said. We interviewed some medical school students and
3 asked them why they were choosing the specialty they chose,
4 and they said the same thing, that like specialty care was
5 sort of attractive because it was easier to gain mastery
6 because there was just sort of like less to learn about;
7 you know, it's just one disease or body system. So that
8 was in our 2019 paper, and we can bring that into this
9 paper as well.
10 And then your third question, I'm afraid I don't
11 know off the top of my head if MA plans have higher shares
12 of their docs who are primary care physicians compared to
13 fee-for-service, but it's something I can consult with my
14 MA colleagues about.
15 MS. GINSBURG: Actually, one more question
16 dealing with medical schools, and this may be futile even
17 to mention it. It is whether we have any control or
18 influence in any way with medical schools about whether
19 they appreciate and recognize that insufficient numbers of
20 primary care physicians is a problem and whether there is
21 anything -- anybody here have any influence --
22 DR. CHERNEW: They clearly do, and it's just --

1 yes.

2 MS. GINSBURG: It's just --

3 DR. CHERNEW: We'll just leave it -- just for the

4 purposes of time, we'll just leave it at yes.

5 MS. GINSBURG: Oh, okay.

6 [Laughter.]

7 MS. GINSBURG: That's it. Those are my

8 questions. Thank you.

9 DR. MATHEWS: Can I add two points to this? So

10 everything Rachel said is correct about medical schools'

11 motivations for practicing in primary care or not, but two

12 other things I would like to say out loud.

13 One is there is also a prestige factor that even

14 in medical school it is conveyed that specialty medicine is

15 more prestigious than primary care, and that does seem to

16 have an influence on people's career paths.

17 The second I want to reinforce is I know you were

18 asking for non-financial reasons, but even in medical

19 school, when we've talked to these folks, they are acutely

20 aware of differences in compensation, and that is a factor

21 in their selection of one residency track over another. So

22 even at that stage in their educational development,

1 differences in lifetime compensation is something they are
2 thinking about.
3 MS. GINSBURG: It feels like we don't have a
4 whole lot of options for trying to increase the number of
5 primary care physicians. Increasing the pay will help, but
6 it's not likely to have a major -- to cause a major shift.
7 But, anyway, good report, great background, and I hope
8 we'll be moving forward. Thanks.
9 MS. KELLEY: Greg.
10 MR. POULSEN: Thanks. I also appreciated this.
11 I thought there were lots of really good information in it.
12 It did beg one really key question to me, though, when we
13 talked about the two options. Since we identified the
14 problem as being derived, at least significantly, because
15 of an inappropriate calculation over time of RVUs, why did
16 we not suggest an option which was let's revisit the RVUs
17 periodically so that we could identify and make them
18 accurate? I'm obviously getting smiley looks, so there's
19 more to this story than I'm aware of.
20 MS. BURTON: I think Jim or somebody else will
21 fill in the details, but my bullet points are I believe
22 Congress did instruct CMS to periodically revalue codes,

1 and they in turn asked the AMA specialty society RUC
2 committee to do that. And the last time I think we did the
3 numbers; a very small share of codes were actually reduced
4 when they revalued them. But I'm going to stop and let Jim
5 or Dana pop in if I've kind of missed any details.
6 DR. MATHEWS: No, all of that is correct, and
7 we've gone on record recommending that CMS and the RUC work
8 to identify overvalued codes and, you know, revalue them
9 accordingly.
10 DR. CHERNEW: If we thought that process was
11 working well, we wouldn't nominee certain other processes.
12 MR. POULSEN: Right, I got it. But I'll have
13 more to say in Round 2.
14 MS. KELLEY: Scott.
15 DR. SARRAN: Rachel, excellent work, really well
16 frames the issue. Just one question. In terms of the
17 payment bumps that went into effect in 2021 for E&M
18 services, is there any feedback relevant to how that's been
19 either perceived or the impact it has had either from
20 specialty societies or any other reasonable sources of
21 input?
22 MS. BURTON: Like reading talking points from

1 specialty societies, I think they all thought that it was
2 needed, but they did not like the fact that it had to be
3 done in a budget-neutral manner and had to reduce their
4 payment rates.
5 Then the other data point I would mention is the
6 graph that I showed earlier that showed compensation for
7 different types of clinicians, and you can see there's a
8 line for primary care physicians, and it does kind of --
9 the slope increases in 2021.
10 DR. SARRAN: Any specific feedback from either
11 American Academy of Family Practice, American Academy of
12 Peds, or ABIM about whether they thought that that was
13 directionally and sort of order of magnitude sufficient to
14 create enhanced morale and enhanced choice of their
15 specialties?
16 MS. BURTON: I'm not sure.
17 DR. SARRAN: Okay.
18 MS. KELLEY: That is the end of Round 2 unless I
19 have missed anyone.
20 DR. CHERNEW: And since we have a full Round 2, I
21 think we are ready to jump into that. And if I have this
22 right, it is Betty who is my first round. Way to go,

1 Michael. Go, Betty.
2 DR. RAMBUR: Thank you. Thank you so much for
3 this important work. I just wanted to say how strongly I
4 support this work because we can't have a strong health
5 care system or affordable health care system without a
6 strong primary care foundation.
7 I have a few other ideas and thoughts, and then
8 we'll go to the recommendations at hand. But I wanted to
9 underscore that my concerns and thoughts are coming out of
10 concern for who will care for us, not advocating or
11 disadvocating for any one group.
12 I think we have to really look at the assumption
13 that primary care physicians deliver more complex care. We
14 would think it should be that way. That's an assumption
15 embedded in this work. And if I may just briefly, I'll
16 just share four studies that bring this into question, and
17 there's many more.
18 One is a study of -- a systemic review of 37
19 studies from seven countries; 23 were in the U.S. They
20 found that the nurse practitioners and physicians in
21 primary care really had the same kind of tasks, providing
22 care from minor to complex care, with a slight trend

1 towards NPs treating socially complex patients and
2 physicians focusing on medical complex patients. And that
3 relates to what we talked about earlier with social
4 determinants of health. And, of course, in this country we
5 don't particularly value socially complex care yet, but
6 hopefully we change that.
7 That leads to a second study, a different group
8 of scientists who were looking at practice characteristics
9 of primary care physicians and nurse practitioners; there's
10 not PAs in this study. They found that the nurse
11 practitioners were more likely than MDs to practice in
12 rural and urban, provide care in a wider range of community
13 settings, treat Medicaid patients and other vulnerable
14 populations. They delivered similar services and spent
15 their time in nearly identical ways, but did not have their
16 salaries adjusted for productivity or quality.
17 Finally -- well, two more, and I have a potential
18 solution about this complex issue. This is a large study
19 in VA of people who had diabetes. They found effective
20 care with NPs and PAs delivered 6 to 7 percent lower
21 because the physicians used more emergency inpatient
22 services. I'll give these to you, and you can critique the

1 methods. I'm comfortable with them.
2 Then, finally, an article that was just in Health
3 Affairs about physicians not feeling comfortable treating
4 patients with disabilities, part of it being reimbursement,
5 but other things as well.
6 Taken as a whole, this suggests that the
7 assumption that physicians treat more complex patients is
8 not universally true.
9 So what I would love us to explore -- and I don't
10 know how complex this is -- some sort of modifier by
11 complexity that really encourages everyone to work at the
12 top of their license, including physicians, and that it be
13 independent from provider type. And I think there would be
14 a lot of value in that because I know from my own
15 experience, I think it would be very valuable to really
16 make sure that the people who are having the education to
17 take care of the most medically complex are doing that.
18 The second point I want to make is incentives for
19 team-based care. If I may refer, sorry, to something Karen
20 DeSalvo mentioned when we were talking about primary care
21 before -- some of you were here -- she shared a very
22 poignant story about a patient whose blood pressure was not

1 controlled, could not get it under control. And working
2 with that patient for a long time, she realized that the
3 person was drinking pickle juice because of a belief -- a
4 health belief that that would be advantageous. This is
5 such an example of why we need primary care, but I would
6 respectfully suggest we don't need MDs, PAs, or nurse
7 practitioners for that, and that might be a role for RNs in
8 primary care -- and Macy Foundation has done a lot on that
9 -- or social workers. But, of course, those are all labor
10 costs or staff in primary care, so that's part of the
11 problem. I think that they could better understand health
12 care needs and could relieve MDs of some of those kinds of
13 things.
14 Figure 3, I would encourage us to either add a
15 second -- excuse me, Figure 4 -- this is Figure 3 that has
16 salaries. I think it would be helpful to include NP and PA
17 salaries, which are roughly half of that of primary care
18 physicians. I'm not trying to argue that point, but if we
19 break that out by nurse practitioners and PAs in primary
20 care versus specialties, you see the same bifurcation. And
21 nurse practitioners are typically prepared as family nurse
22 practitioners or adult gero nurse practitioners, which is

1 primary care. Just like everybody else, there's more money
2 in the specialties, more glamour, and that's where they go.
3 I think it would be helpful for Congress to understand
4 that.
5 I have just a few more points. Thank you. The
6 anti-primary care culture that's talked about on page 14 is
7 really important. It has been brought up here today. And
8 I just wanted to make a quick comment on GME. We know that
9 a lot of primary care slots, residencies, go unfilled. I
10 have some concern about GME in general. If you look back
11 at its history, it was supposed to be in place for a short
12 time until something better was found, and here we are all
13 these years later, and GME disproportionately prepares
14 specialists and being lucrative for hospitals and health
15 systems. But if we're going to have GME, I really think we
16 need to consider GNE and really support those individuals
17 who want to work in primary care. There's, you know, the
18 trials of graduate nurse education. And I'm still giddy
19 about the idea of GNE in long-term care and skilled nursing
20 facilities. That could really create a really different
21 kind of environment there.
22 A document references the states with restrictive

1 practice laws, and that is true, there are restrictive
2 practice states. In 2014, the Federal Trade Commission
3 promulgated a white paper about how problematic that is,
4 and although state laws are not in our purview, certainly
5 access is, and there's lot of information about the access
6 problems related to that.
7 So thank you for letting me share that, and I
8 want to underscore that I have a great deal of respect and
9 support for my physician colleagues, but there is so much
10 to be done, if we could just get this payment, you know,
11 morass cleared up so that we could all just do the work.
12 In terms of the options you have put forward, I'd
13 like to hear more about both of them. I like the budget
14 neutrality and the multipayer repercussions of Option 1, so
15 I was really liking that when I read it. And then when I
16 read Option 2, I really liked that. I'm not sure how
17 either of them work with incident-to billing, and I think,
18 you know, I really am looking forward to hearing more about
19 that discussion. But I think it's definitely important
20 that we take this -- if we can change primary care in this
21 country, or even help, we will have done some really
22 important work.

1 DR. CHERNEW: Just one clarifying point. These
2 are not either/or recommendations.
3 DR. RAMBUR: Right.
4 DR. CHERNEW: It's not like, well, I like this
5 one or that one.
6 DR. RAMBUR: And thank you for bearing my
7 diatribe.
8 MS. BURTON: And I think you understand this, but
9 just to clarify, both options would apply to NPs and PAs in
10 addition to physicians.
11 DR. CHERNEW: I'll say one other thing in case
12 it's not clear. As you know, we're usually like two cycles
13 until we get to recommendations. We're in the first of
14 those, so any of these things -- we're not going to be
15 voting on any of this stuff until next cycle. This is sort
16 of directionally part of a launched workforce type of
17 activity. So just to give you some idea of where we --
18 yes?
19 DR. RAMBUR: The other thing I think about
20 complexity modifier is that it's so easy in a fee-for-
21 service system to really send patients to a specialist or,
22 you know, someplace else. And if we could somehow get that

1 incentive out of there, I think it would be helpful.
2 MS. KELLEY: Lynn.
3 MS. BARR: Thanks, Betty, for a lot of that, and
4 I'm a plus one. I'm making sure these payments would apply
5 to NPs and PAs as well, would love to see that in the
6 report.
7 Back to my point earlier about the decline in
8 PCPs, I would like to see if you could look at a couple
9 other levels beside 15, because it would be curious -- and
10 you could adjust it for MA penetration over years. But I'd
11 be curious to really see. That number is so low that I
12 don't know if it really reflects what's happening. So I'd
13 just be curious to see it at 50 and 100, maybe, as a couple
14 other data points, to see if those trends remain flat.
15 DR. MATHEWS: So, just to be clear, you are
16 suggesting that we exclude physicians with higher counts of
17 Medicare beneficiaries from the calculation of primary care
18 over total?
19 MS. BURTON: She wants to increase the minimum.
20 So you'd have to treat at least 100 to be counted, right?
21 MS. BARR: To be counted, right. I'm afraid the
22 threshold is too -

1 DR. MATHEWS: That is what I said.
2 MS. BARR: Yeah, yeah, yeah, yeah. Just because
3 I'm afraid the threshold is too low for us to actually see
4 anything. And that we might see a really sharp -- and
5 again, adjusted for MA penetration over the years. We
6 might see a much sharper decline and have more of a sense
7 of urgency if we were looking at a more typical population
8 of PCPs, because I almost never see a PCP with 15 Medicare
9 beneficiaries or less, and so I'd just be curious just to
10 see something more real world. Maybe Jonathan or others
11 could weigh in on that.
12 I like the idea of payment being adjustable by
13 some sort of quality, you know, not just an across-the-
14 board, but maybe this is an add-on payment that you earn
15 for doing some things, like access and saying, "Okay. You
16 can get this add-on payment, but you have to see your
17 patients within a week," you know, some sort of criteria
18 that really solves a major problem for us that could bring
19 down overall costs, because we're talking about potentially
20 increasing costs to the government and to the taxpayers.
21 I'm concerned about -- of course, I can't even
22 read the -- oh. I'm concerned about kind of the lack of

1 results in CPC+, and Option 2 sounds a lot like CPC+, as
2 you mention in your paper. And so, you know, I'm more in
3 favor of something that's not a bunch of busy work kind of
4 thing that then ties to an add-on payment that we could
5 never really tie it to the results that we'd like to see.
6 If we go down a path of a beneficiary assignment,
7 I would like the patients to be able to assign themselves
8 and also for the providers to be able to say, "These are my
9 patients." So, if there's something tied to attribution,
10 we want to make sure that there's flexibility on how that
11 happens outside of just a pure claims, and that providers
12 could all say, "This isn't my patient," so allowing some
13 kind of flexibility around that.
14 And I'm a fan of Option 1. Thank you.
15 DR. CHERNEW: And you're not a fan of Option 2?
16 MS. BARR: I am not a fan of Option 2 because it
17 seems like CPC+, and I don't feel like we got the results
18 out of CPC+.
19 MS. KELLEY: Greg.
20 MR. POULSEN: Well, I very much agree with what
21 Lynn just said.
22 I want to make clear, I think capitation and

1 value-based care and prepayment is the ultimate solution to
2 this, because the value of primary care becomes very
3 apparent in that world.
4 And if you look at both current organizations
5 that have high degrees of prepayment, they tend to value
6 primary care significantly more, and that shows up in the
7 pay, and it shows up in the numbers.
8 I can't speak for the whole industry, but I
9 certainly can for some where the relative ratio of primary
10 care is significantly higher than it is in the broad world.
11 So let me just be really clear there, because I'm
12 going to say on Option 2, I think I'm deeply troubled by it
13 for a number of reasons.
14 But before we get to that, I really do want to
15 suggest that we have an Option Zero, which is let's
16 redefine the RVUs, if we need to just reorient people to
17 that and point out that the genesis of the problem comes
18 from that. Let's take a good hard look at it, maybe put
19 some teeth into it so that it has to be zero-based. If you
20 can't increase one without decreasing another, that that
21 might be a mechanism. So, again, it's out of the scope,
22 but I think it ought to be definitely put into scope, if we

1 possibly.
2 I am supportive, though, if that is either
3 impossible or insufficient to do that effectively, to look
4 at Option 1, and the reason I like Option 1 and Option Zero
5 significantly more is that we get a multiplier effect.
6 Other payers tend to follow what Medicare does,
7 and in either Option Zero, which is re-basing the RVUs or
8 enhancing the RVUs that are associated with E&M codes as
9 Option 1 suggests, I would strongly suspect that we would
10 see other payers follow that, and we would have an impact
11 that's far broader than simply the amount coming through
12 fee-for-service Medicare. I think it would instantly be
13 followed by Medicaid, but it would be quickly followed, I
14 think, by commercial plans as well. So I would support
15 those for that reason.
16 Now, I will tell you why I'm wary of Option No.
17 2. I think that we have seen that it's essentially a
18 partial capitation, and partial capitations, whether for
19 primary care or secondary care, are subject to enormous
20 abuse. It's an invitation to play games. You can play
21 games in a whole number of ways. You can play games with
22 attribution, have people come in and see you and then kiss

1 them goodbye, so that you can be identified as their
2 physician of record.
3 We also, though, I think, have tremendous
4 potential if the way that you're being paid is for having
5 people on your enrollment to send people off for other
6 services of almost all types, and suddenly, "Oh, you need
7 to see a gastroenterologist for that," "Oh, we need to see
8 a neurologist for that," "We need to see a gynecologist for
9 that," and so forth and so on.
10 And we've seen all of those abuses happen. If
11 anybody's lived through partial cap -- and I have -- those
12 kind of abuses just take place, and the patients, the
13 beneficiaries get caught in the middle of those.
14 And, additionally -- we even talked about it here
15 -- it becomes incredibly complex to administer and figuring
16 out who gets attributed and who doesn't, and what
17 mechanisms are part of that, I think, become not only --
18 well, they're both difficult and subject to abuse. So, for
19 those reasons, I think I feel most strongly that if we can
20 pursue an option zero, I think that's the best because it
21 meets the problem at its source.
22 Option 1, I think is also positive and goes in

1 the right direction. Option 2, I think I'd be very wary
2 of.
3 DR. CHERNEW: I think I want to say one thing
4 about Option 2, just to get it all on the table early in
5 this discussion as opposed to late. You don't need to
6 react to this.
7 The other challenge with, say, the RVU kind of
8 approach, just in general, is there's a whole bunch of new
9 services that primary care physicians are doing, a lot of
10 virtual things, and in the fee-for-service world, it
11 becomes quite hard to figure out how to pay for all of
12 these things in the fee-for-service world.
13 And so I am very sympathetic to your concerns
14 with gaming on attribution and a bunch of other things in
15 the partial cap model. So I guess I don't know. If we're
16 tweeting, I would like that, or maybe there's some other
17 thing. You can tell I can't pronounce that. I don't know
18 what I'm talking about. But the point is that resonates
19 with me a lot.
20 On the other hand, to go down a world where we're
21 trying to increasingly fee-for-service-ize a very
22 complicated way of which the physicians and the

1 nonphysicians that are interacting with patients in a
2 primary care setting, it seems really ill-suited to do
3 that. So it's not simply is how do we support primary care
4 doctors in this sort of financial way. It's really how do
5 we pay for an ever-changing, complex set of services that
6 don't lend themselves well.
7 MR. POULSEN: I totally agree with you, and if I
8 could just insert, that's why I think the idea of a global
9 capitation is such a beneficial way to provide primary
10 care. I think that's the right way to do it.
11 It's the partial cap that I think is very
12 difficult, because you start to define. Some physicians --
13 we all know them today. They're the ones that are happy to
14 make phone calls for which they're not paid today. It's
15 going to work because of their natural work ethic. For
16 others, it's going to not work, and creating all the
17 machinery to keep it fair between those two groups is, I
18 think, the thing that will make it difficult.
19 DR. CASALINO: Greg. if I may just ask, Greg,
20 global CAP for an organization or global cap for individual
21 primary care physicians?
22 MR. POULSEN: Global cap for an organization

1 which includes primary care physicians.

2 DR. CASALINO: Okay. But you would not advocate

3 global cap for individual --

4 MR. POULSEN: No. I think once you get to

5 individual anybodys, whether it's primary, secondary care,

6 I think it's subject to all kinds of abuse.

7 DR. CHERNEW: I'm going to move us along, but I

8 will say on this point, I think maybe we should think about

9 a foundational -- an APM model with a foundational

10 population-based payment is something to explore. That's a

11 bit of a joke since we did that.

12 [Laughter.]

13 DR. CHERNEW: You know it's a problem when you

14 have to announce your jokes. That happens to be more than

15 I care.

16 MR. POULSEN: Only to the newbies.

17 DR. CHERNEW: Are we still online? It's not

18 going so well.

19 Anyway, but yes. So I think -- yes. So we have

20 a notion -- we have done -- and I think there was a lot of

21 support in the Commission last cycle on a version of where

22 I think you were going, that some -- you called it "global

1 cap." We called it a "population-based alternative payment
2 model," but it's not --
3 MR. POULSEN: Right.
4 DR. CHERNEW: It works through primary care the
5 way we did it.
6 But, again -- yeah. So let's just keep going
7 through the set of comments, and I will try and be quiet.
8 MS. KELLEY: Stacie.
9 DR. DUSETZINA: Thanks for the great report,
10 Rachel.
11 So I've been -- just first for the options that
12 are laid out, I guess I also really had a slight preference
13 for Option 1 out of two options. I know that we don't have
14 to pick, but my disagreement with Option 2 was really
15 around the attribution and how challenging that would be.
16 It just felt like that was a lot of work that may send the
17 money to the wrong person potentially, and Option 1 just
18 seemed more appealing to me from that standpoint.
19 I think I really appreciated all the comments so
20 far from the other Commissioners and especially Betty's
21 comments, and I was thinking along the same lines of, you
22 know, what is the problem we're trying to solve here, and

1 in some ways, the setup of the chapter has really kind of
2 reminded me of the geriatric workforce piece where we all
3 ended up split because it's such a complicated problem.
4 It's like are we trying to incentivize people to come into
5 programs that maybe they're not -- they have all the
6 disincentives to do. And so, if we're trying to go down
7 that same path, I worry a little bit. We might get to the
8 same place of like it maybe feels too hard to fix it
9 through just some payment redesign.
10 But I did think, you know, the other thing is
11 having people feel really good about their jobs and that
12 they're working at the top of their skill sets, and I think
13 that that is one of the places where these potentially
14 increased payments for E&M -- the E&M fee schedule could
15 help and also going to, like, everybody on the team working
16 to the top of their skill set. So that includes the NPs,
17 PAs, basically everybody having better compensation for
18 this work.
19 But it did strike me as really hearkening back to
20 some of those concerns about workforce that are broader,
21 like of how to fix it, and I hope that we'll be able to get
22 there. It's just a tricky part, and I'm not sure that it's

1 always payment that's going to make the difference. At
2 least it's getting people into the workforce.
3 MS. KELLEY: Jonathan.
4 DR. JAFFERY: Thanks, Dana.
5 So echoing others' comments, this is great
6 chapter. I really love that we're working on this.
7 I do feel like maybe -- you know, I'm struggling
8 with that we've lost a little bit of the thread of what
9 we're trying to get to. So the purpose here is to try and
10 increase interest in primary care.
11 We've sort of laid out that trying to pay better
12 for that will be the key lever there, and then I'll come
13 back to that in a second, why I think that we should think
14 about maybe a couple other things.
15 I'm going to diverge a little bit from what my
16 fellow Commissioners are mostly saying, and I actually am
17 not crazy about Option 1 and actually think that we should
18 think about Option 2 a little bit more. And, again,
19 recognize these aren't mutually exclusive. I do think that
20 there's a revaluing of the fee-for-service system and RVU
21 system. So. to go to Greg's Option Zero, I know we've sort
22 of advocated for that before. It hasn't gotten a lot of

1 traction, or if it has, it hasn't worked very well. But
2 that doesn't mean that it's the thing, and I think
3 Commission has a long history of having to repeat itself
4 and wait, be patient until something gets adopted.
5 So maybe there's a way to update and be a little
6 more -- put a little more force behind how that should
7 happen, but I think that to me is a better way to get at
8 trying to reconcile the differentials between specialty
9 care and primary care payment that have occurred through
10 our RVU system.
11 Rather than creating another additional, more
12 complicated, in my mind, separate track of fee-for-
13 service, which does just propagate the fee-for-service
14 system -- and that's my problem and my biggest issue with
15 Option 1. To me, while it might get to some better payment
16 for primary care, it still is sort of putting the primary
17 care docs on this treadmill to get there.
18 I think about Option 2, I can appreciate some of
19 the issues Greg and others have brought up about the
20 potential gaming of some sort of partial capitation. But I
21 do think, for one, that moves us further towards
22 population-based payments than another fee-for-service like

1 Option 1 seems to be more similar to.

2 And I also think there's gaming that goes on,

3 anyway. I'm not sure that there isn't already incentive

4 for somebody just to refer out rather than dealing with the

5 problem, whether or not they're getting a capitated payment

6 or not.

7 So, in terms of -- and one other thing I like

8 about it -- and you brought up the piece about adjusting

9 for risk -- this ties back to this morning's conversation.

10 That could be social risk. That does not have to be, you

11 know, HCCs. So if we're adjusting for that payment, that

12 whatever per-beneficiary, per- month payment or whatever it

13 is for social risk, that very much gets to the dynamic that

14 Dana described where we're paying up front for people

15 because it's more difficult to take care of them and not

16 trying to sort of mask disparities that exist.

17 I think one of the things that people have

18 brought up has been about attribution, and I think that's a

19 fair point. We've talked in the chapter about asking

20 beneficiaries for their usual source of primary care,

21 annually or whatnot. I've advocated for this, I think, my

22 entire time on Commission that that's something that we

1 should be able to do, that people, by and large, they do
2 that. For commercial insurance, they actually pick a
3 primary care doc. That happens all the time. So I don't
4 think that's as big a problem as sometimes we've said it
5 is, even though I know that there are some beneficiaries
6 and others who may push back against it. That doesn't mean
7 it's not the right thing to do, and that would help deal
8 with that attribution question.
9 The final comment I'll make is getting to that
10 work/life balance where, on whatever slide it was, that was
11 one of the biggest factors, and I agree that clearly --
12 and, Jim, you pointed out that the data shows that even in
13 med school, people are concerned about the payments, the
14 compensation differential.
15 There is more to this than work/life balance.
16 There's more to work/life balance than just pay, and I
17 guess I worry that by just saying that we're going to pay
18 people more so that they can hire staff because the tasks
19 that primary care docs and other providers have to do -- or
20 primary care providers -- excuse me -- has become so
21 difficult and onerous and unpleasant that they don't want
22 to do it anymore isn't really addressing the problem.

1 So, at the end, I guess thinking a little bit
2 more about what -- and maybe even there's an opportunity to
3 do some focus groups about what is the work/life balance,
4 and I suspect it's a lot more about some of the things that
5 are keeping people working after dinner, about the EMR. We
6 actually know there is some data about that, about things
7 along those lines that we can't simply just pay for, and
8 again, I don't know that paying people to hire more staff
9 to deal with those things is necessarily the right
10 approach.
11 So I'm starting to ramble. So I'm going to stop,
12 but thanks. This has been a great discussion.
13 MS. KELLEY: Kenny.
14 MR. KAN: Like Lynn and Betty, I'm a plus one on
15 this framework being also applied to NPs and PAs.
16 I'm leaning towards Option 1 with potential
17 reward modifiers for SDO because due to this multiplier
18 effect and to help mitigate health care disparities.
19 MS. KELLEY: Amol?
20 DR. NAVATHE: Thanks, Rachel, for this fantastic
21 work. I think another really fundamentally important
22 aspect of the Medicare program to consider.

1 I have a few comments here. I really like
2 Jonathan's point, which is we should be very clear about
3 what we're trying to accomplish here, and I think there a
4 milieu of different potential objectives, and I think they
5 take us in potentially different directions, and they also
6 potentially highlight that neither of these options may
7 actually get us fully to where we want to go because likely
8 many of these issues are multifactorial.
9 Just listening I've heard issues of PCP, primary
10 care physician attrition being an issue that we're trying
11 to solve for. There is a notion of trying to sort of
12 protect PCPs within the E&M RVU-based system that we have.
13 There are issues of equality that have come up between PCPs
14 and specialists. There is trying to improve how primary
15 care works, potentially from a kind of capacity to taking
16 care of patients perspective that is a potential objective,
17 underlying objective here. And then there is a shift
18 toward a system that's more ready for APMs.
19 So there are potentially many different goals
20 here, and I think it makes it complex, in some sense, to
21 pick a policy option, because it depends on which of these
22 you feel are the most important. I think kind of a subtext

1 to many of our comments may, in fact, be what we, as
2 Commissioners, think we are trying to accomplish as the
3 most important goal.
4 I would say, at least the way I've been thinking
5 about this in some sense, is at this juncture, given Mike's
6 framing that this is a step one in the process, it may make
7 a lot of sense to pursue both options simultaneously right
8 now. I think Greg's Option Zero also is a nice one,
9 although I think historically has proven to be fairly
10 challenging.
11 So alongside that I certainly would say Option 1
12 is important, and I think it does accomplish some of the
13 goals, perhaps even without having added dollars put into
14 the pool. Even if we think about just essentially a
15 mechanism to rebalance the fee schedule, especially set up
16 the system in a way that as RVUs evolve over time, that
17 we're not anchored to a system that's always going to
18 essentially be value E&M.
19 And so it's a pretty fundamental structural
20 change that protects the diagnostic, nonprocedural
21 specialists, primary care certainly being chief amongst
22 them, but then also others that seems like a very important

1 thing that we can do, even if it doesn't solve all of our
2 problems, because it at least shifts our current system in
3 the direction I think that probably many Commissioners
4 would likely support.

5 So I think in some sense of it as improving the
6 current system, given that we have the current system and
7 we're probably not going to chuck it overnight.

8 The second point around the population-based
9 payment for a second option, I think personally I would
10 feel that it is important to continue to pursue for many of
11 the reasons that Jonathan highlighted, that we're broadly
12 speaking, I think, at MedPAC, trying to move toward a
13 system that creates more accountability, that's building
14 more capacity infrastructure at the primary care level.

15 I agree with Lynn that CPC+ results weren't as
16 fantastic, but that was an APM construct and this is not
17 quite an APM construct here, in some sense.

18 I agree with some of the practical challenges on
19 attribution and potential gaming. I think those are
20 important challenges for us to be thinking through.

21 But I think rather than admit defeat at step one
22 it makes sense to try to push through and say what could

1 this look like and what do we worry about, then, as some of
2 the practical challenges? But it becomes a practical
3 challenge that's highly related and correlated to our APM
4 work of how would we create a national APM structure for
5 the entire Medicare program? And this seems like primary
6 care -- this being primary care -- it seems like a great
7 place for us to start chewing on that, because we do, I
8 think, from the prior work the Commission has done, feel
9 like that's the direction that we do want the whole
10 Medicare program to be going.
11 And so I think not pursuing Option 2 is a missed
12 opportunity for us as a Commission and potentially, in the
13 long run, for the Medicare program as well.
14 The third point I wanted to make is I wanted to
15 support Betty's point that I think we should more
16 explicitly call out that while this is framed in the
17 context of primary care physicians that primary care is
18 more inclusive, from a workforce perspective, than primary
19 care physicians. That becomes really important for us to I
20 think explicitly articulate as part of any of the primary
21 care workforce issues as we go forward. Thanks.
22 MS. KELLEY: Okay. I have Robert next, so I will

1 read his comment.

2 "Excellent report. Thank you. I support the
3 idea of exploring the two conceptual policy approaches that
4 aim to raise Medicare payments to primary care clinicians.
5 I believe this is a promising step forward in addressing
6 the gaps in primary care.

7 "I wanted to take this opportunity to make three
8 points that speak to the complexity of this problem.
9 First, I think it's important that we clearly define what
10 we mean by primary care. In my mind, when I think of
11 primary care services, this includes the fields of general
12 internal medicine, family medicine, pediatrics, medicine
13 pediatrics, obstetrics and gynecology.

14 "Second, for these primary care services to be
15 successful, especially when practicing in areas with
16 insufficient access to health care, we may need to address
17 the presence of basic clinical support services, such as
18 general radiology for plain films and ultrasound or
19 telehealth services for specialty support and consultation.

