MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Via GoToWebinar

Monday, November 8, 2021
11:16 a.m.

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DR. CHERNEW: Great. Hello, everybody. Welcome to the November MedPAC meeting. We are thrilled for the set of topics that we are going to discuss. I'm not going to take much more time, but let me just start with one that I think is of particular importance.

I'm turning it over to -- I think Luis is going to start --

MR. SERNA: That's correct.

DR. CHERNEW: -- to talk about benchmarks in ACOs.

MR. SERNA: Good morning. Today we will discuss benchmark incentives for ACOs. We would like to thank Rachel Burton and Geoff Gerhardt for their input and assistance with this work.

The audience can download a PDF of the presentation from the control panel on the right-hand side of your screen.

For today's presentation, first, we will cover the current state of ACO participation and savings. Then we will explain how benchmarks are set in Medicare's ACO
programs. Finally, we will discuss some of the more prominent benchmark challenges for Commissioner consideration as we explore payment policy for alternative payment models over the next couple cycles.

While downside risk, participation requirements, and beneficiary assignment play important roles, today's presentation will exclusively focus on how benchmarks are set.

The Medicare shared savings program, or MSSP, is by far the largest ACO program, covering 10.7 million beneficiaries that account for about one-fifth of beneficiaries with both Part A and B coverage.

While early evaluations showed very modest net savings, starting in 2019, monthly shared savings payments per assigned beneficiary increased dramatically, doubling from 2018 to 2019. The sudden proliferation of shared savings payments coincided with changes to MSSP prompted by its Pathways to Success program. Pathways focused on incentives to move ACOs more quickly toward downside risk.

However, the abundance of shared savings payments since 2019 makes net savings for the Medicare program increasingly unlikely.
The Next Generation ACO, or NextGen, and Direct Contracting models have higher levels of risk and reward and prospective payments relative to MSSP. NextGen began in 2016 and will end in 2021. The program currently has 35 ACOs.

Evaluations shows that NextGen generated modest gross savings that were exceeded by shared savings payments over the 2016 to 2019 period. NextGen will be succeeded by Direct Contracting, which began in April 2021, and offers options for full capitation and risk.

Medicare sets ACO benchmarks to determine an ACO's shared savings and losses. The per capita Part A and B expenditures for beneficiaries assigned to an ACO are compared with the ACO's benchmark.

The benchmark has two major components, baseline spending and performance year updates. Baseline spending is computed using the expenditures for comparable beneficiaries who would have been eligible for ACO assignment during the baseline years. Performance year updates make risk score adjustments and apply trend factors between an ACO's baseline years and its performance year.

Baseline spending in MSSP is computed using the...
three most recent years before the start of an ACO's agreement period. This baseline period stays fixed for five years. At that point, benchmarks are updated or rebased to include more recent spending, including blending in spending for all assignable beneficiaries in an ACO's region.

NextGen and Direct Contracting use a rolling baseline period that is rebased annually. Like MSSP, rebasing has increasingly included an ACO's regional spending in its baseline calculation.

MSSP updates benchmarks to allow for a 3 percent increase due to coding. Spending is trended forward retrospectively, using a blend of an ACO's actual regional spending and national spending.

NextGen and Direct Contracting adjust benchmarks for coding by up to 3 percent. Spending is trended forward into the next year by projected national spending for the assignable population and adjusted for local wage and practice indices.

Rebasing and trending can penalize ACOs for their own gross savings. A downward ratcheting effect occurs when ACOs produce gross savings. These lower spending
levels become part of an ACO's baseline spending when its benchmark is rebased. In MSSP, the lower spending levels are also part of an ACO's trend factor.

If ACOs consistently produce savings for Medicare and benchmark levels decline from the ratcheting effect, ACOs would have to continuously find new efficiencies, putting long-term ACO participation at risk.

The ratcheting effect can reduce the incentives for ACO gross savings while keeping undesirable incentives for Medicare. This has contributed toward a current imbalance in benchmark incentives.

Benchmarks reward increased efforts to code diagnoses completely, which undermines risk adjustment.

In addition, rebasing has increasingly incorporated regional spending into benchmarks. This rewards ACOs that are already efficient relative to their region with higher benchmarks.

In the last five years, CMS has implemented an abundance of policy changes, but benchmark incentives have not become more balanced. Some of those changes are listed here. These changes have not removed the ratcheting effect nor increased the overall likelihood of net savings to the
Medicare program.

If it is optimal to keep the current structure for updating benchmarks, there are alternatives that indirectly limit benchmark ratcheting.

One alternative is to slowly blend in the rebased benchmark. For example, MSSP has five-year agreement periods. The rebased benchmark would be slowly phased in starting in year six of an ACO's participation. Full rebasing would occur in year ten.

A second alternative would rebase using a three-year lag between the baseline period and the first performance year in an agreement period. While current policy updates benchmarks using the three most recent years of data, this alternative would create a three-year lag between the baseline period and performance year when benchmarks are rebased. However, these alternatives only delay the effect of benchmark ratcheting and do not directly address the ratcheting effect.

One alternative that directly addresses ratcheting and has the potential to better balance benchmark incentives is administrative trending. This would require a restructuring of how benchmarks are
This alternative would avoid rebasing and ratcheting by using an administratively set trend factor. This factor could be based on a discounted projection of Medicare fee-for-service spending growth or another metric such as projected GDP growth.

The main rationale for avoiding rebasing and trending forward benchmarks indefinitely is it would no longer penalize ACOs that generate savings, since their benchmark would never be ratcheted downward. This could give ACOs an incentive to generate larger savings.

If ACO gross savings are substantial enough, this could create an increasing divergence or wedge between benchmarks and actual program spending.

If benchmarks do not surpass what spending would have been in the absence of ACOs, both ACOs and the Medicare program would be able to share in the savings developed by the wedge.

This new method of updating benchmarks could allow for greater predictability in benchmarks while aligning with policy goals.

However, administrative trending has its
challenges. For example, administrative trending relies on a reasonable approximation of projected program savings several years into the future. If benchmarks exceed actual spending to the point where program savings are surpassed, benchmarks may need to be updated to reflect more recent data.

If ACO participation increases, removing the empirical basis for benchmarks could enhance pressure on policymakers to increase benchmarks.

In addition, initial baseline spending would be susceptible to random variation in spending changes, particularly for small ACOs. ACOs could be rewarded or penalized for one-time changes in policy, practice patterns, or changes in beneficiary assignment. This could result in selection bias where ACOs with a favorable benchmark continue their participation, but those with an unfavorable benchmark drop out. Under current policy, rebasing at least partially helps mitigate this type of selection bias.

Further, incentives for coding intensity and selection would remain and would still need to be addressed.
In conclusion, ACO gross savings are likely being surpassed by shared savings payments.

The abundance of benchmark policies have not improved the balance of incentives, especially the ratcheting down of benchmarks.

Current policy diminishes the long-term incentives for ACOs to achieve savings while rewarding ACOs for activities that do not improve care delivery, such as coding.

This brings us to our questions for Commissioner discussion. Do the issues related to rebasing and the downward ratcheting effect necessitate a new method for updating benchmarks? Should the Commission develop ideas around setting administrative benchmark updates? How should ACO benchmarks be adjusted to account for differences in risk scores and coding intensity? Finally, are there other alternatives to address benchmark challenges?

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

DR. CHERNEW: Thank you. That was really helpful.
I am going to turn it over to Dana to run the queue. Dana?

MS. KELLEY: All right. I have Lynn first with a Round 1 question.

MS. BARR: Thank you very much. Again, thanks for your work. I really appreciate it. I'm very concerned about this topic.

I have two Round 1 questions. One of them is the assumption that you have that there is no longer savings in the Medicare shared savings program, where all of the evidence prior to these new changes in the program have been that the program was underpaying the provider. So can you please present the evidence that you have that we're actually now overpaying the providers and that the program is no longer making money for Medicare? Because that certainly doesn't jibe with what I've been thinking or reading.

And my second question is I was surprised that nowhere in this discussion was the discussion of the rural glitch, which is something that people have been extremely vocal about, NACOs, et cetera. So, when you're doing the regional benchmark, disproportionately disadvantaged is
rural providers because they are the entire -- they're being compared to themselves, and so the numbers don't work. So I was also curious as to what is your thinking about these particular topics as relates to rural and the rural glitch.

But I am definitely in favor of getting rid of ratcheting.

Thank you.

MR. SERNA: Sure. I'll take the first question first.

So the evaluations for the program generally are through 2016, and so when you compare what shared savings per beneficiary were during that period and compare it to how much it increased in 2019 and 2020, those gross savings that were estimated during the early years of the program would have also had to increase far more than what was estimated in those evaluations, including the evaluations that we did.

So we say it's increasingly unlikely that annual gross savings are exceeding the shared savings payments going to ACOs. So it's not actually in conflict with any of the evaluations that have been on MSSP thus far.
The second question, what you referred to as the "rural glitch," we actually do mention it in terms of the ratcheting in the trend factor. So that is part of the ratcheting discussion where we talk about how because that trend factor now is partially based on an ACO's spending, it is essentially also part of this ratcheting effect in MSSP.

MS. BARR: Thank you.

MS. KELLEY: Okay. I have Paul next.

DR. PAUL GINSBURG: Thank you. This is a really, really helpful presentation. Very well done.

I have a couple of questions about the regions, and the first one is, you know, what compilation sizes as far as numbers of Medicare beneficiaries to the regions range from?

The other question is, over a multiyear period, how large are the differences in rates of growth of spending per capita or per Medicare enrollee across the regions? I think something seemed to assume there were pretty large differences in growth rates, and I just want to know if you have any information on that.

MR. SERNA: I don't have any information
immediately for you. In general, it kind of follows the geographic variation and spending historically from what we've seen, but I can say that similar to some issues that Lynn has raised, if you're an ACO in a particular small region, your region, it is based on your service area. So, if your service area has a relatively small population, of course, that's going to increase the likelihood that there's going to be more year-to-year variation. It should kind of even out over time, but even with smaller regions, it can still be an issue even if, for example, you use something like a five-year period instead of year-to-year.

DR. PAUL GINSBURG: Thanks.

MS. KELLEY: Bruce?

MR. PYENSON: Thank you very much.

In one of the slides, you had mentioned a counterfactual, and I wonder if you could describe that a little bit. I think you were using that in the context of setting benchmarks, and in particular, is the counterfactual based on non-ACO participants or the entire fee-for-service or the entirety of Medicare Advantage and fee-for-service?

Thank you.
MR. SERNA: I'm sorry. Could you clarify your question a bit? I'm not understanding what the specific question is.

MR. PYENSON: Oh, the question --

DR. CHERNEW: Can I try and jump in Luis?

Bruce, let me see if I can do this, and, Luis, this may clarify the question or at least clarify my misunderstanding.

I think the counterfactual that Luis mentioned was sort of more conceptual, what spending would have been had there been no ACOs for the population of people that were in ACOs because they actually do exist. So imagine a world with and without ACOs. The with-ACO ones, a bunch of people in ACOs, they're spending there. The without, we don't know what the without is going to be; hence, it's a counterfactual. But whatever we think that is, I think that's conceptually what Luis was talking about.

Luis, now you get to correct me if I was wrong, or, Bruce, you get to correct me if I misinterpreted your question.

MR. SERNA: So I'll just briefly say that that's correct, and that's in the context of setting benchmarks.
initially for a longer period of time. You still have to have some sense. If those trend factors are, indeed, based on some concept of fee-for-service spending growth, you have to have some sense of what that's going to be over time if you're setting those trend factors permanently for longer periods.

DR. CHERNEW: For, yeah, Bruce, I think if you believe, for example, the CBO or the OACT projections -- and that's a separate question -- but I think they are trying to project a current law projection of where spending would be. And so if spending fell below that, if there was as policy put in place now that held spending below that, all else equal, that policy would be scored, I believe, as saving money. And so the counterfactual, in practice, turns out to be the baseline against which any policy change is scored.

There are a bunch of reasons why the forecast might not be a counterfactual, and other nuances, but I think that's conceptually in the spirit of what Luis was talking about. I imagine you have a reaction, Bruce.

MR. PYENSON: Well, I understand what you said. I'm not sure I understand what that means for benchmarks.
So I think what you explained was looking at total Medicare spending, but then the counterfactual is a group of people who found themselves in ACOs and what their spending would have been in fee-for-service, and that might be different from setting a benchmark? I guess that's my confusion.

DR. CHERNEW: Yeah. There is some selection issue. So I probably should have kept the forecasting part out, how you get it, and I think this is more a conceptual point that if you had a bunch of groups that you thought without ACOs would have spending growing at 5 percent, and with ACOs they grow at 4 percent, the counterfactual for that group of people would have been the 5 percent. How you measure it, what it means in practice, how you set the benchmarks, is, you know, a little bit separate. But I think where Luis was going if you were going to set something for a long run you would want to have a projection of what the participants would have spent in the absence of ACOs as your counterfactual. How you get there is a separate analytic question.

I'm not sure we're clarifying your clarifying question. We may be muddying it. I may have to extricate myself from the discussion. Do you have any follow-up,
Bruce?

MR. PYENSON: Thank you. Not at this point.

Thank you.

DR. CHERNEW: Luis, any reaction, or else we'll move on.

MR. SERNA: If I'm understanding correctly, I think what you're saying, Bruce, is that it doesn't matter if your trend factor is closer to policy goals that are separate from actual spending, and that's probably true, but that's a larger discussion for how the trend factor would be set, which can be done in a number of ways.

MR. PYENSON: I think you've gotten at the core of my question. Thank you.

MS. KELLEY: Okay. Our last Round 1 question is from Larry.

DR. CASALINO: Thanks, Dana. Luis and Jeff, nice work, as always. So the materials are very interesting and focus very heavily on rebasing and what to do about trends going forward. But if I understood them correctly, they don't have much to say about setting the initial benchmark. And if I understand correctly, let's say we did administrative, or Congress did administrative, or CMS did
administrative trends for updating, that would, I think, get rid of the ongoing ratcheting problem. But then if you started with a high benchmark, because you were a high-spending ACO or high-spending region, or whatever, you'd kind of have a permanent advantage with the administrative trending forward, which is, in some ways, even worse than the ratcheting effect, potentially.

Have you guys thought about that at all? Do you want to make any comment to help us when we get to discussing that?

MR. SERNA: So I will say that was in the discussion about what the challenges would be, and kind of the ongoing challenges, is that initial baseline starting point would have an effect on participation, potentially for several years. In the chapter, we did talk about the various ways that baseline spending can be calculated and some of the pros and cons of those things, whether it's on a regional basis, whether it's using an ACO's historical spending. But obviously, there are tradeoffs for whichever method you would choose.

DR. CASALINO: And, Luis, you understand correctly, though, that if administrative trending was used
just kind of straight, the advantage or disadvantage you had from your initial baseline benchmark would be permanent, unless something was done to kind of narrow the gaps, essentially the gaps in the baseline benchmarks, over time.

MR. SERNA: That's correct.

DR. CASALINO: Okay.

MR. SERNA: I didn't mean to interrupt you.

DR. CASALINO: No, no. That's great. Thank you.

MR. SERNA: Okay, so there are several things in the chapter that we tried to enlighten for that potential consideration. One was if you don't adjust for regional efficiency in the baseline period perhaps one thought is you could do something about it in the trend factor, have some kind of differential trend factor for regional efficiency. That would be one way, over time, but that's something strictly for your consideration. But that issue is discussed in the chapter, but clearly there is no solution given, just kind of things for you all to consider.

DR. CASALINO: Thank you.

DR. CHERNEW: Yeah, so let me jump in. Larry, I
think two things. One is what you said is spot on. Two is 
that's why, as we pursue this work, thinking about how to 
avoid locking in baseline inefficiencies is going to be 
very important and a topic for discussion. I think it 
might be one of the central topics for discussion, at least 
in the realm of the updating portion of it.

So the key point is you can do that in ways that 
have a ratchet -- in other words, you save and then we take 
it away -- or you can do it in a way that works more 
administrative, which is we force some level of 
convergence, we can control the pace, but it's not affected 
by your success. In other words, the more successful you 
are, you don't lose more. That's sort of the distinction 
here.

DR. CASALINO: And Mike, just to make sure I 
understand you correctly, though, so giving slightly 
different trends administratively to force convergence, 
that does get rid of the ratcheting problem. Still, 
though, do I understand correctly that if you have 
favorable benchmark initially, let's say, you still would 
be able to profit based on being an efficient ACO or 
region, for as long as it took for convergence to happen.
Is that accurate?

DR. CHERNEW: If you have an inefficient benchmark to start and you can achieve those efficiencies quickly, you have more opportunities to save. That is true. And I guess I'll say something about that when we jump into Round 2, but what you said is true, although it's also possibly the case that there is a faster convergence by raising the lower end, in which case you could also say that if you started off efficiently as the benchmarks might converge. In other words, if you're starting 10 percent below some average and your benchmark is rising at a rate faster than average because you started below, you could also profit.

I'm trying very hard not to signal a particular formulaic response. We are nowhere close to exactly what the formula would be. I'm really trying to outline the possible things that one could do, and your question, Larry, I think correctly points out one of the challenges that any benchmark system would have to address. I think that in that sense it is spot on. But there's a lot of flexibility in how you address those challenges, and I think in the spirit of what Luis said, this chapter was
intended to at least begin to raise those challenges, if not provide the solutions to them.

Did I capture that right, Luis?

MR. SERNA: That's exactly right.

DR. CHERNEW: It's hard since you're all so small on my screen to catch exactly what's going on. Dana, are we ready to move on?

MS. KELLEY: Yes, ready for Round 2. Would you like me to start? Jonathan Jaffery is first.

DR. CHERNEW: Well, let me just make a comment, in the spirit of the discussion we were just having, to kick off this discussion, and then we'll just go through the queue and I will try and be quieter.

The savings for the Medicare program, in my opinion, can be achieved by either lower benchmark growth than what otherwise might have happened, thereby pulling out some money, or by pulling out past savings by rebasing from the groups that have been successful. So when a group is successful you can pull out their savings, do some rebasing or some other policy.

My personal view is that, depending on the details, the rebasing dramatically lowers the incentives to
save. And so if you don't have incentives to save, it's hard to have the program do well because there's not a big pie to share. So my personal view is savings to the program achieved by slower benchmark growth is a valuable way to think about how Medicare can promote access to high-quality care in an efficient manner. But that's just my view, and now I think we're going to go through to catch all of yours.

So I guess, yes, we'll turn it over, and you said Jonathan was first. So Jonathan, you're up.

DR. JAFFERY: Great. Thanks Michael, and thanks for this, Luis and Jeff. This is great and I think really sets us up nicely for some of the important work that we need to do moving forward, and we're starting to really get into kind of the meat of some of the main issues that we started to talk about last month.

I'll try and direct my comments towards the discussion questions you put up here and think about this in terms of setting some principles around how we think about this, recognizing that there's a lot of specifics, as Mike mentioned a second ago. We are not going to solve all those issues today. That's really a multi-cycle effort.
So first of all, thinking about concerns about long-term downward ratcheting and do we need different ways to update, a new way to update benchmarks, I would, you know, enthusiastically say absolutely. This has been an issue that we've all recognized for some time and spoken about how this creates a non-sustainable way to continue participation for ACOs. We can't just continuously have our benchmarks go down. And, in fact, if you think about it sort of philosophically, the goal for spending for an ACO should not be zero, and we could argue that the quality needs to continuously improve, and we'll never top out at that. But the goal of spending is not zero, so we need a different way to think about this, and ratcheting down will not work long term.

I'll jump to the risk adjustment real quick, just to sort of put that aside. I think this is a huge issue, of course. We've talked about it in lots of different discussions. It's a problem that crosses into MA, maybe even more urgently there. And we do need a better and simpler approach to risk adjustment that isn't all coding-based and is less burdensome for doctors, and is much less susceptible to gaming. I think you pointed out in the
presentation that these issues are going to remain with any
of the potential benchmarking changes, so it is a bit of a
separate issue.

That said, one specific comment, in the meantime,
while we're thinking through and trying to get to better
risk adjustment methodologies, expanding the timeline to
two years of collecting codes could, in fact, be helpful,
and basing them on two years of diagnostic codes. That, if
nothing else, would decrease the burden. It really is an
issue that we see happen on January 1st, when suddenly it's
just starting over.

So in terms of, you know, should the Commission
start thinking about how to set administrative benchmarks,
I would love to see us dig into this work. I'd also love
to see us set some sort of long-term vision and maybe work
backwards a bit. One of the recurring themes that you have
in the chapter is how to balance these three things, right
-- rewarding providers for efficiency, achieving savings
for the Medicare program, and not adversely impacting
provider participation.

And so it is very difficult to see how we have
that balance and get that balance right, year over year
over year, when participation remains voluntary in the long
run, or if not participating remains just sort of a
comfortable and lucrative option for people.

So in a perfect world -- in my perfect world,
anyway -- at some point in the not-too-distance future
we've got all Medicare beneficiaries in some population-
based, value-based payment model, whether that's MA or an
ACO. And, in fact, CMMI's recent white paper suggests a
similar goal of by 2030, to have all Medicare
beneficiaries, and the vast majority of Medicaid
beneficiaries in some such model. So I'd love to see us
kind of moving in that direction as well, and I think that
helps us think through a lot of these issues.

I agree that the regional consideration is
challenging. Lynn mentioned it for rural areas. I think
I've shared with the group in the past, we've looked at
this. My ACO does end up making the region, and I think we
did a calculation of how having more of a regional
adjustment impacted us as a low-cost ACO, and it impacted
the benchmark two cents per beneficiary per month. So it
really is a very minor effect, or can have a very minor
effect if you really make up that region.
And then I think the final comment I'll make, I think, and this builds on Larry's comments a bit, his question, is really getting to this issue of convergence. I think in the long term, again, there may be different ways to get there. There are undoubtedly different ways to get there. But it doesn't make sense that in the long term we have such regional variation in terms of total cost of care.

Beyond the risk adjustment and some other kind of local geographic considerations of wage index and things like that, it's hard to see justification for having 50 percent higher or two-fold total cost of care in one region of the country, that we'd just memorialize and that would exist in perpetuity. So whether that's by bringing up some of the baseline for some of the lower costs, or bringing it down quickly for higher costs, how quickly we make that convergence happen, long term this has to have an eye towards more standardized approach to what the right amount to spend for a population of Medicare beneficiaries is across the country.

Thanks.

MS. KELLEY: Brian.
DR. DeBUSK: Good morning, and I'd like to thank the staff for a really great chapter, very well written. I share the concern that ratcheting is a problem, and I think we should do away with it. But I would go a step further and argue that any strictly formulaic approach to this problem is going to be a problem in and of itself. As Jonathan mentioned, one example in the highest-penetrated MA counties, it may be difficult to even reliably calculate things like average fee-for-service spending.

And I think that this really underscores how a formula can lock in a specific methodology, and that formula may not reflect our overall program goals. And it also runs the risk of sending us off like alchemists, looking for this perfect formula that's going to meet all these different geographic and national needs.

I think that also strictly formulaic solutions become particularly problematic when they are coupled with voluntary participation, because it transforms the core competence into the ACO's ability to favorably select, number one, whether or not to participate, but also then to favorably select the providers and the beneficiaries within that specified methodology. In other words, the rules are
transparent but the behavioral response of the providers doesn't have to be.

So I do favor administratively set, prospectively trended benchmarks, and I think we can always incorporate formulaic methodologies into them. But then it's an option; it's not a requirement. And, for example, tying a prospective trend to some other economic measure, like GDP, seems very reasonable. And I also think that that gives us a lot more flexibility in dealing with coding itself, because we can treat that as part of the administrative process. For example, it gives us the opportunity to normalize coding intensity periodically.

We can incorporate two years of risk score coding, which Jonathan mentioned, and I hope we do, and I would like to see more frequent calibration of the HCC model. I don't think we've recalibrated -- I think 2014 and 2015 were maybe the base and performance years of the latest recalibration. I may stand corrected on that.

But the other comment I wanted to make, I favor some form of mandatory participation, obviously, an administrative benchmark with mandatory participation. But I do want to make one observation. It really intensifies
the attribution process, because then the persistent over- and under-spenders really become inescapable. And so I do think as we move forward with exploring mandatory options, I do think we need to keep in mind, could we inadvertently create some access issues for those highest-utilizing beneficiaries?

Thank you.

MS. KELLEY: Lynn.

MS. BARR: Good morning and thanks. Thanks again to the staff for a great chapter. So, you know, this is a very difficult discussion as we, you know, learn about people talking about how we're overpaying ACO participants and that they are gaming the system. But there are a lot of people in there that aren't gaming the system and got a reasonable adjustment in Pathways. And so how do we break that apart, right, is really the question? I mean, for us we thought that was a reasonable adjustment, but we, at the same time, are seeing what you're seeing, with a lot of gaming of the system.

So, you know, we want to make sure we're not throwing the baby out with the bath water, in some cases. And, you know, I think that the important thing is, what is
the national spend? How much does a beneficiary cost the
taxpayer? And I think the more that we can drive expensive
ACOs to the national spend and reward efficient providers
for reducing costs and staying below that national trend,
so we may want to look at the national spend as a way of
driving benchmark policy, because ultimately that's what
we're trying to get to, and I agree with Jonathan that
getting rid of the national variation is silly and
expensive, and it can't be good for the patients.
So those are my thoughts. Thank you.

MS. KELLEY: Betty?

DR. RAMBUR: Thank you so much. I really
appreciated the chapter and the comments of the other
Commissioners, and I'll just build on a few of them.
I also think that setting the base and the trend
is one of the most foundational important things, and the
retrospective ratcheting is definitely a problem. I think
about it as the good management penalty. So I am
supportive of prospective administrative trend, exploring
that more deeply.

That said, I'm also thinking a lot about how can
we incent behavior that is really about care redesign,
getting some of that cost that's already baked in the cake out of there, and just as one brief example, I see all the time the response to more children with asthma is to hire another pulmonologist, but not to have social workers or community workers or nurses go into the home and think about mold abatement, getting pets out of the bedroom, is the child under stress, whatever. And so we're so steeped in that reflexive biomedical model that it's very difficult to shift on anything that has, you know, a fee-for-service chassis.

I am very concerned about how the coalition of the willing creates a selection bias, and I would be strongly in favor of moving aggressively, as Jonathan and others have suggested, towards this not being an alternative payment model but the payment model with bundled payments underneath because it's obviously a challenge.

And then, finally, to the extent that the gaming with coding adjustments be addressed, you know, for the individuals that are doing it, they are not feeling they're being manipulative or unethical. They're just taking advantage of the opportunities they see in front of them.
So I'm not the person who can figure out how we redesign this so that we don't have that, but I think it's very important.

So I think this is an important conversation and well worth our time and effort, and I thank you for your thoughtfulness and what you've brought forward.

MS. KELLEY: David.

DR. GRABOWSKI: Great. Thanks, Luis and Jeff.

This is great work. I do believe ratcheting is a major problem, and I'm really glad the Commission is taking this on.

So let me just start with my high-level comment. I think we want to base benchmarks administratively. We want to update them at a preset or concurrent regional or national growth rate. We don't want to rebase them based on performance. That's sort of at the high level.

In terms of the details, if we're thinking about regional versus national growth rates, I like a regional perspective or administrative benchmark. I don't think you can just flip that on, however. Larry raised this in Round 1. We're going to need an on-ramp period to what Mike termed "convergence." And I think Mike said this in Round
1, but we don't have to sit idly by and just wait for that convergence. We can actually adjust benchmarks across areas.

One idea that has been put forward, I think by Mike Chernew and Michael McWilliams and others, you can set the lowest spending regions that have the greatest growth in benchmark relative to those higher-spending regions. So you could make this a policy instrument.

In terms of when we do get to this next phase, how to do this -- and I think Brian already mentioned this -- I like the idea of using kind of GDP growth, for example, or some other factor. I do think you're going to need to have that informed by fee-for-service growth to protect providers against losses from the increases set by the Congress. And I do think you're going to have to have periodic systemwide rebasing that's informed by fee-for-service spending. So I don't think you can purely rely on GDP, but I do think we can do this with some rebasing.

A final comment, and maybe I'm getting ahead of myself here, but I can't help it. Regional benchmarks for ACOs in this next space could be harmonized with Medicare Advantage, and what I mean by that is that the benchmarks
for a beneficiary with the same risk score in the same region would be identical across the two programs. If we had a comprehensive ACO program here spanning fee-for-service Medicare, the ACO benchmarks could be used instead of fee-for-service spending as a cap on plan bids. I know that's an issue we've talked a lot about in Medicare Advantage. I don't want to blur two big issues here, but I do think there's a lot of opportunity to kind of do more here once we get this right. And I know I'm way out in the future, but I want to think big.

So, once again, happy we're doing this work and really excited we're digging into this. Thanks.

DR. CHERNEW: Before we go on, Dana, I want to make one clarifying comment just for the audience, writ large. Fee-for-service is a complicated concept in this conversation because right now ACOs are part of fee-for-service. So if all providers or beneficiaries were in an ACO, just hypothetically, understand that fee-for-service is really just the other ACOs. That's the way that that would work out. And so you would be -- if, for example, we set a benchmark at the average of fee-for-service, that would de facto be the average of ACOs, which would de facto
mean half the ACOs would have to lose by definition.
Actually, not necessarily, depending on how you weight it,
but that's more technical.

It is certainly true that -- now, maybe we're
fine with that. Maybe we're okay with that. I worry a lot
about that personally. But that is important to understand
where ACOs and fee-for-service fit because sometimes we
talk about them like they're different, but
programmatically, the ACOs are in a new way of paying in
fee-for-service. So I'm going to stop there, and I just
wanted to remind folks of that, and now we'll go on to the
rest of the queue, Dana.

MS. KELLEY: Okay. I have Jaewon next.

DR. RYU: Thanks, Dana, and thanks for a great
chapter. A complex area. I think I could probably add a
plus one to a lot that's already been said. I'll just kind
of go through the list here of notes that I had taken.

I, too, am against the ratcheting effect. I
think it does exactly what we don't want to do, which is to
penalize success. And so I am also in favor of an
administratively or prospectively set benchmark, and I like
the idea of pegging it to something like the GDP or some
other instrument along those lines.

I think this notion of convergence, however, I think there are areas or counties or locations, however you want to define it, that clearly have higher rates of spending at a starting point versus others. And I think on some level you start where you start, and so I think we have to be somewhat recognizing of that reality. But over time you would like to see convergence.

I'd love to see something done around differential rates of growth so that you can have a slower or a more aggressive slowing down of a rate of growth in counties that are higher spending, and then maybe that rampway or the trend line doesn't look as aggressive for areas that already have a low spending rate.

At the same time, this starts feeling, to me at least, a little bit like the MA quartile benchmark system, and so I think we've got to be a little careful not introducing some of the flaws that we've discussed around that model. But I think as a concept I do like that it gets us to where I think is a good spot.

I think the last point I would make; I can't separate this thinking from whether or not the program
would be mandatory or voluntary. I think if it's voluntary, I think the added layer of complexity and thinking through the administratively or prospectively set benchmark needs to be that it's still got to be a more favorable environment or more attractive environment than being outside of the ACO or alternative payment environment. And so, you know, to me it's cleaner if it's mandatory; then everybody's in. But if we are not going down that road, then I think we also have to ensure that it's a more attractive setting for people to come into.

MS. KELLEY: Paul.

DR. PAUL GINSBURG: Well, thanks, Dana. You know, as I was reading this chapter, I just kept thinking over and over again about, wow, with a voluntary system, it is so hard to come up with a good benchmark policy. And, you know, my colleagues that preceded me have been very strong -- and I support them -- about the importance of going to a more mandatory system, and I'm saying more mandatory because I would envision a situation where for some provider types it would be mandatory; for others there would be strong incentives to participate, and the incentives would be basically you get higher fee-for-
service rates if you're in an ACO and you get lower fee-
for-service rates if you're not in an ACO.

I think getting back to the benchmark issue, I
think we should be saying not only what would be the best
way of doing benchmarks now under our current voluntary
system, presuming we moved in the direction of mandatory,
how would we do benchmarks under a mandatory system,
because I think we could do a much better job in having
equitable and efficient benchmarks with closer to a
mandatory system.

Another comment I wanted to make is that, you
know, I think that the regions are too small, and we might
want to bring into our discussion discussions like we had
over the years in Medicare Advantage, where, you know, the
Commissioners come up with the MedPAC areas instead of
carriers going to, you know, the parts of metropolitan
statistical areas within a state and then the rural
counties in a state. And I think if we had bigger regions,
we could rethink and maybe a system -- a blend of regional
approaches might look much more attractive if we had larger
regions. You know, maybe we could even have like census
divisions, like nine of them, rather than the small regions
we have today, which just don't work that well.

A final comment is this issue that's come up a few times about ACO selection of providers, and I've been really concerned about the implications of this. Imagine a primary care practice that is the only practice in town that goes into nursing homes to treat their patients. Well, I would imagine if you looked at their attributed beneficiaries spending, it's going to be a lot higher than the other primary care practices, and that, you know, we don't -- you know, the more selection we have, there's a risk of decreasing access as well as really gaming the system. So I think we should be focusing on that element of risk selection as well as, you know, the coding problems.

MS. KELLEY: Amol?

DR. NAVATHE: Thank you. Luis and Jeff, fantastic work here in outlining a number of different sort of historical legacy designs as well as those four challenges.

I wanted to say a few things here. I think the first thing is I would advocate, if possible, for us to actually be very explicit about what the goalposts are here
in terms of where we're trying to head, because I think at
times it can be a little bit dizzying in terms of all the
different tensions that we're trying to balance. And, in
fact, articulating where we're trying to head, prioritizing
this notion, for example, of Medicare savings and making
that very clear, at the same time noting that there's a
number of different tensions that are created from a design
perspective, I think that would be very helpful to dispute
up front in the writeup to set out -- set this out
explicitly.

And just to give some examples, when I say, you
know, what are some of the principles that are worth
outlining, I think it could be something as straightforward
-- I think some of these are said in the chapter, and it
might just be kind of pulling them forward to a certain
extent. So, number one, our goal is generating Medicare
savings; number two, encourage participation and reward it.
We heard this from a number of Commissioners several times
here that one of the concerns about the ratchet, for
example, the ratcheting downward is that it doesn't
encourage participation, particularly amongst those that
are doing well or it's rewarded. We may want to reward
high performers. In terms of driving savings, those -- also in terms of better improving rapidly, for example, we might have a goal around having a system that's more robust to coding variation, and we might want something that is more -- that is simpler and, therefore, easier for provider groups and ACOs to respond to the incentives, too, which, for example, a retrospective trend factor might be more challenging for. I think as we set out these principles, highlight the tensions, I think it will help us navigate some of the complexity here.

