MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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11:16 a.m.

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

2 [11:16 a.m.]

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

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

10 MR. SERNA: That's correct.

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

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

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

20 For today's presentation, first, we will cover
21 the current state of ACO participation and savings. Then
22 we will explain how benchmarks are set in Medicare's ACO

1 programs. Finally, we will discuss some of the more
2 prominent benchmark challenges for Commissioner
3 consideration as we explore payment policy for alternative
4 payment models over the next couple cycles.
5 While downside risk, participation requirements,
6 and beneficiary assignment play important roles, today's
7 presentation will exclusively focus on how benchmarks are
8 set.
9 The Medicare shared savings program, or MSSP, is
10 by far the largest ACO program, covering 10.7 million
11 beneficiaries that account for about one-fifth of
12 beneficiaries with both Part A and B coverage.
13 While early evaluations showed very modest net
14 savings, starting in 2019, monthly shared savings payments
15 per assigned beneficiary increased dramatically, doubling
16 from 2018 to 2019. The sudden proliferation of shared
17 savings payments coincided with changes to MSSP prompted by
18 its Pathways to Success program. Pathways focused on
19 incentives to move ACOs more quickly toward downside risk.
20 However, the abundance of shared savings payments since
21 2019 makes net savings for the Medicare program
22 increasingly unlikely.

1 The Next Generation ACO, or NextGen, and Direct
2 Contracting models have higher levels of risk and reward
3 and prospective payments relative to MSSP. NextGen began
4 in 2016 and will end in 2021. The program currently has 35
5 ACOs.
6 Evaluations shows that NextGen generated modest
7 gross savings that were exceeded by shared savings payments
8 over the 2016 to 2019 period. NextGen will be succeeded by
9 Direct Contracting, which began in April 2021, and offers
10 options for full capitation and risk.
11 Medicare sets ACO benchmarks to determine an
12 ACO's shared savings and losses. The per capita Part A and
13 B expenditures for beneficiaries assigned to an ACO are
14 compared with the ACO's benchmark.
15 The benchmark has two major components, baseline
16 spending and performance year updates. Baseline spending
17 is computed using the expenditures for comparable
18 beneficiaries who would have been eligible for ACO
19 assignment during the baseline years. Performance year
20 updates make risk score adjustments and apply trend factors
21 between an ACO's baseline years and its performance year.
22 Baseline spending in MSSP is computed using the

1 three most recent years before the start of an ACO's
2 agreement period. This baseline period stays fixed for
3 five years. At that point, benchmarks are updated or
4 rebased to include more recent spending, including blending
5 in spending for all assignable beneficiaries in an ACO's
6 region.
7 NextGen and Direct Contracting use a rolling
8 baseline period that is rebased annually. Like MSSP,
9 rebasing has increasingly included an ACO's regional
10 spending in its baseline calculation.
11 MSSP updates benchmarks to allow for a 3 percent
12 increase due to coding. Spending is trended forward
13 retrospectively, using a blend of an ACO's actual regional
14 spending and national spending.
15 NextGen and Direct Contracting adjust benchmarks
16 for coding by up to 3 percent. Spending is trended forward
17 into the next year by projected national spending for the
18 assignable population and adjusted for local wage and
19 practice indices.
20 Rebasing and trending can penalize ACOs for their
21 own gross savings. A downward ratcheting effect occurs
22 when ACOs produce gross savings. These lower spending

1 levels become part of an ACO's baseline spending when its
2 benchmark is rebased. In MSSP, the lower spending levels
3 are also part of an ACO's trend factor.
4 If ACOs consistently produce savings for Medicare
5 and benchmark levels decline from the ratcheting effect,
6 ACOs would have to continuously find new efficiencies,
7 putting long-term ACO participation at risk.
8 The ratcheting effect can reduce the incentives
9 for ACO gross savings while keeping undesirable incentives
10 for Medicare. This has contributed toward a current
11 imbalance in benchmark incentives.
12 Benchmarks reward increased efforts to code
13 diagnoses completely, which undermines risk adjustment.
14 In addition, rebasing has increasingly
15 incorporated regional spending into benchmarks. This
16 rewards ACOs that are already efficient relative to their
17 region with higher benchmarks.
18 In the last five years, CMS has implemented an
19 abundance of policy changes, but benchmark incentives have
20 not become more balanced. Some of those changes are listed
21 here. These changes have not removed the ratcheting effect
22 nor increased the overall likelihood of net savings to the

1 Medicare program.
2 If it is optimal to keep the current structure
3 for updating benchmarks, there are alternatives that
4 indirectly limit benchmark ratcheting.
5 One alternative is to slowly blend in the rebased
6 benchmark. For example, MSSP has five-year agreement
7 periods. The rebased benchmark would be slowly phased in
8 starting in year six of an ACO's participation. Full
9 rebasing would occur in year ten.
10 A second alternative would rebase using a three-
11 year lag between the baseline period and the first
12 performance year in an agreement period. While current
13 policy updates benchmarks using the three most recent years
14 of data, this alternative would create a three-year lag
15 between the baseline period and performance year when
16 benchmarks are rebased. However, these alternatives only
17 delay the effect of benchmark ratcheting and do not
18 directly address the ratcheting effect.
19 One alternative that directly addresses
20 ratcheting and has the potential to better balance
21 benchmark incentives is administrative trending. This
22 would require a restructuring of how benchmarks are

1 currently updated.

2 This alternative would avoid rebasing and

3 ratcheting by using an administratively set trend factor.

4 This factor could be based on a discounted projection of

5 Medicare fee-for-service spending growth or another metric

6 such as projected GDP growth.

7 The main rationale for avoiding rebasing and

8 trending forward benchmarks indefinitely is it would no

9 longer penalize ACOs that generate savings, since their

10 benchmark would never be ratcheted downward. This could

11 give ACOs an incentive to generate larger savings.

12 If ACO gross savings are substantial enough, this

13 could create an increasing divergence or wedge between

14 benchmarks and actual program spending.

15 If benchmarks do not surpass what spending would

16 have been in the absence of ACOs, both ACOs and the

17 Medicare program would be able to share in the savings

18 developed by the wedge.

19 This new method of updating benchmarks could

20 allow for greater predictability in benchmarks while

21 aligning with policy goals.

22 However, administrative trending has its

1 challenges. For example, administrative trending relies on
2 a reasonable approximation of projected program savings
3 several years into the future. If benchmarks exceed actual
4 spending to the point where program savings are surpassed,
5 benchmarks may need to be updated to reflect more recent
6 data.
7 If ACO participation increases, removing the
8 empirical basis for benchmarks could enhance pressure on
9 policymakers to increase benchmarks.
10 In addition, initial baseline spending would be
11 susceptible to random variation in spending changes,
12 particularly for small ACOs. ACOs could be rewarded or
13 penalized for one-time changes in policy, practice
14 patterns, or changes in beneficiary assignment. This could
15 result in selection bias where ACOs with a favorable
16 benchmark continue their participation, but those with an
17 unfavorable benchmark drop out. Under current policy,
18 rebasing at least partially helps mitigate this type of
19 selection bias.
20 Further, incentives for coding intensity and
21 selection would remain and would still need to be
22 addressed.

1 In conclusion, ACO gross savings are likely being
2 surpassed by shared savings payments.
3 The abundance of benchmark policies have not
4 improved the balance of incentives, especially the
5 ratcheting down of benchmarks.
6 Current policy diminishes the long-term
7 incentives for ACOs to achieve savings while rewarding ACOs
8 for activities that do not improve care delivery, such as
9 coding.
10 This brings us to our questions for Commissioner
11 discussion. Do the issues related to rebasing and the
12 downward ratcheting effect necessitate a new method for
13 updating benchmarks? Should the Commission develop ideas
14 around setting administrative benchmark updates? How
15 should ACO benchmarks be adjusted to account for
16 differences in risk scores and coding intensity? Finally,
17 are there other alternatives to address benchmark
18 challenges?
19 We look forward to your discussion, and now I
20 turn it over to Mike.
21 DR. CHERNEW: Thank you. That was really
22 helpful.

1 I am going to turn it over to Dana to run the
2 queue. Dana?
3 MS. KELLEY: All right. I have Lynn first with a
4 Round 1 question.
5 MS. BARR: Thank you very much. Again, thanks
6 for your work. I really appreciate it. I'm very concerned
7 about this topic.
8 I have two Round 1 questions. One of them is the
9 assumption that you have that there is no longer savings in
10 the Medicare shared savings program, where all of the
11 evidence prior to these new changes in the program have
12 been that the program was underpaying the provider. So can
13 you please present the evidence that you have that we're
14 actually now overpaying the providers and that the program
15 is no longer making money for Medicare? Because that
16 certainly doesn't jibe with what I've been thinking or
17 reading.
18 And my second question is I was surprised that
19 nowhere in this discussion was the discussion of the rural
20 glitch, which is something that people have been extremely
21 vocal about, NACOs, et cetera. So, when you're doing the
22 regional benchmark, disproportionately disadvantaged is

1 rural providers because they are the entire -- they're
2 being compared to themselves, and so the numbers don't
3 work. So I was also curious as to what is your thinking
4 about these particular topics as relates to rural and the
5 rural glitch.
6 But I am definitely in favor of getting rid of
7 ratcheting.
8 Thank you.
9 MR. SERNA: Sure. I'll take the first question
10 first.
11 So the evaluations for the program generally are
12 through 2016, and so when you compare what shared savings
13 per beneficiary were during that period and compare it to
14 how much it increased in 2019 and 2020, those gross savings
15 that were estimated during the early years of the program
16 would have also had to increase far more than what was
17 estimated in those evaluations, including the evaluations
18 that we did.
19 So we say it's increasingly unlikely that annual
20 gross savings are exceeding the shared savings payments
21 going to ACOs. So it's not actually in conflict with any
22 of the evaluations that have been on MSSP thus far.

1 The second question, what you referred to as the
2 "rural glitch," we actually do mention it in terms of the
3 ratcheting in the trend factor. So that is part of the
4 ratcheting discussion where we talk about how because that
5 trend factor now is partially based on an ACO's spending,
6 it is essentially also part of this ratcheting effect in
7 MSSP.
8 MS. BARR: Thank you.
9 MS. KELLEY: Okay. I have Paul next.
10 DR. PAUL GINSBURG: Thank you. This is a really,
11 really helpful presentation. Very well done.
12 I have a couple of questions about the regions,
13 and the first one is, you know, what compilation sizes as
14 far as numbers of Medicare beneficiaries to the regions
15 range from?
16 The other question is, over a multiyear period,
17 how large are the differences in rates of growth of
18 spending per capita or per Medicare enrollee across the
19 regions? I think something seemed to assume there were
20 pretty large differences in growth rates, and I just want
21 to know if you have any information on that.
22 MR. SERNA: I don't have any information

1 immediately for you. In general, it kind of follows the
2 geographic variation and spending historically from what
3 we've seen, but I can say that similar to some issues that
4 Lynn has raised, if you're an ACO in a particular small
5 region, your region, it is based on your service area. So,
6 if your service area has a relatively small population, of
7 course, that's going to increase the likelihood that
8 there's going to be more year-to-year variation. It should
9 kind of even out over time, but even with smaller regions,
10 it can still be an issue even if, for example, you use
11 something like a five-year period instead of year-to-year.
12 DR. PAUL GINSBURG: Thanks.
13 MS. KELLEY: Bruce?
14 MR. PYENSON: Thank you very much.
15 In one of the slides, you had mentioned a
16 counterfactual, and I wonder if you could describe that a
17 little bit. I think you were using that in the context of
18 setting benchmarks, and in particular, is the
19 counterfactual based on non-ACO participants or the entire
20 fee-for-service or the entirety of Medicare Advantage and
21 fee-for-service?
22 Thank you.

1 MR. SERNA: I'm sorry. Could you clarify your
2 question a bit? I'm not understanding what the specific
3 question is.
4 MR. PYENSON: Oh, the question --
5 DR. CHERNEW: Can I try and jump in Luis?
6 Bruce, let me see if I can do this, and, Luis,
7 this may clarify the question or at least clarify my
8 misunderstanding.
9 I think the counterfactual that Luis mentioned
10 was sort of more conceptual, what spending would have been
11 had there been no ACOs for the population of people that
12 were in ACOs because they actually do exist. So imagine a
13 world with and without ACOs. The with-ACO ones, a bunch of
14 people in ACOs, they're spending there. The without, we
15 don't know what the without is going to be; hence, it's a
16 counterfactual. But whatever we think that is, I think
17 that's conceptually what Luis was talking about.
18 Luis, now you get to correct me if I was wrong,
19 or, Bruce, you get to correct me if I misinterpreted your
20 question.
21 MR. SERNA: So I'll just briefly say that that's
22 correct, and that's in the context of setting benchmarks

1 initially for a longer period of time. You still have to
2 have some sense. If those trend factors are, indeed, based
3 on some concept of fee-for-service spending growth, you
4 have to have some sense of what that's going to be over
5 time if you're setting those trend factors permanently for
6 longer periods.
7 DR. CHERNEW: For, yeah, Bruce, I think if you
8 believe, for example, the CBO or the OACT projections --
9 and that's a separate question -- but I think they are
10 trying to project a current law projection of where
11 spending would be. And so if spending fell below that, if
12 there was as policy put in place now that held spending
13 below that, all else equal, that policy would be scored, I
14 believe, as saving money. And so the counterfactual, in
15 practice, turns out to be the baseline against which any
16 policy change is scored.
17 There are a bunch of reasons why the forecast
18 might not be a counterfactual, and other nuances, but I
19 think that's conceptually in the spirit of what Luis was
20 talking about. I imagine you have a reaction, Bruce.
21 MR. PYENSON: Well, I understand what you said.
22 I'm not sure I understand what that means for benchmarks.

1 So I think what you explained was looking at total Medicare
2 spending, but then the counterfactual is a group of people
3 who found themselves in ACOs and what their spending would
4 have been in fee-for-service, and that might be different
5 from setting a benchmark? I guess that's my confusion.
6 DR. CHERNEW: Yeah. There is some selection
7 issue. So I probably should have kept the forecasting part
8 out, how you get it, and I think this is more a conceptual
9 point that if you had a bunch of groups that you thought
10 without ACOs would have spending growing at 5 percent, and
11 with ACOs they grow at 4 percent, the counterfactual for
12 that group of people would have been the 5 percent. How
13 you measure it, what it means in practice, how you set the
14 benchmarks, is, you know, a little bit separate. But I
15 think where Luis was going if you were going to set
16 something for a long run you would want to have a
17 projection of what the participants would have spent in the
18 absence of ACOs as your counterfactual. How you get there
19 is a separate analytic question.
20 I'm not sure we're clarifying your clarifying
21 question. We may be muddying it. I may have to extricate
22 myself from the discussion. Do you have any follow-up,

1 Bruce?

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

3 Thank you.

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

5 move on.

6 MR. SERNA: If I'm understanding correctly, I

7 think what you're saying, Bruce, is that it doesn't matter

8 if your trend factor is closer to policy goals that are

9 separate from actual spending, and that's probably true,

10 but that's a larger discussion for how the trend factor

11 would be set, which can be done in a number of ways.

12 MR. PYENSON: I think you've gotten at the core

13 of my question. Thank you.

14 MS. KELLEY: Okay. Our last Round 1 question is

15 from Larry.

16 DR. CASALINO: Thanks, Dana. Luis and Jeff, nice

17 work, as always. So the materials are very interesting and

18 focus very heavily on rebasing and what to do about trends

19 going forward. But if I understood them correctly, they

20 don't have much to say about setting the initial benchmark.

21 And if I understand correctly, let's say we did

22 administrative, or Congress did administrative, or CMS did

1 administrative trends for updating, that would, I think,
2 get rid of the ongoing ratcheting problem. But then if you
3 started with a high benchmark, because you were a high-
4 spending ACO or high-spending region, or whatever, you'd
5 kind of have a permanent advantage with the administrative
6 trending forward, which is, in some ways, even worse than
7 the ratcheting effect, potentially.
8 Have you guys thought about that at all? Do you
9 want to make any comment to help us when we get to
10 discussing that?
11 MR. SERNA: So I will say that was in the
12 discussion about what the challenges would be, and kind of
13 the ongoing challenges, is that initial baseline starting
14 point would have an effect on participation, potentially
15 for several years. In the chapter, we did talk about the
16 various ways that baseline spending can be calculated and
17 some of the pros and cons of those things, whether it's on
18 a regional basis, whether it's using an ACO's historical
19 spending. But obviously, there are tradeoffs for whichever
20 method you would choose.
21 DR. CASALINO: And, Luis, you understand
22 correctly, though, that if administrative trending was used

1 just kind of straight, the advantage or disadvantage you
2 had from your initial baseline benchmark would be
3 permanent, unless something was done to kind of narrow the
4 gaps, essentially the gaps in the baseline benchmarks, over
5 time.
6 MR. SERNA: That's correct.
7 DR. CASALINO: Okay.
8 MR. SERNA: I didn't mean to interrupt you.
9 DR. CASALINO: No, no. That's great. Thank you.
10 MR. SERNA: Okay, so there are several things in
11 the chapter that we tried to enlighten for that potential
12 consideration. One was if you don't adjust for regional
13 efficiency in the baseline period perhaps one thought is
14 you could do something about it in the trend factor, have
15 some kind of differential trend factor for regional
16 efficiency. That would be one way, over time, but that's
17 something strictly for your consideration. But that issue
18 is discussed in the chapter, but clearly there is no
19 solution given, just kind of things for you all to
20 consider.
21 DR. CASALINO: Thank you.
22 DR. CHERNEW: Yeah, so let me jump in. Larry, I

1 think two things. One is what you said is spot on. Two is
2 that's why, as we pursue this work, thinking about how to
3 avoid locking in baseline inefficiencies is going to be
4 very important and a topic for discussion. I think it
5 might be one of the central topics for discussion, at least
6 in the realm of the updating portion of it.
7 So the key point is you can do that in ways that
8 have a ratchet -- in other words, you save and then we take
9 it away -- or you can do it in a way that works more
10 administrative, which is we force some level of
11 convergence, we can control the pace, but it's not affected
12 by your success. In other words, the more successful you
13 are, you don't lose more. That's sort of the distinction
14 here.
15 DR. CASALINO: And Mike, just to make sure I
16 understand you correctly, though, so giving slightly
17 different trends administratively to force convergence,
18 that does get rid of the ratcheting problem. Still,
19 though, do I understand correctly that if you have
20 favorable benchmark initially, let's say, you still would
21 be able to profit based on being an efficient ACO or
22 region, for as long as it took for convergence to happen.

1 Is that accurate?
2 DR. CHERNEW: If you have an inefficient
3 benchmark to start and you can achieve those efficiencies
4 quickly, you have more opportunities to save. That is
5 true. And I guess I'll say something about that when we
6 jump into Round 2, but what you said is true, although it's
7 also possibly the case that there is a faster convergence
8 by raising the lower end, in which case you could also say
9 that if you started off efficiently as the benchmarks might
10 converge. In other words, if you're starting 10 percent
11 below some average and your benchmark is rising at a rate
12 faster than average because you started below, you could
13 also profit.
14 I'm trying very hard not to signal a particular
15 formulaic response. We are nowhere close to exactly what
16 the formula would be. I'm really trying to outline the
17 possible things that one could do, and your question,
18 Larry, I think correctly points out one of the challenges
19 that any benchmark system would have to address. I think
20 that in that sense it is spot on. But there's a lot of
21 flexibility in how you address those challenges, and I
22 think in the spirit of what Luis said, this chapter was

1 intended to at least begin to raise those challenges, if
2 not provide the solutions to them.
3 Did I capture that right, Luis?
4 MR. SERNA: That's exactly right.
5 DR. CHERNEW: It's hard since you're all so small
6 on my screen to catch exactly what's going on. Dana, are
7 we ready to move on?
8 MS. KELLEY: Yes, ready for Round 2. Would you
9 like me to start? Jonathan Jaffery is first.
10 DR. CHERNEW: Well, let me just make a comment,
11 in the spirit of the discussion we were just having, to
12 kick off this discussion, and then we'll just go through
13 the queue and I will try and be quieter.
14 The savings for the Medicare program, in my
15 opinion, can be achieved by either lower benchmark growth
16 than what otherwise might have happened, thereby pulling
17 out some money, or by pulling out past savings by rebasing
18 from the groups that have been successful. So when a group
19 is successful you can pull out their savings, do some
20 rebasing or some other policy.
21 My personal view is that, depending on the
22 details, the rebasing dramatically lowers the incentives to

1 save. And so if you don't have incentives to save, it's
2 hard to have the program do well because there's not a big
3 pie to share. So my personal view is savings to the
4 program achieved by slower benchmark growth is a valuable
5 way to think about how Medicare can promote access to high-
6 quality care in an efficient manner. But that's just my
7 view, and now I think we're going to go through to catch
8 all of yours.
9 So I guess, yes, we'll turn it over, and you said
10 Jonathan was first. So Jonathan, you're up.
11 DR. JAFFERY: Great. Thanks Michael, and thanks
12 for this, Luis and Jeff. This is great and I think really
13 sets us up nicely for some of the important work that we
14 need to do moving forward, and we're starting to really get
15 into kind of the meat of some of the main issues that we
16 started to talk about last month.
17 I'll try and direct my comments towards the
18 discussion questions you put up here and think about this
19 in terms of setting some principles around how we think
20 about this, recognizing that there's a lot of specifics, as
21 Mike mentioned a second ago. We are not going to solve all
22 those issues today. That's really a multi-cycle effort.

1 So first of all, thinking about concerns about
2 long-term downward ratcheting and do we need different ways
3 to update, a new way to update benchmarks, I would, you
4 know, enthusiastically say absolutely. This has been an
5 issue that we've all recognized for some time and spoken
6 about how this creates a non-sustainable way to continue
7 participation for ACOs. We can't just continuously have
8 our benchmarks go down. And, in fact, if you think about
9 it sort of philosophically, the goal for spending for an
10 ACO should not be zero, and we could argue that the quality
11 needs to continuously improve, and we'll never top out at
12 that. But the goal of spending is not zero, so we need a
13 different way to think about this, and ratcheting down will
14 not work long term.
15 I'll jump to the risk adjustment real quick, just
16 to sort of put that aside. I think this is a huge issue,
17 of course. We've talked about it in lots of different
18 discussions. It's a problem that crosses into MA, maybe
19 even more urgently there. And we do need a better and
20 simpler approach to risk adjustment that isn't all coding-
21 based and is less burdensome for doctors, and is much less
22 susceptible to gaming. I think you pointed out in the

1 presentation that these issues are going to remain with any
2 of the potential benchmarking changes, so it is a bit of a
3 separate issue.
4 That said, one specific comment, in the meantime,
5 while we're thinking through and trying to get to better
6 risk adjustment methodologies, expanding the timeline to
7 two years of collecting codes could, in fact, be helpful,
8 and basing them on two years of diagnostic codes. That, if
9 nothing else, would decrease the burden. It really is an
10 issue that we see happen on January 1st, when suddenly it's
11 just starting over.
12 So in terms of, you know, should the Commission
13 start thinking about how to set administrative benchmarks,
14 I would love to see us dig into this work. I'd also love
15 to see us set some sort of long-term vision and maybe work
16 backwards a bit. One of the recurring themes that you have
17 in the chapter is how to balance these three things, right
18 -- rewarding providers for efficiency, achieving savings
19 for the Medicare program, and not adversely impacting
20 provider participation.
21 And so it is very difficult to see how we have
22 that balance and get that balance right, year over year

1 over year, when participation remains voluntary in the long
2 run, or if not participating remains just sort of a
3 comfortable and lucrative option for people.
4 So in a perfect world -- in my perfect world,
5 anyway -- at some point in the not-too-distance future
6 we've got all Medicare beneficiaries in some population-
7 based, value-based payment model, whether that's MA or an
8 ACO. And, in fact, CMMI's recent white paper suggests a
9 similar goal of by 2030, to have all Medicare
10 beneficiaries, and the vast majority of Medicaid
11 beneficiaries in some such model. So I'd love to see us
12 kind of moving in that direction as well, and I think that
13 helps us think through a lot of these issues.
14 I agree that the regional consideration is
15 challenging. Lynn mentioned it for rural areas. I think
16 I've shared with the group in the past, we've looked at
17 this. My ACO does end up making the region, and I think we
18 did a calculation of how having more of a regional
19 adjustment impacted us as a low-cost ACO, and it impacted
20 the benchmark two cents per beneficiary per month. So it
21 really is a very minor effect, or can have a very minor
22 effect if you really make up that region.