20 "A point of frustration and burnout among primary
21 care physicians is the degree of difficulty in formulating
22 treatment plans when these services are not readily

1 available. Of course, we could address these deficiencies
2 separately through other policy proposals.
3 "Third, a highly effective strategy to
4 incentivize medical students to enter primary care
5 physicians is through expanded and robust loan forgiveness
6 programs. Unfortunately, this appears to be outside of the
7 scope of MedPAC.
8 "Otherwise, I look forward to future analysis and
9 discussion on this topic."
10 And I have Scott next.
11 DR. SARRAN: Yeah, so I want to quickly weave
12 together what I think are three themes that in my mind lead
13 towards Option 2, some of which we've heard. First is we
14 don't just want more PCPs, the second is it's not just
15 about the money, and the third is it's not just about fee-
16 for-service Medicare and isolation from MA.
17 So we don't just want more PCPs. What we want is
18 more PCPs doing better chronic disease care, right?
19 Because if all we wanted was primary care access, CVS and
20 Walgreens are fine for that. What we want is better
21 chronic disease care.
22 It's not just about the money. Slide 4

1 reinforces there are multiple reasons why people don't
2 choose PCP as a career. You can take, I think, all the
3 non-financial ones and lump them together as professional
4 experience and professional satisfaction.
5 And not just about fee-for-service Medicare.
6 Most PCPs today don't experience Medicare as just a fee-
7 for-service Medicare provider. They experience Medicare
8 downstream from their MA-contracted relationships as well
9 as fee-for-service Medicare.
10 So I think we need to take all of that together,
11 what we've learned -- and this reinforces Betty's earlier
12 points -- what we want is team-based primary care, that
13 Greg, as you keep reminding us, is not going to occur.
14 We're not going to transform that under a fee-for-service
15 payment structure.
16 And although a complex approach to capitating
17 PCP, such as CPC+, is challenging to execute, manage, and
18 reap the benefits of, if we think about it not in isolation
19 as an APM but rather as an enabling vehicle to take PCPs
20 who today have one foot on the dock and one on the boat --
21 so the dock is fee-for-service Medicare grinding out people
22 with billable CPT codes, and their foot on the boat is

1 their relationships with MA, which are moving towards, if
2 they haven't already, towards some type of capitation and
3 accountability.
4 And so in my mind it's not that Option 2 has to
5 be perfect. It just needs to be directionally consistent
6 with where PCPs are already going with their MA
7 relationships and wanting to go in terms of building team-
8 based chronic care-oriented practices.
9 So that's, in my mind, why I'd rather go,
10 understanding that it's not perfect, with an Option 2.
11 And the last comment I'll make is if we go down
12 the road of whether it's a pure Option 2 or a mix of Option
13 2 and Option 1 and/or Zero, let's try to keep in mind the
14 keep-it-simple principle, because this is, I think, more
15 about being directionally correct than being perfect. It
16 doesn't matter, I don't think, if the attribution is
17 correct plus-minus 10 percent. Who cares? It's
18 directionally correct.
19 I wouldn't do HCC-type complexity stuff. Maybe a
20 simple count of the number of chronic disease codes, per
21 beneficiary, per year, sort one or two versus anything more
22 than two, something like that. The point is I think there

1 are ways to keep it simple and still be meaningful and
2 directionally correct with where we want things to be
3 going.
4 MS. KELLEY: Jaewon.
5 DR. RYU: Thank you, Dana, and thank you, Rachel.
6 I thought the chapter was excellent. In particular, I
7 really liked that you included the description about the
8 flaws of the RVU model and so forth. I think that's
9 something that impedes many areas of progress, and I don't
10 know that we spend enough time actually talking about all
11 the ways that that's inherently flawed. I think this
12 chapter did a great job of that, so thank you for that.
13 I'd love to see us explore both options further.
14 I think both have very compelling features but also some
15 things I, at least, get snagged on.
16 I also think maybe before even getting to the
17 options I think this is a very long journey to try to
18 correct us, because if you think about some of the dynamics
19 of what keeps people from going into primary care -- and I
20 think the chapter hit on many of those aspects -- but some
21 of them are cultural, and it's very tough to get a firm
22 handle on things that are cultural. And cultural things

1 also tend to be very deeply rooted, and I think it gets to
2 the environments in which we're training future physicians,
3 some of the dynamics around academic medical centers. Many
4 of the teaching environments have sort of longstanding,
5 almost quasi-tradition levels of culture, and I think
6 uprooting and sort of resetting that will take time.
7 I think part of it is also wrapped up in the
8 dynamic between fee-for-service and value-based payment
9 models. You know, your typical tertiary academic medical
10 center that has tons of GME programs, training many of
11 these future potential primary care specialty folks, you
12 know, it's tertiary care. It's fee-for-service heavy, on
13 average, and I think that plays into some of the dynamics
14 that you describe in the chapter.
15 Given all of that, I think it's important to at
16 least take a first step and start moving in the right
17 direction. Between the two, I'd probably lean a little bit
18 towards Option 1, but I like a lot of the features of
19 Option 2, frankly. But maybe I'll just list some of what I
20 thought.
21 I really like that Option 1, to me, seems
22 simpler, and it's also got the added benefit of flowing

1 through to MA payments. So I think there is a compounding
2 effect of what it could industry-wide.
3 On the Option 2 front, I do think there is huge
4 value in sort of incorporating some risk adjustment aspect.
5 I like that it is sort of a step towards population health.
6 There are a lot of things that you would want good primary
7 care to do that doesn't reflect in any RVU. But call these
8 other medical services or what have you, other social
9 services, you'd want some recognition of that, and I think
10 Option 2 does a better job with that.
11 But ultimately, I think the part on Option 2 that
12 is tricky, and probably more complicated, is around the
13 attribution piece. There are many folks -- and I think
14 we've talked about this in prior discussions -- many
15 specialties that deliver primary care-esque services, and
16 especially the most complex patients that are probably
17 jointly or co-managed by multiple physicians and other
18 members of the care team, that it's tough to parse out who
19 would get the PCP cap.
20 And so I think that would be very prone to
21 gamesmanship. We've seen that in even attribution models
22 around the MSSP program, and I think it would complicate

1 things there.

2 But it's also a model you wouldn't want to

3 discourage the cardiologists or the nephrologists or

4 whoever from having a role in that primary care model. And

5 so I think that's the tricky part of Option 2, but

6 certainly not insurmountable. It just needs more fleshing

7 out and exploration.

8 MS. KELLEY: Cheryl.

9 DR. DAMBERG: So I agree with a lot of the

10 comments that have already been made by my fellow

11 Commissioners.

12 I do think, as Jaewon noted, we are at the very

13 early stages of playing this out, and this is pretty

14 complicated. So, you know, I'd be interested in seeing

15 kind of more meat on the bones around both options.

16 The second option struck me as more complicated

17 and also potentially more opportunities for gaming. So I

18 think as you think through some of the details for Option 2

19 I think it would be helpful to understand what kinds of

20 things could be put in place to mitigate those

21 opportunities for gaming, whether it's around attribution,

22 risk adjustment, and determining whether you are switching

1 your primary care specialty.
2 And one of the questions that I had, that I
3 didn't see referenced, that we've talked about, say, for
4 the hospital setting, is application of safety net index to
5 try to account for greater resource needs for certain types
6 of patients, and whether there's some opportunity to weave
7 that type of concept into this exploratory work.
8 And then to kind of underscore Greg's initial
9 point, I do think we need to keep emphasizing the need to
10 revisit the RVUs and kind of rebalancing on that front,
11 while we search for a better model.
12 MS. KELLEY: Dana.
13 DR. SAFRAN: Yeah, thanks. And really great work
14 on this, Rachel, and interesting to know that David and I
15 will be gone when the recommendation comes out. So
16 hopefully whoever comes in this seat after us can have some
17 great ideas.
18 But I'll just make a couple of comments. One is
19 on this question of the problem that we're trying to solve,
20 I think there are two that we've pointed to. One is
21 problems with respect to having adequate primary care
22 workforce, and the other is a kind of inequity in pay. But

1 I hear us sort of leaning towards the first as really the
2 problem we're trying to solve, and I think I'll just add my
3 voice to those who have kind of expressed that money is not
4 going to solve that problem, that there are so many other
5 contributors.
6 And I can just add a little color to that to
7 share. Yesterday I had the good fortune to be speaking on
8 a panel with a bunch of health ministers from some European
9 and Asian countries. And we were in the speakers' room
10 having just some conversation ahead of time, and workforce,
11 of course, came up. And every one of them was talking
12 about the workforce challenges, including that they have
13 inadequate primary care supply relative to specialty
14 supply. And these are countries that, you know, fully pay
15 for medical school and do all kinds of interventions.
16 So I think there's just so much more, and several
17 of you have pointed to the other issues, including that
18 when young doctors are in medical school people tell them,
19 "You're too smart to go into primary care." So we're not
20 going to solve that with $30,000 more dollars a year.
21 A second point is in terms of the options, I
22 really resonated with Jonathan's comments about Option 1

1 feeling like it kind of doubles down on fee-for-service,
2 which was probably why I hadn't really been liking Option
3 1. And I had been liking Option 2. Greg's comments were
4 sobering about the gaming, so we'd really have to think
5 about that.
6 And one of the things I liked about it was the
7 patient attribution, and maybe a way to get around the
8 gaming is that only the patients can attribute themselves
9 by declaring, and maybe at the rear. But I did like the
10 population aspect of that, but don't mistake that for me
11 saying I'd like to go ahead and do capitated payment for
12 primary care, because like I said at the outset, I don't
13 think throwing money at this is going to solve it. I just
14 like the idea of getting patient attribution into Medicare.
15 I really liked -- who first brought this up? --
16 the RVU fix. Was that you, Greg? Option Zero? Yeah. I
17 really did kind of like that. Betty's point about, you
18 know, possibly a multiplier for complexity had some appeal,
19 but my worry there is how do we do that without creating
20 gamesmanship about coding. So we'd really have to think
21 hard about that.
22 But it does strike me that Option 1 and Option 2

1 are kind of lipstick on the pig, because the underlying
2 problem really is the RVUs being so broken.
3 So I wish I had a good Option 3 to put on the
4 table but I'm afraid that I don't, so I wish you better
5 luck on the next round of Commissioners.
6 DR. CHERNEW: We're about at time. I know Larry
7 wants to speak. I know Amol and Kenny want to speak,
8 except you've already spoken, so we'll see how time goes.
9 [Off-record remark.]
10 DR. CHERNEW: Okay, there you go. So we'll see
11 where we are, but I do want to say one thing. The big
12 difference between Option 1 -- I'm not going to use your
13 analogy, but Option 1 I think does have this issue that
14 we're trying to adjust for the fact that we have a problem
15 with the way budget neutrality is applied in RVUs. I think
16 that's basically the subjects here, and I think you're
17 basically right.
18 Option 2, per Amol's earlier comment, addresses a
19 range of issues only some of which relate to RVU
20 mismatching. It relates to a whole bunch of other things
21 that are challenging that arise. So, anyway -- well, I
22 should have been quiet until we get to the end. Larry, you

1 go.

2 DR. CASALINO: First of all, Rachel, great job,
3 as you can see from the discussion.

4 Second, I'd say I think it has really been a good
5 discussion. Of all the meetings I've been to of MedPAC,
6 this is one where the most, I thought, person after person,
7 sentence after sentence, I thought, yes, yes, yes, yes,
8 yes, yes. But then it turned out that they disagreed with
9 the person who always said yes, yes, yes.

10 [Laughter.]

11 DR. CASALINO: But it really has been a good
12 discussion, and probably because of that, my thoughts are
13 less organized than they were before we started. I will
14 say that -- I'll just repeat as a primary care physician
15 that, yeah, it's way more than just money. And Dana's
16 right. I mean, when I was leaving medical school, the
17 faculty who liked me said, "You're too smart to go into
18 primary care," literally, and the ones who didn't like me
19 didn't say it quite as literally, but gave the strong
20 impression that, "That's about right for someone like you."

21 DR NAVATHE: I was going to say nobody said that
22 to me.

1 [Laughter.]

2 DR. CASALINO: And, Mike, I know we're at time.
3 Just one main reason to be in primary care, one of the
4 factors that hasn't been mentioned too much, and that's why
5 I want to mention it, in terms of going into primary care
6 or not, if you don't have time to talk to patients, there's
7 no sense being a primary care physician. And there's so
8 many things that take away from that. Prior auth. hasn't
9 been mentioned. In our seven-physician practice, two of
10 our highest paid employees did nothing but get prior
11 authorization, most of which benefitted the specialists.
12 It didn't provide income for us.

13 The other thing is this is before -- prior to my
14 years of practice, but before EMTALA, managed care
15 companies required prior authorization before a patient
16 could be treated in an emergency room. So every time I was
17 on call, you know, once every six days or so, I would get
18 multiple calls at night from the emergency room saying,
19 "Your patient Dana Safran is here with chest pain. May we
20 have permission to treat?" Right? It wasn't really Dana,
21 but --

22 [Laughter.]

1 DR. CASALINO: So, I mean, is that stupid or
2 what? Every primary care physician in the country,
3 multiple times, every time they're on call, probably not
4 one of them ever said, "No, don't treat my patient. Send
5 them home." So this is the kind of thing that makes people
6 not want to go into primary care. Okay. So --
7 UNIDENTIFIED: Hassle factor.
8 DR. CASALINO: Yes. I think Greg was right to
9 bring up Option Zero, and I think there probably should be
10 more explicit discussion of that. And my response would
11 be, I guess, people have been saying -- there's books,
12 there's articles, there's MedPAC recommendations -- forever
13 that the RVUs should be fixed, which means fixing the RUC.
14 I think it's a safe bet to say the RUC is not going to get
15 fixed. CMS would have to say, "No more RUC, we're going to
16 do this a different way," or a completely revised RUC.
17 One potential -- but I do think the Option Zero
18 thing, whether it says what I say or not, should be
19 addressed specifically, because it is an option. It's the
20 default option right now.
21 One benefit that hasn't been mentioned
22 potentially of Option 1 would bring -- it would bring out

1 the thing that primary care specialists struggle over,
2 income, into the open, right? Right now it happens all
3 within the RUC where primary care physicians are completely
4 outnumbered and it's hopeless, right? And the most
5 powerful specialties kind of get what they want. That's
6 why things don't get revalued.
7 Some version of Option 1 with two different E&M
8 panels, so to speak, for different kinds of physicians,
9 this -- there would still be a struggle about who's going
10 to get the money, but in this case, it would be a very
11 public struggle. And I think it would be fairer that way.
12 Okay. People have mentioned this. It
13 strengthens the fee-for-service system and rewards
14 physicians who do more Option Zero or Option 1.
15 Option 2, as people have said, is much more
16 complicated. I'm not too sympathetic, the arguments to
17 attribution is a major obstacle. They're really using
18 attribution for ACOs, for example, albeit to an ACO and not
19 -- well, let me stop and leave it at that. But I think
20 there are ways of doing it and asking patients once a year,
21 "Who's your primary physician?" It costs Medicare some
22 money, but it could and should be done, and it would help -

1 - it could be done for ACOs or primary care physicians or
2 both, depending on if the physician is a primary care
3 physician. Some patients aren't going to designate anyone,
4 and they can then just be attributed by the standard claim-
5 based measures. Not too much more, Mike.
6 Option 2 is a way to move toward population-based
7 care, away from fee-for-service-based payment. And it
8 could possibly be designed -- and, Greg, this may be
9 impossibly complicated. I don't entirely agree that in
10 partial capitation that physicians would have an -- would
11 just refer everybody, because you can do that even in fee-
12 for-service, right? You can refer every -- and it is done.
13 You can refer every complicated patient so you can see more
14 patients in a day. So fee-for-service doesn't really solve
15 that problem. It's just more visible in partial
16 capitation. But John Newhouse recommended this like 30
17 years ago, which is if you had partial cap/fee-for-service
18 payment, you could try to set the partial cap and the fee-
19 for-service payment so that a physician was kind of
20 indifferent about whether they provide a fee-for-service
21 visit, whether telehealth or in person, or not. Right?
22 It's enough so that you're not losing money by doing it,

1 but you're not making a lot either. And this would require
2 a pretty large per bene/per month cap payment and a much
3 smaller fee-for-service payment.
4 Option 2, the last thing I'll say, would not help
5 non-procedural specialists, though -- or it might not,
6 depending on how the attribution was done, I guess. And
7 Option 1 would. I'll stop there.
8 DR. CHERNEW: Kenny, are you super, super, super
9 quick since we're late?
10 MR. KAN: Super quick. I just wish to clarify my
11 earlier remarks on Option 1 leaning, but I had something
12 stuck in my throat previously. So I agree with Jaewon that
13 this is a very long journey. Can this be a two-step
14 journey? So over the next one or two years we look at
15 initial Option 1 while fostering Option 2 for its
16 simplicity and multiplier effect and then, thereafter, you
17 know, that way I'm hoping that we can actually address
18 something while giving MedPAC, and then Option 2, can claim
19 a win, you know, Option 2 longer term over the next three
20 to five years it is a really huge lift to address the
21 various attribution concerns.
22 DR. CHERNEW: I think -- yeah, right. So we're

1 going to now -- we are over by a few minutes. We're going
2 to take a three-minute break instead of a five-minute
3 break, and that's going to put us only five minutes behind.
4 So remember all of this when you get to your Round 1
5 questions, by the way, because I am -- as the day goes on,
6 I am going to get stricter at the end of the comments when
7 you want to -- you know.
8 So, Rachel, thank you. That was terrific. And
9 we're going to come back in three minutes, and I think,
10 Dan, you're going to be presenting on site-neutral work.
11 So we're just taking three minutes to do a switch-over, and
12 it's going to be 3 minutes.
13 [Recess.]
14 DR. CHERNEW: Welcome back. That was our five-
15 minute, three-minute break.
16 And I think now we're going to start with another
17 topic of great MedPAC interest and substantial work, and
18 we're going to turn it over to Dan who's going to discuss
19 site-neutral payments.
20 So, Dan, you're up.
21 DR. ZABINSKI: Thank you, Mike.
22 All right. To start, the audience can download a

1 PDF version of the slides for this presentation on the
2 handout section of the control panel that's on the right-
3 hand side of your screen.
4 From 2012 to 2014, the Commission evaluated the
5 effects of aligning payment rates for services provided in
6 hospital outpatient departments with payment rates for
7 physicians -- payment rates for services provided in
8 physician offices.
9 At the November 2021 and April 2022 meetings, we
10 presented an analysis that built on the Commission's
11 previous work, and we published that work in the June 2022
12 report.
13 Our goal today is to review these previous
14 findings and provide a platform for developing draft
15 recommendations for this coming spring.
16 Okay. In fee-for-service Medicare, there's
17 distinct payment systems for the three ambulatory settings:
18 the physician offices; hospital outpatient departments, or
19 HOPDs; and ambulatory surgical centers, or ASCs. And the
20 payment rates often differ for the same service in these
21 three settings.
22 In particular, the outpatient perspective payment

1 system, or OPPS, which is the payment system for most HOPD
2 services, typically has a higher payment rate than the
3 physician fee schedule and the ASC payment system for most
4 services.
5 And the primary concern about these differences
6 in payment rates among the ambulatory settings is that they
7 result in providers in higher-cost settings, acquiring
8 providers in lower-cost settings, then billing at higher
9 rates. For example, hospitals can consolidate with
10 physician practices and convert them to provider-based
11 apartments.
12 Hospitals can then bill for the physician
13 services at the usually higher OPPS rates, with little or
14 no change in the site of care.
15 In recent years, hospital acquisition of
16 physician practices has led to the billing of office
17 visits, echocardiography services, cardiac imaging
18 services, and chemotherapy administration shifting from the
19 physician fee schedule to the OPPS. And this shift to
20 services increased Medicare program outlays and
21 beneficiaries' cost-sharing obligations.
22 The Congress passed the Bipartisan Budget Act of

1 2015 to more closely aligned the OPPS payment rates with
2 the physician fee schedule rates, but the impact of this
3 policy has been limited.
4 This table shows how hospital acquisition of
5 physician practices has shifted the billing of services
6 from offices to HOPDs. From 2012 to 2021, you can see that
7 the share of office visits, chemotherapy, cardiac imaging,
8 and echocardiography that were provided in HOPDs increased
9 substantially. I note that these are just a subset of the
10 services in which billing has shifted from offices to
11 HOPDs.
12 Also, this shift of services illustrates the need
13 to align payment rates across the ambulatory settings.
14 So it would be easy just to simply set the OPPS
15 and ASC payment rates to the physician fee schedule payment
16 rates and say that we're done, but these sites of care have
17 important differences that we have to consider. First,
18 some services that are provided in HOPDs can't be provided
19 in offices or ASCs because they're not covered under the
20 physician fee schedule or the ASC system. The most obvious
21 of these are ED visits, but there's also relatively complex
22 services such as lumbar spine fusions that are covered

1 under only the OPPS. And these services must continue to
2 be paid at the standard OPPS rates.
3 Another issue is that the OPPS and the ASC system
4 have more packaging of ancillary items in their payment
5 units than does a physician fee schedule, and we have to
6 account for this additional packaging when aligning payment
7 rates.
8 And, finally, we should align payment rates
9 across settings only if it's safe and reasonable to provide
10 the service in the lower-cost settings for most
11 beneficiaries.
12 Now, another relevant issue is that some have
13 argued that patient severity should be accounted for when
14 aligning payment rates across settings, because sicker
15 patients could increase the cost of providing care.
16 So we investigated this doing a regression
17 analysis that estimated the relationship between a
18 beneficiary's Charson Comorbidity Index, or CCI, which is
19 the measure of health status, and HOPD charges for services
20 for which we did align payment rates across ambulatory
21 settings. And we found that the relationship between
22 beneficiary CCI and the level of HOPD charges was weak.

1 Specifically, for all services that we evaluated, in no
2 instance would a 10 percent increase in a beneficiary CCI
3 increase charges by more than 1 percent. So from that
4 result, we conclude that, in general, adjustments for
5 patient severity are not needed for an effective system of
6 aligning payment rates.
7 Then we identify the services for which we think
8 it's reasonable to align payment rates across the
9 ambulatory settings by collecting services into ambulatory
10 payment classifications, or APCs, which is the payment
11 classification system for payment in the OPPS.
12 APCs are collections of services that are similar
13 in terms of cost and clinical attributes. For each APC, we
14 determined the volume from 2016 through 2019 in each of the
15 ambulatory settings. If we found that offices had the
16 highest volume in any year from 2016 through 2019 for an
17 APC, we aligned the OPPS and ASC payment rate with a
18 physician fee schedule rate for that APC with an addition
19 for greater packaging under the OPPS and the ASC payment
20 system.
21 But if we found that ASCs had the highest volume
22 for an APC, we aligned the OPPS payment rate with the ASC

1 payment rate, but we kept the physician fee schedule rate
2 the same.
3 And, finally, if we found that HOPDs had the
4 highest volume form in APC, we made no change to the
5 payment rates in all three settings.
6 So, on this slide, we have an example why
7 Medicare payments are usually higher when a service is
8 provided in an HOPD than in an office and how we align the
9 payment rates across these settings.
10 The service in this example is a level 2 nerve
11 injection. The first column shows the payments that
12 Medicare makes if the service is provided in an office. We
13 add the payments for physician work, non-facility practice
14 expense, or PE, and professional liability insurance, or
15 PLI, to get a total payment in the office of $256.
16 In the second column, we show the payments that
17 Medicare makes if the service is provided in an HOPD. As
18 we did in the first column, we had the payments for
19 physician work, facility PE in this case, and the PLI, but
20 we also add the OPPS payment to the hospital to get a total
21 payment in the HOPD of $701 for the same service.
22 Then in the third column, we adjusted the OPPS

1 payment so that it equals the difference between the non-
2 facility PE from the first column and the facility PE in
3 the second column, resulting in a smaller payment to the
4 HOPD of $154 in the third column.
5 Making this adjustment to the OPPS reduces the
6 total payment for the service provided in the HOPD to $254,
7 which is the same as a total payment in the physician
8 office that we saw in the first column, and we used this
9 concept of the difference between the non-facility PE and
10 the facility PE as the basis for aligning payment rates
11 across the three ambulatory settings.
12 Okay. So the OPPS has 169 APCs for services and
13 a lot more for drugs and devices, but we're focusing on
14 services today. Using the methods that we've discussed;
15 we've determined that it's reasonable to align the payment
16 rates for 68 of those service APCs. We specifically
17 identified 57 APCs for which we aligned OPPS and ASC
18 payment rates with the physician fee schedule payment
19 rates.
20 These APCs constitute 22 percent of the total
21 spending under the OPPS and 11 percent of the total
22 spending under the ASC system. Most of these APCs are low-

1 complexity services, such as office visits and x-rays.
2 We also identified 11 APCs for which we thought
3 are reasonable to align the OPPS rates with ASC rates.
4 These APCs constitute about 4 percent of the total spending
5 under the OPPS.
6 And, finally, we did not align the payment rates
7 for the remaining 101 service APCs.
8 So, for the 68 APCs for which we more closely
9 align the payment rates across the three ambulatory
10 settings, if the changes in payments for aligning the
11 payment rates were taken simply as savings, under the OPPS,
12 cost sharing would decrease by $1.7 billion, and program
13 outlays would be lower by $6.6 billion.
14 Under the ASC payment system, cost sharing would
15 decline by $60 million and program outlays by $230 million.
16 But under current law, CMS is required to offset the
17 changes in payments by increasing the OPPS payment rates
18 for the other 101 APCs, for which we would not align
19 payment rates to produce a budget-neutral result.
20 On this table, we show that percent change in
21 total Medicare revenue for various hospital categories from
22 the payment alignment policies that we presented coupled

1 with the current law budget neutrality adjustment that CMS
2 would use. By definition, the net effect on total Medicare
3 revenue for all hospitals is zero, as indicated in the top
4 row, but rural hospitals would have a decrease in total
5 revenue of 2.3 percent, while urban hospitals would
6 experience a revenue increase of 0.2 percent.
7 Also, government hospitals would have a total
8 revenue decrease of 0. Percent, while nonprofit and for-
9 profit hospitals would have little or no change in their
10 total Medicare revenue.
11 One alternative to using the pool of money from
12 the lower payment rates in a budget neutrality adjustment
13 would be to use that pool of money instead as savings to
14 Medicare and beneficiaries. This option would reduce
15 program outlays by $6.6 billion and beneficiary cost-
16 sharing obligations by $1.7 billion each year. But this
17 alternative would require congressional action, as the
18 budget neutrality adjustment is current law.
19 And one concern we have about using the lower
20 payment rates from the payment rate alignment policies as
21 program savings is that hospitals would have lower Medicare
22 revenue. Losses in Medicare revenue for some of these

1 hospital categories could adversely affect access to care
2 for vulnerable populations.
3 A particular concern is that the effect would be
4 stronger on the revenue for rural hospitals relative to
5 urban hospitals because the low-complexity services for
6 which we align payment rates are the largest share of this
7 whole Medicare revenue for rural hospitals relative to
8 urban hospitals.
9 Specifically, we found that rural hospitals would
10 have a decrease in total Medicare revenue of 6.9 percent,
11 while urban hospitals would have a smaller decrease of 3.8
12 percent.
13 In addition, the nonprofit and government
14 hospitals would both have larger decreases in total
15 Medicare revenue than for-profit hospitals.
16 So, in response to these potential losses in
17 revenue for the safety-net hospitals, a second alternative
18 is to focus part of the effects of the lower payment rates
19 on hospitals that serve vulnerable beneficiaries. We
20 considered a temporary stop-loss policy that would
21 accomplish that goal. For illustrative purposes, we used
22 DSH percentages to identify hospitals that serve vulnerable

1 populations. The specific stop-loss policy that we
2 evaluated would limit the loss from two payment rate
3 alignment policies that we discussed to 4.1 percent of the
4 total Medicare revenue if the hospital also had a DSH
5 percentage above the median dish of 28.1 percent.
6 And at this point, I want to be clear that this
7 stop-loss policy would be a temporary policy. In no way
8 would this stop-loss policy substitute for the work on
9 supporting safety-net hospitals that my colleagues will be
10 discussing tomorrow.
11 Then, on this table, the first column shows the
12 combined effects for several hospital categories of the
13 payment alignment policies without any budget neutrality
14 adjustment, and these are the effects that we saw two
15 slides ago.
16 Now, the second column shows the effects of
17 adding the temporary stop-loss policy from the previous
18 slide. Rural hospitals would still have a larger decrease
19 in total Medicare revenue than would urban hospitals, but
20 the difference in revenue loss between the urban and rural
21 hospital categories would be smaller with the stop-loss
22 policy than without it.

1 Also, the difference in revenue loss between the
2 nonprofit and government versus the for-profit hospitals
3 would be smaller with the stop-loss policy than without it.
4 So far, we've talked about a lot of complicated
5 issues, and we've shown you a lot of numbers. At this
6 point, I want to focus on the purpose of this analysis.
7 One thing is that we want to address the
8 principle that Medicare and beneficiaries should not pay
9 more than necessary for ambulatory services.
10 Then, second, we want to reduce incentives for
11 providers to consolidate, which typically leads to the
12 billing of services shifting from lower-cost settings to
13 higher-cost setting. And the potential impacts of the
14 aligning the payment rates are substantial.
15 Now, once again, under current law, CMS is
16 obligated to use the pool of money that would result from
17 aligning payment rates to increase the OPPS payment rates
18 for the 101 APCs for which we would not align payment
19 rates, which these services include things such as ED
20 visits and complex surgical procedures, and making this
21 budget-neutral adjustment would help hospitals maintain
22 their standby capacity.

1 But there are possible alternatives to the
2 current law, including using the funds to lower program
3 outlays and beneficiary cost-sharing obligations or using
4 the funds for temporary policies to support safety-net
5 providers. But note that both of these policies would
6 require congressional actions.
7 So, for today's discussion, we'll address the
8 Commissioners' questions, and comments about the analysis,
9 and regarding the alignment of ambulatory payment rates, in
10 the spring, there was consensus among the Commissioners
11 about this policy. And our intent is now to move to draft
12 recommendations in the coming spring.
13 To guide us on our development of those draft
14 recommendations, the Commission should determine what
15 should be done with the pool of money resulting from
16 aligning the payment rates. Options include using the
17 funds in a budget-neutral adjustment, as required by
18 current law, or using them entirely as savings for the
19 program and beneficiaries, or finally, or in a stop-loss
20 policy to temporarily support safety-net providers.
21 And that concludes, and I turn it back to Mike.
22 DR. CHERNEW: Dan, thank you.

1 We are going to jump in to Round 1. So I will
2 emphasize Round 1 is for clarifying questions only. So, if
3 you find you're talking at some length about your views or
4 asking what else you could be doing or something later,
5 like if you say, "Well, I think you should do this. Did
6 you think about that?" that's not Round 1. Round 1 is
7 "What did you mean by blank? How did you do the analysis?"
8 So, with that said, let's go through Round 1.
9 MS. KELLEY: Lynn.
10 MS. BARR: Thank you.
11 Thanks, Dan, for a really, really informative
12 chapter.
13 So I thought that copays for beneficiaries and
14 PPS hospitals were capped at the rate that's paid in a
15 clinic so that they don't actually pay the 20 percent of
16 the full copay. Did I just dream that up? Is that not
17 true?
18 DR. ZABINSKI: Well, the idea is that under the
19 OPPS, the copay for a service cannot exceed the inpatient
20 PPS deductible of 1,500-something dollars.
21 MS. BARR: But isn't it also kept at the fee-for-
22 service rate? Is that not true? I mean, I thought there

1 was a law passed in 1996 that actually made that happen.
2 Like if you go to a clinic at the hospital, you pay the
3 same copay you would pay if you went to a freestanding
4 physician office.
5 DR. ZABINSKI: No.
6 MS. BARR: Not true?
7 DR. ZABINSKI: No.
8 MS. BARR: Okay. I apologize. I'll have to go
9 look at that again.
10 Obviously, this -- if we take all this money out
11 of the hospitals, right, so today the average hospital has
12 50 percent of their revenue is outpatient, for rural, it's
13 75. That's where you have the disparities. Won't we have
14 to correct then when we do our next payment update? Then
15 their Medicare margin is going to go way down, and so won't
16 we just have to put the money back in the hospitals through
17 that system?
18 DR. CHERNEW: I couldn't -- you know, I'm not old
19 enough, far enough away. I couldn't completely read your
20 expression there, but it looked like I was supposed to say
21 something.
22 [Laughter.]