The third point I wanted to make is that I think it would really be helpful to start -- I know we're at a preliminary stage here, but as we go forward, to do some analytic work to understand, for example, how pernicious the ratchet effect is on benchmarks, on the potential for savings, showing, for example, that an ACO that is improving rapidly over time, how it gets penalized. I think that would be helpful.

I think similarly with the administrative benchmark, I'm generally in favor of that concept. I think it would be helpful to understand how we would deal with certain scenarios where what happens in the future actually
doesn't match up with what we prospectively thought. And, therefore, what kinds of risk corridors, minimum savings rates, what are the other dimensions that would need to be a part of that.

The last point I wanted to make is I agree with something that Paul was just basically hinting at, which is I think some of the analytic work may actually be useful in terms of can we actually design a benchmark rebasing and trend-based system in a voluntary world that is not highly vulnerable to the selection effects. I would love to see that, and I have generally been a big fan of the idea that we do voluntary programs as a way to garner participation potentially amongst those groups that have the most either to save or feel that they can improve a lot. But I think this is highlighting that it's possible -- or it may not be possible to truly design a system that doesn't create some strong election effects where you end up having a group that is above -- you know, above average spending, for example, above benchmark if you do it regionally that is not going to join, or vice versa, you have a group that is very efficient and you're creating a system. I'm not sure that we can blend 50/50 and do this and that and actually
solve all the dimensions.

So I think, Jeff and Luis, one of the questions I have is: Can we do some work around this analytically to see if we can actually build a robust system? My speculation here is it actually may be quite challenging.

So thank you very much for taking us in this direction. I think it's very valuable, and I look forward to the following work.

DR. CHERNEW: Thanks, Amol. I just want to jump in and make one reaction to one thing you said just quickly. This is just a Chernew view. My view of APMs generally for big-picture principles is we're not -- the goal is not to get everyone into an APM per se. The goal is to provide efficient care, high-quality care at an efficient cost and allow the delivery system flexibility to do that and succeed.

If it turns out that other mechanisms like Medicare Advantage can do a lot better than APMs or the APMs just simply can't work for a bunch of other reasons, I would have no problem finding some other better mechanism to achieve broader program goals. So I just wanted to put out there that it's not -- participation for the sake of
participation doesn't mean we have won. What means we have won is when we have high-quality care to all populations at an efficient cost.

So that's just my perspective. We can have a broader discussion of that, but let's move on in the queue.

MS. KELLEY: I have Bruce next.

MR. PYENSON: Thank you. I want to thank the authors but also the other Commissioners because I think the concepts that the Commissioners have brought up this morning are really very important and very helpful and useful.

I would say I definitely am an advocate of the administratively set long-term benchmark goals, and that's something that ought to be done with a policy goal in mind. And I like the percent of GDP kind of connection there.

I would say that I've been an advocate of moving away from the annual, the 12-month cycle of rate setting for both Medicare fee-for-service fees as well as Medicare Advantage benchmarks and bid process. It seems silly in the third decade of the 21st century that we can't set goals and targets that are more than 12 months long. We can certainly do that. We've got incredible data systems
and insights, and let's do that, because the current system of annual updates favors organizations that can game the system, and the longer-term goals of things like population health are not consistent with one-year churning.

Like others, I don't see the solution in a voluntary system, that some form of mandatory or quasi-mandatory system is essential. The current system has led to what used to be termed a "breakdown" of the insurance pool, and for the reasons that Paul and Betty mentioned, the selection issues, I think we have less time to deal with this than we might think, that the selection issues for provider networks for beneficiaries on side of both ACOs and Medicare Advantage plans are available now. And they're being used and being aggressively sought after because they're so effective in the current system.

So I think we have less time than we think to move to a mandatory system to avoid those kind of selection issues.

I would like to offer a concept to avoid some of the selection issues, which recognizes that health outcomes are a product, not of an individual doctor, not of an individual hospital, but of a community, and that all
participants in the community ought to be held accountable for the outcomes of that community. And that includes Medicare Advantage along with accountable care organizations in the mandatory system we envision.

So connecting those outcomes and the actions taken on a community basis is one way to avoid the selection issue; that is, everybody does well or everybody gets penalized if the system on a local basis isn't working correctly.

Just a final point, a technical note. The focus on trends takes me back to the beginning of my career as an actuary when we didn't have very good data systems, and trend was seen as king. Trends took on a quantity as though it was a physical measurement like temperature or the portion of carbon dioxide in the atmosphere. So trends was used to move the status quo forward.

I don't think that's what we want here. We want to set benchmarks based on policy. We have the data to do that in detail in a deliberative way. Trend will be a consequence of policy, not a driver of policy. So I just want to put in that technical note to change our emphasis.

The iterative process that's used today to set insurance
premiums and bids and others, you know, certainly considers a historical trend, but it's based on policy goals and forecasts and financial goals. And I think that's what we should do and get away from the focus on trend.

But, again, my compliments to the authors. Thank you.

MS. KELLEY: Marge.

MS. MARJORIE GINSBURG: Yeah. My comments will be very brief.

The discussion has been fabulous. The report is amazingly detailed and yet somehow understandable. This whole topic to me is one of the more complex, difficult ones that we have to face, and I completely support the comments that others have made towards getting rid of the ratcheting effect going towards administrative benchmarks.

My main comment was just to reflect on other big issues that we often weigh in on, and it seems that there are kind of three principles that always rise to the top, at least this is how I interpret it: simplicity, fairness, and affordability.

This is not simple, the way it is now, and I think our movement towards getting rid of the ratcheting
effect will move us more towards that concept of simplicity, and I think that is going to be really important as we move forward and as other medical groups move forward.

The other comment I want to make is that are any of the -- maybe it's a question. Are any of the other things that we weigh in on, such as quality bonuses for MAs, require them to be evaluated based on their previous years' success, or does everything always start with a clean slate? Is this the only area where people have been held accountable for their success previously as they go forward? So that's just the general question of has this really been a bit of an outlier in terms of requiring that all the ACOs be evaluated based on their previous success. So that's a general question.

My comments are I'm excited about moving forward with the comments of my colleagues. Thank you.

MS. KELLEY: Stacie?

DR. DUSZTINA: Thanks for the great chapter here.

I'm going to, as Jaewon said, plus one for a lot of the things that have been said already, including trying
to address the ratcheting problem.

And, also, specifically, I think not penalizing ACOs that were efficient in their baselines and rewarding those who are inefficient seems like a really good goal to have.

Probably, following up a little bit on what Amol was saying is I think that we need a little bit more information around some of these decisions, specifically for the trends.

I appreciate the comments and people being supportive of pegging to GDP. I wonder also about how to take into account things like unusually bad years and also like new technology coming into the program, what that would look like if we used non-ACO fee-for-service spending to try to understand new technology adoption and GDP. How would those differ in what we ended up with if we used a trend? So I think seeing a little bit more information about those would be really helpful.

Another thing that I don't know, and maybe this goes a little bit to Marge's prior comments, was about setting the initial baseline or initial grouping for the ACOs is -- what does happen if you look back for three
years prior trend instead of the one year? How different
would that look as far as how efficient a practice looked,
and what can we do, thinking about moving those targets
around for defining an ACO's performance in at least a
baseline year?

Again, I reiterate what others have said, really
excellent chapter, and I'm excited that we're taking on
this important work.

MS. KELLEY: Larry.

DR. CASALINO: Yeah. So I too am in favor of
looking very seriously at prospectively using some kind of
an administrative guideline to rebase or to trend forward,
and it's interesting to see we seem to have virtual
unanimity on the Commission about that. The ratcheting is
just so patently unfair. I'm surprised there hasn't been
much more about it than there has been, and I think the
reason it hasn't been is because the program hasn't been
mandatory. But, even so, it creates a kind of cynicism
and, I think, really hurts the long-term goal of trying to
have providers organize in such a way they can improve care
for population of patients. So I think the sooner
something can be done about that the better.
I just want to emphasize a couple of, in a way, minor points but that are important, I think. I think Dana Safran may have something to say in a little bit about her experience with the Alternative Quality Contract program in Massachusetts.

But one of the things, setting projected increases years in advance, honestly, the problem with that is something could come along that couldn't be foreseen, a major change in the economy, new technologies being introduced that are expensive. That's tricky because often expensive new technologies are put into place and used a lot when they really shouldn't be, but that's a side point.

The main issue is I think that Blue Cross Blue Shield of Massachusetts, which Dana will talk about, was able to be very flexible and change quickly, what it wanted to do with the prospective setting of benchmarks, and I'm not sure that CMS could do that.

The other thing is in addition to changing benchmarks, sometimes just on an annual basis, my understanding -- Dana, correct me if I'm wrong -- is that Blue Cross Blue Shield of Massachusetts had to make some kind of on-the-fly adjustments for unexpected things that
came along, and that turned into kind of a black box, which I'm not sure would be acceptable in the Medicare program. These are problems, I think, should be dealt with going forward with administratively updating things.

And then just two minor points. There's been a lot of talk about mandatory today. I know that this session isn't about that, but I just want to flag this for when we do have a session in the future perhaps about mandatory versus voluntary participation in ACOs or APM programs. The more we make something mandatory, Medicare makes something mandatory, then the more financial pressure put on organizations in a mandatory program, the more risk that organizations will skimp on quality. So we're talking only about controlling spending today, but I think there's a lot more room and really a need for more attention to, in some way, better than we have now, a measured and rewarding quality of care in organizations.

I saw this in California with full-risk capitation in the '90s. The more financial pressure the more risk to quality, so I don't think we should forget that.

The other thing was obvious, but we don't want to
forget with mandatory is what are the options for smaller practices. I think we do want to give explicit thought -- and, again, this is off topic for today, but with all this talk about mandatory, I just want to mention it and flag it for the future. We do want to give specific thought to not just setting up incentives and demands in such a way that we basically hand the medical care system over to very large corporations. We already see that, some risk of that in the newest ACO program.

So I'll stop with that.

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

DR. JAFFERY: Yeah. Thanks.

Just briefly, just to address Larry's comments about CMS being able to adjust quickly on the fly, I mean, certainly, that is a challenge, and I think Blue Cross Blue Shield of Massachusetts and other places can do this a little more easily.

But I just wanted to point out that we did see some changes. There is some precedence in the most recent year or two because of the pandemic. So there was a lot of different things that CMS did adjust to account for the
fact that COVID changed everything for people. So I think we may just want to remember that.

MR. PYENSON: A good point, Jonathan.

MS. KELLEY: Paul, I think you had something on this point also?

DR. PAUL GINSBURG: Yeah. I also have something different that Larry said. He was talking about the concern that, in a sense, if a system is mandatory and there's too much pressure on costs. Well, of course, there are risks to quality. To me, the answer is modulating the pressure carefully because, in a sense, by having it voluntary, that just means too many people can just ignore it, ignore the concern about costs as opposed to just take more sober responses to it. So I think they're really different issues.

MS. KELLEY: Dana.

DR. SAFRAN: Thank you.

Apologies if I missed the earlier part of this session, so I hope that my comments will not be redundant, and I can't indicate which comments I'm building on and agreeing with, so forgive me for that.

I do really appreciate the tremendous work on
this chapter. This is complex, critically important to the success of the payment reform models, so really appreciate this chapter.

Really appreciate the proposed direction around considering prospective benchmark setting, as some have referenced already. In my time at Blue Cross Massachusetts, as we were beginning our work on the global budget contract called the Alternative Quality Contract, or AQC, in 2007, launched in 2009, that model was a five-year contract and did in its first iteration use prospective benchmarking. We did that because we thought that having an absolute number, having a provider who's in the model know what my rate of increase is in absolute percentage terms next year and the year after that and the year after that would be extremely important for their planning to manage that.

But, as I think Larry foreshadowed, the market crash in 2008 took what had in our negotiations for 2009 contracts, seemed to be ambitious and relatively aggressive rates of decline year-over-year, and those absolute trend targets, they no longer work. So we do have to think about those things.
The other thing that came up that I also think can be worked around, but it's just an important lesson learned, is that as we went through those early contracts, five-year contracts with absolute budget targets, we began to see that there were certain things that really had to be considered outside of provider's control. A pandemic is a good example, and this would affect their ability to manage to that absolute trend target.

So we developed a kind of set of things that we would create as adjustments outside of the trend targets at the end of the year, and while that was very well received and very fair, it also undercut our ability to have providers know month by month how they were doing against their target. They could only know at the end of the year when those adjustments were made.

I think we can -- and CMS can really troubleshoot those things and build in mechanisms. So I don't see them as a reason to avoid prospective benchmark setting. I think it's a really valuable thing to consider here.

Someone mentioned the point about new technology, and I'll just reference that that was one of the things that we had on the list of outside factors excused. I'd
want us to think carefully before we entirely excuse it, because part of what was, I think, really valuable about that, that we never got to see come to fruition, is it has the providers who are in the contract now actually having to be thoughtful partners in deciding which new treatments and technologies actually get into the system and get used because they have an accountability for the total cost of care, and those may not have been anticipated.

So it really makes them partners and thinking hard about many of the things that we know have been escalators of Medicare costs, and I think that's a really important value of having a prospectively set trend target. So I'd argue for that benefit as well.

Finally, just a couple last things. One is on the ratchet effect, you know, the voluntary nature of the program really does make it so that we have to pay attention to that, because, you know, as other, I think, it sounds like, may have been pointing out, if this remains a voluntary set of programs and you can just opt out whenever your budget starts looking unappealing or the terms start looking unappealing, we have really undercut our success.

Two is I'd love to see this chapter incorporate a
bit more in the way of insights about how the benchmarking that was used in different stages of this work -- for example, in the early years of MSSP we saw net savings -- can we glean some insights about what was it about the way that benchmarking was handled that may have contributed to that and the shifts to different approaches to benchmarking that may have undercut that there, or other programs. So I'd like to see us do that.

And finally, and I think Amol may have already mentioned this point but I'll just double down on it, I think the chapter needs to be grounded in a set of principles that we would use to assess different approaches to benchmarking, things like a principle that says we want to limit ratchet effect given voluntary participation, or we want to prioritize participation in savings in regions that have the highest opportunity for impact perhaps. There are many things we could consider, but I think grounding this in some principles will be very valuable. So thanks, and thanks again for the great work.

MS. KELLEY: Pat.

MS. WANG: Thank you. I want to agree with the other Commissioners but state for the record I think the
ratchet effect is terrible. It's really, you know, the bridge to nowhere. So the work to try to develop something that is prospective, administratively set, is very important.

I just wanted to sort of touch on some of the conversations that we had about convergence with the MA program, and put some of my questions out there because I have trouble trying to kind of think about this a little bit. You know, I think what David Grabowski suggested is a goal, a very good goal that somehow these do convert.

But let me just raise some of my own confusion. For one thing, I wondered whether there was any sense in looking at the benchmarks that are set by CMS for the MA program, which I frankly, to me it's a black box, to others it's probably not. I think it's a three-year rolling average of fee-for-service in a particular area, and it builds in new technology, it builds in developments, it builds in changes in the fee schedule, and updates, et cetera, et cetera.

I just don't know whether there is any comparability, but I would just be curious if it's possible even, especially in an area where an ACO kind of dominates,
like the county, because the benchmarks, ultimately, are county-based, before you start applying those cliffs, the 95, 100, 107. Just even like sort of pure play, what would they look like today and whether there's a relationship between the two that could be of interest. If there is a relationship then perhaps there are some insights into the way that MA program currently sets MA benchmarks, which they do a three-year, weighted rolling average. They build in many of the things that people here said. There might be some insights there.

The second thing that I have to confess -- and I apologize because I don't have a provider hat on. I have an insurance company hat on -- the different purposes of ACO, population-model ACOs versus MA, and I welcome the correct and the illumination -- I think of ACOs as being a way to improve the way that providers systems operate. And it's possible that that provider system that is participating in the ACO has very specific characteristics in its market, whereas an MA plan, which is doing business in that market, is responsible for delivering something to a beneficiary. And in doing that they may select different hospitals, physicians, providers to deliver that package.
That's how they're measured.

And so, you know, I just wonder whether we need to kind of think a little bit about the relative purposes of MA versus ACO before we think there can be total convergence. I think a population-based ACO can be highly successful, because it has improved itself, but if they were participating and all of a sudden you said tomorrow, "Okay, you're getting the MA benchmark," it could be a disaster for them because maybe their costs were higher to begin with, if their costs, you know, in an ACO model they have success, especially, you know, with just partial regional blends.

So I think it might be a little bit of an apple and an orange, and I think we'd want to think that through a little bit before we sort of said they should be converging that way.

The other thing is that, as Mike pointed out, ACOs are fee-for-service, and so to the extent that an area is dominated by ACOs in the fee-for-service system, I think that that fee-for-service experience is what is feeding the MA benchmark, because the MA benchmark is based on fee-for-service. So does it get circular at a certain point?
They're not two completely separate things.

Finally, these are just questions, I guess I have. The issue of mandatory also, I just want to sort of -- we talk about mandatory as though we are only talking about providers, and I kind of get that there is a flavor of mandatory which says this is the new way that Medicare pays everybody in the fee-for-service system. I think that's easier to do for some of the smaller APOS, like bundles, the joint replacements, things like that. For the population-based models, I think it's really hard -- I would issue caution, I guess, of saying that fee-for-service should be made lower or less attractive. It's very appealing. But I think that there are, doing the population-based models it's very complicated, it's resource intensive, there are a lot of providers that just couldn't pull that off. And I wouldn't want to degrade their payment because we've recognized the value of the population-based models. So I think that we have to balance those things.

And the final thing about mandatories is that nobody has talked about the beneficiary. Maybe we don't need to, and I think mandatory is not a third rail kind of
expression. There are many mandatory Medicaid managed care programs in the states now that produce a higher quality of care than a comparable commercial insurance company would, for example, for children. I'll just use that as an example because so many kids are covered by Medicaid.

So I think that's something that we need to grapple with. And one of the things about the whole APM ACO conversation is that it is so rich, but I think we need to make sure we're talking about the same things when we're using phrases and words. So I think, you know, the more we can sort of define what we're talking about and what we're not talking about would be helpful. Thank you.

DR. CHERNEW: Great. So I think we are going to let Jonathan have the last word, and I am going to then sum up, and then we'll take our break. So Jonathan.

DR. JAFFERY: Yeah, thanks, Mike. I'll be brief. I just wanted to respond to Pat, one of the things you made me think about. First of all, I do think that similar thinking about the convergence of MA and ACOs and how that would work is important, to David's comment. But there's one piece, as we're talking about principles, that we've talked about before as a group, that I don't think came up
today that I think we should bear in mind, and that's recognizing that MA plans may take population-based payments and capitation, or whatever the case may be, but then I think it's still 85 percent of payments to providers are turned around and paid in a fee-for-service model. I know that varies a lot in different markets. But if we still have half of beneficiaries in MA plans and most of those payments are in a fee-for-service model, we're losing a lot in terms of how providers are paid and how we're going to get into more value-based care. So I guess we should put that up as a principle too, in my mind, as we talk about this. Thanks.

DR. CHERNEW: Okay. So that was a really rich discussion. I am grateful that I heard a lot of consensus around some issues, for example, that the ratchet does reduce incentives for saving and is, in fact, a problem, and that at least we should continue to explore the possibility of prospective administratively set benchmarks. I will say, as this conversation illustrated, there is no prejudgment on what that will look like, and there are just a few issues I just want to note that I heard here. One of them is we need to think about
convergence, and I'm going to put off convergence with MA, although, Pat, your comments were spot on in a number of ways on that point, and just talk about convergence within the ACO program.

The challenge here is that the money is where the most inefficient practices are, which means we need to get those organizations in, and my personal belief is we need to be careful as we push down on our spending target for those groups, because I think we risk being a little naïve about how easy it is to change. And to, I think, Pat, your point, the beneficiaries are important. We do not want to harm the beneficiaries as we go through this transition. So that will mean some inequity as we move forward into convergence, and I do think we're going to have to think through how we deal exactly with that process.

I will say that there was a lot of discussion about mandatory-ness. I don't like the word "mandatory." I think it's more about incentives. But the point remains there are a lot of concerns if there are voluntary programs that there's a lot of selection, you actually may do worse than you otherwise think, and it makes the benchmark setting much more complex. But we certainly aren't going
to be able to force all groups into strong, two-sided risk models. That came up last session. So this is why we had the discussion last time about multitrack models and trying to make sure that the models matched the providers in some ways, and of course, there's a whole other issue about how episodes work into this, and that might work more into some tracks than others.

There are a bunch of other comments that I think are really important. Risk adjustment was a theme raised by many of you and it obviously matters in every population-based model. Attribution is a crucial one, and we will have to have some discussions about how attribution can work. If we don't have attribution working it's hard for any of these models to be successful.

I will point out that this basic notion of prospective administrative type fees is how we deal with almost all other fees in the Medicare program. We're about to jump into December and January discussion of updates. All of those are versions of prospectively set administrative fees. It's not tied to spending for an organization in quite the same way. And Maryland also has a model that sort of combines an administrative-set target
with -- they have a particular way of how they deal with fee-for-service spending in the Maryland model.

So there is, I think, a lot of work to be done as we push this forward, but I do believe we have consensus on a basic direction of how we might want to set benchmarks in the context of a broader, multitrack ACO program, which itself will have lumped in other types of alternative payment models. And we're going to have to do so in a way that protects the beneficiaries, and particularly the organizations that serve them, as we make this transition.

So that is my summary. I want to tell the public that we really do miss being in person, and we really would like to get their comments. So you can reach out. I'll let Jim give the exact website. There is medpac.gov. I think there is a specific website for comments. Jim, do you want to do that?

DR. MATHEWS: You can send comments to meetingcomments@medpac.gov.

DR. CHERNEW: Okay. So please do that. Those of you that have sent comments, you know we will reach out and acknowledge them, occasionally engage. We really very much do appreciate them.
So, Jim, do you have any other comments, or do Commissioners have any other comments before we break for lunch?

DR. MATHEWS: None here.

DR. CHERNEW: Okay. So we are going to break for lunch. We will come back at 1:45. We are going to begin what I hope will be a very important, multicycle effort to figure out how we can develop policies to support the safety net, an area of particular interest to me and I think many of you.

So again, thank you for those of you who joined us. Please send comments, and I'll see the rest of you at 1:45. So signing off for lunch.

[Whereupon, at 12:52 p.m., the Commission was recessed, to reconvene at 1:45 p.m., this same day.]
AFTERNOON SESSION

[1:46 p.m.]

DR. CHERNEW: Welcome back, everybody. This is going to be our afternoon session of our November MedPAC meeting. We are going to start with a topic which really is not new in many respects to MedPAC concerns, but I think it's a topic that deserves more and more unified attention. It's one that's very important to me and to, I think, many of the Commissioners and staff, which is how Medicare policy can be used to support safety-net providers.

So with that, Brian, I'm going to turn it over to you.

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

Our presentation today focuses on clinicians and hospitals. While we start with these two sectors, we
anticipate broadening our work in the future. First for clinicians and then separately for hospitals, we'll walk through motivations for examining safety-net providers. We'll also review Medicare's current policies to support safety-net providers. While often important to maintain access, we don't consider policies designed solely to support isolated providers such as extra payments for critical access hospitals as safety-net adjustments, so we don't discuss them in our presentation.

Next we'll discuss possible definitions the Commission might use to identify safety-net providers. At a conceptual level, our goal is to have one safety-net definition that applies to providers in both urban and rural areas and that is applicable across sectors, even if how that definition is operationalized varies across sectors. We'll also review some of our analyses on the characteristics of safety-net providers compared with other providers.

Finally, we'll end our presentation with questions for the Commission to consider. We expect the Commission's discussion of Medicare's role in preserving safety-net providers to occur over several meetings and to
continue into next year's cycle. The process will be deliberative because changes to safety-net policies could have long-lasting effects. Our goal is to come back to you in the spring with additional information that incorporates your feedback.

Moving on to the motivations for examining safety-net clinician groups, the Commission has concluded each year as part of its assessment of payment adequacy that beneficiaries have good access to clinician care overall. To arrive at this conclusion, the Commission conducts a nationwide beneficiary survey, analyzes beneficiary surveys sponsored by other organizations, analyzes claims to measure the volume of care received and the supply of clinicians, and conducts focus groups with beneficiaries and providers for important qualitative context.

Despite these consistently positive findings, some stakeholders have voiced concerns. First, as we detail in your paper, future updates to the physician fee schedule payment rates are scheduled to be quite low while private payer rates continue to increase. This could result in a growing gap between private payer rates and
Medicare rates, which could make treating Medicare beneficiaries relatively less attractive.

Second, despite having good access to clinician care overall, access and care might be more challenging for certain subgroups of beneficiaries. One group of particular concern is dual-eligible beneficiaries as they tend to have lower incomes and have higher health care needs than other beneficiaries.

Going back to our presentation last month, you'll remember we found that dual-eligible beneficiaries use substantially more care than other beneficiaries. We noted that high utilization in this context was positive in that it suggested providers accepted and treated dual-eligible beneficiaries as patients. However, while most dual-eligible beneficiaries are able to access care, our analysis of the Medicare current beneficiary survey suggests that some dual-eligible beneficiaries face greater challenges accessing care.

For example, in 2018, we found that 11 percent of dually eligible beneficiaries compared with only 6 percent of non-dual-eligible beneficiaries had a health problem for which they thought they should see a doctor but didn't.
While we can't definitively conclude what drives this difference, state Medicaid programs increasingly do not pay full cost sharing for clinician services for dual-eligible beneficiaries. This results in clinicians often being paid 20 percent less for treating dual-eligible beneficiaries compared with other beneficiaries, which may in turn result in clinicians being less willing to treat dual-eligible beneficiaries. Some research suggests that states failing to pay cost sharing for dual-eligible beneficiaries is associated with modest decreases in access to clinician care.

While we focus on dual-eligible beneficiaries, we're aware that other populations, such as low-income beneficiaries who do not qualify for full Medicaid benefits, could also face access challenges. We plan on presenting more information on such beneficiaries in the spring.

Medicare has multiple programs designed to support safety-net clinicians. Medicare provides a 10 percent incentive payment for fee schedule services that are performed in certain health professional shortage areas. The incentive payment is available to physicians,
including primary care physicians and specialists, but is not available to other types of clinicians, such as nurse practitioners and physician assistants.

Medicare also has separate payment systems for FQHCs and RHCs which may act as safety-net providers.

Relative to fee schedule rates, clinicians who bill under FQHCs and RHCs receive enhanced Medicare payment rates, and FQHCs and RHCs largely furnish primary care.

Now moving on to how the Commission might identify safety-net providers. Based in part of feedback from the Commission during our October meeting, we define safety-net providers based on the characteristics of the beneficiaries they treat instead of where they are located or the type of facility they are.

Specifically, our working definition of "safety net providers" are those who treat a disproportionate share of low-income patients or who are substantially dependent on public payers. We chose this definition for a few reasons. First, treating low-income beneficiaries might entail extra costs that are not adequately reflected in Medicare's standard payment systems and result in lower revenues. Second, public payers generally have lower
payment rates than commercial insurers, making it more difficult for providers who are substantially dependent on public payers to compete with other providers who are not.

We operationalize this definition differently across sectors. We identify safety-net clinician groups based on the share of their Medicare patients who are dual-eligible beneficiaries. For hospitals, we also use this measure and explore a handful of other alternatives.

As our first step in our analysis, we analyzed the extent to which dual-eligible beneficiaries receive care from a wide range of clinician groups or whether they were disproportionately cared for by certain groups.

As the figure on the slide shows, we found that many clinician groups billing under the physician fee schedule had a low share of their Medicare claims associated with dual-eligible beneficiaries in 2019. For example, the tall green bar indicates that 40 percent of the groups who billed under the physician fee schedule had fewer than 5 percent of their Medicare claims associated with dual-eligible beneficiaries. On the other end of the distribution, the red bars, about 13 percent of groups who billed under the fee schedule had 50 percent or more of
their Medicare claims associated with dual-eligible beneficiaries.

These results have a few implications. First, implementing an across-the-board payment increase for all providers in order to support safety-net providers would be poorly targeted. In contrast, adjusting any additional financial support based on the share of a group's Medicare patients who are dual-eligible beneficiaries would result in substantially better targeting.

Second, establishing a minimum threshold to be considered a safety-net provider could be difficult because there did not appear to be obvious natural breaks in the distribution and each threshold would result in some clinician groups just missing the criteria. In your mailing materials, we discuss how such cliffs can lead to narrowly targeted programs expanding over time.

Now Jeff will discuss safety-net hospitals.

DR. STENSLAND: While access to hospital care has been good in most areas, there have been concerns that some providers may struggle. Over time, we have seen differences between commercial rates and Medicare rates diverge, with strong commercial rate growth contributing to
strong profit margins in recent years. However, some
safety-net hospitals face financial challenges if they have
large shares of public payer patients and few commercially
insured patients. It is hard for them to compete for labor
and technology with neighboring hospitals that have a more
favorable payer mix. This differential in resources
between the haves and the have-nots would not be addressed
by paying everyone more, and that brings us to the topic of
special payments to safety-net hospitals.

MedPAC and its predecessors have a long history
of working to assist safety-net providers with their
financial challenges. In 1985, ProPAC, a predecessor to
MedPAC, discussed how hospitals serving a disproportionate
share of poor patients may face financial challenges
because low-income patients could cost more to treat and
often generated lower payments.

In 1986, following a ProPAC recommendation,
Congress enacted the Medicare disproportionate share
program, which increased Medicare rates paid to hospitals
serving a disproportionate share of low-income patients.

In 2010, Congress recognized that some DSH
hospitals have more charity care and bad debts than other
hospitals and shifted most of the DSH funds to funding
uncompensated care at these DSH hospitals.

In 1989, Congress also enacted the Medicare
dependent hospital program to assist small rural hospitals
that primarily served Medicare patients.

As background, I want to familiarize you with the
current DSH payments. For a hospital to be eligible for
the DSH program, the sum of the hospital's Medicaid share
of patients plus the hospital's share of Medicare patients
who are on SSI must exceed 15 percent. This means the
hospitals must either serve at least a moderate share of
Medicaid patients or at least serve a moderate share of
low-income Medicare patients, and about 80 percent of
hospitals meet this threshold.

In 2022, these hospitals will receive about $3.5
billion of DSH add-on payments to their inpatient services.
They will also receive about $7.2 billion of payments to
help cover their uncompensated care costs. The $7.2
billion is equivalent to about 20 percent of these
hospitals' total uncompensated care costs.

There are some potential concerns with the
current DSH metric. First, it indirectly subsidizes
Medicaid. Higher shares of Medicaid patients result in
higher Medicare payments through the DSH program. Second,
DSH shares are negatively correlated with Medicare shares.
This means that hospitals with high shares of Medicare
patients tend to receive a lower percentage add-on to their
payments through the DSH program.

So how well are the DSH payments working? Are
the DSH funds going to hospitals that are struggling
financially? To examine this question, we divided
hospitals into quartiles based on their disproportionate
share patient percentage. The first column in this figure
represents hospitals with a low DSH percentage, meaning
they receive no DSH adjustment or a relatively small DSH
adjustment. We see that they have relatively strong all-
payer margins of 6.1 percent in 2016.

In contrast, the column on the right shows the
profitability of hospitals with the highest DSH adjustment.
The column on the right shows that, despite receiving
larger DSH payments, these high-DSH hospitals tend to have
a bit lower all-payer margins, with a median margin of 3.2
percent. This suggests DSH payments are fairly well
targeted and have reduced the disparity of profitability
between low-DSH and high-DSH hospitals.

The second row looks at closures. Despite receiving higher DSH payments, hospitals in the highest DSH quartile were slightly more likely to close.

Next we discussed alternative metrics for identifying safety-net hospitals. The more complex metrics are in your paper, and there's always the opportunity to investigate new metrics as we move forward. In this paper, I will just talk about the simple metric, using dual-eligible Medicare beneficiaries.

In this slide, we divide hospitals into quartiles based on the share of Medicare patient days that were fully dual eligible. Start with the first row. The first column shows that hospitals with low dual-eligible shares tended to have high all-payer margins, with the median margin of 8.5 percent. The column shows that hospitals whose Medicare patients tend to be poor materially have lower all-payer margins. That's the right-hand column, with the highest quartile having a median margin of 1.7 percent. This differential that we see here is even larger than the one we saw in the prior slide when we examined DSH shares.

In addition, the trends are fairly linear,
suggesting that a policy of continuously increasing payment rates to hospitals as their dual share increases would tend to level out all-payer margins. The second row shows that hospitals with large shares of dual-eligible patients tend to have a higher risk of closure than hospitals with fewer dual-eligible patients.

The point here is that even after accounting for DSH payments, hospitals that have high shares of dual-eligible beneficiaries still face more financial challenges than hospitals whose Medicare patients tend to have higher income.

One concern with the current DSH program is that hospitals with high Medicare shares tend to have lower DSH percentages. Thus, high-Medicare-share hospitals tend to get lower DSH payments.

However, there is a separate program for hospitals with high Medicare shares called the Medicare dependent hospital program. The original idea was that small rural hospitals lacked the economies of scale to be successful in the Medicare prospective payment system. The MDH payment system increased payments to these small rural hospitals based on their historical costs. The details are
One concern is that the MDH program is limited to small rural hospitals. We may want a safety-net definition that applies to both rural and urban hospitals. Second, it only provides an add-on payment to inpatient services, and it makes cost-based payments. Cost-based payments mean that if a hospital has historically been able to afford high costs, then they will get a larger add-on payment, and hospitals that have been forced to keep their costs low may not receive any add-on payment under the MDH program.

As we stated earlier, Medicare beneficiaries and commercially insured beneficiaries have comparable access to physician and hospital care. However, there are certain physician practices and hospitals that disproportionately serve poor patients. As the gap between rates physicians receive for treating low-income Medicare patients diverges from commercial rates, physicians may be more reluctant to accept additional low-income Medicare patients into their practice.

With respect to hospital payments, the gap between Medicare prices and commercial prices continues to grow, with hospitals that have few commercial patients...
possibly having trouble competing with other wealthier hospitals for labor and technology.

This led us to looking to our targeted payments for providers that serve a disproportionate share of low-income beneficiaries. As Brian mentioned, the physician fee schedule has limited adjustments for providers serving a disproportionate share of low-income patients currently.