1 And then I think the final comment I'll make, I
2 think, and this builds on Larry's comments a bit, his
3 question, is really getting to this issue of convergence.
4 I think in the long term, again, there may be different
5 ways to get there. There are undoubtedly different ways to
6 get there. But it doesn't make sense that in the long term
7 we have such regional variation in terms of total cost of
8 care.
9 Beyond the risk adjustment and some other kind of
10 local geographic considerations of wage index and things
11 like that, it's hard to see justification for having 50
12 percent higher or two-fold total cost of care in one region
13 of the country, that we'd just memorialize and that would
14 exist in perpetuity. So whether that's by bringing up some
15 of the baseline for some of the lower costs, or bringing it
16 down quickly for higher costs, how quickly we make that
17 convergence happen, long term this has to have an eye
18 towards more standardized approach to what the right amount
19 to spend for a population of Medicare beneficiaries is
20 across the country.
21 Thanks.
22 MS. KELLEY: Brian.

1 DR. DeBUSK: Good morning, and I'd like to thank
2 the staff for a really great chapter, very well written. I
3 share the concern that ratcheting is a problem, and I think
4 we should do away with it. But I would go a step further
5 and argue that any strictly formulaic approach to this
6 problem is going to be a problem in and of itself. As
7 Jonathan mentioned, one example in the highest-penetrated
8 MA counties, it may be difficult to even reliably calculate
9 things like average fee-for-service spending.
10 And I think that this really underscores how a
11 formula can lock in a specific methodology, and that
12 formula may not reflect our overall program goals. And it
13 also runs the risk of sending us off like alchemists,
14 looking for this perfect formula that's going to meet all
15 these different geographic and national needs.
16 I think that also strictly formulaic solutions
17 become particularly problematic when they are coupled with
18 voluntary participation, because it transforms the core
19 competence into the ACO's ability to favorably select,
20 number one, whether or not to participate, but also then to
21 favorably select the providers and the beneficiaries within
22 that specified methodology. In other words, the rules are

1 transparent but the behavioral response of the providers
2 doesn't have to be.
3 So I do favor administratively set, prospectively
4 trended benchmarks, and I think we can always incorporate
5 formulaic methodologies into them. But then it's an
6 option; it's not a requirement. And, for example, tying a
7 prospective trend to some other economic measure, like GDP,
8 seems very reasonable. And I also think that that gives us
9 a lot more flexibility in dealing with coding itself,
10 because we can treat that as part of the administrative
11 process. For example, it gives us the opportunity to
12 normalize coding intensity periodically.
13 We can incorporate two years of risk score
14 coding, which Jonathan mentioned, and I hope we do, and I
15 would like to see more frequent calibration of the HCC
16 model. I don't think we've recalibrated -- I think 2014
17 and 2015 were maybe the base and performance years of the
18 latest recalibration. I may stand corrected on that.
19 But the other comment I wanted to make, I favor
20 some form of mandatory participation, obviously, an
21 administrative benchmark with mandatory participation. But
22 I do want to make one observation. It really intensifies

1 the attribution process, because then the persistent over-
2 and under-spenders really become inescapable. And so I do
3 think as we move forward with exploring mandatory options,
4 I do think we need to keep in mind, could we inadvertently
5 create some access issues for those highest-utilizing
6 beneficiaries?
7 Thank you.
8 MS. KELLEY: Lynn.
9 MS. BARR: Good morning and thanks. Thanks again
10 to the staff for a great chapter. So, you know, this is a
11 very difficult discussion as we, you know, learn about
12 people talking about how we're overpaying ACO participants
13 and that they are gaming the system. But there are a lot
14 of people in there that aren't gaming the system and got a
15 reasonable adjustment in Pathways. And so how do we break
16 that apart, right, is really the question? I mean, for us
17 we thought that was a reasonable adjustment, but we, at the
18 same time, are seeing what you're seeing, with a lot of
19 gaming of the system.
20 So, you know, we want to make sure we're not
21 throwing the baby out with the bath water, in some cases.
22 And, you know, I think that the important thing is, what is

1 the national spend? How much does a beneficiary cost the
2 taxpayer? And I think the more that we can drive expensive
3 ACOs to the national spend and reward efficient providers
4 for reducing costs and staying below that national trend,
5 so we may want to look at the national spend as a way of
6 driving benchmark policy, because ultimately that's what
7 we're trying to get to, and I agree with Jonathan that
8 getting rid of the national variation is silly and
9 expensive, and it can't be good for the patients.
10 So those are my thoughts. Thank you.
11 MS. KELLEY: Betty?
12 DR. RAMBUR: Thank you so much. I really
13 appreciated the chapter and the comments of the other
14 Commissioners, and I'll just build on a few of them.
15 I also think that setting the base and the trend
16 is one of the most foundational important things, and the
17 retrospective ratcheting is definitely a problem. I think
18 about it as the good management penalty. So I am
19 supportive of prospective administrative trend, exploring
20 that more deeply.
21 That said, I'm also thinking a lot about how can
22 we incent behavior that is really about care redesign,

1 getting some of that cost that's already baked in the cake
2 out of there, and just as one brief example, I see all the
3 time the response to more children with asthma is to hire
4 another pulmonologist, but not to have social workers or
5 community workers or nurses go into the home and think
6 about mold abatement, getting pets out of the bedroom, is
7 the child under stress, whatever. And so we're so steeped
8 in that reflexive biomedical model that it's very difficult
9 to shift on anything that has, you know, a fee-for-service
10 chassis.
11 I am very concerned about how the coalition of
12 the willing creates a selection bias, and I would be
13 strongly in favor of moving aggressively, as Jonathan and
14 others have suggested, towards this not being an
15 alternative payment model but the payment model with
16 bundled payments underneath because it's obviously a
17 challenge.
18 And then, finally, to the extent that the gaming
19 with coding adjustments be addressed, you know, for the
20 individuals that are doing it, they are not feeling they're
21 being manipulative or unethical. They're just taking
22 advantage of the opportunities they see in front of them.

1 So I'm not the person who can figure out how we redesign
2 this so that we don't have that, but I think it's very
3 important.
4 So I think this is an important conversation and
5 well worth our time and effort, and I thank you for your
6 thoughtfulness and what you've brought forward.
7 MS. KELLEY: David.
8 DR. GRABOWSKI: Great. Thanks, Luis and Jeff.
9 This is great work. I do believe ratcheting is a major
10 problem, and I'm really glad the Commission is taking this
11 on.
12 So let me just start with my high-level comment.
13 I think we want to base benchmarks administratively. We
14 want to update them at a preset or concurrent regional or
15 national growth rate. We don't want to rebase them based
16 on performance. That's sort of at the high level.
17 In terms of the details, if we're thinking about
18 regional versus national growth rates, I like a regional
19 perspective or administrative benchmark. I don't think you
20 can just flip that on, however. Larry raised this in Round
21 1. We're going to need an on-ramp period to what Mike
22 termed "convergence." And I think Mike said this in Round

1 1, but we don't have to sit idly by and just wait for that
2 convergence. We can actually adjust benchmarks across
3 areas.
4 One idea that has been put forward, I think by
5 Mike Chernew and Michael McWilliams and others, you can set
6 the lowest spending regions that have the greatest growth
7 in benchmark relative to those higher-spending regions. So
8 you could make this a policy instrument.
9 In terms of when we do get to this next phase,
10 how to do this -- and I think Brian already mentioned this
11 -- I like the idea of using kind of GDP growth, for
12 example, or some other factor. I do think you're going to
13 need to have that informed by fee-for-service growth to
14 protect providers against losses from the increases set by
15 the Congress. And I do think you're going to have to have
16 periodic systemwide rebasing that's informed by fee-for-
17 service spending. So I don't think you can purely rely on
18 GDP, but I do think we can do this with some rebasing.
19 A final comment, and maybe I'm getting ahead of
20 myself here, but I can't help it. Regional benchmarks for
21 ACOs in this next space could be harmonized with Medicare
22 Advantage, and what I mean by that is that the benchmarks

1 for a beneficiary with the same risk score in the same
2 region would be identical across the two programs. If we
3 had a comprehensive ACO program here spanning fee-for-
4 service Medicare, the ACO benchmarks could be used instead
5 of fee-for-service spending as a cap on plan bids. I know
6 that's an issue we've talked a lot about in Medicare
7 Advantage. I don't want to blur two big issues here, but I
8 do think there's a lot of opportunity to kind of do more
9 here once we get this right. And I know I'm way out in the
10 future, but I want to think big.
11 So, once again, happy we're doing this work and
12 really excited we're digging into this. Thanks.
13 DR. CHERNEW: Before we go on, Dana, I want to
14 make one clarifying comment just for the audience, writ
15 large. Fee-for-service is a complicated concept in this
16 conversation because right now ACOs are part of fee-for-
17 service. So if all providers or beneficiaries were in an
18 ACO, just hypothetically, understand that fee-for-service
19 is really just the other ACOs. That's the way that that
20 would work out. And so you would be -- if, for example, we
21 set a benchmark at the average of fee-for-service, that
22 would de facto be the average of ACOs, which would de facto

1 mean half the ACOs would have to lose by definition.
2 Actually, not necessarily, depending on how you weight it,
3 but that's more technical.
4 It is certainly true that -- now, maybe we're
5 fine with that. Maybe we're okay with that. I worry a lot
6 about that personally. But that is important to understand
7 where ACOs and fee-for-service fit because sometimes we
8 talk about them like they're different, but
9 programmatically, the ACOs are in a new way of paying in
10 fee-for-service. So I'm going to stop there, and I just
11 wanted to remind folks of that, and now we'll go on to the
12 rest of the queue, Dana.
13 MS. KELLEY: Okay. I have Jaewon next.
14 DR. RYU: Thanks, Dana, and thanks for a great
15 chapter. A complex area. I think I could probably add a
16 plus one to a lot that's already been said. I'll just kind
17 of go through the list here of notes that I had taken.
18 I, too, am against the ratcheting effect. I
19 think it does exactly what we don't want to do, which is to
20 penalize success. And so I am also in favor of an
21 administratively or prospectively set benchmark, and I like
22 the idea of pegging it to something like the GDP or some

1 other instrument along those lines.
2 I think this notion of convergence, however, I
3 think there are areas or counties or locations, however you
4 want to define it, that clearly have higher rates of
5 spending at a starting point versus others. And I think on
6 some level you start where you start, and so I think we
7 have to be somewhat recognizing of that reality. But over
8 time you would like to see convergence.
9 I'd love to see something done around
10 differential rates of growth so that you can have a slower
11 or a more aggressive slowing down of a rate of growth in
12 counties that are higher spending, and then maybe that
13 rampway or the trend line doesn't look as aggressive for
14 areas that already have a low spending rate.
15 At the same time, this starts feeling, to me at
16 least, a little bit like the MA quartile benchmark system,
17 and so I think we've got to be a little careful not
18 introducing some of the flaws that we've discussed around
19 that model. But I think as a concept I do like that it
20 gets us to where I think is a good spot.
21 I think the last point I would make; I can't
22 separate this thinking from whether or not the program

1 would be mandatory or voluntary. I think if it's
2 voluntary, I think the added layer of complexity and
3 thinking through the administratively or prospectively set
4 benchmark needs to be that it's still got to be a more
5 favorable environment or more attractive environment than
6 being outside of the ACO or alternative payment
7 environment. And so, you know, to me it's cleaner if it's
8 mandatory; then everybody's in. But if we are not going
9 down that road, then I think we also have to ensure that
10 it's a more attractive setting for people to come into.
11 MS. KELLEY: Paul.
12 DR. PAUL GINSBURG: Well, thanks, Dana. You
13 know, as I was reading this chapter, I just kept thinking
14 over and over again about, wow, with a voluntary system, it
15 is so hard to come up with a good benchmark policy. And,
16 you know, my colleagues that preceded me have been very
17 strong -- and I support them -- about the importance of
18 going to a more mandatory system, and I'm saying more
19 mandatory because I would envision a situation where for
20 some provider types it would be mandatory; for others there
21 would be strong incentives to participate, and the
22 incentives would be basically you get higher fee-for-

1 service rates if you're in an ACO and you get lower fee-
2 for-service rates if you're not in an ACO.
3 I think getting back to the benchmark issue, I
4 think we should be saying not only what would be the best
5 way of doing benchmarks now under our current voluntary
6 system, presuming we moved in the direction of mandatory,
7 how would we do benchmarks under a mandatory system,
8 because I think we could do a much better job in having
9 equitable and efficient benchmarks with closer to a
10 mandatory system.
11 Another comment I wanted to make is that, you
12 know, I think that the regions are too small, and we might
13 want to bring into our discussion discussions like we had
14 over the years in Medicare Advantage, where, you know, the
15 Commissioners come up with the MedPAC areas instead of
16 carriers going to, you know, the parts of metropolitan
17 statistical areas within a state and then the rural
18 counties in a state. And I think if we had bigger regions,
19 we could rethink and maybe a system -- a blend of regional
20 approaches might look much more attractive if we had larger
21 regions. You know, maybe we could even have like census
22 divisions, like nine of them, rather than the small regions

1 we have today, which just don't work that well.
2 A final comment is this issue that's come up a
3 few times about ACO selection of providers, and I've been
4 really concerned about the implications of this. Imagine a
5 primary care practice that is the only practice in town
6 that goes into nursing homes to treat their patients.
7 Well, I would imagine if you looked at their attributed
8 beneficiaries spending, it's going to be a lot higher than
9 the other primary care practices, and that, you know, we
10 don't -- you know, the more selection we have, there's a
11 risk of decreasing access as well as really gaming the
12 system. So I think we should be focusing on that element
13 of risk selection as well as, you know, the coding
14 problems.
15 MS. KELLEY: Amol?
16 DR. NAVATHE: Thank you. Luis and Jeff,
17 fantastic work here in outlining a number of different sort
18 of historical legacy designs as well as those four
19 challenges.
20 I wanted to say a few things here. I think the
21 first thing is I would advocate, if possible, for us to
22 actually be very explicit about what the goalposts are here

1 in terms of where we're trying to head, because I think at
2 times it can be a little bit dizzying in terms of all the
3 different tensions that we're trying to balance. And, in
4 fact, articulating where we're trying to head, prioritizing
5 this notion, for example, of Medicare savings and making
6 that very clear, at the same time noting that there's a
7 number of different tensions that are created from a design
8 perspective, I think that would be very helpful to dispute
9 up front in the writeup to set out -- set this out
10 explicitly.
11 And just to give some examples, when I say, you
12 know, what are some of the principles that are worth
13 outlining, I think it could be something as straightforward
14 -- I think some of these are said in the chapter, and it
15 might just be kind of pulling them forward to a certain
16 extent. So, number one, our goal is generating Medicare
17 savings; number two, encourage participation and reward it.
18 We heard this from a number of Commissioners several times
19 here that one of the concerns about the ratchet, for
20 example, the ratcheting downward is that it doesn't
21 encourage participation, particularly amongst those that
22 are doing well or it's rewarded. We may want to reward

1 high performers. In terms of driving savings, those --
2 also in terms of better improving rapidly, for example, we
3 might have a goal around having a system that's more robust
4 to coding variation, and we might want something that is
5 more -- that is simpler and, therefore, easier for provider
6 groups and ACOs to respond to the incentives, too, which,
7 for example, a retrospective trend factor might be more
8 challenging for. I think as we set out these principles,
9 highlight the tensions, I think it will help us navigate
10 some of the complexity here.
11 The third point I wanted to make is that I think
12 it would really be helpful to start -- I know we're at a
13 preliminary stage here, but as we go forward, to do some
14 analytic work to understand, for example, how pernicious
15 the ratchet effect is on benchmarks, on the potential for
16 savings, showing, for example, that an ACO that is
17 improving rapidly over time, how it gets penalized. I
18 think that would be helpful.
19 I think similarly with the administrative
20 benchmark, I'm generally in favor of that concept. I think
21 it would be helpful to understand how we would deal with
22 certain scenarios where what happens in the future actually

1 doesn't match up with what we prospectively thought. And,
2 therefore, what kinds of risk corridors, minimum savings
3 rates, what are the other dimensions that would need to be
4 a part of that.
5 The last point I wanted to make is I agree with
6 something that Paul was just basically hinting at, which is
7 I think some of the analytic work may actually be useful in
8 terms of can we actually design a benchmark rebasing and
9 trend-based system in a voluntary world that is not highly
10 vulnerable to the selection effects. I would love to see
11 that, and I have generally been a big fan of the idea that
12 we do voluntary programs as a way to garner participation
13 potentially amongst those groups that have the most either
14 to save or feel that they can improve a lot. But I think
15 this is highlighting that it's possible -- or it may not be
16 possible to truly design a system that doesn't create some
17 strong election effects where you end up having a group
18 that is above -- you know, above average spending, for
19 example, above benchmark if you do it regionally that is
20 not going to join, or vice versa, you have a group that is
21 very efficient and you're creating a system. I'm not sure
22 that we can blend 50/50 and do this and that and actually

1 solve all the dimensions.

2 So I think, Jeff and Luis, one of the questions I

3 have is: Can we do some work around this analytically to

4 see if we can actually build a robust system? My

5 speculation here is it actually may be quite challenging.

6 So thank you very much for taking us in this

7 direction. I think it's very valuable, and I look forward

8 to the following work.

9 DR. CHERNEW: Thanks, Amol. I just want to jump

10 in and make one reaction to one thing you said just

11 quickly. This is just a Chernew view. My view of APMs

12 generally for big-picture principles is we're not -- the

13 goal is not to get everyone into an APM per se. The goal

14 is to provide efficient care, high-quality care at an

15 efficient cost and allow the delivery system flexibility to

16 do that and succeed.

17 If it turns out that other mechanisms like

18 Medicare Advantage can do a lot better than APMs or the

19 APMs just simply can't work for a bunch of other reasons, I

20 would have no problem finding some other better mechanism

21 to achieve broader program goals. So I just wanted to put

22 out there that it's not -- participation for the sake of

1 participation doesn't mean we have won. What means we have
2 won is when we have high-quality care to all populations at
3 an efficient cost.
4 So that's just my perspective. We can have a
5 broader discussion of that, but let's move on in the queue.
6 MS. KELLEY: I have Bruce next.
7 MR. PYENSON: Thank you. I want to thank the
8 authors but also the other Commissioners because I think
9 the concepts that the Commissioners have brought up this
10 morning are really very important and very helpful and
11 useful.
12 I would say I definitely am an advocate of the
13 administratively set long-term benchmark goals, and that's
14 something that ought to be done with a policy goal in mind.
15 And I like the percent of GDP kind of connection there.
16 I would say that I've been an advocate of moving
17 away from the annual, the 12-month cycle of rate setting
18 for both Medicare fee-for-service fees as well as Medicare
19 Advantage benchmarks and bid process. It seems silly in
20 the third decade of the 21st century that we can't set
21 goals and targets that are more than 12 months long. We
22 can certainly do that. We've got incredible data systems

1 and insights, and let's do that, because the current system
2 of annual updates favors organizations that can game the
3 system, and the longer-term goals of things like population
4 health are not consistent with one-year churning.
5 Like others, I don't see the solution in a
6 voluntary system, that some form of mandatory or quasi-
7 mandatory system is essential. The current system has led
8 to what used to be termed a "breakdown" of the insurance
9 pool, and for the reasons that Paul and Betty mentioned,
10 the selection issues, I think we have less time to deal
11 with this than we might think, that the selection issues
12 for provider networks for beneficiaries on side of both
13 ACOs and Medicare Advantage plans are available now. And
14 they're being used and being aggressively sought after
15 because they're so effective in the current system.
16 So I think we have less time than we think to
17 move to a mandatory system to avoid those kind of selection
18 issues.
19 I would like to offer a concept to avoid some of
20 the selection issues, which recognizes that health outcomes
21 are a product, not of an individual doctor, not of an
22 individual hospital, but of a community, and that all

1 participants in the community ought to be held accountable
2 for the outcomes of that community. And that includes
3 Medicare Advantage along with accountable care
4 organizations in the mandatory system we envision.
5 So connecting those outcomes and the actions
6 taken on a community basis is one way to avoid the
7 selection issue; that is, everybody does well or everybody
8 gets penalized if the system on a local basis isn't working
9 correctly.
10 Just a final point, a technical note. The focus
11 on trends takes me back to the beginning of my career as an
12 actuary when we didn't have very good data systems, and
13 trend was seen as king. Trends took on a quantity as
14 though it was a physical measurement like temperature or
15 the portion of carbon dioxide in the atmosphere. So trends
16 was used to move the status quo forward.
17 I don't think that's what we want here. We want
18 to set benchmarks based on policy. We have the data to do
19 that in detail in a deliberative way. Trend will be a
20 consequence of policy, not a driver of policy. So I just
21 want to put in that technical note to change our emphasis.
22 The iterative process that's used today to set insurance

1 premiums and bids and others, you know, certainly considers
2 a historical trend, but it's based on policy goals and
3 forecasts and financial goals. And I think that's what we
4 should do and get away from the focus on trend.
5 But, again, my compliments to the authors. Thank
6 you.
7 MS. KELLEY: Marge.
8 MS. MARJORIE GINSBURG: Yeah. My comments will
9 be very brief.
10 The discussion has been fabulous. The report is
11 amazingly detailed and yet somehow understandable. This
12 whole topic to me is one of the more complex, difficult
13 ones that we have to face, and I completely support the
14 comments that others have made towards getting rid of the
15 ratcheting effect going towards administrative benchmarks.
16 My main comment was just to reflect on other big
17 issues that we often weigh in on, and it seems that there
18 are kind of three principles that always rise to the top,
19 at least this is how I interpret it: simplicity, fairness,
20 and affordability.
21 This is not simple, the way it is now, and I
22 think our movement towards getting rid of the ratcheting

1 effect will move us more towards that concept of
2 simplicity, and I think that is going to be really
3 important as we move forward and as other medical groups
4 move forward.
5 The other comment I want to make is that are any
6 of the -- maybe it's a question. Are any of the other
7 things that we weigh in on, such as quality bonuses for
8 MAs, require them to be evaluated based on their previous
9 years' success, or does everything always start with a
10 clean slate? Is this the only area where people have been
11 held accountable for their success previously as they go
12 forward? So that's just the general question of has this
13 really been a bit of an outlier in terms of requiring that
14 all the ACOs be evaluated based on their previous success.
15 So that's a general question.
16 My comments are I'm excited about moving forward
17 with the comments of my colleagues. Thank you.
18 MS. KELLEY: Stacie?
19 DR. DUSETZINA: Thanks for the great chapter
20 here.
21 I'm going to, as Jaewon said, plus one for a lot
22 of the things that have been said already, including trying

1 to address the ratcheting problem.
2 And, also, specifically, I think not penalizing
3 ACOs that were efficient in their baselines and rewarding
4 those who are inefficient seems like a really good goal to
5 have.
6 Probably, following up a little bit on what Amol
7 was saying is I think that we need a little bit more
8 information around some of these decisions, specifically
9 for the trends.
10 I appreciate the comments and people being
11 supportive of pegging to GDP. I wonder also about how to
12 take into account things like unusually bad years and also
13 like new technology coming into the program, what that
14 would look like if we used non-ACO fee-for-service spending
15 to try to understand new technology adoption and GDP. How
16 would those differ in what we ended up with if we used a
17 trend? So I think seeing a little bit more information
18 about those would be really helpful.
19 Another thing that I don't know, and maybe this
20 goes a little bit to Marge's prior comments, was about
21 setting the initial baseline or initial grouping for the
22 ACOs is -- what does happen if you look back for three

1 years prior trend instead of the one year? How different
2 would that look as far as how efficient a practice looked,
3 and what can we do, thinking about moving those targets
4 around for defining an ACO's performance in at least a
5 baseline year?