1 DR. CHERNEW: So we don't have to do any -- do
2 you want to jump in, Dan?
3 [Laughter.]
4 DR. ZABINSKI: I'm not sure how to -- that's a
5 really hard question to answer.
6 DR. CHERNEW: So let me try, and then you can
7 correct me.
8 DR. ZABINSKI: Okay.
9 DR. CHERNEW: I like this. I like this I will
10 try and Dan will correct me. Think about what you would
11 say, and then you can tell me how I got what I got wrong.
12 We don't have to do anything, but your point that
13 if we do this and organizations lose money, they will look
14 less well financially than they otherwise would, and if
15 they look less well financially than they otherwise would,
16 that would feed into our payment adequacy measures, which
17 would then feed into our update recommendations.
18 The issue with, to some extent, on the table that
19 Dan went through is how should we think about this. One
20 approach is that we deal with these as separate
21 discussions, that this discussion is about the principles
22 around site-neutral, and then we -- in our update

1 recommendations or as Dan pointed out in our safety-net
2 recommendations, we put the money back or some portion of
3 the money back, and how much we put back depends on the
4 payment adequacy data in the sense of the updates or what
5 we decide to do ultimately in the safety-net work.
6 MS. BARR: But just writ large we don't think
7 hospitals today are terribly overpaid, and so if we cut
8 their payments significantly we would be likely to --
9 DR. CHERNEW: Well, I will reserve until December
10 a comment on whether hospital are overpaid or not overpaid,
11 because we will have a whole session on that. I think it
12 is likely the case that some we might say are overpaid and
13 some might not be overpaid, depending how you think about
14 what the phrase "overpaid" means, which is a whole other
15 set of comments that we will defer, but loosely related to
16 our payment adequacy indicators. So we're going to look at
17 access quality, access to capital, a bunch of other
18 standard things to make some assessment about that.
19 There is no mechanical connection between our
20 site neutral work and our updated work, although there is
21 an implicit connection, which you've raised. That's
22 correct. There's also a very important distributional

1 issue that arises in essentially who's providing some of
2 the services that would be hurt in the site neutral work
3 and who do we think is eligible for more money, and how we
4 do with our update work and stuff. So that is all true.
5 The last thing I'll say is the longstanding
6 interest in site neutral is essentially to try and get the
7 relative pricing right for the same services, so we want to
8 get the relative prices right. Doing that in a way that
9 maintains sort of a level being right, if you will, is sort
10 of what you're raising, and I think that is ultimately
11 true.
12 So if we thought hospitals are very overpaid,
13 then we might make a different decision about what we think
14 should happen with this extra money. One way to think
15 about this is that this extra money should go back to the
16 Treasury but we will then, if this were implemented, we
17 would just note if you do this you need to think about how
18 to compensate losers, if you will, in particular ways. And
19 that's sort of where we are in this version of the
20 discussion.
21 The three things that Dan put on the table is
22 keep it all in the Treasury, and understand that's just for

1 this portion of it. It could all come back out of the
2 Treasury in our update recommendation, but keep it all in
3 the Treasury; take some of it and put it in the safety net,
4 and we're going to have a separate safety net discussion.
5 So it's a little odd to have this money going into the
6 safety net and then in a safety net discussion where
7 there's other money going in and we have to sort them out.
8 But you could do that. Or do it in what I believe is the
9 current law version, which is it's all just budget neutral,
10 so none of the money is coming out from hospitals but there
11 are, in fact, distributional consequences which Dan went
12 through.
13 I'm not sure if that was clarifying, but I am
14 very interested in Dan's assessment of how I did.
15 DR. ZABINSKI: Very well. I will say one thing.
16 To me there's a real tension going on here, that, okay,
17 yeah, on the one hand you've got this situation where
18 things are really moving from the lower cost physician
19 office over to the HOPD, and that's not always a good
20 thing. Okay. But if you align the payment rates, you're
21 going to reduce the hospital revenue.
22 The thing is, if you don't, the longer you wait

1 to take care of the issue, the worse it's going to get for
2 the hospitals when you align the payment rates, because as
3 they take more away from the physician office and you drop
4 their payment rates for them, you're going to hurt them
5 even more 10 years from now than you would today.
6 DR. CHERNEW: One more thing. Amol explained to
7 me what I said about Round 1 at the beginning of this
8 session. So part of the role of the Vice Chair is to
9 control me when I get out of control. He knows. He knows.
10 It's inefficient to give money to hospitals by
11 overpaying for services that could be more efficiently
12 provided in a different setting. That's just a general
13 point. So if we wanted more money to go to hospitals, or
14 I'm just using that as an example, we should do that in a
15 way that doesn't distort the incentives around site of care
16 and encourage consolidation and do a whole bunch of other
17 things.
18 The issues you raise are important because the
19 process by which we get there has a number of places where
20 it might break down, and a number of places where you might
21 worry that it might break down. We will typically deal
22 with that in how we write about this in the chapter, but of

1 course one doesn't know exactly how Congress is going to
2 respond to these things.
3 I actually am reasonably confident that they will
4 not take a lot of money out of the system, harming a lot of
5 stakeholders, and then just letting it sit for a whole
6 range of reasons. But I can't say that I'm correct about
7 that, and many of the people will now be sending into
8 meetingcomments@medpac.gov where I had that wrong. It's
9 just to emphasize meetingcomments@medpac.gov.
10 But I think that's sort of the tension here, and
11 I think I'll stick with the purpose here is to note that
12 subsidizing any organization through overpaying for
13 particular services is more than just giving them money.
14 It's setting a whole range of incentives in play that you
15 might not want to have happen. But when you undo past bad
16 incentives you have to worry that you're undoing cross-
17 subsidies that have consequences.
18 I hope that was clarifying. Thank you, Amol, for
19 the time.
20 I think we have Cheryl next.
21 MS. KELLEY: Yes, Cheryl.
22 DR. DAMBERG: Thanks. I'm really supportive of

1 this work and this chapter in particular. I think this was
2 long overdue, so I hope we can make some progress on this.
3 I have two questions just to clarify. In the
4 text it talks about the stop-loss being temporary, and I
5 was trying to understand why temporary. It is just to kind
6 of wean them off of it?
7 DR. ZABINSKI: Yeah, that's the general idea, to
8 allow them to adjust their operations and things like that,
9 yeah.
10 DR. DAMBERG: Okay. All right. No cliff effect.
11 All right.
12 And then the second thing, in terms of a question
13 is, so you've laid out three different options for what
14 should be done with the savings. Are you thinking about
15 any combination of these, so maybe the government takes
16 back some of the money but maybe redirects a portion of it
17 to the safety net?
18 DR. ZABINSKI: Yeah, sure. You know, one way to
19 run the numbers is a combination of do a little bit of the
20 stop-loss and then take the remaining funds in a budget
21 neutrality way.
22 DR. DAMBERG: Or as a savings to the government

1 and to beneficiaries?

2 DR. ZABINSKI: I haven't done that but that's

3 technically on the table.

4 DR. CHERNEW: There are an infinite number of

5 ways of dealing with this, and many of them will dovetail

6 with other conversations we're going to have, like the

7 update factors and other things. So I will just make a

8 general statement and then we'll go on. This is a Round 2

9 comment so I get more.

10 It is complicated when we take one chapter that

11 we're dealing with now, like site neutral, and then try and

12 do a bunch of things in there that then have implications

13 for other places. So maybe not the correct way but the

14 cleaner way is either to keep it budget neutral, which is

15 current law, and then figure out what else is going on, if

16 we want to take money out, take money out in the updates or

17 not, or let it all flow back to the government, and if we

18 want to put more money in, put more money in, in these

19 other ways. When we start getting more complicated things

20 to do with this bolus of money because all of the money is

21 fungible, we end up having complex interactions with other

22 places that we're talking about what's going to happen to

1 payment for these various providers.

2 So my preference -- and again, this is all about

3 your preferences -- my preference is either to do the

4 budget neutral way and adjust otherwise or do it that it

5 all goes to the government and adjust otherwise, and not

6 try and say this bolus of money should be used to meet

7 these other things that they're going to dovetail to other

8 chapters. It doesn't have to be that way, but that's more

9 of a writing clarity place than it is a sort of substantive

10 thing, because Lynn's original clarifying comment, which

11 was a clarifying comment, by the way, was actually spot on.

12 This is going to have to be sorted out through a whole

13 series of other policy options. That is correct.

14 MS. KELLEY: Scott had a Round 1 question.

15 DR. CHERNEW: Oh, okay.

16 DR. SARRAN: Quick question. When we look at,

17 for example, your Slide 9, showing a hypothetical service,

18 do we know anything based on hospital cost reports about

19 hospital margins, if we lumped everything into one of three

20 categories, one being inpatient, the second being alignable

21 services, like what you've got here, and the third being

22 the more high-complexity, non-alignable services? Because

1 that, I think, could help us as we think about downstream
2 impacts and making changes.
3 DR. ZABINSKI: No, we don't. I mean, we haven't
4 broken down things to that detail, but it probably would be
5 helpful to know that.
6 DR. CHERNEW: Dana?
7 MS. KELLEY: Okay. That's the end of Round 1,
8 that I have in my queue anyway.
9 DR. CHERNEW: Great.
10 MS. KELLEY: Do you want to go to Round 2, Mike?
11 DR. CHERNEW: I do, and I think that's also going
12 to start with Lynn.
13 MS. KELLEY: Yes.
14 MS. BARR: I am on the record as not being in
15 favor of this at all, for a number of reasons. One of them
16 is now is not the time to be messing with these types of
17 things, and we've got to let the whole COVID thing sort
18 out, and inflation sort out, and this is just not the time.
19 But, you know, more specifically, a 5 percent hit
20 on rural? I mean, how many more hospitals do we want to
21 close? That doesn't seem wise. I think we're just going
22 to end up paying for it another way. We're going to create

1 a lot of drama and issues. I think that a lot of hospitals
2 historically did not hire primary care physicians because
3 they lost money on them, and they made money on specialists
4 and so they had lots of specialists.
5 And the problem is primary care physicians cannot
6 really survive as independent practices because of the
7 complexity that we have created in our system today, with
8 advanced payment models and everything else. And we have
9 access issues. And so anything that's going to threaten
10 primary care access seems like a really bad idea. Anything
11 that's going to threaten sort of the whole system right now
12 I think is a very bad idea.
13 And I think that consolidation, again, is caused
14 more by the complexity of 21st century medicine than it is
15 by profiteering. I think it's interesting that we say,
16 well, PCPs aren't making these decisions because of money,
17 but we're saying that hospitals are? And in the 2,500
18 safety net hospitals that I work with I don't think that's
19 true. I'm not saying that's not true across the board, but
20 I don't think this is true.
21 So I am vehemently opposed.
22 MS. KELLEY: Greg.

1 MR. POULSEN: Okay. Well, I'm sympathetic to
2 Lynn's point but I'm actually going to go down a different
3 path.
4 I'm absolutely supportive of finding ways to
5 encourage providing services in the most efficient location
6 possible. I believe that's realistic. We talked about
7 ones that are quite realistic.
8 My biggest concern focus is around the statement
9 that was on Slide 6, which is we're looking for services --
10 I was wanting to get the quote right -- in lower-cost
11 settings, that can be provided in lower-cost settings for
12 most beneficiaries. I'm worried about the "most" part,
13 because I think that if this policy is pursued, we really
14 are, in effect, asking high-cost settings to discontinue
15 providing these services. That's the logical outcome, if
16 you're paying somebody less than their cost, even if you're
17 providing them another subsidy somewhere else, they will be
18 better off financially to discontinue that service and
19 recoup the difference. And that's what any logical
20 organization would be expected to do.
21 And so I think we ought to ask ourselves maybe a
22 different question, which is if hospitals discontinued the

1 service or procedure in question altogether, would the
2 community be negatively impacted either because they are,
3 first, there's a subset of patients that require the
4 greater capabilities of that setting, or second, they're in
5 a community where there isn't a financially viable
6 alternative to provide that service?
7 If the answer to both of those questions is no,
8 then I think we absolutely ought to pursue this approach.
9 And I know that organizations like mine would be
10 financially, negatively impacted, but that's what we should
11 probably be doing.
12 The however is if the answer to one of those two
13 questions is yes, then we are depending upon somebody doing
14 something that's inappropriate from a financial perspective
15 and hoping that they will do that. And I think that's
16 probably a hope that we shouldn't necessarily expect to
17 come true.
18 So if we expect that to be the case then I think
19 we might want to think about this some more. Are there
20 alternatives to just continuing what we're doing? I think
21 there might be. There may be an Option 4, just to make
22 life more complicated, that we tried out. We can talk

1 about that.

2 You know, one thing we might consider is a
3 payment for services that are necessary in the higher-cost
4 setting because they're being done after hours or to a
5 patient who requires a different level of care. You know,
6 somebody had an example that we had with imaging studies.
7 There are people that are in a traumatic situation where
8 they're not ambulatory, and so they're fundamentally
9 different even though the procedure was coded the same.

10 So there may be an alternative there where
11 because of acuity, time of day, or in a rural setting,
12 because there simply is no legitimate alterative within the
13 community, would we want to consider some sort of premium
14 pay associated with that. I know that's complicated but I
15 also know that it's been done, and it's a conceivable way
16 to do that, that would encourage care to be done in the
17 lowest-cost setting whenever possible, but that you've got
18 a backup when it isn't possible to do it in the lowest-cost
19 setting.

20 DR. CASALINO: Greg, when you say it's been done
21 do you mean by your health plan?

22 MR. POULSEN: Yeah, and others. We didn't make

1 it up. We stole it from others. I suspect Jaewon may have
2 dealt with a similar situation. I don't know that. But a
3 number of organizations similar to ours have had to do
4 that.
5 [Discussion off microphone.]
6 MR. POULSEN: There we go. So I guess what I
7 would say, though, is we no longer do that because we then
8 move to what I think is the far better solution, which is
9 prospective payment for the totality of care. So we no
10 longer have that internal transfer payment confusion. It
11 was suboptimal but it was better than simply not having the
12 service be available.
13 So I guess from my thought I think that there is
14 a potential unintended consequence for certain services
15 where if we pay at a rate that is not sustainable and yet
16 we depend upon it being done in the higher-cost setting
17 because the community needs it or because we need it for
18 certain types of patients, for certain times of day, then I
19 think that we may paint ourselves a little bit into a
20 corner, and I'd love to have the conversation in Round 3
21 further, if we want to.
22 DR. CHERNEW: Just to quickly react, though. The

1 first thing is I think the belief, given the set of
2 services are very uncomplicated for what they are, that the
3 price in the lower-cost setting is actually not below the
4 cost of a higher-cost setting. It's just the higher-cost
5 setting is getting a higher price because of how the
6 conversion factors went out. So I don't think that if you
7 lowered the price for these services to the price of the
8 lower-cost setting that that marginal service would not be
9 profitable. We should look into that, which is really your
10 point. But it is not inherently the case that the price
11 for these services in the high-cost setting is actually
12 equal to the cost of those high-cost settings. I think
13 what's really happening is the price in those high-cost
14 settings is well above the marginal cost of those services,
15 and they're cross-subsidizing the rest of the enterprise
16 through them.
17 MR. POULSEN: Yeah, and that may be the case. I
18 will just tell you, though, looking at, for instance,
19 imaging services. That was the poster child for us and it
20 may not be the poster child for the set that we're looking
21 at here. But when we looked at those the cost was indeed
22 significantly higher to provide them in a hospital setting

1 than it was in an outpatient setting, and some of it was
2 related to differences that were not captured in coding
3 between patient types that were coming for those services.
4 And so expecting somebody to be able to do a
5 service that includes people that are not ambulatory or
6 have other issues or are coming in in the middle of the
7 night and expecting that service to be done at a cost which
8 is the same as somebody who can schedule it, walk in, lie
9 down, have the imaging test completed, and then get up and
10 walk out, you know, that's not realistic.
11 I realize that I'm using a subset as opposed to
12 the superset, because I don't know what the superset is.
13 DR. CHERNEW: The takeaway is understanding if
14 the prices when you do this become sub-cost for the other
15 organizations is, in fact, an important thing to know.
16 DR. NAVATHE: And it's marginal.
17 DR. CHERNEW: Yes, and it's marginal, not average
18 cost, as Amol said, which is what I would have said.
19 I think now, if I have this right, you're going
20 to read something from Robert. Is that right?
21 MS. KELLEY: Yes. Robert has a comment and a
22 question, actually.

1 He says, "Thank you for a thoughtful and well-
2 developed presentation. I support exploring draft
3 recommendations regarding the alignment and allocation of
4 ambulatory payment rates."
5 His question regards how ambulatory surgery
6 centers are defined for the purpose of this analysis.
7 "There are various models for ASCs and variability in
8 accreditation, licensure, and certification standards. I
9 presume that outpatient surgery settings that are not
10 otherwise accredited, licensed, or certified, are excluded.
11 Is that correct?"
12 DR. ZABINSKI: That is correct.
13 MS. KELLEY: Okay. I have Amol next with a Round
14 2 comment.
15 DR. NAVATHE: Thanks, Dan. Superb work, really
16 important for the efficiency of the Medicare program.
17 So I really liked Greg's comments. I think
18 there's a lot of layers of complexity here. I think we do
19 need to be thoughtful about it. But at the same time, I
20 think we also have to be careful that we don't sort of try
21 to solve for a very small portion that ends up sort of
22 hindering the entire efficiency of the Medicare program.

1 And to some extent, I would say in terms of the different
2 policy options, on the one hand, I would say, you know, if
3 we can get program savings based on efficiency here, we
4 should get program savings, because it's, generally
5 speaking, very hard to do that. You know, in most cases,
6 the different policy objectives we're talking about are
7 usually putting additional dollars to help support where we
8 need to support and/or making investments in things like
9 APMs with the hope that down the road we're going to get
10 some bending of the trend or what have you. And this is a
11 particular case that I think there has been a lot of
12 interest for many years to try to actually capture some of
13 these in savings.
14 On the one hand, I would say let's try to get the
15 savings if we can get them. That being said, Lynn and Greg
16 have highlighted some of the unintended effects, and I
17 think in that sense, what may be the most important is to
18 get the incentives right and try to keep organizations
19 essentially as whole as we can to mitigate some of the
20 negative financial impacts, and whether that's through
21 targeted safety-net additions or even taking the sort of
22 OPPS and instead of averaging the dollar savings that we

1 would get across only the services that aren't included
2 here, we could in fact just deploy it across the whole OPPS
3 set, kind of do the math to get the formula right.
4 But I think it is really important -- the last
5 two points I would make I think it's really important to
6 try to get these marginal incentives right, because there
7 is a strong incentive for consolidation. I think I
8 disagree with you, Lynn. I think that it is a driver of
9 consolidation for sure, particularly in the specialty
10 space. I think we know a lot of cardiology groups,
11 oncology groups, that end up moving into consolidation
12 maybe in part because of the complexity of care, but
13 there's a major financial reason to try and drive in that
14 direction. And we know that that has a strong impact on
15 commercial prices, which can have this boomerang effect on
16 Medicare costs, which then comes back and hits the Medicare
17 program in terms of rates.
18 So I think it's really fundamentally important to
19 try to make an assertive recommendation in this space to
20 move in this direction. It's less important perhaps on
21 which policy option we pick in terms of how to distribute
22 the savings. And what we need to do is allocate them in a

1 way that, as I said, sort of keeps organizations whole or
2 mitigates the financial impact negatively, I think that
3 would be fine in my judgment or opinion.
4 I think, Greg, your point is very well taken
5 about the cost piece because we don't necessarily want a
6 bunch of organizations stopping services. And I think
7 what's important there is for us to tease out the average
8 cost of the service versus the marginal cost, because as we
9 do in our payment adequacy work, a lot of times we're
10 looking at -- or providing this service relative to not
11 providing that service for this particular patient, is the
12 organization going to lose money? And because many of the
13 different infrastructure components that are needed to
14 provide this care because the care on average is not super
15 complex care -- we're not talking about cardiac surgery
16 here -- most organizations will have the capacity to do
17 that care.
18 So I think that we should certainly look into it,
19 but I don't think it's unreasonable that we would arrive at
20 the conclusion that, in fact, the marginal incentives can
21 work, because we're not setting payments at zero,
22 obviously.

1 Thanks.
2 MS. KELLEY: Kenny?
3 MR. KAN: Thank you for the insightful piece.
4 Overall, I'm supportive of the framework and the issues
5 raised. I do acknowledge Lynn's and Greg's concerns about
6 potential unintended consequences. I believe that that
7 should not discourage us from finding a way how to work
8 through those, because I believe that if we don't, it's a
9 missed opportunity.
10 MS. KELLEY: Jaewon.
11 DR. RYU: Yeah, just a couple comments. For me,
12 it's really tough to parse out between the site-neutral
13 work -- i.e., this chapter -- and the payment update and
14 the safety-net dynamics. The trains are all hitting the
15 station at the same time, and I think it's really difficult
16 to sort of think of each one in isolation. But if I just
17 looked at this, I do think this was another one where it's
18 been a long journey, and I think it's important that we at
19 least take a step towards better aligning between settings.
20 And for that reason, I am supportive of moving forward, but
21 with a couple caveats.
22 I think one is if you look at the 57 APCs -- I

1 think this was Table 6.2 in the reading materials -- you
2 know, some of those seem pretty straightforward; others I'm
3 less certain. But I think this gets to Greg's concern.
4 How solid do we feel and how conservative or aggressive are
5 we being? I think that merits another re-look.
6 And then as far as what we do with the savings, I
7 would be strongly in favor -- and this hits on Lynn's
8 point. I don't think now is the time to take dollars out
9 of the hospital sector of the industry. I think there's
10 still a lot of re-equilibrating that's yet to happen. So
11 I'd be in favor of the budget-neutral, the current law
12 approach, and then separately, you know, you could address
13 the adequacy of payment and that body of work. I think
14 that's just a cleaner approach as I try to parse out the
15 three different dynamics that we're facing.
16 MS. KELLEY: Scott.
17 DR. SARRAN: Yeah, I'm going to briefly, I think,
18 largely reinforce both Jaewon and Lynn. When I look at
19 this issue through the lens of major metropolitan
20 marketplaces, I think it should be full speed ahead down
21 this road, because I think there's no question that the
22 differential payments for relatively low complexity

1 services going to hospital outpatient departments has been
2 a big driver of hospitals acquiring specialty practices,
3 and that's not an unvarnished good thing, you know, at
4 best. But the world is -- our American world isn't
5 comprised simply of large metropolitan marketplaces, and we
6 have, I think, the complexity, as people have pointed out,
7 including Lynn, that I don't think we understand the full
8 cost structure of a post-COVID world yet, because the labor
9 costs, I think they're still shaking their way, you know,
10 through the system.
11 So I think the right thing is to continue to --
12 it's kind of keep the foot on the gas -- I'm mixing
13 analogies here -- but not pull the trigger until --
14 [Laughter.]
15 DR. SARRAN: I apologize. Until -- yeah, yeah,
16 whatever. Unless two conditions are met. One is that
17 we're certain that we are not, in fact, dropping the
18 reimbursement for services below the variable cost of
19 providing that service, and I think we kind of think we're
20 probably not -- you know, when you parse that variable cost
21 from fully allocated cost, right, but we don't know for
22 sure, right? We think so, but we're not sure. I think we

1 need to be sure.

2 And second is I think we can -- and maybe, Mike,

3 if you're comfortable with this -- wouldn't be an

4 eventuality, but we can't do something that could pull

5 money away from rural hospitals until we're sure -- rural

6 and safety net until we're sure that money will flow via

7 another body of work or another mechanism.

8 MS. KELLEY: Betty.

9 DR. RAMBUR: Thank you. I really appreciate this

10 conversation. I continue to be very enthusiastic about

11 moving forward with this and the site-neutral approach.

12 And I hear what you're saying about the pain of the

13 organizations, but I'm also thinking about the pain of the

14 Medicare beneficiaries, the pain of the Medicare program

15 itself, which is really not our specific responsibility,

16 but certainly the Medicare beneficiaries are.

17 So when I read this, I really leaned toward

18 Option 2 or picking the savings and returning it as being

19 the most logical and fair consequence, it seemed to me.

20 And I know that requires congressional action. I don't

21 know how likely that would be. I certainly wouldn't want

22 budget neutral to go totally away because I think we need

1 the budget neutral on the top part. It can't be more
2 expensive than X, but certainly savings, it seems to me,
3 should be returned. So I hear these arguments, but I think
4 there's a lot of pain in a lot of places.
5 Thanks.
6 MS. KELLEY: Larry?
7 DR. CASALINO: Can you show Slide 9 again,
8 please? I started out before this session, you know, very
9 much in favor of making the changes recommended, and I
10 didn't have that strong feelings about what would be done
11 with the savings.
12 If you look at these numbers, they're pretty
13 striking, the $701 versus $256. So that to me is a huge
14 issue. And consolidation is a huge issue. Medicare has
15 done so much, not -- for the most part, I hope
16 deliberately, to foster consolidation. And certainly this
17 is one of the main things, you know, Amol's good example of
18 cardiologists. So I came in very strongly favoring this
19 work.
20 Now, Lynn's comments, I think that, you know,
21 consolidation in rural areas might make sense. So I
22 acknowledge that.

1 In terms of the money for rural hospitals, I
2 think we should always try to go with the MedPAC principle
3 that we try to get payment on whatever issue we're talking
4 about right, and then if rural hospitals need help or
5 safety-net hospitals, we do that directly, not by
6 contortions in each separate policy. So I wasn't
7 convinced, but with Greg, I had to say it really is true
8 that there are times when it's appropriate for a patient to
9 be in an HOPD, maybe because it's the middle of the night
10 and they need something. Maybe it's because the patient
11 can't walk, for example, and the things that you can't
12 really get at -- you could get the time of day out of
13 claims data, maybe, but you couldn't get some of these
14 other important things that would be legitimate reasons to
15 have a higher site of care at claims very easily, I don't
16 think.
17 So that is -- I would want to hear more from Greg
18 and maybe Jaewon about are there reasonable ways, without
19 requiring prior authorization, to make exceptions,
20 basically, or decide if the site was appropriate for a
21 service which otherwise, you'd expect to be done at a
22 lower-cost site. So I think that deserves more

1 investigation, because if there are ways, reasonable ways
2 to plausibly identify such patients, I would feel a lot
3 better about the recommendation in this chapter.
4 In terms of marginal cost, I think it should be
5 true that if the marginal cost is -- if the net income is
6 higher than the marginal cost, hospitals wouldn't stop
7 doing these services, presumably. But I think it would be
8 very hard to get an accurate estimate of marginal cost.
9 What does it cost to have staff who can be available in the
10 middle of the night or whatever? So I'd want to know more
11 about whether marginal costs could plausibly be estimated
12 and if that would be a way to set these. But I do think we
13 should proceed with working on this, and I think we should
14 do something, because both the consolidation and the cost
15 difference here, including, as Betty said, the Medicare
16 beneficiaries, they're so stark, both of those things, and
17 to just look the other way I think would be a real mistake.
18 I think Greg has raised some real issues, but one
19 way or another, I think they probably could be dealt with.
20 MS. KELLEY: Stacie.
21 DR. DUSETZINA: Thank you. So I keep going back
22 and forth about what I want to say about this. I think I

1 do want to reiterate that I agree with the idea of site-
2 neutral payments, and, you know, I know this is such a
3 well-done and careful analysis of, you know, what types of
4 care could have high volume in these different settings and
5 could be reasonably performed there.
6 I think Jaewon's comments reminded me to look
7 back at the table of the procedures we're talking about,
8 and they do seem like there would be -- as somebody said,
9 it's not surgical procedures. You know, we're talking
10 about drug administration; we're talking about things that
11 seem like lower cost on average to provide. So I think
12 that makes me worry a little bit less.
13 I do also appreciate the sensitivity around
14 taking money out, and I also worry about the idea that
15 Congress would need to act to do something different than
16 site-neutral. But I think maybe going back to Amol's and
17 Larry's comments, it would be really nice to be able to do
18 something, move a little bit more in this direction, so I
19 do support trying to get the payments to align better with
20 the lower cost of providing them in the lower-intensity
21 settings. I'm not sure what to do with the savings. But,
22 you know, it does seem very attractive. We've talked about

1 many things we'd like to pay more for, so it seems like
2 that would be nice, although I know it's complicated to
3 jump from one topic to the next. But I just want to be on
4 the record that I very much support the idea of this, and I
5 think Larry's comments about consolidation also are a good
6 reminder. If we don't make changes, we'll just keep
7 getting more of what we've been getting over the last 10-
8 plus years.
9 Thanks.
10 DR. CHERNEW: We have a few more people. If you
11 look at the -- even if you thought there was a cost
12 difference, if you look at some of the magnitudes of the
13 numbers, it's pretty striking. It's not just like, okay,
14 it's 50 percent more. You know, you're multiples more in
15 many of these cases, so it's not sort of, well, okay, it's
16 going to cost us 20 percent more at the margin to do this
17 for a lot of what these things are. But, yes, I
18 understand.
19 So we have a few more people. I'm sorry. I've
20 lost track.
21 MS. KELLEY: Cheryl is next.
22 DR. CHERNEW: Cheryl and then --

1 MS. KELLEY: And then we have some Round 3
2 questions.
3 DR. CHERNEW: Good. So we'll get to Round 3.
4 We'll make very brief Round 3 comments because we will be -
5 -
6 DR. DAMBERG: All right. I will keep this quick.
7 I also want to go on the record that I support this work
8 and the movement in this direction, and I really appreciate
9 the comments that Greg and Lynn made, but I think we can
10 work through those issues.
11 I just want to pile on to Amol and Larry. I
12 think we have to work to try to improve efficiency and
13 really stay focused on, you know, not overpaying for
14 services, and to take some of the steam out of -- or the
15 incentives to consolidate. I can say firsthand I have been
16 on the commercial side sort of party to what's happening
17 with explicit redirecting of traffic to the hospital
18 outpatient department for just a basic dermatology visit.
19 And so the immediate, you know, direction was to the HOPD,
20 and I could see a provider within three days, and if I
21 wanted to be in the non-HOPD, in the ambulatory care site,
22 it would be three weeks. So I think there's a lot of

1 gaming going on within the system that we need to take the
2 steam out of.
3 MS. KELLEY: Before we move to Round 3 people,
4 Lynn had a quick question.
5 MS. BARR: I just have a couple more Round 1.
6 You mentioned the co-pays of the beneficiaries. Did that
7 take into account that most of those are paid by med supp,
8 so, what, 80 percent of co-pays are paid by med supp
9 policies and other -- you know, so what is the actual cost?
10 You quoted a big number. But is that really out-of-pocket
11 of the beneficiaries?
12 DR. ZABINSKI: No, I was sort of careful to say,
13 you know, it's their obligations.
14 MS. BARR: Right, that could -- that's mostly
15 covered.
16 DR. ZABINSKI: Right, although it affects their
17 premiums, though.
18 MS. BARR: Right. No, it definitely --
19 DR. ZABINSKI: So, I mean, they pay one way or
20 another.
21 MS. BARR: It affects total cost. And, you know,
22 so one thing is looking at procedures versus visits, and,

1 you know, maybe possibly differently. But why is -- my big
2 question is: Why is the differential so large? How did we
3 get there, you know, where it is three -- is three times
4 the amount reasonable? I mean, isn't that what we're --
5 isn't that the shock and awe here, is the amount, and so
6 how did we get there?
7 DR. ZABINSKI: My take on it is that there's --
8 although I'm not sure this is right, but, you know, there's
9 different ways of setting the payment rates in the two
10 settings. By the two settings, I mean offices and HOPDs.
11 HOPDs, they take -- by that I mean CMS takes -- charges
12 adjusted the cost from claims, and skipping over many of
13 the details, they just take an average for a particular
14 service, and that's what the payment rate is with a little
15 on top of it, and then the fee schedule, you go through the
16 whole RUC process, and, you know, it's a decision -- the
17 decisionmakers make that choice. That's part of it.
18 MS. BARR: So, I mean, could -- a potential
19 solution may be to reduce the disparities between the
20 payments as opposed to get, you know, really site-neutral,
21 but like, you know, let's get rid of ridiculous, you know,
22 and, you know, based on costs and profitability and have a

1 better understanding of that.
2 And then, you know, kind of my final question is
3 -- I'm most concerned about this in terms of reduction of
4 primary care access and how -- because there was --
5 hospitals didn't employ primary care physicians ten years
6 ago, right? They only employed specialists, and now they
7 all employ primary care physicians because you can make a
8 lot of money on a clinic visit, right? And so I'm just
9 curious how this could affect primary care as -- is there
10 any information you can give us about how these policies
11 have driven primary care employment by hospitals, say, in
12 the last ten years?
13 DR. ZABINSKI: Well, explicit -- I'm not sure you
14 can get anything explicit, but, you know, the trends would
15 show that, you know, it's having a big effect. I mean,
16 there's a lot of employment. There's these services moving
17 from one setting to the other.
18 Many of the -- you know, the rate at which
19 physicians practice solely on their own and own their own
20 practice has really dwindled. They're becoming employees,
21 either employees or their practices are owned by either the
22 health system or the hospital. So that's an indication

1 that's pretty strong.
2 DR. CHERNEW: Can I inject one other? It's not
3 that they're actually moving in the sense of like they're
4 moving. They may well be in the same place. The ownership
5 is changing, and there's just a huge arbitrage opportunity
6 to do the same thing. So, in the sort of marginal cost
7 sense, it's not quite the same as "Oh, I was practicing in
8 my office, and now I'm going to practice in a different
9 building." There's complicated ownership arbitrage issues
10 here that are going on.
11 I mean, again, I think all the points that have
12 been raised are right. I think the other thing that I
13 would say in response and then I'll defer to Dan and any of
14 the staff to correct me, this is a version of the -- we
15 don't -- why don't we just adjust all the RVUs and get it
16 right, right? So it turns out the process is not like that
17 they went through the marginal cost for every service,
18 which is very hard to do, given all the economies of scale
19 and scope in hospitals, anyway. So there's a lot of
20 averages and then weights and things applied, and that
21 inevitably gets things wrong. Some things are overpaid;
22 some things are underpaid.