In contrast, in the hospital sector, Medicare shifts about 6 percent of all hospital payments toward DSH hospitals as special payments. The data suggest these payments are fairly well targeted in that hospitals getting the largest special payments are still hospitals with relatively low margins and a slightly higher risk of closure.

However, there is a concern that the current DSH payments are negatively correlated with Medicare shares. Thus, hospitals that focus most on serving Medicare beneficiaries may receive lower adjustments.

Given the limitations of the current programs, what types of changes may be needed to Medicare's safety-net payments? And these are various questions for your discussion. Should we replace the current policies? Or
should we add to existing policies? Do we need new metrics to identify safety-net providers?

What are the preferred metrics for physician practices? And what are the preferred metrics for hospitals?

In the case of hospitals, we see that the current DSH payments are negatively correlated with Medicare shares of discharges. Given that, do we need a separate policy for Medicare dependence? Or should the hospitals' Medicare shares be woven into a single composite safety-net metric?

Now I'll turn it back to Mike.

DR. CHERNEW: Brian and Jeff, thanks so much.

I believe this chapter, when it comes out, will be a real resource for everybody interested in this topic. You really got a lot there. It's a very complicated topic because there's so many programs. It's so important.

Dana, let's go through the Round 1 queue.

MS. KELLEY: All right. I have Lynn first.

MS. BARR: Thank you. I was quick on the queue button here.

So I have three questions. Thanks for doing this work, and I know this is a beast to tackle.
One of the questions I have is, does the all-payer margin include 340B, and does it include community taxes? Is it really just all-payer, or does it include other payments?

And the other two questions I have is 80 percent of hospitals get DSH, but only 50 percent get 340B. Is there anything interesting in the difference between the two? And, you know, they use a higher criteria. How would that affect your analysis if you used a higher criterion on DSH?

Then the third question I have is, as we think about health equity, you can't look at this without thinking about what CMS is saying about we care about rural, we care about LGBTQ, we care about underserved minorities. And as we, you know, in the ACO space really see their impact on cost and equality is disproportionate to the other parts of the population, have you thought about looking at this in terms of the kind of lens that CMS is looking at in terms of health equity?

DR. STENSLAND: First question, all-payer margins are total margins, so everything is in there, 340B, taxes, investment income. It's all in there.
We looked at operating income, which doesn't have some of that stuff in there, and that you get a similar story.

The next question on 340B, those things are -- it's really quite different, and there's very different, for a better phrase, "value judgments" in the 340B program from the DSH program, and that all critical access hospitals can be in the 340B program, no matter what their payer mix.

MS. BARR: Right.

DR. STENSLAND: There's also a lower threshold for rural than there is for urban, and then that creates some issues where some urban places like Lenox Hill in Manhattan or the Brigham in Boston decide to become rural, reclassified as rural, then they get in a lower threshold, and they get in 340B programs. So there's different thresholds.

But you're right. The primary reason why there's fewer in the 340B program is the cutoff level is a little bit higher.

And then health equity, we can get into that. That's probably at least Stage 2 of this project. I think
it's an important topic and something we'll have to weave into here, but that's going to be another question of whether we can address that well enough by focusing on income, or does there need to be some other considerations?

MS. BARR: Thank you.

MS. KELLEY: David, do you have a Round 1 question?

DR. GRABOWSKI: Yes. Thanks.

So great work. Thank you for this, Brian and Jeff.

Every time we have a session where we discuss the use of duals to capture social risk, someone -- and that someone is often me -- raises the point that the characteristics of duals differ across states, and obviously, this reflects differences in states' low-income Medicare populations and Medicaid policies.

So my question -- and maybe the answer is just sample size, but have we ever tried incorporating state into our share of duals measure? Is there enough? Is there sufficient sample by state? I can imagine in New York or in New Jersey, you could do this, maybe in Montana less so, but have we experienced at all, Jeff and Brian, in
trying to overcome this issue with the duals measure that we just -- there's different characteristics by state -- by actually incorporating state and comparing providers within states against one another?

Thanks.

DR. STENSLAND: We haven't done it. We could do it -- I'm not sure exactly where this -- where you're going with this.

There's certainly states like Louisiana that have more full duals and other states that have fewer full duals like New Hampshire, but would we have a within-the-state comparison, or would we still be giving higher DSH payments to people in Louisiana than New Hampshire on average?

Where would this go?

DR. GRABOWSKI: I think it's a more general question about how do you actually adjust here if we're worried about the characteristics of duals, as you suggest, being different in Louisiana than New York. Can we actually compare Louisiana with Louisiana and New York with New York? Maybe you don't want to do that; there are reasons. But this is purely for capturing that, that sort of risk or social risk factor here.
DR. STENSLAND: Mm-hmm. I think we can consider that. We haven't considered it to date. There are other options too besides just the simple dual measure. You could have the LIS measure. You could use that, which is more national. There's different ways we could approach it, and I think that will be part of this long multisession discussion.

DR. GRABOWSKI: Thanks, Jeff.

MS. KELLEY: Jonathan Jaffery.

DR. JAFFERY: Thanks, Dana.

Yeah. I want to echo this is a fabulous chapter and a great start to a really important discussion. I really appreciate how we're approaching this and recognizing its multi-session discussions, and there's other things to layer on top of it. And I agree with Mike. It's going to be a great resource for others.

Just, I guess, a quick question. The chapter talks a lot about the lesser of policies that states have, and the presentation mentioned how Medicaid is increasingly not paying full cost sharing and this may be impacting access. If we look back, 2013, 2014, I guess ACA, there was parity policies of payment for at least primary care
services. Do we have good analysis? Have we ever looked at that and seen how that may have changed or impacted any kind of access or outcomes when that policy came into place and maybe as it started to erode?

MR. O'DONNELL: Right. So we haven't done our own research, but others in the academic world have. And I want to say Roberts, in particular, has done work on this. I think the conclusion was that the bump that resulted from the ACA parity policy didn't do much to improve access, and so that's what the literature says.

Then the question is, why do you think that might have happened, or why did these large payment bumps not improve access? And I think when we talk to people, the things they say are, "Well, it's only a two-year program, so the bump only lasted two years." So providers might have said, "You know, it's not worth me changing my practice behavior because it's only temporary." And, apparently, the implementation of it was relatively fraught. So it was a two-year program, and I think some practices didn't start seeing any due dollars until six months into it.

So I think the temporary nature of it makes it
hard to draw kind of causal conclusions off of that.

DR. JAFFERY: Thank you.

MS. KELLEY: Bruce, did you have a Round 1 question?

MR. PYENSON: I did.

One question I have is that it appears as though Medicare Advantage is certainly popular among the dual eligibles, and that contrasts to some of the access issues that you've identified. I'm wondering if you have insight into that.

And a related question is that you mentioned the cost-sharing issues with physicians, dual eligibles for physician services. My impression is that's not as significant an issue when it comes to hospital cost sharing, and I'm wondering if you have insights into that.

So two questions on differentials, Medicare Advantage versus fee-for-service, and the other is within fee-for-service hospital versus physicians.

MR. O'DONNELL: Yes. So I'll start, and, Jeff, you can jump in.

On the MA versus fee-for-service issue, we didn't include it in this paper, but we are looking at for both
full duals and partial duals -- we're looking at survey measures to see whether, for instance, partial duals and MA have better access because it essentially acts as a supplemental payer.

And I think we'll cover this more in the spring, but I think the headline news for us is that it doesn't appear that MA completely solves the problem, and so you still see partial duals, for example, in MA having access to care issues related to costs. So we can explore more in the spring what that means, but I think that's one nugget that we have behind the scenes that we hadn't shared.

And I think your second question, Bruce, on cost sharing for hospitals versus physicians, I do think your instinct is right to think that the cost sharing is a larger issue for the physician world relative to the hospital world, and so just as a very basic level, hospitals get bad debt or 65 percent of bad debt, and clinician practices who bill under the fee schedule don't get that. So I think that's at least one thing to kind of start off with, that it probably is a larger issue for the clinician space.

MR. PYENSON: A somewhat related issue -- sorry,
a third question -- is on the people who have Medicare Part A only and how those -- how you might think about those in this analysis. I didn't see mention of those folks, but do you have thoughts on that?

MR. O'DONNELL: Yeah. We can certainly try to drill down into that population in the future. I think the difficulty becomes -- and I don't know the exact numbers, but that's, what, 8 to 10 percent of the population? So it becomes harder for us to identify that subset in some survey data. So there's often times limited numbers, but we can definitely take a look at in claims data to see where we can dig up information on those folks.

DR. STENSLAND: We're going to look into it. I think it's harder than it may seem on the surface because you may have some very different subgroups within that group. Like, you may have some people that have enough supplemental insurance from some other employer where they decide not to buy into Part B, and then you might have some people who are really poor, and they think that that's just too much money to pay for Part B and "I'm just not going to do it." And so those are going to be two very different types of people, and whenever we look into it, we'll have
to kind of differentiate those folks.

MS. KELLEY: Pat, do you have a question?

MS. WANG: Thank you.

I wanted to ask about UCP because what used to be DSH is now like more than 70 percent is paid through this uncompensated care thing. It's a confusing thing because it's not specific to Medicare volume or Medicare DSH, but it is paid by Medicare. And I just was curious whether you had looked at the hospitals that get the highest share of those UCP payments, those $7 billion-plus now that's flowing through that pool, I guess, and whether there's a correlation to your high-Medicare share, high-Medicare DSH. So that's the first question.

And then the second question was whether there are any good measures of low-income-ness, low-income patient populations served in hospital outpatient departments. You know, we can look at physicians, we can look at FQHCs, but it's possible that the outpatient departments of hospitals have different low-income shares than what winds up in the inpatient. It could go either way.

But I just wondered whether there was any way to
capture that. It would be in the UCP data, but again, 
that's kind of all-payer. So I just -- or it's no-payer, I 
guess.

So those are my two questions.

DR. STENSLAND: In terms of the uncompensated 
care, we have some of those correlations in Table B-1, but 
it's way in the back of the paper, and there is a fairly -- 
you know, it's a moderate correlation between your share of 
your revenue represented by uncompensated care and the 
share of Medicare patients who are dual or your DSH share. 
So there is some correlation there, and places that have 
more uncompensated care do tend to have lower total profit 
margins, though we don't see much of a relationship with 
whether they close or not.

In terms of outpatient, I think that is a great 
thought, and I think as we move forward, we should be 
looking at outpatient shares also and not just inpatient 
shares. That's maybe one of the decision points that kind 
of the Commission will make as we go along. I think 
there's kind of some process of narrowing the scope of what 
econometrics we're going to look at, and then maybe we 
could also widen it in terms of the types of inpatient,
outpatient, other sectors that we look at, but definitely a

good point that we can address as we kind of move and

refine this.

MS. WANG: And I'm sorry. Can I just ask one

other question? This is a -- and maybe -- just help me

think through the relevance of teaching status. I assume

there's a very large overlap between high-DSH hospitals and

teaching hospitals. So when you do your correlations, how

do you know what's keeping the hospital open? Because

teaching status delivers a whole boat full of money, too.

How do you know whether it's DSH payments that are helping

the hospital, that's the driving characteristics, or

whether it's the teaching payments? How do you think about

that?

I realize they're separate payment programs, but

they're interrelated when it comes to the characteristics

of the safety-net hospitals.

DR. STENSLAND: I haven't looked at that yet.

You know, we did some regressions, but we didn't put the

teaching status in there or the resident-to-bed ratio in

there, and that's something we could look at to see if that

-- and I don't even know if it's going to be -- I'm
guessing it's going to be also related to the size of the hospital. So, if we put that in there, we should probably also look at size of the hospital. We could try to tease out what effect teaching independent of size has on your profitability or your risk of closure. It could easy go in two different ways. It could make your all-payer profitability lower and your risk of closure lower also, because we don't hear of a lot of teaching hospitals actually closing. But we could look into it further.

MS. WANG: Thank you.

MS. KELLEY: Wayne, did you have a question?

DR. RILEY: Yes. It was largely along with what Commissioner Wang just queried about the teaching status. Needless to say, a teaching safety-net hospital is very near and dear to my heart, having trained in one and now overseeing one at a health sciences university.

But, Jeff, the other thing, in terms of the commercial penetration, commercial margin penetration of safety-net hospitals, could you give some color commentary on that?

DR. STENSLAND: One of the problem is we don't have good data on the commercial share of patients because
that doesn't show up on the cost report.

We know the Medicaid share of days. We know the Medicare share of days. We know the Medicare share of revenue, but the commercial, we can't really get at. Sometimes we can get at something that would be non-Medicare, non-Medicaid, but then we're throwing commercial in with uncompensated care, uninsured. We don't have great data on that.

We thought about trying to go look at some of the data that people are supposed to be reporting in terms of their commercial prices, but that is pretty incomplete and not always easily accessible at this point. I know I'm not answering that question very well, but we don't have great data on that at this point.

DR. RILEY: Yeah. Thanks for sharing that. That is one of my concerns. I can just say anecdotally, here at our safety-net teaching hospital, probably only about between 10 and 15 percent commercial, so obviously, a large book of business taking care of Medicare and predominantly Medicaid beneficiaries. So you're right. It is kind of a Rubik's cube trying to figure out the commercial aspect of safety-net teaching hospitals and safety-net hospitals in
But I agree with some of the questions. Pat read my mind in some of the other aspects. Thanks.

DR. STENSLAND: One thing we can do that we did do in here is when you measure things -- like, you can measure your uncompensated care burdens as a share of your total revenue. So, in essence, then if you have a lot of commercial revenue, you've got a bigger total revenue, and that uncompensated care revenue will seem smaller. So there is some ways to indirectly get at it.

DR. RILEY: Yeah. I guess we're in search of a proxy, I guess, in some respects to try to get that understanding, if you will.

Thank you.

MS. KELLEY: Dana, did you have a Round 1 question?

DR. SAFRAN: Yes. Sorry. Two questions about statements that were made in that chapter. The first one was, on page 13 of the written materials you make the point that the original justification for DSH payments was that low-income Medicare beneficiaries were thought to be more expensive in ways not accounted for by DRGs, and cite a
2007 MedPAC report as well as another paper, indicating that that was true less than 25 percent of the time, or that 25 percent, at most, of DSH payments were justified by higher Medicare costs associated with treating low-income patients.

Can you just say a little bit more about that?

DR. STENSLAND: So I think when they looked at this originally back in 1985, there wasn't much in terms of risk adjustment in what you're getting paid when they first started out with the DRG system. And there was a feeling that poorer people tend to be sicker, and therefore they are going to cost more to treat and they also may have fewer resources outside the hospital. You may even have to keep them in the hospital longer if they don't have the resources to go home and get care. And people had done some analysis of that early on.

Later on we did some empirical estimates where we would run these regressions, similar to what we did for the IME discussion we had, where the dependent variable is the cost per discharge and the independent variable is all of our risk adjusters, how much extra is left over when we look at their disproportionate share index and how much
does that explain of their costs. And it looked like, at most, 25 percent of the current DSH payments that were being paid out could be justified by that empirical level of how much extra these folks cost.

But at that point people were saying, well, yeah, it isn't just cost that justifies these DSH payments. It is also that these hospitals just have more poor patients in general, and they are going to have more uncompensated care. They are going to have more charity care. So then the rationale, I think, in the ACA, was well, if we now have this blended rationale, it's just not higher cost of poor folks, it's higher cost of poor folks and more uncompensated care, let's split the dollars out so we'll have some of it going for this empirically justified higher cost of treating poor folks and then other part will actually go to uncompensated care, and it will be distributed so that hospitals that have more uncompensated care get a bigger share of that pot.

DR. SAFRAN: Got it. Thank you, Jeff.

My other question was, on page 21 you made the argument that duals appear to have good access because they have higher case mix, that they appear to be using more
services. I understand that that's the descriptive
observation, but how do we get from that to an assessment
that they have adequate access, meaning, you know, they
have higher case mix, how do we know what they actually
need relative to what they're getting?

MR. O'DONNELL: So I think what we are going for
when we describe duals' access to care is that I think we
tried to start off with the forest picture and to say, you
know, this is what we talked about last month, they get a
lot of care, and then we look at kind of survey data.
There are differences between duals and non-duals, and I
think this is a kind of value judgment of how big you think
those differences might be. So some of the differences
we're seeing are, you know, 3, 4, 5 percentage points. So
they appear to be persistent but they are kind of modest,
to a certain extent.

And so we are really just trying to paint a
picture of here is why you might want to go look at access
to care for this particular group. And we didn't want to
say that we thought there was kind of a house-on-fire
problem, because we don't think there is. But we do think,
on the margins, there are some who have greater difficulty
accessing care.

So I think that's the picture we were trying to paint, and maybe there are particular words that were inarticulate. But I think that was the goal.

DR. SAFRAN: Got it. Thank you, Brian.

DR. CHERNEW: So I think that was the end of Round 1. Is that right, Dana?

MS. KELLEY: That is correct.

DR. CHERNEW: Great. So that was really great.

I want to ask one other Round 1 question. I seldom do this. A lot of what we're doing here is measured off the cost reports. We are going to spend a lot of time on the cost reports over the next two months as well, in December and January. Can you say something about the stability, manipulability, the liability of the cost reports if we base a lot of what we're doing on data that's only available via the cost reports? Is that a problem when we think through some of these definitional things, if we move to policy options?

DR. STENSLAND: At least for the hospitals I don't think it is that problematic. The number of your days that are Medicare and the number of your days that are
Medicaid, as those become part of payment then they start
to be audited, and I think you're going to get reasonably
good data there.

   The margin data that we have, like our total
margins, what's this all-payer margin, this is supposed to
be the revenue from the hospital's financial statements
that they get from their accountants, and then they're
supposed to put those numbers in the cost reports and send
those financial statements to CMS so they can check that
these are balancing out. So I think that number is fairly
good.

   I think what is more risky is the uncompensated
care data is probably less than optimal, I think, because
there is some potential for lobbying there on how it's
presented. And we've got some comment letters on that.
And there's also the issue of, as Wayne said, we are kind
of limited in what we have. So I am not as concerned about
the quality of what we have but maybe in the limitation of
what we have, and we don't have good data on either
commercial prices or commercial volumes at these places.

DR. CHERNEW: Thanks, Jeff. All right, Dana, I
know we have a robust Round 2 queue, which is encouraging,
so why don't we get to it.

MS. KELLEY: All right. I have Jon Perlin first.

DR. PERLIN: Thanks, Dana, and many thanks, Brian and Jeff, for a terrific chapter. I think that was excellent. Well, I'll bite on your two discussion questions. I do think we have to add to the considerations, current policies, and have some considerations for metrics.

I want to make five brief points, and a couple are essentially statements that were implied by some of the questions that were asked in Round 1. First, as a statement, I do think we should make equity explicit in all of its forms. That is something that we're trying to drive through work, such as making sure that safety-net institutions are adequately supported.

Second, an observation. It strikes me as somewhat discontinuous that we're talking with such an institutional focus, not an individual patient focus. It appears, per your Slide 11 that you presented, that there are reasonably good correlations between DSH and Medicare-dependent hospitals, that those are important. But it just strikes me that we have this lingering, unresolved issue of
needing risk adjustment around patients in terms of understanding their needs and servicing them, whether they are in ACO, whether they're in nursing homes, whether they're in Medicare Advantage, et cetera.

And, you know, some metric of the aggregate of the patient burden would seem to be a future aspiration, and minimally we need study on that to see if the institutional aggregate of patient burden is, in fact, institutional burden, understanding that there are certain issues, be they rural or urban, that have to do with less-than-desirable geography, if you will, with respect to what might be alternatively available in terms of payer mix.

Third, and this is really the explicit of David Grabowski's question, is my concerns, actually our concerns about dual eligible as a proxy being imperfect at best, given the differences between the states, and, you know, it likely underestimates a burden, including uncompensated care. Let me come back to that.

Fourth, I think there is a difference between using Medicaid as an index and saying, by virtue of using this index it is tantamount to subsidizing Medicaid beneficiaries. You know, the burden on an institution of
taking care of an uncompensated plus Medicaid, and certain
very high-needs Medicare beneficiaries, including whole or
partial dual eligibles is something that is more resource
intensive, and using one component of that in Medicare as a
metric would seem to be supported by the data that you
present, including the Appendix Table B1.

And then finally, I understand and appreciate
Jeff's comments about strains and the limitations of the
cost reporting, but my goodness, uncompensated care, it
seems like a direct measure. I could either look outside
and try to determine what area might have ice or I can just
look at the thermometer and know this is the temperature,
and uncompensated care is fundamentally a direct
measurement of patients who don't have resources as
indicated. That is an audited report and substantially
robust, so I would suggest that's one of the best ways to
add to the composite of the burden.

Thanks very much.

MS. KELLEY:  Lynn.

MS. BARR:  Thank you, and I am plus-one on all of
Jonathan's comments. You know, I think about where are we
going with this analysis and what are we really trying to
do, and what we're really trying to do is to adjust payment appropriately for providers that take on the underserved. And so you have to kind of think that through about how will this data then affect payment policy, how does it affect ACO benchmarks, how does it affect MACRA? You know, all we look at dual eligibles, and that does not promote health equity.

And so I think we have to broaden our definition of the safety net and to look at the patients they serve and to make sure that we are thinking about how we adjust our payments for providers to ensure that they do have access to care, and that they do have the best quality care. Because I agree, these patients that are underserved take a lot more time than patients that don't, and their quality scores tend to be lower, and it's one of our biggest issues in health care reform and advanced payment models is recognizing those differences and not penalizing providers, whether it's MACRA or anything else, for taking care of the underserved. Thank you.

DR. CASALINO: Lynn, if I can just ask you a question. When you said "patients they serve," it seems like dual eligible is too narrow for you. What other kind
of patients do you have in mind, and are you suggesting
that these other kinds of patients would be somehow part of
the definition of what is a safety-net hospital?

MS. BARR: That's exactly right, Larry. So we
know that certain populations had large disparities in
their health compared to average. And so when there are
disparities I think they need to be addressed in our
policies. So, for example, African Americans, rural
patients, patients that are underserved by the current
system should be what we count, not just dual eligibles.

DR. CASALINO: That's concisely said. So I will
just, if I may just say one sentence, one thing we haven't
been discussing is, are we talking about safety net meaning
take care of hospitals that take care of a lot of poor
patients, or are we talking about trying to eliminate
health disparities in care, period? Those are actually
potentially the same question or different questions, and
it actually hasn't come up in the materials or in our
discussions. I hadn't really thought about it too
explicitly either. But it's a good point.

MS. BARR: Thank you. I hope that is the
question we're asking.
MS. KELLEY: Stacie.

DR. DUSZETZINA: So like the others, an excellent chapter. It was great to read, and I think you pointed out so many important issues with some of the current measures and how outdated they are, how they were based on rules and data that, you know, we had at the time but maybe need a second look now.

I also really like the percent of duals measure and how well it seemed to perform relative to our current measures, maybe with the DSH payment percentage. I don't want to discount Lynn's comment about including other important measures, but I think for the sake of convenience and what you have equally measured the percent of duals seems to be outperforming their current measures.

You know, I think the graph that you showed on Slide 7 where it shows the percent of duals, billing for duals by different providers, was really striking, and I thought you made a very helpful point in the piece about avoiding cliff effects by doing some sort of weighting to account for the percent share.

I want to go back a little bit maybe to a comment that David Grabowski mentioned about how to incorporate
states, and the way I was thinking about that was thinking about the variation in states' Medicaid policies, and how this percentage of duals might be biased to some states versus another. So maybe one way of thinking about it is incorporating it within state weighting to account for dual share to try to get at within a state maybe that has lower duals overall, that you're not penalizing hospitals there. The last thing I wanted to ask and maybe just comment on, you know, it's really sad to see the kind of low performance of the ADI measures. I know we've talked quite a bit about the importance of other measures that we might use to try to better understand the vulnerability of a community. And, you know, one of the documents that was shared in advance of the meeting mentioned the Robert Wood Johnson PLACES measure as another alternative that seems to have a lot of area-level variables. And it may be one to consider pursuing to try to add in a little bit more depth of what's going on at the community level. But, in general, I think this is an outstanding first step, and I really appreciate the work you are all doing.

MS. KELLEY: Jaewon.
DR. RYU: Yeah, I would also echo a big thanks to Brian and Jeff. Another complicated area. But getting to these questions, I am also in favor of revisiting how we define and try to better align the policies around supporting those who actually serve the populations that are more vulnerable. I think there is a lot in the chapter and in this presentation that suggests that we have a lot more work to do there. So I am all in favor of that.

I like the combo measures. I think the safety net index, or whatever it was referenced in the readings, I think that seemed to have the strongest correlation or relationship to those that are treating truly vulnerable populations. I had not thought of LIS in place of the percent duals. I think Jeff had mentioned that. I'm kind of intrigued by that. I think that's an idea also worth pursuing, as is Stacie's point just now around maybe you actually do the apples-to-apples within a given state and that way it is a little more comparable based on the Medicaid eligibility that systems are dealing with, or providers are dealing with.

A couple of points on access that I did want to make, and I know that Pat referenced this a little bit, as
did Dana. But I think we need a little more information around, I would say, specialty outpatient access in particular. If you look at Table 5, you have physician office and the percentage of claims that are from duals is 12 percent, and I think earlier in the material the percentage of overall beneficiaries that are duals is something like 14 or 15 percent. So you have underrepresentation in terms of that physician office environment, and yet I think the readings also referenced that primary care in that physician office is overrepresented, which would suggest that really specialty in the office, in the physician office or clinic environment is particularly underrepresented. I think this goes to Dana's comment earlier.

You know, there is a higher disease burden in the duals population. That would suggest that they are tremendously underserved when it comes to specialty care. And I think that also corroborates or jives with what we anecdotally hear from many FQHCs that are constantly struggling to find specialty capacity for their patients. I think teasing that out a little more might be helpful in terms of getting an accurate, or more accurate picture of
where access stands.

And then similarly, on the hospital side, I think some of the description in the chapter kind of tees it up as, you know, there's access to hospital services or you have all-out closure, and it almost feels a little bit too binary to me. I think if there's a way to get at really what I think is a continuum between those two extremes, of the poles, so to speak, where you have deterioration of clinical programs as the haves and the have-nots between hospitals, that have-nots are not able to invest and continue to have the resources to support some of those clinical programs, and I think those are the environments where the access may not be as good as what we think it is, even though the hospital itself has not closed. So if there's a way to tease that out as well with some further analysis I think that would be helpful.

MS. KELLEY:  Paul.

DR. PAUL GINSBURG: Yes. First I'd like to give a plus-one to the last point that Jaewon made about it's not just keeping the hospitals open but avoiding the situations where they are open but the clinical programs are very much impaired by their problematic financial
situation.

I have a couple of points to make. One is I think we should pay more attention to the issue that was raised by this presentation about the degree to which cost-sharing for duals is not being paid by states, and I think this is causing that to be a barrier to access, particularly for physician services.

You know, I think there's a lot that we can do as far as better targeting additional support for safety-net providers, meaning providers that serve a large share of people that are vulnerable to inadequate care. But I'm concerned about so many of the measures that have been used have been not targeted so much. Like 80 percent of hospitals are getting DSH payments of some sort, and to me, that percentage should be much, much lower. And to me, this is a real policy decision about, you know, if we can't focus on the providers that are truly safety-net providers, you know, we're not going to be very successful in meeting that goal if too much of the money is siphoned off to other providers that really have less need for it.

I was struck by the chart you had about how 13 percent of the physician practices had 50 percent or more
duals in their panels, their patient populations. And it
seems as though it's important to target more of the
support to those practices. I think our health
professional shortage areas measure is way too old and it's
really failing to do the job of targeting our extra support
to providers that are taking care of the vulnerable
populations.

And finally, the point has been mentioned, and I
agree, that in the hospital sector there has been overly
strong concentration on inpatients, and the hospitals that
provide extensive uncompensated care and care to Medicaid
beneficiaries, whether they are duals or not, in their
outpatient departments is very important and should really
be a priority for supports.

MS. KELLEY: Amol?

DR. NAVATHE: Thanks, Brian and Jeff, for the
great work here. I'm very, very supportive of our
continuing to flesh this out, and I appreciate Jeff's
framing that this is a multi-session body of work that
we're taking on here.

I wanted to primarily echo support for a number
of things that my fellow Commissioners have beaten me to saying already, so that's great.

The first thing, I just wanted to echo support for what David and Stacie were saying regarding looking at the within variation at the state level and looking at the dual eligibility variation. My thinking is very similar to Stacie's, which is basically if we can understand how much of the variation described at the state level and what's happening within the state level, I think we could, in fact, replicate some of the charts that Stacie had pointed to as well as some of the tables around the hospitals, when we control for that state level or we can stratify by those state thresholds. I think that will help us understand how much of this is being driven by versus -- driven by the state-level variation policy versus all kind of underlying relationships. That's definitely worth doing.

Jeff, along the way you had mentioned LIS as a potential individual level measure. I thought that was worth doing. I think there's -- I think we should acknowledge straight up that there's going to be no perfect measure here, and so the more measures that we can use, especially those that are already used in some part of the
Medicare program, broadly speaking, will be a good thing. I echo the support for the idea that we want to move away from cliffs and sort of towards continuous measures. I think that's a very good point. And I also wanted to touch on what Jaewon and others have already mentioned. I think that there's a lot of programs that are orientated towards safety-net hospitals. There's a lot less in terms of safety net on the clinician side, and I think this chapter and writeup did a very nice job of articulating why that should be a major concern for us in terms of access, in terms of the physician fee schedule, physician offices, and ambulatory surgery centers being particularly disproportionate area where we see differences between duals and non-duals, for example. So I think we should take that very seriously. Jaewon mentioned the specialty services. We looked at some data previously about that as well. So I think it would be good to continue to dive a little bit more deeply on these issues to see how we might design policy, not only identification but also to control policy adjustments to help support and taking care of the underserved populations here that we're worried about.
The last analytic point that I think is worth doing, it was mentioned in the writeup at one point. I think it was tucked in the clinician space, but I think it belongs overall as an analysis, is this notion of area served versus population served. So we have -- we've done some analysis, I think, here. Most of it is focused on what are the characteristics of the populations actually treated at a hospital or actually treated by a clinician group, and there's a distinction between what is the area served or where the physical location is of said hospital or clinician group. And when there's a misfit there, I think it would actually be helpful to better understand what that variation of fit versus misfit looks like in terms of the area sort of versus the actual patient population treated. If we can dive into that a little bit further, I think that would help us understand a little bit more about the dynamics that are up later.

Thank you.

MS. KELLEY: Bruce.

MR. PYENSON: Thank you. My compliments to the authors.

I want to pick up on a point that Larry started,
which was are we talking about safety-net hospitals or are we talking about disparities in health care or both. And I'd like to raise the question of why in many urban areas do safety-net hospitals exist and why are there concentrations of poor patients in some hospitals and there's also rich hospitals that don't have those patients. I think the answer is often tied up in historical racism, systemic racism, referral patterns, historical patterns, and perhaps local geography. There's probably lots of reasons for that. So I would urge us to not try to solve that by establishing separate but equal health systems, that perhaps a better way to think about it is school busing, that all the hospitals in a region -- talking about urban areas -- in an urban area should be responsible for a reasonable portion of poor patients or patients with special needs. And I think that's a better approach than going down the path of creating separate systems for poor people by funding them a bit more. So I just want to caution us about the direction we're going, but I think the chapter is a terrific starting point, but I'd really urge us to try to solve the bigger issue of the disparities and not the narrower issue of
safety net.

Thank you.

MS. KELLEY: Betty.

DR. RAMBUR: Thank you very much. I really appreciated this chapter, and I know this work will be a heavy lift, and I'm glad that we're taking it on.

My comments really complement the people who have spoken before me, and just to follow up on Bruce, separate and equal is never equal, so I think that would be important for us to think about that.

Very briefly, as someone who spent most of her life living in isolated areas, I just want to underscore that I strongly agree that an isolation metric is not a safety-net metric. And I particularly appreciated the piece in there and the material about Rush Medical Center in Cook County, given that I did my graduate work there, and they are entirely different worlds. And I've lived in relatively affluent isolated areas and very poor ones, and so I really was glad that we laid it out that way.

I agree with Paul that the percentage of DSH is way too high, and so there's some real work we have to do there. And Stacie mentioned the outdated definitions, and
Jaewon, about going to -- resources going to those that serve the underserved populations. I just want to mention the piece in there that talked about the 10 percent incentive payment going to physicians in HPSAs but not nurse practitioners and physician assistants, when the data is very clear now that nurse practitioners and physician assistants are far more likely to work in underserved areas with vulnerable populations, et cetera, et cetera. So there's certainly some work to do there.

I would also just ask us, as we think about moving ahead with terms, I'd like to invite us and the entire nation to permanently retire the term "mid-level." It may seem like an easy thing, and I'm certainly not criticizing this report because it's used all the time, but if nurse practitioners and PAs are in the middle, then what? Is it primary care providers and specialists? And who's on the bottom? And where's the patient in this?

There is a lot of evidence about the effectiveness of nurse practitioners, as the literature I know the best, as effective providers, and they're not in the middle of anything other than trying to deliver good patient care. So it does sort of imply less, and the data
does not support that. So I encourage all of us to retire that term.

Others of you said things that I strongly agree with, but I'll leave that for now, and thank you for this effort, and I look forward to working together with all of you on this. Thanks.

MS. KELLEY: Marge.

MS. MARJORIE GINSBURG: Thank you. Yes, fabulous report, very exciting work that we've got ahead of us.

Betty, I completely support your comment about the use of the term "mid-level." Let's dump it. And I also agree with Paul, who was taken aback by the high percentage of hospitals getting DSH payments. Eighty-two percent, that must tell us something. Let's get rid of this thing or completely change it so it actually has some meaning.

Appendix A, which was very valuable and includes all the various ways in which we try to compensate for and make better care for people, it feels like it all needs to be harmonized -- that's our new word, our go-to word for ACOs. I think maybe it's time we use the word for the support we give to what we're now calling at the moment "safety-net hospitals."
And my last comment, like others, I appreciate David's comment about the states and their relative high versus low versus hardly any at all support for Medicaid. I'm not sure what we do with that. I mean, if Medicare steps in and says don't worry, folks, we'll take care of it if you, the state, doesn't want to pay the fair share, the cost-sharing part, what message does that send? And is that simply going to get other states to start backing away?

On the other hand, what can we do to put more pressure -- what can we do, if anything, to put more pressure on states to start paying their fair share? So I'll just throw that out for the rest of you to come up with the answers. Thank you.