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

9 MS. KELLEY: Larry.

10 DR. CASALINO: Yeah. So I too am in favor of
11 looking very seriously at prospectively using some kind of
12 an administrative guideline to rebase or to trend forward,
13 and it's interesting to see we seem to have virtual
14 unanimity on the Commission about that. The ratcheting is
15 just so patently unfair. I'm surprised there hasn't been
16 much more about it than there has been, and I think the
17 reason it hasn't been is because the program hasn't been
18 mandatory. But, even so, it creates a kind of cynicism
19 and, I think, really hurts the long-term goal of trying to
20 have providers organize in such a way they can improve care
21 for population of patients. So I think the sooner
22 something can be done about that the better.

1 I just want to emphasize a couple of, in a way,
2 minor points but that are important, I think. I think Dana
3 Safran may have something to say in a little bit about her
4 experience with the Alternative Quality Contract program in
5 Massachusetts.
6 But one of the things, setting projected
7 increases years in advance, honestly, the problem with that
8 is something could come along that couldn't be foreseen, a
9 major change in the economy, new technologies being
10 introduced that are expensive. That's tricky because often
11 expensive new technologies are put into place and used a
12 lot when they really shouldn't be, but that's a side point.
13 The main issue is I think that Blue Cross Blue
14 Shield of Massachusetts, which Dana will talk about, was
15 able to be very flexible and change quickly, what it wanted
16 to do with the prospective setting of benchmarks, and I'm
17 not sure that CMS could do that.
18 The other thing is in addition to changing
19 benchmarks, sometimes just on an annual basis, my
20 understanding -- Dana, correct me if I'm wrong -- is that
21 Blue Cross Blue Shield of Massachusetts had to make some
22 kind of on-the-fly adjustments for unexpected things that

1 came along, and that turned into kind of a black box, which
2 I'm not sure would be acceptable in the Medicare program.
3 These are problems, I think, should be dealt with going
4 forward with administratively updating things.
5 And then just two minor points. There's been a
6 lot of talk about mandatory today. I know that this
7 session isn't about that, but I just want to flag this for
8 when we do have a session in the future perhaps about
9 mandatory versus voluntary participation in ACOs or APM
10 programs. The more we make something mandatory, Medicare
11 makes something mandatory, then the more financial pressure
12 put on organizations in a mandatory program, the more risk
13 that organizations will skimp on quality. So we're talking
14 only about controlling spending today, but I think there's
15 a lot more room and really a need for more attention to, in
16 some way, better than we have now, a measured and rewarding
17 quality of care in organizations. '
18 I saw this in California with full-risk
19 capitation in the '90s. The more financial pressure the
20 more risk to quality, so I don't think we should forget
21 that.
22 The other thing was obvious, but we don't want to

1 forget with mandatory is what are the options for smaller
2 practices. I think we do want to give explicit thought --
3 and, again, this is off topic for today, but with all this
4 talk about mandatory, I just want to mention it and flag it
5 for the future. We do want to give specific thought to not
6 just setting up incentives and demands in such a way that
7 we basically hand the medical care system over to very
8 large corporations. We already see that, some risk of that
9 in the newest ACO program.
10 So I'll stop with that.
11 MS. KELLEY: Jonathan, did you have something on
12 this point?
13 DR. JAFFERY: Yeah. Thanks.
14 Just briefly, just to address Larry's comments
15 about CMS being able to adjust quickly on the fly, I mean,
16 certainly, that is a challenge, and I think Blue Cross Blue
17 Shield of Massachusetts and other places can do this a
18 little more easily.
19 But I just wanted to point out that we did see
20 some changes. There is some precedence in the most recent
21 year or two because of the pandemic. So there was a lot of
22 different things that CMS did adjust to account for the

1 fact that COVID changed everything for people. So I think
2 we may just want to remember that.
3 MR. PYENSON: A good point, Jonathan.
4 MS. KELLEY: Paul, I think you had something on
5 this point also?
6 DR. PAUL GINSBURG: Yeah. I also have something
7 different that Larry said. He was talking about the
8 concern that, in a sense, if a system is mandatory and
9 there's too much pressure on costs. Well, of course, there
10 are risks to quality. To me, the answer is modulating the
11 pressure carefully because, in a sense, by having it
12 voluntary, that just means too many people can just ignore
13 it, ignore the concern about costs as opposed to just take
14 more sober responses to it. So I think they're really
15 different issues.
16 MS. KELLEY: Dana.
17 DR. SAFRAN: Thank you.
18 Apologies if I missed the earlier part of this
19 session, so I hope that my comments will not be redundant,
20 and I can't indicate which comments I'm building on and
21 agreeing with, so forgive me for that.
22 I do really appreciate the tremendous work on

1 this chapter. This is complex, critically important to the
2 success of the payment reform models, so really appreciate
3 this chapter.
4 Really appreciate the proposed direction around
5 considering prospective benchmark setting, as some have
6 referenced already. In my time at Blue Cross
7 Massachusetts, as we were beginning our work on the global
8 budget contract called the Alternative Quality Contract, or
9 AQC, in 2007, launched in 2009, that model was a five-year
10 contract and did in its first iteration use prospective
11 benchmarking. We did that because we thought that having
12 an absolute number, having a provider who's in the model
13 know what my rate of increase is in absolute percentage
14 terms next year and the year after that and the year after
15 that would be extremely important for their planning to
16 manage that.
17 But, as I think Larry foreshadowed, the market
18 crash in 2008 took what had in our negotiations for 2009
19 contracts, seemed to be ambitious and relatively aggressive
20 rates of decline year-over-year, and those absolute trend
21 targets, they no longer work. So we do have to think about
22 those things.

1 The other thing that came up that I also think
2 can be worked around, but it's just an important lesson
3 learned, is that as we went through those early contracts,
4 five-year contracts with absolute budget targets, we began
5 to see that there were certain things that really had to be
6 considered outside of provider's control. A pandemic is a
7 good example, and this would affect their ability to manage
8 to that absolute trend target.
9 So we developed a kind of set of things that we
10 would create as adjustments outside of the trend targets at
11 the end of the year, and while that was very well received
12 and very fair, it also undercut our ability to have
13 providers know month by month how they were doing against
14 their target. They could only know at the end of the year
15 when those adjustments were made.
16 I think we can -- and CMS can really troubleshoot
17 those things and build in mechanisms. So I don't see them
18 as a reason to avoid prospective benchmark setting. I
19 think it's a really valuable thing to consider here.
20 Someone mentioned the point about new technology,
21 and I'll just reference that that was one of the things
22 that we had on the list of outside factors excused. I'd

1 want us to think carefully before we entirely excuse it,
2 because part of what was, I think, really valuable about
3 that, that we never got to see come to fruition, is it has
4 the providers who are in the contract now actually having
5 to be thoughtful partners in deciding which new treatments
6 and technologies actually get into the system and get used
7 because they have an accountability for the total cost of
8 care, and those may not have been anticipated.
9 So it really makes them partners and thinking
10 hard about many of the things that we know have been
11 escalators of Medicare costs, and I think that's a really
12 important value of having a prospectively set trend target.
13 So I'd argue for that benefit as well.
14 Finally, just a couple last things. One is on
15 the ratchet effect, you know, the voluntary nature of the
16 program really does make it so that we have to pay
17 attention to that, because, you know, as other, I think, it
18 sounds like, may have been pointing out, if this remains a
19 voluntary set of programs and you can just opt out whenever
20 your budget starts looking unappealing or the terms start
21 looking unappealing, we have really undercut our success.
22 Two is I'd love to see this chapter incorporate a

1 bit more in the way of insights about how the benchmarking
2 that was used in different stages of this work -- for
3 example, in the early years of MSSP we saw net savings --
4 can we glean some insights about what was it about the way
5 that benchmarking was handled that may have contributed to
6 that and the shifts to different approaches to benchmarking
7 that may have undercut that there, or other programs. So
8 I'd like to see us do that.
9 And finally, and I think Amol may have already
10 mentioned this point but I'll just double down on it, I
11 think the chapter needs to be grounded in a set of
12 principles that we would use to assess different approaches
13 to benchmarking, things like a principle that says we want
14 to limit ratchet effect given voluntary participation, or
15 we want to prioritize participation in savings in regions
16 that have the highest opportunity for impact perhaps.
17 There are many things we could consider, but I think
18 grounding this in some principles will be very valuable.
19 So thanks, and thanks again for the great work.
20 MS. KELLEY: Pat.
21 MS. WANG: Thank you. I want to agree with the
22 other Commissioners but state for the record I think the

1 ratchet effect is terrible. It's really, you know, the
2 bridge to nowhere. So the work to try to develop something
3 that is prospective, administratively set, is very
4 important.
5 I just wanted to sort of touch on some of the
6 conversations that we had about convergence with the MA
7 program, and put some of my questions out there because I
8 have trouble trying to kind of think about this a little
9 bit. You know, I think what David Grabowski suggested is a
10 goal, a very good goal that somehow these do convert.
11 But let me just raise some of my own confusion.
12 For one thing, I wondered whether there was any sense in
13 looking at the benchmarks that are set by CMS for the MA
14 program, which I frankly, to me it's a black box, to others
15 it's probably not. I think it's a three-year rolling
16 average of fee-for-service in a particular area, and it
17 builds in new technology, it builds in developments, it
18 builds in changes in the fee schedule, and updates, et
19 cetera, et cetera.
20 I just don't know whether there is any
21 comparability, but I would just be curious if it's possible
22 even, especially in an area where an ACO kind of dominates,

1 like the county, because the benchmarks, ultimately, are
2 county-based, before you start applying those cliffs, the
3 95, 100, 107. Just even like sort of pure play, what would
4 they look like today and whether there's a relationship
5 between the two that could be of interest. If there is a
6 relationship then perhaps there are some insights into the
7 way that MA program currently sets MA benchmarks, which
8 they do a three-year, weighted rolling average. They build
9 in many of the things that people here said. There might
10 be some insights there.

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

1 That's how they're measured.
2 And so, you know, I just wonder whether we need
3 to kind of think a little bit about the relative purposes
4 of MA versus ACO before we think there can be total
5 convergence. I think a population-based ACO can be highly
6 successful, because it has improved itself, but if they
7 were participating and all of a sudden you said tomorrow,
8 "Okay, you're getting the MA benchmark," it could be a
9 disaster for them because maybe their costs were higher to
10 begin with, if their costs, you know, in an ACO model they
11 have success, especially, you know, with just partial
12 regional blends.
13 So I think it might be a little bit of an apple
14 and an orange, and I think we'd want to think that through
15 a little bit before we sort of said they should be
16 converging that way.
17 The other thing is that, as Mike pointed out,
18 ACOs are fee-for-service, and so to the extent that an area
19 is dominated by ACOs in the fee-for-service system, I think
20 that that fee-for-service experience is what is feeding the
21 MA benchmark, because the MA benchmark is based on fee-for-
22 service. So does it get circular at a certain point?

1 They're not two completely separate things.
2 Finally, these are just questions, I guess I
3 have. The issue of mandatory also, I just want to sort of
4 -- we talk about mandatory as though we are only talking
5 about providers, and I kind of get that there is a flavor
6 of mandatory which says this is the new way that Medicare
7 pays everybody in the fee-for-service system. I think
8 that's easier to do for some of the smaller APOs, like
9 bundles, the joint replacements, things like that. For the
10 population-based models, I think it's really hard -- I
11 would issue caution, I guess, of saying that fee-for-
12 service should be made lower or less attractive. It's very
13 appealing. But I think that there are, doing the
14 population-based models it's very complicated, it's
15 resource intensive, there are a lot of providers that just
16 couldn't pull that off. And I wouldn't want to degrade
17 their payment because we've recognized the value of the
18 population-based models. So I think that we have to
19 balance those things.
20 And the final thing about mandatories is that
21 nobody has talked about the beneficiary. Maybe we don't
22 need to, and I think mandatory is not a third rail kind of

1 expression. There are many mandatory Medicaid managed care
2 programs in the states now that produce a higher quality of
3 care than a comparable commercial insurance company would,
4 for example, for children. I'll just use that as an
5 example because so many kids are covered by Medicaid.
6 So I think that's something that we need to
7 grapple with. And one of the things about the whole APM
8 ACO conversation is that it is so rich, but I think we need
9 to make sure we're talking about the same things when we're
10 using phrases and words. So I think, you know, the more we
11 can sort of define what we're talking about and what we're
12 not talking about would be helpful. Thank you.
13 DR. CHERNEW: Great. So I think we are going to
14 let Jonathan have the last word, and I am going to then sum
15 up, and then we'll take our break. So Jonathan.
16 DR. JAFFERY: Yeah, thanks, Mike. I'll be brief.
17 I just wanted to respond to Pat, one of the things you made
18 me think about. First of all, I do think that similar
19 thinking about the convergence of MA and ACOs and how that
20 would work is important, to David's comment. But there's
21 one piece, as we're talking about principles, that we've
22 talked about before as a group, that I don't think came up

1 today that I think we should bear in mind, and that's
2 recognizing that MA plans may take population-based
3 payments and capitation, or whatever the case may be, but
4 then I think it's still 85 percent of payments to providers
5 are turned around and paid in a fee-for-service model. I
6 know that varies a lot in different markets. But if we
7 still have half of beneficiaries in MA plans and most of
8 those payments are in a fee-for-service model, we're losing
9 a lot in terms of how providers are paid and how we're
10 going to get into more value-based care. So I guess we
11 should put that up as a principle too, in my mind, as we
12 talk about this. Thanks.
13 DR. CHERNEW: Okay. So that was a really rich
14 discussion. I am grateful that I heard a lot of consensus
15 around some issues, for example, that the ratchet does
16 reduce incentives for saving and is, in fact, a problem,
17 and that at least we should continue to explore the
18 possibility of prospective administratively set benchmarks.
19 I will say, as this conversation illustrated,
20 there is no prejudgment on what that will look like, and
21 there are just a few issues I just want to note that I
22 heard here. One of them is we need to think about

1 convergence, and I'm going to put off convergence with MA,
2 although, Pat, your comments were spot on in a number of
3 ways on that point, and just talk about convergence within
4 the ACO program.
5 The challenge here is that the money is where the
6 most inefficient practices are, which means we need to get
7 those organizations in, and my personal belief is we need
8 to be careful as we push down on our spending target for
9 those groups, because I think we risk being a little naïve
10 about how easy it is to change. And to, I think, Pat, your
11 point, the beneficiaries are important. We do not want to
12 harm the beneficiaries as we go through this transition.
13 So that will mean some inequity as we move forward into
14 convergence, and I do think we're going to have to think
15 through how we deal exactly with that process.
16 I will say that there was a lot of discussion
17 about mandatory-ness. I don't like the word "mandatory."
18 I think it's more about incentives. But the point remains
19 there are a lot of concerns if there are voluntary programs
20 that there's a lot of selection, you actually may do worse
21 than you otherwise think, and it makes the benchmark
22 setting much more complex. But we certainly aren't going

1 to be able to force all groups into strong, two-sided risk
2 models. That came up last session. So this is why we had
3 the discussion last time about multitrack models and trying
4 to make sure that the models matched the providers in some
5 ways, and of course, there's a whole other issue about how
6 episodes work into this, and that might work more into some
7 tracks than others.
8 There are a bunch of other comments that I think
9 are really important. Risk adjustment was a theme raised
10 by many of you and it obviously matters in every
11 population-based model. Attribution is a crucial one, and
12 we will have to have some discussions about how attribution
13 can work. If we don't have attribution working it's hard
14 for any of these models to be successful.
15 I will point out that this basic notion of
16 prospective administrative type fees is how we deal with
17 almost all other fees in the Medicare program. We're about
18 to jump into December and January discussion of updates.
19 All of those are versions of prospectively set
20 administrative fees. It's not tied to spending for an
21 organization in quite the same way. And Maryland also has
22 a model that sort of combines an administrative-set target

1 with -- they have a particular way of how they deal with
2 fee-for-service spending in the Maryland model.
3 So there is, I think, a lot of work to be done as
4 we push this forward, but I do believe we have consensus on
5 a basic direction of how we might want to set benchmarks in
6 the context of a broader, multitrack ACO program, which
7 itself will have lumped in other types of alternative
8 payment models. And we're going to have to do so in a way
9 that protects the beneficiaries, and particularly the
10 organizations that serve them, as we make this transition.
11 So that is my summary. I want to tell the public
12 that we really do miss being in person, and we really would
13 like to get their comments. So you can reach out. I'll
14 let Jim give the exact website. There is medpac.gov. I
15 think there is a specific website for comments. Jim, do
16 you want to do that?
17 DR. MATHEWS: You can send comments to
18 meetingcomments@medpac.gov.
19 DR. CHERNEW: Okay. So please do that. Those of
20 you that have sent comments, you know we will reach out and
21 acknowledge them, occasionally engage. We really very much
22 do appreciate them.

1 So, Jim, do you have any other comments, or do
2 Commissioners have any other comments before we break for
3 lunch?
4 DR. MATHEWS: None here.
5 DR. CHERNEW: Okay. So we are going to break for
6 lunch. We will come back at 1:45. We are going to begin
7 what I hope will be a very important, multicycle effort to
8 figure out how we can develop policies to support the
9 safety net, an area of particular interest to me and I
10 think many of you.
11 So again, thank you for those of you who joined
12 us. Please send comments, and I'll see the rest of you at
13 1:45. So signing off for lunch.
14 [Whereupon, at 12:52 p.m., the Commission was
15 recessed, to reconvene at 1:45 p.m., this same day.]
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2 AFTERNOON SESSION

3 [1:46 p.m.]

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

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

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

21 Our presentation today focuses on clinicians and
22 hospitals. While we start with these two sectors, we

1 anticipate broadening our work in the future. First for
2 clinicians and then separately for hospitals, we'll walk
3 through motivations for examining safety-net providers.
4 We'll also review Medicare's current policies to support
5 safety-net providers. While often important to maintain
6 access, we don't consider policies designed solely to
7 support isolated providers such as extra payments for
8 critical access hospitals as safety-net adjustments, so we
9 don't discuss them in our presentation.
10 Next we'll discuss possible definitions the
11 Commission might use to identify safety-net providers. At
12 a conceptual level, our goal is to have one safety-net
13 definition that applies to providers in both urban and
14 rural areas and that is applicable across sectors, even if
15 how that definition is operationalized varies across
16 sectors. We'll also review some of our analyses on the
17 characteristics of safety-net providers compared with other
18 providers.
19 Finally, we'll end our presentation with
20 questions for the Commission to consider. We expect the
21 Commission's discussion of Medicare's role in preserving
22 safety-net providers to occur over several meetings and to

1 continue into next year's cycle. The process will be
2 deliberative because changes to safety-net policies could
3 have long-lasting effects. Our goal is to come back to you
4 in the spring with additional information that incorporates
5 your feedback.

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

17 Despite these consistently positive findings,
18 some stakeholders have voiced concerns. First, as we
19 detail in your paper, future updates to the physician fee
20 schedule payment rates are scheduled to be quite low while
21 private payer rates continue to increase. This could
22 result in a growing gap between private payer rates and

1 Medicare rates, which could make treating Medicare
2 beneficiaries relatively less attractive.
3 Second, despite having good access to clinician
4 care overall, access and care might be more challenging for
5 certain subgroups of beneficiaries. One group of
6 particular concern is dual-eligible beneficiaries as they
7 tend to have lower incomes and have higher health care
8 needs than other beneficiaries.
9 Going back to our presentation last month, you'll
10 remember we found that dual-eligible beneficiaries use
11 substantially more care than other beneficiaries. We noted
12 that high utilization in this context was positive in that
13 it suggested providers accepted and treated dual-eligible
14 beneficiaries as patients. However, while most dual-
15 eligible beneficiaries are able to access care, our
16 analysis of the Medicare current beneficiary survey
17 suggests that some dual-eligible beneficiaries face greater
18 challenges accessing care.
19 For example, in 2018, we found that 11 percent of
20 dually eligible beneficiaries compared with only 6 percent
21 of non-dual-eligible beneficiaries had a health problem for
22 which they thought they should see a doctor but didn't.

1 While we can't definitively conclude what drives this
2 difference, state Medicaid programs increasingly do not pay
3 full cost sharing for clinician services for dual-eligible
4 beneficiaries. This results in clinicians often being paid
5 20 percent less for treating dual-eligible beneficiaries
6 compared with other beneficiaries, which may in turn result
7 in clinicians being less willing to treat dual-eligible
8 beneficiaries. Some research suggests that states failing
9 to pay cost sharing for dual-eligible beneficiaries is
10 associated with modest decreases in access to clinician
11 care.
12 While we focus on dual-eligible beneficiaries,
13 we're aware that other populations, such as low-income
14 beneficiaries who do not qualify for full Medicaid
15 benefits, could also face access challenges. We plan on
16 presenting more information on such beneficiaries in the
17 spring.
18 Medicare has multiple programs designed to
19 support safety-net clinicians. Medicare provides a 10
20 percent incentive payment for fee schedule services that
21 are performed in certain health professional shortage
22 areas. The incentive payment is available to physicians,

1 including primary care physicians and specialists, but is
2 not available to other types of clinicians, such as nurse
3 practitioners and physician assistants.
4 Medicare also has separate payment systems for
5 FQHCs and RHCs which may act as safety-net providers.
6 Relative to fee schedule rates, clinicians who bill under
7 FQHCs and RHCs receive enhanced Medicare payment rates, and
8 FQHCs and RHCs largely furnish primary care.
9 Now moving on to how the Commission might
10 identify safety-net providers. Based in part of feedback
11 from the Commission during our October meeting, we define
12 safety-net providers based on the characteristics of the
13 beneficiaries they treat instead of where they are located
14 or the type of facility they are.
15 Specifically, our working definition of "safety
16 net providers" are those who treat a disproportionate share
17 of low-income patients or who are substantially dependent
18 on public payers. We chose this definition for a few
19 reasons. First, treating low-income beneficiaries might
20 entail extra costs that are not adequately reflected in
21 Medicare's standard payment systems and result in lower
22 revenues. Second, public payers generally have lower

1 payment rates than commercial insurers, making it more
2 difficult for providers who are substantially dependent on
3 public payers to compete with other providers who are not.
4 We operationalize this definition differently
5 across sectors. We identify safety-net clinician groups
6 based on the share of their Medicare patients who are dual-
7 eligible beneficiaries. For hospitals, we also use this
8 measure and explore a handful of other alternatives.
9 As our first step in our analysis, we analyzed
10 the extent to which dual-eligible beneficiaries receive
11 care from a wide range of clinician groups or whether they
12 were disproportionately cared for by certain groups.
13 As the figure on the slide shows, we found that
14 many clinician groups billing under the physician fee
15 schedule had a low share of their Medicare claims
16 associated with dual-eligible beneficiaries in 2019. For
17 example, the tall green bar indicates that 40 percent of
18 the groups who billed under the physician fee schedule had
19 fewer than 5 percent of their Medicare claims associated
20 with dual-eligible beneficiaries. On the other end of the
21 distribution, the red bars, about 13 percent of groups who
22 billed under the fee schedule had 50 percent or more of

1 their Medicare claims associated with dual-eligible
2 beneficiaries.
3 These results have a few implications. First,
4 implementing an across-the-board payment increase for all
5 providers in order to support safety-net providers would be
6 poorly targeted. In contrast, adjusting any additional
7 financial support based on the share of a group's Medicare
8 patients who are dual-eligible beneficiaries would result
9 in substantially better targeting.
10 Second, establishing a minimum threshold to be
11 considered a safety-net provider could be difficult because
12 there did not appear to be obvious natural breaks in the
13 distribution and each threshold would result in some
14 clinician groups just missing the criteria. In your
15 mailing materials, we discuss how such cliffs can lead to
16 narrowly targeted programs expanding over time.
17 Now Jeff will discuss safety-net hospitals.
18 DR. STENSLAND: While access to hospital care has
19 been good in most areas, there have been concerns that some
20 providers may struggle. Over time, we have seen
21 differences between commercial rates and Medicare rates
22 diverge, with strong commercial rate growth contributing to

1 strong profit margins in recent years. However, some
2 safety-net hospitals face financial challenges if they have
3 large shares of public payer patients and few commercially
4 insured patients. It is hard for them to compete for labor
5 and technology with neighboring hospitals that have a more
6 favorable payer mix. This differential in resources
7 between the haves and the have-nots would not be addressed
8 by paying everyone more, and that brings us to the topic of
9 special payments to safety-net hospitals.
10 MedPAC and its predecessors have a long history
11 of working to assist safety-net providers with their
12 financial challenges. In 1985, ProPAC, a predecessor to
13 MedPAC, discussed how hospitals serving a disproportionate
14 share of poor patients may face financial challenges
15 because low-income patients could cost more to treat and
16 often generated lower payments.
17 In 1986, following a ProPAC recommendation,
18 Congress enacted the Medicare disproportionate share
19 program, which increased Medicare rates paid to hospitals
20 serving a disproportionate share of low-income patients.
21 In 2010, Congress recognized that some DSH
22 hospitals have more charity care and bad debts than other

1 hospitals and shifted most of the DSH funds to funding
2 uncompensated care at these DSH hospitals.
3 In 1989, Congress also enacted the Medicare
4 dependent hospital program to assist small rural hospitals
5 that primarily served Medicare patients.
6 As background, I want to familiarize you with the
7 current DSH payments. For a hospital to be eligible for
8 the DSH program, the sum of the hospital's Medicaid share
9 of patients plus the hospital's share of Medicare patients
10 who are on SSI must exceed 15 percent. This means the
11 hospitals must either serve at least a moderate share of
12 Medicaid patients or at least serve a moderate share of
13 low-income Medicare patients, and about 80 percent of
14 hospitals meet this threshold.
15 In 2022, these hospitals will receive about $3.5
16 billion of DSH add-on payments to their inpatient services.
17 They will also receive about $7.2 billion of payments to
18 help cover their uncompensated care costs. The $7.2
19 billion is equivalent to about 20 percent of these
20 hospitals' total uncompensated care costs.
21 There are some potential concerns with the
22 current DSH metric. First, it indirectly subsidizes

1 Medicaid. Higher shares of Medicaid patients result in
2 higher Medicare payments through the DSH program. Second,
3 DSH shares are negatively correlated with Medicare shares.
4 This means that hospitals with high shares of Medicare
5 patients tend to receive a lower percentage add-on to their
6 payments through the DSH program.
7 So how well are the DSH payments working? Are
8 the DSH funds going to hospitals that are struggling
9 financially? To examine this question, we divided
10 hospitals into quartiles based on their disproportionate
11 share patient percentage. The first column in this figure
12 represents hospitals with a low DSH percentage, meaning
13 they receive no DSH adjustment or a relatively small DSH
14 adjustment. We see that they have relatively strong all-
15 payer margins of 6.1 percent in 2016.
16 In contrast, the column on the right shows the
17 profitability of hospitals with the highest DSH adjustment.
18 The column on the right shows that, despite receiving
19 larger DSH payments, these high-DSH hospitals tend to have
20 a bit lower all-payer margins, with a median margin of 3.2
21 percent. This suggests DSH payments are fairly well
22 targeted and have reduced the disparity of profitability

1 between low-DSH and high-DSH hospitals.