1 It's easy to say in the hospital setting or in
2 the ASC setting, they shouldn't under overpay for any
3 services, and who's going to disagree with you shouldn't
4 under overpay for any services?
5 But the problem is to get to that process turns
6 out to be very hard, and the elements of each different fee
7 schedule typically operate independently of the elements
8 for all the other fee schedules, and so the way you get
9 there is you have conversion factor changes. You have cost
10 report changes. You have a whole bunch of other things
11 that are going on in these different fee schedules that
12 just make the actual fees for any given service. And we're
13 not talking one service. There's a myriad. I never used
14 that in a MedPAC meeting before. There's a plethora of --
15 these meetings are so fun. There's a plethora of services
16 that are trying to be priced, and it's virtually
17 impossible, given all the economies of scope and scale
18 across the different settings to get them right, so you end
19 up with them wrong.
20 And in some cases, because of this, you see these
21 very big disparities for what I think the mailing materials
22 would have described is reasonably -- I'm an economist, I'm

1 not a doctor, so I'll defer again to others, but reasonably
2 uncomplicated services. And so that has given rise to a
3 number of different distortions in the market, and that's
4 kind of what the purpose of this is.
5 But to your point from your Round 1, Round 1
6 question, there are shifts in money, and that does create
7 problems that we are not unaware of. We're actually quite
8 concerned about it, and so figuring out how to do that
9 without getting into a world where we're subsidizing
10 organizations by distorting all of these prices is kind of
11 the spirit of how this is playing out.
12 Sorry. That was a long -- that was a Round 3
13 answer to a Round 1 question.
14 We have -- I think Greg is a Round 3, and Amol
15 will have a Round 3, and then we will -- I'm really going
16 to shut us down.
17 MR. POULSEN: Okay. I guess I'd start off by
18 respectfully disagreeing that we ought to look at this as a
19 variable cost kind of look, because ultimately in the long
20 term, all costs become variable.
21 I mean, at some point, you have to start
22 replacing equipment. You have to decide whether you're

1 going to employ one more person. At the end of the day, if
2 you're adding capacity for whatever purpose, you have to
3 pay for it.
4 So are there economies of scale? Yeah, but at
5 the scope we're looking at, I think those -- if we apply
6 those, we're going to regret it in the long term. That
7 would be my view.
8 I think, though, that in some cases we may be --
9 at least from my perspective, we may be agreeing more than
10 we're not, because I think a lot of these services that
11 we're talking about truly can be provided in any setting.
12 With the example that we gave, a level 2 nerve
13 injection, I'm guessing that is never going to require the
14 intensity of a hospital or the middle of the night.
15 So there may be a whole list here which -- and I
16 tried to put that in my first criteria. If we took this
17 service altogether out of a hospital, would the community
18 be negatively impacted? And if we can do that, that's
19 great. We should do that. I think that would be a
20 beneficial thing. We shouldn't be paying more for
21 something that we can get elsewhere and that would be
22 adequate and sufficient for the needs of the community.

1 So, if we could go down that path, then I'd suddenly get
2 very, very comfortable.
3 If then for the others, which occasionally but
4 not frequently require the additional capabilities that we
5 would have, whether it's because of geographic proximity in
6 a small rural community where you're just simply not going
7 to create that, you're not going to duplicate that service
8 in another setting, or because we need it for the middle of
9 the night or in an emergent kind of situation, if we could
10 then come up with some sort of a premium structure
11 associated with just those patients -- and, Larry, I think
12 that's possible. I think that we wouldn't have to come up
13 with anything terribly complex.
14 It's just simply potentially something which is
15 what we did when we did it internally. We simply said, "I
16 certify that this patient required the services that
17 couldn't have been done in an outpatient setting," end of
18 statement, and then you can go through and check that up,
19 and it's fraud if you are doing that inappropriately. And
20 I think that you could do something like that.
21 Whether we should do something like that, I don't
22 know. But I think we could do something like that. Then

1 that would allow us then to recognize the fact that at
2 least in the -- and again, I was familiar with imaging
3 services because they were the high-dollar items where we
4 looked at this. What we found is the costs aren't hugely
5 different. It wasn't that 256 versus 701 was outrageous.
6 It wasn't outrageous at all when you compared the one
7 patient who walked in, lied down, got the imaging set up,
8 walked out, versus the other one brought in on a gurney
9 lifted by three people onto the table, et cetera.
10 So, if we had a way to recognize that rare
11 differential -- where they're not rare, we're not talking
12 about them, right? Because that was already we were
13 talking about only those situations where it can mostly
14 have been done in an outpatient setting. Great.
15 But if we had a way to recognize that rare but
16 situation that does in fact happen and to get there, then I
17 think we'd probably be in a place that people would become
18 intellectually comfortable with and that we wouldn't create
19 the kind of un uneven playing field or unintended
20 consequences that we otherwise might be thinking about, if
21 there's access.
22 DR. NAVATHE: So I quickly want to make two

1 points. One, I thought I forgot to mention -- and I thank
2 Betty for bringing up the beneficiary point, because that's
3 really fundamentally important, right? It feels truly
4 unfair to ask beneficiaries to pay more for a care that
5 they could receive elsewhere, and that's just a MedPAC but
6 Medicare and good governance principles. So I think that's
7 one really important point.
8 The second point, I think -- and I think this is
9 probably just worth putting into a bucket of things, Dan,
10 that we need to work through and explore more, and I'm
11 going to volunteer Greg as somebody who will be willing to
12 spend some time on it. And I'll raise my hand too.
13 I pulled up this list again to stare at it while
14 you were talking to Greg, and it strikes me that I think
15 there's another dimension that we have to analyze here,
16 which is not -- you know, maybe one missed test is whether
17 a hospital could stop doing this procedure and would it be
18 okay for the community. I think a related one, perhaps, is
19 what are the capabilities needed to provide this, and are
20 they actually differentially specific for this procedure?
21 Because if they're going to be provided anyways, right, and
22 we're talking specifically, right, about relatively

1 uncommon or exceptional circumstances, we're not going to
2 hire labor for an exceptional circumstance. We're going to
3 have the labor there and be able to provide the service in
4 the exceptional circumstance. And so we're not going to
5 shut down a part of our ED over something that's very rare.
6 So I think that we have to think about this also
7 in that context, and I think maybe going through some of
8 these services and applying this kind of framework to get
9 comfortable that we're not creating a big unintended
10 effect, my sense is just clinically looking at this set and
11 from an operational perspective that I think for the vast
12 majority of these, we're probably in a safe space. And if
13 there's one or two that are not, it would be great to call
14 that out in some capacity.
15 DR. CHERNEW: Okay. We are going to skip our
16 break. That's the Round 3 cost.
17 [Laughter.]
18 UNIDENTIFIED: Punitive.
19 DR. CHERNEW: Right, exactly.
20 Well, you know, I'm often figuring out like -- it
21 used to be we just said, "I'm sorry. There's not time for
22 Round 3." So I think that that was an important discussion

1 to follow through. I'm willing to do that. Understand
2 that now we're moving on to what we're going to do. Carol
3 is in the wings. So she's going to come up, and we're
4 going to talk about the post-acute PPS work. So, if you
5 need to take a break, you can take a break, but understand
6 we're still
7 going to be talking. So that's kind of where we are.
8 We're switching out Carol's name so we know she's
9 not Dan, and now she's Carol.
10 All right. Carol, go ahead.
11 DR. CARTER: I'm ready. Okay. Good afternoon,
12 everyone.
13 Today's presentation is the second in a series to
14 prepare a mandated report on a prospective payment system
15 for post-acute care. Before I get started, I want to thank
16 Kathryn Linehan for her help with this work and to remind
17 the audience that they can download a PDF version of these
18 slides on the handout section of the control panel on the
19 right-hand of the screen.
20 The IMPACT Act required MedPAC and the Secretary
21 of Health and Human Services to report on designs for
22 unified post-acute care, or PAC, payment system. The

1 designs must span the four PAC settings -- home health
2 agencies, skilled nursing facilities, inpatient rehab
3 facilities, and long-term care hospitals -- and base
4 payments on patient characteristics and not the setting.
5 Our mandated report is due on June 30th, 2023.
6 To remind you of our timetable, today we'll
7 discuss the Secretary's prototype design. In March, we
8 plan to discuss refinement to the design that CMS should
9 consider making and the additional diagnostics it should
10 perform in evaluating its revised design. We will also
11 review various implementation issues, the draft report, and
12 the Chair's draft recommendation.
13 The April meeting will be your last chance to
14 review the entire report, and you will vote on the draft
15 recommendation.
16 In July, the Secretary issued his report on a
17 prototype design, and today we'll focus our discussion of
18 the prototype on four questions.
19 First, which design features would help keep
20 payments aligned with the cost of a stay, and does the
21 prototype include them? We modeled a high-level design to
22 identify preferred features.

1 Second, would the prototype establish accurate
2 payments? Here we report the CMS/ASPE comparison of
3 payments to actual cost of stays.
4 Third, would the profitability of different types
5 of cases be reasonably uniform? We examined the reported
6 variation and profitability across broad clinical groups.
7 And, last, what are the estimated impacts from
8 providers' payments? We report the estimated changes in
9 payments that were included in the ASPE/CMS report.
10 In a PAC PPS, payments would be based on the
11 predicted cost of a stay. Therefore, we want design
12 features that help correctly predict the cost of stays. We
13 estimated predicted costs and then compared them to actual
14 costs. The model results would indicate which features are
15 needed to align payments with the cost of care.
16 I'll give you two examples. If the risk
17 adjustment included a measure of severe wounds and the
18 predicted costs were equal to actual costs, we would know
19 that the design should include a measure of severe wounds
20 in the risk adjustment, or if a measure of low-income
21 status was not included in the risk adjustment, yet
22 predicted costs were accurate for dual eligible LIS

1 beneficiaries, we would conclude that the design would not
2 need a separate adjuster for low-income status.
3 Moving to the psycho column, we predicted costs
4 using patient characteristics such as primary reason for
5 treatment, comorbidities, functional. cognitive and
6 disability statuses, and patient age. Except for
7 functional status, the patient characteristics were
8 gathered from PAC and hospital claims. We included an
9 indicator for home health stays to prevent large over- and
10 underpayments. In contrast to the CMS/ASPE approach that
11 we'll see in a minute, we did not include indicators for
12 other settings.
13 We used claims, cost reports, and patient
14 assessment data from 2019.
15 The results of our modeling indicate that a PAC
16 PPS could establish reasonably accurate payments using
17 existing data. We examined the results for more than 50
18 reporting groups, such as clinical categories and patient
19 complexity. We were particularly focused on the results
20 for beneficiaries who may be especially vulnerable to
21 selective admitting practices if payments were not
22 accurate, such as beneficiaries who are medically complex,

1 frail or had low functional status, or were disabled.
2 Predicted costs were within 2 percent of actual
3 stay costs for all but three groups. For these groups,
4 including patients with HIV and patients recovering from
5 trauma, special care should be taken in designing a case
6 mix system, so that payments were accurate for them; for
7 example, by having a separate case-mix group.
8 As expected, the model was not accurate for stays
9 treated in IRFs or LTCHs. This is because many of the
10 types of patients treated in these high-cost settings are
11 also treated in lower-cost settings. Therefore, the
12 predicted costs were much lower than their actual costs.
13 This is not a result that the design should correct.
14 Our updated analysis combined with previous work
15 indicate that a PAC PPPs should include the features listed
16 here on this slide. Each feature is discussed more fully
17 in the paper.
18 The design should include a stay as the unit of
19 service and include an adjustment for home health stays.
20 It should not include adjustments for SNF, IRF, and LTCH
21 stays. These would undermine the purpose of the unified
22 payment system.

1 It should include a uniform set of risk
2 adjusters, a short stay, and high-cost outlier policies.
3 The design should not include a broad rural
4 adjuster. If any adjustment is warranted, CMS should
5 develop a targeted rural payment policy.
6 The design should not include a teaching
7 adjustment or an adjustment for the share of low-income
8 beneficiaries treated by a provider.
9 The last two items illustrate the tradeoff
10 between having a uniform design and more tailored policies.
11 Our results indicated the need for an adjustment for home
12 health follow-on stays but not for follow-on institutional
13 PAC stays.
14 Similarly, the results for source of admission,
15 either a referral from a hospital or a community admission,
16 differed for home health and institutional PAC stays.
17 Uniform adjustments are likely to result in less accurate
18 payments for some stays.
19 With these preferred features of mind, let's look
20 now at the CMS/ASPE design. Its structure is similar to
21 other prospective payment systems.
22 The prototype design would establish a payment

1 for each PAC stay using a set of case-mix groups and
2 payment adjusters.
3 Starting at the top, each stay would be assigned
4 first to a broad clinical group, the first blue row, and
5 then took case-mix group, the second blue row, based on
6 diagnoses and functional status.
7 Then the relative weight for each case-mix group
8 would be multiplied by three adjusters: an adjuster if the
9 stay was furnished by a rural provider, the PAC setting,
10 and a comorbidity adjustment.
11 The final payment weight would be multiplied by a
12 base rate to establish the PAC PPS payment.
13 Now let's compare the prototype design to the
14 preferred features that we identified. The prototype
15 design generally includes our preferred features, and I've
16 highlighted the differences between the two.
17 The prototype uses the stay as the unit of
18 service, though consecutive home health episodes were
19 considered one stay. It includes an adjustment for home
20 health stays, but it also includes adjusters for the other
21 settings as well. This is a key departure from a uniform
22 design.

1 Adjusters for the institutional settings
2 implicitly accept all cost differences across settings, and
3 these differences could be due to unmeasured differences in
4 case mix, the costs associated meeting regulatory
5 requirements, and practice patterns such as length of stay.
6 The setting adjustments may, however, a
7 reasonable transition policy that would give providers time
8 to adjust their cost structures to a unified PPPs and to
9 common regulatory requirements, and it would give
10 policymakers time to align those requirements. These
11 adjusters could be phased out over time as the Secretary's
12 report notes. Most of the risk adjusters are uniform, and
13 the design includes a short stay and high-cost outlier
14 policies.
15 The prototype includes a broad rural adjuster
16 that would apply to all rural stays. Given that some of
17 our work showed that at least some of the cost differences
18 between rural and urban cases are likely due to factors
19 that do not by themselves warrant adjustment, such as being
20 hospital-based or low volume, CMS should reevaluate the
21 need for any adjuster. If warranted, it should include a
22 targeted policy aimed at low-volume isolated providers

1 needed to ensure beneficiary access.
2 The design does not include adjustments for
3 providers with teaching programs or for their share of low-
4 income patients, and these are consistent with our
5 preferred features.
6 The design includes adjustments for stays that
7 follow prior PAC stays and for stays that follow a
8 hospitalization, but these were applied to all PAC stays.
9 These features may result in systematic overpayments for
10 some stays and will illustrate the tradeoff between having
11 a uniform design feature and payment accuracy.
12 CMS/ASPE reported that the prototype would
13 establish accurate payments by broad clinical group. These
14 are things like stroke and major joint replacement and
15 respiratory cases. For a sample of stays in 2017 through
16 2019, estimated payments were within 2 percent of actual
17 cost for almost all of the patient groups. The model is
18 equally accurate for low- and high-cost stays.
19 The report does not analyze the accuracy of
20 individual case-mix groups, and payments may be less
21 accurate for these more granular case-mix groups.
22 The model was less accurate for stays in 2020,

1 but this was a period of considerable disruption. Because
2 this year was atypical, it is not a year that CMS would
3 want to use when finalizing a design.
4 When some types of cases are likely to be more
5 profitable than others, providers have an incentive to
6 selectively admit them and to avoid others. Uniform
7 profitability helps guard against selective admissions.
8 Although CMS and ASPE did not evaluate this aspect of its
9 design, we examined the variation and the reported
10 profitability of different types of cases. The reported
11 results indicate that for at least broad clinical groups,
12 the profitability would be relatively uniform, though the
13 profitability was more variable in 2020.
14 As noted in the discussion of accuracy, when CMS
15 reevaluates a refined design, it should examine the
16 differences in profitability for individual case-mix groups
17 or at least those where there is sufficient case counts for
18 analysis. What may appear as fairly uniform profitability
19 across broad groups may mask larger differences for
20 individual case-mix groups, and these large differences
21 could create incentives for selective admitting practices.
22 The CMS/ASPE prototype would redistribute

1 payments across providers. The modeling of the impacts
2 assume that prototype payments across all stays would
3 remain the same as current payments. Payments to home
4 health agencies would decline by an estimated 4 percent,
5 and payments to IRFs would decrease by an estimated 6
6 percent. For SNFs, the design includes a more robust risk
7 adjustment than current policy, and so on net would raise
8 payments by an estimated 1 percent.
9 LTCHs would experience a large increase in
10 payments because current policy with the dual rate
11 structure lowers payments for cases that do not qualify for
12 LTCH payments. Under the prototype, these non-qualifying
13 cases would be paid full PAC PPS rates, so there would be a
14 large increase in payments relative to current law.
15 Payments to rural hospitals on net would
16 increase, and I've not noted it here, but it's in the
17 paper. Payments would generally increase to nonprofit
18 providers, and payments would be lower for for-profit
19 providers.
20 Our work identified design features to look for
21 in a prototype design. Our basic takeaway is that the
22 CMS/ASPE prototype is a good starting point. When CMS

1 refines its design, it will use more recent data that will
2 capture recent changes in costs and site of service and at
3 the same time include the dampened effects of COVID-19.
4 Because the SNF, IRF, and LTCH adjusters may make
5 sense only in the transition to a unified design, CMS
6 should propose the schedule to lower and eventually phase
7 out these adjusters. To avoid over- and under-payments, it
8 should also reconsider the definition of a home health stay
9 in the adjuster for any follow-on PAC care.
10 It should also reevaluate the need for any rural
11 adjuster and, if warranted, design a targeted policy for
12 low-volume isolated providers.
13 CMS needs to design a short-stay and high outlier
14 policies and include these stays and payments for them in
15 its evaluations.
16 Finally, CMS will need to consider the tradeoffs
17 between accuracy and uniformity in the features of a
18 refined design. A design that is accurate may not meet the
19 overarching policy of having a unified payment system.
20 I'm glad to answer any questions you might have
21 about this work or about the CMS/ASPE report. I'd like to
22 hear if there are other analyses of the prototype design

1 you'd like us to conduct, though we are limited by the
2 information that's included in the report. And, finally,
3 we're interested in your considerations of the tradeoffs
4 between accuracy and uniformity,
5 And, with that, I'll turn things back to Mike.
6 DR. CHERNEW: So, yes, we're going to go start
7 with Round 1. So, Carol, thank you. This has been a
8 decade's worth of work from the first time on the
9 Commission.
10 MS. KELLEY: Lynn, Round 1.
11 MS. BARR: The Round 1 queen today, right?
12 So guess what I'm going to talk about, Carol? It
13 would be the rural recommendation. I guess you probably
14 knew that.
15 So a couple of Round 1 questions. Could you
16 quantify or would you be able to quantify what the
17 contribution of the SNFs are to the overall rural hospital
18 margin? You were saying rural hospitals own the majority,
19 a lot of the SNFs that are in rural, and by not adjusting
20 those payments, that's going to take a direct hit on rural.
21 And I'm curious as to whether that would be significant to
22 them. Does that make sense to you?

1 DR. CARTER: Not really. Can you go at it again?
2 MS. BARR: Sure. If I'm a rural hospital and I
3 own the SNF, how much is that impacting my financial bottom
4 line?
5 DR. CARTER: Well, so it would depend what kind
6 of hospital you were. If you're a critical access hospital
7 --
8 MS. BARR: Yeah.
9 DR. CARTER: -- you're paid not on the PPPs.
10 You're paid your costs. They're out of this.
11 MS. BARR: They're not in this, right?
12 DR. CARTER:
13 MS. BARR: So rural PPS hospitals.
14 DR. CARTER: Right.
15 And so your question is how would this affect --
16 MS. BARR: Right. So you're asking them to not
17 do the rural adjustments.
18 DR. CARTER: Even with our modeling -- and it
19 isn't ours versus theirs, but rural providers, their
20 payments would increase under this design and under the
21 prototype design.
22 MS. BARR: But you're suggesting they don't give

1 them the rural adjuster?
2 DR. CARTER: I'm suggesting that they should
3 design a targeted policy for isolated low-volume providers.
4 MS. BARR: Right. So I was just kind of curious
5 about -- I don't know what isolated means. I mean, they're
6 rural, but there are all kind of isolated --
7 DR. CARTER: Well, 35 miles is what's critical
8 out there.
9 MS. BARR: So then they'd be generally critical
10 access.
11 DR. CARTER: Yeah. I don't know how -- what that
12 overlap is.
13 MS. BARR: All right. So my other Round 1
14 question is, can you also add to the report the percentage
15 of long-term care facilities, post-acute care facilities
16 that have poor quality and how that compares in urban
17 versus rural areas? Because I believe the rural post-acute
18 care is much lower. It has significantly lower quality,
19 and I'm more concerned about the impact of this on them.
20 And so whether or not this, you know, as possibly a
21 justification for the payment, that may be what was in
22 CMS's mind or in the ASPE report, because I believe there's

1 a fairly large disparity in quality. So could you document
2 that for us?
3 DR. CARTER: Well, so one thing we are planning
4 on doing in the spring is talking about various
5 implementation issues, and one thing we've always talked
6 about is when PAC PPS is implemented, there should be hand
7 in hand with the value-based purchasing program. And as
8 part of that would be a performance on different quality
9 measures.
10 MS. BARR: Which could cut their payments even
11 further. If they're already disadvantaged -- I just want
12 to -- I want to recognize what I believe is true, but I
13 don't know is true --
14 DR. CARTER: Mm-hmm.
15 MS. BARR: -- that they're disadvantaged in terms
16 of quality already and so if that should be considered in
17 your recommendation on rural.
18 DR. CARTER: Well, I don't know if they're
19 disadvantaged. So I'd have to look at the differences in
20 quality and --
21 MS. BARR: Yeah.
22 DR. CARTER: And your language, I guess I'm a

1 little tripping over "disadvantaged."

2 MS. BARR: Okay. A much higher proportion of

3 rural PPS facilities are low quality.

4 DR. CARTER: Mm-hmm.

5 MS. BARR: Should we take that into account as

6 you're designing things? But, first of all, we need to

7 know what the numbers are. So that's my Round 1 is, is

8 that true? I believe it's true -

9 DR. CARTER: Mm-hmm.

10 MS. BARR: -- but I don't have the data.

11 DR. CARTER: Right. And I guess I would want to

12 look at what the rural margins are to know whether those

13 providers actually have decent margins, but they're not

14 spending it on quality.

15 MS. BARR: Yeah. That would be great. Thank

16 you.

17 MS. KELLEY: Larry.

18 DR. CASALINO: Yeah, Carol, as always, nice work

19 on a difficult subject. I just have one question. In our

20 model we used cost reports as one of the adjusters, really,

21 right? To what extent -- since the cost reports are going

22 to reflect, I think, widely different costs by setting --

1 and we say, well, we shouldn't use setting for obvious
2 reasons. Are we partly using setting by using cost reports
3 as a predictor? In other words, are we less different from
4 the ASPE recommendation than I thought we were?
5 DR. CARTER: Well, both sets of analysis used
6 cost reports in part to estimate costs of states. But our
7 modeling decidedly does not include adjusters for the other
8 settings besides the home health adjuster --
9 DR. CASALINO: No, I understand that we don't --
10 yeah, I mean, this is a major point, that we don't use the
11 other settings.
12 DR. CARTER: Yes.
13 DR. CASALINO: But if the cost reports show
14 widely varying costs per setting and we use those costs,
15 aren't we to some extent in effect adjusting for setting?
16 I'm not arguing we should. It's just a question.
17 DR. CARTER: No, I don't think so, and maybe we
18 can talk offline. But we've used the cost reports to
19 estimate the costs, but that's just in looking at their
20 costs per case. But we haven't used that in factoring in
21 any adjustment. I guess I'm -- maybe we'll take this
22 offline.

1 DR. DAMBERG: [Off microphone.]
2 DR. CARTER: I mean, different settings have
3 different costs, and their cost reports show that. But in
4 our modeling, we didn't take those cost differences -- I
5 mean, it's included in the averaging, right? We're setting
6 payments equal to the average predicted cost, so we've
7 pooled all of the stays for -- across all four settings and
8 predicting an average payment. So in that sense, we've
9 used the cost reports and we've acknowledged the cost
10 differences.
11 DR. GRABOWSKI: So I think, Larry, though, like
12 all the ventilator patients are in LTCHs. That's obviously
13 going to get weighted a lot more in terms of that patient
14 type. If more of the stroke patients are in home health
15 and SNF, you're going to get more of that weight, and then
16 obviously we're adjusting for home health. But there is --
17 I think you're worried about sort of endogenating or
18 circularity here and --
19 DR. CASALINO: Yeah.
20 DR. GRABOWSKI: -- to some degree it is a
21 function of where beneficiaries are being treated today.
22 But it's looking across the four settings.

1 DR. CASALINO: I'm not asking this because I have
2 some point I want to make, really. It's just trying to
3 understand the difference between the two models. I may be
4 being dense here, but, again, if Setting A has a cost of
5 $10 and Setting B has a cost of $20 and Setting C has a
6 cost of $50, and we say we're not going to adjust by
7 setting, but we adjust by the 10, 20, and 50, to some
8 extent we are adjusting for setting.
9 DR. CHERNEW: I think -- if you pick easier
10 numbers for me to do the math, they basically average the
11 10, 20, 50, they get one number, and then they all get --
12 if I understand correctly, they all basically get that
13 average number across the settings. And so it's not -- the
14 payment part's not adjusted, but it is reflective of the
15 average across the settings, with the exception of home
16 health, which has a separate indicator for it.
17 DR. CARTER: Right. And so what David was saying
18 is important. So when you've got a case-mix type like vent
19 that's completely dominated by LTCHs, the price of that
20 type of case is basically going to be set by the cost of
21 LTCHs because they are 95 percent of cases.
22 DR. CHERNEW: Just because they're higher weight

1 than that average. They're more -- the averaging puts more
2 weight on because there's a lot of people there.
3 DR. CARTER: Right.
4 MS. KELLEY: Dana.
5 DR. SAFRAN: Yeah, thanks. It is exciting to see
6 this all coming together and see the CMS and ASPE report
7 having so much in common with our recommendations.
8 The question I have has to do with the adjustment
9 that we recommended against and CMS/ASPE also recommended
10 against for a provider's share of low-income. And, you
11 know, reflecting back on a couple of the conversations
12 we've had today about social complexity and the value of
13 kind of accounting for that in payment, can you remind us
14 why we said no on that?
15 DR. CARTER: So the CMS/ASPE report didn't
16 discuss the low-income share, so they were silent on that.
17 Our findings were that, overall, providers that took high
18 shares of low-income patients were underpredicted, and so
19 you would underpay for them. But if you looked across
20 settings, those results were very uneven. And when we
21 looked at the 20th percentile, the 40th percentile, there
22 was not a steady increase in the more low-income patients

1 you had, the worse the predictions were for your cost. So
2 it was a very uneven relationship.
3 Then when we looked at how the model performed
4 from a beneficiary perspective, so looking at LIS/duals
5 benes, we did not have underpredictions. And so kind of
6 putting those all together, we decided that -- it didn't
7 look to us like you needed a separate adjustment for that.
8 DR. SAFRAN: If I could just ask a follow-up,
9 that was really, really helpful and clear. Knowing that
10 cost measures compared to quality measures require much
11 larger sample sizes to get to stable, reliable information,
12 I just wonder whether what you're describing as a kind of
13 noisiness might have more to do with small sample sizes and
14 less to do with the validity of that adjustment. So I'll
15 just -- maybe that was a Round 2. Sorry. That was a Round
16 2.
17 DR. CHERNEW: That was a clarifying comment.
18 DR. SAFRAN: Okay. Thank you.
19 [Off-microphone discussion.]
20 DR. CARTER: I'd have to go back and look, but my
21 guess is we don't have sample size issues for the things
22 we're looking at. We have a lot of records in here. And

1 at least in our analysis, we included 3.6 million stays,
2 and even by quintiles, by setting, I think we had enough in
3 the cells to make those statements. But I could go back
4 and look at that.
5 DR. SAFRAN: It doesn't depend on facility-level
6 information, the estimates, the soundness of the estimates?
7 DR. CARTER: No, we were pooling -- we were
8 resolving pooled information across providers.
9 DR. SAFRAN: I'll follow up with you offline. We
10 can think about it.
11 DR. CARTER: Okay.
12 DR. SAFRAN: Thanks.
13 MS. KELLEY: Okay. That's all I have for Round
14 1, so we'll move to Round 2, and David is first.
15 DR. GRABOWSKI: Great. Well, first of all, thank
16 you, Carol. This is just super work. I'm really excited
17 that we're continuing along this journey, and this one
18 really is a journey. Jaewon used that a couple of times
19 earlier, but this has been, what, ten years or so? So it's
20 -- this is my final year on the Commission, and it was
21 ongoing when I joined, so it's been a lot of work on this
22 issue. Carol, you've been amazing in leading it.

1 I wanted to make one broad comment and then five
2 kind of more specific comments on the CMS/ASPE model. So
3 the broad comment is really about where we are today versus
4 where we were as a program, and post-acute care in
5 particular, when this was initially introduced. I think
6 the idea behind the unified PAC was that Medicare was
7 paying these very different rates across the four settings
8 for very similar types of patients, and this was an
9 opportunity to correct all the distortions that that
10 created.
11 So much has changed about post-acute care and
12 Medicare over that ten-year period, most obviously the
13 expansion in Medicare Advantage, many of the alternative
14 payment models which have treated post-acute care like a
15 piggybank and kind of taken out some of the low-value post-
16 acute care. We've seen this transition in home health and
17 skilled nursing facilities towards the patient-driven
18 payment model and the patient-driven groupings model, which
19 now pay post-acute care providers based on patient
20 characteristics versus the amount of therapy delivered.
21 Site-neutral for long-term care hospitals is a huge
22 development, maybe the single best post-acute care policy

1 over the past decade in terms of really curbing low-value
2 use. And then obviously the pandemic has even shifted
3 things more recently in terms of post-acute. So a ton of
4 changes. And I'm not certain the unified PAC is as
5 relevant today as it was when we started.
6 That said, I still think it would help. I just
7 think we have to remember it's still based on fee-for-
8 service, and at the end of the day, alternative payment
9 models and Medicare Advantage are probably better ways of
10 addressing low-value PAC. But I do think unified post-
11 acute care payment could be part of a broader solution. So
12 I'm still bullish on going down this road.
13 Some specific comments on the CMS/ASPE model.
14 First, I don't want to bury the lead and say it very
15 clearly, their model shows that a PAC PPS is possible, and
16 it really -- although we took a very different approach --
17 "we" being MedPAC took a very different approach. You have
18 two independent analyses using kind of different methods
19 that both support the feasibility of shifting to a unified
20 PAC PPS. So we shouldn't lose sight of that, even though
21 I'm going to offer some criticisms in a minute of the
22 CMS/ASPE approach, I think overall very positive.

1 The biggest difference, Carol -- and you raised
2 this -- between MedPAC and CMS is this adjustment for post-
3 acute care setting. Their approach has the advantage of
4 improving the accuracy of their estimates, but it really
5 undermines that long-term goal of directing patients to
6 lower-cost settings when there's overlap. If you have
7 stroke patients being treated in multiple settings, you
8 really want to direct them to the lower-cost settings.
9 CMS/ASPE is very up-front about this in their
10 report. They don't try to hide this. They do this
11 adjustment to improve payment accuracy. I like the idea
12 that this is sort of a stepping stone towards an ultimate
13 destination, and so as long as we don't treat their model
14 as the final model, I think it's a really good step. And,
15 indeed, I don't know if you'd want to take this huge step
16 to go from kind of the four PPSs we have today with very
17 different models to one unified PAC PPS with no adjustment
18 by site. I actually think there's a nice middle ground
19 there, a stepping stone, as you move towards a unified PAC.
20 In the long run, you want to, I think, maximize
21 kind of uniformity by dropping this adjustment by setting,
22 but in the short run, I actually like the adjustment as a

1 sort of on ramp to the unified PAC.
2 The third comment, I think the one number that
3 really stood out to me in the CMS/ASPE model was the idea
4 that they didn't really account for the current overpayment
5 in existing post-acute care payment rules. I said earlier
6 how much I like site-neutral for LTCHs, and to see their
7 model giving LTCHs a 17 percent increase really undermines
8 all the gains we've made under site neutrality. So that's
9 something that really needs to be adjusted in their model,
10 and you say that well, Carol, in the piece. But I just
11 wanted to double down on that.
12 The fourth point is on the rural adjustment. I
13 am glad Lynn is sitting on the other side of the table for
14 this. I don't think the broad rural adjustment makes
15 sense. I prefer what Carol suggested in a more targeted
16 approach, and so I don't have -- I'll just leave that
17 there, but I did want to get that on the record.
18 A final thing, Carol, just an editorial comment.
19 I think you really kind of raised this issue of this
20 tradeoff that's present between the uniform design features
21 that MedPAC puts forward except for the HHA adjuster and
22 the payment accuracy that CMS is really trying to maximize.