MS. KELLEY: Dana.

DR. SAFRAN: Yes, thank you. Just piling on with congratulations for starting this important work and the plan to continue it, extremely important and valuable. A few comments. One is I really, like others, agree with and would like to see us continue to explore this idea of having the added payment apply at the patient level versus the facility or provider level. I think that
avoids the cliff issue as we've talked about and really is a much more appropriate way to think about properly compensating for the added costs associated with care. I'll come back to that point about the added costs in a moment, but just make the point that that added payment, based on the patients being cared for, seems to me should apply to all clinicians. I believe this was the chapter that indicated that it didn't apply right now to nurse practitioners or others, and, you know, that seems to me just absurd. So I would offer that it should apply across the board regardless of who's taking care of the patient.

To that point about what it costs, you know, I was really struck by that statement that I asked about in Round 1 that the evidence shows that, you know, less than 25 percent of the DSH payments were justified by higher costs of care. And I don't want us to be confused by that because listening to the response that you provided, Jeff, it's clear that that was based on the status quo and really is, I think, from an era with a mind-set toward, you know, whatever care is provided is provided in the four walls of a care setting. And thankfully we're in a new era now. We're thinking about social determinants of health. We're
thinking about what it is that patients need outside of what can happen in the clinical setting. And so, you know, I think we do have to recognize added costs that are associated, you know, and even -- I think it was Lynn who mentioned just the additional time required to communicate effectively and assess the needs and then make a plan for helping take care of the needs. And it did strike me when Lynn was saying that those types of things wouldn't have shown up on that prior analysis. So I just want to make that point.

Then a couple final points. One, I was really struck by the explication in the chapter about how duals -- how the payment for duals really ends up with providers getting less than because of the way the Medicaid lesser-of rules have been implemented, and I really wanted to just underscore that absolutely seems to need attention. And it also feels, you know, as I think about the current momentum in the private sector around health equity, which we all have to applaud -- it's long overdue -- I do worry a little bit that this disparity in payment and, therefore, in care and attention could be made worse by the added financial incentives that providers will be receiving from commercial
payers to pay special attention to closing care gaps and improving health equity of their populations if we aren't sort of balancing that over on the side of those who have lower socioeconomic status. So I just wanted to highlight that point.

And then I think the last point that I'd like to make is, again, reflective of the question I asked in Round 1 and some comments I heard other Commissioners make. I don't think we should be assuaged by the counting of visits and assume that that means that patients who are lower socioeconomic status but higher case mix are actually getting what they need. What I saw in the survey-based data that you reported was 2X rates of access barriers and challenges for these populations. So I want us to not be satisfied just by counting visits or hospital stays and assume that that means, you know, that these folks are getting the care they need.

Thank you.

MS. KELLEY: David.

DR. GRABOWSKI: Thanks, Dana. So I'll be brief. Most of what I wanted to say has already been said. I just wanted to stress two things.
First, I'm very supportive of this direction. I think it's already been said but I'll say it again. We currently do a really poor job of directing resources to safety-net providers. Paul did a great job of kind of outlining some of those issues with the DSH program. This is a perfect issue for MedPAC to be focusing our attention on, so I'm really happy we're working on this.

The second point, I just want to raise this issue. I'm really intrigued by coming up with Medicare-specific metrics. I think the duals measure that was outlined in the chapter, as Stacie said, is a really good starting point. The results that you put together in the chapter look promising, and I think we can build on those. We've had lots of good comments. And I raised in Round 1 about kind of the state variation. I was thinking about these within-state comparisons.

Jeff, I really liked your idea, like others did, about the LIS, using that as a way to get around this problem. Stacie had this great idea about the share of duals in the state. So there's a lot more work that can be done here to kind of overcome this problem, but I'm really excited over thinking about this duals measure and where
So as I said, I will be brief. I really mean it. This is great work, and I look forward to seeing future iterations. Thanks.

MS. KELLEY: Pat.

MS. WANG: Thank you, and I echo the compliments for the work, the quality of this particular paper, and the work that I think is going to continue. It's really quite important.

I just want to offer my perspective from a perspective of the work that I do. It is critical to find a way to identify and support safety-net providers. Critical. I think that one of the questions, though, that MedPAC needs to consider is: Is that the goal or is that an essential piece of a longer journey to ensuring that vulnerable underserved, underrepresented Medicare beneficiaries get better care, better quality, and, you know, really address some of the health equity issues that we have discussed?

I would suggest that payment policy is not the whole thing, but it is a very powerful tool to shape a delivery system, and that MedPAC should have as one of its
goals to stabilize -- identify and stabilize and support
safety-net providers, but also to try to use payment
incentives to reshape the delivery system to better serve
the population.

Access to a safety-net provider, a hospital, is
important, but it's really not access. I believe that a
lot of the data that we have seen that suggests that duals
have full access may be a little bit misleading because I
am guessing that a lot of that access is through the doors
of the emergency room. And it's not really the kind of
care that we would want for ourselves and that we would
hope for the folks that we feel responsible to.

From my experience, the issues confronting
communities that are very underserved are weak hospitals,
it rolls into quality, and, you know, just trying to stay
alive with like five minutes of cash on hand. But bigger
problems are communities live in what I would call "health
care deserts." You know, other than FQHCs, God bless them,
it's a very fragmented, siloed, inadequate, you know, sort
of supply of care deliverers and care components. Somebody
mentioned access to specialists. Gigantic problem. And so
if payment policy can help with that, that's great. But I
think it goes beyond payment policy. Paying more to
specialists to see my members is really essential, but it's
not going to solve the problem because there are other
reasons that people don't want to open their doors to
Medicaid and dual people.

And so I think part of it is just also
understanding provider shapes and provider types that are
very, very suited to taking care of the people. I think
FQHCs are an incredible model. Don't forget community
resources like community-based organizations. They're kind
of left out of the equation, but at least in my world, they
are so important to help patients navigate the system.

So I would sort of hope that our ambition is
bigger than it's really hard to pinpoint money to what we
would define as safety-net hospitals, but I'm urging us to
kind of go several steps further to figure out how else
payment policy can reshape the delivery system for the
populations that we care about.

In that regard, I really appreciate, Jeff, that
you can take a look at ambulatory care data, especially in
the hospital setting. And the reason is that, you know,
there's too much inpatient care being delivered to these
populations. What's needed is more ambulatory care. If there -- and it's not the fault of the hospital. It's that there's no ambulatory care around. If there's a way to incentivize or focus money to support the development of more robust ambulatory care systems -- and I really am focused on the hospitals here because they are often really the only source of care, at least in the communities that I am familiar with -- to help them build out ambulatory care capacity, that is what is really needed by the population beyond an inpatient bed. You know, it's like the precursor.

I wanted to suggest the -- I appreciate that you guys are fiddling around with this ADI to try to get at more characteristics of sort of the community served by different providers, and I want to go back to something we discussed at the last meeting. It was to see whether or not you can identify communities in need by looking at ambulatory care-sensitive admissions.

It's a good marker of adequacy of primary care in a community, and it could be -- if you have access to that sort of information, it could be another kind of geographic filter to layer on to something. Like, if you identify a
provider, you know, check all the boxes of the safety-net index and the rate of potentially preventable admissions is very, very high, then you'll know that maybe you've checked another box. I think looking at indicators like that is important.

On the question I asked before about teaching status, here's the things that is perplexing me a little bit about this. If, in fact, teaching status is very highly correlated with your high safety-net indicator index, is it possible that GME is a safety-net payment? Jeff, you said something interesting earlier, which was "I don't know of very many teaching hospitals that have closed." Maybe the variable, the important variable there is the teaching payments.

It's very complicated. Maybe we need to think about safety-net payments as including more than something that's labeled DSH today.

Just a couple of other comments. Identifying safety-net provider communities, populations of concern, I think it's like the river that runs through a lot of payment policy discussions, and I'd suggest that if we feel secure, when we feel secure that we kind of narrow down
what a safety-net provider is, then it should affect and run through the way that those providers interact with other payment policy decisions that get made, what gets paid for outpatient care, what gets paid for GME, what gets paid in the fee schedule. I mean, it's not just a siloed sort of DSH-like payment.

The final thing I just wanted to mention to put on Jeff and Brian's radar screens, I don't know whether this is maybe a down-the-road thing, and this is the way that DSH UCP payments are treated in the MAPD benchmark as compared to GME, the Medicare Advantage benchmarks.

We know that for Medicare Advantage, GME gets pulled out and gets paid separately by CMS to the teaching hospital. It's not paid by the plan, and the idea of this was to, I think, try to have a level playing field between teaching hospitals, which are more expensive, and nonteaching hospitals to prevent plans from piling all their care into the non-teaching institution and putting teaching hospitals as a disadvantage.

DSH is not treated the same way. DSH UCP is part of the MA benchmark, and it is part of the premium. And the anomalous thing that happens here is if that county,
let's say, that hospital care is 30 percent of the benchmark and DSH is 35 percent of the hospital cost, that money is rolling through into every MA plan's premium, including those who never sent anybody to a DSH hospital, and those who send all of their members to DSH hospitals because that's who they serve. It's a very curious thing because DSH raises a level of premium for all plans, no matter who they serve, and it has a very different impact if you don't send anybody to a DSH hospital and you never pay a DSH payment versus you sent everybody to a DSH hospital and you pay all of the DSH payments. It has a differential impact.

If you carve that money out of the premium, there would be very little left. I mean, it would really have a big impact on the premium, but it is -- it always interested me that teaching hospitals were deemed worthy of protection in this way, but DSH hospitals are in a different category, apparently. So, for future reference, it might be something that you want to think about.

Thanks.

MS. KELLEY: Jonathan Jaffery.

DR. JAFFERY: Thanks, Dana.
I'll be pretty brief because, really, everybody has made most of my points, and they've been excellent. I'm really supportive of this work. It's excellent foundation. I just want to emphasize maybe one or two points.

One is that, at a high level, the support for this principle that we should define safety-net providers by the populations they serve rather than the types of organizations they are or where they're located, and then that leads into some of these other things like continuous eligibility rather than cliffs and thinking about things like LIS or something else creative that wouldn't be subject to much state variation or things like that.

But I also just really want to emphasize this notion that's come up around this is -- and I know, Jeff, you started off saying this. So I know this is where you're thinking too. This is where we're starting and thinking about -- this is going to be a continuous discussion that includes layering on health equity, which is very different. Health equity -- and there's a lot of overlap with economic disadvantage, but they're not the same thing.
Dana was talking about situations where it takes more resources to care for somebody, and there are all sorts of examples where you can think about a language barrier that requires more resources that may have nothing to do with economic disadvantage for that individual, but it's a real barrier and can impact outcomes. So I think it's super important that we are addressing this and very excited to be part of this conversation.

The second thing I just wanted to mention is a bit more granular, and I was intrigued, while I was reading the chapter, about the issues around primary care versus specialty care and thinking about FQHCs in particular. So a number of people have brought up FQHCs. I think, Jaewon, you started off bringing that into the conversation, and this notion that primary care treats some of our dually eligible individuals much more than specialty care -- specialists do, I wonder if that's really driven primarily, if not almost exclusively, by how much FQHCs take care of the dually eligible individuals, because we saw those percentages be so high in the chapter.

So I wonder if there's more work we can think about, analytic work around some of that, and then really
thinking about are there policies we can build into place here that are supportive for some of the great systems we already have, the FQHCs, to get more support for specialty care.

As a specialist with a close relationship with our FQHC in town here, I know what a struggle it is for them and how a lot of times, things that will happen with their patient population, in the nephrology care happen, it's really just sort of happenstance and just relationships based on me being friends with the CMO and the CEO there. It's not systematic, and so if there are some policy and payment approaches we can think about to try and mitigate that disparity, that would be wonderful. Again, thank you for bringing this work to the forefront, and I'm super-excited about it.

MS. KELLEY: Larry.

DR. CASALINO: Yeah. Jonathan, you must have read my mind because just about everything you said, I was going to say. So I'll make a few comments very quickly and then spend a little bit of time, not much, on a fourth. I like the dual eligible idea as a simple way of identifying safety net, but I don't think we can just stick
our heads in the sand and ignore the variations across
states in that. So I think maybe some more work on whether
defining -- using the in-state comparisons would be enough
or that wouldn't work across the board, LIS, as Jeff and
others have mentioned, or is there another measure or
combo? Whatever we do, I think we have to explicitly
address the state dual eligible issue if we think about
using that as the thing that defines safety net.

A related point, and Dana and Jonathan have made
it, it's satisfying to have a clear description of safety
net and say this is safety net and this isn't safety net.
So these are safety-net hospitals, these are safety-net
physician offices, and these aren't. There's real
advantages to that.

On the other hand, that would be a cliff, and it
doesn't have to be a cliff. If we were using dual
eligibles, for example, it could be payment varies by your
percentage of dual eligibles, more complicated, but that's
the second point.

A third quick point, which others have made, 80
percent of hospitals get DSH payments is kind of
ridiculous, especially when there's 13 percent of physician
offices or physicians that are seeing 50 percent of dual eligibles, and they don't get any extra money, don't get any help at all. FQHCs do, but physicians in private practice don't. That really needs to be changed, and that's something that MedPAC, one would think, could take on pretty quickly.

Actually, there's a subpoint to this, which I wasn't going to originally make, but listening to Jonathan talk about specialists and the problem with not just FQHCs but any physician has in getting a specialist to see a dual eligible patient or, God forbid, a Medicaid patient -- and I agree there's a lot of reasons why physicians don't take Medicaid patients. It's not just low-payment rates. But, you know, most physicians have had many, many, many, many years of their training heavily subsidized by the federal and state governments, and again, an incredible return on the years they spent training, an incredible economic return. And the idea that they are not willing to see just a couple of percent even of their patients who have Medicaid or dual eligible, to me, it's really unacceptable. I'd love to see MedPAC open a line of work on specialists and dual eligible patients and think about whether there's
anything CMS should or could do about that.

And the last point I want to make -- and this might take an extra minute -- I just want to pose the question to the staff and the Commissioners. Is this about eliminating disparities, or is it about keeping hospitals and physician officers who have a poor payer mix because they serve a lot of poor people and enabling them hopefully to provide good care? I think it's clearly the latter.

This is about what can we do for hospitals and physicians who -- and perhaps other sectors who take care of a lot of poor people, and therefore, they have a poor payer mix, and there, they don't have any money. I think that's the issue we're addressing. We're not trying to eliminate disparities through this mechanism.

I think helping hospitals and physician offices that do have a poor payer mix would help reduce disparities to the extent that racial and ethnic minorities, for example, get their care from safety net physicians and hospitals, but it isn't going to solve the problem altogether, and I don't think we can through this mechanism.

For that reason, I think it would be better not
to use the word "vulnerable patients" or "disadvantaged patients" when we talk about this, because there are lots of vulnerable patients in the world. You could have a very wealthy LGBTQ patient, for example, who has great commercial insurance and is not hurting the providers at all in terms of whatever they're getting paid, but who is disadvantaged because of lack of understanding of who they are and so on. And you can multiply those examples.

So I think every time we use the word "vulnerable" or "disadvantaged," we kind of open the topic up to this is about eliminating disparities. I don't see this as a mechanism for eliminating disparities. I see it as a mechanism for reducing disparities by helping hospitals and physician offices that take care of poor patients, period.

I think MedPAC could open a line of work because I think Pat was suggesting into ways that payment incentives and other things that Medicare could do to reduce disparities other than disparities caused just purely by poverty such as racial, ethnic, or sexual orientation. There's no end to the kind of disparities one could address.
So that's it.

MS. KELLEY: That's all I have in the queue, Mike.

DR. CHERNEW: I think Bruce Pyenson wanted to get in a point, given there was some time left.

Is that right, Bruce?

MR. PYENSON: It's right. Actually, a couple of points. One item that I welcome seeing through the analysis is some discussion on the use of funds for charity care. I think that's been a topic of some interest in policy circles, and having that as a comparator might be helpful in a number of ways. So that's one point.

Perhaps this goes without saying. I know the analysis that we've seen was using the hospital closures as an outcome of the regression analysis. It's not that's a measure of distress. It's perhaps not the best measure because there's lots of reasons why hospitals might close, and there's relatively few. And they're, well, typically small.

So those are my two additional comments. Thank you.

DR. CHERNEW: Okay. Dana, am I right that that
is the end of the queue now?

MS. KELLEY: Yes, it is.

DR. CHERNEW: I'll pause for a minute to see if anyone wants to add anything. It's been a very rich discussion. Then I will summarize.

DR. RAMBUR: Can I make one brief comment? I just can't help but underscore the point that Larry made about the enormous subsidy that we do have for physician education and some expectation on the part of us that that has been used to serve Medicaid patients, duals, whatever. But I just can't help but point out the irony of the money that the nation does not spend on nursing education or graduate education and the proportion of those nurse practitioners that do work with Medicaid patients and dual eligible patients.

I don't have that data right in front of me, but it is sort of an ironic situation, and to the extent that we can align things up better, to better meet the needs of this nation, I think we would have done something that is very important. So I wanted to just throw that out there and thank Larry for bringing that point up.

DR. CHERNEW: Okay. And now you've spurred
Brian, I think, to want to make a comment.

DR. DeBUSK: I also want to make a comment on Betty's observation. It is interesting that we have GME funding for physicians, but there's this gap in how we treat, for example, nursing, nurse practitioners, physician assistants. Notice, Betty, I did not use the midlevel term. For what it's worth, Marge set me straight a couple of years ago. But the observation I'm making too, you're also seeing the rise of hospitals participating more and more in nursing education; for example, receiving their bachelor's, receiving their FNP. And you're seeing this rise of nurse staffing companies accounting for a larger and larger share of nurses.

I do want to caution. I suspect we are building those costs into Medicare payments, but we're doing it through the market basket updates, through the cost reports, and the -- I'm agreeing with you, and my point here is I think if we don't manage how we handle this education, the system with its formulaic approach is going to manage it for us through shifting the hospital wage index calculation and through the market basket updates.

So my advice would be I think we should be more
proactive and decide how we want their education to be shaped.

DR. CHERNEW: Okay. So what that set of comments illustrates is how multifaceted our entire health care system is and how many different levers we have. In other word, we talk about putting things through various lenses. This broad issue can be looked at, when we talk about education, we had an IME chapter. We will do education again. A lot of the themes that were raised today relate to how we do quality measurement and a whole range of things related to quality and performance measurement that spans all of the payment systems.

Let me give sort of my both reaction to this and general overview in very broad terms and sort of make the high-level point that the enthusiasm for this topic was really exceptional, and I'm very thrilled for that. And I think when I loop back with the staff, I think we'll find continued significant enthusiasm, and so this has been a very, broadly speaking, far-ranging and fruitful discussion, straying into areas perhaps more than we can get to in this chapter, but that doesn't mean more than we will think about as we go through all the other things that
So, again, I'll give my views, and we'll see how it plays out. The first one is I think, by and large, this is about access to high-quality care and the acknowledgement that provider availability is central to that access but acknowledging that it's only one aspect of that access. Having providers is, in many ways, a necessary but not sufficient aspect of access, and we need to think through that.

I think there's been a strong seaman's discussion about the importance for outpatient care, some particular attention to specialists, but more broadly, access to outpatient care, which I think is important.

I think we will continue to ponder as we go through this aspects of performance measurement. My personal view is, as I said, some of the financial support is necessary to help some providers survive, but it's not necessarily sufficient to achieve the main goal, which is access to high-quality care. So we will have to continue to think through this in the context of the performance measurement things that we do and a broader set of policies that we have.
The other theme that I think played out in this discussion, which is an important one, is the, broadly speaking, idea of measurement and targeting, and we are sort of groping around for better measures to accomplish what we want to accomplish. And I think many of the comments, some of the weaknesses of the duals and things we might do about it, some other measures, are well appreciated.

I guess I'll say one last thing, lest to be confused. I mentioned the importance of provider-ability for access, and that remains true. That does not mean that we should pay in a way that keeps all providers open all the time. So we really need to try to figure out here a way to target the money to the providers that are really central to meeting the broad mission of the Medicare program, and again, if I haven't mentioned it, the beneficiary access to high-quality care and having sufficient resources but not excessive resources to support that.

So that's how I see this playing out. We are struggling with the exact vocabulary to use in describing all these things, and we're struggling sometimes with the
boundaries about exactly where different concepts should fit in our broad agenda.

But that's my summary, and I was going to pause to see if there are any other questions, but I actually think my sense from the chat is there are some to her comments. So I'll phrase it this way, without calling any of you out. Anyone want to say anything?

DR. DUSETZINA: Mike, your wrap-up comments spurred one more kind of question in my mind or one more data request, and it gets back to this point of specialty care and trying to think about how to incorporate that better.

I do wonder if there's a possibility of collecting information on the -- even if it's the percent of duals measure by institutions for both their inpatient care and their outpatient care.

Part of the reason I'm thinking about this is thinking about hospitals that currently get some forms of DSH payments because they accept Medicaid-covered individuals or duals through the emergency department and in inpatient care but do not accept those same individuals in their outpatient clinics, and I really think that it
would be helpful to understand more about the correlation between their percentage of dual populations between those sites of care to try to maybe do a better job of rewarding systems and hospitals that are taking care of patients in both care settings.

DR. CHERNEW: Agreed. And this issue, again, the nature of what a hospital is has changed over the grand arc of the Medicare program, and we're continuing to struggle with that, which is why, of course, this chapter has expanded behind just simply hospital care. And, of course, outpatient care is a combination of outpatient care delivered by hospitals, outpatient care delivered by other settings, some of which are facilities, others are physician offices, et cetera. This is a broad, complex topic, and so I appreciate that. And we will take that comment under advisement to see what we can actually do in that spirit.

So I've done my wrap-up. I'm going to pause again for a second and see if anyone wants to add something. If not, we're going to move on to a discussion of telehealth. This was supposed to be the transition where I pointed out that access to high-quality care in
many cases also includes access to telehealth services in a broad range of ways. So we will tie this together when we look at some of the data coming up, but before we make that transition, any last words? That sounds so final.

[No response.]

DR. CHERNEW: Okay. Hearing none, we will move on.

I think, Ariel, are you going to kick us off on our telehealth session to update us on where we are?

MR. WINTER: Yes.

DR. CHERNEW: Great. Take it away.

MR. WINTER: Good afternoon. The audience can download a PDF version of these slides in the handout section of the control panel on the right-hand side of the screen.

In today's presentation, we will review Medicare's temporary expansion of coverage for telehealth services during the public health emergency and the policy option for covering telehealth after the PHE that was in our March report this year.

We will also provide an update on telehealth use during the pandemic, information on beneficiaries' and
clinicians' experiences with telehealth, findings from our interviews with direct-to-consumer telehealth companies, information on telebehavioral health, policy options for Medicare to collect more data on the use of telehealth services.

Some of this material will be incorporated into various March report chapters, but we are not planning to have a freestanding telehealth chapter for this meeting cycle.

DR. CASALINO: Ariel, this is Larry. Can I interrupt for just a second? We're missing five or six Commissioners, and we're about to be missing -- about to add to that number. I suspect some audience members may also be missing. We're a little bit ahead of schedule. I wonder if we could just take a five-minute break, and that way, everybody can hear what you're saying, audience and Commissioners, and we'll still be on schedule. Would that be okay?

MS. KELLEY: Sure. Why don't we go ahead and do that, Larry.

Ariel, I'm sorry. Do you mind?

MR. WINTER: No problem.
MS. KELLEY: Okay. Let's just --

MR. WINTER: I'll be back in five minutes.

MS. KELLEY: Okay. Thank you.

DR. CASALINO: Great.

[Recess.]

DR. CHERNEW: Okay, Ariel, why don't you jump on in, and hopefully we will get the other folks. They should actually be here, but hopefully we will see them soon.

MR. WINTER: Okay. Great. Thank you. Good afternoon. The audience can download a PDF version of these slides in the handout section of the control panel on the right-hand side of the screen.

In today's presentation, we will review Medicare's temporary expansion of coverage for telehealth services during the public health emergency, and the policy option for covering telehealth after the PHE that was in our March report this year. We will also provide update on telehealth use during the pandemic; information on beneficiaries' and clinicians' experiences with telehealth; findings from our interviews with direct-to-consumer telehealth companies; information on telebehavioral health; and policy options for Medicare to collect more data on the
use of telehealth services.

Some of this material will be incorporated into various March report chapters, but we are not planning to have a freestanding telehealth chapter for this meeting cycle. At this meeting, we would like to get your feedback on this material, and other topics you would like us to explore.

Before the PHE, Medicare's coverage of telehealth was flexible in Medicare Advantage plans, two-sided ACOs, and other payment systems. However, coverage of telehealth was limited by statute under the physician fee schedule because of concerns about its impact on spending and program integrity. Under the fee schedule, Medicare paid for a limited set of telehealth services provided to beneficiaries in rural areas in certain settings, such as physicians' offices and hospitals. As a result, use of telehealth was very low. It accounted for less than 1 percent of fee schedule spending in 2019.

During the early months of the PHE there was a steep decline in the use of in-person services, which led to major concerns about beneficiaries' access to care. As a result, the Congress and CMS temporarily expanded
coverage of telehealth services under the fee schedule.

This table lists the key policy changes that apply during the PHE. First, Medicare began paying for telehealth services provided to beneficiaries in both rural and urban areas in any setting, including patients' homes. Second, Medicare expanded coverage to over 140 additional telehealth services and began paying for audio-only interactions for certain services. Third, CMS began paying either the facility or non-facility rate for a telehealth service, depending on the clinician's location. Before the PHE, Medicare always paid the facility rate, which is usually less than the non-facility rate. And fourth, clinicians are allowed to reduce or waive beneficiary cost sharing for telehealth services.

In our March report, we described a policy option for covering telehealth after the PHE. Under this option, Medicare would continue certain telehealth expansions for a limited duration, such as one to two years, after the PHE ends.

These expansions would include paying for specified telehealth services provided to all beneficiaries, regardless of their location; covering
additional telehealth services if there is potential for clinical benefit; and covering certain telehealth services when they are provided through an audio-only interaction, if there is potential for clinical benefit.

Continuing these expansions for a limited period of time would allow policymakers to gather more evidence about the impact of telehealth, when combined with in-person care, on access, quality, and cost. This evidence should inform any permanent changes to Medicare's telehealth policies.

Our policy option also calls for returning to some of Medicare's prior telehealth policies after the PHE, along with establishing some additional safeguards. First, Medicare should go back to paying the fee schedule's facility rate for telehealth services, and second, providers should not be allowed to reduce or waive beneficiary cost sharing for telehealth services.

Further, there should be additional safeguards to protect Medicare and beneficiaries from unnecessary spending and potential fraud related to telehealth. These include applying additional scrutiny to outlier clinicians; requiring clinicians to provide an in-person, face-to-face
visit before ordering costly DME and lab tests; and
prohibiting "incident to" billing for telehealth services
provided by any clinician who can bill Medicare directly.

In addition, we noted in our report that CMS
currently has the authority to offer telehealth waivers to
clinicians who participate in alternative payment models.

Now, I'll switch gears and talk about our
analysis of the use of telehealth services during 2020,
based on preliminary Medicare claims data. This slide
shows the number of fee-for-service beneficiaries who
received at least one telehealth service during each month
of 2020. This number sharply increased in March and April
as providers and beneficiaries avoided in-person visits.
The number declined between April and Oct. as in-person
visits rebounded. But it began to increase again at the
end of the year, probably due to the growth of new COVID
cases.

Across the entire year, 14.1 million fee-for-
service beneficiaries received at least one telehealth
service, representing 40 percent of all FFS beneficiaries.

Now we're going to look at telehealth's share of
primary care services during 2020. Primary care includes
evaluation and management office and outpatient visits, chronic and transitional care management services, annual wellness visits, and some other codes.

Almost all primary care services can be provided either in person or by telehealth. In-person visits are shown in dark gray on the chart. Telehealth visits are in light gray.

The growth of telehealth services partially offset the steep drop of in-person visits in March and April of 2020. In April, telehealth accounted for 47 percent of all primary care services. As in-person visits bounced back, telehealth's share declined each month between May and October. But telehealth's share began increasing again during November and December, as the number of COVID cases began growing. In December, telehealth accounted for 17 percent of all primary care services.

Preliminary data from 2021 show that telehealth accounted for about 10 percent of primary care visits in September 2021, which is the most recent data we have available.

Here are some other relevant findings from our
analysis of Medicare claims data, and there are more
details in your mailing paper. E&M office and outpatient
visits accounted for almost three-quarters of allowed
charges for telehealth services in 2020, and 95 percent of
these telehealth visits were for established patients.
Telephone E&M visits accounted for 18 percent of allowed
charges for telehealth services during the year.

We also examined the types of conditions
associated with telehealth services. We found that mental,
behavioral, and neurodevelopmental disorders accounted for
the highest share of allowed charges for telehealth, 25
percent.

Looking at geographic variation, the number of
telehealth services per beneficiary varied by geographic
region in 2020. However, changes in the use of telehealth
during the year were generally similar across regions. The
volume peaked in April, declined during the summer and
fall, and began rising again late in the year.

We also examined the use of telehealth for
different subgroups of beneficiaries. We found that
beneficiaries who were under age 65 used more telehealth
services than older beneficiaries, those who were disabled
and those with end-stage renal disease used more services than aged beneficiaries, dually-eligible beneficiaries used more telehealth than other beneficiaries, and urban residents used more telehealth than rural residents.

Next, I'll summarize our review of the literature on the use of telehealth in the US during the PHE. Most of the studies we reviewed focused on commercially-insured patients or Medicare Advantage enrollees.

In general, the main findings of these studies are consistent with the results of our Medicare claims analysis. The volume of telehealth increased during the PHE, mental health conditions accounted for a high proportion of telehealth services, and the use of telehealth varied among different groups of patients. For example, patients in high poverty areas had lower use of telehealth than patients in low-poverty areas.

And now I'll now turn things over to Ledia.

MS. TABOR: MedPAC's annual beneficiary telephone survey and virtual focus groups with beneficiaries and clinicians provide additional insight about experiences with telehealth. Because the survey and focus groups were conducted in the spring and summer of this year they allow...
us to track more recent experiences than the claims analysis and literature review. Many beneficiaries reported having telehealth visits over the past year mainly with clinicians with whom they have an existing relationship. They were generally satisfied with these visits. Consistent with our analysis of Medicare claims, many clinicians in our focus groups reported that they continued to provide telehealth after rapidly expanding it early in the pandemic. Some clinicians appreciated the convenience and flexibility it allows in terms of the visit length and location, while others preferred in-person visits due to perceived better quality of care or to provide procedures and testing. Many beneficiaries and clinicians would like to continue the option of telehealth visits after the PHE.

Switching topics, Commissioners have asked us to continue researching direct-to-consumer telehealth companies, so we conducted interviews with five different telehealth companies of various sizes and organizational structures. Four of the five companies we interviewed do not currently bill fee-for-service Medicare and do not plan to do so in the foreseeable future.
The companies' primary clients are mainly commercial health plans, large employers, and health systems. The companies provide their clients' patients with telehealth visits for mainly urgent, low-acuity care needs, and many of the companies offer tele-behavioral health visits. A few of the companies are beginning to offer virtual primary care products, built on a continuous relationship with patients, but none of them were focusing these services on elderly patients.

Companies varied in their arrangements with clinicians, meaning some employed full-time clinicians while others contracted with clinicians on a part-time basis.

Switching to another topic of interest to the Commissioners, tele-behavioral health services. These services include individual therapy, group therapy, and treatment for substance use disorders. The high use of telehealth for treating mental health conditions means that telehealth services have played an important role in treating mental and behavioral health conditions during the public health emergency.

The literature before the PHE suggests that
patients utilizing telehealth care have comparable short-term outcomes, for example, that are medication compliance and reduced symptoms, to those utilizing in-person care for behavioral health conditions. Tele-behavioral health services also improves access, especially for patients experiencing geographic, social, or health-related barriers. However, more research needs to be conducted on the impact of tele-behavioral health on cost and long-term outcomes.

Prior to the PHE, beneficiaries had to receive all services at an originating site, like a clinician's office in a rural area, with the clinician at a distant site. In 2021, the CAA removed geographic restrictions and added the patient's home as an originating site for tele-behavioral health services that are used to diagnose, evaluate, or treat a mental health disorder. The CAA also requires that a non-telehealth service, i.e., an in-person visit, be provided by the clinician furnishing mental telehealth services within six months prior to the initial telehealth service.

In the 2022 physician fee schedule rules finalized last week, CMS is implementing this statutory
requirement by requiring that a non-telehealth service be provided by the clinician furnishing mental telehealth services or a clinician within their group within six months prior to the initial telehealth service, and at least once every 12 months thereafter by the same practitioner. The in-person every 12 months requirement can be waived if clinicians document how a tele-behavioral service outweighs the risks and burden of an in-person visit.

CMS also proposes to cover audio-only behavioral health services when in-person service is furnished within 12 months by the same provider, and the beneficiary doesn't have the capability for telehealth. A claims modifier will be required to denote that the service was audio-only.

Switching to the topic of lack of data on some telehealth visits. Before the PHE, CMS only paid for physician fee schedule telehealth services that were provided using two-way audio and video communication technology. During the PHE, however, CMS has waived this requirement for some services because not all beneficiaries have the capability to engage in a video telehealth visit from their home.
Under the Commission's policy option from our March 2021 report, CMS should continue to temporarily cover some telehealth services delivered through an audio-only interaction after the PHE when the agency determines there is potential for clinical benefit. However, for most telehealth billing codes, there is no way to determine whether a telehealth service was delivered by an audio-only interaction or an audio-plus-video interaction, using Medicare claims data. Consequently, it is difficult to use claims data to assess the impact of audio-only telehealth services on access, quality, and cost, or to monitor potential fraud to the Medicare program and its beneficiaries.

Also, as Evan brought up at the September Commission meeting, home health agencies do not report data on services provided by telehealth. This is also true for hospice providers.

To improve the availability of data to evaluate how telehealth and audio-only services impact access, quality, and costs, CMS could require a claims modifier to audio-only claims paid under the physician fee schedule. They could also collect claims data on telehealth services
Throughout the upcoming year we will continue to monitor the use of telehealth, beneficiary and clinician experiences with telehealth, and the growing telehealth literature. Today, we would like to get your feedback on these materials, the policy options to collect better data on the use of telehealth, and other topics the Commission could explore regarding telehealth.

I'll turn it back to Mike and look forward to the discussion.