2 The second row looks at closures. Despite

3 receiving higher DSH payments, hospitals in the highest DSH

4 quartile were slightly more likely to close.

5 Next we discussed alternative metrics for

6 identifying safety-net hospitals. The more complex metrics

7 are in your paper, and there's always the opportunity to

8 investigate new metrics as we move forward. In this paper,

9 I will just talk about the simple metric, using dual-

10 eligible Medicare beneficiaries.

11 In this slide, we divide hospitals into quartiles

12 based on the share of Medicare patient days that were fully

13 dual eligible. Start with the first row. The first column

14 shows that hospitals with low dual-eligible shares tended

15 to have high all-payer margins, with the median margin of

16 8.5 percent. The column shows that hospitals whose

17 Medicare patients tend to be poor materially have lower

18 all-payer margins. That's the right-hand column, with the

19 highest quartile having a median margin of 1.7 percent.

20 This differential that we see here is even larger than the

21 one we saw in the prior slide when we examined DSH shares.

22 In addition, the trends are fairly linear,

1 suggesting that a policy of continuously increasing payment
2 rates to hospitals as their dual share increases would tend
3 to level out all-payer margins. The second row shows that
4 hospitals with large shares of dual-eligible patients tend
5 to have a higher risk of closure than hospitals with fewer
6 dual-eligible patients.

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

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

16 However, there is a separate program for
17 hospitals with high Medicare shares called the Medicare
18 dependent hospital program. The original idea was that
19 small rural hospitals lacked the economies of scale to be
20 successful in the Medicare prospective payment system. The
21 MDH payment system increased payments to these small rural
22 hospitals based on their historical costs. The details are

1 in your mailing materials.

2 One concern is that the MDH program is limited to
3 small rural hospitals. We may want a safety-net definition
4 that applies to both rural and urban hospitals. Second, it
5 only provides an add-on payment to inpatient services, and
6 it makes cost-based payments. Cost-based payments mean
7 that if a hospital has historically been able to afford
8 high costs, then they will get a larger add-on payment, and
9 hospitals that have been forced to keep their costs low may
10 not receive any add-on payment under the MDH program.

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

20 With respect to hospital payments, the gap
21 between Medicare prices and commercial prices continues to
22 grow, with hospitals that have few commercial patients

1 possibly having trouble competing with other wealthier
2 hospitals for labor and technology.
3 This led us to looking to our targeted payments
4 for providers that serve a disproportionate share of low-
5 income beneficiaries. As Brian mentioned, the physician
6 fee schedule has limited adjustments for providers serving
7 a disproportionate share of low-income patients currently.
8 In contrast, in the hospital sector, Medicare
9 shifts about 6 percent of all hospital payments toward DSH
10 hospitals as special payments. The data suggest these
11 payments are fairly well targeted in that hospitals getting
12 the largest special payments are still hospitals with
13 relatively low margins and a slightly higher risk of
14 closure.
15 However, there is a concern that the current DSH
16 payments are negatively correlated with Medicare shares.
17 Thus, hospitals that focus most on serving Medicare
18 beneficiaries may receive lower adjustments.
19 Given the limitations of the current programs,
20 what types of changes may be needed to Medicare's safety-
21 net payments? And these are various questions for your
22 discussion. Should we replace the current policies? Or

1 should we add to existing policies? Do we need new metrics
2 to identify safety-net providers?
3 What are the preferred metrics for physician
4 practices? And what are the preferred metrics for
5 hospitals?
6 In the case of hospitals, we see that the current
7 DSH payments are negatively correlated with Medicare shares
8 of discharges. Given that, do we need a separate policy
9 for Medicare dependence? Or should the hospitals' Medicare
10 shares be woven into a single composite safety-net metric?
11 Now I'll turn it back to Mike.
12 DR. CHERNEW: Brian and Jeff, thanks so much.
13 I believe this chapter, when it comes out, will
14 be a real resource for everybody interested in this topic.
15 You really got a lot there. It's a very complicated topic
16 because there's so many programs. It's so important.
17 Dana, let's go through the Round 1 queue.
18 MS. KELLEY: All right. I have Lynn first.
19 MS. BARR: Thank you. I was quick on the queue
20 button here.
21 So I have three questions. Thanks for doing this
22 work, and I know this is a beast to tackle.

1 One of the questions I have is, does the all-
2 payer margin include 340B, and does it include community
3 taxes? Is it really just all-payer, or does it include
4 other payments?
5 And the other two questions I have is 80 percent
6 of hospitals get DSH, but only 50 percent get 340B. Is
7 there anything interesting in the difference between the
8 two? And, you know, they use a higher criteria. How would
9 that affect your analysis if you used a higher criterion on
10 DSH?
11 Then the third question I have is, as we think
12 about health equity, you can't look at this without
13 thinking about what CMS is saying about we care about
14 rural, we care about LGBTQ, we care about underserved
15 minorities. And as we, you know, in the ACO space really
16 see their impact on cost and equality is disproportionate
17 to the other parts of the population, have you thought
18 about looking at this in terms of the kind of lens that CMS
19 is looking at in terms of health equity?
20 DR. STENSLAND: First question, all-payer margins
21 are total margins, so everything is in there, 340B, taxes,
22 investment income. It's all in there.

1 We looked at operating income, which doesn't have
2 some of that stuff in there, and that you get a similar
3 story.
4 The next question on 340B, those things are --
5 it's really quite different, and there's very different,
6 for a better phrase, "value judgments" in the 340B program
7 from the DSH program, and that all critical access
8 hospitals can be in the 340B program, no matter what their
9 payer mix.
10 MS. BARR: Right.
11 DR. STENSLAND: There's also a lower threshold
12 for rural than there is for urban, and then that creates
13 some issues where some urban places like Lenox Hill in
14 Manhattan or the Brigham in Boston decide to become rural,
15 reclassified as rural, then they get in a lower threshold,
16 and they get in 340B programs. So there's different
17 thresholds.
18 But you're right. The primary reason why there's
19 fewer in the 340B program is the cutoff level is a little
20 bit higher.
21 And then health equity, we can get into that.
22 That's probably at least Stage 2 of this project. I think

1 it's an important topic and something we'll have to weave
2 into here, but that's going to be another question of
3 whether we can address that well enough by focusing on
4 income, or does there need to be some other considerations?
5 MS. BARR: Thank you.
6 MS. KELLEY: David, do you have a Round 1
7 question?
8 DR. GRABOWSKI: Yes. Thanks.
9 So great work. Thank you for this, Brian and
10 Jeff.
11 Every time we have a session where we discuss the
12 use of duals to capture social risk, someone -- and that
13 someone is often me -- raises the point that the
14 characteristics of duals differ across states, and
15 obviously, this reflects differences in states' low-income
16 Medicare populations and Medicaid policies.
17 So my question -- and maybe the answer is just
18 sample size, but have we ever tried incorporating state
19 into our share of duals measure? Is there enough? Is
20 there sufficient sample by state? I can imagine in New
21 York or in New Jersey, you could do this, maybe in Montana
22 less so, but have we experienced at all, Jeff and Brian, in

1 trying to overcome this issue with the duals measure that
2 we just -- there's different characteristics by state -- by
3 actually incorporating state and comparing providers within
4 states against one another?
5 Thanks.
6 DR. STENSLAND: We haven't done it. We could do
7 it -- I'm not sure exactly where this -- where you're going
8 with this.
9 There's certainly states like Louisiana that have
10 more full duals and other states that have fewer full duals
11 like New Hampshire, but would we have a within-the-state
12 comparison, or would we still be giving higher DSH payments
13 to people in Louisiana than New Hampshire on average?
14 Where would this go?
15 DR. GRABOWSKI: I think it's a more general
16 question about how do you actually adjust here if we're
17 worried about the characteristics of duals, as you suggest,
18 being different in Louisiana than New York. Can we
19 actually compare Louisiana with Louisiana and New York with
20 New York? Maybe you don't want to do that; there are
21 reasons. But this is purely for capturing that, that sort
22 of risk or social risk factor here.

1 DR. STENSLAND: Mm-hmm. I think we can consider
2 that. We haven't considered it to date. There are other
3 options too besides just the simple dual measure. You
4 could have the LIS measure. You could use that, which is
5 more national. There's different ways we could approach
6 it, and I think that will be part of this long multisession
7 discussion.
8 DR. GRABOWSKI: Thanks, Jeff.
9 MS. KELLEY: Jonathan Jaffery.
10 DR. JAFFERY: Thanks, Dana.
11 Yeah. I want to echo this is a fabulous chapter
12 and a great start to a really important discussion. I
13 really appreciate how we're approaching this and
14 recognizing its multi-session discussions, and there's
15 other things to layer on top of it. And I agree with Mike.
16 It's going to be a great resource for others.
17 Just, I guess, a quick question. The chapter
18 talks a lot about the lesser of policies that states have,
19 and the presentation mentioned how Medicaid is increasingly
20 not paying full cost sharing and this may be impacting
21 access. If we look back, 2013, 2014, I guess ACA, there
22 was parity policies of payment for at least primary care

1 services. Do we have good analysis? Have we ever looked
2 at that and seen how that may have changed or impacted any
3 kind of access or outcomes when that policy came into place
4 and maybe as it started to erode?
5 MR. O'DONNELL: Right. So we haven't done our
6 own research, but others in the academic world have. And I
7 want to say Roberts, in particular, has done work on this.
8 I think the conclusion was that the bump that
9 resulted from the ACA parity policy didn't do much to
10 improve access, and so that's what the literature says.
11 Then the question is, why do you think that might
12 have happened, or why did these large payment bumps not
13 improve access? And I think when we talk to people, the
14 things they say are, "Well, it's only a two-year program,
15 so the bump only lasted two years." So providers might
16 have said, "You know, it's not worth me changing my
17 practice behavior because it's only temporary." And,
18 apparently, the implementation of it was relatively
19 fraught. So it was a two-year program, and I think some
20 practices didn't start seeing any due dollars until six
21 months into it.
22 So I think the temporary nature of it makes it

1 hard to draw kind of causal conclusions off of that.

2 DR. JAFFERY: Thank you.

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

4 question?

5 MR. PYENSON: I did.

6 One question I have is that it appears as though

7 Medicare Advantage is certainly popular among the dual

8 eligibles, and that contrasts to some of the access issues

9 that you've identified. I'm wondering if you have insight

10 into that.

11 And a related question is that you mentioned the

12 cost-sharing issues with physicians, dual eligibles for

13 physician services. My impression is that's not as

14 significant an issue when it comes to hospital cost

15 sharing, and I'm wondering if you have insights into that.

16 So two questions on differentials, Medicare

17 Advantage versus fee-for-service, and the other is within

18 fee-for-service hospital versus physicians.

19 MR. O'DONNELL: Yes. So I'll start, and, Jeff,

20 you can jump in.

21 On the MA versus fee-for-service issue, we didn't

22 include it in this paper, but we are looking at for both

1 full duals and partial duals -- we're looking at survey
2 measures to see whether, for instance, partial duals and MA
3 have better access because it essentially acts as a
4 supplemental payer.
5 And I think we'll cover this more in the spring,
6 but I think the headline news for us is that it doesn't
7 appear that MA completely solves the problem, and so you
8 still see partial duals, for example, in MA having access
9 to care issues related to costs. So we can explore more in
10 the spring what that means, but I think that's one nugget
11 that we have behind the scenes that we hadn't shared.
12 And I think your second question, Bruce, on cost
13 sharing for hospitals versus physicians, I do think your
14 instinct is right to think that the cost sharing is a
15 larger issue for the physician world relative to the
16 hospital world, and so just as a very basic level,
17 hospitals get bad debt or 65 percent of bad debt, and
18 clinician practices who bill under the fee schedule don't
19 get that. So I think that's at least one thing to kind of
20 start off with, that it probably is a larger issue for the
21 clinician space.
22 MR. PYENSON: A somewhat related issue -- sorry,

1 a third question -- is on the people who have Medicare Part
2 A only and how those -- how you might think about those in
3 this analysis. I didn't see mention of those folks, but do
4 you have thoughts on that?
5 MR. O'DONNELL: Yeah. We can certainly try to
6 drill down into that population in the future. I think the
7 difficulty becomes -- and I don't know the exact numbers,
8 but that's, what, 8 to 10 percent of the population? So it
9 becomes harder for us to identify that subset in some
10 survey data. So there's often times limited numbers, but
11 we can definitely take a look at in claims data to see
12 where we can dig up information on those folks.
13 DR. STENSLAND: We're going to look into it. I
14 think it's harder than it may seem on the surface because
15 you may have some very different subgroups within that
16 group. Like, you may have some people that have enough
17 supplemental insurance from some other employer where they
18 decide not to buy into Part B, and then you might have some
19 people who are really poor, and they think that that's just
20 too much money to pay for Part B and "I'm just not going to
21 do it." And so those are going to be two very different
22 types of people, and whenever we look into it, we'll have

1 to kind of differentiate those folks.

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

3 MS. WANG: Thank you.

4 I wanted to ask about UCP because what used to be

5 DSH is now like more than 70 percent is paid through this

6 uncompensated care thing. It's a confusing thing because

7 it's not specific to Medicare volume or Medicare DSH, but

8 it is paid by Medicare. And I just was curious whether you

9 had looked at the hospitals that get the highest share of

10 those UCP payments, those $7 billion-plus now that's

11 flowing through that pool, I guess, and whether there's a

12 correlation to your high-Medicare share, high-Medicare DSH.

13 So that's the first question.

14 And then the second question was whether there

15 are any good measures of low-income-ness, low-income

16 patient populations served in hospital outpatient

17 departments. You know, we can look at physicians, we can

18 look at FQHCs, but it's possible that the outpatient

19 departments of hospitals have different low-income shares

20 than what winds up in the inpatient. It could go either

21 way.

22 But I just wondered whether there was any way to

1 capture that. It would be in the UCP data, but again,
2 that's kind of all-payer. So I just -- or it's no-payer, I
3 guess.
4 So those are my two questions.
5 DR. STENSLAND: In terms of the uncompensated
6 care, we have some of those correlations in Table B-1, but
7 it's way in the back of the paper, and there is a fairly --
8 you know, it's a moderate correlation between your share of
9 your revenue represented by uncompensated care and the
10 share of Medicare patients who are dual or your DSH share.
11 So there is some correlation there, and places that have
12 more uncompensated care do tend to have lower total profit
13 margins, though we don't see much of a relationship with
14 whether they close or not.
15 In terms of outpatient, I think that is a great
16 thought, and I think as we move forward, we should be
17 looking at outpatient shares also and not just inpatient
18 shares. That's maybe one of the decision points that kind
19 of the Commission will make as we go along. I think
20 there's kind of some process of narrowing the scope of what
21 econometrics we're going to look at, and then maybe we
22 could also widen it in terms of the types of inpatient,

1 outpatient, other sectors that we look at, but definitely a
2 good point that we can address as we kind of move and
3 refine this.
4 MS. WANG: And I'm sorry. Can I just ask one
5 other question? This is a -- and maybe -- just help me
6 think through the relevance of teaching status. I assume
7 there's a very large overlap between high-DSH hospitals and
8 teaching hospitals. So when you do your correlations, how
9 do you know what's keeping the hospital open? Because
10 teaching status delivers a whole boat full of money, too.
11 How do you know whether it's DSH payments that are helping
12 the hospital, that's the driving characteristics, or
13 whether it's the teaching payments? How do you think about
14 that?
15 I realize they're separate payment programs, but
16 they're interrelated when it comes to the characteristics
17 of the safety-net hospitals.
18 DR. STENSLAND: I haven't looked at that yet.
19 You know, we did some regressions, but we didn't put the
20 teaching status in there or the resident-to-bed ratio in
21 there, and that's something we could look at to see if that
22 -- and I don't even know if it's going to be -- I'm

1 guessing it's going to be also related to the size of the
2 hospital. So, if we put that in there, we should probably
3 also look at size of the hospital. We could try to tease
4 out what effect teaching independent of size has on your
5 profitability or your risk of closure. It could easy go in
6 two different ways. It could make your all-payer
7 profitability lower and your risk of closure lower also,
8 because we don't hear of a lot of teaching hospitals
9 actually closing. But we could look into it further.
10 MS. WANG: Thank you.
11 MS. KELLEY: Wayne, did you have a question?
12 DR. RILEY: Yes. It was largely along with what
13 Commissioner Wang just queried about the teaching status.
14 Needless to say, a teaching safety-net hospital is very
15 near and dear to my heart, having trained in one and now
16 overseeing one at a health sciences university.
17 But, Jeff, the other thing, in terms of the
18 commercial penetration, commercial margin penetration of
19 safety-net hospitals, could you give some color commentary
20 on that?
21 DR. STENSLAND: One of the problem is we don't
22 have good data on the commercial share of patients because

1 that doesn't show up on the cost report.

2 We know the Medicaid share of days. We know the

3 Medicare share of days. We know the Medicare share of

4 revenue, but the commercial, we can't really get at.

5 Sometimes we can get at something that would be non-

6 Medicare, non-Medicaid, but then we're throwing commercial

7 in with uncompensated care, uninsured. We don't have great

8 data on that.

9 We thought about trying to go look at some of the

10 data that people are supposed to be reporting in terms of

11 their commercial prices, but that is pretty incomplete and

12 not always easily accessible at this point. I know I'm not

13 answering that question very well, but we don't have great

14 data on that at this point.

15 DR. RILEY: Yeah. Thanks for sharing that. That

16 is one of my concerns. I can just say anecdotally, here at

17 our safety-net teaching hospital, probably only about

18 between 10 and 15 percent commercial, so obviously, a large

19 book of business taking care of Medicare and predominantly

20 Medicaid beneficiaries. So you're right. It is kind of a

21 Rubik's cube trying to figure out the commercial aspect of

22 safety-net teaching hospitals and safety-net hospitals in

1 general.

2 But I agree with some of the questions. Pat read

3 my mind in some of the other aspects. Thanks.

4 DR. STENSLAND: One thing we can do that we did

5 do in here is when you measure things -- like, you can

6 measure your uncompensated care burdens as a share of your

7 total revenue. So, in essence, then if you have a lot of

8 commercial revenue, you've got a bigger total revenue, and

9 that uncompensated care revenue will seem smaller. So

10 there is some ways to indirectly get at it.

11 DR. RILEY: Yeah. I guess we're in search of a

12 proxy, I guess, in some respects to try to get that

13 understanding, if you will.

14 Thank you.

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

16 question?

17 DR. SAFRAN: Yes. Sorry. Two questions about

18 statements that were made in that chapter. The first one

19 was, on page 13 of the written materials you make the point

20 that the original justification for DSH payments was that

21 low-income Medicare beneficiaries were thought to be more

22 expensive in ways not accounted for by DRGs, and cite a

1 2007 MedPAC report as well as another paper, indicating
2 that that was true less than 25 percent of the time, or
3 that 25 percent, at most, of DSH payments were justified by
4 higher Medicare costs associated with treating low-income
5 patients.
6 Can you just say a little bit more about that?
7 DR. STENSLAND: So I think when they looked at
8 this originally back in 1985, there wasn't much in terms of
9 risk adjustment in what you're getting paid when they first
10 started out with the DRG system. And there was a feeling
11 that poorer people tend to be sicker, and therefore they
12 are going to cost more to treat and they also may have
13 fewer resources outside the hospital. You may even have to
14 keep them in the hospital longer if they don't have the
15 resources to go home and get care. And people had done
16 some analysis of that early on.
17 Later on we did some empirical estimates where we
18 would run these regressions, similar to what we did for the
19 IME discussion we had, where the dependent variable is the
20 cost per discharge and the independent variable is all of
21 our risk adjusters, how much extra is left over when we
22 look at their disproportionate share index and how much

1 does that explain of their costs. And it looked like, at
2 most, 25 percent of the current DSH payments that were
3 being paid out could be justified by that empirical level
4 of how much extra these folks cost.
5 But at that point people were saying, well, yeah,
6 it isn't just cost that justifies these DSH payments. It
7 is also that these hospitals just have more poor patients
8 in general, and they are going to have more uncompensated
9 care. They are going to have more charity care. So then
10 the rationale, I think, in the ACA, was well, if we now
11 have this blended rationale, it's just not higher cost of
12 poor folks, it's higher cost of poor folks and more
13 uncompensated care, let's split the dollars out so we'll
14 have some of it going for this empirically justified higher
15 cost of treating poor folks and then other part will
16 actually go to uncompensated care, and it will be
17 distributed so that hospitals that have more uncompensated
18 care get a bigger share of that pot.
19 DR. SAFRAN: Got it. Thank you, Jeff.
20 My other question was, on page 21 you made the
21 argument that duals appear to have good access because they
22 have higher case mix, that they appear to be using more

1 services. I understand that that's the descriptive
2 observation, but how do we get from that to an assessment
3 that they have adequate access, meaning, you know, they
4 have higher case mix, how do we know what they actually
5 need relative to what they're getting?
6 MR. O'DONNELL: So I think what we are going for
7 when we describe duals' access to care is that I think we
8 tried to start off with the forest picture and to say, you
9 know, this is what we talked about last month, they get a
10 lot of care, and then we look at kind of survey data.
11 There are differences between duals and non-duals, and I
12 think this is a kind of value judgment of how big you think
13 those differences might be. So some of the differences
14 we're seeing are, you know, 3, 4, 5 percentage points. So
15 they appear to be persistent but they are kind of modest,
16 to a certain extent.
17 And so we are really just trying to paint a
18 picture of here is why you might want to go look at access
19 to care for this particular group. And we didn't want to
20 say that we thought there was kind of a house-on-fire
21 problem, because we don't think there is. But we do think,
22 on the margins, there are some who have greater difficulty

1 accessing care.