1 I don't know if there's a better way, but there's some way,
2 whether it's a text box or something, to really show that
3 tradeoff kind of more directly in the modeling, because
4 it's a really fundamental point. You say it in the
5 abstract of the piece. It comes up. But I feel like it
6 gets kind of lost of how it actually gets operationalized,
7 and I just think for the lay person -- I don't know, do lay
8 people read our reports? But even for a sophisticated
9 policy audience, I think we want to really lay out that
10 tradeoff well for them so they can understand why is CMS
11 doing this, what are the implications. You know, they're
12 trying to maximize a slightly different goal.
13 Once again, great work, Carol, and I'm really
14 excited to see where this chapter goes for the rest of this
15 cycle, so thank you.
16 MS. KELLEY: Lynn.
17 MS. BARR: Thank you. I would like to talk about
18 the rural adjuster just a little bit more.
19 [Laughter.]
20 MS. BARR: Quickly. So it's a 13 percent
21 adjustment that then gives 3 percent to rural. So if we
22 don't do the adjustment, it's a 10 percent hit. Urban is

1 fine. Urban is zero, right? Rural takes a 10 percent hit
2 without the adjustment. We could argue that it's a 10
3 percent adjustment versus 13, but I don't think it's fair
4 to take that much money off the table for rural providers
5 that are struggling to stay open today, have the poorest
6 quality in the country.
7 Thank you.
8 MS. KELLEY: Scott.
9 DR. SARRAN: So when I read through this and
10 thought about it, I thought about it through two lenses.
11 One is long-time Medicare Advantage chief medical officer,
12 and the other was consulting work I did with one of the
13 large conveners in BPCI, and then looking at all the
14 published literature, which is quite a bit, in BPCI. And I
15 asked myself if this would address some of the issues and
16 enable some of the solutions that I think are common from
17 both those experiences. And then I further asked myself,
18 based, David, on what you said: Well, do we still need it,
19 right? Because it is a different -- you know, the industry
20 has evolved because of interim regulations.
21 And I think the answer is yes on all of those,
22 maybe not as strongly as we did, fill in the blank, five

1 years ago, because I think there are still two major
2 issues, two major take-homes from either Medicare Advantage
3 vantage point or a BPCI lens, which is we still see a fair
4 amount of clinically unnecessary high-cost setting
5 utilization, LTCHs and IRFs, when it's not driven by
6 clinical need when, you know, a high-end, high-capability
7 SNF exists in that marketplace and can deliver appropriate
8 services at a lower-cost setting. And there's still
9 unnecessarily high lengths of stay in fee-for-service
10 Medicare and SNFs. Everybody who's involved in Medicare
11 Advantage looks at that and, of course, that -- I think
12 somebody used the word "piggybank." That was a large
13 piggybank for BPCI, appropriately so. "Piggybank" is not
14 the right term because, you know, it's a negative
15 connotation, but it was an appropriate source of savings.
16 And, by the way, the BPCI literature, I think --
17 you know, you can summarize by saying, hey, they took a lot
18 of money out of post-acute, the successful players in BPCI
19 took a lot of money out of post-acute, largely by avoiding
20 unnecessarily high-cost settings and by reducing SNF
21 lengths of stay. And, by the way, there was no evidence of
22 negative quality impact, none at all by doing that. So it

1 sort of reinforced that, yeah, there was this fat in the
2 system, and you can address it.
3 So I think the solution on the table net of our
4 piece about don't automatically adjust for the setting, so,
5 you know, our solution, not the pure CMS solution, I think
6 it is pretty solidly correct. I think we'd all believe
7 that the political realities based on the strong lobbying
8 power of the industries in question, as well as the
9 realities I think everybody respects that these are
10 industries that have not yet recovered from the business
11 and clinical impacts of COVID, are going to dictate that
12 whatever is implemented will be implemented in a step-wise
13 fashion. So, you know, I kind of figure like that's a
14 given. These industries have clout. They get listened to.
15 And, by the way, they should be listened to now because
16 they haven't yet recovered, right?
17 So net of all that, I think this is the right
18 thing. I think we should call out that our model, as
19 you've got on Slide 9, without adjusting for SNF or for
20 LTCH, is the right approach, and we should advocate for an
21 understanding that there will logically and necessarily be
22 some kind of phase-in.

1 MS. GINSBURG: A question. Do we know for sure
2 that CMS/ASPE actually looked at our model before they
3 designed their own?
4 DR. CARTER: Well, we published very similar
5 model results in 2016, so I'm sure that they have looked at
6 it.
7 MS. GINSBURG: So you think yes, but nobody came
8 and asked particular questions, why did we do it this way
9 versus that way? There was no dialogue?
10 DR. CARTER: We've had plenty of dialogue back
11 and forth, but mostly about their design. I think, you
12 know, our work has been in the public for years. So they
13 have --
14 MS. GINSBURG: They knew what they were --
15 DR. CARTER: Well, I think they've put the
16 setting indicators to improve their accuracy, so it wasn't
17 like they didn't know about our work. I think they put
18 those in there to improve the accuracy of their model, and
19 I think they thought that some of those differences between
20 settings reflect the costs associated with regulatory
21 requirements, which are quite different across the
22 settings. So I think there are reasons for why they did

1 it. The question is, as a long-term design, is that a
2 feature that you would want?
3 MS. GINSBURG: I was just curious whether at the
4 time they were doing this, did they come and talk to staff
5 at all about the fact that --
6 DR. CARTER: We've talked with them about the
7 adjusters.
8 MS. GINSBURG: At the time that they were
9 created?
10 DR. CARTER: Yes, we talked with them explicitly
11 about the adjusters.
12 MS. KELLEY: I have one last Round 2 comment,
13 unless there's someone else who wants to get into the
14 queue.
15 Okay, Robert has a comment that I will read.
16 "Excellent presentation. Thank you for clearly
17 laying out issues. I actually do not have major concerns
18 with the use of adjusters by PAC setting, specifically
19 because it may lead to improvements in payment accuracy.
20 The CMS model may be a good bridge as we continue to
21 explore longer-term prospective payment systems that are
22 more uniform in the payment structure. I look forward to

1 reviewing draft recommendations during this analytic
2 cycle."
3 DR. CHERNEW: And if I understand that look from
4 Dana that was the last Round 2 comment. So I'm going to
5 pause for a second and see if people want to say something,
6 and then I'm going to wrap up.
7 One of the things that actually struck me about
8 this, and it actually comes up a lot, is what the notion of
9 payment accuracy means. To some extent, payment accuracy
10 means the payment is somehow equaling the cost, but that's
11 not how we use it all the time, in ways is the cost of an
12 efficient provider, and there are a bunch of questions like
13 that.
14 So the challenge we have here is the
15 comprehensiveness of this, in some sense, a greater breadth
16 than what we were just talking about before in terms of
17 site neutral, which is which patients can be in which
18 places, to what extent is the site a case-mix indicator or
19 a cost indicator, and all the other things we could
20 probably replay some of the discussion from our site
21 neutral discussion we had a moment ago, here to think
22 through it.

1 I think what I hear, of course, is there is a lot
2 of enthusiasm to continuing to think about these types of
3 issues. I don't think we're going to come back with
4 another broad post-acute PPS chapter, at least not in the
5 window that I see. But the underlying ideas behind getting
6 efficient care delivered in the efficient site, and paying
7 the amount that's appropriate for that care matters, and
8 where, again, it's just a challenge.
9 There are a whole bunch of cross-subsidies, a
10 whole bunch of economies of scope and production, in a
11 whole bunch of complicated ways across these sites, and
12 we're always worried that if we unravel one of the
13 inefficiencies, one of the sources of the cross-subsidy,
14 that we're going to be left in a world where, oops, this
15 other care is no longer viable. We can't support the care
16 that's really needed because we're no longer subsidizing in
17 this way that we were, and that's a concern.
18 And I think we've spent a lot of time thinking
19 about that, and we will continue to engage policymakers
20 should they decide to go down this path. And in the spirit
21 of Marge's comment, understand that our chapters are never
22 the end of any of those things. As any of these things

1 move forward there are comment letters that we make when
2 they put out the regulations, there is a lot of staff-level
3 comment about specific things, as Carol was alluding to a
4 minute a go, and I think that as many of you noted, the
5 issues that arose when this journey was started, have been
6 addressed in a number of different ways, and there is
7 obviously still more to be done, as I think David said.
8 And so we will see where that goes.
9 But for now, what I hear is broad support for
10 this chapter, broad support for the ideas, and I think I'm
11 going to then close with just a thank you to Carol, unless,
12 Jim, do you want to add anything?
13 DR. MATHEWS: No.
14 DR. CHERNEW: All right. So we are then going to
15 adjourn for the evening, and we're going to pick up
16 tomorrow. I think we're starting in the morning, is it
17 safety net that's first? Yeah. So we're going to start at
18 9:00 tomorrow morning, when we're going to deal with safety
19 net and Medicare Advantage benefit standardization for
20 tomorrow.
21 To folks that are listening at home, please reach
22 out and give us comments. You can reach us at

1 meetingcomments@medpac.gov. You can go on the website.
2 You can reach out by just otherwise contacting the staff.
3 But we do want to hear from the public about the material
4 that was discussed this afternoon, or for that matter this
5 morning.
6 And again, thank you, and thank you to the staff
7 for all the work on all the chapters that we heard this
8 afternoon and this morning.
9 So we are now adjourned.
10 [Whereupon, at 4:51 p.m., the meeting was
11 adjourned, to reconvene at 9:00 a.m. on Friday, November 4,
12 2022.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

The Horizon Ballroom
Ronald Reagan Building
International Trade Center
1300 Pennsylvania Avenue, NW
Washington, D.C. 20004

-and-

Via GoToWebinar

Friday, November 4, 2022
9:00 a.m.

COMMISSIONERS PRESENT:

MICHAEL CHERNEW, PhD, Chair
AMOL S. NAVATHE, MD, PhD, Vice Chair
LYNN BARR, MPH
LAWRENCE P. CASALINO, MD, PhD
ROBERT CHERRY, MD, MS, FACS, FACHE
CHERYL DAMBERG, PhD, MPH
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AGENDA PAGE

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1 P R O C E E D I N G S

2 [9:00 a.m.]

3 DR. CHERNEW: Good morning, everybody, and thank
4 you for joining us for our Friday morning MedPAC meeting.
5 I'll make the same joke I made yesterday that if you want
6 to give us feedback, it is MeetingComments@MedPAC.gov. I
7 think now we're okay.

8 So we're going to start this morning with a
9 continuing work of looking at safety net. We have some
10 safety-net physician work, and we're doing a lot of safety-
11 net hospital work. I think it's been a -- this is the
12 second year of this sort of general work in the cycle of
13 how we support safety-net providers, and so I'm going to
14 turn it over to Jeff and Alison. And I think Jeff is going
15 to start.

16 Jeff.

17 DR. STENSLAND: All right. Well, good morning.
18 All right. We're good to go.

19 Today we are going to discuss payments to safety-
20 net hospitals, and this can be seen as a follow-up to our
21 June 2022 chapter on safety-net providers. The audience
22 can download a PDF version of these slides in the handout

1 section of the control panel, which is on the right-hand
2 side of the screen.
3 In 2020, the House Ways and Means Committee
4 asked MedPAC to examine access to care for rural and
5 vulnerable beneficiaries. We found that rural and urban
6 beneficiaries used similar volumes of care. We also found
7 dual-eligible beneficiaries and beneficiaries with multiple
8 chronic conditions used more care, as we expected.
9 However, we have ongoing concerns about whether
10 the safety net for low-income beneficiaries will be
11 maintained. Specifically, hospitals serving low-income
12 beneficiaries may have trouble competing with other
13 hospitals for labor and technology. This may eventually
14 force some closures.
15 However, large across-the-board increases in
16 Medicare payment rates are not financially responsible.
17 Therefore, last year we started to investigate targeting
18 safety-net funding to providers that serve low-income
19 Medicare beneficiaries. Our initial work on this topic was
20 published in our June 2022 report to Congress.
21 The overarching change we have been discussing
22 for the past year is to have Medicare payments more

1 directly tied to the care of Medicare patients, with higher
2 payments for providers serving low-income Medicare
3 beneficiaries.
4 In June, our report discussed how to identify and
5 financially support safety-net providers. The chapter
6 outlined a two-step process for identifying safety-net
7 providers and determining the level of supplemental
8 payments for these providers. While the framework is the
9 same for all sectors, the profitability of treating
10 different types of patients varies by sector. So the
11 specific characteristics that we used to identify safety-
12 net providers will also vary by sector.
13 Some Medicare safety-net providers will need
14 additional funds beyond Medicare basic rates. Others may
15 be adequately paid under Medicare's current payment rates.
16 In our June report, we reported on an example of
17 how this framework could be applied to the hospital sector.
18 Today we update that framework.
19 I want to emphasize that we've created a way to
20 identify Medicare safety-net hospitals and determine
21 appropriate Medicare safety-net payments. The process for
22 determining appropriate safety-net payments from Medicaid

1 or other payers may differ from the Medicare process.
2 We identified low-income beneficiaries as those
3 receiving the Part D low-income subsidy, and we refer to
4 these as LIS beneficiaries.
5 Our metric for measuring low-income status
6 differs from much of the health services literature, which
7 defines low-income as fully dual-eligible beneficiaries.
8 We have expanded the definition of low-income Medicare
9 beneficiaries to include all dual-eligible beneficiaries
10 plus non-dual-eligible beneficiaries that receive the LIS
11 subsidy. This is a more inclusive definition of low income
12 that appears to do a better job of predicting margins and
13 closures.
14 The LIS metric has some face validity in that the
15 LIS beneficiaries are much more likely to be disabled,
16 Black, Hispanic, and have ESRD. They are also slightly
17 more likely to be female or live in a rural area.
18 A side benefit of using the LIS metric is that it
19 may encourage hospitals to help their patients sign up for
20 Medicare savings programs which help with the Part B
21 premiums and/or cost sharing and result in automatic
22 qualification for the LIS program.

1 Now I will present an example of how this
2 framework could be applied to the hospital sector. I have
3 updated the work from our June chapter which used 2016 data
4 with 2019 data and made some refinements to our methods,
5 but the results are largely consistent with our earlier
6 work.
7 The first step is to identify Medicare safety-net
8 hospitals. For hospitals, low-income Medicare patients
9 tend to cost more to treat, and our data suggests hospitals
10 are less likely to receive full cost sharing when treating
11 low-income beneficiaries, including those who have Medicaid
12 as their secondary insurance.
13 In some cases, Medicaid simply does not pay the
14 full cost-sharing amounts. Higher costs and lower revenues
15 tend to equate to LIS beneficiaries being less profitable
16 than other patients.
17 In addition, patients with public insurance
18 usually do not generate material profits for hospitals.
19 Therefore, hospitals with high shares of low-income
20 Medicare patients or high shares of patients with public
21 insurance would be deemed safety-net providers.
22 Now, that's just the first step of the process.

1 The second step is to ask whether these hospitals serving a
2 disproportionate share of low-income patients need
3 assistance from Medicare, and I think the answer is yes.
4 We see that even with current safety-net payments, we
5 showed in our June chapter hospitals serving lower-income
6 populations had lower profit margins and were more likely
7 to close.
8 In addition, Medicare patients do not generate
9 material profit margins on average.
10 Therefore, some safety-net funds are justified.
11 However, the question remains as to how to determine each
12 hospital's magnitude of that safety-net payment and
13 determine the magnitude in aggregate of all those safety-
14 net payments across all hospitals.
15 As background, I want to familiarize you with
16 the current DSH payments. For a hospital to be eligible
17 for the DSH program, the sum of the hospital's Medicaid
18 share of patient days plus the hospital's share of Medicare
19 patients who receive supplemental security payments must
20 exceed 15 percent. This means the hospital must either
21 serve at least a modest share of Medicaid patients or have
22 at least a modest share of low-income Medicare patients.

1 About 80 percent of hospitals meet this DSH threshold.
2 In 2019, these hospitals received about $3.1
3 billion of DSH add-on payments to their inpatient payment
4 rates. They received about $8.3 billion of payments to
5 assist with uncompensated care costs. The $8.3 billion is
6 equivalent to about 20 percent of these hospitals total
7 uncompensated care costs.
8 There are five potential concerns with the DSH
9 and uncompensated care payments we've raised in the past.
10 First, DSH indirectly subsidizes Medicaid. Higher shares
11 of Medicaid patients results in higher Medicare inpatient
12 payment rates.
13 Second, DSH shares are negatively correlated with
14 Medicare shares. This means that hospitals with high
15 shares of Medicare patients tend to receive a lower
16 percentage add-on to their payments.
17 Third, the DSH payments are inpatient-only add-on
18 payments, and this may not be appropriate as the industry
19 moves more and more to outpatient services.
20 Fourth, it is not clear that given Medicare’s
21 financial difficulties, Medicare should shoulder such a
22 large share of the uncompensated care burden.

1 Fifth, current uncompensated care payments are
2 distorted to paying greater amounts to hospitals with few
3 fee-for-service patients and more Medicare Advantage
4 patients.
5 Now, this slide explains the fee-for-service/MA
6 bias I just mentioned.
7 As we explained in more detail in your mailing
8 material, the current system is biased toward providing
9 less funding to hospitals primarily serving fee-for-service
10 patients and more funding to hospitals serving mostly MA
11 patients. This stems from how the current method of
12 determining the add-on payment per discharge.
13 Let's walk through this example to explain this.
14 First, assume two hospitals both have $2 million in
15 uncompensated care costs. The first hospital in the first
16 column primarily has fee-for-service discharges, with 750
17 Medicare fee-for-service discharges and 250 MA discharges.
18 The hospital in the second column primarily serves MA
19 patients with 250 fee-for-service discharges and 750 MA
20 discharges.
21 The first step is CMS computes an interim add-on
22 payment to each fee-for-service discharge. This add-on is

1 computed so that both hospitals would receive the same
2 share of uncompensated care costs from fee-for-service
3 Medicare. In 2019, that was about 20 percent of
4 uncompensated care costs. That means the hospitals would
5 both receive fee-for-service add-on payments equal to about
6 $400,000 or 20 percent of the $2 million in uncompensated
7 care costs.
8 Now, next is where the bias comes in. The add-on
9 amount is computed as the total uncompensated care payment
10 divided by the number of fee-for-service discharges. For
11 the first hospital, this add-on is $0.4 million divided by
12 750 or $533 per discharge.
13 However, MA plans generally pay fee-for-service
14 rates per discharge. These uncompensated care interim add-
15 on payments are built into the MA rates. The net result is
16 the first hospital gets that $533 add-on for 250 MA
17 discharges, and the second hospital would get an estimated
18 $1,600 add-on for its 750 MA discharges.
19 In the end, the high fee-for-service hospital
20 gets a about half a million dollars, while the high MA
21 hospital gets about three times that amount. The
22 difference is all due to the distorting effects of how the

1 uncompensated care interim add-on payment is computed into
2 the fee-for-service prices, those fee-for-service prices
3 that are then in turn used by MA plans.
4 So we have shown some concerns with the current
5 DSH and uncompensated care payments. So what alternative
6 are we going to talk about that may be better?
7 In the June chapter, we presented a metric is
8 called the Safety-Net Index that can be used to identify
9 and pay safety-net hospitals. The safety-net index is
10 computed as the sum of three factors. The first is the
11 hospital's LIS share, meaning the share of inpatient and
12 outpatient Medicare claims that are for beneficiaries
13 receiving the low-income subsidy. The second is
14 uncompensated care cost as a share of revenue, and the
15 third one half of the Medicare share of inpatient days.
16 The rationale for this particular formulation for the
17 Medicare Safety-Net Index is discussed in your June
18 chapter.
19 The purpose of adding in Medicare shares is to
20 acknowledge that Medicare profit margins are substantially
21 below where they used to be when the DSH program was
22 enacted in 1985.

1 In this illustrative example, we allow about 90
2 percent of hospitals to receive some SNI payments. The
3 supplemental payments, however, as we show on the next
4 slide, change as your share of low-income patients that you
5 serve changes.
6 This graphic illustrates an option for
7 distributing safety-net add-on payments. In this
8 illustrative example, 90 percent of hospitals would qualify
9 for some add-on to both inpatient and outpatient payment
10 rates, but the amount of the add-on would increase as the
11 SNI increases. The increase is slow and continuous. So
12 there's no cliffs where providers with a slightly higher
13 SNI score would receive dramatically higher payments.
14 The maximum SNI in this illustrative example is
15 at about 26 percent for hospitals with an SNI at the 95th
16 percentile.
17 Now, we compare the current DSH and uncompensated
18 care payments paid under current policy to what the SNI
19 payments illustrated in this graphic would be under the
20 alternative policy.
21 The first line shows that fee-for-service
22 Medicare spent about $3.1 billion on DSH and $8.3 billion

1 on uncompensated care in 2019. If we redistributed that
2 money using an SNI metric, there would be $11.4 billion to
3 be redistributed.
4 The second row illustrates that the driving
5 factor behind DSH payments are the share of inpatient days
6 where Medicaid is the primary payer. Uncompensated care
7 payments, in contrast, are driven by uncompensated care
8 costs at each hospital. They'll also be higher for
9 hospitals with high MA shares.
10 The SNI is a composite measure that increases
11 when there's a larger share of Medicare patients who
12 qualify for LIS, Medicare shares are larger, and
13 uncompensated care costs are large relative to hospital
14 revenues.
15 The DSH and the SNI are distributed as add-ons
16 payments to Medicare claims. The uncompensated care
17 payments are different. Hospitals with small Medicare
18 revenues can still receive large uncompensated care
19 payments from the Medicare program.
20 The uncompensated care payments are also
21 different in that the share of uncompensated care costs
22 paid do not increase as low-income share increases.

1 The biggest change we are talking about is
2 shifting about $8 billion from the uncompensated care pool
3 to the SNI. So are we talking about when we say
4 uncompensated care costs?
5 The uncompensated care costs are charity care and
6 bad debts. In 2019, the total uncompensated care provided
7 by American hospitals was about $40 billion. About 53
8 percent of that was charity care to the uninsured. About
9 15 percent was charity care for the insured who had
10 insurance but were not expected to pay their cost sharing,
11 and about 32 percent was classified as bad debt.
12 In 2019, fee-for-service Medicare paid hospitals
13 about $8 billion in uncompensated care payments covering
14 about 20 percent of these costs. In addition, those
15 uncompensated care payments resulted in increases to MA
16 benchmarks of about another 3- to $4 billion.
17 There are some important mechanics with respect
18 to how the SNI add-on payment would be distributed to
19 providers.
20 First, The SNI add-on would also apply to
21 inpatient and outpatient payments. In contrast, current DSH
22 payments only apply to the inpatient patients.

1 Second, we are proposing CMS distribute safety-
2 net funds for both fee-for-service and MA patients.
3 Importantly, the proposed SNI payments would be made
4 directly from CMS to the providers rather than just be
5 added to MA benchmarks. This differs from current policy.
6 Currently, CMS distributes safety-net payments for fee-for-
7 service patients only. These higher DSH and uncompensated
8 care payments then result in higher MA benchmarks in
9 counties with safety-net providers. This in turn results
10 in higher payments to MA plans with patients in those
11 counties.
12 However, it is not clear that these payments to
13 MA plans always reach the hospitals. For example, MA plans
14 could leave safety-net providers out of their network if
15 they deem the Medicare rates for those hospitals is too
16 high. By directly sending MA payments to safety-net
17 hospitals, CMS could assure that the providers serving the
18 low-income Medicare beneficiaries receive the funds.
19 There is a precedent for this method. Currently,
20 CMS generally sends all indirect medical education payments
21 directly to hospitals rather than including them in the MA
22 benchmark. CMS pays directly for the fee-for-service side

1 and the MA side when doing indirect medical education.

2 Now, in this slide, we simulate what would happen

3 if DSH and uncompensated care payments were replaced with

4 the safety-net payments determined by the SNI.

5 Look at the top row which shows Medicare margins.

6 It shows that hospitals with the lowest SNI had a Medicare

7 margin of negative 12.4 percent. The hospitals with the

8 highest SNI quartile had a Medicare margin of negative 0.9

9 percent. This difference is because high SNI hospitals

10 currently get greater DSH and uncompensated care payments,

11 and they tend to have lower costs.

12 Next, we simulate what would happen if we

13 redistributed those payments using the SNI. Now, look at

14 the last column on the right. The first two rows show that

15 the simulated Medicare margins of high SNI hospitals would

16 increase from about negative 0.9 percent under the

17 DSH/uncompensated care policy to about 3 percent under the

18 SNI policy. The philosophical idea is that these high SNI

19 hospitals do not have the type of patient mix that allows

20 them to generate large profits on commercial patients.

21 Therefore, we want to have a Medicare fee structure for

22 these hospitals that give them a high enough probability of

1 having Medicare at least cover their cost of serving low-
2 income Medicare patients.
3 In the first three rows, we simulate how total --
4 in the final three rows -- excuse me -- we simulate how
5 total, meaning all payer margins, would change. You see
6 the last column. The high SNI hospitals would have their
7 total margins increase from about 3.1 percent to 4.2
8 percent under the redistribution of SNI funds.
9 The last row, I simulate what would happen if
10 added $1 billion to the SNI pool of dollars. This means
11 the SNI would consist of all the dollars currently spent on
12 DSH and uncompensated care plus an additional $1 billion.
13 This is just for illustrative purposes, and the $1 billion
14 would represent about one-half a percent increase in
15 payments to hospitals.
16 In this example, if $1 billion was added to the
17 pool, the last row shows that the total margins for the
18 high-SNI hospitals would increase to about 4.4 percent.
19 This shows that for about every $1 billion added to the
20 uncompensated care pool, high-SNI hospitals, all-payer
21 profit margins would increase by an average of about two-
22 tenths of 1 percent.

1 Hospitals with high Medicare shares and high
2 shares of low-income Medicare beneficiaries would tend to
3 benefit from this redistribution I just talked about.
4 These hospitals are slightly more likely to be rural.
5 Hospitals with low Medicare shares and high
6 levels of uncompensated care would tend to see reductions
7 in payments. Some of these hospitals are some large public
8 hospitals that have high levels of uncompensated care but
9 few Medicare fee-for-service patients.
10 Across all categories of hospitals -- the rural,
11 urban, teaching, non-teaching, for-profit, government,
12 nonprofit -- some hospitals would gain and others would see
13 reductions. About 5 percent of hospitals in all categories
14 would lose 1 to 2 percent of revenue. About 5 percent of
15 hospitals in all categories would gain 3 to 5 percent of
16 revenue. And this is asymmetric because the hospitals that
17 tend to lose revenue tend to be much larger, and a 1 to 2
18 percent loss in revenue for the 5 percent of large
19 hospitals can offset about the 3 to 5 percent gain for
20 relatively small hospitals that tend to be the hospitals,
21 the ones that gain the most revenue.
22 So, in summary, we showed in the June chapter and

1 today how the SNI can be used to identify safety-net
2 hospitals. It could also do a better job than the DSH in
3 identifying Medicare hospitals that are at greater risk of
4 closure. It also avoids the negative correlation with
5 Medicare shares that is a problem with the DSH metric.
6 The SNI could also be used to redirect Medicare
7 safety-net funding. The key implications of doing this
8 are, first, there would be more finding for hospitals
9 serving high shares of low-income Medicare beneficiaries.
10 There would be less direct funding of uncompensated care
11 costs for hospitals with relatively few Medicare patients.
12 Safety-net support would be equal for hospitals serving
13 mostly fee-for-service patients and those serving mostly MA
14 patients.
15 So now we have some discussion questions for you.
16 First, are there any clarifications regarding how the
17 safety-net payments or proposed SNI safety-net payment
18 adjustments would work? Is there support for moving toward
19 an SNI recommendation as part of the update process that
20 Mike will walk you through in December?
21 I turn it back to Mike.
22 DR. CHERNEW: Okay. I'm very excited about all

1 of this work. There's a lot of complexities here in what's
2 going on and a lot of distributional things that are going
3 on here, somewhere between thinking about how the Medicare
4 and the Medicaid program and uncompensated care interact,
5 which is a complicated question, and then thinking about
6 what do we do in situations where hospitals have a
7 challenging case mix and payer mix, probably true.
8 I will reserve my thoughts on those topics now,
9 and I think we should just jump through the queue. So, if
10 I have this correct, then I guess it's the theme of the
11 meeting. Lynn, you're number one, and then Dana will run
12 the queue.
13 MS. BARR: Newly retired. You know, it's like I
14 got something to do. Sorry.
15 [Laughter.]
16 DR. CHERNEW: It's one of those game shows where,
17 you know -- we need the buzzers.
18 MS. BARR: Well, you know, Jeff and Mike, I am
19 extremely excited at this work, and I have two clarifying
20 questions I'd like to ask. There's two kind of concerns
21 that are in the back of my head that I'm thinking about.
22 One of them is these large county hospitals. Even though

1 they have a small share, that share is not made up by
2 commercial patients, you know, so the share of Medicare
3 patients doesn't really reflect their -- you know,
4 necessarily how they serve the community. I think about
5 San Francisco General. And I'm wondering, like -- and the
6 hit on them is pretty severe.
7 So I was wondering, have you thought anything
8 about how we might protect those government hospitals?
9 Have you considered perhaps, if there is a $1 billion add-
10 on, is there a way to differentially, you know -- and maybe
11 that isn't on the same curve, and could that smooth things
12 out a little bit? Maybe that starts a little further down.
13 Or is there an absolute value? Because if the share is
14 small but the number is large, and the hospital has to cut
15 services because these payments -- I mean, we've been in
16 those hospitals. They've got nothing, right? And so if we
17 cut those payments to them, then they may have to cut
18 services that will affect our Medicare beneficiaries.
19 So I was curious if you -- have you done any
20 modeling that might be able to kind of smooth that out?
21 DR. STENSLAND: Well, in terms of the modeling
22 we've actually done, it's just looking at the change in the

1 total margins that appears as you increase the size of the
2 pool. And the one factor I want to remind you of, even
3 though some of the hospitals that see a reduction in their
4 total revenue are these large government providers. The
5 large government providers actually receive the biggest
6 add-on of any of the hospitals. So as the pool is
7 increased, the large government providers get a
8 disproportionate share of any of those increases in the
9 pool because they have -- they tend to still have a very
10 high SNI index. So you'll have big government hospitals
11 often with an SNI index of one, and they're getting the
12 full maximum, what the maximum is in this chart, 26 percent
13 in the first example, 26 in the next example.
14 So you could easily see as you add an extra
15 billion dollars, you might see an extra 2 percent add-on
16 for these high SNI big government hospitals. So that's
17 kind of the modeling part, the math part.
18 The other part is a philosophical part, and
19 that's the philosophical question of is this Medicare's
20 role or is that somebody else's role. Is Medicare in the
21 financial position right now where it should be paying a
22 large share of the uncompensated care cost? Should that be

1 part of Medicare's role or not? And that's not a
2 quantitative question that I can answer. That's a
3 philosophical question for you to all agree on.
4 MS. BARR: Got it.
5 DR. CHERNEW: First, I want to keep us on
6 clarifying questions, so I'm going to try --
7 MS. BARR: Right.
8 DR. CHERNEW: There are two threads that are
9 going on here, and they're both very important. One of
10 them is this notion within the Medicare payment system,
11 just within Medicare, there are concerns that the cost of
12 serving Medicare beneficiaries -- some types of Medicare
13 beneficiaries are higher and that there's challenges for
14 hospitals if they were 100 percent Medicare. We want to
15 address that issue, right? That's one thread that's going
16 through this.
17 The other thread, which is the point of your
18 question and I think the point of Jeff's answer, is the way
19 that we've set up the Medicare program has some -- I'd say
20 implicit, maybe explicit. Certainly with Jeff's comment,
21 it's now explicit -- it's cross-subsidies between Medicare
22 and other types of patients in a range of ways. So these

1 hospitals you're talking about, if I understand this
2 correctly, in some sense we remove that cross-subsidy so
3 they get hurt because they were serving a lot of those
4 patients. But then, of course, we give it back in the
5 other way. It's just net-net, they lost more than they
6 gained. I think -- is that -- and that's why their margin
7 goes down.
8 MS. BARR: And that's unique to the governmental
9 hospitals.
10 DR. CHERNEW: I think it would be true of any of
11 the type of hospitals that these big government hospitals
12 kind of fit that way, because essentially part of what's
13 happening here is there's more safety net for Medicare
14 patients, but less of a role of Medicare in providing
15 support for non-Medicare safety-net patients. I think
16 that's the basic situation that's happening.
17 DR. STENSLAND: That's basically what's
18 happening. I just want to reaffirm that the distributions
19 aren't that different. You know, if you look at how much
20 do you gain, when you see some distribution for the
21 government hospitals and some distribution for the
22 nonprofit hospitals, and they're not that much different,

1 they're just off a little bit. So in any one of these
2 categories, you're going to have some hospitals that win
3 and some hospitals that lose. And I think that's where we
4 have that little section where we talk about, okay, what is
5 kind of the tails? Like what happens if you're at the
6 fifth percentile of the winners or the fifth percentile of
7 the losers? And you notice the fifth percentiles of the
8 winners and losers aren't that much different for the
9 different credit reporting agencies. I don't want to
10 overemphasize the differences between the category.
11 MS. BARR: Thank you. My second clarifying
12 question was if these payments now are made as add-on
13 payments as opposed to the way they were sent directly,
14 that should affect the ACO benchmarks and ACO performance
15 of those hospitals, because suddenly they'll be getting
16 paid more and it won't be in their benchmark. So will
17 there be a recommendation in the report that there's some
18 adjustment to ACO benchmarks to reflect that we're moving
19 dollars from one place to another?
20 DR. STENSLAND: Right now all of the
21 uncompensated care dollars and the DSH dollars are in the
22 ACO benchmarks.