DR. CHERNEW: Thanks, Ledia. This is such a big topic and it is one I think we are going to be following as I believe this new mode of care delivery will continue to grow and be important for many of our beneficiaries, so thank you for sort of building the infrastructure and focusing our attention on data and other policy issues.

So Dana, why don't we jump through the queue.

MS. KELLEY: All right. I have Larry first with a Round 1 question.

DR. CASALINO: So yeah, just a few things. Nice job. I'm very glad, guys, that we're continuing to track telehealth. And a few Round 1 questions. One is you say
pretty clearly in the materials, and also just now, Ledia, in your presentation, that there is no sure way to track audio visits except for I guess there's three modifiers or three types of claims that they thought was an audio visit. That might have been in the materials, not what you just said.

But then in the materials, and also in what you just said in various places, said 18 or 19 percent of telehealth services delivered were audio only. So should we take that 18 or 19 percent to be their minimum that you could identify just from the claims where it is identified, but in fact, because you can't tell for a lot it could be higher and we have no idea how much higher? Is that a fair statement?

MR. WINTER: Yes, that's correct.

MS. TABOR: And I'll just add that I think there's kind of two different types of audio services. There's the audio-only E&M that became billable during the PHE, and that's the 18 percent. But then there's also other services like group therapy, for example, that CMS is allowing audio-only interaction during the PHE. And for those, there's no modifier to know whether that was...
performed by telehealth or audio-only.

DR. CASALINO: This is kind of important, I think, because audio's going to be a controversial issue. And so I think to really spell it out in one place in the report, that this is the way we could tell when there were audio visits, this is the percent that were audio visits. But, in fact, the audio visits might be higher -- are higher. We just don't know how much higher. And I think that would be helpful because I was a little confused by that.

Then two other quick questions. I was just desperately -- when Dana was calling my name -- looking for in the materials, but I couldn't find it, I couldn't tell if you guys were proposing that the audio modifier be required by CMS for any telehealth service in which audio-only is used or only for behavioral health services. I don't know why I thought that you might have said only for behavioral health services, but is that wrong? Or are you just proposing that audio modifiers be included whenever audio-only is done for any kind of service?

MS. TABOR: I think for any kind of service it would be beneficial for us and others to know when it was
DR. CASALINO: Probably that's clear in the report and it was just unclear to me, but you might just double check it because that's pretty important.

And then the last question is, you know, you point out, as you have before, that prior to the PHE, when Medicare was paying for telehealth services, it was -- for audio-visual telehealth services, it was paying the facility fee. And in the materials here -- I can't remember if it's on the slide or not -- you say Medicare should go back to paying the facility fee.

But I want to keep this at Round 1 so I'm not going to comment, but I'd just ask you guys, is there a rationale for using the facility fee as the rate at which to pay for telehealth services? I personally can't see one, but I'd be curious what you have to say or what you think Medicare has to say. So that's a question.

And then just as a more general statement, I think it would be great if the staff could, in continuing the telehealth work, try to focus some attention on, you know, what should the payment rate be if it's AV or if it's audio-only. And should the payment rate vary and what
should the payment rate vary on, whether it's bricks-and-mortar providers that are delivering the service or Teladocs that don't have bricks and mortar? So for AV and for audio, for bricks and mortar or for telehealth, what's the rationale for a facility rate? Are there other rates that there would be perhaps a stronger rationale for? I think this is also, you know, vitally important, right? And I think that -- I'm not sure we should just accept Medicare was paying the facility rate so that's the way it should be and everybody gets paid the same, and get paid at the rate of E&M visits or -- well, I'll go back. So more work on that part I think would be very, very important, because I'm not sure anybody's doing it, and it does seem pretty fundamental.

MR. WINTER: And just to answer your question, Larry, about why they were paying the facility rate before the PHE, why we suggested going back to that policy after the PHE. So before the PHE, telehealth services were only covered if the beneficiary was in an originating site, and Medicare paid a special -- made a special payment of about $25 to that originating site, whether a hospital or a clinic or a physician's office, to cover some of the
overhead costs associated with the telehealth visit. But the distant clinician is actually providing the service through telehealth. They don't incur any overhead costs because they're not seeing the patient in person. If there are any overhead costs, they're being incurred by the originating site. And so that was the rationale by CMS on only pay the facility fee before the PHE.

And then we suggested in our discussion in the March report chapter that CMS should go back to that policy because when a clinician is providing a telehealth -- whether or not there's an originating site fee, the distant-site clinician is not incurring the same overhead costs that a physician incurs when they see the patient in their office, like supplies and clinical staff, equipment, and that sort of thing. So that was our thinking for why CMS should go back to that policy after the PHE is over.

But we will continue to look at this further, and we talk about the need for additional research on what the appropriate payment rate should be in the long term, and that's in the March report.

DR. CASALINO: Great. Thank you.

MS. KELLEY: Dana, do you have a Round 1
question?

DR. SAFRAN: I do. Thanks. On page 25 of the meeting materials, there's a paragraph where you list the visits -- the types of care that are considered to be acceptable for telehealth visits, and I was curious whether you have information about what percentage of all encounters these categories represent and also what percentage of spend or ambulatory spend, however we want to view the denominator.

MS. TABOR: You mean across all payers?

DR. SAFRAN: No. For Medicare. I didn't see -- if that information was there, I didn't see for Medicare what this represents. It looked like it represented quite a lot.

MS. TABOR: For the direct-to-consumer companies, only one of the five that we spoke with has opted to start billing Medicare during -- Medicare fee-for-service during the PHE. They weren't allowed to before, so it's kind of, again, a new business opportunity for them. And for that one organization we spoke with, I think the volume was pretty low. There wasn't a lot of take-up for Medicare fee-for-service beneficiaries, and the kind of commercial
and other health plan system market continued to dominate their patients.

DR. SAFRAN: Thanks, Ledia. I'm sorry. I think I didn't ask my question clearly, so let me try again. On page 25, it says, "Clinicians described situations when telehealth is suitable, including for patients with stable medical conditions, medication refills, current disease management, remote monitoring" -- it has kind of a long list, second opinions postoperative or follow-up visits, but kind of a long list. So my question is: For the Medicare program, what percentage of encounters does this list represent? And what percentage of spend or ambulatory spend does this list of encounters represent?

MR. WINTER: So it's hard to -- it's hard to give you an exact number because we were just listing some examples that we heard from clinicians. And in some of these examples, it's really hard to tell from claims data whether the visit was -- whether they discussed medication refills or follow-up on a chronic condition without access to the medical records. But based on the claims data we were able to look at -- look at the claims and look at telehealth by HCPCS code and by broader categories. And if
you look at the pie chart on page 9, that shows that when you look at the E&M telehealth visits, which were almost all telehealth visits, you can see how it breaks down between our bread-and-butter office outpatient visits, which was roughly three-quarters of E&M; 17 percent was behavioral health; and so on.

So, you know, there's a limit to how much we can drill down into telehealth using claims data, but hopefully this gives you a sense, and if you have additional information or additional ways you'd like us to cut the data, we'd like to hear that, too.

DR. SAFRAN: I guess my reason for the question is it does strike me that from that list, where clinicians described situations where telehealth is suitable, to me that list looked like it is probably 50 percent or more of ambulatory encounters. And that just seems like a very important thing for us to know, for, you know, 50 percent of the ambulatory encounters and currently 50 percent of ambulatory spend, you know, clinicians believed that encounters could happen through telehealth. Whatever that percentage is, whether 50 percent is the right number or not, it just strikes me that that is really quite
compelling. That was a pretty robust list, so that was the reason I was asking the question.

MS. TABOR: I think, Dana, to that point, one thing we heard also during the focus groups from clinicians was it's not just necessarily the type of service; it's also the patient and how well they know the patient, how stable the patient is. So I can make that kind of caveat clearer in the text.

DR. SAFRAN: Yeah, okay. Sounds good. Either way, it's a pretty compelling point that, like, you know, a very large share of medical care that today happens in clinical settings, clinicians view as things that could happen, you know, in perpetuity using remote technology if payment is right and the technology's there. So I think that's pretty interesting and important.

MR. WINTER: And as we found, at the end of 2020, 17 percent of all primary care services are being provided by telehealth. So this is a pretty substantial chunk.

DR. SAFRAN: Thank you.

DR. CHERNEW: Stacie, did you want to say something on this point before we get back to the Round 1 queue?
DR. DUSETZINA: Yeah, I was just thinking through how best to capture that information from the claims, and I appreciate Dana's point about that laundry list of services, because it sounds like just about everything could be covered.

I do wonder, you know, I often think about this as did you need any more follow-up, right? Were there labs ordered? Were there things where if the patient wasn't physically there, you would have to require them to come in? So I wonder if there's some way to narrow that down, you know, to the patients who didn't have -- you know, if we saw like all of these services, and we wanted to know how common they were in Medicare, I think we'd have to say and how many didn't have any additional services that would have required the patient to be there in person, because that seems to be a determining factor, I think.

MR. WINTER: So that's a good idea, and we can look into that. One thing we heard in talking to clinicians and DTC companies is that they will sometimes see patients by telehealth, and then if the patient needs follow-up labs or tests, then they'll send them to an inpatient provider for that, an inpatient location to get
those tests. But the encounter and then the follow-up
encounter could be done by telehealth.

DR. CHERNEW: Larry, I think you want to continue
on this point?

DR. CASALINO: Yeah, just a quick comment. It
was probably obvious, but the clinician often and probably
even usually doesn't know in advance whether anything else
will be needed -- blood test, urine test, imaging -- in
advance of the visit. Even if they think they know in
advance of the visit, they may be wrong. So you can't
really tell in advance what's going to be needed.

DR. CHERNEW: Okay. Dana.

MS. KELLEY: Marge?

MS. MARJORIE GINSBURG: Yes, thank you. Great
report, and I love all the additional information we have
now and we heard earlier. I have been sort of a curmudgeon
on this topic, and one of the issues that comes up for me
now is the issue of potential for Medicare fraud. My
understanding, the way this is written, is that the patient
must have an in-person visit with their primary care doc or
one of their physicians before a telehealth meeting can
take place. But I am very concerned about the potential
for fraud on the part of telehealth companies that basically see this as a rich potential for making money from a lot of seniors who are susceptible to fraud more easily perhaps than younger folks.

So one question in particular is: Are telehealth companies required to be registered in any way with the federal government to establish their legitimacy, to assure that data are being collected that reflect real Medicare visits? I'm looking for ways that might mitigate my concern for opening this door to a great deal of fraud.

Thank you.

MS. TABOR: I'll make one clarifying point to something you were saying, Marge, that the recent change of requiring an in-person visit is only for tele-behavioral health. It's not for all telehealth. And as far as fraud, you know, we know that this was a concern, and we spoke about this in the March report, and a good deal of oversight and monitoring is going to be needed, and in the report we list out some ways to do that. But it continues to be a concern.

Ariel, I don't know if you have anything else to add.
MR. WINTER: Yeah, the DTC company itself may not be required to register with the federal government, but if a clinician is billing Medicare, that clinician has to be enrolled in Medicare. Medicare has information about that clinician and has the ability to track their claims. So certainly the clinicians are part — Medicare has information about the clinicians, not the DTC company that employs them.

MS. MARJORIE GINSBURG: So we don't see any compelling reason to explore the idea of the companies themselves being required to register in any way?

MR. WINTER: I think that's a policy question that, you know, you all can talk about and we can go back and think about. It's not something we've looked into thus far.

MS. KELLEY: Lynn?

MS. BARR: Thank you for an excellent chapter, and, you know, I think adding telehealth as a service to all of us is something we all would like to have as part of our benefit package. So, you know, I really appreciate us moving down this path.

I have a couple of questions. One of them is
that, yeah, as you pointed out, there's disparities in utilization in rural versus urban. It could be related to, you know, broadband access. It could be related to a whole bunch of things. We don't really know why.

But then you also mentioned that a large number of these visits are for mental health services which require that in-person visit, and we don't have very many mental health services in our rural communities where they could have that in-person visit. I think that many patients in rural communities access mental and behavioral health services using Zoom and pay for it themselves.

Right?

So the question is: As you looked at the data, was there -- you know, the disparities, was that related to differences in utilization of mental health services? Or was it across the board?

MR. WINTER: So if I could just clarify, you're asking whether the disparities -- the differences between use of telehealth by urban versus rural residents, was that related to differences in the use of tele-mental health?

MS. BARR: Yes, yes.

MR. WINTER: Okay. I don't know offhand, but I
can certainly drill down and look into that.

MS. BARR: Thank you. I would really appreciate that.

Ledia, I think I -- you know, I have been very confused about this, so I appreciate you saying this again. You have to see them in person for mental health, but you don't have to see them in person for regular visits, right? And that's the current standard today?

MS. TABOR: That is the -- well, and I'll add another kind of dimension to it. There is what's during the public health emergency versus what's after. So the Consolidated Appropriations Act of 2021 made the tele-behavioral health services permanent, not requiring -- they took away the originating site rule requirements for the remainder of the PHE as well as for, you know, beyond the PHE. And that does per the law require an in-person visit six months beforehand and now, per CMS regulation, within a year after that telehealth visit.

Then the second thing --

MS. BARR: Okay, so -- go ahead.

MS. TABOR: Like E&M visits outside of rural areas without originating site that are being allowed
MS. BARR: Got it. And so one of the things I'm sure that MedPAC is considering is whether or not -- you know, what sort of policies would be appropriate after the public health emergency related to E&M visits. And I think it's very important to consider this whole in-person thing when you're dealing with large geographies and issues with access to care.

One of the concerns that we have related to the ACOs is loss of attribution due to providers doing annual wellness visits to Medicare patients, you know, which can be very profitable and then can result in attribution. Have you seen any -- so it is a particular concern of how these telehealth visits could change attribution. Have you seen anything related to that at all?

MS. TABOR: It's not an issue that I've looked into, but we can loop back with our ACO team and also our MA team for that as well.

MS. BARR: Got it. When you're saying that 95 percent of these visits are with their existing provider, that means that they saw that provider prior to the public health emergency, they again are tied to the public health emergency.
health emergency? Is that what you --

MR. WINTER: It could be. So an established --

the definition of an "established patient" is whether the

same clinician or someone in the same specialty in their

practice saw the beneficiary within the prior three years.

So they could have seen them, you know, three months ago
during the -- after the PHE started or two years ago before
it started.

MS. BARR: Okay.

MR. WINTER: We'd have to do further analysis to
differentiate. And, Lynn, I'm sorry. Your first question,
I actually do have some information about that. It's on
page 34 of the paper. We looked at the share of tele-
behavioral health services received by different categories
of beneficiaries, and there's a table there on page 34, and
the bottom two rows looked at urban beneficiaries versus
beneficiaries in rural areas. And the urban beneficiaries
were more likely to receive at least one tele-behavioral
health service, and they received on average more tele-
behavioral health services per beneficiary than rural
residents.

MS. BARR: Yeah, I --
MR. WINTER: So the disparity -- sorry.

MS. BARR: Got it. I did see that, Ariel. I was just wondering if that made up the -- if that made up the bulk of the disparity between the two populations, because it was a significant difference, and so I just wasn't able to interpret from that what was the impact on behavioral mental health services.

MR. WINTER: Yeah, I don't think it --

MS. BARR: And, again, if there's something we could be doing about -- I'm sorry?

MR. WINTER: I don't think it was the bulk of the difference, but I can get you some more precise numbers.

MS. BARR: Thank you.

MS. KELLEY: Pat, did you have a Round 1 question?

MS. WANG: I did, and my Round 1 question is just very basic, because I'm really confused now about behavioral health. Would you mind just going through one more time before the public health emergency what the rules were and then during the public health emergency and the current view? And don't hesitate to say a few more words about the significance of an originating site requirement.
What does that really mean?

MR. WINTER: I can start walking through it, and we can --

MS. WANG: I apologize because you've been talking about it.

MR. WINTER: No, this is a good question because the policy changes are very confusing, and I often struggle to keep up with them myself.

Before the PHE, only beneficiaries in rural areas could receive any telehealth service, with certain exceptions which I won't go into right now, and they could only do so if they went to what was called an "originating site," which would be like a hospital, an FQHC, or a physician's office, and while they were in that originating site, they could communicate with a clinician in a different location, called a "distant-site clinician," and receive, in this case, a behavioral health service, psychotherapy or psychiatric evaluation, something like that. And that was very limited, and they were a very small percentage of beneficiaries who got these telehealth services before PHE began at the end of March of 2020.

So, under the PHE, the rules about -- the rule
that only beneficiaries -- that beneficiaries could only
get telehealth services in a rural area was temporarily
suspended. So they could get these telehealth services in
urban or rural areas, and they no longer have to be an
originating site. They could be at home. They could be in
the office. They'll be anywhere. So that's the case
between March of 2020 and, I believe, the end of 2021.

Beginning in 2022, as I understand it -- and
Ledia will correct me if I'm wrong -- they have to -- if a
beneficiary wants to get a tele-mental health service from
a clinician, they must have been that clinician in person
in the prior six months for a tele-mental health service or
another clinician in the same practice, in the same
specialty.

But that rule, that policy is in effect for -- is
in effect for the long term. It doesn't change. It
doesn't go away after the PHE, and that beneficiary can be
at home, and they can be in urban areas.

MS. WANG: Okay, okay. So we shouldn't view that
in-person requirement as a substitute for the originating
site, or do you think that -- was that -- I think one of
you is nodding, and the other is shaking their head. I
MR. WINTER: No, that's a good question.

It's not technically a substitute. It's not the same thing because they can get the tele-mental health service at home. They don't have to be in a hospital or an FQHC or a physician's office, but it's kind of a parallel - I think the intent is parallel.

The point of the originating site, part of it was to kind of limit excessive use, inappropriate use to constrain volume, and I think that's the same intent of requiring the beneficiary to see the clinician in person first before they get a telehealth service.

There are some others of the rationale too, which is that to make sure that the bene has an established relationship with the beneficiary -- I'm sorry -- the beneficiary has an established relationship with the clinician before they get behavioral health or telehealth, but part of the rationale is to kind of tamp down on volume growth.

MS. WANG: Okay. It's just interesting because I could see where the originating site allows more access than the in-person requirement because going to your local,
whatever, facility, if there are no psychiatrists in a
hundred square miles of where you live, you can still do it
just by traveling to your local hospital. The in-person
visit seems to me to have a bigger constraint on access.
I was going to ask whether you could drill down
more on access to psychiatrists in particular who are in
such short supply for all populations because they tend not
to take insurance, period, much less Medicare, and whether
you were able to detect any greater access to MDs,
psychiatrists in particular.

MR. WINTER: That's a really good question. It's
something we're beginning to look at and will continue to
look at.
And one wrinkle I'll add to what I said earlier
is that this rule that the beneficiary has to see the
clinician in person within six months of the first
telehealth visit does not apply -- I don't believe it
applies to beneficiaries in rural areas. They're not
subject to that in-person visit requirement.

MS. WANG: Gotcha.

MR. WINTER: But after the PHE ends, they will
have to go back to the originating-site requirement.

MR. WINTER: It applies differently to benes in rural areas. That's the best of my recollection.

MS. WANG: Okay. Really helpful. Thank you so much.

MS. KELLEY: Lynn, did you have a follow-up on this question?

MS. BARR: Yeah. I just wanted to make sure I understood what happened in -- what's going to happen in January of 2020, assuming the PHE ends. Then there will not be any more telehealth for non-mental health visits that have the patient's home as the originating site? It's only behavioral and mental health as of January? Is that right?

MR. WINTER: That's correct, in addition to beneficiaries who are receiving treatment for substance use disorders and a few other categories like telestroke.

MS. BARR: So no more telehealth to the home when this is over?

MR. WINTER: After the PHE ends, unless Congress makes a change or CMS makes a change.
MS. KELLEY: Okay. Paul, I think you had a Round 1 question.

DR. PAUL GINSBURG: Yes, I do.

I remember at a Commission meeting about a year ago, many of us were quite concerned about the potential for beneficiaries going to telehealth companies for services to fragment medical care, and even long term, maybe undermine the viability of the brick-and-mortar practices. And it seems like based on your survey of telehealth companies, at least the ones you chose, this Medicare fee-for-service is really not one of their objectives, that their business is on working for insurance companies and some provider health systems for some large employers. Does this mean that we can conclude that we should put that aside and it's really not unlikely to be a significant issue, or are there things I'm missing?

MS. TABOR: I will say that from what we heard; I don't personally have the concern that telehealth companies will fragment primary care in the near future. I mean, I don't have a crystal ball, and it's something that we can kind of keep our eye out on. But based on what the companies said, "We've got enough to do with our commercial
clients, that Medicare fee-for-service doesn't seem like the opportunity for us right now." So, unless that changes, I'm not too concerned.

DR. PAUL GINSBURG: Thanks.

MS. KELLEY: Betty, did you have a question on this?

DR. RAMBUR: Yes. I just had a brief question. I want to make sure I understand this.

So you interviewed five, and four of the five indicated that they were not interested in the Medicare fee-for-service, correct? So I was curious how representative those five are of these companies because if that, indeed, is the case, if that can be generalized more broadly, it really changes the dynamics.

MS. TABOR: So I will say we scanned the current literature, you know, news articles, kind of trade press quite a bit over the past year, and so there were a number of articles that were interviewing vendors about the same issue. And that's how we identified the one that was billing fee-for-service, and we actually spoke with them several times, and that's where we learned that kind of their strategies have changed over time when they hadn't
seen the volume picked up that they thought was potential.
And then we were even able to talk to a company that per
this industry press article said, "We're thinking about
fee-for-service. We're gearing up for it." Then we talked
to them again this summer, and their story has changed,
again, saying, "We've got enough to do kind of with our
commercial clients there."

I will say we spoke with the majority of the key
players in this. There are a number of smaller telehealth
companies that we didn't speak with. We didn't speak to a
couple, but we've covered kind of major players.

MS. KELLEY: Okay. That's all I have for Round
1. Shall we move to Round 2, Mike?
DR. CHERNEW: Absolutely.

MS. KELLEY: All right. I have Jonathan first.
DR. JAFFERY: Thanks. Thanks, Dana, and thanks
so much, Ariel and Ledia. This is a great chapter. I'm
really glad we're doing more of this and thinking about
this, this key question you have about collecting more data
on audio-only visits.

When we first started these conversations, I know
there was a lot of concern about having prolonged ability
to use audio-only visits. I think there's a lot of momentum going into it, that that was something that that would go away or we shouldn't think about it, that it was suboptimal. I've always been concerned about that. So I really do want to collect this data and understand a little bit better. I think that's really important.

I can share some of my own experiences as somebody who really tried to do a lot of telehealth visits, both audio-only and audiovisual, and as somebody who's got a practice that is predominantly chronic disease and also has a lot of lab-heavy type of care. I think it's actually been really helpful for me to connect with different patients that had trouble getting into the clinic or it's just a burden overall in a number of ways. They have to take off work, or their family member or their kid, usually their daughter, has to take off work and things like that, and they may have limited technology to manage, either the access to it or just sort of the capabilities to manage the visual part, the video part.

I think that Dana's question about how much of this care falls into those categories, I recognize, Ariel and Ledia, that you were just sort of lifting some examples
based on some of your focus groups, but I do think it is probably worth looking at that a little bit more specifically and recognizing that those categories are a bit different. So procedures was in there, and it's pretty clear that you're not going to get skin biopsy through a virtual visit.

But labs are a different beast, to Larry's point. We often order them afterwards. My clinic site doesn't actually do routine labs, and so that's really a non -- it's a separate issue, and if somebody cannot travel 30 minutes but then get labs later or beforehand, 5 minutes away from their home, that could be a huge advantage.

I mean, the biggest thing, going back to our most recent conversation this afternoon, is about the equity piece and disparities. I don't want to lose the thread of that.

And then, finally, going back to our first discussion this morning, the notion of mandatory advanced APMs, two-sided ACOs, or particularly if we've got capitation, some of these issues start to go away. The fraud issue maybe doesn't go away, but it's a little bit -- or maybe it's a lot less to worry about if the providers
are actually accountable for the total cost, and I think about this in a number of ways where we're talking about putting new innovations.

One of the great things, great opportunities about ACOs is the possibility of providers being more innovative in space, in these spaces, whether it's telehealth or putting in, you know, providing air conditioners to folks with asthma, to address social determinants, or doing more home-based care. So I think the more that we can think about that, tying it to the conversation this morning, might be an important thread as well.

So, anyway, really appreciate digging more into this, and again, getting more data on the use of these is, I think, going to be crucial for these conversations going forward. Thanks.

MS. KELLEY: Stacie?

DR. DUSZETZINA: Thank you. A wonderful chapter, and I think this is such an important area, so thank you so much.

I will say fully endorse additional modifiers to be able to better capture where audio-only visits are
1 happening. I think that we should absolutely do that
2 because I do think it's really important for thinking about
3 people's access to these services.
4 Following up on some of the other points that
5 have already been made, I do think the audio-only and
6 rurality access to technology question is a big one.
7 I could tell -- there was a table in the chapter
8 that tried to tease apart audio-only versus all telehealth,
9 and you could see there was a pretty big gap in any
10 telehealth between rural and urban. It looked similar in
11 the audio-only, and that to me kind of suggests if we don't
12 compensate providers similarly between those two, we may be
13 in a bind where people living in rural areas are at a
14 disadvantage, maybe because they just literally cannot have
15 a video going. So I think we should absolutely try to dig
16 into that issue on who is using audio-only and these areas
17 where there's no broadband access, for example.
18 Also, I think that the data on the use of
19 behavioral health services is really quite stunning. These
20 are services that I think that generally Medicare
21 beneficiaries underuse, and I am all for making it easier
22 and not harder to access those services. I thought a lot
about the access to behavioral health, not just for
Medicare beneficiaries but for many people who are a bit
resistant to seeking care, and the idea that we can
courage that by making audio, video, or audio-only
options available, I think is a really good thing.

So I'm a little bit disappointed by the in-person
requirement, partly because it's really hard to find a
person to see you. So I think it is a real challenge to
add that particularly for behavioral health.

On the other hand, I know this is an area where
we're worried about fraud. So I think the same is true for
other medical services that people see. So it seems just
maybe inequitable that the six-month in-person visit is
tied to one type of service and not to the other, and I
think that we should really think about the fairness of
that and maybe make it easier for people to receive
behavioral services.

I guess the only one other thing that I was
curious about -- and this was sort of a small note in the
report -- you all did such a great job asking about how
this was working for patients and for physicians, and there
was a component in there about the physicians' time burden.
And I wondered a little bit about the patient time burden, and specifically, are beneficiaries just stuck sitting there at a computer, waiting for the physician to show up, or is there something that's really maybe more convenient for them? So I'm just curious if you had learned anything about the burden on the beneficiaries' time. I guess you might think that it would be much simpler because you're not having to drive to the office and sit in the office waiting room, but if you're sitting there at your kitchen table or whatever for an hour waiting for someone to join a call, that seems like a burden as well.

MS. TABOR: That's a good point, Stacie, and I can just respond to that. We did hear mainly from beneficiaries about the convenience factor that like not having to pay for parking, sit in traffic, depending on where they lived, and also kind of having to take the time to go to the office. And we did hear a couple kind of accounts of having to wait for the physician in front of the computer, but they didn't seem like it was an hour. It was, you know, perhaps 10 or 15 minutes. You know, and that's qualitative kind of small sample, but that's what we heard.
DR. DUSETZINA: Well, that's great to hear.

Thank you.

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

DR. PAUL GINSBURG: Yeah, just on Stacie's point. As someone who has had some televisits, yes, the patients do wait on their computers in the same way that they wait in the office for the physician to show up. I personally found it much preferable, because I could do other things on my computer while I was waiting. And I don’t think -- and actually, the waits work. On this small sample they weren’t very long.

DR. DUSETZINA: Yeah, and just as a response to that, I think that here is where the capability of a person to use the technology, if they're audio-only or they're not very computer literate they're not multitasking with their email necessary, so they feel constrained to be sitting in the same spot, at a desktop computer, versus, you know, those of us who have the visit pulled up on an app and are busy doing other things. So I think that maybe that experience could be variable, based on different levels of technology, literacy, or, you know, multitasking. Good
point though, Paul.

MS. KELLEY: Brian.

DR. DeBUSK: First of all, I'm glad to see that we're following telehealth closely. Just a couple of points here. I do think that there's benefit in maintaining the beneficiaries' home as an originating site. I hope we continue that policy; I think particularly in behavioral health. But I think that it's beneficial to beneficiaries who have maybe some socioeconomic risk. I think there's a great equity, or opportunity to improve equity here.

And along that same line, I hope that we maintain, in the claims information, the distinction between the originating site being the patient's home versus the originating site being a provider's office, because I think that's going to affect some of their downstream recommendations of whether to use facility or non-facility rates for the claim itself. So again, I think the beneficiary's home is a wonderful originating site. I hope we preserve the information on the claims so that we can collect it.

The other thing that I was really encouraged to
see that the direct-to-consumer health companies are largely focused on health plans and large employers. Paul made this comment earlier. You know, the idea of a telehealth non-bricks-and-mortar company calling on Medicare beneficiaries, it looks like that's largely a non-issue.

I think the opportunity here, though, would be for maintaining this requirement for some periodic, in-person visits. If I heard Ariel correctly, I believe we don't require those in-person visits in rural areas, which I think is good policy, but I do think this idea of having some type of gating mechanism for some type of breaker, just to make sure that we don't have excessive use, and I think the in-person visit is an excellent way to do that.

The other thing I wanted to mention, I do think a claims modifier on the audio-only visits for all the claims, as opposed to just the three CPT codes that support it now, is good policy. It would be nice to be able to differentiate those two, because again, I think that the people who are at the most socioeconomic risk are probably the ones that would benefit the most from the audio-only technology as well.
And my final comment, I just want to support Jonathan's comment that, you know, in a world where fee-for-service has two-sided risk, a lot of our telemedicine concerns go away. So those are my comments, and thank you.

MS. KELLEY: Dana.

DR. SAFRAN: Just a couple of quick comments. One was just an observation that, you know, this conversation about the increased access to behavioral health I think is really striking and a big part of what I was excited about in this chapter. And, in particular, I noticed, on Table 5, that there was near parity in racial groups' use of tele-behavioral health, and that seemed like an important success that we shouldn't go without mentioning. So I just wanted to highlight that here.

I also saw really high use of tele-behavioral health by duals, and that was really interesting too. I probably wouldn't have predicted that without seeing those data.

Two things I'll mention that I didn't see in the report, and I apologize if they were there and I missed them. One was there wasn't any reference to state
licensing issues and how those would need to be addressed. And I think those are so important and such a really important barrier, that I just wanted to call that out.

And then despite a lot of conversation over the summer meetings about some of what's come up today around the payment model matters and concerns about overuse of telehealth in fee-for-service, et cetera, I didn't see anything in the chapter that kind of addresses the potential financial impact of permanently expanding access to telehealth without, you know, broadly, not restricted to Medicare Advantage or ACO or other total cost of care accountability models, whether to pay at the same rate, which I know Larry has been raising. And I think those are really important issues.

And I know earlier we had quite a bit of conversation, that I think was important, later this year, about how do you get the timing right for moving telehealth price down from parity with in-person visits so as not to have it become inaccessible or no longer an option for beneficiaries, but at the same time not keep it paying at the same rate for so long that we're overpaying for services that really can be delivered at lower costs?
So I just thought, unless I missed it, that it would be valuable for the chapter to have some treatment of those important issues. Thanks.

MS. KELLEY: Larry.

DR. CASALINO: Thanks, Dana. Yeah, I couldn't agree more strongly about we want all audio telehealth to be identified as such. So that's an easy enough thing to do, and CMS should do it as soon as possible, in my opinion.

And I agree with all the people who are saying that, you know, there are organizations that are fully capitated or provider organizations who are taking a lot of risk, and part of the point of giving people a lot of risk during full capitation is they will figure out then what are the best ways to deliver care, what works, what is most efficient. And they will figure out the proper mix of services, from physicians or other people, from audio to audio-visual to in-person, much better than fee-for-service. But for now we are stuck with fee-for-service and probably will be for quite a while.

So I do want to just highlight again -- and I had thought it would be too ambitious to put this in whatever
gets published next, in the text, about telehealth -- but
the sooner you guys can devote more attention to this, the
better, I think, to relative payment rates. And so just to
say a little bit about that. Paul Ginsburg raised the
issue of damage to bricks-and-mortar providers on
fragmentation and damage to bricks-and-mortar providers
possibly when care is provided by telehealth-only companies
or call them Teladocs. And I agree that those are both
contcerns. But, you know, then there's the other
fundamental principle of not paying more for service than
the service costs, or not paying a lot more for the service
than the service costs.

The fact that the main Teladocs are not planning
to market directly, except for one of them, to Medicare
beneficiaries now is not an issue now. I don't think we
should assume that that's never going to change. That
could change as a result of one meeting in one of those
companies. And yet the payment rates and the relative
payment rates, by site of service and by what kind of
organization is providing the service, they are going to be
set now and they will be hard to change if this becomes an
issue in the future. So I do think the relative payment
rates are an issue right now, regardless of whether Teladocs mostly are targeting Medicare beneficiaries or not.

Also, I think if the payment rates are equal for in-person and telehealth, and equal for bricks-and-mortar versus Teladoc, then it is going to be more tempting for some more fly-by-night companies to come in and start marketing to Medicare beneficiaries. There's more potential for abuse.

So my own feeling, again, with the principle being let's pay to cover costs, then I think if we don't go back to originating sites, which is kind of nuts, I think, then the facility fee is not really relevant as a measure of cost, and some of the things would have to be thought about. My take on it, just from common sense, is that in-person should probably be reimbursed higher than telehealth, because I think, again, the costs are higher. You need staff on site, you need an exam room, and so on and so forth. The costs are probably considerably higher.

Telehealth-only, really what you need is just the clinician and the cost of the telehealth service.

So I agree with Dana that the timing of this is
tricky, but I would think that in-person would get paid more than telehealth, regardless of who is providing it. And then I would think in terms of who is providing it, bricks-and-mortar do have higher costs than Teladoc companies, probably a lot higher. We need to have bricks-and-mortar providers. And so I would think that bricks-and-mortar would get paid more than Teladoc for telehealth visits.

And then the last issue I think in relative payment rates, and to me the most difficult one, because the first two, to me, are -- others might not agree but to me they're pretty much no-brainers -- is you pay for audio-only at the same rate as audio-visual. And this is where principles conflict, I think. If we used the principle of what's the cost of providing the service, I think it probably is somewhat higher, maybe not a great deal higher, for audio-visual versus audio-only, but probably not a great difference.