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

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

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

8 MS. KELLEY: That is correct.

9 DR. CHERNEW: Great. So that was really great.
10 I want to ask one other Round 1 question. I seldom do
11 this. A lot of what we're doing here is measured off the
12 cost reports. We are going to spend a lot of time on the
13 cost reports over the next two months as well, in December
14 and January. Can you say something about the stability,
15 manipulability, the liability of the cost reports if we
16 base a lot of what we're doing on data that's only
17 available via the cost reports? Is that a problem when we
18 think through some of these definitional things, if we
19 move to policy options?

20 DR. STENSLAND: At least for the hospitals I
21 don't think it is that problematic. The number of your
22 days that are Medicare and the number of your days that are

1 Medicaid, as those become part of payment then they start
2 to be audited, and I think you're going to get reasonably
3 good data there.
4 The margin data that we have, like our total
5 margins, what's this all-payer margin, this is supposed to
6 be the revenue from the hospital's financial statements
7 that they get from their accountants, and then they're
8 supposed to put those numbers in the cost reports and send
9 those financial statements to CMS so they can check that
10 these are balancing out. So I think that number is fairly
11 good.
12 I think what is more risky is the uncompensated
13 care data is probably less than optimal, I think, because
14 there is some potential for lobbying there on how it's
15 presented. And we've got some comment letters on that.
16 And there's also the issue of, as Wayne said, we are kind
17 of limited in what we have. So I am not as concerned about
18 the quality of what we have but maybe in the limitation of
19 what we have, and we don't have good data on either
20 commercial prices or commercial volumes at these places.
21 DR. CHERNEW: Thanks, Jeff. All right, Dana, I
22 know we have a robust Round 2 queue, which is encouraging,

1 so why don't we get to it.

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

3 DR. PERLIN: Thanks, Dana, and many thanks, Brian

4 and Jeff, for a terrific chapter. I think that was

5 excellent. Well, I'll bite on your two discussion

6 questions. I do think we have to add to the

7 considerations, current policies, and have some

8 considerations for metrics.

9 I want to make five brief points, and a couple

10 are essentially statements that were implied by some of the

11 questions that were asked in Round 1. First, as a

12 statement, I do think we should make equity explicit in all

13 of its forms. That is something that we're trying to drive

14 through work, such as making sure that safety-net

15 institutions are adequately supported.

16 Second, an observation. It strikes me as

17 somewhat discontinuous that we're talking with such an

18 institutional focus, not an individual patient focus. It

19 appears, per your Slide 11 that you presented, that there

20 are reasonably good correlations between DSH and Medicare-

21 dependent hospitals, that those are important. But it just

22 strikes me that we have this lingering, unresolved issue of

1 needing risk adjustment around patients in terms of
2 understanding their needs and servicing them, whether they
3 are in ACO, whether they're in nursing homes, whether
4 they're in Medicare Advantage, et cetera.
5 And, you know, some metric of the aggregate of
6 the patient burden would seem to be a future aspiration,
7 and minimally we need study on that to see if the
8 institutional aggregate of patient burden is, in fact,
9 institutional burden, understanding that there are certain
10 issues, be they rural or urban, that have to do with less-
11 than-desirable geography, if you will, with respect to what
12 might be alternatively available in terms of payer mix.
13 Third, and this is really the explicit of David
14 Grabowski's question, is my concerns, actually our concerns
15 about dual eligible as a proxy being imperfect at best,
16 given the differences between the states, and, you know, it
17 likely underestimates a burden, including uncompensated
18 care. Let me come back to that.
19 Fourth, I think there is a difference between
20 using Medicaid as an index and saying, by virtue of using
21 this index it is tantamount to subsidizing Medicaid
22 beneficiaries. You know, the burden on an institution of

1 taking care of an uncompensated plus Medicaid, and certain
2 very high-needs Medicare beneficiaries, including whole or
3 partial dual eligibles is something that is more resource
4 intensive, and using one component of that in Medicare as a
5 metric would seem to be supported by the data that you
6 present, including the Appendix Table B1.
7 And then finally, I understand and appreciate
8 Jeff's comments about strains and the limitations of the
9 cost reporting, but my goodness, uncompensated care, it
10 seems like a direct measure. I could either look outside
11 and try to determine what area might have ice or I can just
12 look at the thermometer and know this is the temperature,
13 and uncompensated care is fundamentally a direct
14 measurement of patients who don't have resources as
15 indicated. That is an audited report and substantially
16 robust, so I would suggest that's one of the best ways to
17 add to the composite of the burden.
18 Thanks very much.
19 MS. KELLEY: Lynn.
20 MS. BARR: Thank you, and I am plus-one on all of
21 Jonathan's comments. You know, I think about where are we
22 going with this analysis and what are we really trying to

1 do, and what we're really trying to do is to adjust payment
2 appropriately for providers that take on the underserved.
3 And so you have to kind of think that through about how
4 will this data then affect payment policy, how does it
5 affect ACO benchmarks, how does it affect MACRA? You know,
6 all we look at dual eligibles, and that does not promote
7 health equity.

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

20 DR. CASALINO: Lynn, if I can just ask you a
21 question. When you said "patients they serve," it seems
22 like dual eligible is too narrow for you. What other kind

1 of patients do you have in mind, and are you suggesting
2 that these other kinds of patients would be somehow part of
3 the definition of what is a safety-net hospital?
4 MS. BARR: That's exactly right, Larry. So we
5 know that certain populations had large disparities in
6 their health compared to average. And so when there are
7 disparities I think they need to be addressed in our
8 policies. So, for example, African Americans, rural
9 patients, patients that are underserved by the current
10 system should be what we count, not just dual eligibles.
11 DR. CASALINO: That's concisely said. So I will
12 just, if I may just say one sentence, one thing we haven't
13 been discussing is, are we talking about safety net meaning
14 take care of hospitals that take care of a lot of poor
15 patients, or are we talking about trying to eliminate
16 health disparities in care, period? Those are actually
17 potentially the same question or different questions, and
18 it actually hasn't come up in the materials or in our
19 discussions. I hadn't really thought about it too
20 explicitly either. But it's a good point.
21 MS. BARR: Thank you. I hope that is the
22 question we're asking.

1 MS. KELLEY: Stacie.
2 DR. DUSETZINA: So like the others, an excellent
3 chapter. It was great to read, and I think you pointed out
4 so many important issues with some of the current measures
5 and how outdated they are, how they were based on rules and
6 data that, you know, we had at the time but maybe need a
7 second look now.
8 I also really like the percent of duals measure
9 and how well it seemed to perform relative to our current
10 measures, maybe with the DSH payment percentage. I don't
11 want to discount Lynn's comment about including other
12 important measures, but I think for the sake of convenience
13 and what you have equally measured the percent of duals
14 seems to be outperforming their current measures.
15 You know, I think the graph that you showed on
16 Slide 7 where it shows the percent of duals, billing for
17 duals by different providers, was really striking, and I
18 thought you made a very helpful point in the piece about
19 avoiding cliff effects by doing some sort of weighting to
20 account for the percent share.
21 I want to go back a little bit maybe to a comment
22 that David Grabowski mentioned about how to incorporate

1 states, and the way I was thinking about that was thinking
2 about the variation in states' Medicaid policies, and how
3 this percentage of duals might be biased to some states
4 versus another. So maybe one way of thinking about it is
5 incorporating it within state weighting to account for dual
6 share to try to get at within a state maybe that has lower
7 duals overall, that you're not penalizing hospitals there.
8 The last thing I wanted to ask and maybe just
9 comment on, you know, it's really sad to see the kind of
10 low performance of the ADI measures. I know we've talked
11 quite a bit about the importance of other measures that we
12 might use to try to better understand the vulnerability of
13 a community. And, you know, one of the documents that was
14 shared in advance of the meeting mentioned the Robert Wood
15 Johnson PLACES measure as another alternative that seems to
16 have a lot of area-level variables. And it may be one to
17 consider pursuing to try to add in a little bit more depth
18 of what's going on at the community level.
19 But, in general, I think this is an outstanding
20 first step, and I really appreciate the work you are all
21 doing.
22 MS. KELLEY: Jaewon.

1 DR. RYU: Yeah, I would also echo a big thanks to
2 Brian and Jeff. Another complicated area. But getting to
3 these questions, I am also in favor of revisiting how we
4 define and try to better align the policies around
5 supporting those who actually serve the populations that
6 are more vulnerable. I think there is a lot in the chapter
7 and in this presentation that suggests that we have a lot
8 more work to do there. So I am all in favor of that.
9 I like the combo measures. I think the safety
10 net index, or whatever it was referenced in the readings, I
11 think that seemed to have the strongest correlation or
12 relationship to those that are treating truly vulnerable
13 populations. I had not thought of LIS in place of the
14 percent duals. I think Jeff had mentioned that. I'm kind
15 of intrigued by that. I think that's an idea also worth
16 pursuing, as is Stacie's point just now around maybe you
17 actually do the apples-to-apples within a given state and
18 that way it is a little more comparable based on the
19 Medicaid eligibility that systems are dealing with, or
20 providers are dealing with.
21 A couple of points on access that I did want to
22 make, and I know that Pat referenced this a little bit, as

1 did Dana. But I think we need a little more information
2 around, I would say, specialty outpatient access in
3 particular. If you look at Table 5, you have physician
4 office and the percentage of claims that are from duals is
5 12 percent, and I think earlier in the material the
6 percentage of overall beneficiaries that are duals is
7 something like 14 or 15 percent. So you have
8 underrepresentation in terms of that physician office
9 environment, and yet I think the readings also referenced
10 that primary care in that physician office is
11 overrepresented, which would suggest that really specialty
12 in the office, in the physician office or clinic
13 environment is particularly underrepresented. I think this
14 goes to Dana's comment earlier.
15 You know, there is a higher disease burden in the
16 duals population. That would suggest that they are
17 tremendously underserved when it comes to specialty care.
18 And I think that also corroborates or jives with what we
19 anecdotally hear from many FQHCs that are constantly
20 struggling to find specialty capacity for their patients.
21 I think teasing that out a little more might be helpful in
22 terms of getting an accurate, or more accurate picture of

1 where access stands.

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

17 MS. KELLEY: Paul.

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

1 situation.

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

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

21 I was struck by the chart you had about how 13
22 percent of the physician practices had 50 percent or more

1 duals in their panels, their patient populations. And it
2 seems as though it's important to target more of the
3 support to those practices. I think our health
4 professional shortage areas measure is way too old and it's
5 really failing to do the job of targeting our extra support
6 to providers that are taking care of the vulnerable
7 populations.
8 And finally, the point has been mentioned, and I
9 agree, that in the hospital sector there has been overly
10 strong concentration on inpatients, and the hospitals that
11 provide extensive uncompensated care and care to Medicaid
12 beneficiaries, whether they are duals or not, in their
13 outpatient departments is very important and should really
14 be a priority for supports.
15
16 MS. KELLEY: Amol?
17 DR. NAVATHE: Thanks, Brian and Jeff, for the
18 great work here. I'm very, very supportive of our
19 continuing to flesh this out, and I appreciate Jeff's
20 framing that this is a multi-session body of work that
21 we're taking on here.
22 I wanted to primarily echo support for a number

1 of things that my fellow Commissioners have beaten me to
2 saying already, so that's great.
3 The first thing, I just wanted to echo support
4 for what David and Stacie were saying regarding looking at
5 the within variation at the state level and looking at the
6 dual eligibility variation. My thinking is very similar to
7 Stacie's, which is basically if we can understand how much
8 of the variation described at the state level and what's
9 happening within the state level, I think we could, in
10 fact, replicate some of the charts that Stacie had pointed
11 to as well as some of the tables around the hospitals, when
12 we control for that state level or we can stratify by those
13 state thresholds. I think that will help us understand how
14 much of this is being driven by versus -- driven by the
15 state-level variation policy versus all kind of underlying
16 relationships. That's definitely worth doing.
17 Jeff, along the way you had mentioned LIS as a
18 potential individual level measure. I thought that was
19 worth doing. I think there's -- I think we should
20 acknowledge straight up that there's going to be no perfect
21 measure here, and so the more measures that we can use,
22 especially those that are already used in some part of the

1 Medicare program, broadly speaking, will be a good thing.
2 I echo the support for the idea that we want to
3 move away from cliffs and sort of towards continuous
4 measures. I think that's a very good point. And I also
5 wanted to touch on what Jaewon and others have already
6 mentioned. I think that there's a lot of programs that are
7 orientated towards safety-net hospitals. There's a lot
8 less in terms of safety net on the clinician side, and I
9 think this chapter and writeup did a very nice job of
10 articulating why that should be a major concern for us in
11 terms of access, in terms of the physician fee schedule,
12 physician offices, and ambulatory surgery centers being
13 particularly disproportionate area where we see differences
14 between duals and non-duals, for example. So I think we
15 should take that very seriously. Jaewon mentioned the
16 specialty services. We looked at some data previously
17 about that as well. So I think it would be good to
18 continue to dive a little bit more deeply on these issues
19 to see how we might design policy, not only identification
20 but also to control policy adjustments to help support and
21 taking care of the underserved populations here that we're
22 worried about.

1 The last analytic point that I think is worth
2 doing, it was mentioned in the writeup at one point. I
3 think it was tucked in the clinician space, but I think it
4 belongs overall as an analysis, is this notion of area
5 served versus population served. So we have -- we've done
6 some analysis, I think, here. Most of it is focused on
7 what are the characteristics of the populations actually
8 treated at a hospital or actually treated by a clinician
9 group, and there's a distinction between what is the area
10 served or where the physical location is of said hospital
11 or clinician group. And when there's a misfit there, I
12 think it would actually be helpful to better understand
13 what that variation of fit versus misfit looks like in
14 terms of the area sort of versus the actual patient
15 population treated. If we can dive into that a little bit
16 further, I think that would help us understand a little bit
17 more about the dynamics that are up later.
18 Thank you.
19 MS. KELLEY: Bruce.
20 MR. PYENSON: Thank you. My compliments to the
21 authors.
22 I want to pick up on a point that Larry started,

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

1 safety net.

2 Thank you.

3 MS. KELLEY: Betty.

4 DR. RAMBUR: Thank you very much. I really

5 appreciated this chapter, and I know this work will be a

6 heavy lift, and I'm glad that we're taking it on.

7 My comments really complement the people who have

8 spoken before me, and just to follow up on Bruce, separate

9 and equal is never equal, so I think that would be

10 important for us to think about that.

11 Very briefly, as someone who spent most of her

12 life living in isolated areas, I just want to underscore

13 that I strongly agree that an isolation metric is not a

14 safety-net metric. And I particularly appreciated the

15 piece in there and the material about Rush Medical Center

16 in Cook County, given that I did my graduate work there,

17 and they are entirely different worlds. And I've lived in

18 relatively affluent isolated areas and very poor ones, and

19 so I really was glad that we laid it out that way.

20 I agree with Paul that the percentage of DSH is

21 way too high, and so there's some real work we have to do

22 there. And Stacie mentioned the outdated definitions, and

1 Jaewon, about going to -- resources going to those that
2 serve the underserved populations. I just want to mention
3 the piece in there that talked about the 10 percent
4 incentive payment going to physicians in HPSAs but not
5 nurse practitioners and physician assistants, when the data
6 is very clear now that nurse practitioners and physician
7 assistants are far more likely to work in underserved areas
8 with vulnerable populations, et cetera, et cetera. So
9 there's certainly some work to do there.
10 I would also just ask us, as we think about
11 moving ahead with terms, I'd like to invite us and the
12 entire nation to permanently retire the term "mid-level."
13 It may seem like an easy thing, and I'm certainly not
14 criticizing this report because it's used all the time, but
15 if nurse practitioners and PAs are in the middle, then
16 what? Is it primary care providers and specialists? And
17 who's on the bottom? And where's the patient in this?
18 There is a lot of evidence about the
19 effectiveness of nurse practitioners, as the literature I
20 know the best, as effective providers, and they're not in
21 the middle of anything other than trying to deliver good
22 patient care. So it does sort of imply less, and the data

1 does not support that. So I encourage all of us to retire
2 that term.
3 Others of you said things that I strongly agree
4 with, but I'll leave that for now, and thank you for this
5 effort, and I look forward to working together with all of
6 you on this. Thanks.
7 MS. KELLEY: Marge.
8 MS. MARJORIE GINSBURG: Thank you. Yes, fabulous
9 report, very exciting work that we've got ahead of us.
10 Betty, I completely support your comment about the use of
11 the term "mid-level." Let's dump it. And I also agree
12 with Paul, who was taken aback by the high percentage of
13 hospitals getting DSH payments. Eighty-two percent, that
14 must tell us something. Let's get rid of this thing or
15 completely change it so it actually has some meaning.
16 Appendix A, which was very valuable and includes
17 all the various ways in which we try to compensate for and
18 make better care for people, it feels like it all needs to
19 be harmonized -- that's our new word, our go-to word for
20 ACOs. I think maybe it's time we use the word for the
21 support we give to what we're now calling at the moment
22 "safety-net hospitals."

1 And my last comment, like others, I appreciate
2 David's comment about the states and their relative high
3 versus low versus hardly any at all support for Medicaid.
4 I'm not sure what we do with that. I mean, if Medicare
5 steps in and says don't worry, folks, we'll take care of it
6 if you, the state, doesn't want to pay the fair share, the
7 cost-sharing part, what message does that send? And is
8 that simply going to get other states to start backing
9 away?
10 On the other hand, what can we do to put more
11 pressure -- what can we do, if anything, to put more
12 pressure on states to start paying their fair share?
13 So I'll just throw that out for the rest of you
14 to come up with the answers. Thank you.
15 MS. KELLEY: Dana.
16 DR. SAFRAN: Yes, thank you. Just piling on with
17 congratulations for starting this important work and the
18 plan to continue it, extremely important and valuable.
19 A few comments. One is I really, like others,
20 agree with and would like to see us continue to explore
21 this idea of having the added payment apply at the patient
22 level versus the facility or provider level. I think that

1 avoids the cliff issue as we've talked about and really is
2 a much more appropriate way to think about properly
3 compensating for the added costs associated with care.
4 I'll come back to that point about the added costs in a
5 moment, but just make the point that that added payment,
6 based on the patients being cared for, seems to me should
7 apply to all clinicians. I believe this was the chapter
8 that indicated that it didn't apply right now to nurse
9 practitioners or others, and, you know, that seems to me
10 just absurd. So I would offer that it should apply across
11 the board regardless of who's taking care of the patient.
12 To that point about what it costs, you know, I
13 was really struck by that statement that I asked about in
14 Round 1 that the evidence shows that, you know, less than
15 25 percent of the DSH payments were justified by higher
16 costs of care. And I don't want us to be confused by that
17 because listening to the response that you provided, Jeff,
18 it's clear that that was based on the status quo and really
19 is, I think, from an era with a mind-set toward, you know,
20 whatever care is provided is provided in the four walls of
21 a care setting. And thankfully we're in a new era now.
22 We're thinking about social determinants of health. We're

1 thinking about what it is that patients need outside of
2 what can happen in the clinical setting. And so, you know,
3 I think we do have to recognize added costs that are
4 associated, you know, and even -- I think it was Lynn who
5 mentioned just the additional time required to communicate
6 effectively and assess the needs and then make a plan for
7 helping take care of the needs. And it did strike me when
8 Lynn was saying that those types of things wouldn't have
9 shown up on that prior analysis. So I just want to make
10 that point.
11 Then a couple final points. One, I was really
12 struck by the explication in the chapter about how duals --
13 how the payment for duals really ends up with providers
14 getting less than because of the way the Medicaid lesser-of
15 rules have been implemented, and I really wanted to just
16 underscore that absolutely seems to need attention. And it
17 also feels, you know, as I think about the current momentum
18 in the private sector around health equity, which we all
19 have to applaud -- it's long overdue -- I do worry a little
20 bit that this disparity in payment and, therefore, in care
21 and attention could be made worse by the added financial
22 incentives that providers will be receiving from commercial

1 payers to pay special attention to closing care gaps and
2 improving health equity of their populations if we aren't
3 sort of balancing that over on the side of those who have
4 lower socioeconomic status. So I just wanted to highlight
5 that point.
6 And then I think the last point that I'd like to
7 make is, again, reflective of the question I asked in Round
8 1 and some comments I heard other Commissioners make. I
9 don't think we should be assuaged by the counting of visits
10 and assume that that means that patients who are lower
11 socioeconomic status but higher case mix are actually
12 getting what they need. What I saw in the survey-based
13 data that you reported was 2X rates of access barriers and
14 challenges for these populations. So I want us to not be
15 satisfied just by counting visits or hospital stays and
16 assume that that means, you know, that these folks are
17 getting the care they need.
18 Thank you.
19 MS. KELLEY: David.
20 DR. GRABOWSKI: Thanks, Dana. So I'll be brief.
21 Most of what I wanted to say has already been said. I just
22 wanted to stress two things.

1 First, I'm very supportive of this direction. I
2 think it's already been said but I'll say it again. We
3 currently do a really poor job of directing resources to
4 safety-net providers. Paul did a great job of kind of
5 outlining some of those issues with the DSH program. This
6 is a perfect issue for MedPAC to be focusing our attention
7 on, so I'm really happy we're working on this.
8 The second point, I just want to raise this
9 issue. I'm really intrigued by coming up with Medicare-
10 specific metrics. I think the duals measure that was
11 outlined in the chapter, as Stacie said, is a really good
12 starting point. The results that you put together in the
13 chapter look promising, and I think we can build on those.
14 We've had lots of good comments. And I raised in Round 1
15 about kind of the state variation. I was thinking about
16 these within-state comparisons.
17 Jeff, I really liked your idea, like others did,
18 about the LIS, using that as a way to get around this
19 problem. Stacie had this great idea about the share of
20 duals in the state. So there's a lot more work that can be
21 done here to kind of overcome this problem, but I'm really
22 excited over thinking about this duals measure and where

1 this work might go.

2 So as I said, I will be brief. I really mean it.

3 This is great work, and I look forward to seeing future

4 iterations. Thanks.

5 MS. KELLEY: Pat.

6 MS. WANG: Thank you, and I echo the compliments

7 for the work, the quality of this particular paper, and the

8 work that I think is going to continue. It's really quite

9 important.

10 I just want to offer my perspective from a

11 perspective of the work that I do. It is critical to find

12 a way to identify and support safety-net providers.

13 Critical. I think that one of the questions, though, that

14 MedPAC needs to consider is: Is that the goal or is that

15 an essential piece of a longer journey to ensuring that

16 vulnerable underserved, underrepresented Medicare

17 beneficiaries get better care, better quality, and, you

18 know, really address some of the health equity issues that

19 we have discussed?

20 I would suggest that payment policy is not the

21 whole thing, but it is a very powerful tool to shape a

22 delivery system, and that MedPAC should have as one of its

1 goals to stabilize -- identify and stabilize and support
2 safety-net providers, but also to try to use payment
3 incentives to reshape the delivery system to better serve
4 the population.

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

13 From my experience, the issues confronting
14 communities that are very underserved are weak hospitals,
15 it rolls into quality, and, you know, just trying to stay
16 alive with like five minutes of cash on hand. But bigger
17 problems are communities live in what I would call "health
18 care deserts." You know, other than FQHCs, God bless them,
19 it's a very fragmented, siloed, inadequate, you know, sort
20 of supply of care deliverers and care components. Somebody
21 mentioned access to specialists. Gigantic problem. And so
22 if payment policy can help with that, that's great. But I

1 think it goes beyond payment policy. Paying more to
2 specialists to see my members is really essential, but it's
3 not going to solve the problem because there are other
4 reasons that people don't want to open their doors to
5 Medicaid and dual people.
6 And so I think part of it is just also
7 understanding provider shapes and provider types that are
8 very, very suited to taking care of the people. I think
9 FQHCs are an incredible model. Don't forget community
10 resources like community-based organizations. They're kind
11 of left out of the equation, but at least in my world, they
12 are so important to help patients navigate the system.
13 So I would sort of hope that our ambition is
14 bigger than it's really hard to pinpoint money to what we
15 would define as safety-net hospitals, but I'm urging us to
16 kind of go several steps further to figure out how else
17 payment policy can reshape the delivery system for the
18 populations that we care about.
19 In that regard, I really appreciate, Jeff, that
20 you can take a look at ambulatory care data, especially in
21 the hospital setting. And the reason is that, you know,
22 there's too much inpatient care being delivered to these

1 populations. What's needed is more ambulatory care. If
2 there -- and it's not the fault of the hospital. It's that
3 there's no ambulatory care around. If there's a way to
4 incentivize or focus money to support the development of
5 more robust ambulatory care systems -- and I really am
6 focused on the hospitals here because they are often really
7 the only source of care, at least in the communities that I
8 am familiar with -- to help them build out ambulatory care
9 capacity, that is what is really needed by the population
10 beyond an inpatient bed. You know, it's like the
11 precursor.
12 I wanted to suggest the -- I appreciate that you
13 guys are fiddling around with this ADI to try to get at
14 more characteristics of sort of the community served by
15 different providers, and I want to go back to something we
16 discussed at the last meeting. It was to see whether or
17 not you can identify communities in need by looking at
18 ambulatory care-sensitive admissions.
19 It's a good marker of adequacy of primary care in
20 a community, and it could be -- if you have access to that
21 sort of information, it could be another kind of geographic
22 filter to layer on to something. Like, if you identify a

1 provider, you know, check all the boxes of the safety-net
2 index and the rate of potentially preventable admissions is
3 very, very high, then you'll know that maybe you've checked
4 another box. I think looking at indicators like that is
5 important.