1 MS. BARR: They are, okay.
2 DR. STENSLAND: So then if we just shift it to
3 being an SNI add-on, there's nothing that really changes
4 with the ACO benchmarks. What could happen is if you take
5 the SNI payments and you pay them directly for MA, you'd be
6 taking them out of the MA benchmarks.
7 MS. BARR: Right.
8 DR. STENSLAND: Okay, but then the MA plans
9 wouldn't be paying them and they wouldn't be in their
10 benchmarks.
11 MS. BARR: But if there's a difference in
12 payment, should they consider that when they're thinking --
13 like if suddenly we put another billion dollars out there,
14 that wouldn't be in the benchmark.
15 DR. STENSLAND: If we put an extra billion
16 dollars out there, I think that would be in the ACO's
17 benchmark, but it would also be in any sort of comparison
18 benchmark or any sort of -- if we're doing a prospectively
19 set rate, it's going to be in the prospectively set rate.
20 Everybody's going to know that, you know, this billion is
21 going to everybody, so whether you're in an ACO or not in
22 an ACO, that's going to increase your payments.

1 MS. BARR: I'm pretty sure they'll take the
2 billion. They won't care as much. Thank you.
3 DR. CHERNEW: As this gets -- as we move through
4 these recommendations, there are always a lot of nuances in
5 other parts of the program that we don't quite get into.
6 And so I think the most important thing for us to think
7 through is some of the philosophical issues that were
8 raised, and then CMS would have to sort through how that
9 influences, you know, the ACO benchmarks and just a slew of
10 other things that go on. Is that basically -- okay. So I
11 think next clarifying question.
12 MS. KELLEY: Robert has a question, so I will
13 read it: "The proposal clearly suggests that
14 disproportionate share hospital and uncompensated care
15 payments could be better targeted to hospitals that treat a
16 high share of Medicare beneficiaries with low incomes
17 through the Safety-Net Index. My question may be more
18 appropriate for Mike or Jim. There may be some confusion
19 as to whether or not Medicare savings generated from 340B
20 cost sharing should be redirected to SNI add-on payments in
21 this model. I believe some of the confusion stems from a
22 recent comment letter by the Commission to CMS. My

1 understanding, however, based solely on the pre-reading
2 materials for this session is that the 340B program is not
3 directly impacted by this proposal since Part B drugs are
4 excluded from the SNI add-on payment.
5 Can you confirm if my assumption is correct and
6 there is no impact to the 340B program under this draft
7 proposal?”
8 DR. STENSLAND: That is correct. There is no
9 impact under this proposal. And the recommendation that we
10 had before in the past was that some of the savings in the
11 340B program should be sent to hospitals via the
12 uncompensated care pool. If we move to an SNI, then
13 theoretically somebody could say, well, those savings
14 should be moved to the SNI pool.
15 So, in essence, this recommendation doesn't
16 affect what happens either way. Like if you're saying
17 we're trying to redirect -- or we're not going to redirect
18 the 340B savings, well, then it wouldn't differ whether we
19 had this recommendation or not. Whether we would redirect
20 the 340B savings, that would be the same whether you have
21 the DSH and the uncompensated care pools getting the
22 redirected money or whether you have the SNI getting the

1 redirected money.

2 MS. KELLEY: Okay. Amol, you had a Round 1

3 question?

4 DR. NAVATHE: Yes, I have two Round 1 questions.

5 The first question I have is intended to be truly

6 clarifying, but I'm just kind of curious. Have we explored

7 different weights? We have the weights across the three

8 criteria of one, one, and a half. And I was curious,

9 especially given -- I realize there's some tension here in

10 the uncompensated care side because we are taking -- the

11 compensated care pool, if you will, dollars, is larger and

12 so in some sense we don't want to completely ignore that

13 because that would potentially create much larger shifts.

14 But at the same time, to the language in the draft, we also

15 want to try to direct funds more directly toward hospitals

16 that are caring for larger numbers of Medicare

17 beneficiaries.

18 So I was just curious how we arrived at an equal

19 weight for the uncompensated care portion and a lesser

20 weight for the third criterion?

21 DR. STENSLAND: So this was back -- a year ago, I

22 think, we maybe presented this stuff, but this was -- we

1 ran some regressions where -- this is back when we were
2 looking at 2016 data, and we were saying, well, if we look
3 at your SNI in 2016 and then we're going to try to predict
4 what your margins will be in the future and whether you'll
5 close between 2016 and 2020; and when we ran those
6 regressions there were certain coefficients that would pop
7 up on the Medicare share, the LIS share, and the
8 uncompensated care, which were explanatory variables in
9 there. And those coefficients were about, you know, close
10 to this half for your Medicare share and about one for your
11 LIS share and about one for your uncompensated care share.
12 So it was just something that was empirically derived, and
13 the numbers were close to those, and so I just set at that
14 level. You know, if you looked at the confidence intervals
15 of what we think those parameters would be, it would
16 include the one, the one, and the 0.5. But there's no
17 great philosophical thing that if somebody said you wanted
18 to move those a little bit this way or that way, I wouldn't
19 say that, oh, well, that's dramatically different, you
20 know, if you had a 0.6 or a 0.4 rather than a 0.5. There's
21 no big philosophical harm that is done in that.
22 DR. NAVATHE: Okay. Thanks. That's super

1 helpful. Thanks for refreshing on that piece.

2 The second point I was curious about is perhaps a

3 little bit philosophical, but the -- so you note, for

4 example, in including the criteria around the Medicare

5 days, that -- and this is in one of the tables in the

6 reading materials -- that it's important to include the MA

7 days as well. And I was curious, you know, in the kind of

8 conceptual basis for the SNI up front, we talk about, you

9 know, these -- taking care of these patients can be more

10 costly for a variety of reasons. And at the same time, if

11 we think about SNPs, special needs plans, and D-SNPs in

12 particular here, some of that extra cost is being captured

13 in the D-SNP benchmark potentially.

14 And so I was curious. Does the way that we think

15 about MA also just directly apply to D-SNPs? Or in that

16 context, is there -- I don't want to call it "double

17 payment," but in some sense, you know, are we being

18 particularly generous? And maybe we want to be

19 particularly generous, and that's fine, but I'm just kind

20 of curious. Is there a little bit of overlap in the

21 rationale as we think about -- particularly in the context

22 of D-SNPs?

1 DR. STENSLAND: I might be missing something, but
2 when I think of our -- when we're talking about why we're
3 going to pay extra per unit to these hospitals serving high
4 shares of low-income Medicare beneficiaries, it's that we
5 think that the cost to the hospital per unit of service is
6 higher. And I think when we think of the extra payments
7 for the D-SNP, we think that that is more units of service
8 for that person, and so then the aggregate costs for the
9 year are higher. So I kind of think of those as two
10 different things. Like I don't think of the D-SNPs as
11 paying higher rates for things because the costs for those
12 individuals are higher. I think of them as having more
13 units of service.
14 DR. NAVATHE: I see. Okay. I think we can leave
15 it there, and maybe we'll chat a little bit offline.
16 Thanks.
17 MS. KELLEY: That's all I have for Round 1 unless
18 anyone else wants to jump in?
19 [No response.]
20 DR. CHERNEW: Okay. Round 2, Lynn.
21 MS. BARR: I am so excited about this paper and
22 this report and these recommendations. I just want to say

1 I wholeheartedly, fully support what you're doing here. I
2 would like to see if there was some way we could do a
3 little bit of protection around those large county
4 hospitals. I do think that -- I get it that they don't
5 have as high a share of Medicare patients, but I don't know
6 if there's anything we can do about that. But I think
7 their actual numbers of Medicare patients are very
8 significant, and having been in many of those hospitals, I
9 know that taking away a significant amount of dollars from
10 them is going to hurt them painfully. So if there's
11 anything that can be done about that in terms of --
12 particularly, I'm very, very excited about the extra
13 billion dollars, and if that can somehow be, you know, kind
14 of peanut-buttered over those county hospitals, I would be
15 in favor of that. But I'm very much in favor of this
16 proposal.
17 DR. MATHEWS: Lynn, can I jump in on this point?
18 First, I want to clarify a point that came up in Amol's
19 comments and something that Mike said a few minutes ago.
20 We are not completely eliminating the cross-subsidy because
21 uncompensated care and DSH are -- or DSH are still included
22 in the formula. We are trying to shift Medicare dollars to

1 those hospitals that are essential sources of care for low-
2 income Medicare beneficiaries, and part of that hinges on
3 the payer mix of those hospitals. So we're not like
4 completely disregarding uncompensated care as part of this
5 effort. But this is being driven by, you know, a
6 philosophy of Medicare dollars for Medicare beneficiaries
7 and the providers who serve those beneficiaries. If there
8 are concerns about, you know, large impacts on publicly
9 funded safety-net hospitals that are essential sources of
10 care for non-Medicare patients, obviously the Congress
11 could consider things like transitions, grandfathering, a
12 number of different approaches to mitigate those impacts.
13 But, you know, our approach has been driven more by this
14 larger philosophical orientation.
15 DR. STENSLAND: I'd just clarify. I think Jim
16 said the DSH and the uncompensated care is still in the
17 formula. I think you meant to say the dual-eligible and
18 the uncompensated care are still in the formula.
19 DR. MATHEWS: Correct. Sorry about that.
20 MS. KELLEY: Stacie.
21 DR. DUSETZINA: I also just want to say how much
22 I support this work and moving forward with this effort.

1 I also greatly appreciate how clear your examples
2 are of how things work today and how things are not working
3 today. I think that they really help to make it concrete
4 where there are some broken parts that are much in need of
5 being reformed.
6 I also just want to reiterate the support for the
7 idea of bringing in both the inpatient and the outpatient
8 care. I think that is just philosophically super important
9 to move in that direction. And I really -- you know, from
10 your presentation today, I finally like really got that
11 difference with MA versus fee-for-service. I think that
12 was so clear and so well done. So I just really wanted to
13 say highly supportive.
14 You know, like Lynn's questions and comments, I
15 did wonder if there's an opportunity to think about -- and
16 maybe also to Amol's comment, bringing in a little bit more
17 of that -- how we got to these different weights and
18 thinking about hospital closure risk and thinking about the
19 mix of patients who are being served, like in hospitals
20 that currently treat a high percentage of Medicaid-insured
21 patients, do they also -- is that almost always correlated
22 with also serving a lot of low-income Medicare

1 beneficiaries where maybe we aren't -- like, theoretically
2 we're worried about these hospitals, but maybe they end up
3 just by default benefitting from both formulas, because I
4 think that's where people will have the most alarm, is this
5 concept that somehow now we take money out of a system that
6 is serving a lot of low-income individuals and that we need
7 for emergency care or access in a community. But I think
8 something that gives a little bit more insight into -- you
9 know, are these highly correlated in a way where we really
10 aren't going to lose places of care that Medicare
11 beneficiaries would need?
12 DR. STENSLAND: And I would just say that the
13 correlations are pretty high, so if you're looking at DSH
14 payments, you know, the DSH -- the Medicaid share and the
15 dual-eligible share, I don't remember exactly what the
16 coefficient is, but it's pretty high. So this reduction
17 that you're going to see in some of these large public
18 hospitals isn't so much because their SNI score is lower
19 than their DSH score. The SNI score might actually be
20 higher than their DSH score. But it's because they have
21 lots of uncompensated care relative to their Medicare
22 payments. So they might be getting an add-on to their

1 Medicare payments. It's 100 percent of standard Medicare
2 rates. So they're getting 100 percent add-on. And if we
3 structure an SNI where the maximum add-on now is 26 percent
4 or 28 percent, they're going to probably see a reduction in
5 payments. And it kind of gets back to that philosophical
6 question of should we be paying somebody double the normal
7 Medicare rates and is that something Medicare should be
8 doing.
9 DR. CHERNEW: I mean, again, we have a very
10 consistent theme here in these comments, that there is this
11 philosophical point that Geoff has made, which is currently
12 the way the system is set up, the Medicare program, is
13 carrying a lot of water to do things, some of which are
14 outside of Medicare. And so part of this involves thinking
15 about how we feel about that and how we worry about that if
16 we were to change that. And as Jim pointed out, I think
17 consistent with MedPAC philosophy, there are a bunch of
18 things you could do to solve that problem in a way that
19 wouldn't be through the Medicare program.
20 But you may have views. I think both of you
21 expressed some concern about that, legitimately. I
22 completely understand.

1 I think the person who is next is Jonathan.
2 DR. JAFFERY: So first of all, yeah, also echoing
3 what Stacie said, the chapter and the presentation are so
4 crystal clear, taking a very complicated policy and
5 recommendation and making it really understandable, which I
6 know isn't easy. And trying to re-explain it to somebody
7 else, I fail miserably. So that's great.
8 I think I will add to some of the philosophical
9 points that others have made around this. First, I will
10 mention I do agree with the MA piece, the MA doing a direct
11 payment. I think that makes a lot of sense.
12 But I guess I'm going to go back to my concerns
13 about that 5th percentile. And as you pointed out, Geoff,
14 it cuts across all sectors. It's not specific, although
15 there are several government urban and teaching hospitals
16 where it's actually a greater than 2 percent all-payer
17 margin, negative all-payer margin, in fact. But even the
18 others, other than rural, it's all north of 1.5 percent.
19 So those are big changes. It's not an insignificant number
20 of institutions.
21 I do understand the philosophical point we're
22 trying to make here and approach we're trying to take, but

1 I guess I'm thinking a little bit about yesterday's
2 conversation about site neutral, and where we talked about
3 what do we do about hospitals that are providing certain
4 kinds of services and need to maintain a certain capacity,
5 certainly for Medicare beneficiaries but understanding that
6 also sort of bleeds over into all people.
7 Jim, you just alluded to maybe a transition
8 period or something like that, and I think whenever we do
9 make these big changes those are useful. I worry a little
10 bit, unlike site neutral where we could hypothesize, at
11 least, that organizations could take that time period and
12 transition their operations, it's not as clear to me how an
13 organization would shift or react to this, whether it's
14 next year or five years later.
15 And I guess the one thing to think about
16 philosophically is how do we think about organizations that
17 are providing services -- and maybe this goes back to the
18 capacity piece -- that are relatively unique for large
19 geographies. I'm thinking of Wisconsin has about 5.7 or
20 5.8 million people, and there are two burn units. And
21 certainly those serve all the populations, not just
22 Medicare, but they do serve Medicare, low-income and non-

1 low-income, and I don't know how these would affect
2 organizations like that across the country.
3 But there are services like that where we do
4 maintain a capacity, and they may not get benefit from this
5 proposal, based on their share of low-income Medicare
6 beneficiaries, but they are serving those populations
7 broadly.
8 So I guess that's where my concern really lies is
9 what is the impact going to be on organizations in that 5th
10 percentile and below, because it really does feel
11 substantial. And I'm not sure that I can see a way where
12 we can transition organizations away from that.
13 So I'll stop there. Thanks.
14 MS. KELLEY: Cheryl.
15 DR. DAMBERG: I just want to congratulate the
16 team on such an excellent chapter, it was really
17 informative, and to echo Stacie's comments. The examples
18 were enormously helpful.
19 One of the things that I was wondering,
20 particularly in the context of Jonathan's comments about
21 this transition period, and thinking about how that might
22 play out, is I don't know whether sort of in the transition

1 period you could modify the weights on the component parts,
2 and that might sort of help with that adjustment period,
3 like putting more weight on the uncompensated care part.
4 Without seeing the regression models I can't get into the
5 details to sort that.
6 And then I think the other piece -- and it's
7 possible you have the data and it's just not being
8 displayed in the documents we reviewed -- the table on page
9 18 that shows the average change within those quartiles,
10 I'm wondering whether it would be helpful to show the 25th
11 and the 75th percentile, just to see what the range is
12 within those quartiles.
13 But overall I wholeheartedly agree that this is a
14 better targeting of Medicare resources, and I agree with
15 directing MA safety net funds directly to providers and not
16 the plans, although I think in our last discussion we
17 talked about some issues around accountability and what
18 happens with that money. So I still think that that's sort
19 of top of mind for probably many of the Commissioners.
20 I also agree that the SNI payments for fee-for-
21 service be excluded from that MA benchmark. I think that
22 is a particularly problematic feature, the existing

1 structure of these types of payments. And I agreed with
2 the exclusion of the Part B drugs. That seemed pretty
3 straightforward.
4 And in terms of the table on page 14, the
5 potential expansion to include the LIS share of MA claims
6 when the encounter data are sufficiently complete, I liked
7 that feature, in part, as it creates an incentive for MA
8 plans to improve their encounter data.
9 MS. KELLEY: Greg.
10 MR. POULSEN: Thank you. I'd like to pile on in
11 terms of saying what an excellent bit of work this is. I
12 think that the proposal is overall really thoughtful and
13 takes us in a beneficial direction.
14 I think the safety net index is both meaningful
15 and understandable, and I think it is both more meaningful
16 and more understandable than the current approaches that we
17 have through DSH.
18 On the philosophical point, I think I lean fairly
19 strongly towards the this is Medicare for Medicare needs,
20 Medicare funding for Medicare needs, and I think I'd throw
21 in an additional point. I don't disagree with the needs
22 that are defined and how challenged some of those

1 organizations are.

2 But I would also point out that different states
3 and different municipalities have taken very, very
4 different approaches in terms of how they approach the
5 safety net, and the fact that some communities so that less
6 effectively than others. I don't know that it's Medicare's
7 role to redress that, and that seems to me that what we're
8 saying with this proposal does not try and do that to the
9 same degree that we have done it in the past, and I like
10 that direction myself.

11 So I understand that there are needs that are
12 likely to be challenged in the interim, and I do think that
13 it warrants to look at a good transition period, that I
14 think Cheryl said. So I think that's something we could
15 look into because there are organizations and there are
16 communities where the need for a balanced transition
17 approach might be necessary.

18 I may be the only person in the room that's a
19 little uncomfortable with the idea of having direct payment
20 to facilities that are in MA. Part of that is
21 philosophical, but part of it is that I'd love us to find
22 ways -- and it goes beyond the scope of this discussion --

1 but find ways to move MA to a position where providers,
2 including hospitals, are being paid on a value-based
3 payment basis. The large percent of MA today is paid fee-
4 for-service. It's private insurance but paying fee-for-
5 service.
6 And I think to the extent that we could modify
7 that, that would do vastly more than these dollars would to
8 make both the providers and the beneficiaries achieve more
9 in the Medicare Advantage world. And so putting Band-Aids
10 on this kind of process to get those providers, I don't
11 love as much as if we could do something that would redress
12 it more holistically by getting those payments, those pre-
13 payments to the providers where they can provide much more
14 effective care, which would be, I think, the pathway that
15 most of us would like to see it go.
16 And so, again, I'm not opposed to the idea of
17 getting the money to those organizations, but I don't like
18 the idea that we're bypassing the primary role that we have
19 of getting the money into the correct incentive pool to
20 begin with.
21 I'll stop there. Thanks much.
22 MS. KELLEY: Amol.

1 DR. NAVATHE: Thanks, Geoff and Alison. As
2 everyone said, I would also echo this terrific work. It's
3 very clear, very compelling.
4 A couple of points here. First off -- well, a
5 couple of points. The first big point is that I would say
6 I'm highly supportive of this work. I really favor trying
7 to move towards a recommendation in December. That's one
8 of the points that you had asked.
9 The second point, I think I understand Greg's
10 point. I think overall, given some of the concerns that
11 have more broadly been raised, I think I would still end up
12 favoring this idea of the dollars going directly to the
13 institutions, to the hospital, in part because I think it
14 would create some additional uncertainty, which would
15 potentially make it more challenging just from an
16 implementation perspective.
17 On the broad philosophical point that Jonathan
18 and others have raised, I think it's really fundamentally
19 an important point. I think it's also fundamentally
20 important that we have a very rational policy design to how
21 we think about Medicare funding for Medicare beneficiaries
22 and the potential distortions that we end up creating in

1 terms of how we fund, even thinking about this as an add-on
2 versus how the current DSH system works.
3 Because I think, in part, what the add-on does,
4 which is really nice, is from a conceptual but also a
5 practical perspective in the cases where Medicare is adding
6 this add-on, it makes the per-beneficiary margin basically
7 higher. It tilts the incentive toward caring for Medicare
8 beneficiaries in a much stronger, more direct way than the
9 way the current system works.
10 And so I think transitions may make sense.
11 Whether we do it by changing weights or we just simply
12 blend over time to the new system, I think either one would
13 have my support. But I think we should really be thinking
14 about how the policy design affects these incentives on a
15 kind of marginal Medicare patient basis, because I think it
16 will drive the way that hospitals end up perceiving how
17 they should be potentially investing in the care of
18 Medicare beneficiaries.
19 And I think that's something that hasn't quite
20 been articulated yet by the Commissioners, so I wanted to
21 make sure that we make that point, because that's a really
22 important policy design point.

1 Thank you.
2 MS. KELLEY: Jaewon.
3 DR. RYU: Yeah, thanks. I'm also supportive of
4 the recommendations or the approach. I think it's a good
5 step. It's probably not perfect but I think it's
6 significantly better than what the current state is, for
7 all the reasons that people have mentioned.
8 On the philosophical point, I agree that the
9 Medicare program should not be the one that addresses
10 shortcomings that really should be within the purview of
11 other programs, but I also think it's important to
12 acknowledge that it's impossible to ring-fence the programs
13 from one another, and I think even short of hospital
14 closures if other programs or funding sources -- let's say
15 Medicaid or others, or county systems -- aren't supporting
16 some of these facilities, you know, programs will go away
17 as well.
18 So I think just being aware and acknowledging. I
19 still think this is the right approach, but I think there
20 is this spillover effect that needs to be acknowledged.
21 On the MA side, I agree, and I happen to like the
22 approach of having it go outside the health plans. I think

1 my main reason for that is I think many of these hospitals
2 are the same hospitals that probably don't stand in a
3 market position to effectively negotiate with many of the
4 MA plans out there to fully extract these dollars and have
5 them flow their way. And so I think the risk of that is
6 significant. So having the dollars go directly to the
7 providers or to the facilities I think makes better sense.
8 MS. KELLEY: Betty.
9 DR. RAMBUR: Thank you very much. I thought it
10 was a brilliant chapter and I really appreciated the
11 comments from all of the Commissioners, which have been
12 very enlightening.
13 I'm just going to be brief about where I'm at. I
14 am very enthusiastic about this, and we talk about it as a
15 philosophical question but it's really an issue of ethics
16 and economics as well. To me, it's absolutely unequivocal
17 that Medicare beneficiaries and the taxes that support
18 their care should not be used to subsidize other payers and
19 problems. That's very clear to me. In my view, what you
20 permit, you promote, and Medicare simply can't afford that.
21 So I'm strongly in favor of moving forward in that
22 direction, very forcefully.

1 In terms of the MA, I'm maybe, I'll have to say,
2 agnostic, because I hear what Greg said and I can see that,
3 and I hear these other arguments. So I'm, at this point,
4 agnostic about that, or undecided maybe, rather than
5 agnostic.
6 But thank you for this great work, and I think
7 it's really important.
8 MS. KELLEY: Scott.
9 DR. SARRAN: I just have two brief comments. In
10 terms of the philosophical underpinnings, if you will,
11 around Medicare and Medicare subsidizing or not subsidizing
12 other payers, I strongly agree we should not and cannot.
13 And it sounds like there's good consensus on that.
14 In terms of the MA payments and whether those
15 should go directly, I think, Greg, I hear your point and I
16 agree that fundamentally, philosophically, the MA program
17 should be about value-based care, and therefore why are we
18 paying most hospitals, as most MA plays do today, fee-for-
19 service.
20 But I think the current approach is so profoundly
21 distorting in a way that actually hurts the hospitals that
22 we are meaning to help, meaning that because their

1 benchmarks and their fee-for-service rates and prices are
2 so high, MA plans rationally steer away from those
3 hospitals. So then those hospitals are losing the volume
4 that is their best payer mix, typically, because as has
5 been pointed out, those hospitals don't have the market
6 clout -- that I think, Jaewon, you pointed out -- those
7 hospitals don't have the market clout to negotiate, by and
8 large, to negotiate high fee-for-service rates in the
9 commercial space. So Medicare becomes, because of their
10 inflated, by virtue of the current system, their Medicare
11 fee-for-service payments are so high, that's their best
12 payer, then MA plans steer away from them because that's a
13 rational act to do that.
14 So correcting that will, I think, reduce MA
15 plans' financial pressure that results in them steering
16 away, which is one of the good things we can do for those
17 hospitals.
18 MS. KELLEY: Wayne.
19 DR. RILEY: Yeah, thank you. Jaewon, in most
20 part, channeled what my comments were around the
21 philosophical issue of how it's hard to, in some policy
22 sense, demarcate between Medicare and Medicaid and other

1 policy type hospitals.

2 You know, as Commissioners we all know that

3 hospital closures are not abstract. Indeed, three days

4 ago, in Atlanta, Wellstar closed a very important safety

5 net hospital that has now created chaos within the city of

6 Atlanta, Fulton County. So I love the elegance and the

7 rigor of the work, but I do worry about the effect on

8 certain critical hospitals.

9 Jonathan made the point of burns. Nobody does

10 burns but public general hospitals. And so the swipe –

11 well, that's not fair -- but the sort of erosion that some

12 public general hospitals will have with the new

13 methodology, again, we need to be mindful of that because

14 it does have the effect of eroding critical services that

15 other hospitals do not want to do, such as Level 1 trauma,

16 burns, perinatal center, the really critical things that we

17 look to from our public general hospitals.

18 MS. KELLEY: Larry.

19 DR. CASALINO: Yeah. Great chapter, great

20 presentation, and really good comments from the

21 Commissioners, I think.

22 I wholeheartedly support it. I would be happy to

1 go with things just as they are without any changes, and I
2 do support -- I do take Greg's point. I see it as a fairly
3 long-term point, and so for the moment at least, I'd be
4 happy to have the arrangement, as recommended.
5 I want to talk a little bit about the
6 "philosophical point," as we keep calling it, make a couple
7 points that haven't made yet.
8 I think, in general, it's always better to be
9 transparent than not transparent, I think, right? So there
10 is the principle of Medicare should not be paying for the
11 taxes and what beneficiaries pay into Part B. That money
12 should not be going to support non-Medicare patients.
13 That's a pretty easy philosophical point.
14 But its corollary or second point is transparency
15 is always better, I think, and so right now the cost of
16 operating -- I trained a lot at San Francisco General. I
17 have a sense of the size and magnitude of some of these --
18 the size and importance of some of these hospitals. But I
19 think right now it's kind of hidden, you know, their needs
20 for support, and the federal government is supporting them,
21 not state government or the county government or the city
22 government. I mean, there's support from those sources too

1 but less than there would have to be if Medicare wasn't
2 supporting. So I think making that clear allows for better
3 policy to be made and clearer policy debates.
4 There's also the point that -- two other points.
5 One is that it's not like Medicare is flowing in, has lots
6 of excess money around, and it's not like Medicare is
7 politically safe, right? So, for people who would like to
8 attack Medicare, showing that it's in fiscal trouble, is a
9 useful point, and I think anything we can do to help
10 Medicare be in less financial trouble is useful for the
11 future of Medicare, generally.
12 And the last point I'd make about this so-called
13 "philosophical point" is I do wonder a little bit about our
14 consistency as a Commission across topics that we've just
15 discussed. Actually, no, I guess, so much this meeting but
16 at other meetings. So we don't want to support -- we don't
17 want Medicare dollars going to support uncompensated care,
18 for example, or to support, in fact, Medicaid patients. So
19 we're saying, you know, kind of, that that money has to
20 come from somewhere else for these large public hospitals
21 or could be smaller public hospitals.
22 But, yeah, we are willing to have Medicare

1 dollars go to perhaps more than would be strictly
2 indicated, go to keep rural hospitals open, for example,
3 and you could say, "No. It is the state government's
4 responsibility to do that. Why do the feds have to do it?"
5 So I'm not arguing for any change in the
6 proposal. I like the proposal. Frankly, I just want to
7 raise this question: Are we really consistent about our
8 principle that Medicare just pays for Medicare
9 beneficiaries across everything we discuss?
10 And then there's the philosophical consistency,
11 which isn't ideal, but I think the question is how much
12 we're going to weigh practical effects. So we really
13 thought these public hospitals were going to close. If
14 this proposal went through as is, we might feel a little
15 bit less rigorous about the philosophical consistency.
16 I would be interested in comments today and/or
17 when this topic comes up again, when we're discussing other
18 sectors, so to speak. If we always are going to apply the
19 principle really rigorously that Medicare dollars just go
20 to support Medicare beneficiaries, I agree with the
21 principle, but we haven't had this open discussion about
22 it, I think, in terms of practical effects in a while.

1 And what Wayne said about it, I wasn't aware of
2 that Atlanta story. That's pretty grim. It's all very
3 nice for us to say the state government should pay, the
4 county government, the city government, but if they don't,
5 what happens?
6 MS. KELLEY: David?
7 DR. GRABOWSKI: Great. So, first, super work,
8 Jeff. This was a really superb chapter, and I'm very
9 supportive of this direction.
10 Larry, that was a perfect bleeding because I
11 wanted to sort of think also about this philosophical
12 issue, and the sector that always, not surprisingly, comes
13 to mind for me are skilled nursing facilities. And we have
14 a discussion. We'll have one next month exactly about this
15 cross-subsidy issue that Medicare shouldn't be, you know,
16 financing low-Medicaid payments in nursing homes. The
17 Commission has been very clear on that, yet if you look at
18 the economics of nursing homes, we pay double-digit margins
19 in Medicare. The non-Medicare margins have been -- they
20 weren't in 2020, but prior to that have been negative most
21 years. And so it's a classic example, and I think it
22 creates a lot of distortions, like free ridership.

1 So I think in the longer term, this is very
2 consistent with what MedPAC has advocated, but it's
3 obviously hard in a lot of ways to correct out there. And
4 it's hard to unwind these issues, as we're seeing here, and
5 it's certainly hard in nursing homes.
6 But I think there are a lot of examples where
7 MedPAC has been very direct about not wanting to cross-
8 subsidize other payers.
9 Thanks.
10 MS. KELLEY: Kenny?
11 MR. KAN: I'm very excited and supportive of this
12 body of work, as I believe it's a more effective targeted
13 allocation of Medicare dollars.
14 Like Jaewon and my other fellow Commissioners, I
15 do agree that such payments should be made directly to the
16 facilities and not to the MA plans.
17 However, after reflecting on Greg's concern, I
18 would suggest that such payments that's made directly to
19 the facilities incorporate a value-based element with
20 revised modifier -- reward modifier kicker for SDOH to help
21 mitigate some of the health care disparities that we
22 discussed yesterday.

1 I strongly recommend that we be careful about
2 potential cost shifting to commercial plans. So, echoing
3 concerns of some of my other Commissioners, like Cheryl, I
4 recommend that we at least have a two-to-three-year
5 transition period.
6 MS. KELLEY: Greg, I think you had an additional
7 comment and Jonathan also. Is that all right?
8 DR. CHERNEW: Yeah. No, that's perfect. This
9 is the mythical Round 3.
10 [Laughter.]
11 MR. POULSEN: I even called it Round 3.
12 DR. CHERNEW: I don't know exactly. I'm so
13 befuddled.
14 So we're going to have limited time, obviously,
15 but there's at least -- keep going. So I think we are
16 going to have Greg and Jonathan. Then I do want some time
17 to reflect on how this conversation has gone, but go on,
18 Greg.
19 MR. POULSEN: Perfect. So I completely agree
20 with the challenges that Jonathan and Wayne raised. I
21 think those are -- you know, that they're profound, they're
22 troubling, they're incredibly important.