But as several people have said, there may be disparities in who is best able to use audio-visual as opposed to who can use audio. And so if we really did pay significantly more, Medicare did, for audio-visual than
audio-only, that would add a principle of paying what
something costs, but it could increase disparities, which
is another one of our principles. So I think that one
requires some careful thinking.

In any case, I think the sooner you guys can get
to this, you won't make any friends in doing it, probably,
but I think it's a really critical issue about a service
that's going to be very basic to the health care system
going forward, I'm quite sure.

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

DR. PAUL GINSBURG: Yes. Yes. I agree with
Larry that this is something that should be a priority for
staff to work on so that the Commission can get its ideas.
And what I'm thinking about is that assuming it's a world
of mostly brick-and-mortar practices, it's one of these
situations where in specialties where telehealth works,
that there will be kind of a steady state where a brick-
and-mortar physicians will spend some of his or her time on
telehealth and some on in-person visits. So that even
though an economist might first thing, well, we should pay
marginal cost for each, you realize if we paid marginal
cost for each the average cost might not be covered. So this would kind of push us closer to paying more than the facility fee for the telehealth visits, and maybe almost as much as the in-person visits. It's just not a simple thing, because assuming telehealth will be a more than trivial part of a brick-and-mortar practice's business.

MS. KELLEY: Betty.

DR. RAMBUR: Thank you very much. I am pleased that we are continuing to address this important issue, and as other have said this will continue. A few brief thoughts from me.

I have been a supporter of audio-only, because of my concerns about broadband in rural areas, and I'm very supportive of having a modifier so that we can identify, for example, which services are replacement versus additive, which ones might be causing downstream additional use, and we could really start to have some empirically based payment here.

I just also want to underscore, even though we're talking about rural and distance in broadband, distance can also be an enormous challenge in inner cities, and it disproportionally falls on the poor often.
I support the beneficiary's home as an originating site, and there is, in my experience, an enormous family burden often for getting an elder in for a visit, and to the extent that those can be done at home, it's a great advantage. And I say this as a daughter but I also see many of my peers struggling with managing what it has meant, prior to telehealth, to get people to appointments that probably could have been done either audio-only or audio-video.

My sense is that audio-video and audio should be reimbursed the same, because it's possible that some of the audio-only visits actually have other kinds of complexities, and I do think it should be lower than face-to-face but not so low as to disincent providers from using telehealth appropriately.

I have to give a shout-out for Dana for thinking about the licensing issues cross-state. And just briefly, a few years back, before COVID, a colleague and I did a study on the nursing workforce in the state of Vermont, and almost one-fifth of the nurses reported telehealth as their primary practice, and they had licenses in as many states because it was not a compact state. So this is going to
take some attention.

And then I just wanted to underscore what was said by Jonathan, Brian, Larry, and perhaps others. If we have an all-inclusive total cost of care model then we can let those delivering the services, and their patients, figure out what has the best outcomes and the lowest cost. And so I do think that these conversations are tied together.

So thank you all for your hard work and wonderful comments from the other Commissioners.

MS. KELLEY: Jon Perlin?

DR. PERLIN: Yeah. Let me just add my thanks for a terrific report. I'll be very brief. I think most of the points have been made. I think this point about health equity has to be succinctly and directly addressed as digital health equity. And I've got to say, I think that's not unrelated to home as the originating site. Betty has just very eloquently spoken to the reasons why that may be challenging in rural, urban, and other situations.

Second, on the facility parity aspect. It's clear there are overhead costs that are not going away. I think modifiers will help us understand how telehealth
becomes part of continuum of services.

Finally, I can't believe that Betty didn't beat me to this comment. I think there's something that's really interesting in the data presented in the chapter about who is actually providing the mental health care. It's licensed clinical social workers. And I think it's important that they have the authority for reimbursement under these programs, because that's frankly 95 percent of who is providing the services. Obviously, this is also part of the utility of working in the context of a larger health program. Thanks.

MS. KELLEY: Lynn, did you want to jump back in here?

MS. BARR: Yeah. And I'm still struggling, trying to understand the policy, and I'm supposed to understand this for a living.

So my understanding of the physician fee schedule is it did extend telehealth for E&M and other types of services, non-behavior, mental health through 2023. And what I don't understand is whether or not an in-person visit is required, but did I -- I mean, that's what was in the physician fee schedule, right?
MS. TABOR: Perhaps also -- I'll speak for Jim, if it's okay. We can talk to you offline if this is helpful, as far as how we're interpreting the rules, but I think what you're thinking of is that there was a group of codes called -- that are on the allowable telehealth services list, so during the PHE and then after the PHE with the originating site requirement, can actually be done by telehealth, can be billed by telehealth. And there's some of those services that were not on the allowable telehealth list prior to the PHE but were added during the PHE, and now there's kind of thoughts that, hey, now that we've been able to do this, we think there could be clinical benefit in continuing to allow telehealth to cover physical therapy is one of the examples.

And so now CMS has said we'll continue to cover those until the end of 2023 to continue gathering evidence about its potential effect on cost, quality, and access.

MS. BARR: Got it, and there have been no in-person requirement. Okay. Because annual wellness visits is on that list, right, as one of those extending -- and that it concerned me because annual wellness visits is a main driver of attribution to ACOs. So I'm trying to
understand how all these things fit together and could potentially -- if there's no restrictions on who can do them, then I will see Teladoc doing these really quickly because they're super profitable if you're just, like, trying to get in and get out, you know?

MS. TABOR: Well, although -- to one of your earlier points, although there is no in-person requirement, there is the originating site requirement. Let's say the public health emergency ends this January.

MS. BARR: Mm-hmm. Oh, so then --

MS. TABOR: So that means we go back --

MS. BARR: There won't be -- oh, so it will be back to the originating site. Okay. Thank you.

MS. TABOR: Exactly.

MS. BARR: All right. I'll call you.

MS. TABOR: Thank you.

MR. WINTER: And the rules are completely different for behavioral health services?

MS. BARR: Got it.

MR. WINTER: It's more complicated.

MS. BARR: Got it. Yeah. Well, I think people were reading the behavioral health and sort of
extrapolating that to a lot of the other policies, and it just wasn't very clear.

Okay. Thanks.

MS. KELLEY: Mike, that's the end of the line.

DR. CHERNEW: That just sounds so final, Dana.

MS. KELLEY: It's the end of the day as well.

DR. CHERNEW: Yes. We are getting to the end of the day, and we will come back and have a good day tomorrow.

Let me give a little bit of a general summary and state where I think we are. The first one is there's obviously a ton of interest in this just as a general point. There's a lot of interest in the need for access to behavioral health.

As the discussions we had last time, last cycle, we constantly struggle with the balance between access to things that we know are good and important, overall, and because of disparity, equity issues, and concerns about program equity.

I will say -- and I haven't gone back through the transcript -- the tone of this discussion was very different in many ways in terms of the emphasis of that
balance than it was before, but that's a little bit beside the point.

There was a lot of discussion about how to set the right prices, just so you know. We are not, this cycle, planning to come up with recommendations around prices for telehealth services.

I'm looking at Jim in the corner of my screen. I see a nod there.

So, just so you know, we're not going to come back later this cycle and answer any of the Casalino questions, surely to Larry's dismay. But, in any case, that doesn't mean we're not thinking about them. It's mostly a timing issue, and to wait, what happened last time is we had said that we are going to wait for the evidence to play out to understand what's really going on. This chapter and the material in it is going to be integrated to other things as we continue that monitoring process. That includes, for example, how things interact with APMs and a number of other issues that arose.

Jim, do you want to say anything on that particular point?

DR. MATHEWS: No. Nothing more to add.
DR. CASALINO: And, Mike, just to be clear -- just to be clear, I wasn't asking for recommendations right away. I was just asking that the staff work on this in terms of relative prices, so that we can move --

DR. CHERNEW: And we will do that.

DR. CASALINO: -- forward on these recommendations at some point.

DR. CHERNEW: That's right. And some of the things where I think there's certainly a lot of consensus, like getting identifiers for audio-only, that may work into one of the January-type recommendations of things that we're doing. So stay tuned for that part. I think there's probably a lot of consensus in that data-gathering point.

I will say a few things that -- had I been in a different role, I would have said in Round 2 comments, but I haven't -- the one that I'm most interested in is some of these services were previously being delivered but not necessarily being billed. So you could have called up your doctor and asked for a bunch of things, ask questions, and when we move them to being billed and as they grow, I think it's untenable to not bill. As doctors do more and more of
their services delivered this way, it's untenable.

We really have to think about how they get compensated for that. That creates a number of challenges. It creates beneficiary copays. You run the risk to the patient who had called up their doctor before and asked questions about a range of things. Now that's getting billed to the visit. There's a copay that might be generated. So there's some complexities with how that plays out when we take previously services that were fitting into the nooks and crannies of medical providers serving their patients and now begin to bill them.

I'll defer to Betty about how this is being handled by the vast majority of to her providers in terms of how they handle this issue, but I worry about that interaction and how it plays out, and I worry about what will happen when there's other types of communication, not audio and video, but there's asynchronous types of communication. There's more complicated email exchanges with people. We are really changing. I think the pandemic accelerated a growing technological transformation of how certain types of care are being delivered, and our payment models are simply not well suited to deal with a lot of
those things.

And, in the past, when it was small, it kind of fit into the system in this sort of part of what it meant to be a patient, and now it's becoming much more formalized, which is raising all the questions, Larry, that you raised. And, I think that is a challenge.

But the broader point -- that wasn't a summary. That was a comment. The broader point here is this is such a complicated area, and it's moving so quickly that where we are now in our sort of Commission activity is tracking, collecting data, thinking about what data we need, analyzing that data. We had a set of policy options before. We will undoubtedly at some point revisit those, but for now, I think it's really useful to hear your comments about what's happening and your concerns and where you think we should go. So I have found all of that quite useful.

I think I will pause there to see if there's any parting thoughts.

Actually, Brian put a note in the chat which reminded me of one other point that I had on my list, which is I think we're going to need to also begin to track
services ordered through telehealth visits. We had a long conversation about this before. There's concern that it's not you're paying for the televisit. It's that the televisit is being used to do a whole bunch of other things.

It fits a little bit into the attribution issue that you raised, Lynn, which has long been a concern -- we had discussed that before -- and continues, I think, to be a concern when we think about that, but also a range -- Bruce did not speak at length about comments that he had spoken at length about, I think, in the past. But there's a concern that if we open things wide open, we don't know what we're going to get, and we're going to have to figure out how to track and control that. And that is challenging because of how important we acknowledge all of these services are for a whole range of beneficiaries and for a whole range of different services.

So I guess I'll pause there and see if anyone wants to add anything before we sign off for the night.

Stacie.

DR. DUSETZINA: Mike, just to follow up on that point you just made, I think collecting information on the
timing of the telehealth visits, either whether they occur just before and how close to before an in-person visit and then how quickly they're being billed just after an in-person visit could help to shed some light on these concerns about these normal conversations you might have with your physician or your care team after a visit and not being overbilled in those cases, but also the extent to which a telehealth visit ends up being "Oh, you need to come in person right away."

So do we want to be paying for both of those things or paying differently when the visit is a stand-alone service outside of this window of time? It would be great to have data collected on that, and especially, as we start to enter a more stabilize period where in-person visits are more -- have a regular occurrence for people again.

DR. CHERNEW: Yes. And, as an side, there's a whole range of visits apart from telehealth where we've bundled services and follow-ups as part of the actual service, and I think this becomes complex.

The other challenges, of course, is when you see telehealth used as an additive service as opposed to a
substitute, which you will see a lot of, it is unclear in many cases. Are we solving a problem of underuse where there were groups of people that were not getting enough access, and we have now solved that, which is part of the great benefit of telehealth, or are we adding additional services that really weren't needed, but now for convenience and for whatever other reasons, we are delivering services that really weren't necessarily providing the value that they were needed?

I don't know the answer to many of those questions. We will continue to monitor this as we go forward and continue to think about other policy options as we continue to gather all of this data.

And I think it was you, Larry, who said we will try our best not to be simply backward-looking but to anticipate policies looking forward, because just because we haven't seen something doesn't mean that we won't see something.

Okay. So, again, thank you all today. Thank you all today for coming. I learned a lot, and I think we had three very important sessions. Thank you to the staff for once again outstanding work. To the public, please reach
out to us at meeting comment -- is it "comment" or
"comments," Jim?

DR. MATHEWS: Comments. Plural, with an "s."

DR. CHERNEW: Plural. "Comments," plural with an "s." Meetingcomments@MedPAC.gov. Please send us your
thoughts. We really do look forward to them, and again,
thank you, everybody for your time today. We will
reconvene tomorrow at ten o'clock. We will be talking then
about aligning payments across sites, followed by a
discussion of Part D in long-term care facilities.

So we hope to see you tomorrow. Thank you for
your time today, and everybody be safe and healthy. Okay.
Bye, everybody.

[Whereupon, at 5:15 p.m., the Commission was
recessed, to reconvene at 10:00 a.m., Tuesday, November 9,
2021.]
MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Via GoToWebinar

Tuesday, November 9, 2021
10:01 a.m.

COMMISSIONERS PRESENT:

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DR. CHERNEW: Hi, everybody. Welcome to the second day of our November MedPAC meeting, a rare and special Tuesday meeting. We have two great topics today, and the first one we're going to jump right into is about aligning fee-for-service payment rates across ambulatory settings or known often for short, "site-neutral payment."

Dan, I am turning it over to you.

DR. ZABINSKI: Thank you, and good morning.

To start, I just want to say that the audience can download a PDF version of the slides for this presentation in the handout section of the control panel that's on the right side of your screen.

All right. From 2012 to 2014, the Commission evaluated the effects of aligning payment rates for services provided in hospital outpatient departments with payment rates for services provided in physician offices.

Today we will present an analysis that builds on the Commission's previous work, with the most important new feature in today's presentation being the addition of services provided in ambulatory surgical centers.
We also want to be clear that we're revisiting this topic of site-neutral payments to get sense of how we want to proceed on this issue, and we're not yet working towards any recommendations.

Fee-for-service Medicare has distinct payment systems for three ambulatory settings: physician offices; hospital outpatient departments, or HOPDs; and ambulatory surgical centers, or ASCs. And payment rates often differ for the same service among these three settings.

In particular, the outpatient prospective payment system, or OPPS, which is the payment system for most HOPD services, has higher payment rates than the physician fee schedule and the ASC payment system for most services.

These differences in payment rates across settings for the same service raises the question: Why does Medicare have these different payment rates when the same service can be safely provided in more than one setting?

The primary concern about these differences in payment rates among ambulatory settings is that they result in providers in higher-cost settings acquiring providers in lower-cost settings, then billing at the higher rates. For
example, hospitals can consolidate with physician practices and convert them to provider-based departments. Hospitals can then bill for the physician services at the usually higher OPPS rates with little or no change in the site of care.

In recent years, hospital acquisition of physician practices has led to an increase in the share of office visits, echocardiography services, cardiac imaging services, and chemotherapy administration provided in HOPDs with an analogous decrease in the share as provided in physician offices.

The Congress passed the Bipartisan Budget Act of 2015 to more closely align OPPS payment rates with physician fee schedule rates. However, the effect of this policy has been limited, as services affected by this policy constitute only about 1 percent of OPPS payments.

On this table, we show how hospital acquisition of physician practices has led to the billing of two important services being shifted from offices to HOPDs. From 2012 to 2019, the share of office visits provided in HOPDs increased from 9.6 percent to 13.1 percent, and the share of chemotherapy administration services has increased
from 35.2 percent to 50.9 percent.

And as services shift from ASCs to HOPDs, beneficiary cost sharing and program spending increase. On this slide, we have an example of why Medicare payments are usually higher when a service is provided in an HOPD than in an office and how the payment rates can be aligned across these two settings.

The service in this example is a level 2 nerve injection. The first column shows the payments that Medicare makes if the service is provided in an office. The middle column shows the payments if the service is provided in an HOPD, and the third column shows the payments if we adjust the OPPS payment rates so that the total payment in the HOPD aligns with the total payment in the office.

In all three columns, there's three payments to the physician under the physician fee schedule: the physician's work; the practice expense, or PEOPLE; and the professional liability insurance, or PLI. Notice that the payments for work and PLI are the same in all three columns. However, the PE is higher in the office than in the HOPD, making the payment going to the physician higher.
in the office than in the HOPD.

However, there's an additional payment under the OPPS when the service is provided in an HOPD that doesn't occur when it is provided in an office.

And for most ambulatory services, the additional payment under the OPPS is greater than the difference between the non-facility PE and the facility PE, which makes the service more costly to Medicare and beneficiaries when provided in the HOPD.

In this case, the middle column shows the total payment is about $701 when provided in an HOPD, while the first column shows the total payment is $256 when provided in an office.

In the third column, we adjust the OPPS payment so that the total payment is equal across these two settings.

Specifically, we set the OPPS payment equal to the difference between the non-facility PE from the first column and the facility PE from the second column, which results in an OPPS payment of $154. When we add this $154 to the total payment to the physician, the total cost of this service when it's provided in an HOPD is $256, the
same as the total when the service is provided in an office. We used this concept of the difference between the non-facility PE and the facility PE as the basis for aligning payment rates across the three ambulatory settings.

It would be great if we could just set all the OPPS and ASC payment rates equal to the difference between the non-facility PE and the facility PE from the physician fee schedule and say that we're done, but there's some important issues that must be addressed before we proceed to align payment rates across ambulatory settings.

First, some services that are provided in HOPDs can't be provided in offices or ASCs because they are not covered under the physician fee schedule or the ASC system. The most obvious of these are ED visits, critical care, and trauma care, but there's also relatively complex services such as some joint replacement procedures that are covered under only the OPPS. And these services must continue to be paid at standard OPPS rates.

Another issue is that the OPPS and the ASC system have different payment units than the physician fee schedule. That is, the OPPS and the ASC system have more
packaging of ancillary items in their payment units than
does the physician fee schedule, and we must account for
this additional packaging of ancillary items when aligning
payment rates.

And, finally, we should align payments across
settings only if it is reasonable to provide the service in
lower-cost settings for most beneficiaries. On the next
slide, we discuss how we make that determination.

We identified the services for which it is
reasonable to align payment rates across settings by first
collecting services into ambulatory payment
classifications, or APCs, which is the payment
classification system in the OPPS. The idea of APCs is
that CMS collects services that are similar cost and
clinical attributes into the same APC. All services in the
same APC have the same payment rate under the OPPS and
generally have the same payment rate under the ASC system,
and for each APC, we then determined the volume in each of
the three ambulatory settings.

When we found that offices had the largest
volume, we aligned OPPS and ASC rates with physician fee
schedule rates using the difference between the non-
facility and facility PEs, with an addition for greater packaging under the OPPS and ASC payment system. But if ASCs had the largest volume, we aligned the OPPS payment rates with the ASC payment rates, but we kept the physician fee schedule rates the same. Aligning OPPS rates with ASC rates is straightforward because the OPPS and ASC system have largely the same payment units, and ASC rates are usually just scaled-down OPPS rates.

Finally, if we found that the largest volume for an APC occurs in the OPD, we didn't believe it was reasonable to align the payment rates for that APC across the settings, so payments were unchanged in each setting.

The OPPS has 162 APCs for services, and we identified 57 APCs for which we aligned OPPS and ASC rates with the physician fee schedule rates. These APCs constitute 22 percent of the total spending under the OPPS and 12 percent of the total spending under the ASC system.

We also identified 11 APCs for which we aligned OPPS rates with ASC rates, and these APCs constitute about 4 percent of the total spending under the OPPS.

And, finally, we did not align payment rates for the remaining 94 APCs.
For the 57 APCs for which we aligned payment rates across the three ambulatory settings, most are low-complexity services, such as office visits.

More closely aligning the OPPS and the ASC payment rates with the physician fee schedule rates would reduce beneficiary cost sharing and program outlays. Under the OPPS, cost sharing would decrease by $1.6 billion, and program outlays would decline by $6.4 billion, a decrease of about 12 percent.

Under the ASC payment system, cost sharing would decrease by $70 million, and program outlays would decline by $270 million, a decrease of about 6 percent.

For the 11 APCs for which we aligned OPPS payment rates with ASC payment rates, all these APCs represent surgical procedures, including ophthalmologic, gastrointestinal, and musculoskeletal procedures.

Aligning the OPPS payment rates for these APCs would reduce cost sharing by $260 million and program outlays by $1.1 billion, which is about 2 percent of total OPPS spending.

A concern we have about aligning OPPS payment rates with ASC rates is that rural areas and some states have few
ASCs, and if hospitals would respond to the lower ASC payment rates for these 11 APCs by reducing the provision of these services, that could lead to access problems in areas that have few ASCs.

Now, so far, we've seen that aligning payment rates would have the benefit of reducing beneficiary cost-sharing obligations and Medicare program outlays, but we are also concerned that overall Medicare revenue for hospitals that serve vulnerable populations would decrease.

For all hospitals, overall Medicare revenue would decrease by 4.5 percent by combining the two payment alignment policies, but the impact on overall Medicare revenue would be greater for government hospitals and rural hospitals.

Yesterday my colleagues, Jeff and Brian, discussed policies that would be intended to ensure access to care for vulnerable populations. With the goals of their analysis in mind, we evaluated stop-loss policies that would soften the impacts of the payment alignment policies on hospitals that serve a relatively high share of vulnerable beneficiaries, using DSH percentage to identify hospitals that serve these populations.
The stop-loss policies that we evaluated included -- for the policy for which we aligned payment rates for the 57 APCs across all three settings, we evaluated a stop-loss policy that would limit the loss in overall Medicare revenue to the median decrease among all hospitals of 3.3 percent if the hospital has a DSH percentage above the median of 28.1 percent.

Then for the policy for which we aligned OPPS payment rates with ASC rates for 11 APCs, we evaluated a policy that would limit the loss in overall Medicare revenue to the median decrease among all hospitals of 0.7 percent if the hospital also had a DSH percentage above the median.

In the end, we found that 28 percent of hospitals would receive stop-loss relief under at least one of the policies, and 10 percent of hospitals would receive stop-loss relief under both stop-loss policies.

On this table, the first column shows the combined effects of both the payment alignment policies without any of the stop-loss policies for several hospital categories.

We found out rural hospitals would have a
decrease in overall Medicare revenue of 7.6 percent, while urban hospitals would have a smaller decrease of 4.3 percent. Note, though, that critical access hospitals would not be affected by these payment alignment policies because they are not paid under the OPPS.

In addition, nonprofit and government hospitals would both have larger decreases in Medicare revenue than for-profit hospitals.

In the second column, we show the decrease in total Medicare revenue if we combine the two payment alignment policies with the two stop-loss policies we discussed on the previous slide.

Rural hospitals would still have larger decreases in revenue than urban hospitals, but the difference between rural and urban hospitals would be smaller than the difference without the stop-loss policies. Also, the stop-loss policies would reduce the difference in payment decreases between nonprofit and government hospitals versus for-profit hospitals.

So, in the final column, we don't want anyone to forget about the benefits of the payment alignment policies, because beneficiary cost sharing among rural
hospitals would decrease by a greater percentage than among beneficiaries in urban hospitals. Also, it would decrease by larger percentage in nonprofit and government hospitals than in for-profit hospitals.

Okay. So far, we've shown that the potential impacts of aligning payment rates across ambulatory settings could be substantial, and with that in mind, it's important to remember the purpose of this analysis.

First, we want to address the principle that Medicare and beneficiaries should not pay more than necessary for ambulatory services.

Second, we want to reduce incentives for providers to consolidate, which typically leads to the billing of services shifting from lower-cost settings to higher-cost settings.

We also want to make it clear that the pool of money from aligning payment rates does not have to be used to reduce program spending. Possible alternatives include you could use the funds to increase the OPPS payment rates for the 94 APCs for which we would not align payments, which include services such as ED visits and complex surgical procedures. Doing this would help hospitals maintain standby capacity.
Alternatively, the funds could be used for policies to support safety-net providers.

So, for today's discuss, we'll address Commissioners' questions and comments about this analysis.

We also have two questions for the Commission to consider. First, should Medicare align payment rates across ambulatory settings, and second, how should the savings be allocated?

That concludes the presentation. Now I it over to the Commission for discussion and questions.

   DR. CHERNEW: Thanks, Dan.

   This extends a long interest we've had in basically site-neutral payment policies. There's a lot of complexities here that you raised.

   So I'm going to turn it over to you, Dana, to run the queue.

   MS. KELLEY: All right. I think Stacie had the first Round 1 question.

   DR. DUSETZINA: Thanks, Dana.

   Dan, great job on this. I had a question about defining the services. My understanding is you looked at the service and where they were most often delivered across
the sites of care in 2019, and I guess my question is, does
this kind of implicitly bake in some of the shifts inside
of care delivery that we've seen over time, particularly
thinking about some of the information provided about
chemotherapy shifting to hospital outpatient departments?

So, when you're assessing the site of care in
2019, I guess I'm curious. Where did chemotherapy end up?
Does that end up looking like it should continue to be paid
under OPPS? And maybe there's a larger question of, is
2019 the right time to be looking at this, or should we
also look at a historical perspective to think about how
services have been shifted over time?

DR. CASALINO: Yeah, the chemotherapy would, in
general, be aligned with the physician fee schedule rates.
I will add, and this is kind of an offshoot, but the
chemotherapy drugs would not be touched, as long as they
are separately paid under the OPPS, and, you know, most of
them are. So from that respect there's kind of a partial
shift for chemotherapy. The service itself would be paid
under the physician fee schedule, but the drugs would be
paid under the OPPS.

Historical, that's an interesting angle to take.
I'm not sure what to make of -- okay, are you thinking of
in terms of trying to get back to where things used to be
in terms of where service is provided, or what?

DR. DUSETZINA: You know, I think it was sort of,
maybe it's the framing in the chapter or my read of it, of
trying to determine, you know, where services could safely
be provided. So like pulling from how services are used or
built across these different settings for determining
whether or not they could be provided in any of those
different settings. That was kind of my read of the way
that services were being selected. And if that's the case,
it seems like if we know that the site of care has shifted
for some services over time, that doesn't change maybe --
maybe it does. It probably depends on the service. But
maybe they could have been delivered in a different site of
care but just that practice has changed or site of care
shift has happened, so you're seeing them not as being
provided as often in some sites as others.

I don't know if that helps to clarify, but it's
really kind of about if the question is can they safely be
provided in any of these sites of care, we might to take a
longer time horizon than just looking at 2019, to make that
DR. MATHEWS: If you don't mind I'm going to jump in here, just to make a couple of points. One, Stacie, you are correct. To the extent we are looking at volume by setting in 2019, that does include prior waves, for lack of a better word, where the setting has shifted from the physician office to a hospital outpatient department. Cardiology and orthopedics come to mind as having done that migration in succession.

And so as an analytic exercise, it would, at least theoretically, be possible to look at the distribution of services in a prior year to determine which setting had the most volume and make a determination of payments from a prior year. So that's conceptually something we could do.

But another point I would like to make sure punches through here is that when we are talking about these shifts in setting, in many instances the shift in setting is represented by a change in the sign over the door. It is not that services have migrated from individual clinician offices wholesale to a different pile of bricks and mortar called a hospital outpatient
department. It is that the hospital has purchased the physician practice and put, you know, St. Elsewhere, you know, offsite outpatient department on the physician practice. And that's something to not lose track of as we are using terms like "shift in setting." In many instances, this shift in setting is in name only.

DR. DUSETZINA: Yeah, and I completely agree, and I think that's what I'm concerned you might miss by bringing in 2019, specifically is this kind of slapping a new label on the exact same practice, physician building, et cetera. So I think that there could be something to think about there, specifically around, you know, how do we define this package of services.

And one of the other ways, I was thinking about it, would be maybe there's a threshold where, you know, like if over a certain percent of the services are provided in one setting then we'd count it.

But thank you for that clarification, and I'll let others jump in.

DR. CHERNEW: There are several comments on this point. I don't know if that exchange answered some of those questions, and we do have a somewhat longer queue to
go through. But, Dana, if you want to go through the on-
this-point set of questions and then we'll come back to the
queue.

MS. KELLEY: Okay. Larry.

DR. CASALINO: Yeah. Thanks, Dana and Michael.

You can take me out of the Round 1 queue, Dana, because I
think you raised exactly the point I was going to ask a
question about, and I think she expressed it very well, and
Jim's point just kind of put another nail in.

But I just want to emphasize again, let's suppose
that hospitals began to employ all cardiologists, or 90
percent of cardiologists. Then all or 90 percent of
echocardiograms would be done in hospital facilities,
right. And so, therefore, we'd say, oh, they should be
paid at the hospital rate. And that clearly is just wrong.

It has nothing to do with safety. It has nothing to do
with anything except that Medicare changed the payment
rates for these things and, therefore, you could do much
better as a cardiologist being employed by a hospital than
not.

So I think Stacie's idea is a good one, and the
question is really how to implement it, and I would be
interested, Dan, if you have any thoughts about that. You know, I mean, in principle, to really do this right, it's one that's going to use volume as the criteria. One would have to go back to a year before wage consolidation, and that could mean looking back quite far, which doesn't feel right, although I'm not sure what's wrong with it. But I think it would be more right than the current way of doing it.

So I think this does bear more thought. I'd love to hear more thought, Dan, from you, or Jim, or other Commissioners. But this is really a big deal, because at the limit, in this kind of thought experiment, everything could be billed at the hospital outpatient rate, just because hospitals have bought all the practices and therefore have a majority of the volume of procedures.

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

DR. NAVATHE: Yeah. So a highly related point. I also certainly agree with Stacie's and Larry's point that it's worth looking at, and I think we could look at what services, if we use the same volume criteria we could just simply use a threshold of where would we have seen a shift
because of what happened between, pick some year, 2015 or 2012, and 2019. We see some services that would have been in another setting, and particularly an office setting, that switched to an HOPD. That would be something that would be worth looking at.

The point that I wanted to make is, it's just highly related -- it's slightly adjacent to but highly related -- is we also know that there's a lot of geographic variability in ASC availability, and so I was curious, Dan, if you had a chance to look at how this would look, the relative volume, how that would look in markets where there's ASC availability versus there is less ASC availability, because that could potentially strongly influence a ranking, if you will.

DR. ZABINSKI: I haven't, you know, explicitly looked at the volume by area, but I really have thought about the issue. I mean, it's clear that in rural areas and a few states that ASCs are pretty sparse and pretty rare. I mean, you know, the poster child on this is Vermont. They have two ASCs and they're both in the Burlington area, while hospitals are quite evenly distributed -- well, somewhat distributed. There's a lot
more of them throughout the state than there are ASCs. So access could be a real problem for ASCs in Vermont, but also, you know, a few other states and also in rural areas. So that's an issue to consider when particularly aligning HOPD rates with ASC rates, if hospitals decide to cut back on the extent to which they provide services if they're going to get a lower ASC rate for a service.

DR. NAVATHE: Great. So, I mean, my recap of that sounds like it may be worth looking at temporal shifts in a highest volume setting and also in geographic variation based on ASC availability. Okay. Thanks, Dan.

MS. KELLEY: Okay. I think we've cleared out the related questions to Stacie's initial question, so I'm going to move to Lynn with a Round 1 question.

MS. BARR: Great. Thank you. This is a very complicated topic, and I think you guys did a really good job, and I'm very much in favor of site neutrality, for a variety of reasons. But it's complicated. So there's a couple of things I wanted to bring up. One of them is that under COVID, according to some recent publications, now 70 percent of physicians are employed. So it may be too late to stop consolidation. We
might have to figure out how to deal with it.

One of the issues that I'm thinking about here is I see a lot of safety-net providers that are 340B, that are converting physician clinics to provider-based HOPD, only because that's the only way they can get 340B. And there is a major policy disconnect between CMS and HRSA, because this is guidance from HRSA and it was just easy for them. They were like, hey, if it's on your cost report you can claim it. So anything that's on their cost report makes them eligible for 340B.

I can give you examples of many of our clients, they are hospitals that have not converted their clinics to HOPD because they don't like it, the patients don't like getting two bills, they don't want to charge them more, and they are foregoing $10 to $20 million a year in profit on 340B because of that decision. As we put more pressure on them in other areas they are going to have to start converting those clinics, and I would argue that the biggest cause of the conversion to HOPD is 340B.

So my Round 1 question is, can you tease out all this growth of physician hospitals and look for 340B, and then if you took that out, do we really have a problem, or
is this a problem that we could solve with a policy at HRSA that says, you know what, you don't have to convert it to a hospital department. You can just make it a fee-for-service clinic as long as you employ the docs. And that, in my opinion, would be a much better way to prevent this expansion of hospital HOPD.

So I want to make sure that we're not solving the right problem, which is this stupid tie of these clinics to 340B that makes no sense to anyone.

The second comment I have is I'm very concerned -

DR. CHERNEW: Lynn? I'm sorry. I hate to interrupt but I just want to make sure that this is a Round 1 question, not a Round 2 set of comments.

MS. BARR: It could possibly go into Round 2. I apologize, Michael. It was about the 5.8 percent on rural, so I could save that for Round 2.

DR. CHERNEW: Well, again, you should ask all the Round 1 questions you have. Your point on 340B is well taken. I don't mean to interrupt. I just want to make sure we maintain the discipline between Round 1 and Round 2.
MS. BARR: Absolutely, Michael. I could have been skirting on the edge of disaster there. I apologize.

DR. CHERNEW: Sorry to interrupt. We'll put Lynn into Round 2. Again, I'm not sure she can stay, but put Lynn in Round 2.

DR. ZABINSKI: All right. So you had that first question?

DR. CHERNEW: Go ahead, Dan.

DR. ZABINSKI: Okay. Thank you. I would say that at the current time, yeah, 340B is a big reason for the conversion of offices to HOPD. I don't think it's the only one. And probably if you went back six, seven years, I don't think it was the main reason at that time. It was more of a change in the physician fee schedule in how they paid cardiologists. So things change over time.

But I also do think that the 340B is a very relevant issue to this, and we could take a look at how that all fits in and how much of a driver it is right now.

MS. BARR: I would love to see a recommendation to HRSA about, you know, considering other ways of qualifying providers, because it's a constant battle for me. I'm trying to keep people from converting every day.
And it's only because of 340B and no other reason. So six years ago may have been a different situation, but it's really hard to tell a safety-net hospital, "No, you can't have that $10 million."

DR. ZABINSKI: Yeah.