6 On the question I asked before about teaching
7 status, here's the things that is perplexing me a little
8 bit about this. If, in fact, teaching status is very
9 highly correlated with your high safety-net indicator
10 index, is it possible that GME is a safety-net payment?

11 Jeff, you said something interesting earlier,
12 which was "I don't know of very many teaching hospitals
13 that have closed." Maybe the variable, the important
14 variable there is the teaching payments.

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

18 Just a couple of other comments. Identifying
19 safety-net provider communities, populations of concern, I
20 think it's like the river that runs through a lot of
21 payment policy discussions, and I'd suggest that if we feel
22 secure, when we feel secure that we kind of narrow down

1 what a safety-net provider is, then it should affect and
2 run through the way that those providers interact with
3 other payment policy decisions that get made, what gets
4 paid for outpatient care, what gets paid for GME, what gets
5 paid in the fee schedule. I mean, it's not just a siloed
6 sort of DSH-like payment.
7 The final thing I just wanted to mention to put
8 on Jeff and Brian's radar screens, I don't know whether
9 this is maybe a down-the-road thing, and this is the way
10 that DSH UCP payments are treated in the MAPD benchmark as
11 compared to GME, the Medicare Advantage benchmarks.
12 We know that for Medicare Advantage, GME gets
13 pulled out and gets paid separately by CMS to the teaching
14 hospital. It's not paid by the plan, and the idea of this
15 was to, I think, try to have a level playing field between
16 teaching hospitals, which are more expensive, and
17 nonteaching hospitals to prevent plans from piling all
18 their care into the non-teaching institution and putting
19 teaching hospitals as a disadvantage.
20 DSH is not treated the same way. DSH UCP is part
21 of the MA benchmark, and it is part of the premium. And
22 the anomalous thing that happens here is if that county,

1 let's say, that hospital care is 30 percent of the
2 benchmark and DSH is 35 percent of the hospital cost, that
3 money is rolling through into every MA plan's premium,
4 including those who never sent anybody to a DSH hospital,
5 and those who send all of their members to DSH hospitals
6 because that's who they serve. It's a very curious thing
7 because DSH raises a level of premium for all plans, no
8 matter who they serve, and it has a very different impact
9 if you don't send anybody to a DSH hospital and you never
10 pay a DSH payment versus you sent everybody to a DSH
11 hospital and you pay all of the DSH payments. It has a
12 differential impact.
13 If you carve that money out of the premium, there
14 would be very little left. I mean, it would really have a
15 big impact on the premium, but it is -- it always
16 interested me that teaching hospitals were deemed worthy of
17 protection in this way, but DSH hospitals are in a
18 different category, apparently. So, for future reference,
19 it might be something that you want to think about.
20 Thanks.
21 MS. KELLEY: Jonathan Jaffery.
22 DR. JAFFERY: Thanks, Dana.

1 I'll be pretty brief because, really, everybody
2 has made most of my points, and they've been excellent.
3 I'm really supportive of this work. It's excellent
4 foundation. I just want to emphasize maybe one or two
5 points.
6 One is that, at a high level, the support for
7 this principle that we should define safety-net providers
8 by the populations they serve rather than the types of
9 organizations they are or where they're located, and then
10 that leads into some of these other things like continuous
11 eligibility rather than cliffs and thinking about things
12 like LIS or something else creative that wouldn't be
13 subject to much state variation or things like that.
14 But I also just really want to emphasize this
15 notion that's come up around this is -- and I know, Jeff,
16 you started off saying this. So I know this is where
17 you're thinking too. This is where we're starting and
18 thinking about -- this is going to be a continuous
19 discussion that includes layering on health equity, which
20 is very different. Health equity -- and there's a lot of
21 overlap with economic disadvantage, but they're not the
22 same thing.

1 Dana was talking about situations where it takes
2 more resources to care for somebody, and there are all
3 sorts of examples where you can think about a language
4 barrier that requires more resources that may have nothing
5 to do with economic disadvantage for that individual, but
6 it's a real barrier and can impact outcomes. So I think
7 it's super important that we are addressing this and very
8 excited to be part of this conversation.
9 The second thing I just wanted to mention is a
10 bit more granular, and I was intrigued, while I was reading
11 the chapter, about the issues around primary care versus
12 specialty care and thinking about FQHCs in particular.
13 So a number of people have brought up FQHCs. I
14 think, Jaewon, you started off bringing that into the
15 conversation, and this notion that primary care treats some
16 of our dually eligible individuals much more than specialty
17 care -- specialists do, I wonder if that's really driven
18 primarily, if not almost exclusively, by how much FQHCs
19 take care of the dually eligible individuals, because we
20 saw those percentages be so high in the chapter.
21 So I wonder if there's more work we can think
22 about, analytic work around some of that, and then really

1 thinking about are there policies we can build into place
2 here that are supportive for some of the great systems we
3 already have, the FQHCs, to get more support for specialty
4 care.
5 As a specialist with a close relationship with
6 our FQHC in town here, I know what a struggle it is for
7 them and how a lot of times, things that will happen with
8 their patient population, in the nephrology care happen,
9 it's really just sort of happenstance and just
10 relationships based on me being friends with the CMO and
11 the CEO there. It's not systematic, and so if there are
12 some policy and payment approaches we can think about to
13 try and mitigate that disparity, that would be wonderful.
14 Again, thank you for bringing this work to the
15 forefront, and I'm super-excited about it.
16 MS. KELLEY: Larry.
17 DR. CASALINO: Yeah. Jonathan, you must have
18 read my mind because just about everything you said, I was
19 going to say. So I'll make a few comments very quickly and
20 then spend a little bit of time, not much, on a fourth.
21 I like the dual eligible idea as a simple way of
22 identifying safety net, but I don't think we can just stick

1 our heads in the sand and ignore the variations across
2 states in that. So I think maybe some more work on whether
3 defining -- using the in-state comparisons would be enough
4 or that wouldn't work across the board, LIS, as Jeff and
5 others have mentioned, or is there another measure or
6 combo? Whatever we do, I think we have to explicitly
7 address the state dual eligible issue if we think about
8 using that as the thing that defines safety net.
9 A related point, and Dana and Jonathan have made
10 it, it's satisfying to have a clear description of safety
11 net and say this is safety net and this isn't safety net.
12 So these are safety-net hospitals, these are safety-net
13 physician offices, and these aren't. There's real
14 advantages to that.
15 On the other hand, that would be a cliff, and it
16 doesn't have to be a cliff. If we were using dual
17 eligibles, for example, it could be payment varies by your
18 percentage of dual eligibles, more complicated, but that's
19 the second point.
20 A third quick point, which others have made, 80
21 percent of hospitals get DSH payments is kind of
22 ridiculous, especially when there's 13 percent of physician

1 offices or physicians that are seeing 50 percent of dual
2 eligibles, and they don't get any extra money, don't get
3 any help at all. FQHCs do, but physicians in private
4 practice don't. That really needs to be changed, and
5 that's something that MedPAC, one would think, could take
6 on pretty quickly.
7 Actually, there's a subpoint to this, which I
8 wasn't going to originally make, but listening to Jonathan
9 talk about specialists and the problem with not just FQHCs
10 but any physician has in getting a specialist to see a dual
11 eligible patient or, God forbid, a Medicaid patient -- and
12 I agree there's a lot of reasons why physicians don't take
13 Medicaid patients. It's not just low-payment rates. But,
14 you know, most physicians have had many, many, many, many
15 years of their training heavily subsidized by the federal
16 and state governments, and again, an incredible return on
17 the years they spent training, an incredible economic
18 return. And the idea that they are not willing to see just
19 a couple of percent even of their patients who have
20 Medicaid or dual eligible, to me, it's really unacceptable.
21 I'd love to see MedPAC open a line of work on specialists
22 and dual eligible patients and think about whether there's

1 anything CMS should or could do about that.

2 And the last point I want to make -- and this

3 might take an extra minute -- I just want to pose the

4 question to the staff and the Commissioners. Is this about

5 eliminating disparities, or is it about keeping hospitals

6 and physician officers who have a poor payer mix because

7 they serve a lot of poor people and enabling them hopefully

8 to provide good care? I think it's clearly the latter.

9 This is about what can we do for hospitals and physicians

10 who -- and perhaps other sectors who take care of a lot of

11 poor people, and therefore, they have a poor payer mix, and

12 there, they don't have any money. I think that's the issue

13 we're addressing. We're not trying to eliminate

14 disparities through this mechanism.

15 I think helping hospitals and physician offices

16 that do have a poor payer mix would help reduce disparities

17 to the extent that racial and ethnic minorities, for

18 example, get their care from safety net physicians and

19 hospitals, but it isn't going to solve the problem

20 altogether, and I don't think we can through this

21 mechanism.

22 For that reason, I think it would be better not

1 to use the word "vulnerable patients" or "disadvantaged
2 patients" when we talk about this, because there are lots
3 of vulnerable patients in the world. You could have a very
4 wealthy LGBTQ patient, for example, who has great
5 commercial insurance and is not hurting the providers at
6 all in terms of whatever they're getting paid, but who is
7 disadvantaged because of lack of understanding of who they
8 are and so on. And you can multiply those examples.
9 So I think every time we use the word
10 "vulnerable" or "disadvantaged," we kind of open the topic
11 up to this is about eliminating disparities. I don't see
12 this as a mechanism for eliminating disparities. I see it
13 as a mechanism for reducing disparities by helping
14 hospitals and physician offices that take care of poor
15 patients, period.
16 I think MedPAC could open a line of work because
17 I think Pat was suggesting into ways that payment
18 incentives and other things that Medicare could do to
19 reduce disparities other than disparities caused just
20 purely by poverty such as racial, ethnic, or sexual
21 orientation. There's no end to the kind of disparities one
22 could address.

1 So that's it.
2 MS. KELLEY: That's all I have in the queue,
3 Mike.
4 DR. CHERNEW: I think Bruce Pyenson wanted to get
5 in a point, given there was some time left.
6 Is that right, Bruce?
7 MR. PYENSON: It's right. Actually, a couple of
8 points. One item that I welcome seeing through the
9 analysis is some discussion on the use of funds for charity
10 care. I think that's been a topic of some interest in
11 policy circles, and having that as a comparator might be
12 helpful in a number of ways. So that's one point.
13 Perhaps this goes without saying. I know the
14 analysis that we've seen was using the hospital closures as
15 an outcome of the regression analysis. It's not that's a
16 measure of distress. It's perhaps not the best measure
17 because there's lots of reasons why hospitals might close,
18 and there's relatively few. And they're, well, typically
19 small.
20 So those are my two additional comments. Thank
21 you.
22 DR. CHERNEW: Okay. Dana, am I right that that

1 is the end of the queue now?

2 MS. KELLEY: Yes, it is.

3 DR. CHERNEW: I'll pause for a minute to see if

4 anyone wants to add anything. It's been a very rich

5 discussion. Then I will summarize.

6 DR. RAMBUR: Can I make one brief comment? I just

7 can't help but underscore the point that Larry made about

8 the enormous subsidy that we do have for physician

9 education and some expectation on the part of us that that

10 has been used to serve Medicaid patients, duals, whatever.

11 But I just can't help but point out the irony of the money

12 that the nation does not spend on nursing education or

13 graduate education and the proportion of those nurse

14 practitioners that do work with Medicaid patients and dual

15 eligible patients.

16 I don't have that data right in front of me, but

17 it is sort of an ironic situation, and to the extent that

18 we can align things up better, to better meet the needs of

19 this nation, I think we would have done something that is

20 very important. So I wanted to just throw that out there

21 and thank Larry for bringing that point up.

22 DR. CHERNEW: Okay. And now you've spurred

1 Brian, I think, to want to make a comment.

2 DR. DeBUSK: I also want to make a comment on

3 Betty's observation. It is interesting that we have GME

4 funding for physicians, but there's this gap in how we

5 treat, for example, nursing, nurse practitioners, physician

6 assistants. Notice, Betty, I did not use the midlevel

7 term. For what it's worth, Marge set me straight a couple

8 of years ago. But the observation I'm making too, you're

9 also seeing the rise of hospitals participating more and

10 more in nursing education; for example, receiving their

11 bachelor's, receiving their FNP. And you're seeing this

12 rise of nurse staffing companies accounting for a larger

13 and larger share of nurses.

14 I do want to caution. I suspect we are building

15 those costs into Medicare payments, but we're doing it

16 through the market basket updates, through the cost

17 reports, and the -- I'm agreeing with you, and my point

18 here is I think if we don't manage how we handle this

19 education, the system with its formulaic approach is going

20 to manage it for us through shifting the hospital wage

21 index calculation and through the market basket updates.

22 So my advice would be I think we should be more

1 proactive and decide how we want their education to be
2 shaped.
3 DR. CHERNEW: Okay. So what that set of comments
4 illustrates is how multifaceted our entire health care
5 system is and how many different levers we have. In other
6 word, we talk about putting things through various lenses.
7 This broad issue can be looked at, when we talk about
8 education, we had an IME chapter. We will do education
9 again. A lot of the themes that were raised today relate
10 to how we do quality measurement and a whole range of
11 things related to quality and performance measurement that
12 spans all of the payment systems.
13 Let me give sort of my both reaction to this and
14 general overview in very broad terms and sort of make the
15 high-level point that the enthusiasm for this topic was
16 really exceptional, and I'm very thrilled for that. And I
17 think when I loop back with the staff, I think we'll find
18 continued significant enthusiasm, and so this has been a
19 very, broadly speaking, far-ranging and fruitful
20 discussion, straying into areas perhaps more than we can
21 get to in this chapter, but that doesn't mean more than we
22 will think about as we go through all the other things that

1 we do.

2 So, again, I'll give my views, and we'll see how
3 it plays out. The first one is I think, by and large, this
4 is about access to high-quality care and the
5 acknowledgement that provider availability is central to
6 that access but acknowledging that it's only one aspect of
7 that access. Having providers is, in many ways, a
8 necessary but not sufficient aspect of access, and we need
9 to think through that.

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

14 I think we will continue to ponder as we go
15 through this aspects of performance measurement. My
16 personal view is, as I said, some of the financial support
17 is necessary to help some providers survive, but it's not
18 necessarily sufficient to achieve the main goal, which is
19 access to high-quality care. So we will have to continue
20 to think through this in the context of the performance
21 measurement things that we do and a broader set of policies
22 that we have.

1 The other theme that I think played out in this
2 discussion, which is an important one, is the, broadly
3 speaking, idea of measurement and targeting, and we are
4 sort of groping around for better measures to accomplish
5 what we want to accomplish. And I think many of the
6 comments, some of the weaknesses of the duals and things we
7 might do about it, some other measures, are well
8 appreciated.
9 I guess I'll say one last thing, lest to be
10 confused. I mentioned the importance of provider-ability
11 for access, and that remains true. That does not mean that
12 we should pay in a way that keeps all providers open all
13 the time. So we really need to try to figure out here a
14 way to target the money to the providers that are really
15 central to meeting the broad mission of the Medicare
16 program, and again, if I haven't mentioned it, the
17 beneficiary access to high-quality care and having
18 sufficient resources but not excessive resources to support
19 that.
20 So that's how I see this playing out. We are
21 struggling with the exact vocabulary to use in describing
22 all these things, and we're struggling sometimes with the

1 boundaries about exactly where different concepts should
2 fit in our broad agenda.
3 But that's my summary, and I was going to pause
4 to see if there are any other questions, but I actually
5 think my sense from the chat is there are some to her
6 comments. So I'll phrase it this way, without calling any
7 of you out. Anyone want to say anything?
8 DR. DUSETZINA: Mike, your wrap-up comments
9 spurred one more kind of question in my mind or one more
10 data request, and it gets back to this point of specialty
11 care and trying to think about how to incorporate that
12 better.
13 I do wonder if there's a possibility of
14 collecting information on the -- even if it's the percent
15 of duals measure by institutions for both their inpatient
16 care and their outpatient care.
17 Part of the reason I'm thinking about this is
18 thinking about hospitals that currently get some forms of
19 DSH payments because they accept Medicaid-covered
20 individuals or duals through the emergency department and
21 in inpatient care but do not accept those same individuals
22 in their outpatient clinics, and I really think that it

1 would be helpful to understand more about the correlation
2 between their percentage of dual populations between those
3 sites of care to try to maybe do a better job of rewarding
4 systems and hospitals that are taking care of patients in
5 both care settings.

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

18 So I've done my wrap-up. I'm going to pause
19 again for a second and see if anyone wants to add
20 something. If not, we're going to move on to a discussion
21 of telehealth. This was supposed to be the transition
22 where I pointed out that access to high-quality care in

1 many cases also includes access to telehealth services in a
2 broad range of ways. So we will tie this together when we
3 look at some of the data coming up, but before we make that
4 transition, any last words? That sounds so final.
5 [No response.]
6 DR. CHERNEW: Okay. Hearing none, we will move
7 on.
8 I think, Ariel, are you going to kick us off on
9 our telehealth session to update us on where we are?
10 MR. WINTER: Yes.
11 DR. CHERNEW: Great. Take it away.
12 MR. WINTER: Good afternoon. The audience can
13 download a PDF version of these slides in the handout
14 section of the control panel on the right-hand side of the
15 screen.
16 In today's presentation, we will review
17 Medicare's temporary expansion of coverage for telehealth
18 services during the public health emergency and the policy
19 option for covering telehealth after the PHE that was in
20 our March report this year.
21 We will also provide an update on telehealth use
22 during the pandemic, information on beneficiaries' and

1 clinicians' experiences with telehealth, findings from our
2 interviews with direct-to-consumer telehealth companies,
3 information on telebehavioral health, policy options for
4 Medicare to collect more data on the use of telehealth
5 services.

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

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

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

21 Ariel, I'm sorry. Do you mind?

22 MR. WINTER: No problem.

1 MS. KELLEY: Okay. Let's just --

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

3 MS. KELLEY: Okay. Thank you.

4 DR. CASALINO: Great.

5 [Recess.]

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

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

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

1 use of telehealth services.

2 Some of this material will be incorporated into

3 various March report chapters, but we are not planning to

4 have a freestanding telehealth chapter for this meeting

5 cycle. At this meeting, we would like to get your feedback

6 on this material, and other topics you would like us to

7 explore.

8 Before the PHE, Medicare's coverage of telehealth

9 was flexible in Medicare Advantage plans, two-sided ACOs,

10 and other payment systems. However, coverage of telehealth

11 was limited by statute under the physician fee schedule

12 because of concerns about its impact on spending and

13 program integrity. Under the fee schedule, Medicare paid

14 for a limited set of telehealth services provided to

15 beneficiaries in rural areas in certain settings, such as

16 physicians' offices and hospitals. As a result, use of

17 telehealth was very low. It accounted for less than 1

18 percent of fee schedule spending in 2019.

19 During the early months of the PHE there was a

20 steep decline in the use of in-person services, which led

21 to major concerns about beneficiaries' access to care. As

22 a result, the Congress and CMS temporarily expanded

1 coverage of telehealth services under the fee schedule.
2 This table lists the key policy changes that
3 apply during the PHE. First, Medicare began paying for
4 telehealth services provided to beneficiaries in both rural
5 and urban areas in any setting, including patients' homes.
6 Second, Medicare expanded coverage to over 140 additional
7 telehealth services and began paying for audio-only
8 interactions for certain services. Third, CMS began paying
9 either the facility or non-facility rate for a telehealth
10 service, depending on the clinician's location. Before the
11 PHE, Medicare always paid the facility rate, which is
12 usually less than the non-facility rate. And fourth,
13 clinicians are allowed to reduce or waive beneficiary cost
14 sharing for telehealth services.
15 In our March report, we described a policy option
16 for covering telehealth after the PHE. Under this option,
17 Medicare would continue certain telehealth expansions for a
18 limited duration, such as one to two years, after the PHE
19 ends.
20 These expansions would include paying for
21 specified telehealth services provided to all
22 beneficiaries, regardless of their location; covering

1 additional telehealth services if there is potential for
2 clinical benefit; and covering certain telehealth services
3 when they are provided through an audio-only interaction,
4 if there is potential for clinical benefit.
5 Continuing these expansions for a limited period
6 of time would allow policymakers to gather more evidence
7 about the impact of telehealth, when combined with in-
8 person care, on access, quality, and cost. This evidence
9 should inform any permanent changes to Medicare's
10 telehealth policies.
11 Our policy option also calls for returning to
12 some of Medicare's prior telehealth policies after the PHE,
13 along with establishing some additional safeguards. First,
14 Medicare should go back to paying the fee schedule's
15 facility rate for telehealth services, and second,
16 providers should not be allowed to reduce or waive
17 beneficiary cost sharing for telehealth services.
18 Further, there should be additional safeguards to
19 protect Medicare and beneficiaries from unnecessary
20 spending and potential fraud related to telehealth. These
21 include applying additional scrutiny to outlier clinicians;
22 requiring clinicians to provide an in-person, face-to-face

1 visit before ordering costly DME and lab tests; and
2 prohibiting "incident to" billing for telehealth services
3 provided by any clinician who can bill Medicare directly.
4 In addition, we noted in our report that CMS
5 currently has the authority to offer telehealth waivers to
6 clinicians who participate in alternative payment models.
7 Now, I'll switch gears and talk about our
8 analysis of the use of telehealth services during 2020,
9 based on preliminary Medicare claims data. This slide
10 shows the number of fee-for-service beneficiaries who
11 received at least one telehealth service during each month
12 of 2020. This number sharply increased in March and April
13 as providers and beneficiaries avoided in-person visits.
14 The number declined between April and Oct. as in-person
15 visits rebounded. But it began to increase again at the
16 end of the year, probably due to the growth of new COVID
17 cases.
18 Across the entire year, 14.1 million fee-for-
19 service beneficiaries received at least one telehealth
20 service, representing 40 percent of all FFS beneficiaries.
21 Now we're going to look at telehealth's share of
22 primary care services during 2020. Primary care includes

1 evaluation and management office and outpatient visits,
2 chronic and transitional care management services, annual
3 wellness visits, and some other codes.
4 Almost all primary care services can be provided
5 either in person or by telehealth. In-person visits are
6 shown in dark gray on the chart. Telehealth visits are in
7 light gray.
8 The growth of telehealth services partially
9 offset the steep drop of in-person visits in March and
10 April of 2020. In April, telehealth accounted for 47
11 percent of all primary care services. As in-person visits
12 bounced back, telehealth's share declined each month
13 between May and October. But telehealth's share began
14 increasing again during November and December, as the
15 number of COVID cases began growing. In December,
16 telehealth accounted for 17 percent of all primary care
17 services.
18 Preliminary data from 2021 show that telehealth
19 accounted for about 10 percent of primary care visits in
20 September 2021, which is the most recent data we have
21 available.
22 Here are some other relevant findings from our

1 analysis of Medicare claims data, and there are more
2 details in your mailing paper. E&M office and outpatient
3 visits accounted for almost three-quarters of allowed
4 charges for telehealth services in 2020, and 95 percent of
5 these telehealth visits were for established patients.
6 Telephone E&M visits accounted for 18 percent of allowed
7 charges for telehealth services during the year.
8 We also examined the types of conditions
9 associated with telehealth services. We found that mental,
10 behavioral, and neurodevelopmental disorders accounted for
11 the highest share of allowed charges for telehealth, 25
12 percent.
13 Looking at geographic variation, the number of
14 telehealth services per beneficiary varied by geographic
15 region in 2020. However, changes in the use of telehealth
16 during the year were generally similar across regions. The
17 volume peaked in April, declined during the summer and
18 fall, and began rising again late in the year.
19 We also examined the use of telehealth for
20 different subgroups of beneficiaries. We found that
21 beneficiaries who were under age 65 used more telehealth
22 services than older beneficiaries, those who were disabled

1 and those with end-stage renal disease used more services
2 than aged beneficiaries, dually-eligible beneficiaries used
3 more telehealth than other beneficiaries, and urban
4 residents used more telehealth than rural residents.
5 Next, I'll summarize our review of the literature
6 on the use of telehealth in the US during the PHE. Most of
7 the studies we reviewed focused on commercially-insured
8 patients or Medicare Advantage enrollees.
9 In general, the main findings of these studies
10 are consistent with the results of our Medicare claims
11 analysis. The volume of telehealth increased during the
12 PHE, mental health conditions accounted for a high
13 proportion of telehealth services, and the use of
14 telehealth varied among different groups of patients. For
15 example, patients in high poverty areas had lower use of
16 telehealth than patients in low-poverty areas.
17 And now I'll now turn things over to Ledia.
18 MS. TABOR: MedPAC's annual beneficiary telephone
19 survey and virtual focus groups with beneficiaries and
20 clinicians provide additional insight about experiences
21 with telehealth. Because the survey and focus groups were
22 conducted in the spring and summer of this year they allow

1 us to track more recent experiences than the claims
2 analysis and literature review.
3 Many beneficiaries reported having telehealth
4 visits over the past year mainly with clinicians with whom
5 they have an existing relationship. They were generally
6 satisfied with these visits. Consistent with our analysis
7 of Medicare claims, many clinicians in our focus groups
8 reported that they continued to provide telehealth after
9 rapidly expanding it early in the pandemic. Some
10 clinicians appreciated the convenience and flexibility it
11 allows in terms of the visit length and location, while
12 others preferred in-person visits due to perceived better
13 quality of care or to provide procedures and testing. Many
14 beneficiaries and clinicians would like to continue the
15 option of telehealth visits after the PHE.
16 Switching topics, Commissioners have asked us to
17 continue researching direct-to-consumer telehealth
18 companies, so we conducted interviews with five different
19 telehealth companies of various sizes and organizational
20 structures. Four of the five companies we interviewed do
21 not currently bill fee-for-service Medicare and do not plan
22 to do so in the foreseeable future.