1 But I do question whether it's Medicare's role to
2 redress those kinds of issues. The two biggest markets
3 that my organization serves are Denver and Salt Lake -- or
4 Colorado and Utah. Those two states have taken
5 dramatically different approaches to the safety net, and
6 one depends upon a focused facility, Denver Health, to
7 provide the most significant components of that.
8 Utah has taken the opposite, where that's been
9 spread around, and my organization provides the strong
10 majority of those services, blended with a whole bunch of
11 other people. So it doesn't have that same focused
12 appearance that it has.
13 Similarly if we look at services like level 1
14 trauma burns, NICU, and so forth, they're very different in
15 those two communities, depending upon the way that those
16 communities have approached it.
17 Both, I think, arguably, work, but they would be
18 impacted very differently, depending on what we do with
19 these approaches. Candidly, I like the idea of saying that
20 we're about doing what's right for Medicare and communities
21 are going to have to over time, totally with Cheryl in
22 terms of let's do this in a way that doesn't have anybody

1 hit a brick wall, but that over time we can move towards
2 something that is accountable, and different communities,
3 different states may approach that in different ways, as
4 they should be.
5 So, at any rate, let me then shift to the direct
6 pay. I clearly believe that we would like to see MA move
7 in a way that makes it more accountable and makes the
8 providers increasingly accountable within that program.
9 That said, I think we need to be pragmatic, and
10 I, by no means, would throw my body across the tracks in
11 terms of not paying directly to Medicare -- or to hospitals
12 that are in the Medicare Advantage program. And I believe
13 that would be the preferable way as we approach others. I
14 just never want to miss a chance to ask us to make Medicare
15 Advantage a more accountable program and a more effective
16 program than it is today, and I think that we should take
17 every opportunity to both highlight that and move in that
18 direction, so thanks.
19 DR. JAFFERY: Great. I like Round 3, sort of
20 point and counterpoint at the end.
21 So I guess I just want to clarify the point I was
22 trying to make because there's been a lot of discussion

1 about it around some of these other services, and I brought
2 up burn. I think Wayne brought up some other things. I
3 think level 1 traumas may be even a better example for
4 Medicare beneficiaries, perinatal probably not as much.
5 So, philosophically, I want to actually reinforce
6 that I do fully support this notion that Medicare should
7 pay for Medicare beneficiaries and not be cross-subsidizing
8 things, and we've got lots of other examples of places
9 where we're trying to move in that direction.
10 In these examples -- and maybe it was brought out
11 by what looks like -- you know, the chart that looks it
12 could be very, very substantial cuts, the fifth percentile
13 and below, that even with the transition period, I struggle
14 to think that a county or state is going to take three or
15 five years to figure that out across the country.
16 But really what I think the difference for me is
17 that some of these services serve large areas and large --
18 supports Medicare beneficiaries across the board in large
19 areas, even if they don't end up serving a large number of
20 low-income Medicare beneficiaries. So that's where I think
21 it's a little bit different and maybe unique from the
22 patients they're actually seeing. It's very much, you

1 know, the fire department approach. They're there because
2 we need them sometimes, and we have to build up that extra
3 capacity. And they really do serve a very broad population
4 of Medicare beneficiaries, low income and non-low income,
5 in a way that that most other providers in their areas
6 don't.
7 So that the distinction, I think, a little bit
8 that I was trying to make as opposed to maybe just the
9 patients they're actually seeing across the board.
10 DR. CHERNEW: Lynn is going to have the last
11 word.
12 MS. BARR: Really quick.
13 I agree with what everyone said, but it is
14 important to improve -- to preserve access, and that's
15 where we should consider cross-subsidizing because what we
16 have done is preserve hundreds of rural hospitals by our
17 policies, and if that money goes away, all those hospitals
18 close, and so if we lose our burn units and our trauma
19 centers. And so I do support only supporting Medicare
20 patients, but that means preserving their access to care as
21 well.
22 DR. CHERNEW: Go on, Larry.

1 DR. CASALINO: Just a very quick comment. This
2 is -- I don't want to say agonizing, but difficult
3 discussion. I just want to ask. Maybe you guys could
4 think a little bit about, is there some cogent convincing
5 way to -- and I don't want to complicate things and go
6 beyond the SNI, but is there some kind of special status
7 that could be given to this category of hospital and not
8 just on a transitional basis but permanently with regard to
9 this proposal? Because it is true that -- well, anything
10 like that would violate the principle of Medicare only
11 paying for Medicare patients. But you would hate to see
12 burn units close or trauma units close because those are
13 important to Medicare beneficiaries, even if there aren't
14 that many of them.
15 And we can't necessarily depend on county, city,
16 or state governments to do what they do. So I'm kind of --
17 you can see I'm talking out both sides of my mouth here.
18 [Laughter.]
19 DR. CHERNEW: Let me try and jump in as we come
20 to the end of Round 3.
21 So here's what I basically hear. I'll do the
22 easy part first. I think there's widespread agreement and

1 support for all the stuff related to MA. So I'm not going
2 to discuss that much.
3 I think there's essentially universal support for
4 the principle of Medicare supports Medicare, Medicare
5 supports Medicare patients.
6 I think there's genuine troubled anguish, concern
7 that if we were to apply that principle the way we would
8 like to apply that principle, some things might happen that
9 we wouldn't want to happen.
10 We've used the phrase "transition" consistently,
11 but I want to point out this is a little bit different than
12 a standard transition discussion because a transition
13 discussion is often sort of within Medicare we're going to
14 adjust. This is almost like we're going to take our money
15 away, and someone else has to step up. And they may or
16 they may not, and if they don't, it's going to be a
17 problem, not just for the people that are not Medicare
18 beneficiaries, but also for the people that are Medicare
19 beneficiaries.
20 And it's been pointed out, we have repeatedly had
21 this discussion in the -- we will have it again in the
22 nursing home and the other post-acute updates where we have

1 said we think that we're overpaying for these services. I
2 think there's a lot of evidence that the Medicare margins
3 are quite high, and we've made the recommendation that
4 Medicare should pay less, very much in the spirit, and that
5 others should pay more.
6 And I will just point out -- so this is my second
7 time around on the Commission. We have been doing this
8 since my first time around on the Commission, and we have
9 yet to have a reduction. I think policymakers have
10 understood that despite our belief that Medicare should pay
11 for Medicare, that the policymaker community, for whatever
12 reason -- I'm not going to make judgment -- has decided
13 that they're willing to have these type of cross-subsidies
14 to support these sets of services, because there's a little
15 bit of a concern about what would happen in practice.
16 This is, I think, playing out exactly in this
17 context. It's not simply that we could say Medicare should
18 do this and then Medicare should do that. We are saying
19 Medicare should do this, and then other people, in some
20 sense, people that we don't make recommendations, should do
21 something else. That's where sort of the philosophical
22 problem is.

1 So I will say, at least for starters, that I
2 believe -- and I have voted repeatedly -- that Medicare
3 should support Medicare patients.
4 I am also troubled, as many of you are, about
5 what the consequences of that mean if the other programs
6 aren't doing what I would like them to do.
7 And so the challenge which we will grapple with,
8 in some sense -- and again, I think we do this in the SNF
9 recommendations -- is we make recommendations consistent
10 with the principle but not naively to the point to believe
11 that if they were implemented as written, there wouldn't be
12 some adjustment. And that's kind of how we're going to
13 have to think through, I think, parts of what this actually
14 means.
15 And so when we go back and think through this,
16 some of this is going to play out in the tone. So I think,
17 again -- again, maybe it's the soda talking. What I would
18 say is the principle of Medicare paying for Medicare is
19 right. If a policymaker said yes but no one else is going
20 to do it and now we're going to have these problems, I
21 would be very sympathetic to that argument and how it plays
22 out but still stick to the recommendations that kind of we

1 make.

2 And so we will think through how that plays out

3 in the tone, because I think the points about some of the

4 organizations and Jonathan's sort of a 5 percentile, what

5 that actually would mean if it was done in the other

6 groups, it's not really a transition. If the other groups

7 decide not to step up, we have a little bit of a problem, a

8 big problem in some cases actually.

9 So I think that's sort of where we are, but

10 again, just to summarize, I think there's universal support

11 for the principle of Medicare paying for Medicare. I think

12 there's universal support around the issues of MA. I think

13 there's genuine concern about what would happen in some

14 settings if we did what the recommendation would suggest,

15 and there was not a response that we think there is no one

16 willing to do this.

17 So we will continue that, and I think we're going

18 to have to sort through the text and how we think about

19 that, and we'll go back and forth with staff, and you will

20 see a version of this.

21 Actually, the last thing I'll say is there does

22 seem to be widespread support for some version of a

1 recommendation like this in December.

2 So that's my lengthy summary. We're going to

3 take now a five-minute break. I will point out we are

4 precisely on time, if I've gotten this correct. So we will

5 be back in five minutes to talk about what I think is a

6 really crucial issue, Medicare Advantage benefits and their

7 standardization or not.

8 [Recess.]

9 DR. CHERNEW: Hello, everybody. Welcome back for

10 our last session of this meeting. We're going to talk

11 about Medicare Advantage and standardizing benefits. This

12 is the second of the two-part series, and I'm going to turn

13 it over to Eric. So, Eric, go ahead.

14 MR. ROLLINS: Thanks. Good morning.

15 For our last presentation, we're going to

16 continue looking at the potential use of standardized

17 benefits in Medicare Advantage plans. In response to

18 Commissioner interest, we started our work on this issue in

19 early September, when we looked at the cost sharing that

20 plans charge for Part A and B services, and today we'll

21 look at MA supplemental benefits. We anticipate that the

22 material from these two sessions will appear as an

1 informational chapter in our June 2023 report to Congress.
2 Before I begin, I'd like to remind the audience that they
3 can download these slides in the handout section on the
4 right-hand side of the screen.
5 I'd like to start by briefly reviewing a few key
6 points from our first presentation. The number of MA plans
7 has grown rapidly in recent years, and this year
8 beneficiaries have an average of 36 plans available.
9 Research has shown that beneficiaries have difficulty
10 comparing plans and deciding which one best meets their
11 needs when they have a large number of choices. One way to
12 address these challenges is by requiring plans to have
13 standardized benefits. This approach would make it easier
14 for beneficiaries to compare plans by giving them a more
15 clearly defined set of choices. When we use the term
16 "standardized benefits," remember that we're referring to
17 both the set of services covered by the plan and the cost
18 sharing that the plan's enrollees pay for those services.
19 Under the MA program, plans must provide the Part
20 A and B benefit package, but they can also offer extra
21 benefits. Many of those extra benefits are tied to
22 Medicare in some way, such as lower cost sharing for Part A

1 and B services or lower Part D premiums, but plans can also
2 provide supplemental benefits that Medicare doesn't cover.
3 These benefits are financed by plan rebates and enrollee
4 premiums. Plans can also keep some of the rebates they use
5 to provide supplemental benefits to cover administrative
6 costs and profits. Plans use supplemental benefits to
7 attract enrollment from fee-for-service Medicare and to
8 compete with other plans, and these benefits play a
9 particularly important role for special needs plans. In
10 recent years, plans have been using a growing share of
11 their rebates to provide supplemental benefits.
12 Traditionally, plans could cover something as a
13 supplemental benefit it was "primarily health related" and
14 "offered uniformly to all enrollees." These requirements
15 kept plans from covering non-medical benefits and targeting
16 benefits to specific types of enrollees. However, in
17 recent years policymakers have given plans more flexibility
18 on both fronts.
19 Plans can now provide benefits that address
20 functional impairments, such as in-home support services,
21 thanks to a broadened definition of the term "primarily
22 health related." They can also provide non-medical

1 benefits such as food and non-medical transportation to
2 beneficiaries with chronic illnesses, as part of a new
3 category of benefits known as special supplemental benefits
4 for the chronically ill, or SSBCI. Finally, plans can now
5 target benefits based on disease state, and plans
6 participating in CMS' Value-Based Insurance Design
7 demonstration can target benefits based on socioeconomic
8 status.
9 Our understanding of supplemental benefits is
10 limited by a lack of data. The government collects
11 reasonably good information about the benefits that each
12 plan offers through the MA bid process, but it does not
13 require plans to submit encounter data for those benefits.
14 Plans also estimate the usage of supplemental benefits when
15 they develop their bids, but there is no retrospective
16 auditing of that information. As a result, although
17 Medicare makes substantial payments to MA plans, we do not
18 know how much plans spend on each type of supplemental
19 benefit, what share of enrollees use those benefits, and
20 whether service use differs by factors such as age, sex,
21 race, disability status, and geographic area. The lack of
22 utilization data is also concerning because there are no

1 network adequacy requirements for supplemental benefits.
2 As we discussed in the mailing materials, some research
3 suggests that utilization for one high-profile benefit,
4 dental coverage, may actually be fairly low.
5 Starting with the 2023 plan year, MA plans will
6 provide some information about their spending on
7 supplemental benefits when they report their medical loss
8 ratios. The MLR data should provide a high-level picture
9 of spending on supplemental benefits, but its usefulness
10 will be somewhat limited because insurers report their MLRs
11 at the contract level instead of at the plan level. The
12 MLR data for the 2023 plan year should be available
13 sometime in the second half of 2025.
14 The coverage of most supplemental benefits has
15 increased in recent years, which is consistent with our
16 findings that MA rebates have been growing rapidly and that
17 plans are using more of their rebates to provide
18 supplemental benefits. Some of the most common benefits
19 are dental, fitness, hearing, and vision coverage, which
20 are offered by more than 90 percent of plans. The growth
21 in coverage has been particularly large for certain
22 benefits. For regular plans, the biggest increases in

1 coverage have been for meals, over-the-counter benefits,
2 and comprehensive or non-routine dental services. For
3 SNPs, the biggest increases have been for meals and fitness
4 benefits. The share of plans that cover newer benefits
5 like SSBCI has been growing but is still relatively low
6 compared to many of the more traditional supplemental
7 benefits.
8 Trying to compare the supplemental benefits
9 offered by different plans can be difficult because plans
10 have a great deal of flexibility in designing their
11 benefits. They decide which items and services to cover,
12 can cap the amount they spend per enrollee, and can charge
13 cost sharing. To provide some examples of how coverage can
14 vary, we looked at MA's dental, hearing, and vision
15 benefits. As we noted earlier, almost all plans offer at
16 least some coverage of these benefits.
17 The first source of variation is figuring out
18 what's actually covered, since terms like "dental coverage"
19 or "hearing coverage" encompass a range of distinct
20 services. As part of the bid process, CMS collects
21 information for 11 types of dental benefits, six types of
22 hearing benefits, and seven types of vision benefits.

1 Plans decide which benefits they will cover, and they get
2 credit in Medicare Plan Finder for offering dental or
3 hearing or vision benefits if they cover at least some
4 services in one of those narrower categories. Dental
5 coverage varies more than hearing or vision coverage, and
6 we found that only 35 percent of regular plans and 53
7 percent of SNPs cover at least some services in all 11
8 dental categories.
9 Even within those narrower categories, plans may
10 only cover certain services, and they can limit the number
11 of services that enrollees can receive. Those coverage
12 limits are relatively uniform for some services, such as
13 hearing exams, and more variable for other services, like
14 dental X-rays. Determining exactly what services a plan
15 covers can be challenging, and beneficiaries will likely
16 need to examine a plan's marketing or member materials or
17 contact a plan representative to get an accurate picture.
18 Unlike Part A and B benefits, plans can put
19 limits on per enrollee spending for supplemental benefits.
20 These limits are common for dental, hearing, and vision
21 benefits. In 2022, 82 percent of regular MA plans have
22 limits on dental benefits, 37 percent have limits on

1 hearing benefits, and 99 percent have limits on vision
2 benefits.
3 As shown on the slide, the median limits for
4 dental and hearing benefits are higher than the median
5 limit for vision benefits. SNPs typically have higher
6 limits than regular plans for all three types of benefits.
7 The richer coverage reflects the fact that SNPs typically
8 use a larger share of their rebates to provide supplemental
9 benefits.
10 Plans can also charge cost sharing for
11 supplemental benefits. They can decide what type of cost
12 sharing to use -- for example, whether to use copayments or
13 coinsurance -- and how much to charge. Unlike Part A and B
14 services, there aren't any aggregate or service-specific
15 limits on cost sharing for supplemental benefits.
16 For dental and hearing benefits, relatively few
17 plans charge cost sharing for routine services like regular
18 exams. Plans are more likely to charge cost sharing for
19 more expensive services. Half of regular plans charge cost
20 sharing for at least some non-routine dental services.
21 These plans typically charge coinsurance, and the median
22 rate for most services is 50 percent. As for hearing aids,

1 64 percent of plans charge cost sharing, usually in the
2 form of copayments that vary depending on the specific
3 model. Cost sharing for vision benefits is rare. Compared
4 to regular plans, the share of SNPs that charge cost
5 sharing is much lower.
6 I mentioned earlier that rebates play a key role
7 in financing supplemental benefits. We provided an
8 illustration of their importance by showing the
9 relationship between rebate amounts and dental, hearing,
10 and vision benefits. As rebates increase, plans are more
11 likely to cover more expensive services such as
12 comprehensive dental services, hearing aids, and
13 eyeglasses. Plans with higher rebates also tend to offer
14 more generous coverage, for example, by having higher
15 limits on per enrollee spending.
16 Another important factor to keep in mind is that
17 rebates vary geographically and are typically larger in
18 areas with relatively high fee-for-service spending. This
19 means that plans in higher-rebate areas tend to have more
20 generous supplemental benefits than plans in lower-rebate
21 areas.
22 Now let's switch gears and examine how

1 policymakers might standardize supplemental benefits.
2 Remember that when we talk about standardization, we're
3 referring to both the set of services covered by plans and
4 enrollee cost sharing. For our first presentation, we
5 looked at Part A and B services. Since all plans cover
6 those services, we didn't need to get into any coverage
7 issues and could just focus on differences in cost sharing.
8 The starting point this time is different because plans now
9 decide which supplemental benefits to provide and the
10 extent of their coverage. Policymakers would need to
11 balance the goals of letting plans design their own
12 benefits and making it easier for beneficiaries to compare
13 plans. That said, standardization could provide a way to
14 make supplemental benefits more transparent to
15 beneficiaries by clarifying what plans cover and to ensure
16 that plans provide sufficient value to MA enrollees and
17 taxpayers, which is a particular concern given the lack of
18 utilization and spending data.
19 One way to realize some of the gains from
20 standardized benefits while giving plans flexibility would
21 be to standardize a limited number of common supplemental
22 benefits. Under this approach, the requirements for

1 standardization would only apply to plans that choose to
2 offer that particular benefit. The rules governing all
3 other supplemental benefits would remain the same. This
4 approach would make it easier for beneficiaries to
5 understand some common benefits offered by MA plans while
6 still letting plans design the rest of their benefit
7 packages, including newer benefits like SSBCI.
8 Dental, hearing, and vision benefits could be
9 potential candidates for standardization. Since most plans
10 now cover them, at least to some extent, they are often
11 highlighted in plan marketing efforts, and as we've seen,
12 the parameters of those benefits often vary.
13 There are several ways that dental, hearing, and
14 vision benefits could be standardized. With respect to
15 coverage, plans could be required to include certain
16 services in their benefit. For example, dental benefits
17 might have to include extractions and dentures. This
18 requirement could be more general in nature -- for example,
19 plans might simply be required to provide at least some
20 coverage for certain services -- or Medicare could go
21 farther and specify the number and type of services that
22 plans would have to cover, thus replacing the coverage

1 limits that are now set by plans. Separately, plans could
2 be required to use certain types of cost sharing or
3 spending limits for a particular supplemental benefit, or
4 Medicare could put limits on the cost-sharing amounts that
5 plans can charge.
6 These reforms could also be combined. One way to
7 achieve a high level of standardization would be to give
8 plans a limited number of options for covering a particular
9 supplemental benefit. These options would essentially be
10 benefit-level versions of the standard packages that we
11 discussed developing for Part A and B cost sharing back in
12 September. Each option would specify the benefit's
13 coverage limits, cost-sharing rules, and per enrollee
14 spending limit.
15 Here's a purely illustrative example of some
16 standardized options for dental benefits. This example is
17 based partly on current MA dental benefits and partly on
18 the stand-alone dental plans offered to federal employees.
19 In this example, regular plans that wanted to offer dental
20 benefits would have only two choices: a standard option
21 and a high option. Both options would cover the same
22 services and have the same coverage limits. Similar to

1 existing MA dental benefits, both options would have no
2 deductible, no cost sharing for preventive services, and a
3 maximum coinsurance rate of 50 percent for major services.
4 However, the high option would clearly be more generous,
5 with lower cost sharing and a higher annual limit. There
6 could also be separate options for SNPs that have higher
7 annual limits and no cost sharing, which would be more
8 consistent with the benefits those plans now offer. Given
9 the geographic variation in MA rebates, plans in high-
10 rebate areas would probably be more likely to use the high
11 option, while plans in low-rebate areas would probably be
12 more likely to use the low option.
13 Stepping back a bit now, the options we just
14 outlined would work in tandem with the options we discussed
15 in September as part of an overall approach for
16 standardizing MA benefits.
17 First, for Part A and B services, plans would be
18 required to use a limited number of benefit packages that
19 have specific out-of-pocket limits and cost-sharing amounts
20 for major services.
21 Second, for a selected number of supplemental
22 benefits, plans would have to meet certain requirements

1 related to the services covered, enrollee cost sharing, and
2 plan spending limits. These requirements would only apply
3 to plans that decide to offer the benefits.
4 Finally, there would be no changes to other
5 supplemental benefits.
6 If these changes were made, beneficiaries would
7 be able to understand what each MA plan charges for Part A
8 and B services and some of the major supplemental benefits
9 it provides with relative ease. The process of selecting a
10 plan would still involve a number of other important
11 factors -- such as the plan's premium, the drugs on its
12 formulary, and its provider network -- but these changes
13 should make the process simpler and easier to navigate.
14 That brings us to the discussion. We'd like to
15 get your views on standardizing supplemental benefits.
16 Which benefits, if any, should be standardized? And in
17 what ways should those benefits be standardized? More
18 broadly, we'd like to know what you think about the overall
19 approach for standardizing MA benefits outlined on the
20 previous slide. As I mentioned at the start of the
21 presentation, we're not going to make any recommendations
22 on this issue during this meeting cycle, and this work will

1 be included as an informational chapter in our June 2023
2 report. So at this point we're looking more for your
3 impressions rather than any specific policy judgments.
4 Having said that, we'd like to know what additional
5 information you would find helpful if we do decide to work
6 toward a recommendation in the future.
7 That concludes my presentation, and I'll now turn
8 it back to Mike.
9 DR. CHERNEW: Great. Thank you so much. And I'm
10 really happy we've gone down this path. Every time I think
11 I know how things work; I realize how much I don't know.
12 But in any case, that's sort of a prelude to Round 1, and I
13 will emphasize Round 1 questions -- not Round 1 comments;
14 Round 1 questions. And I think with that, we're going to
15 start -- is it Larry who's first? Larry, you're first.
16 DR. CASALINO: Someone had to step in. Okay.
17 Great job.
18 I have a few, I think, pretty brave questions.
19 One is: In the chapter, in the written materials, and in
20 the slides, you mention that plans don't report encounter
21 data for supplemental benefits. Am I correct in thinking
22 that for some supplemental benefits like dental, or others

1 know hearing probably, you could theoretically report
2 encounter data, and for others like meals or fitness or
3 whatever, encounter data doesn't really -- hard to say what
4 an encounter is. Is that correct, or am I mistaken?
5 MR. ROLLINS: I think I would generally agree
6 with that. In your example, dental benefits, we already
7 have insurance plans that cover those, and there are codes
8 for the different services that you receive. So you can
9 imagine that being done more easily.
10 Some of the other benefits might be more
11 difficult, like some of the non-medical benefits that you
12 mention. But I think potentially you could develop codes
13 for those services. For example, there are Medicaid
14 programs that cover some of those services now as part of a
15 home and community-based services waiver. So I think some
16 of that infrastructure is maybe more out there, some of the
17 state Medicaid level, it's not necessarily at the federal
18 level. So I think those could be done as well.
19 There might be more lead time need to -- I think
20 you could see where CMS might need to develop sort of some
21 standard codes and give some guidance to plans on how they
22 should, you know, report and classify things.

1 DR. CASALINO: Maybe one thing to think about for
2 the final chapter is whether to emphasize what you just
3 said more and whether it would be desirable for that to
4 happen. But that's too much of a comment, so I won't say
5 any more about it.
6 [Laughter.]
7 DR. CHERNEW: I feel like I need to turn off my
8 camera.
9 DR. CASALINO: I didn't think that was going to
10 get past Mike, and it didn't.
11 All right. Second question, and I should know
12 the answer to this, but I realize I don't. When the plans
13 are calculating their medical loss ratio, are they able to
14 count into the MLR what they've spent on supplemental
15 benefits?
16 MR. ROLLINS: Yes.
17 DR. CASALINO: Okay. And, third, any particular
18 reason for -- I like the idea of having, you know, gold and
19 bronze plans, or whatever. But was there any particular
20 reason to have two levels rather than three, or was that
21 just for illustrative purposes?
22 MR. ROLLINS: It was probably for illustrative

1 purposes, sort of give you kind of the simplest version of
2 the concept. And as I said, you know, using the federal
3 stand-alone dental plans as a template, they have standard
4 and high option, and so I decided to use that for these
5 illustrative examples.
6 You could imagine a situation where there's
7 perhaps, you know, more than two options. Having said
8 that, I think it would probably go to some extent against
9 the sort of larger goal of standardization to have a lot of
10 options.
11 DR. CASALINO: And a last question. In
12 considering the high versus low or three options if you had
13 it, would you recommend going to -- would you classify high
14 versus low, for example, separately for A and B and for the
15 supplemental benefits you're talking about today, or try to
16 bring them all together into a high-low category?
17 MR. ROLLINS: I think that's a policy question
18 your side of the room can talk about more than I can. You
19 could do that for the -- but the approach that we've put in
20 front of you today, we kind of viewed them as sort of two
21 separate parts of the menu that the plans would order off
22 of: Here are your options on the A/B benefit side, and you

1 could combine those as you will with whatever options are
2 available on --
3 DR. CASALINO: Keep them separate, might be more
4 transparent that way. Okay. Thank you.
5 MR. ROLLINS: It would give plans a little more
6 flexibility as well.
7 DR. CASALINO: Yeah.
8 MS. KELLEY: Kenny, Round 1 question?
9 MR. KAN: Sure. I'm very excited about this
10 chapter as the data is very powerful. I'm very supportive
11 of the report being released with no recommendations, as I
12 believe this is a very complicated topic.
13 What would be helpful for the 2023-2024 cycle for
14 me would be to show the tables that are in the pre-reading
15 material, to show what those percentages are and how those
16 things would change for MA plans that have four or more
17 stars and those that have 3 and 3 ½ stars, and here is why.
18 I believe it would not surprise me if when we
19 pull the same report together next fall, those numbers
20 would be down, materially. CMS recently released 2023 MA
21 stars ratings which will be used to construct plan-specific
22 2024 rates, which will be known in Q4 next year.

1 For those 2024 plans, based on these 2023 star
2 ratings, 70 percent of MA enrollees are in contracts with
3 4-plus stars, down from 90 percent in 2022. There were two
4 national HMOs that were materially impacted and experienced
5 a deterioration in their stars ratings.
6 So in addition to stars, the health plans,
7 especially those that offer MAPD plans, MA plans and
8 prescription drugs, which is the majority of that, would
9 also need to begin reflecting margin hit wins from the
10 Inflation Reduction Act of 2022. So I would be very
11 curious to see how all these numbers would change next
12 fall, hence my Round 1 suggestion.
13 DR. CHERNEW: I don't think Eric has a clarifying
14 answer, but we're going to, nevertheless, go forward with,
15 I think, David.
16 MS. KELLEY: No, I have -- David, did you have a
17 Round 1 question?
18 DR. GRABOWSKI: I did not.
19 MS. KELLEY: I have Marge next.
20 MS. GINSBURG: I think my question is fairly
21 simple. I'm familiar with many plans offering these extra
22 benefits with riders, so some get thrown in, yes, it's part

1 of the package, or if you choose instead to pay another
2 $1,000 a year you get a different model. Did you look at
3 all at how common is this? Is it just in California, that
4 I'm familiar with? Is it very common that, in fact, MA
5 plans are offering even a higher level but you pay more to
6 get that? I got the impression that all of this is based
7 on the benefits that are currently within the MA plan
8 without paying an additional premium. Is that right?
9 MR. ROLLINS: That is correct. So the
10 distinction, sort of the terminology is the supplemental
11 benefit can be mandatory, which means it's a standard part
12 of the benefit package and everyone in the plan will get
13 that, where it's optional, whereas, as you say, if you want
14 to get the additional coverage you have to pay an
15 additional premium.
16 Most of the supplemental benefits are mandatory,
17 and so that's what the paper focuses on. There is, I
18 think, a brief mention in the paper of the prevalence of
19 optional benefits. I want to say something like 30 to 40
20 percent of plans have some sort of optional benefit that
21 you can purchase. Dental benefits are most of it, maybe
22 not all of it.

1 MS. GINSBURG: My only other comment, at least at
2 the moment, is the use of the term "comprehensive services"
3 under dental benefits on page 10, and I know you have a lot
4 of language that helps understand that. But I look at the
5 word "comprehensive" and, you know, I know what I'm
6 thinking of when it comes to dental, and that's not what
7 these guys cover. So it's really thin in terms of what we
8 know potential costs of serious dental coverage,
9 particularly among seniors.
10 So I don't know. Maybe I'll try to come up with
11 another word. But it just feels like "comprehensive" is
12 describing something that is far greater than what these
13 folks are actually offering.
14 That's all, my only comment. Thank you.
15 MS. KELLEY: Scott.
16 DR. SARRAN: Just a quick question. I just
17 wanted to make sure I understood why we're presenting this
18 without a recommendation in this cycle. Is it just that we
19 don't think we've had enough time to digest and ruminate?
20 MR. ROLLINS: I think because it's a big and
21 complicated issue. And so, for example, we've needed two
22 presentations to simply just kind of set the table to start

1 having the conversation, and I think the notion that we
2 would get all the way through this initial work, figure out
3 what a recommendation might look like, it was a lot of
4 ground to cover in one cycle.
5 DR. CHERNEW: As a reminder, to get to a
6 recommendation vote we need a policy option, then a draft
7 recommendation, then a vote on the recommendation. So we
8 need three cycles to get there, starting with a policy
9 option. The policy option has to be proceeded with a
10 discussion about what the policy option would look like, so
11 the policy option has the modeling the policy options
12 typically have.
13 And so usually to go from zero to recommendation
14 is typically a two-year arc, where you start with the
15 background materials and you get a sense of where everybody
16 is. Then we move to a policy option, and then we move. So
17 we won't see this again -- in order to get to a
18 recommendation we would have to have a draft recommendation
19 basically in March, and we're not to a policy option to get
20 there yet.
21 MS. KELLEY: I had Dana next with a Round 1
22 question.

1 DR. SAFRAN: Yeah, thanks. It's great to see
2 this taking shape, even though I now understand the very
3 long tail on the process.
4 I have two clarifying questions. One, I didn't
5 see any information about, as early as it is, do we have a
6 hypothesis about whether this is adding cost to Medicare,
7 reducing cost for Medicare? I imagine that there is some
8 administrative cost for managing a process like this.
9 Anyway, I'm curious about that, and then curious
10 also, again, understanding we're super early and we're just
11 sketching this, do you have any notion of market response
12 from MA plans, or might we have the opportunity to do some
13 focus groups with MA plans or interviews, something like
14 that?
15 MR. ROLLINS: I think taking in your points in
16 reverse order, I think it certainly would be informative to
17 talk to some plans, plan actuaries, things like that, to
18 get a sense of how they might react to such a change in the
19 rules governing MA. That discussion is getting a little
20 bit more amorphous because I think, you know, as we laid
21 out here, standardization is a concept and you can
22 implement it in a lot of different ways.