MS. BARR: Thank you. I appreciate that.

MS. KELLEY: Pat.

MS. WANG: I was going to ask a similar question about 340B, and just to put a period at the end of the sentence of the prior conversation, Dan, can you quantify the increase in 340B spending since the beginning, or what you might identify as like the beginning of the big conversion to hospital-owned physician practices? I think that would be an interesting point to add.

I have a question about Slide 5, and this is just my ignorance about how OPPS rates are set. I see what you did here on the OPPS payment line, and there was a lot of detailed description in the paper, which was great. And then on Slide 13, at the end, you made sort of, I think, a policy option, sort of comment, that the savings from going site neutral in what you described could be used to add to the payment rates of the remaining procedures in OPPS, like
emergency room visit, or it could be used for other purposes.

I guess I'd like to just ask a little bit more whether there is an empirical connection between the savings that would be thus generated and the remaining OPPS rates that would not be reduced. And it goes back to this Slide 5. I'm just really curious whether, for example, the OPPS payment, which is this $600, roughly, on the last line, includes some absorption of overhead costs in running OPPS generally that would be shifted rather than disappear if rates were brought down to kind of the freestanding level.

In other words, is the notion of reinvesting savings from this action a discretionary policy option or is it something that empirically some of it should be reinvested, because if you're dropping an OPPS rate to the level of a physician office, for example, are you missing something for the remaining services in the hospital? Maybe the costs are higher because there's more overhead to absorb.

I think that was my question, because it felt like, for the services that were selected, it's paid less,
and leave everything else at its current level. And so I was just wondering if you could talk about that a little.

DR. ZABINSKI: Yeah. This one is complicated.

Yeah, you're right. Okay, on the overhead, in the $598.81 on Slide 5, yeah, there's going to be general overhead for standby capacity and operating the ER and all that sort of thing. And my understanding of it, it pervades throughout all the OPPS payment rates.

So when you align the payment rates, and if the savings are plowed back into the services for which payments weren't aligned, yeah, the overhead is going to be reflected more in those services. And if you want to be idealistic about it, they probably should be. If you want to assign the cost to the services for which the costs were incurred, like ED visits, all the costs of ED visits, it's my understanding, aren't actually reflected in the ED payment rates. They are spread through other services, and aligning the payment rates would probably move those costs, the costs incurred by ED visits, back into the ED payment rates.

I hope that answers your question.

MS. WANG: It's helpful and I apologize. I just
have no idea how like this $598, for example, is identified. Is this something that CMS goes through every year in calculating that, or is it more formula-driven?

DR. ZABINSKI: Yeah. Yeah, they do. It's, again, a pretty complicated process, but just the one sentence is they take hospital charges, adjust them to costs using cost-to-charge ratios, and then use those charges adjusted to cost to set the payment rates.

MS. WANG: Okay. So is it possible then that when they do that at least some of this savings is going to disappear back into the balloon squeezing to increase rates for the remaining OPPS services?

DR. ZABINSKI: Yeah. Well, if we take the route of, you know, putting the -- or how to say it -- if we take the route of using the savings to adjustment payment rates for the non-aligned services, yeah, that would happen. And I think, by law, I think that would be the default. Like a few years ago, CMS did some reducing of 340B payment rates for drugs in a lot of the hospitals, and they reduced the payments for those 340B drugs but to make things budget-neutral they had to increase the payment rates for everything else in the OPPS.
MS. WANG: I see. I see. Okay. Thank you. The only other question I had was on Slide 10. I appreciate that you are pointing out that in rural areas where there's a shortage of ASCs, changing the rates could affect access if hospitals chose to kind of withdraw from what would then be kind of less-profitable. Would you expect that to be a reaction to some of the other services that would be included in this change? I mean, would hospitals start doing less primary care, for example, because it suddenly became less profitable.

DR. ZABINSKI: I don't want to opine on that. I'm not sure.

MS. WANG: Okay. Okay, thanks, Dan.

MS. KELLEY: Paul, did you have something on one of Pat's questions?

DR. PAUL GINSBURG: Yeah, on the first point that Pat made, I think that, you know, what we're getting into is that the fact that some services easily produced in physician offices get paid so much more in the HOPD is really because of very crude overhead allocations that hospital accounting systems use and, you know, the Medicare cost report algorithms used. You know, it's not like
hospitals find it very expensive to produce physician
office visits. It's just the overhead that's allocated to
them. And on the other side, as Dan had mentioned, you
know, there are some services, like in the emergency room,
you know, consider a procedure that is not done very often,
but all the equipment and the training, staff's training or
the staff's presence needs to be around. So in a sense,
those services probably a hospital is losing a lot of money
on.

You know, so one thing you could do is go to a
more sophisticated accounting and overhead allocation,
which certainly could work. But the idea that Dan put
forward about taking some or all of the savings from lower
payments for services that the hospitals do not bring
unique capabilities of, and, you know, taking those savings
and apply them to other services that are not done in
physician offices, it accomplishes similar things. And I
have some more ideas which I'll come back to in Round 2.

DR. CHERNEW: So let me just jump in for a quick
second. There are two more people in Round 1, Amol and
Bruce, and there's nine in Round 2. I want to again just
emphasize I really -- I'm going to feel bad about this
later, but I will just say again it's important for us to have these discussions. Actually, a lot of these comments have been really, really spot-on. But I worry if we blur the Round 1 and the Round 2 too much. It begins to create challenges for people who are waiting patiently to make their comments and then the comments are coming around. And so, again, I wish, wish, wish, wish I could see you all in person so we could sort of discuss this out, but understand that I would really -- for the parts of these questions in Round 1, they should be questions about clarification and specific points, and there should be answers, and we can save some of the more sophisticated policy option things, like Paul was talking about, what we could do or how we might do things. Those are wonderful comments, and I really want to get them, but I want to make sure everybody gets to say them. And so I'd like to keep the more substantive policy discussions to Round 2. So, again, I apologize. I'll put a separate apology in the chat, but let's just go on to Round 1.


DR. CHERNEW: I think that's Amol.

MS. KELLEY: Yes. Amol, you said you have
another Round 1 question?

DR. NAVATHE: I do, yeah, and hopefully this is a good Round 1 question for Mike's criteria.

So, Dan, when you were in the chapter discussing the ancillary items that get packaged and the differences between OPPS and others, on page 15 of the paper there's an example that is given for APC 5012. The question I had is: The logic that was used was that the cost of the packaged items was 13.3 percent of the total cost, and so then we used basically a multiplier of 1.13. You're sort of inflating the new base rate by 13 percent. And I was wondering if the cost of those items, we actually know the cost was $18.49. Is there a reason that we chose to use the 13 percent rather than the absolute dollar value of $18.50, which to me seemed like it would be a fairer way to do it. I was just curious if there was a particular reason or if this was just more of a simulation exercise.

DR. ZABINSKI: This was a -- I thought about both approaches. In fact, the other approach that you mentioned is the way we did it, you know, back eight years ago, or whenever that was. You know, this time around I just felt like, okay, the 13.3 percent is the cost of the ancillaries
1 as a share of the total in the OPPS. And things cost less
2 in the physician office. So I didn't feel it was
3 appropriate to use the full OPPS amount for the ancillary
4 items. So I just went with the percentage of the
5 additional packaged items in the OPPS and applied it to the
6 site-neutral rate.
7 DR. NAVATHE: Okay, got it. Thank you.
8 MS. KELLEY: Bruce, you had a Round 1 question?
9 MR. PYENSON: I actually have several. I think
10 they're fairly fast, and maybe I can rattle them off one at
11 a time so Dan doesn't have to keep a list.
12 The first one, on the application of stop-loss.
13 was that done on a giveaway basis or was it built into the
14 -- to preserve the savings before stop-loss?
15 DR. ZABINSKI: Oh, it was on a giveaway basis.
16 MR. PYENSON: Okay. Thank you. Another
17 question. Yesterday there was some discussion about duals
18 disproportionately using hospital outpatient because of the
19 lack of availability of physician specialists, and I'm
20 wondering if you have an approach to consider that. What
21 were your thoughts on that?
22 DR. ZABINSKI: Let's see. Duals
disproportionately using HOPDs. Well, I think that --
okay. It's -- I guess, you know, the DSH percentage that I
used to identify hospitals that qualify for these stop-loss
eexamples is sort of like that sort of beneficiary wasn't
mined. You know, they have some -- they use the HOPD a
lot, one, to identify hospitals that might serve a high
share of that type of beneficiary. We used the -- you
know, those were the high DSH percentage to identify those.
I recognize that's not perfect. Probably want to use
something better in the future.

MR. PYENSON: Maybe I can clarify the question.

In terms of the distribution of services, the HOPD
dominance as the site of service might be influenced by the
lack of availability of physician specialists, so there
might be some skewing there. But I think you got the gist
of my question.

Another question. On page 5 of the document,
there's a comparison between physician office and HOPD of
first hour of chemotherapy and the transthoracic
echocardiogram with the report, and the percentages are
quite different. Do you have any insight into why the
differences between the two settings are different for
those two procedures?

DR. ZABINSKI: My thoughts on this are exactly like yours, but I don't have an answer to it. You know, there's a lot -- I could throw out any number of examples where it sort of scratches your head about why is this kind of closely aligned with the -- between settings, and that not, even though it seems like, you know, it should be the other way around. And I don't have an answer to that, and I guess the reason is that, you know, there's so many examples of it. I don't think there is one good answer.

MR. PYENSON: My last question is: The analysis that you've done is done on a procedure basis or an APC basis, but there's some services such as chemotherapy that are repeat; or if radiation therapy is an APC, that comes in fractions. Do you think it's worthwhile examining whether physician office, for example, freestanding, does more of them versus hospital outpatient or does less of them for a given patient? Because I think that might give a fairer view of potential savings.

DR. ZABINSKI: I had thought about that. Yeah, I think it would be worthwhile looking into it.

MR. PYENSON: Thank you. Those are my questions.
Thanks, Dan. Terrific report, by the way.

MS. KELLEY: Okay. Shall we hop right into Round 2, Mike?

DR. CHERNEW: Absolutely, and now everything goes. I will watch the time. We have a long queue, so I will watch the time. You can talk about, you know, whatever it is that you want, so go ahead.

MS. KELLEY: Brian, you're up first.

DR. DeBUSK: Thank you. First of all, I was really excited to see this chapter come through. It's been difficult doing the ASC updates over the last five years without wanting to have a discussion around ambulatory site neutrality, so thank you.

I also want to compliment the staff, Dan, on an excellent chapter. I think you used the data that was available very well. I think the analytics were well thought out and well presented. And I do -- I like the idea to turn the APCs that are associated with ED and trauma into comprehensive APCs, because I think that does a better job of aligning the payments with the higher standby cost associated with emergency care. So I really enjoyed that part. But I am concerned that payments being sent
largely by where the procedure is most frequently performed
is a problem. I do think that we need to incorporate a
little bit more information, and that information would
take the form of an acuity adjustment.

I do appreciate that it was mentioned in the
chapter, so thank you for calling that out, but I also want
to point out we don't have to do a full risk adjustment.
This isn't MA risk scoring all over again. We could use a
more general measure of surgical risk, something like the
ASA score, which is really a pillar of surgical
anesthesiology prep work. So we could use something like
an ASA score to create two or even three levels of APC
severity adjustment. And there are several arguments that
would support doing a modest acuity adjustment for APCs,
and I just want to go over a few.

The first one, I think there are a broad range of
patients that may need a specific APC. Picture an
otherwise healthy beneficiary with a fairly complex distal
radius fracture. They may be well served in an ASC, but
then you contrast that with a highly clinically complex
beneficiary with a relatively simple distal radius
fracture. They may need this HOPD level services.
So falling back on this idea that Medicare should pay similar rates for similar care, I do think that similar care is an amalgamation of the patient's immediate clinical need and their overall characteristics.

And I think that leads me into a little bit of a philosophical issue, and that's the issue of alignment. The method proposed in this chapter really sets up on three diverging payment philosophies. In the IPPS, we look at the DRG based on the immediate beneficiary need and then adjust it for severity. A unified post-acute care approach is similarly based on the immediate beneficiary need, and then we adjust it by the patient characteristics. But then based on this chapter, we would find ourselves setting the ambulatory payment really primarily based on where the procedure's performed the most.

So I just want to mention, with an acuity-adjusted APC, we would have the freedom, just like we want to do in post-acute care, to allow the different ambulatory settings to pursue their own strategies.

You know, I have been in ASCs, for example, that are in many ways nicer than most rural hospitals. But, similarly, we might have hospitals that want to pursue
lower-acuity beneficiaries by keeping their operating cost low. So, ideally, an acuity-adjusted ambulatory payment system would lay the groundwork to really a unified Medicare where we look at immediate beneficiary need and those beneficiary characteristics.

The other thing I want to mention is the proposed method has two additional problems, and I think some of this came up in Round 1. We run the risk of creating APC deserts. Imagine a rate that's set from an ASC being pushed into the OPPS in geographies that don't have good ASC access. We know ASCs are typically located in more affluent areas, so there may be a disproportionate impact on our socioeconomically disadvantaged beneficiaries. And, second, it doesn't align well with the emergent strategy that we're witnessing in MA. For the procedures that do remain at the HOPD rates, MA plans are going to be able to identify and select a subpopulation who are ASC eligible and game that margin. So that creates found and essentially free money for MA as well.

But, again, I believe the staff used the data that's available very well, and I enjoyed the analysis.

But I do believe the ambulatory payment system needs at
least a modest acuity adjustment.

Those are my comments. Thank you.

MS. KELLEY: Lynn.

MS. BARR: Thank you. So, again, great chapter, Daniel. Thank you so much for this.

So the slide where we talk about the 5.8 percent for rural is obviously of great concern given there are thin margins. And, also, you know, we have to think about -- so if -- where are they going to go if they can't go to the hospital, right? And knowing that rural hospitals, 75 percent or more of their revenue is outpatient, right? And so they are very, very skewed towards the outpatient side, as you are well aware. So a 5.8 percent cut in 75 percent of their revenue when they've got like an average of 1 to 2 percent margin means they're going out of business. So I think that we need to think about that and maybe just exempt rural hospitals from this because there's really -- I mean, it's beneficiary access. Where else are they going to go, right? Everything's there, and that's the only place it is, and that's kind of the way it needs to be, and it does create some efficiency. So I don't know where you go with that.
The other question about, you know, how should the savings be allocated, you know, as we think about disparities in care, one of the biggest concerns I continue to have is that rural beneficiaries pay huge cost sharing, about 50 percent average cost sharing, for outpatient and rural hospitals. So I would say that if you have any savings from this, you should apply it to the rural beneficiary cost sharing so they pay the same 20 percent cost sharing that every other beneficiary does in the country.

Thank you.

MS. KELLEY: Paul.

DR. PAUL GINSBURG: Yeah, thanks. You know, like Brian, this was excellent, an excellent piece of work and presentation that's really help moving us into this discussion very well.

I want to point out, before I get to what I plan to say, that I really liked Brian's comment about an acuity adjustment. I think it brings out all these issues. The last time I had a colonoscopy, I was told that, well, you're having it done in the hospital outpatient department because you're over 65. And so, you know, I could see
presumably there was standby capacity there that, you know, for the average person of that age -- I'd like to think that I didn't need it -- would be significant, not often used, but needs to be paid for. So I think there's a compelling argument to have acuity adjustments.

I wanted to bring some history. The Commission first took this up during the last -- I guess early in the last decade, and, you know, with what's really close to current law, and it got a good policy reception in the sense that Congress enacted a less aggressive but consistent approach, and the previous administration was particularly aggressive in pushing the legislative authority as far as it could.

What you've done here is kind of the next logical step in identifying a lot more services besides office visits that -- where site-neutral payments could be prepared. But I think as we proceed, we ought to be thinking in terms of doing this not for savings but in a sense to get closer to our longstanding principles about relative payments reflecting relative costs, that we work on in such detail with the physician fee schedule, and then apply it in the hospital outpatient department, which means
higher payments for services that are underpaid today. And
I think the importance of doing this, site-neutral
payments, has really been increased by the changes in the
delivery of care, the changes in concentration, because the
incentives from these distortions in payments seem to be
much more problematic than they might have been ten years
ago and they'll probably continue to get more problematic,
so a kind of more compelling reason to work on this. I'm
really glad we're working on it. But I think we need to
focus not so much on savings but on the matter of more of a
thorough overhaul of paying more for services that are
unique to hospital outpatient departments, the cost of all
the standby capacity, et cetera. And perhaps even this
would make it more politically feasible to move forward,
would be somewhat less of a threat to the viability of
hospitals.

MS. KELLEY: Jon Perlin.

DR. PERLIN: Let me add to the chorus of
appreciation for this chapter.

I also want to add an appreciation for the very
thoughtful discussion around this. It strikes me that our
conversation remains very institution-focused, not patient-
focused, and we put the focus on the patient. Then issues such as those Brian raised and Paul just enunciated about patient acuity make a pretty good -- a big difference.

You know, I know the chapter is somewhat dismissive of the data, but this point about a broken -- as Brian used, a broken arm with complexity, it is a good point.

Consider this example. If you're a 68-year-old and you have a cough, you might not care where you go, and the closest place that's convenient might be your first choice. If you're a 68-year-old and you've had coronary artery disease, you have heart failure, you have diabetes, you know that a cough may not be a cough, and the environment you choose may actually be the higher-complexity environment. And so they are both factors that have to do with the just inherent complexity of need itself, but there's also a degree of self-sorting that a broader data would identify. We've discussed that before in terms of our emergency department conversations in past years. So I think we do need to invoke the patient acuity, recognize the differences and complexity.

While it's attractive to want to just align
those, I think a number of the points that have been made about the history are different than the fundamental aspects of what it takes to be able to provide those standby services. So, if you're a hospital, you are required to be prepared for EMTALA; if you're a trauma center, level 1 or level 2. You've got to have orthopedics, anesthesia, hand surgery, neurosurgery, et cetera, on call, 24/7/365 to maintain that. And if you're that patient for whom a cough may not be a cough and you're choosing an environment that has that standby capacity -- and so the focus through the lens of acuity makes all the sense in the world.

I think it's also important to juxtapose today's conversation with respect to yesterday's conversation about safety-net institutions, and a number of comments were really well made, in particular, a moment ago about the concern on rural institutions. And I just have to toss out if a policy requires a fix in the form of a stop-loss, is it the right policy structure to begin with? Or, if you go a different direction in terms of patient acuity, do you end up with a policy that's more internally coherent? And, as you think about the broader picture of the policies that
we're trying to align, a world that encompasses, areas
where rural is going to have a residual fee-for-service,
where MA operates through a chassis, where reference
pricing is useful but also accommodates an acceleration
through advanced payment models, then maybe we need to
think again about the patient as the center of that
universe and really build out from that patient complexity
as opposed to institutional footprint.

Thanks.

MS. KELLEY: Amol.

DR. NAVATHE: Thank you.

Dan, thanks for this fantastic work. I think
it's just a fundamentally critical issue. I'm so glad to
see that we're pursuing it with a level of rigor and level
of comprehensiveness here.

So I guess in that sense and that same statement,
I guess I should add that I'm supportive of the idea of
moving to site neutral for the reason that Paul and others
and a lot of mentioned around alignment.

I think we should also be very mindful, should be
very front and center. This is also a beneficiary cost-
sharing issue. It was really striking to me in reading the
materials. I don't think it made it into the PowerPoint slide that there are hundreds of millions of dollars of cost-sharing savings to the beneficiaries. So this is not just about the Medicare program as a whole. This is truly about affordability for patients, and let's not lose sight of that. I think that's a really fundamental point.

I think there are some complexities, some of which have already been highlighted. So I'm going to try to not duplicate.

Generally speaking, I understand. I agree with Brian that we've done -- Dan, you've done what you can with the data that we have access to. I am concerned about this notion of using the highest-volume setting as the primary mechanism or method to identify the services that can be most effectively produced or delivered across different settings. I think it might be worth pushing a little bit deeper on this. We suggested some analyses that look at the temporal shifts over time, also the cross-sectional shifts because of ASC. I think those are worth pursuing.

I also wonder if there's more work that a Commission can do in this space by talking to MA plans. There are also commercial insurers. Many of them use
fairly sophisticated utilization management, health plan
functions, prior auth-type techniques to actually
rationalize where the site of service should be, and so it
would be interesting to learn about what are the methods,
what are the data that they might consider as part of that,
in some ways, kind of fee-for-service program, learn from
MA that way. I think that would be actually very helpful
to do.

I noted the rationale around the next topic is
kind of around this question of illness severity. I think
we've touched on it in the context of acuity adjustment.
I'm generally in favor of that, in part, because some of
the comments and language in the chapter describe
overlapping risk score distribution as a way to justify or
rationalize in some sense that there's good overlap.

That being said, I think there's a whole number
of factors. One, overlap doesn't mean that there's perfect
overlap. There's obviously differences that might use this
on the ends of the distribution, and then there's also
these unobservable aspects around other challenges that we
might worry about, rural settings and underserved urban
settings, social determinants of health. That may also be
at play here. That may be part of the decision-making function of clinicians and hospitals as they try to match patients, to some extent, with an appropriate site of service. So I think we should also not lose sight of that. But let me also just restate I am in support of exploring an acuity adjustment.

I think a couple other last points I wanted to make, one, I think if we were able to move in this direction of site-neutral payments, I believe we have made this point a little before, but in many settings, we acquire s cost report. Medicare acquires cost reports as a way to base some of the payment adjustments. I believe we don't get that for ASCs. As part of this type of work, it might be nice to reemphasize that if we're able to get the policy recommendations.

And the last point I wanted to touch on is a point that Jon Perlin also touched on, which was this question of the rationale behind the policy and its potential effects on safety-net institutions, on rural institutions, on a variety of different institutions. I think it's been incredibly important to be mindful of the impact.
I may disagree a little bit with Jon here in that
the notion of a stop-loss provision to me suggests that
there was some legacy way of doing this, and that we want
to mitigate the impact in the short term and may want to
roll it out over time. But I think it's also important to
recognize that from a policy rationale perspective, it may
make much more sense to focus on what works from a broad
economic policy incentive perspective in terms of a site-
neutral payment a la what Paul was saying around alignment,
and then separating out the point that we should absolutely
be supporting institutions in rural areas and safety-net
institutions that are serving underserved urban
populations. But that doesn't mean that it has to happen
through this mechanism of how we think about site-based
payments. I would argue that, in fact, we should think
about it that way. We should think about site-neutral
payments in the context of how we pay for the right setting
of care, and then we should absolutely take some of those
funds, if there are savings from those funds, to then prop
up and help to support our safety-net institutions. But
that should be a separate policy level that we are pulling
there, so that we're not muddying the water and making it
very hard to design an efficient Medicare program, because we're beholding to some of the legacy designs that came out from good intention.

So I will stop there. Thank you so much.

MS. KELLEY: Bruce.

MR. PYENSON: Thank you.

I want to support a number of the points that my colleagues here have made, especially Amol's point about learning from MA and Brian's point on acuity adjustment and the issues of legacy.

I want to make two pretty big-picture points. One is how stop-loss is treated or maybe how it should be treated in general, and I think it's important to recognize that stop-loss comes with a cost. And that cost should be explicitly identified. Typically, in the commercial world, stop-loss comes with a charge, and that's a charge that's applied to the purchasers. And that's one way of doing it, but I think that being very specific about stop-loss and who pays for it and the different ways could be paid for is important, in general.

And I might support some of Amol's -- one of his points about using funds to support particular programs,
for example, safety net.

Another, perhaps, bigger point is we often hear about the intents for surge capacity or emergency or other kinds of capabilities like that, and that's been an ongoing big investment for decades.

And we've just had a case test in the public health emergency of how well that performed, and I think before we get too much further, there needs to be a reckoning of how well did that investment work. The recent studies of mortality, BMJ came out recently with an article on comparing countries' mortality in 2020, the increase in mortality, and it doesn't look good for the United States of the 30-some countries that were evaluated. The U.S. had about the biggest increase in mortality, not quite as big as Russia.

So I think there is a question of whether our assumption about our investment in the kinds of capacity in emergency and standby perform the way it should or whether we should perhaps stop referring to it in the way we are.

Thank you.

MS. KELLEY: Larry?

DR. CASALINO: Yeah. Dan and Jim, I'm really
glad that you guys are tackling this topic. I think it's such an urgent topic because we have so much consolidation going on. It's already far advanced, and in an economy that was our health care system that was functioning well, consolidation would be driven by efficiencies, not by the ability to -- not because you can get higher rates because you're a consolidated entity in through a variety of means. So I think this is urgent. This is not something that can wait 10 years. By then, it will be kind of irrelevant in terms of the amount of consolidation that will have happened.

I'm going to jump actually to my last point first and then go back and add a couple of other things I can say quickly. I think it may be a mistake to try to say what should be done with the savings. That really kind of gets into how what hospital should be paid and how much should they be paid for standby capacity, what's the best way to get them that money and so on. So I think that to give kind of almost off-the-cuff recommendations about how the savings could be used to kind of give back hospitals some of the money that they're losing is a mistake, first of all, because I'm not sure the ideas will be the best
because it really is like talking about how should hospitals be paid, and secondly because it would generate so much controversy because it is about how much should hospitals be paid and how should they be paid more generally, that the points about site-specific neutrality could be lost.

So I think if we show that hospitals are going to lose some money, if the kind of changes that we wind up recommending, if any, were put into effect, I think we could acknowledge that, quantify the losses, and point out that society may want to find a way to give some of this money back to hospitals. But I don't think it's our job to, in this case, talk about how hospitals should be paid.

Dealing with rural hospitals is a tricky question. They could just be exempted, as I think it might have been Lynn suggested. That wouldn't necessarily be a bad thing. There's some reasons to think that physician hospital consolidation in rural areas is not bad. For one thing, it's a way to get some physicians in rural areas and keep them there. But then it would keep beneficiary co-pays on it. So, anyway, that's that point.

The other point I wanted to make is about the
cost of running practices after you acquire them and then a
point about the volume criteria.

There's no question that it costs more for
hospitals to run practices after they acquire it and then
the practices were using them. Some of those costs may be
higher than they need be. I personally have had that
experience of having my practice, my physician practice
purchased by an active medical center, not the one that I
work for now, and then three months later being told that a
practice that was profitable is now losing $400,000 a month
for the hospital or something like that. And this is the
common story. It's partly because of higher costs, partly
because of other things, but I think it's important to
remember no one is putting a gun to hospitals' heads and
saying you have to buy these practices. If hospitals make
the decisions to buy practices, that doesn't mean that
society has to subsidize their higher cost, and I think
it's important to realize that.

The last point I want to make is about the volume
criterion for judging where it's safe to provide a service
and in what setting should set the rates that are going to
be paid. I think Stacie and others have made pretty clear
that just using 2019 would be problematic because there are
so many changes that have already been baked in that came
about not because something is done better or safer
necessarily in a given environment because of Medicare
payment policies that were changed.

On the other hand, looking back to when -- I'm
trying to remember when the cardiology imaging payments
changed. It might have been 2008, something like that.
This is a long way to look back. And then looking forward,
it's true that a lot of kind of major joint replacement
surgeries are probably going to be increasingly moving to
ASCs. So, for those procedures, if we look back even to
2019 and maybe farther back than that, we say these have to
be done at hospitals and pay at the hospital rate, when, in
fact, they probably could be done, can be done safely in
ASCs, although there should be an acuity adjustment. This
is a good example of where that would be important, I
agree. For some sicker patients, you wouldn't do in ASCs.
You would do them in hospitals.

So I think a lot more thinking probably needs to
go into how to select, which of the three settings should
set the pace for the payment rates. I'm not sure we can
just pick a year and leave it at that permanently.

Obviously, this is critical, and it can't seem arbitrary.

But just picking any year, I think it's probably going to be wrong. To me, the whole thing kind of hinges on this.

If we're using the method we used to determine which of the three sites would set the payment rate, it's obviously critical, and I think probably deserves plenty more thought and, again, sooner rather than later because I think this is a process that's already far advanced to consolidation, and it's moving rapidly.

That's it.

MS. KELLEY: Stacie.

DR. DUSETZINA: Thank you. I want to also kind of answer this, how should the savings be reallocated or allocated. In general, I am very much a fan of trying to get to a more site-neutral payment situation, recognizing how complex it is, and I completely agree with Jonathan's and Brian's prior points about acuity adjustment.

You know, I think if the savings could be reallocated -- and this goes to Lynn and Amol kind of have touched on this -- back into beneficiary cost share, that seems like it would be a really nice way for services that
really do need to be performed, for example, in hospital outpatient departments or in other more expensive settings. If we could make that less expensive for the beneficiary or at least not more expensive than if getting it at another site of care, that would be nice.

And it strikes me that maybe potentially there is an opportunity to pick up the cost share that would have been there for the duals, to help with some of the access challenges we talked about yesterday, thinking about Medicaid not picking up the 20 percent, for example. But I really like the idea of trying to recycle any potential savings into helping beneficiaries have more stabilized costs for getting the same procedures, even if they are going to a more expensive site of care.

MS. KELLEY: Betty.

DR. RAMBUR: Thank you. Thank you for the opportunity to comment. In the interest of time I will be brief and a little bit high level. I greatly appreciated the chapter and the comments of Commissioners.

I strongly support the need to align across ambulatory settings, and I have certainly found the empirical evidence that when hospitals acquire physician
practices and there is market consolidation, prices go up.
I have found that to be very compelling, and, in addition,
the challenge that the FTC has with overseeing vertical
integration rather than horizontal.

Jim mentioned the issue of the sign out the door,
and a couple of mentioned the issue of beneficiary cost-
sharing. I would just like to also underscore that. It is
entirely baffling to patients when they receive a service
at one time, at one place, and they receive the exact same
service a very short time later, and there's a dramatic
difference in the cost. And it's just not rational, and I
think we need to address it.

I strongly support Amol's statement, and maybe
others said as well, of the need for the cost report data.
And since Vermont was brought up in the materials as well
as in the conversation, I will just very briefly sketch a
tiny bit of that history. The state had a longstanding
policy, or they had a longstanding practice whereby the
large academic medical center was able to argue that
ambulatory centers would cherry-pick and they would
undermine their ability to survive. And you could go on
that side of the argument or you could say, well no, that
actually was a large market player, preventing others from entering the market. And indeed, I believe it was in 2017, it was finally allowed. The first center, which the report mentioned, is in Burlington, which is the largest city, and then shortly after that a second, which was, you could argue, a competitor, coming from the academic medical center that previously was opposed to an entry of a new player in the market.

The reason I bring this up is I think it's really important that we don't think that all rural areas are homogenous, and I'm not suggesting that we do. And I strongly support the notion that we separate out this very important issue, site neutrality, with the special needs of safety-net facilities. And I don't have the answers of who we would do that but I am very confident that there could be some excellent recommendations.

In terms of the savings, I tend to agree that the most important thing is that we get this to be a more rational system. But if there are savings, I think it would be very important that they go to savings to the beneficiaries and to the Medicare program, and then also to address the safety net issue.
So thank you. I think this is extremely important that we're taking it on. And I know it will take perseverance to get to the other side, but I'm very grateful we are doing it, so thank you.

MS. KELLEY: Paul, did you want to add an additional comment?

DR. PAUL GINSBURG: I just wanted to make a pitch for, you know, one of the ideal ways of perhaps reallocating the prices to other services is to look into bringing the hospital cost accounting norms up to the modern era so that, in a sense, some of the reallocation could actually be done on a true cost basis. And, you know, I'll talk to the staff offline, and I have a couple of PhD accountants to suggest that they might be able to talk to on it.

DR. CHERNEW: Thanks, Paul. Dana, if I understand correctly, that is the end of the queue. Is that correct?

MS. KELLEY: yes.

DR. CHERNEW: Okay. Anyone want to add anything else before I wrap up? Then I'll ask if you want to say anything after my wrap-up.
So let me summarize this very rich discussion.

The first point -- I'll make a very broad point -- and I don't want everybody to think that my answer to every question is alternative payment models. But I must admit this is an area that seems to arise because they're trying to set somewhat micro fees in places where we don't observe costs, we don't observe patient traits, we don't observe a whole bunch of things going on where efficiencies and there's heterogeneity across services, patients, sites, locations, and a whole bunch of other things.

So at least the place where I think the phrase "alternative payment models" might be thought of as something, but we're certainly not going to solve this problem in the near term with alternative payment models, so we have to address this. And I might add, because almost all alternative payment models are based off a fee-for-service chassis, even if everyone was in an APM we would still need to try and get payment better, even though it wouldn't quite be potentially toxic.

So I think there are a lot of comments. I think this might have been raised by many of you. I think Paul raised it. Our goal here, in many ways, is to incent care
to go to the most efficient provider, and so we don't want
to overpay in some places. The problem is we don't know
what efficiency is. It's hard to observe. The service
definitions are a little bit different. Dan mentioned
several reasons, not just in terms of what's bundled into
the service but also the need for backup capacity.

And Brian, I think, mentioned there's a lot of
patient heterogeneity, so some sense of how we deal with
that, acuity differences within services matter. I also
think there's an average versus marginal cost issue. When
we say a site is very expensive, are we talking about
average costs or marginal costs? If we have a lot of
backup capacity it might not be bad to use it in a place if
it otherwise would go to waste. So we have to think
through some of those issues.

All of that said, as we go through this, our
intent is not simply to save money or even to reallocate
money. We are going to have to give broader thought as to
where compensation is needed if revenue goes away, and how
well we can target that any additional compensation.

What I fear would happen -- and maybe "fear" is
the wrong word -- is we're about to, in December, embark on
the beginning of our normal update chapter. If we took 4 percent, or whatever number you wanted, 3 percent, from some center providers, that would inevitably play into our update criteria and lead us to do an across-the-board increase, I believe, in our update recommendations, because profitability would be substantially worse. How much so would depend on the site and a whole bunch of other things.

I very much worry about places where there are fewer alternative and how we deal with changes in payments that might restrict access in those places. That is partly, but not exclusively, a disparities and equity comment, and I worry about how we can get the right amount of information to target these sort of any extra payments where they're needed. Our goal is not to pay too much broadly in order to achieve access in some selected places. So how we do that is clearly going to be a challenge.

My biggest takeaway, past all those substantive points, is that there remains a lot of interest in the Commission for continuing down this path. There's been a lot of suggestions about things that we might do. Dan, I'm pretty sure you said this at the offset. We are not moving towards a recommendation this cycle, so we will not see
this all come to resolution in the chapters this cycle. We are really moving forward in this area, and we will try to tie up many of these loose ends, often along the ways that you suggested, both analytically and otherwise.