1 The companies' primary clients are mainly
2 commercial health plans, large employers, and health
3 systems. The companies provide their clients' patients
4 with telehealth visits for mainly urgent, low-acuity care
5 needs, and many of the companies offer tele-behavioral
6 health visits. A few of the companies are beginning to
7 offer virtual primary care products, built on a continuous
8 relationship with patients, but none of them were focusing
9 these services on elderly patients.
10 Companies varied in their arrangements with
11 clinicians, meaning some employed full-time clinicians
12 while others contracted with clinicians on a part-time
13 basis.
14 Switching to another topic of interest to the
15 Commissioners, tele-behavioral health services. These
16 services include individual therapy, group therapy, and
17 treatment for substance use disorders. The high use of
18 telehealth for treating mental health conditions means that
19 telehealth services have played an important role in
20 treating mental and behavioral health conditions during the
21 public health emergency.
22 The literature before the PHE suggests that

1 patients utilizing telehealth care have comparable short-
2 term outcomes, for example, that are medication compliance
3 and reduced symptoms, to those utilizing in-person care for
4 behavioral health conditions. Tele-behavioral health
5 services also improves access, especially for patients
6 experiencing geographic, social, or health-related
7 barriers. However, more research needs to be conducted on
8 the impact of tele-behavioral health on cost and long-term
9 outcomes.
10 Prior to the PHE, beneficiaries had to receive
11 all services at an originating site, like a clinician's
12 office in a rural area, with the clinician at a distant
13 site. In 2021, the CAA removed geographic restrictions and
14 added the patient's home as an originating site for tele-
15 behavioral health services that are used to diagnose,
16 evaluate, or treat a mental health disorder. The CAA also
17 requires that a non-telehealth service, i.e., an in-person
18 visit, be provided by the clinician furnishing mental
19 telehealth services within six months prior to the initial
20 telehealth service.
21 In the 2022 physician fee schedule rules
22 finalized last week, CMS is implementing this statutory

1 requirement by requiring that a non-telehealth service be
2 provided by the clinician furnishing mental telehealth
3 services or a clinician within their group within six
4 months prior to the initial telehealth service, and at
5 least once every 12 months thereafter by the same
6 practitioner. The in-person every 12 months requirement
7 can be waived if clinicians document how a tele-behavioral
8 service outweighs the risks and burden of an in-person
9 visit.
10 CMS also proposes to cover audio-only behavioral
11 health services when in-person service is furnished within
12 12 months by the same provider, and the beneficiary doesn't
13 have the capability for telehealth. A claims modifier will
14 be required to denote that the service was audio-only.
15 Switching to the topic of lack of data on some
16 telehealth visits. Before the PHE, CMS only paid for
17 physician fee schedule telehealth services that were
18 provided using two-way audio and video communication
19 technology. During the PHE, however, CMS has waived this
20 requirement for some services because not all beneficiaries
21 have the capability to engage in a video telehealth visit
22 from their home.

1 Under the Commission's policy option from our
2 March 2021 report, CMS should continue to temporarily cover
3 some telehealth services delivered through an audio-only
4 interaction after the PHE when the agency determines there
5 is potential for clinical benefit. However, for most
6 telehealth billing codes, there is no way to determine
7 whether a telehealth service was delivered by an audio-only
8 interaction or an audio-plus-video interaction, using
9 Medicare claims data. Consequently, it is difficult to use
10 claims data to assess the impact of audio-only telehealth
11 services on access, quality, and cost, or to monitor
12 potential fraud to the Medicare program and its
13 beneficiaries.
14 Also, as Evan brought up at the September
15 Commission meeting, home health agencies do not report data
16 on services provided by telehealth. This is also true for
17 hospice providers.
18 To improve the availability of data to evaluate
19 how telehealth and audio-only services impact access,
20 quality, and costs, CMS could require a claims modifier to
21 audio-only claims paid under the physician fee schedule.
22 They could also collect claims data on telehealth services

1 provided by home health agencies and hospice providers.
2 Throughout the upcoming year we will continue to
3 monitor the use of telehealth, beneficiary and clinician
4 experiences with telehealth, and the growing telehealth
5 literature. Today, we would like to get your feedback on
6 these materials, the policy options to collect better data
7 on the use of telehealth, and other topics the Commission
8 could explore regarding telehealth.
9 I'll turn it back to Mike and look forward to the
10 discussion.
11 DR. CHERNEW: Thanks, Ledia. This is such a big
12 topic and it is one I think we are going to be following as
13 I believe this new mode of care delivery will continue to
14 grow and be important for many of our beneficiaries, so
15 thank you for sort of building the infrastructure and
16 focusing our attention on data and other policy issues.
17 So Dana, why don't we jump through the queue.
18 MS. KELLEY: All right. I have Larry first with
19 a Round 1 question.
20 DR. CASALINO: So yeah, just a few things. Nice
21 job. I'm very glad, guys, that we're continuing to track
22 telehealth. And a few Round 1 questions. One is you say

1 pretty clearly in the materials, and also just now, Ledia,
2 in your presentation, that there is no sure way to track
3 audio visits except for I guess there's three modifiers or
4 three types of claims that they thought was an audio visit.
5 That might have been in the materials, not what you just
6 said.
7 But then in the materials, and also in what you
8 just said in various places, said 18 or 19 percent of
9 telehealth services delivered were audio only. So should
10 we take that 18 or 19 percent to be their minimum that you
11 could identify just from the claims where it is identified,
12 but in fact, because you can't tell for a lot it could be
13 higher and we have no idea how much higher? Is that a fair
14 statement?
15 MR. WINTER: Yes, that's correct.
16 MS. TABOR: And I'll just add that I think
17 there's kind of two different types of audio services.
18 There's the audio-only E&M that became billable during the
19 PHE, and that's the 18 percent. But then there's also
20 other services like group therapy, for example, that CMS is
21 allowing audio-only interaction during the PHE. And for
22 those, there's no modifier to know whether that was

1 performed by telehealth or audio-only.
2 DR. CASALINO: This is kind of important, I
3 think, because audio's going to be a controversial issue.
4 And so I think to really spell it out in one place in the
5 report, that this is the way we could tell when there were
6 audio visits, this is the percent that were audio visits.
7 But, in fact, the audio visits might be higher -- are
8 higher. We just don't know how much higher. And I think
9 that would be helpful because I was a little confused by
10 that.
11 Then two other quick questions. I was just
12 desperately -- when Dana was calling my name -- looking for
13 in the materials, but I couldn't find it, I couldn't tell
14 if you guys were proposing that the audio modifier be
15 required by CMS for any telehealth service in which audio-
16 only is used or only for behavioral health services. I
17 don't know why I thought that you might have said only for
18 behavioral health services, but is that wrong? Or are you
19 just proposing that audio modifiers be included whenever
20 audio-only is done for any kind of service?
21 MS. TABOR: I think for any kind of service it
22 would be beneficial for us and others to know when it was

1 performed by audio-only.

2 DR. CASALINO: Probably that's clear in the

3 report and it was just unclear to me, but you might just

4 double check it because that's pretty important.

5 And then the last question is, you know, you

6 point out, as you have before, that prior to the PHE, when

7 Medicare was paying for telehealth services, it was -- for

8 audio-visual telehealth services, it was paying the

9 facility fee. And in the materials here -- I can't

10 remember if it's on the slide or not -- you say Medicare

11 should go back to paying the facility fee.

12 But I want to keep this at Round 1 so I'm not

13 going to comment, but I'd just ask you guys, is there a

14 rationale for using the facility fee as the rate at which

15 to pay for telehealth services? I personally can't see

16 one, but I'd be curious what you have to say or what you

17 think Medicare has to say. So that's a question.

18 And then just as a more general statement, I

19 think it would be great if the staff could, in continuing

20 the telehealth work, try to focus some attention on, you

21 know, what should the payment rate be if it's AV or if it's

22 audio-only. And should the payment rate vary and what

1 should the payment rate vary on, whether it's bricks-and-
2 mortar providers that are delivering the service or
3 Teladocs that don't have bricks and mortar? So for AV and
4 for audio, for bricks and mortar or for telehealth, what's
5 the rationale for a facility rate? Are there other rates
6 that there would be perhaps a stronger rationale for? I
7 think this is also, you know, vitally important, right?
8 And I think that -- I'm not sure we should just accept
9 Medicare was paying the facility rate so that's the way it
10 should be and everybody gets paid the same, and get paid at
11 the rate of E&M visits or -- well, I'll go back. So more
12 work on that part I think would be very, very important,
13 because I'm not sure anybody's doing it, and it does seem
14 pretty fundamental.
15 MR. WINTER: And just to answer your question,
16 Larry, about why they were paying the facility rate before
17 the PHE, why we suggested going back to that policy after
18 the PHE. So before the PHE, telehealth services were only
19 covered if the beneficiary was in an originating site, and
20 Medicare paid a special -- made a special payment of about
21 $25 to that originating site, whether a hospital or a
22 clinic or a physician's office, to cover some of the

1 overhead costs associated with the telehealth visit. But
2 the distant clinician is actually providing the service
3 through telehealth. They don't incur any overhead costs
4 because they're not seeing the patient in person. If there
5 are any overhead costs, they're being incurred by the
6 originating site. And so that was the rationale by CMS on
7 only pay the facility fee before the PHE.
8 And then we suggested in our discussion in the
9 March report chapter that CMS should go back to that policy
10 because when a clinician is providing a telehealth --
11 whether or not there's an originating site fee, the
12 distant-site clinician is not incurring the same overhead
13 costs that a physician incurs when they see the patient in
14 their office, like supplies and clinical staff, equipment,
15 and that sort of thing. So that was our thinking for why
16 CMS should go back to that policy after the PHE is over.
17 But we will continue to look at this further, and
18 we talk about the need for additional research on what the
19 appropriate payment rate should be in the long term, and
20 that's in the March report.
21 DR. CASALINO: Great. Thank you.
22 MS. KELLEY: Dana, do you have a Round 1

1 question?

2 DR. SAFRAN: I do. Thanks. On page 25 of the

3 meeting materials, there's a paragraph where you list the

4 visits -- the types of care that are considered to be

5 acceptable for telehealth visits, and I was curious whether

6 you have information about what percentage of all

7 encounters these categories represent and also what

8 percentage of spend or ambulatory spend, however we want to

9 view the denominator.

10 MS. TABOR: You mean across all payers?

11 DR. SAFRAN: No. For Medicare. I didn't see --

12 if that information was there, I didn't see for Medicare

13 what this represents. It looked like it represented quite

14 a lot.

15 MS. TABOR: For the direct-to-consumer companies,

16 only one of the five that we spoke with has opted to start

17 billing Medicare during -- Medicare fee-for-service during

18 the PHE. They weren't allowed to before, so it's kind of,

19 again, a new business opportunity for them. And for that

20 one organization we spoke with, I think the volume was

21 pretty low. There wasn't a lot of take-up for Medicare

22 fee-for-service beneficiaries, and the kind of commercial

1 and other health plan system market continued to dominate
2 their patients.
3 DR. SAFRAN: Thanks, Ledia. I'm sorry. I think
4 I didn't ask my question clearly, so let me try again. On
5 page 25, it says, "Clinicians described situations when
6 telehealth is suitable, including for patients with stable
7 medical conditions, medication refills, current disease
8 management, remote monitoring" -- it has kind of a long
9 list, second opinions postoperative or follow-up visits,
10 but kind of a long list. So my question is: For the
11 Medicare program, what percentage of encounters does this
12 list represent? And what percentage of spend or ambulatory
13 spend does this list of encounters represent?
14 MR. WINTER: So it's hard to -- it's hard to give
15 you an exact number because we were just listing some
16 examples that we heard from clinicians. And in some of
17 these examples, it's really hard to tell from claims data
18 whether the visit was -- whether they discussed medication
19 refills or follow-up on a chronic condition without access
20 to the medical records. But based on the claims data we
21 were able to look at -- look at the claims and look at
22 telehealth by HCPCS code and by broader categories. And if

1 you look at the pie chart on page 9, that shows that when
2 you look at the E&M telehealth visits, which were almost
3 all telehealth visits, you can see how it breaks down
4 between our bread-and-butter office outpatient visits,
5 which was roughly three-quarters of E&M; 17 percent was
6 behavioral health; and so on.
7 So, you know, there's a limit to how much we can
8 drill down into telehealth using claims data, but hopefully
9 this gives you a sense, and if you have additional
10 information or additional ways you'd like us to cut the
11 data, we'd like to hear that, too.
12 DR. SAFRAN: I guess my reason for the question
13 is it does strike me that from that list, where clinicians
14 described situations where telehealth is suitable, to me
15 that list looked like it is probably 50 percent or more of
16 ambulatory encounters. And that just seems like a very
17 important thing for us to know, for, you know, 50 percent
18 of the ambulatory encounters and currently 50 percent of
19 ambulatory spend, you know, clinicians believed that
20 encounters could happen through telehealth. Whatever that
21 percentage is, whether 50 percent is the right number or
22 not, it just strikes me that that is really quite

1 compelling. That was a pretty robust list, so that was the
2 reason I was asking the question.
3 MS. TABOR: I think, Dana, to that point, one
4 thing we heard also during the focus groups from clinicians
5 was it's not just necessarily the type of service; it's
6 also the patient and how well they know the patient, how
7 stable the patient is. So I can make that kind of caveat
8 clearer in the text.
9 DR. SAFRAN: Yeah, okay. Sounds good. Either
10 way, it's a pretty compelling point that, like, you know, a
11 very large share of medical care that today happens in
12 clinical settings, clinicians view as things that could
13 happen, you know, in perpetuity using remote technology if
14 payment is right and the technology's there. So I think
15 that's pretty interesting and important.
16 MR. WINTER: And as we found, at the end of 2020,
17 17 percent of all primary care services are being provided
18 by telehealth. So this is a pretty substantial chunk.
19 DR. SAFRAN: Thank you.
20 DR. CHERNEW: Stacie, did you want to say
21 something on this point before we get back to the Round 1
22 queue?

1 DR. DUSETZINA: Yeah, I was just thinking through
2 how best to capture that information from the claims, and I
3 appreciate Dana's point about that laundry list of
4 services, because it sounds like just about everything
5 could be covered.
6 I do wonder, you know, I often think about this
7 as did you need any more follow-up, right? Were there labs
8 ordered? Were there things where if the patient wasn't
9 physically there, you would have to require them to come
10 in? So I wonder if there's some way to narrow that down,
11 you know, to the patients who didn't have -- you know, if
12 we saw like all of these services, and we wanted to know
13 how common they were in Medicare, I think we'd have to say
14 and how many didn't have any additional services that would
15 have required the patient to be there in person, because
16 that seems to be a determining factor, I think.
17 MR. WINTER: So that's a good idea, and we can
18 look into that. One thing we heard in talking to
19 clinicians and DTC companies is that they will sometimes
20 see patients by telehealth, and then if the patient needs
21 follow-up labs or tests, then they'll send them to an
22 inpatient provider for that, an inpatient location to get

1 those tests. But the encounter and then the follow-up
2 encounter could be done by telehealth.
3 DR. CHERNEW: Larry, I think you want to continue
4 on this point?
5 DR. CASALINO: Yeah, just a quick comment. It
6 was probably obvious, but the clinician often and probably
7 even usually doesn't know in advance whether anything else
8 will be needed -- blood test, urine test, imaging -- in
9 advance of the visit. Even if they think they know in
10 advance of the visit, they may be wrong. So you can't
11 really tell in advance what's going to be needed.
12 DR. CHERNEW: Okay. Dana.
13 MS. KELLEY: Marge?
14 MS. MARJORIE GINSBURG: Yes, thank you. Great
15 report, and I love all the additional information we have
16 now and we heard earlier. I have been sort of a curmudgeon
17 on this topic, and one of the issues that comes up for me
18 now is the issue of potential for Medicare fraud. My
19 understanding, the way this is written, is that the patient
20 must have an in-person visit with their primary care doc or
21 one of their physicians before a telehealth meeting can
22 take place. But I am very concerned about the potential

1 for fraud on the part of telehealth companies that
2 basically see this as a rich potential for making money
3 from a lot of seniors who are susceptible to fraud more
4 easily perhaps than younger folks.
5 So one question in particular is: Are telehealth
6 companies required to be registered in any way with the
7 federal government to establish their legitimacy, to assure
8 that data are being collected that reflect real Medicare
9 visits? I'm looking for ways that might mitigate my
10 concern for opening this door to a great deal of fraud.
11 Thank you.
12 MS. TABOR: I'll make one clarifying point to
13 something you were saying, Marge, that the recent change of
14 requiring an in-person visit is only for tele-behavioral
15 health. It's not for all telehealth. And as far as fraud,
16 you know, we know that this was a concern, and we spoke
17 about this in the March report, and a good deal of
18 oversight and monitoring is going to be needed, and in the
19 report we list out some ways to do that. But it continues
20 to be a concern.
21 Ariel, I don't know if you have anything else to
22 add.

1 MR. WINTER: Yeah, the DTC company itself may not
2 be required to register with the federal government, but if
3 a clinician is billing Medicare, that clinician has to be
4 enrolled in Medicare. Medicare has information about that
5 clinician and has the ability to track their claims. So
6 certainly the clinicians are part -- Medicare has
7 information about the clinicians, not the DTC company that
8 employs them.
9 MS. MARJORIE GINSBURG: So we don't see any
10 compelling reason to explore the idea of the companies
11 themselves being required to register in any way?
12 MR. WINTER: I think that's a policy question
13 that, you know, you all can talk about and we can go back
14 and think about. It's not something we've looked into thus
15 far.
16 MS. KELLEY: Lynn?
17 MS. BARR: Thank you for an excellent chapter,
18 and, you know, I think adding telehealth as a service to
19 all of us is something we all would like to have as part of
20 our benefit package. So, you know, I really appreciate us
21 moving down this path.
22 I have a couple of questions. One of them is

1 that, yeah, as you pointed out, there's disparities in
2 utilization in rural versus urban. It could be related to,
3 you know, broadband access. It could be related to a whole
4 bunch of things. We don't really know why.
5 But then you also mentioned that a large number
6 of these visits are for mental health services which
7 require that in-person visit, and we don't have very many
8 mental health services in our rural communities where they
9 could have that in-person visit. I think that many
10 patients in rural communities access mental and behavioral
11 health services using Zoom and pay for it themselves.
12 Right?
13 So the question is: As you looked at the data,
14 was there -- you know, the disparities, was that related to
15 differences in utilization of mental health services? Or
16 was it across the board?
17 MR. WINTER: So if I could just clarify, you're
18 asking whether the disparities -- the differences between
19 use of telehealth by urban versus rural residents, was that
20 related to differences in the use of tele-mental health?
21 MS. BARR: Yes, yes.
22 MR. WINTER: Okay. I don't know offhand, but I

1 can certainly drill down and look into that.

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

3 that.

4 Ledia, I think I -- you know, I have been very

5 confused about this, so I appreciate you saying this again.

6 You have to see them in person for mental health, but you

7 don't have to see them in person for regular visits, right?

8 And that's the current standard today?

9 MS. TABOR: That is the -- well, and I'll add

10 another kind of dimension to it. There is what's during

11 the public health emergency versus what's after. So the

12 Consolidated Appropriations Act of 2021 made the tele-

13 behavioral health services permanent, not requiring -- they

14 took away the originating site rule requirements for the

15 remainder of the PHE as well as for, you know, beyond the

16 PHE. And that does per the law require an in-person visit

17 six months beforehand and now, per CMS regulation, within a

18 year after that telehealth visit.

19 Then the second thing --

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

21 MS. TABOR: Like E&M visits outside of rural

22 areas without originating site that are being allowed

1 during the public health emergency, they again are tied to
2 the public health emergency.
3 MS. BARR: Got it. And so one of the things I'm
4 sure that MedPAC is considering is whether or not -- you
5 know, what sort of policies would be appropriate after the
6 public health emergency related to E&M visits. And I think
7 it's very important to consider this whole in-person thing
8 when you're dealing with large geographies and issues with
9 access to care.
10 One of the concerns that we have related to the
11 ACOs is loss of attribution due to providers doing annual
12 wellness visits to Medicare patients, you know, which can
13 be very profitable and then can result in attribution.
14 Have you seen any -- so it is a particular concern of how
15 these telehealth visits could change attribution. Have you
16 seen anything related to that at all?
17 MS. TABOR: It's not an issue that I've looked
18 into, but we can loop back with our ACO team and also our
19 MA team for that as well.
20 MS. BARR: Got it. When you're saying that 95
21 percent of these visits are with their existing provider,
22 that means that they saw that provider prior to the public

1 health emergency? Is that what you --

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

3 the definition of an "established patient" is whether the

4 same clinician or someone in the same specialty in their

5 practice saw the beneficiary within the prior three years.

6 So they could have seen them, you know, three months ago

7 during the -- after the PHE started or two years ago before

8 it started.

9 MS. BARR: Okay.

10 MR. WINTER: We'd have to do further analysis to

11 differentiate. And, Lynn, I'm sorry. Your first question,

12 I actually do have some information about that. It's on

13 page 34 of the paper. We looked at the share of tele-

14 behavioral health services received by different categories

15 of beneficiaries, and there's a table there on page 34, and

16 the bottom two rows looked at urban beneficiaries versus

17 beneficiaries in rural areas. And the urban beneficiaries

18 were more likely to receive at least one tele-behavioral

19 health service, and they received on average more tele-

20 behavioral health services per beneficiary than rural

21 residents.