1 So I think those discussions could be
2 interesting. It's a little unclear how much you're going
3 to get out of them, because it's going to be like what do
4 you think standardization means in your head when you're
5 talking to me, and when I'm thinking about what
6 standardization is. So I think we just want to manage some
7 expectations there.
8 In terms of the effect on Medicare spending, I at
9 first blush. I'm not sure that it would have a huge
10 effect. To the effect that you have standardization it's
11 not necessarily changing the size of plan rebates, which is
12 what's really driving spending. It would sort of more get
13 at how those rebates are used when plans are structured.
14 Now beneficiaries might make different choices
15 about what plans they enroll in based on that, and plans
16 sponsors will make different decisions about what kind of
17 products they want to offer. But it would get very
18 complicated, very quickly, and off the top of my head I
19 don't have a strong intuition.
20 DR. CHERNEW: So what I would add to that is if
21 we had standardized benefits, we would hope that shopping
22 would work better, we would hope the markets would be more

1 competitive, we would hope the increase in the
2 competitiveness would, generally speaking, drive down the
3 bids. I actually think even where we are we see evidence
4 that increased competitiveness, in markets that are more
5 competitive, and the bids are lower.
6 And to the extent that you can allow easier
7 comparison and better shopping, you would expect to see the
8 competition part of MA, which is typically cost savings, in
9 general, safe Medicare money. But that's just my
10 hypothesis. Do you have a reaction, Eric, or that's a no,
11 for the record.
12 Is Robert next?
13 MS. KELLEY: Robert is next, so I will read his
14 comment.
15 "Excellent report. Thank you. I am somewhat
16 surprised that we do not have encounter data among those
17 beneficiaries who enroll in supplemental benefits. That
18 information would be useful in understanding what benefits
19 and services are most effective over the long term.
20 "What are the barriers in making data submission
21 a requirement? We may want to consider flushing this out
22 in the final document, including the pros and cons of

1 requiring this information."

2 MR. ROLLINS: That is certainly something that

3 you collectively could decide on if it is something you

4 would want to be part of future work on.

5 DR. CHERNEW: Yeah, also not clear. That's a

6 clarifying. But in any case, I think I'm going to start

7 saying this repeatedly now. If Eric doesn't have an easy

8 answer to yes, this is what I meant, not you could have

9 done this also, it wasn't clarifying.

10 MS. KELLEY: Round 2 is about to begin, unless

11 anyone else a Round 1 question.

12 DR. CHERNEW: Clarifying.

13 MS. KELLEY: A clarifying question.

14 DR. CHERNEW: A clarifying question is what I

15 meant.

16 MS. KELLEY: Okay. Round 2 starts with Kenny.

17 MR. KAN: So to clarify my Round 1 question, my

18 Round 1 ask previously was is it possible for the June

19 report to show the tables that are in the pre-reading with

20 how the prevalence and the design of the MA plans change

21 with 4 stars? Because what we show is an industry average

22 across all plans. Could we show something with 4 stars, or

1 just 3 to 3.5? Because I believe that would help inform,
2 you know, when we get the new data next year, given some of
3 the margin headwinds that the industry faces. So
4 clarifying question for my Round 1, so I wasn't trying to
5 sneak in a Round 2 in Round 1.
6 And now my real Round 2 comment is -- I'm not
7 trying to sneak in a Round 3 comment.
8 DR. CHERNEW: We're actually doing okay enough
9 for time, but, you know, as time gets closer, we might not
10 be. So go ahead, Kenny.
11 MR. KAN: So to Marge's point, I acknowledge that
12 sometimes the benefits that are presented are not
13 necessarily the most beneficiary friendly. However, I
14 would suggest that we be careful about future
15 recommendations in our future work on this not reflect any
16 mandates and also be careful. Because while I believe
17 there are benefits to partial standardization, over-
18 standardization and mandates could actually result in
19 higher consolidation risk.
20 MS. KELLEY: Stacie.
21 DR. DUSETZINA: Thank you very much. This is a
22 very interesting chapter, and I always like the concept of

1 streamlining things. But then every time we get into this
2 it's like, oh, this is so complicated. So I appreciate the
3 work and the efforts going in here.
4 I have a similar point to the point I made the
5 last time we talked about standardizing of benefits, which
6 is I have such a hard time thinking about this conceptually
7 because of the who is in your network part of this. So
8 it's like, you know, you may show me this fantastic dental
9 benefit, but in my area no one is participating in the
10 network, and I find it really difficult to think about
11 those pieces.
12 I am very pro standardizing to the sense that we
13 make it much easier for people to understand what the
14 choices they're making are and the extent of those benefits
15 so that they feel that they're making the best choice for
16 them, but I always get stuck on that other piece of, you
17 know, the network piece of this, which I still think is a
18 hard part and adds so much more dimensionality to a highly
19 dimensional and hard problem.
20 So I guess maybe just in the spirit of
21 streamlining things I'm behind this effort. I think that
22 the reality of how challenging this is going to be is a

1 lot. And maybe a final plug for, as transparent as we can
2 be about the benefits that people are picking, I think
3 that's better. Like as much information as we can give
4 people to make a good choice for them.
5 One final thing is just thinking about the
6 comparison with other benefits. You know, when you were
7 showing those limits I thought, man, that seems really low.
8 Like you said I have dental benefits and then that's your
9 limit. It seems low. But I don't know how that really
10 looks relative to commercial plans or employer-sponsored
11 plans, if there's some way to give context of is this just
12 how we cover these benefits roughly in the U.S.? And is
13 that good enough for Medicare beneficiaries who may have
14 more need, especially on the vision and hearing and dental.
15 But thank you very much for this work and this
16 chapter. I'm behind you in spirit. I'm concerned about
17 the complexity.
18 MS. KELLEY: Scott.
19 DR. SARRAN: Great, great work, and I think one
20 of the reasons I thought we could potentially actually have
21 it move faster is because the work is so good. I think
22 that it leads us to, I think, some conclusions.

1 I think the way these have evolved, a good
2 illustration of some of the positive and then some of the
3 concerns about MA. So the positives is that the private
4 sector has responded in a way that offers now, in a nearly
5 universal fashion, at least some benefits and categories
6 were a lot of beneficiaries couldn't otherwise afford
7 access to those benefits. So that's a positive.
8 The way it illustrates, I think, some of the
9 concerns about MA is that there is, as you pointed out so
10 nicely, there is a significant lack of transparency that
11 raises real questions about how the MA program is spending
12 taxpayer money, and that should be profoundly concerning to
13 us.
14 I respect, Kenny, your comments about, you know,
15 I bet a year from now the landscape will look different
16 because of the stars rating changes and potentially the
17 IRA. But as I quickly noodle on that I don't know that
18 that would change any, or should change any of our take-
19 homes about where we want to go. Yeah, I think the market
20 will look different and perhaps a little more frugal, if
21 you want to use that word, but I don't know that
22 directionally it would change where we want to end up.

1 So I essentially agree with the schematic you've
2 got on Slide 16, which is basically I would strongly
3 recommend we consider going further down the road to
4 maximally standardize the core four or five benefits that
5 have become sort of table stakes -- dental, vision,
6 hearing, fitness, transportation. They've been around for
7 a while now, people have kind of honed in on stuff, and the
8 lack of standardization on those benefits does nothing
9 other than foster confusion. There's no value added in
10 those five common core supplemental benefits to anything
11 other than standardization.
12 I think there's no question and there's lots of
13 science about how well people can make decisions when there
14 are too many variables. We are way beyond, right? I mean,
15 even just the smartest people can't sort these things out.
16 And I think we also want to steer beneficiaries
17 when they are looking at an MA plan to either compare it to
18 another MA plan or compare to the fee-for-service Medicare
19 program. We want to steer them into making decisions on
20 variables that we would all agree are really important --
21 low out of pocket, high premium, vice versa, that's a big
22 one. Network, big one. Stars rating, we want it to be

1 impactful to beneficiaries. And formulary. I mean, that's
2 already, depending on how you count it, those are four big
3 variables that aren't all a bifurcated A or B. They're
4 kind of multidimensional in and of themselves.
5 So where I quickly go in my head anyway is let's
6 do whatever we can to promote maximal transparency and
7 maximal standardization of those core four or five
8 supplemental benefits, and then permit the variation in the
9 other areas that you articulated in Slide 4 -- primarily
10 health-related additional benefits, SSBCIs, and VBID-
11 related benefits.
12 And then, you know, if the programs work well,
13 maybe five years down the road there has been such great
14 private sector work in those areas where we would, I
15 recommend, allow flexibility, that some of those then sort
16 of drop down into, hey, we've seen what really works well,
17 what is attractive, what is adding value, and then some of
18 those could be standardized, and that could be a good
19 market evolution.
20 MS. KELLEY: Greg.
21 MR. POULSEN: So I really appreciate and like the
22 progression that this discussion has taken from our last

1 meeting to this one. The staff work, I think, has been
2 great in terms of taking some of the things that we talked
3 about last time and incorporating that.
4 I felt strongly last time that we shouldn't
5 stifle innovation. I do tend to agree with Scott about the
6 idea of a progression of things that need a great deal of
7 innovation moving to things that can be standardized. I
8 don't think we're as far along maybe as he does, however,
9 in terms of that progression, and it really comes from two
10 points, I think, or two different philosophies of why
11 supplemental benefits are offered.
12 The first one, which is the one where I think
13 most of us gravitate toward, is marketing benefit, the
14 services offered, because we think people will buy the
15 program if it has this with it. And I think that most of
16 us in our thinking have been focused in that area.
17 The however is that I think there are benefits
18 that are also designed to enhance health and reduce the
19 need for traditional covered services. I think that one is
20 really important and I think it's much, much less mature in
21 terms of how it's been thought through. And there are
22 components of vision, dental, hearing, certainly nutrition,

1 maybe transportation that impact that as well, and I tend
2 to think that there's still a lot of development in terms
3 of figuring out which of those really yield benefits.
4 For instance, one plan that I'm familiar with
5 offers dental but it's exclusively a preventive service.
6 If you need to have anything being done you pay for it, but
7 they'll cover everything you want in terms of prophylactic
8 -- x-rays and fluoride treatments and whatever. I'm not a
9 huge dentist-knowledgeable person.
10 But the idea of being able to believe that we've
11 figured out what those packages look like yet, in terms of
12 their ability to incorporate maximum total performance, I
13 just don't think we're probably quite as mature in those
14 areas as we would like to be to standardize the benefits at
15 this point.
16 So even though I initially went down the path of
17 thinking, yeah, that would be really nice to have
18 comparability, I wonder if we're quite there yet, because
19 just about all of these have not only a marketing benefit
20 but also potentially a health enhancement benefit, which
21 may be then for very different reasons than marketing. So
22 just something to toss in.

1 I'm glad we're not at the point of having to make
2 a decision yet. I like that we're at a place where we can
3 continue to think about these ideas.
4 MS. KELLEY: Cheryl.
5 DR. DAMBERG: This is an excellent chapter, and I
6 say full speed ahead in terms of continuing to explore this
7 space. I think anything that we can do to enhance
8 transparency and understanding of different benefits that
9 people have available to them to choose would be enormously
10 helpful. This is an exceedingly complicated market and set
11 of decisions that we're asking people to make, and the
12 prospect of me eventually entering Medicare and having to
13 make this decision is terrifying, despite the fact I
14 probably can navigate this space better than many people.
15 So I'm in favor of simplification and even if
16 that potentially reduces some of the kind of combinations
17 and choices.
18 And I subscribe to Michael's hypothesis that, you
19 know, through improved information in the marketplace, this
20 will enhance competition and potentially lower the bids.
21 So I'm in favor of that.
22 I do think that being able to gather more

1 information through encounter data submission on the
2 supplemental benefits in terms of services used and how
3 much is spent on these would be very helpful. So I'm
4 hopeful that we can continue to signal something in that
5 direction.
6 I think my leaning is potentially to go broader
7 than just say the three sets of services that you laid out,
8 but I couldn't tell you what the other services are because
9 this is sort of a big black box. So I think if there's
10 more information that could be revealed in sort of another
11 iteration of this, that would be helpful.
12 And there was something that Stacie mentioned
13 that I thought was really good, but I'm missing --
14 DR. DUSETZINA: [Speaking off microphone.]
15 DR. DAMBERG: Yeah, the networks.
16 But overall, I'm very favorable about this
17 chapter.
18 MS. KELLEY: Dana.
19 DR. SAFRAN: Yeah. Thanks.
20 So, again, also really appreciative that we're
21 moving forward with this work.
22 I will say that one of the things that's really

1 gotten me more supportive is since our July retreat, where
2 I believe it was the first time we discussed this, we've
3 gotten clearer -- or at least I've gotten clearer based on
4 how you've articulated in this chapter that we would still
5 have some benefits that don't get standardized. And I
6 really appreciate that, because part of what I've worried
7 about with standardizing is the curtailing of innovation.
8 And to the point that we were discussing
9 yesterday around social drivers of health and that
10 addressing those in order to achieve better outcomes for
11 members and beneficiaries should not be outside the scope,
12 and MA is a place where the incentives are all lined up to
13 innovate on those things. And so I'm glad that we're kind
14 of having our cake and eating at too with respect to
15 standardizing the most common supplemental benefits but
16 leaving open for innovation.
17 My other two comments are really follow-ons from
18 your answers to my questions on Round 1. I do strongly
19 urge us, as we start to shape this, to do some interviews
20 with MA plans. And I take your point that, you know,
21 without real specifics for them to react to, you can't take
22 it as something in writing that they're going to support or

1 not support. But I think their reactions and having an
2 open discussion about what we're thinking and how that
3 could take shape in a way that they would see it as really
4 something that they would embrace will help us.
5 So I would strongly urge that we do some market
6 testing with our product design work here before we just
7 put it all down on paper and hope that we're right.
8 And then the other, in follow up to my other
9 question, I would like us to in the June chapter, if we
10 can, have some hypotheses about the effect on cost for
11 Medicare. I think the Medigap program probably gives us an
12 okay starting point. because I believe Medigap went from
13 not standardized to highly standardized, and so there must
14 be some information about what was the impact on the
15 Medicare program from that as well as market competition
16 hypotheses that Michael mentioned and Cheryl referenced.
17 So those are my comments, really supportive,
18 really looking forward to seeing the next round on this.
19 Thanks.
20 MS. KELLEY: Betty.
21 DR. RAMBUR: Thank you.
22 I really am enthusiastic about this work and

1 really appreciate the comments of the Commissioners.

2 As I mentioned last time, a neighbor asked me to

3 help with this, and I was, of course, very confident, you

4 know. I know about this topic!

5 But it was a dizzying array, and in the end, she

6 stayed with her --

7 [Laughter.]

8 DR. RAMBUR: She stayed with what she had, which

9 I'm not sure was the best for her, and for some people that

10 has real economic and health implications.

11 I wanted to make just a few comments. When we

12 first talked about this, perhaps like Larry maybe

13 mentioned, I was assuming it would be like the metal

14 levels, and I'm not hung up on that. But channeling Marge

15 a little bit, the basic versus comprehensive language in

16 some of that, I think is a little bit problematic. So I

17 don't know if we end up with two or a three or whatever,

18 but it seems to me, there will be some natural breaks or,

19 you know, demarcations.

20 The point I really want to focus on is the issue

21 of neural networks and the slide 9 that has the limits, and

22 it was mentioned that these are very low limits. But it's

1 like commercial insurance. Commercial insurance really
2 isn't insurance. It's actually a defined benefit plan, in
3 my view, and I think the problem is that people don't
4 understand that they're signing on for something with
5 relatively narrow -- or small benefits in a narrow network.
6 And so to the extent that could be clear to people and they
7 can understand that, then they can make the choice.
8 I've had experiences just in the past month with
9 working with a patient who's very excited about being on
10 MA. This is a very elderly elder, and he had to go to a
11 different dentist. And this is just -- you know, unbuckles
12 his whole life. It may seem like a small thing, but it's
13 huge.
14 So, if those things could be clearer what the
15 tradeoffs are, I think we would have really done something
16 important.
17 So thank you, and I'm very enthusiastic about the
18 work.
19 MS. KELLEY: Amol?
20 DR. NAVATHE: Thanks, Eric, for very good work.
21 I am also strongly supportive of the direction
22 that we're heading in and continuing to go in that

1 direction, full steam ahead.

2 I think, in general obviously it's very clear

3 that the supplemental benefits provide a lot of value to

4 the Medicare program, to the Medicare Advantage

5 beneficiaries. I think that part is clear.

6 I think it's a little bit less clear for us

7 sitting where we are and probably for beneficiaries as well

8 how much value they're getting from these supplemental

9 benefits, and that's a challenge, right? And so I think I

10 agree with many of the comments that other Commissioners

11 have made -- Dana, Cheryl, others -- that moving toward a

12 system that has greater transparency should be a major

13 priority for us, both in terms of transparency towards

14 beneficiaries but also, in some sense, transparency to the

15 taxpayer as well in terms of what value is actually being

16 generated from that.

17 And, in that sense, I think this is a major step

18 forward, because we are then able to understand at least --

19 and I will say I agree with the idea of initially starting

20 with these three services as the most prevalent

21 supplemental benefits, and I think at least we're taking a

22 step forward in both the transparency piece and the value

1 piece, sort of understanding value piece from that
2 perspective.
3 I will say at the same time that preserving
4 innovation and plan flexibility is also a huge priority,
5 because it's obvious, I think, when you look at that
6 Medicare Advantage program writ large that there's many
7 plans out there that have innovative services to really
8 meet the needs of their beneficiaries. I think it's
9 particularly true in SNPs, but I think it's also generally
10 true. And so we should be mindful of that, that over-
11 standardization, overregulation in some sense, definitely
12 would come at a cost, and so I think there is some balance
13 to be struck here.
14 Again, I think that tilts us towards really
15 focusing on a core set of supplemental services, benefits
16 like these three, and not over engineering and stepping
17 beyond that into transportation and meals and others where
18 there's a lot more heterogeneity, both in terms of what the
19 plans are offering, but also very likely in terms of what
20 beneficiaries who are enrolled in Medicare Advantage may
21 need. And so I think there's a balance to be struck there.
22 I really like Stacie's point around networks as

1 another potential dimension of challenge. I would say to
2 the extent that we can incorporate -- and this is touching
3 on something that Cheryl mentioned -- understanding of use
4 of supplemental benefit is, I guess, in part through
5 encounter data. And if that's something that could also be
6 made transparent as part of the enrollment process, that
7 may go a long way without having to mandate things like
8 network requirements, which I think would touch on some of
9 Kenny's concerns that is this going to be really onerous
10 and burdensome and potentially drive other industry trends
11 that we may not want to actually shift in that direction
12 from a sort of unintended effect perspective.
13 And so simply reporting out essentially and
14 making clear that of the beneficiaries who are enrolled in
15 this particular MA plan, how many actually use the dental
16 benefit, how many actually who are eligible or would
17 require use any of the other, vision benefits, for example,
18 that would give a good sense, at least as a first-order
19 approximation, of how easy it is to access the benefit.
20 And that, I think would be helpful to display to
21 beneficiaries.
22 It also would be fundamentally important for us

1 to understand as policymakers and as taxpayers what is the
2 value that's coming out of that benefit, and so that may be
3 a nice way to strike a balance between let's get at some of
4 the network pieces without having to overregulate in some
5 sense and make it very onerous from an implementation
6 perspective.
7 And to some extent, I think that falls under the
8 common, I think, MedPAC refrain which is, you know, let's
9 not let the perfect be the enemy of the good, in some
10 sense, right? So we want reasonable policy even if we
11 can't have perfect policy.
12 So, overall, I'm very supportive of the
13 direction. I think we're really taking great steps and a
14 major champion for this work. Thank you.
15 MS. KELLEY: Marge?
16 MS. GINSBURG: Yeah. I have a few comments on
17 first one, and I don't think I'd ever mentioned this
18 before, but it just raises the issue right now.
19 I think some may know I ran an organization for
20 many years that did public deliberation on health policy
21 issues, and one project we did, was now probably 10 years
22 ago, started with a thousand-person survey in California.

1 And it wasn't specific to Medicare. It was Medicare,
2 commercial, whatever. And it made it really clear. We
3 asked people to -- we gave them 20 different scenarios or
4 little vignettes, descriptions of coverage, and asked them
5 to rate on how important it is, knowing that services that
6 we're covering were coming out of your pocketbook. In
7 other words, you are a payer here.
8 And the lowest one, the absolutely lowest one of
9 the whole list, which was almost universal, was gym
10 membership, and so it's always stuck in my mind, every time
11 I see the fitness benefit in any of these, on how little
12 people care about that, knowing that they are payers in
13 this. As everything we do here, the Medicare beneficiaries
14 are the payers.
15 The other comment I wanted to make actually was -
16 - Kenny made reference. I think others did too, to using
17 the star rating. So we're kind of in a conflict here
18 because we don't like the current existing star rating.
19 We've been trying to change that for a while. So this is
20 more, do we use that? How do we use that if it's
21 something that the Commission has not been supportive of
22 for a while?

1 People, we're talking about standardizing
2 benefits, and we often compare that to Medigap, which was
3 great, but the Medigap standardization is so easy. One
4 chart. There are maybe eight different categories that the
5 Medigaps cover in part or in whole. That's it. It
6 couldn't be simpler. This is so much more complicated to
7 do, to standardize.
8 All right. Well, having said all that -- oh. I
9 also wanted to make a reference. Someone mentioned about
10 talking to MA plans. I can't remember who had suggested
11 that. Dana. MA plans will hate this, okay?
12 [Laughter.]
13 MS. GINSBURG: We can talk to them, but I don't
14 have any doubt that they will absolutely hate
15 standardization.
16 Going back to the original, should we standardize
17 the A/B coverage versus standardizing the supplemental
18 benefits? And I guess since I think we were offered the
19 opportunity to comment on both here, my preference would
20 definitely be to standardize the A/B coverage, because to
21 me, that's the biggie. And that's so complicated now in
22 trying to figure out what their copays and co-insurance,

1 and most, 80 percent of people, when I talk to them don't
2 even know the term "co-insurance." So we're starting with
3 that. They get it, and I give them a math question, and
4 they figure out what their co-insurance payment would be.
5 But it's so big and it's so complicated, and I
6 have come to believe that we could and should do that,
7 giving all plans two options, and you can't give anybody
8 just one option. So you got to give them sort of the high
9 value and then the other value, and maybe even three
10 options, but at least they're standardized. I'm just not
11 sure yet about the supplemental benefits, because, in some
12 ways, vision is fairly easy. Dental gets very complicated
13 about what's covered, very complicated, and other than
14 saying, okay, we will pay $1,000 for the following dental
15 things and we will pay prevent, that's it.
16 But I think the biggie is the A/B coverage. So
17 it's exciting work. I'm enthusiastic about us moving
18 forward on this and maybe even eventually getting to a
19 recommendation, just that there's still a lot of work to be
20 done.
21 But, Eric, you all have done a fabulous, fabulous
22 job to date, so congratulations. Thank you.

1 MS. KELLEY: Jonathan?
2 DR. JAFFERY: So, Eric, yeah, this is great work.
3 I'm extraordinarily enthusiastic about this. I think this
4 is something that has to be done, and I'll try and be brief
5 because I think my thoughts echo much of what other
6 Commissioners have said. And I think Amol particularly
7 summarized things, the way I was thinking about them,
8 really nicely.
9 But this is so complicated for people. As Betty
10 said, anybody who's tried to help any friend or family
11 member sort through any insurance, whether it's commercial
12 or Medicare, knows that it's just crazy complicated. And I
13 think many things that we've seen and the examples used,
14 the illustrations in the chapter show that actually people
15 are faced with more choices and less transparency than you
16 often get when your employer presents you with a half dozen
17 choices that are already next to impossible to sort
18 through.
19 I do think, as others have mentioned, we have
20 precedence around people understanding networks. We have
21 precedence around standardization through Medigap plans.
22 And then I also think that the points that Dan and others

1 made about trying to strike a balance between what MA plans
2 can continue to do around innovation and serving, actually
3 serving beneficiaries and the program in a way that makes
4 sense can be accomplished through standardization of A and
5 B. And the areas that are very common that people do
6 understand already that you brought out, dental, vision,
7 and hearing, those should be part of what we're offering
8 elderly folks and other Medicare beneficiaries. We could
9 talk about how that shows up in commercial and maybe in
10 fee-for-service Medicare. Obviously, it's a different
11 thing, but we know how important that is. Hearing is
12 something we know is a major driver of cognitive decline in
13 the elderly, and so there may be actually things where
14 providing better hearing coverage actually saves the
15 program money over a long period of time. I would really
16 favor us and support going towards more standardization in
17 those areas.
18 And for now at least, some of these other
19 benefits that are newer and where programs and plans are
20 just having chances to offer things more in the social
21 determinant space, where we have less information and
22 there's a lot less understanding about who needs what, I

1 think that's a place that we can continue to allow plans to
2 really innovate. And maybe we'll see actually some
3 acceleration in that space if plans are not spending their
4 time on trying to do what they do in these other spaces.
5 So great work. I'm excited to get to a
6 recommendation.
7 MS. KELLEY: Larry.
8 DR. CASALINO: I too am very supportive of the
9 work and would really emphasize that I'd like to see it
10 moved along as quickly as possible for our recommendation
11 for A and B standardization and for certain supplemental
12 benefits that people have mentioned.
13 I think it would be fine to leave room and time
14 for innovation for some of the newer benefits, meals,
15 transportation, things like that, but I don't think there's
16 a whole lot of room for innovation in ways that would
17 benefit beneficiaries. There may be room for innovation in
18 ways that would make more money for health plans, for
19 vision, dental, and hearing. These are pretty cut and dry,
20 as the report says. So I don't have any problem with
21 standardizing those. That's the first point.
22 Second point, I think that, you know, we focused

1 on how difficult this makes choice for beneficiaries, and
2 there's obviously undesirable things about making choices
3 difficult for beneficiaries. But there's one thing that
4 hasn't been mentioned. So there's -- we talk about the
5 marketing benefit, as Greg put it, for health plans. They
6 can sign up more people to MA. They can sign up people who
7 compete with other MA plans for beneficiaries to sign up.
8 And Greg correctly pointed out hopefully there's a health
9 benefit to beneficiaries of these supplemental benefits,
10 and certainly on balance I'm sure there is.
11 But there is a third reason to have things be --
12 have lots of choices, and it would be confusing for
13 beneficiaries, and this is true in all industries. The
14 harder it is for consumers to understand their choices, the
15 easier it is for the seller to figure out choices that are
16 very financially beneficial. They may not all be very
17 financially beneficial, but there's some that may be
18 attractive, maybe designed to look attractive, and yet
19 aren't going to cost the seller that much.
20 You know, health plans have a fiduciary duty to
21 make money, most of them, and I think it would be naive to
22 think that they don't have people, very sophisticated

1 people using very sophisticated methods to try to figure
2 out what combinations of choices they can offer that will
3 give them the most benefit for the most -- most benefits of
4 various kinds at the least cost. So that's another reason
5 to standardize, I think.
6 My last point is that -- it's kind of a twofold
7 point. One is, yeah, I agree with Betty and others. If
8 you've ever had to help a friend or a relative or a
9 neighbor with this just once, you never want to have to do
10 it again. I just absolutely dread it, because it's so
11 difficult, it borders on impossible. And I've never felt
12 comfortable making a recommendation, even if I kind of
13 understand their priorities and choices. And if any of us
14 feel that way, you can imagine how it is for the average
15 person. So a strong reason for standardization.
16 Then the last point is about networks, and it's
17 also very difficult to figure that out, right? That's true
18 for commercial, you know, HMO, PPO plans as well. And
19 that's a huge point, right? And it's another possible area
20 for standardization maybe. This may be the most important
21 thing of all for somebody: Am I going to get to see my
22 doctor? If something really goes wrong, can I go to, you

1 know, a tertiary care center or not? And so on. And I
2 wonder if there's been any thinking or there could be
3 thinking from staff and Commissioners on are there
4 potential ways to categorize networks that would be useful
5 and not misleading, so -- and I'm not sure that there are.
6 I've thought about it a little bit, and they all seem too
7 broad to maybe be that useful. But you could think of kind
8 of high, medium, low networks where that would mean -- I
9 mean, it would turn out to be more complicated than I think
10 the percentage of X, Y, Z physicians, nurse practitioners,
11 whatever, that are in our network, because people are
12 concerned, oh, what about such-and-such, so on and so
13 forth?
14 But I think that's an area for -- maybe it's
15 already been done and I'm unaware of it, but some creative
16 thinking about is there a way to fairly simply give people
17 a good sense of networks or some sense of what kind of
18 network am I signing up for would be helpful. So that
19 would really be three potential areas for standardization:
20 network, A&B, and supplemental. And as Scott has pointed
21 out, even limiting -- even categorizing in each of those
22 areas and standardizing, still there's a lot of choices for

1 people to make, and very difficult cognitive task, I think
2 even for the people in this room. Now it's impossible, but
3 even with a lot of standardization in those three areas it
4 would be difficult.
5 I would like to see some thinking about -- it
6 doesn't have to be for this cycle, because I'd love to --
7 I'd hate to see this be held up, but some thinking about
8 standardized ways of categories and networks would be
9 useful.
10 MS. KELLEY: Okay. So that's all we have.
11 DR. CHERNEW: Great. So what's nice about this
12 conversation is there's actually stunning agreement.
13 There's an emoji for both enthusiasm and agreement. I'm
14 just not sure what the emoji is. So let me just summarize
15 quickly.
16 One, people very much like the direction.
17 Two, we understand the tradeoff between
18 innovation and standardization.
19 Three, we think there's a subset of benefits
20 where the variation isn't actually innovation, it's just
21 confusing; it's not helping anyone make a rational choice
22 between things; they just made different choices on very

1 similar things. And so there's a belief that in those
2 areas we should work to standardization.
3 I will emphasize that standardization is not
4 every plan offers the same thing, as was highlighted by the
5 high-low, we could have three versions of it. But the
6 point is when you get a particular thing, you know which of
7 the services in dental is covered, and the same features,
8 you know, copays or whatever, are set for those things so
9 there's not variation across them. And, again, I think the
10 Medigap experience has been largely positive. I will tell
11 you in my role on the Connector in Massachusetts we
12 standardized. It's extremely positive. It covered
13 California. If you ever talk to Peter Lee, what they've
14 done, extremely positive when they standardized around the
15 specific things. And, of course, they're standardizing
16 around financial benefits where the differences are, Did
17 you use the copay or did you use coinsurance? Did you
18 include this out-of-pocket match or that out-of-pocket
19 match and this benefit or that? And I think there's so
20 many different subsets of the benefit, as Eric pointed out.
21 It's just very hard to sort through, you know, all the
22 different versions of what might be included. And we can

1 have different versions of that, and while it is true you
2 give up some flexibility when you do that -- and I don't
3 want to imply that you don't give up that flexibility --
4 the cost you pay for that flexibility in terms of people's
5 cognitive choice I think far outweighs the gain, that some
6 would say, oh, I would have wanted this, but I want to
7 substitute out this small part of the benefit for this
8 other small part of the benefit. I just don't think that's
9 where most beneficiaries are in their level of rationality
10 and choice. And doing so I think will both improve the
11 beneficiary experience and potentially -- there's some
12 conflicting evidence -- potentially improve the competitive
13 nature of this.
14 In the other areas -- and I will make another
15 distinction given Larry's comment -- I don't think we're
16 actually talking about standardizing the network, meaning
17 you need to be here, you need to be here, you need to be
18 here, as much as categorizing it so we can report in a
19 transparent way its breadth as opposed to telling someone
20 else what to do. There's other aspects. The way in which
21 utilization management is applied is just not going to be
22 standardized. That's the secret sauce of some of what the

1 plans do. So there's going to be plans that are going to
2 be easy or not.
3 Now, there are consumer ratings, so I think one
4 thing that happens is you have consumer ratings of how
5 people engage with the plans, and so you can get some
6 sense, and there's other ways you can monitor disenrollment
7 rates, and a bunch of ways you can see if plans are really
8 doing things that you don't want them to do, and I think
9 we'll continue along that path.
10 But the summary of what I get from this is that
11 the world would be better if there was more standardization
12 in the A/B and some of these other non-A/B services than if
13 there was not. And that does not mean we will get to -- as
14 was said, the best won't be the enemy of the good. We're
15 not going to let this get hung up on the fact that we can't
16 standardize everything and some of the things there might
17 be real innovation in those areas. But none of that should
18 prevent us from doing the things that I think we can do.
19 And so that's where we're going to try and get to.
20 It was nice to end on this one. Good job, Jim.
21 So this has been a great day and a half. We've
22 covered a lot of ground. Again, it's nice to end where we

1 are because we're coming back with what I think is going to
2 be amongst the more challenging update seasons, so I will
3 be in touch with you all. But until then, to those folks
4 at home, thank you so much. I hope you've enjoyed this as
5 much as we have. Send your emoji. And you can send that
6 to meetingcomments@MedAPC.gov. You can go on the website
7 to make comments. You can email us. Several folks have
8 emailed us, which is fine, by the way. We like that. And
9 other than that, we hope that everyone here has a good
10 weekend and travel safely, and those of you that are at
11 home, we hope you also have a wonderful weekend.
12 Again, thank you to the staff for everything
13 you've done, and we will be back in December. Have a great
14 Thanksgiving. We're adjourned.
15 [Whereupon, at 11:46 a.m., the meeting was
16 adjourned.]
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