So let me pause to see if I've missed any main themes, and then I'll ask Dan for any last words before we move on to the next topic.

[Pause.]

DR. CHERNEW: Anything you heard that I didn't summarize, or anything I summarized that you didn't hear? Again, it would be nice to see you in person. We could hash this all out. But in lieu of that, let me get a sense of what you think.

DR. ZABINSKI: No, I thought this was a great discussion. I have a good sense of where to go from here, so I'm feeling good.

DR. CHERNEW: Okay. Wonderful. If Dan is feeling good that means you all did a good job. That's sort of the main goal.

So I think now we're going to switch to the last topic of this month, which is some nuanced issues on how Part D works for residents in long-term care facilities.
So with that I am going to turn it over to Rachel.

Rachel, you are up.

DR. SCHMIDT: Good morning. In our last session we're going to look at how Part D benefits are provided to beneficiaries who live in long-term care facilities. Within nursing facilities, we're focusing on long-stay residents rather than those with a post-hospitalization skilled nursing stay. Only about 3 percent of Part D enrollees live in nursing facilities, but they are a population of interest because, in addition to needing considerable help with activities of daily living, they often have cognitive impairments. There is little information available about how well Part D has served them.

Before we dive in, I would like to thank Beth Fuchs and Jack Hoadley, who organized and led stakeholder interviews for this project, as well as my colleagues Shinobu Suzuki, Eric Rollins, and Kathryn Linehan. As a reminder to the audience, you can download a PDF version of these slides in the handouts section of the control panel at the right-hand side of your screen.

The Commission last looked at this issue shortly
after Part D began. That work examined the major changes
that were under way in financing and delivery of drug
benefits in long-term care. Previously, most long-term
care residents had their drug benefits paid by Medicaid,
but with the start of Part D, Medicare took over this role.
At the time, we had concerns about conflicting interests of
stakeholders and how that might affect beneficiaries. We
also discussed whether Part D's consumer choice model, in
which beneficiaries select among competing private plans,
was appropriate for the long-term care setting.

Last year, with the help of a contractor, we
interviewed stakeholders to get an update on how Part D
works today in long-term care. One thing we heard
immediately is that some beneficiaries who, in previous
years might have stayed in a nursing home, today live in
assisted living facilities and other types of residential
care centers. So, we expanded the scope of questions to
include assisted living.

We know more about residents of nursing homes
than residents of assisted living because nursing homes are
subject to federal regulations, surveys, and
certifications. In contrast, assisted living facilities
are regulated at the state level, and there is variation in their definition and requirements. This table compares characteristics of the two groups of beneficiaries, based on residence codes from their Part D claims. However, note that these data should be interpreted cautiously, particularly for assisted living facility residents.

In 2019, about 3 percent of Part D enrollees lived in nursing homes, and their drug spending accounted for about 5 percent of all Part D spending before rebates and discounts. An additional 2 percent of Part D enrollees likely resided in assisted living facilities, and their spending made up about 4 percent of gross Part D spending.

Part D enrollees in nursing homes and assisted living facilities share certain characteristics. During 2019, they were more likely to be enrolled in a stand-alone prescription drug plan, and thus in fee-for-service Medicare, compared with all Part D enrollees. They were much more likely to receive Part D's low-income subsidy, and many of those individuals are dually eligible for Medicaid. You can see there's much higher prevalence of Alzheimer's disease or other dementias, and anxiety and depression in both settings.
However, there are differences between the two.

In 2019, among assisted living facility residents, a higher share was under age 65, and a much higher share had diagnoses of serious non-dementia mental illnesses such as schizophrenia.

The regulatory environment in which nursing homes provide medications is complex. By law, nursing homes must provide residents with all needed care in a timely manner including prescription drugs, even when the source of payment is unclear. Nursing homes must use licensed pharmacists, and they typically do this through an exclusive contract with one long-term care pharmacy. Long-term care pharmacies must be able to provide specialized services such as 24-hour drug delivery, and dispense drugs in packaging that helps to reduce medication errors.

Nursing homes must also provide the services of consultant pharmacists who are responsible for managing the clinical side of medication dispensing as well as regulatory compliance. Consultant pharmacists must conduct monthly medication regimen reviews of each resident.

State regulations differ with respect to how assisted living facility residents receive help with their...
medications, but often assisted living facilities don't provide the same types of dispensing and medication review services as in nursing homes. Assisted living facility residents often have a choice between using community retail pharmacies and a long-term care pharmacy. Most assisted living facilities provide help with or administration of medications, for example, by having a medication technician hand a beneficiary her dose to self-administer.

Here's a diagram to help understand the flow of funds and medications and the relationships among stakeholders. Medicare makes payments to private Part D plans toward the cost of basic drug benefits for each enrollee, as well as for low-income premium subsidies and cost sharing subsidies for LIS enrollees. The role of the long-term care pharmacy is to acquire drugs, dispense the medicines for the facility, and provide other services to help with medication management, billing, record keeping, and so forth.

Plan sponsors and their PBMs need to set up a network of long-term care pharmacies to meet Part D access standards. Most long-term care pharmacies use the services
of a pharmacy services administrative organization, which
is often an affiliate of a group purchasing organization,
to negotiate with plans and PBMs over prescription payment
rates and dispensing fees. Long-term care pharmacies also
use GPOs to help them aggregate their purchasing power when
they buy drugs from manufacturers and wholesalers. Part D
plan sponsors negotiate with brand manufacturers for
rebates in return for preferred placement on the plan's
formulary.

Let me quickly review how enrollment and cost
sharing work under Part D for long-term care residents.
Beneficiaries who are dually eligible for Medicaid, as well
as others who receive Part D's low-income subsidy, are
auto-enrolled into a qualifying Part D plan unless they or
their family pick a plan themselves. Last September, Eric
explained the process CMS uses to set LIS premium
benchmarks and determine which plans are qualifying plans.
Under Part D, dually eligible enrollees at nursing homes
pay no cost sharing, while those at assisted living
facilities pay nominal copayments. Other residents without
the low-income subsidy may choose to enroll in a Part D
plan, and pay the plan's full premiums and cost sharing.
While long-term care facilities may educate residents and families about Part D plan options, facilities may not steer beneficiaries into specific Part D plans. You can understand why some facilities might want to do this. Any one facility has beneficiaries who are enrolled across lots of different Part D plans. If, for example, certain plans require more prior authorization for drugs commonly used in long-term care settings than others, a facility might prefer to avoid that plan. However, CMS is trying to prevent conflicts of interest by prohibiting steering. Under Part D regulations, nursing home residents may switch plans once a month.

With the help of a contractor, we interviewed 29 stakeholders including representatives of nursing homes, beneficiary advocates, plan sponsors, long-term care pharmacies, consulting pharmacists, and so forth. Interviewees did not report major problems with access to medications for beneficiaries living in nursing homes. Cost sharing has not been a barrier because most residents are dually eligible and receive the low-income subsidy, and so they pay no cost sharing. If their drug needs are not met by their plan's formulary, they can
switch plans relatively easily. Nevertheless, a few interviewees reported challenges navigating plans' utilization management requirements.

Interviewees told us that individuals living at assisted living facilities could benefit from services that long-term care pharmacies provide. State regulations vary, but often assisted living facilities do not provide the same level of services as in nursing homes. Stakeholders said that the clinical acuity of some assisted living facility residents can be similar to that of nursing home residents, and services such as medication regimen reviews and specialized packaging may be important for them.

Along the same lines, several stakeholders would like CMS to set standards of payments for pharmacy-at-home services for frail beneficiaries who want to continue living in their communities but need help managing their medications. This model would incorporate services like medication therapy management and convenient packaging, with counseling, to help patients at home or just after a transition to home to reduce medication errors and polypharmacy.

Many interviewees told us that they believed Part
D plan sponsors include most long-term care pharmacies within their network for two reasons. First, CMS has long-term care pharmacy access standards that plan sponsors must follow. And, second, nursing homes generally use an exclusive contract with one long-term care pharmacy. However, stakeholders from smaller long-term care pharmacies and their GPOs and PSAOs believe that plan sponsors have more leverage than they do, resulting in what they perceive to be inadequate payments. Of course, plan sponsors disagree with this.

In 2007, when we first looked at this topic, long-term care pharmacies were negotiating rebates from brand manufacturers separately from Part D plans. However, this time interviewees told us that today long-term care pharmacies do not seem to be negotiating significant rebates.

We heard concerns from some interviewees that within Part D, dispensing quality and medication management need greater attention in both nursing homes and assisted living facilities.

Medicare requires Part D plans to carry out medication therapy management programs for enrollees who
have multiple chronic conditions and take many medications. Several interviewees viewed plans' programs as duplicating the medication reviews that consulting pharmacists conduct for nursing homes.

Historically, nursing home residents have been overprescribed antipsychotic drugs, typically on an off-label basis for behavioral issues. Beneficiary advocates still have concerns about antipsychotics dispensed with no diagnosis of a psychosis. Some told us that medication regimen reviews are not sufficiently robust with respect to antipsychotics, and they are concerned that nursing homes that have reduced antipsychotic use did so by substituting other sedating drugs.

Because of the nation's opioid epidemic, CMS has taken steps to limit misuse and overuse within Part D. Interviewees reported reduced opioid use in long-term care settings, due in part to CMS' attention and plans' subsequent quantity limits. However, we also heard that the focus on opioid use risks creating problems for adequate pain control in long-term care settings.

With respect to Part D plan star ratings, interviewees told us that some of the measures,
particularly those that focus on adherence or beneficiary experience, were less relevant or sometimes even inappropriate for the long-term care population.

At this point, I'm happy to take your questions and feedback, and we plan to include this material in next year's June report.

DR. CHERNEW: Okay. Dana, I think we have a few in the queue, so why don't we get going?

MS. KELLEY: Okay. I have David Grabowski first.

DR. GRABOWSKI: Great. Thanks. So first of all, Rachel, this is great work. I'm really excited that we're looking at this. I've used those early reports you referenced from MedPAC a lot in my research, and so it's definitely time to revisit this issue.

My question really comes to the issue you raised around negotiating the dispensing fees, and in the chapter you talked about both the long-term care pharmacies and the plans telling you the other side had leverage. And maybe that's always to be expected in these kind of reports or stakeholder interviews. But on page 19, you wrote, "It's not uncommon to hear from the GPOs that plans have all the leverage in negotiations," and then on page 20, a plan
respondent said to you, "The long-term care pharmacies bring a lot of leverage to the table."

Do we have any data on this? And that's my first question. I have a follow-up as well, but I found this -- I don't know. It wasn't very satisfying, and maybe that's why we're going to have to leave it because this is stakeholder interviews. But I think, Rachel, it would be nice -- and maybe there is a data source we can sort of bring to bear on that.

DR. SCHMIDT: So you are right, this is kind of a first crack. It was mostly doing the stakeholder interview approach, but there are a lot of claims obviously behind all this, and it would be possible to try and take a look at things like average dispensing fee and that sort of thing.

I think there's going to be a variety of situations. You have a couple of really large long-term care pharmacies, and they're obviously bringing more leverage to the table than the smaller guys. So it's going to be, you know, a complex situation, I imagine.

DR. GRABOWSKI: I appreciate that, and the second question that's related to that answer is just the vertical
integration here, and I want to come back to that in Round 2. But how do we think about these dispensing fees in, you know, the kind of big two long-term care pharmacies are vertically integrated? I guess you just said this, that the big guys have a lot of leverage, but the big guys are also the players that are vertically integrated. So it's beyond just being big. They're integrated. So any thoughts there? And I'll come back to that point.

DR. CASALINO: David, when you say "vertically integrated," what do you mean?

DR. GRABOWSKI: Yeah, so I was going to talk more, and Rachel could answer that, but Omnicare, the largest pharmacy, is vertically integrated with CVS Health. PharMerica, which is the second largest long-term care pharmacy, is connected to Walgreens, Boots. So there's definitely -- Larry, these are not stand-alone entities.

DR. SCHMIDT: So as we've talked about more broadly with vertical integration, it's kind of hard to get a lot of visibility into what happens in those relationships, right? And we can look at things like dispensing fees and claims data and that sort of thing.

But in terms of other transactional fees and transfer
prices, we're not going to have much visibility into that. So it's not a very satisfying answer. I'm sorry, David.

But, yes, you do have this one very large organization that is extremely vertically integrated, and we can try and take a look at it, but I'm a little skeptical about how much detail we'd be able to find, frankly.

DR. GRABOWSKI: Great. Thanks, Rachel. Once again, great work, and I'll follow up in Round 2 here with some further thoughts. Thanks.

MS. KELLEY: Marge, did you have a Round 1 question?

MS. MARJorie Ginsburg: Yes, I do. I have one question and one suggestion. My question is on page 10, Table 2, where MA enrollees, the cost of MA enrollees is significantly less in Part D spending. And is that just because the MA plans negotiate the drug prices so successfully? Or is there some other reason why it's so much less?

Let me go ahead and give my other suggestion, which is on page 15 where we start getting into -- and this is a relatively new field for me in terms of all the organizations. I'm very visual. If there's any way that
you can take this text box and convert it into an org chart so we can actually see how these different entities relate and when and that sort of thing, that would be great.

So, anyway, that's it -- one question, one comment. Thank you. Great report.

DR. SCHMIDT: So in terms of your question, I think you're looking at the table that has the aggregate amount of spending, right?

MS. MARJORIE GINSBURG: Yes.

DR. SCHMIDT: So it's mostly just a function of there are fewer enrollees in Medicare Advantage plans. The majority of the folks in nursing homes and in assisted living facilities for which we have claims are in stand-alone prescription drug plans and, therefore, in fee-for-service Medicare.

MS. MARJORIE GINSBURG: Oh. So this is just about the numbers. It has nothing to do with the average -

DR. SCHMIDT: Right, it's cost per person.

MS. MARJORIE GINSBURG: Okay. Got it. Thanks.

DR. CHERNEW: I think that was the end of the Round 1 queue. Is that right, Dana?
MS. KELLEY: Yes, that's correct.

DR. CHERNEW: I think David is going to be the first one in Round 2, and given he foreshadowed -- oh, Bruce is jumping into Round 1, late-breaking. So, Bruce, why don't you ask your question? But, Rachel, I think it might be useful, in anticipation of what David might say, to go back to your graphic about how the money flows. I think that's going to help people think through exactly what the vertical integration looks like on that picture. But maybe Bruce is going to take us in a completely different direction, so Bruce.

MR. PYENSON: I'll just say a couple of technical issues. One is that another long-term care setting is group homes, and I'm wondering if that's -- if you've thought about adding that to the analysis. That's one question.

The next question, which might be a question for Carol Carter, is that there has been enormous consolidation of the nursing home industry, but it has proved to be in the past remarkably difficult to understand that. I'm wondering if there's any opportunity to bring that into this work.
DR. SCHMIDT: Okay. On the group home question, we did--there's a code that pharmacists are supposed to fill out on Part D claims, and I did look at the group home one. It was a relatively small share of the claims, so for purposes of this exercise, I did not include it. But we could go back and include it in the analysis.

I don't know if other colleagues want to jump in on your second question, but when we were doing the private equity work, I think we found that it's kind of difficult to identify common ownership across some of these nursing homes. And so I'm not sure the degree to which we could identify the common owners.

DR. CARTER: Yeah, and the only thing I would add is that some of the consolidation has still been in pretty small and regional operators, and to the extent--I don't know how they contract with large or small companies to manage the drug benefit, but that would play in as well. We don't know how much consolidation, and the consolidation that we see tends to be in the smaller operators.

[Pause.]

MS. KELLEY: Mike, we can't hear you. You're on mute.
DR. CHERNEW: Oh, sorry. I'm going to ask a Round 1 question, but I think it's intended to lead into what I think David's going to ask about. On this slide, under the GPO/PSAO icon, you note that they negotiate purchase discount payment rates and dispensing fees on behalf of the long-term care pharmacy. From the picture, it looks like they're negotiating with the plan sponsors. Is that essentially correct? Or are they also negotiating with, say, brand drug manufacturers, for example, or negotiating with wholesalers? I'm just trying to make sure I got all the lines right. There's a lot of people on here if you just get drugs from a drug manufacturer to a nursing home resident. I just want to make sure I know who's negotiating with whom for what and what their leverage is in that negotiation.

DR. SCHMIDT: Right, and, you know, in retrospect, I wish I would have changed the title, because it's not really flow of funds; it's flow of drugs as well. We were trying to avoid too many lines on the diagram. But the GPO is essentially helping the smaller long-term care pharmacies negotiate acquisition of drugs, and often they have a PSAO arm that is negotiating with the plan sponsors.
and the PBMs for the contract to be a network provider and also dispensing fees and payment rates from the plan. I don't know if that helps clarify things.

DR. CHERNEW: I'm going to ask again for a second. So they're negotiating with the plan sponsors because they want to be a network provider, if you will, so they basically need to lower their dispensing fees to attract the plan sponsors. That's sort of part of it.

You also mentioned, though, they're negotiating for drug acquisition. I believe that's going a different place on this. That's negotiating with the wholesalers or the brand -- who are they negotiating with to get the acquisition of the drug?

DR. SCHMIDT: In most cases, wholesalers. It's mostly generics being dispensed in terms of the dollar value. So a whole lot of this is -- you're right. There should be an arrow to the wholesalers and to the brand -- but there's some negotiation with brand manufacturers as well. But it doesn't seem to be for rebates. That negotiation just seems to be between the plan sponsors and the manufacturers.

DR. CHERNEW: Right, and I guess the challenge I
would have is that this again is -- when the long-term care pharmacy says, you know, to a wholesaler, "I want lower prices to get the drugs," if the wholesaler said no, they could buy the generic somewhere else, because it's a generic. Is that the basic -- there's multiple wholesalers.

DR. SCHMIDT: Right.

DR. CHERNEW: I got it. Okay. So I think David was number one in the queue. If no one else is jumping in, I think -- I'm going to defer to Dana Kelley, but is that right, Dana?

MS. KELLEY: Yes, that's right.

DR. CHERNEW: Okay, David.

DR. GRABOWSKI: Great. Thanks, Mike. And once again, Rachel, I really enjoyed this chapter. Great work. I want to start with this issue -- and I think I touched on it in Round 1 -- around horizontal and vertical consolidation. I think it's something you want to draw out more in the chapter. I know it's there, but I really think it's a central part of thinking about long-term care pharmacies. The largest long-term care pharmacy, Omnicare, accounts for about a third of the market; the second is
That sounds like, well, there's the other 50 percent of the market, but as Rachel's diagram here shows, those GPOs and PSAOs, they actually help sort of consolidate that part of the market. It's really dominated by three large organizations. So the market is more consolidated, even on the GPO and PSAO side.

And then in terms of the vertical consolidation, Larry already pushed me on this point, but Omnicare, once again the largest long-term care pharmacy, was acquired in 2015 by CVS Health. I don't think I need to explain what CVS Health is. And then in 2017, PharMerica, the second largest long-term care pharmacy, was acquired by a partnership between a private equity firm and an affiliate of Walgreens, Boots Alliance.

So we have, you know, both horizontal and vertical consolidation, and, Rachel, what I would encourage you in the chapter is, is there a way to think through -- maybe we don't yet have the data on this, but what are the implications of this consolidation for patient outcomes?
What are the implications potentially for Medicare expenditures, you know, in thinking through this?

It may be early to speculate on that. I appreciate dispensing fees and other data could help maybe shine more light on this. But at least in the short term, could we at least add some text potentially drawing some of these issues out, recognizing how this market is structured.

The second point I really wanted to raise is long-term care pharmacies are often kind of pushed as a way of sort of quality control. I have a series of papers. I imagine Stacie has done some work on this topic as well. Quality issues are rampant in terms of medications in long-term care settings. The chapter mentioned polypharmacy. There was a recent New York Times piece many of you probably saw on overuse and misuse of antipsychotics. This is especially true for individuals -- long-stay residents with dementia. Pain management has often been found to be inadequate. Medication management more generally has been fairly poor.

And so something else -- and once again you raise it in the chapter, Rachel, but is there a way to kind of
make this point more directly? I think you heard it from some of the stakeholders, but why aren't long-term care pharmacies doing a better job of sort of ensuring quality in terms of medications in this area? Obviously, it's potentially more complicated than that. They have a role. So do the other players here, including the nursing homes. But I think we can -- when I was reading it, I felt like that issue didn't receive enough attention.

A final point, and I was really interested -- I hadn't ever really thought of this model that you heard from the stakeholders around pharmacy-at-home, basically taking the long-term care pharmacy model and bringing it into the community. And I get bringing long-term care pharmacies into assisted living. Bruce mentioned group homes. Those sound like logical next steps. The pharmacy-at-home model sounded like a big step to me. I would want to think more about how we tie this more generally to our work on Part D, access to medications for community-dwelling elders. Are long-term care type pharmacies the right model for individuals who are receiving long-term care in a home or community-based setting? I don't know the answer to that, but these kind of models make a lot of
sense. And I'll just -- you know, assisted living right now, you know, even thinking about this in the context of COVID, you know, think about the booster shots. We have the long-term care pharmacies. That's an easy roll-out in nursing homes. It's much more complicated in assisted living. It's kind of non-existent in the community.

We have a lot of issues with access to -- you know, in terms of Part D in the community potentially. I just don't know if pharmacy-at-home is the next step. And that was kind of -- I know you heard that from the stakeholders, and that received a lot of attention in the sort of concluding section of the chapter. I think we want to be a little more cautious about that model. And I know this was just reporting what the stakeholders told you, but I don't know that that's the next place.

I'll stop there. Once again, great work, and I look forward to continued kind of research on this topic. Thanks.

MS. KELLEY: Stacie.

DR. DUSETZINA: Thank you, Rachel. This is a really great chapter, and it's a throwback to my postdoc days which is kind of the last time I spent much time
Surprisingly, I don't want to talk about the figure that Mike had us look at before, despite my interest in general flow of funds like that. I wanted to bring up two things that I think are really worth maybe thinking about how do we get better at this, and you bring up both in the chapter. One is the issue pain management and how absolutely critical that is. So, you know, I think the nursing home residents, this is a place where we have dramatically overcorrect and are probably causing harm to people for appropriate pain management because of rules that make sense for people who are in the community, that maybe don't make as much sense when someone is being served by, you know, a pharmacy in-house who is really strictly controlling how much medication is available to a person at a given time. So it would be nice to think about, you know, how do we move towards a space where some of those restrictions on, you know, maybe it's quantity limits or other things that are creating problems, can be resolved for business in this setting.

The other is kind of related, around the issue of
quality measures, and I couldn't agree more that, you know, like penalizing plans because of lower adherence to things that we actually don't think that people should necessarily be using. So maybe we want to discontinue statins or we want to discontinue other medications to lower the burden of polypharmacy. And so having the same sets of measures for people who are in the nursing home versus outside and same set of rules maybe doesn't make a lot of sense.

So I think, in general, what this chapter had me thinking was, you know, should there be a population-specific set of measures that we really take into account for what does quality look like, should we add measures of adequacy of pain management, or use of antipsychotics, which has been a long-term problem, but really would get at more of the issues we are most concerned about for nursing home residents, and not accidentally penalize people for doing the things that we would consider good care.

But thank you very much. This is really excellent work, and I'm excited to see this chapter developing.

MS. KELLEY: Betty.

DR. RAMBUR: Well, thank you so much. This was
an absolute education for me, and I just wanted to say thank you so much. It was fascinating. And I just wanted to embellish on a point that was made about the inadequate staffing leading to unnecessary prescribing or inappropriate medications. David just talked about overuse and misuse, and Stacie about underuse.

This absolutely resonates with my own experience as a nurse and as an educator, and I'm again struck how the tentacles of the nation's underinvestment in workforce is laced through everything we do and talk about. It's laced through this, it's laced through the things we talked about yesterday. And I know that that's not a foreground piece in this, but I am really concerned and wondering who is going to be thinking about the development of the nation's workforce.

In the end, so much of this is all about people. So I know it's a bit of a tangent -- well, not a tangent. It's easy to forget about the working surface, and Medicare certainly has invested in preparing the physician workforce. At one time it did a lot in the nursing workforce, but who is actually thinking about workforce development? So I don't know where that goes in a parking
lot, but I think it's an important consideration.

Anyway, thank you for the brilliant information, and I look forward to hearing what comes next.

MS. KELLEY: Brian.

DR. DeBUSK: Yes. Thank you. Thanks to staff for an excellent chapter. I wanted to first of all echo some of David's earlier comments about learning more about vertical integration and how some of these relationships are arranged.

You know, just as a specific, what does even having a risk corridor in the Part D plan mean when the plan also owns the pharmacy, the wholesaler, the PBM, and the GPO? So understanding those interworkings, what transactions, if any, have to be arm's length, is there really any governance, or are there regulations around how some of these interactions have to be done?

The other thing I'm really interested in is, especially with the new rebate data that we've gotten, do we better understand how drugs are tied together, number one, through manufacturers' rebates. You know, do we see examples where Drug A is linked to Drug B. And also, I want to understand the role that these curated generic
formularies play. I know all of the wholesalers have basically their own set of preferred generics, and it's my understanding that they tie, for example, the markups to the individual pharmacy's participation in those generic formularies. And any transparency there, any insight or understanding would be greatly appreciated.

But again, thank you for a very interesting chapter.

MS. KELLEY: Pat.

MS. WANG: Thanks. I just wanted to pick up on David's comment about long-term care at home, to suggest additional areas of exploration going forward. Because with the increasing emphasis and value placed on home and community-based services I suspect that there has already started to be a shift, at least in regions of the country, where Medicaid programs have invested in HCBS to keep folks who might otherwise have met criteria for nursing facility admission at home, with aides and support to the extent, to Betty's very good point, that the workforce is in deep shortage right now.

To the extent that folks who might have been in nursing facilities in the past are increasingly going to be
at home, they might be more likely to be enrolled in some sort of managed care program, whether sponsored by Medicaid or if they're duals, the fully integrated dual-eligible SNP programs, you know, similar to the MMPs, the demos of the Medicare and Medicaid programs for folks who meet long-term care criteria.

If that's the case, then I think that there could be some sort of inventory, I guess, of the sorts of requirements that those payers are placing on those responsible for managing the care, at least of folks who are eligible for government coverage. You know, I can tell you my experience. There are specific requirements, and the quality metrics would reflect some of the issues that were raised here and of concern.

I think that the other implication of this, and, you know, maybe this is longer term, and David would know this better than anybody, is whether we do expect a shift in the type of resident who is going to be in long-term care living in a nursing facility. From what I have seen, this is going to tend to be folks who cannot be safely cared for at home any longer and who might have quite a bit of home support, but, you know, because of dementia,
Alzheimer's, things of that nature, really are not safe at home, they are finally going into a nursing facility, you know, and families get involved, and so forth and so on.

I just wonder whether longer term, we should keep a focus on the needs of what is going to become the more intensive nursing facility population. I don't know if we've seen these trends, but there's so much emphasis, at least in my state, on trying to keep people home, where they can stay home. It is going to shift who winds up in a nursing facility and has different implications for who is keeping an eye on medication management and other things.

DR. GRABOWSKI: Really quickly, Mike and Dana, on this, just because Pat called me out there, on this. You're exactly right, Pat, and we have seen that trend nationally. Acuity is increasing, and Rachel even mentioned this in the chapter, that in assisted living we've seen a similar trend, as individuals who were previously in nursing homes are now in assisted living, and the whole continuum has shifted. So we're going to see greater medication needs, not just in assisted living but also out there in the community.

And so I definitely think it should be a MedPAC
area of focus. It's an open question to me as to whether long-term care pharmacies are the right answer for that population, or whether it's something that can be managed through a standard pharmacy.

MS. WANG: Yeah, and if I might, just on that point, to the extent that there is some sort of capitated organization who is responsible for organizing that care, you would expect those care managers, those pharmacy techs, and those medical directors to be keeping an eye on what's going on with the member at home.

MS. KELLEY: Bruce.

MR. PYENSON: Thank you. Terrific chapter. There are a couple of items that are database explorations I'd like to suggest. I'm not sure if we have the resources or time to do them for the June chapter. But one item that historically has been a challenge for Part D plans has been the transcriptional scripts of people in long-term care, because transitional scripts were a drug that's not on formulary or fell off formulary or was being used by a beneficiary before switching plans, is much more generous for people in nursing homes than for people not in nursing homes. And this has been a significant issue in the past.
It has been a significant issue for Part D plans. And I think that might be something worth evaluating. I believe you can find those in the PDE information.

DR. SCHMIDT: Can I respond, Bruce, because we actually asked about that in our stakeholder interviews. I think that you've raised the issue before, which caught our eye. And among the stakeholders -- well, first of all, there's been a change in the policy. It used to be that folks in nursing homes would get a 90-day supply, and that's been reduced to a 30-day supply. So that may address some of the problems that you've seen in past years, or it may still be playing out. I don't know fully. But when we asked stakeholders as to whether this has been kind of a way of gaming to get around plan sponsors' formularies, we didn't hear much in the way of yesses from the stakeholders. We can continue to monitor the issue.

MR. PYENSON: Thank you. I appreciate your comment on that. Another question I have is whether there's concentration of particular Part D plans, LIS plans. It seems unusual that we're in an era of active campaigns by enrollment brokers and others, and I think it
would be fairly easy to look in the data, even though we can't quite capture the horizontal consolidation of nursing homes, but within some of the larger ones, whether we see clustering.

Some of the issues, I think, that have been raised are part of the MDS reporting, and I think it might be helpful to talk about the relevance, perhaps strengths or weaknesses, but just the existence of the minimum data set and how may or may not address some of the quality issues that you and others have identified.

And finally, the Part B drug issue might be very interesting. It might relate to some of the same long-term care pharmacies. I would not, in particular, there appears to be the emergency of very long-acting antipsychotic drugs that would probably fall under Part B. So understanding how that interacts with the long-term care pharmacies, if it does, might be helpful information.

Thank you. I know maybe all of these are not in scope for June, but I really appreciate the chapter.

MS. KELLEY: Amol.

DR. NAVATHE: Thanks. So I want to make a comment and then I had a quick question as well. My
comment is really just echoing Stacie's point that I think it would be nice to see how we could support additional quality metrics, or even revisions to the quality metrics, to be more suited to these settings relative to the sort of general Part D beneficiary. Some of the pieces around antipsychotic use, opioid use, et cetera, I think could be, at least in part, addressed, or included in how we think about quality.

The second point is a question which is, so it seems like relative to, you know, standard Part D here there might be opportunities for multiple organizations that are negotiating with the basic manufacturers, namely here the long-term care pharmacies. So Rachel, I was just curious, in the rebate data that we have, that we at MedPAC have received, is that also covered and/or are there reasons to believe that the types of medications that may be disproportionately used in these facilities, is there sort of a differing strategy for the manufacturers on the rebates and/or for the plan sponsors?

DR. SCHMIDT: So in terms of the data that we have, it's what plans are reporting to CMS that they are receiving from manufacturers. The plans should be
knowledgeable if their long-term care pharmacies are also getting rebates, but I don't know for certain that is the case. If they're aware, they're supposed to be reporting, I believe, and I don't know what's in there yet. We're still kind of getting that underway.

I'm sorry. Remind me of the second question, the second part of that?

DR. NAVATHE: My second question is so clinically my hypothesis would be that there's different medications that tend to disproportionately get used in this facility setting, and so are we likely to see -- would you hypothesize that there would be different rebates, basically, from a strategy perspective, from either manufacturers or plan sponsor?

DR. SCHMIDT: We're definitely seeing, I think as I said before, mostly generic use. I mean, in terms of the quantity of prescriptions dispensed there are a lot of brand-name drugs, but they tend to be smaller, lower-priced brand-name drugs relative to Part D enrollees as a whole. So it may be the case that it's not the drugs for which there are large rebates associated. There's also less dispensing of specialty drugs in the long-term care
setting. Many of those do not necessarily have large rebates, but some do.

I don't know if that helps answer your question.

DR. NAVATHE: Yep. No, it does. Thank you.

MS. KELLEY: Mike, that's it.

DR. CHERNEW: That's what I was going to ask about. Wonderful. I will pause, as always, to see if anyone wants to add anything.

[Pause.]

DR. CHERNEW: Okay. Hearing no comments, I think I'll summarize this briefly. First point is there, I think, unanimous interest on the part of all of you to understand how the quality of care is working in long-term care facilities and the prescription drug aspect of that is just one part of it, but I think that interest transcends that. Certainly there are probably measures related to use of drugs, diagnosis of conditions for which there are effective drug treatments, and how the market around that works.

One of the things, I think Stacie [inaudible] matters [inaudible] assessment for quality measures may not all be appropriate in the context of different types of
care for different types of patients, and I think we need to think through that.

That general theme, I think, dovetails with, I think, some of the points [inaudible] was mentioning, and it came up in Brian's comments, and it was clear in that picture that you showed, Rachel, that I asked you to put up, which is this is a very complicated market. We're trying to do something relatively simple, which is getting drugs from a manufacturer to a beneficiary, and there a number of different steps that both the money and the drugs flow through in order to get there, and there are payment issues in a whole range of different junctures in that space. And when the different organizations have complex ownership relationships it makes understanding those junctures difficult, even if we had all the information, which, by the way, we don't always have.

So that is my way of saying that I think, Rachel, there's widespread appreciation for the work you've done here. I think it fits well into the type of stuff that MedPAC looks into. I think it emphasizes our willingness to do both quantitative and qualitative work, to get a sense of what industry stakeholders think is going on in a
range of places. This is certainly a place that is complicated enough that we need both the quantitative and qualitative work.

So I will just close by adding my thank you for all of this work, and thank you to the Commissioners for all of their related comments.

Again, one more pause before I say goodbye for the month.

[Pause.]

DR. CHERNEW: All right. Hearing no other comments, let me thank all of you for the time you spent this month. I thought we had a set of really interesting and important discussions. I, of course, as always, will follow up with Jim, and we will circle back as each of these chapters moves to the next phase.

In the meantime, I wish you all a healthy and happy thanksgiving, and we will see you all again in December. So thank you.

Jim, do you have anything to add?

Oh, actually, sorry. Before you all go, to the public, if you have comments on any of the topics today please reach out to us at meetingcomments@medpac.gov. I
almost missed that.

So we are grateful to all of you that could join us. You also should have a healthy and happy Thanksgiving. Please reach out to us. And again, thank you, and we'll see you all in December.

[Whereupon, at 12:24 p.m., the Commission was adjourned.]