22 MS. BARR: Yeah, I --

1 MR. WINTER: So the disparity -- sorry.
2 MS. BARR: Got it. I did see that, Ariel. I was
3 just wondering if that made up the -- if that made up the
4 bulk of the disparity between the two populations, because
5 it was a significant difference, and so I just wasn't able
6 to interpret from that what was the impact on behavioral
7 mental health services.
8 MR. WINTER: Yeah, I don't think it --
9 MS. BARR: And, again, if there's something we
10 could be doing about -- I'm sorry?
11 MR. WINTER: I don't think it was the bulk of the
12 difference, but I can get you some more precise numbers.
13 MS. BARR: Thank you.
14 MS. KELLEY: Pat, did you have a Round 1
15 question?
16 MS. WANG: I did, and my Round 1 question is just
17 very basic, because I'm really confused now about
18 behavioral health. Would you mind just going through one
19 more time before the public health emergency what the rules
20 were and then during the public health emergency and the
21 current view? And don't hesitate to say a few more words
22 about the significance of an originating site requirement.

1 What does that really mean?
2 MR. WINTER: I can start walking through it, and
3 we can --
4 MS. WANG: I apologize because you've been
5 talking about it.
6 MR. WINTER: No, this is a good question because
7 the policy changes are very confusing, and I often struggle
8 to keep up with them myself.
9 Before the PHE, only beneficiaries in rural areas
10 could receive any telehealth service, with certain
11 exceptions which I won't go into right now, and they could
12 only do so if they went to what was called an "originating
13 site," which would be like a hospital, an FQHC, or a
14 physician's office, and while they were in that originating
15 site, they could communicate with a clinician in a
16 different location, called a "distant-site clinician," and
17 receive, in this case, a behavioral health service,
18 psychotherapy or psychiatric evaluation, something like
19 that. And that was very limited, and they were a very
20 small percentage of beneficiaries who got these telehealth
21 services before PHE began at the end of March of 2020.
22 So, under the PHE, the rules about -- the rule

1 that only beneficiaries -- that beneficiaries could only
2 get telehealth services in a rural area was temporarily
3 suspended. So they could get these telehealth services in
4 urban or rural areas, and they no longer have to be an
5 originating site. They could be at home. They could be in
6 the office. They'll be anywhere. So that's the case
7 between March of 2020 and, I believe, the end of 2021.
8 Beginning in 2022, as I understand it -- and
9 Ledia will correct me if I'm wrong -- they have to -- if a
10 beneficiary wants to get a tele-mental health service from
11 a clinician, they must have been that clinician in person
12 in the prior six months for a tele-mental health service or
13 another clinician in the same practice, in the same
14 specialty.
15 But that rule, that policy is in effect for -- is
16 in effect for the long term. It doesn't change. It
17 doesn't go away after the PHE, and that beneficiary can be
18 at home, and they can be in urban areas.
19 MS. WANG: Okay, okay. So we shouldn't view that
20 in-person requirement as a substitute for the originating
21 site, or do you think that -- was that -- I think one of
22 you is nodding, and the other is shaking their head. I

1 can't tell.

2 MR. WINTER: No, that's a good question.

3 It's not technically a substitute. It's not the

4 same thing because they can get the tele-mental health

5 service at home. They don't have to be in a hospital or an

6 FQHC or a physician's office, but it's kind of a parallel -

7 - I think the intent is parallel.

8 The point of the originating site, part of it was

9 to kind of limit excessive use, inappropriate use to

10 constrain volume, and I think that's the same intent of

11 requiring the beneficiary to see the clinician in person

12 first before they get a telehealth service.

13 There are some others of the rationale too, which

14 is that to make sure that the bene has an established

15 relationship with the beneficiary -- I'm sorry -- the

16 beneficiary has an established relationship with the

17 clinician before they get behavioral health or telehealth,

18 but part of the rationale is to kind of tamp down on volume

19 growth.

20 MS. WANG: Okay. It's just interesting because I

21 could see where the originating site allows more access

22 than the in-person requirement because going to your local,

1 whatever, facility, if there are no psychiatrists in a
2 hundred square miles of where you live, you can still do it
3 just by traveling to your local hospital. The in-person
4 visit seems to me to have a bigger constraint on access.
5 I was going to ask whether you could drill down
6 more on access to psychiatrists in particular who are in
7 such short supply for all populations because they tend not
8 to take insurance, period, much less Medicare, and whether
9 you were able to detect any greater access to MDs,
10 psychiatrists in particular.
11 MR. WINTER: That's a really good question. It's
12 something we're beginning to look at and will continue to
13 look at.
14 And one wrinkle I'll add to what I said earlier
15 is that this rule that the beneficiary has to see the
16 clinician in person within six months of the first
17 telehealth visit does not apply -- I don't believe it
18 applies to beneficiaries in rural areas. They're not
19 subject to that in-person visit requirement.
20 MS. WANG: Gotcha.
21 MR. WINTER: But after the PHE ends, they will
22 have to go back to the originating-site requirement.

1 MS. WANG: Okay, okay. Wow. Okay. Thank you so
2 much.
3 MR. WINTER: It applies differently to benes in
4 rural areas. That's the best of my recollection.
5 MS. WANG: Okay. Really helpful. Thank you so
6 much.
7 MS. KELLEY: Lynn, did you have a follow-up on
8 this question?
9 MS. BARR: Yeah. I just wanted to make sure I
10 understood what happened in -- what's going to happen in
11 January of 2020, assuming the PHE ends. Then there will
12 not be any more telehealth for non-mental health visits
13 that have the patient's home as the originating site? It's
14 only behavioral and mental health as of January? Is that
15 right?
16 MR. WINTER: That's correct, in addition to
17 beneficiaries who are receiving treatment for substance use
18 disorders and a few other categories like telestroke.
19 MS. BARR: So no more telehealth to the home when
20 this is over?
21 MR. WINTER: After the PHE ends, unless Congress
22 makes a change or CMS makes a change.

1 MS. KELLEY: Okay. Paul, I think you had a Round
2 1 question.
3 DR. PAUL GINSBURG: Yes, I do.
4 I remember at a Commission meeting about a year
5 ago, many of us were quite concerned about the potential
6 for beneficiaries going to telehealth companies for
7 services to fragment medical care, and even long term,
8 maybe undermine the viability of the brick-and-mortar
9 practices. And it seems like based on your survey of
10 telehealth companies, at least the ones you chose, this
11 Medicare fee-for-service is really not one of their
12 objectives, that their business is on working for insurance
13 companies and some provider health systems for some large
14 employers. Does this mean that we can conclude that we
15 should put that aside and it's really not unlikely to be a
16 significant issue, or are there things I'm missing?
17 MS. TABOR: I will say that from what we heard; I
18 don't personally have the concern that telehealth companies
19 will fragment primary care in the near future. I mean, I
20 don't have a crystal ball, and it's something that we can
21 kind of keep our eye out on. But based on what the
22 companies said, "We've got enough to do with our commercial

1 clients, that Medicare fee-for-service doesn't seem like
2 the opportunity for us right now." So, unless that
3 changes, I'm not too concerned.
4 DR. PAUL GINSBURG: Thanks.
5 MS. KELLEY: Betty, did you have a question on
6 this?
7 DR. RAMBUR: Yes. I just had a brief question.
8 I want to make sure I understand this.
9 So you interviewed five, and four of the five
10 indicated that they were not interested in the Medicare
11 fee-for-service, correct? So I was curious how
12 representative those five are of these companies because if
13 that, indeed, is the case, if that can be generalized more
14 broadly, it really changes the dynamics.
15 MS. TABOR: So I will say we scanned the current
16 literature, you know, news articles, kind of trade press
17 quite a bit over the past year, and so there were a number
18 of articles that were interviewing vendors about the same
19 issue. And that's how we identified the one that was
20 billing fee-for-service, and we actually spoke with them
21 several times, and that's where we learned that kind of
22 their strategies have changed over time when they hadn't

1 seen the volume picked up that they thought was potential.
2 And then we were even able to talk to a company that per
3 this industry press article said, "We're thinking about
4 fee-for-service. We're gearing up for it." Then we talked
5 to them again this summer, and their story has changed,
6 again, saying, "We've got enough to do kind of with our
7 commercial clients there."

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

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

14 DR. CHERNEW: Absolutely.

15 MS. KELLEY: All right. I have Jonathan first.

16 DR. JAFFERY: Thanks. Thanks, Dana, and thanks
17 so much, Ariel and Ledia. This is a great chapter. I'm
18 really glad we're doing more of this and thinking about
19 this, this key question you have about collecting more data
20 on audio-only visits.

21 When we first started these conversations, I know
22 there was a lot of concern about having prolonged ability

1 to use audio-only visits. I think there's a lot of
2 momentum going into it, that that was something that that
3 would go away or we shouldn't think about it, that it was
4 suboptimal. I've always been concerned about that. So I
5 really do want to collect this data and understand a little
6 bit better. I think that's really important.
7 I can share some of my own experiences as
8 somebody who really tried to do a lot of telehealth visits,
9 both audio-only and audiovisual, and as somebody who's got
10 a practice that is predominantly chronic disease and also
11 has a lot of lab-heavy type of care. I think it's actually
12 been really helpful for me to connect with different
13 patients that had trouble getting into the clinic or it's
14 just a burden overall in a number of ways. They have to
15 take off work, or their family member or their kid, usually
16 their daughter, has to take off work and things like that,
17 and they may have limited technology to manage, either the
18 access to it or just sort of the capabilities to manage the
19 visual part, the video part.
20 I think that Dana's question about how much of
21 this care falls into those categories, I recognize, Ariel
22 and Ledia, that you were just sort of lifting some examples

1 based on some of your focus groups, but I do think it is
2 probably worth looking at that a little bit more
3 specifically and recognizing that those categories are a
4 bit different. So procedures was in there, and it's pretty
5 clear that you're not going to get skin biopsy through a
6 virtual visit.
7 But labs are a different beast, to Larry's point.
8 We often order them afterwards. My clinic site doesn't
9 actually do routine labs, and so that's really a non --
10 it's a separate issue, and if somebody cannot travel 30
11 minutes but then get labs later or beforehand, 5 minutes
12 away from their home, that could be a huge advantage.
13 I mean, the biggest thing, going back to our most
14 recent conversation this afternoon, is about the equity
15 piece and disparities. I don't want to lose the thread of
16 that.
17 And then, finally, going back to our first
18 discussion this morning, the notion of mandatory advanced
19 APMs, two-sided ACOs, or particularly if we've got
20 capitation, some of these issues start to go away. The
21 fraud issue maybe doesn't go away, but it's a little bit --
22 or maybe it's a lot less to worry about if the providers

1 are actually accountable for the total cost, and I think
2 about this in a number of ways where we're talking about
3 putting new innovations.
4 One of the great things, great opportunities
5 about ACOs is the possibility of providers being more
6 innovative in space, in these spaces, whether it's
7 telehealth or putting in, you know, providing air
8 conditioners to folks with asthma, to address social
9 determinants, or doing more home-based care. So I think
10 the more that we can think about that, tying it to the
11 conversation this morning, might be an important thread as
12 well.
13 So, anyway, really appreciate digging more into
14 this, and again, getting more data on the use of these is,
15 I think, going to be crucial for these conversations going
16 forward. Thanks.
17 MS. KELLEY: Stacie?
18 DR. DUSETZINA: Thank you. A wonderful chapter,
19 and I think this is such an important area, so thank you so
20 much.
21 I will say fully endorse additional modifiers to
22 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

1 about the access to behavioral health, not just for
2 Medicare beneficiaries but for many people who are a bit
3 resistant to seeking care, and the idea that we can
4 encourage that by making audio, video, or audio-only
5 options available, I think is a really good thing.
6 So I'm a little bit disappointed by the in-person
7 requirement, partly because it's really hard to find a
8 person to see you. So I think it is a real challenge to
9 add that particularly for behavioral health.
10 On the other hand, I know this is an area where
11 we're worried about fraud. So I think the same is true for
12 other medical services that people see. So it seems just
13 maybe inequitable that the six-month in-person visit is
14 tied to one type of service and not to the other, and I
15 think that we should really think about the fairness of
16 that and maybe make it easier for people to receive
17 behavioral services.
18 I guess the only one other thing that I was
19 curious about -- and this was sort of a small note in the
20 report -- you all did such a great job asking about how
21 this was working for patients and for physicians, and there
22 was a component in there about the physicians' time burden.

1 And I wondered a little bit about the patient time burden,
2 and specifically, are beneficiaries just stuck sitting
3 there at a computer, waiting for the physician to show up,
4 or is there something that's really maybe more convenient
5 for them? So I'm just curious if you had learned anything
6 about the burden on the beneficiaries' time. I guess you
7 might think that it would be much simpler because you're
8 not having to drive to the office and sit in the office
9 waiting room, but if you're sitting there at your kitchen
10 table or whatever for an hour waiting for someone to join a
11 call, that seems like a burden as well.
12 MS. TABOR: That's a good point, Stacie, and I
13 can just respond to that. We did hear mainly from
14 beneficiaries about the convenience factor that like not
15 having to pay for parking, sit in traffic, depending on
16 where they lived, and also kind of having to take the time
17 to go to the office. And we did hear a couple kind of
18 accounts of having to wait for the physician in front of
19 the computer, but they didn't seem like it was an hour. It
20 was, you know, perhaps 10 or 15 minutes. You know, and
21 that's qualitative kind of small sample, but that's what we
22 heard.

1 DR. DUSETZINA: Well, that's great to hear.
2 Thank you.
3 MS. KELLEY: Paul, did you have something on this
4 point?
5 DR. PAUL GINSBURG: Yeah, just on Stacie's point.
6 As someone who has had some televisits, yes, the patients
7 do wait on their computers in the same way that they wait
8 in the office for the physician to show up. I personally
9 found it much preferable, because I could do other things
10 on my computer while I was waiting. And I don't think --
11 and actually, the waits work. On this small sample they
12 weren't very long.
13 DR. DUSETZINA: Yeah, and just as a response to
14 that, I think that here is where the capability of a person
15 to use the technology, if they're audio-only or they're not
16 very computer literate they're not multitasking with their
17 email necessary, so they feel constrained to be sitting in
18 the same spot, at a desktop computer, versus, you know,
19 those of us who have the visit pulled up on an app and are
20 busy doing other things. So I think that maybe that
21 experience could be variable, based on different levels of
22 technology, literacy, or, you know, multitasking. Good

1 point though, Paul.

2 MS. KELLEY: Brian.

3 DR. DeBUSK: First of all, I'm glad to see that

4 we're following telehealth closely. Just a couple of

5 points here. I do think that there's benefit in

6 maintaining the beneficiaries' home as an originating site.

7 I hope we continue that policy; I think particularly in

8 behavioral health. But I think that it's beneficial to

9 beneficiaries who have maybe some socioeconomic risk. I

10 think there's a great equity, or opportunity to improve

11 equity here.

12 And along that same line, I hope that we

13 maintain, in the claims information, the distinction

14 between the originating site being the patient's home

15 versus the originating site being a provider's office,

16 because I think that's going to affect some of their

17 downstream recommendations of whether to use facility or

18 non-facility rates for the claim itself. So again, I think

19 the beneficiary's home is a wonderful originating site. I

20 hope we preserve the information on the claims so that we

21 can collect it.

22 The other thing that I was really encouraged to

1 see that the direct-to-consumer health companies are
2 largely focused on health plans and large employers. Paul
3 made this comment earlier. You know, the idea of a
4 telehealth non-bricks-and-mortar company calling on
5 Medicare beneficiaries, it looks like that's largely a non-
6 issue.
7 I think the opportunity here, though, would be
8 for maintaining this requirement for some periodic, in-
9 person visits. If I heard Ariel correctly, I believe we
10 don't require those in-person visits in rural areas, which
11 I think is good policy, but I do think this idea of having
12 some type of gating mechanism for some type of breaker,
13 just to make sure that we don't have excessive use, and I
14 think the in-person visit is an excellent way to do that.
15 The other thing I wanted to mention, I do think a
16 claims modifier on the audio-only visits for all the
17 claims, as opposed to just the three CPT codes that support
18 it now, is good policy. It would be nice to be able to
19 differentiate those two, because again, I think that the
20 people who are at the most socioeconomic risk are probably
21 the ones that would benefit the most from the audio-only
22 technology as well.

1 And my final comment, I just want to support
2 Jonathan's comment that, you know, in a world where fee-
3 for-service has two-sided risk, a lot of our telemedicine
4 concerns go away.
5 So those are my comments, and thank you.
6 MS. KELLEY: Dana.
7 DR. SAFRAN: Just a couple of quick comments.
8 One was just an observation that, you know, this
9 conversation about the increased access to behavioral
10 health I think is really striking and a big part of what I
11 was excited about in this chapter. And, in particular, I
12 noticed, on Table 5, that there was near parity in racial
13 groups' use of tele-behavioral health, and that seemed like
14 an important success that we shouldn't go without
15 mentioning. So I just wanted to highlight that here.
16 I also saw really high use of tele-behavioral
17 health by duals, and that was really interesting too. I
18 probably wouldn't have predicted that without seeing those
19 data.
20 Two things I'll mention that I didn't see in the
21 report, and I apologize if they were there and I missed
22 them. One was there wasn't any reference to state

1 licensing issues and how those would need to be addressed.
2 And I think those are so important and such a really
3 important barrier, that I just wanted to call that out.
4 And then despite a lot of conversation over the
5 summer meetings about some of what's come up today around
6 the payment model matters and concerns about overuse of
7 telehealth in fee-for-service, et cetera, I didn't see
8 anything in the chapter that kind of addresses the
9 potential financial impact of permanently expanding access
10 to telehealth without, you know, broadly, not restricted to
11 Medicare Advantage or ACO or other total cost of care
12 accountability models, whether to pay at the same rate,
13 which I know Larry has been raising. And I think those are
14 really important issues.
15 And I know earlier we had quite a bit of
16 conversation, that I think was important, later this year,
17 about how do you get the timing right for moving telehealth
18 price down from parity with in-person visits so as not to
19 have it become inaccessible or no longer an option for
20 beneficiaries, but at the same time not keep it paying at
21 the same rate for so long that we're overpaying for
22 services that really can be delivered at lower costs?

1 So I just thought, unless I missed it, that it
2 would be valuable for the chapter to have some treatment of
3 those important issues. Thanks.
4 MS. KELLEY: Larry.
5 DR. CASALINO: Thanks, Dana. Yeah, I couldn't
6 agree more strongly about we want all audio telehealth to
7 be identified as such. So that's an easy enough thing to
8 do, and CMS should do it as soon as possible, in my
9 opinion.
10 And I agree with all the people who are saying
11 that, you know, there are organizations that are fully
12 capitated or provider organizations who are taking a lot of
13 risk, and part of the point of giving people a lot of risk
14 during full capitation is they will figure out then what
15 are the best ways to deliver care, what works, what is most
16 efficient. And they will figure out the proper mix of
17 services, from physicians or other people, from audio to
18 audio-visual to in-person, much better than fee-for-
19 service. But for now we are stuck with fee-for-service and
20 probably will be for quite a while.
21 So I do want to just highlight again -- and I had
22 thought it would be too ambitious to put this in whatever

1 gets published next, in the text, about telehealth -- but
2 the sooner you guys can devote more attention to this, the
3 better, I think, to relative payment rates. And so just to
4 say a little bit about that. Paul Ginsburg raised the
5 issue of damage to bricks-and-mortar providers on
6 fragmentation and damage to bricks-and-mortar providers
7 possibly when care is provided by telehealth-only companies
8 or call them Teladocs. And I agree that those are both
9 concerns. But, you know, then there's the other
10 fundamental principle of not paying more for service than
11 the service costs, or not paying a lot more for the service
12 than the service costs.
13 The fact that the main Teladocs are not planning
14 to market directly, except for one of them, to Medicare
15 beneficiaries now is not an issue now. I don't think we
16 should assume that that's never going to change. That
17 could change as a result of one meeting in one of those
18 companies. And yet the payment rates and the relative
19 payment rates, by site of service and by what kind of
20 organization is providing the service, they are going to be
21 set now and they will be hard to change if this becomes an
22 issue in the future. So I do think the relative payment

1 rates are an issue right now, regardless of whether
2 Teladocs mostly are targeting Medicare beneficiaries or
3 not.
4 Also, I think if the payment rates are equal for
5 in-person and telehealth, and equal for bricks-and-mortar
6 versus Teladoc, then it is going to be more tempting for
7 some more fly-by-night companies to come in and start
8 marketing to Medicare beneficiaries. There's more
9 potential for abuse.
10 So my own feeling, again, with the principle
11 being let's pay to cover costs, then I think if we don't go
12 back to originating sites, which is kind of nuts, I think,
13 then the facility fee is not really relevant as a measure
14 of cost, and some of the things would have to be thought
15 about. My take on it, just from common sense, is that in-
16 person should probably be reimbursed higher than
17 telehealth, because I think, again, the costs are higher.
18 You need staff on site, you need an exam room, and so on
19 and so forth. The costs are probably considerably higher.
20 Telehealth-only, really what you need is just the clinician
21 and the cost of the telehealth service.
22 So I agree with Dana that the timing of this is

1 tricky, but I would think that in-person would get paid
2 more than telehealth, regardless of who is providing it.
3 And then I would think in terms of who is providing it,
4 bricks-and-mortar do have higher costs than Teladoc
5 companies, probably a lot higher. We need to have bricks-
6 and-mortar providers. And so I would think that bricks-
7 and-mortar would get paid more than Teladoc for telehealth
8 visits.
9 And then the last issue I think in relative
10 payment rates, and to me the most difficult one, because
11 the first two, to me, are -- others might not agree but to
12 me they're pretty much no-brainers -- is you pay for audio-
13 only at the same rate as audio-visual. And this is where
14 principles conflict, I think. If we used the principle of
15 what's the cost of providing the service, I think it
16 probably is somewhat higher, maybe not a great deal higher,
17 for audio-visual versus audio-only, but probably not a
18 great difference.
19 But as several people have said, there may be
20 disparities in who is best able to use audio-visual as
21 opposed to who can use audio. And so if we really did pay
22 significantly more, Medicare did, for audio-visual than

1 audio-only, that would add a principle of paying what
2 something costs, but it could increase disparities, which
3 is another one of our principles. So I think that one
4 requires some careful thinking.
5 In any case, I think the sooner you guys can get
6 to this, you won't make any friends in doing it, probably,
7 but I think it's a really critical issue about a service
8 that's going to be very basic to the health care system
9 going forward, I'm quite sure.
10 MS. KELLEY: Paul, did you have something on this
11 point?
12 DR. PAUL GINSBURG: Yes. Yes. I agree with
13 Larry that this is something that should be a priority for
14 staff to work on so that the Commission can get its ideas.
15 And what I'm thinking about is that assuming it's a world
16 of mostly brick-and-mortar practices, it's one of these
17 situations where in specialties where telehealth works,
18 that there will be kind of a steady state where a brick-
19 and-mortar physicians will spend some of his or her time on
20 telehealth and some on in-person visits. So that even
21 though an economist might first thing, well, we should pay
22 marginal cost for each, you realize if we paid marginal

1 cost for each the average cost might not be covered. So
2 this would kind of push us closer to paying more than the
3 facility fee for the telehealth visits, and maybe almost as
4 much as the in-person visits. It's just not a simple
5 thing, because assuming telehealth will be a more than
6 trivial part of a brick-and-mortar practice's business.
7 MS. KELLEY: Betty.
8 DR. RAMBUR: Thank you very much. I am pleased
9 that we are continuing to address this important issue, and
10 as other have said this will continue. A few brief
11 thoughts from me.
12 I have been a supporter of audio-only, because of
13 my concerns about broadband in rural areas, and I'm very
14 supportive of having a modifier so that we can identify,
15 for example, which services are replacement versus
16 additive, which ones might be causing downstream additional
17 use, and we could really start to have some empirically
18 based payment here.
19 I just also want to underscore, even though we're
20 talking about rural and distance in broadband, distance can
21 also be an enormous challenge in inner cities, and it
22 disproportionately falls on the poor often.

1 I support the beneficiary's home as an
2 originating site, and there is, in my experience, an
3 enormous family burden often for getting an elder in for a
4 visit, and to the extent that those can be done at home,
5 it's a great advantage. And I say this as a daughter but I
6 also see many of my peers struggling with managing what it
7 has meant, prior to telehealth, to get people to
8 appointments that probably could have been done either
9 audio-only or audio-video.
10 My sense is that audio-video and audio should be
11 reimbursed the same, because it's possible that some of the
12 audio-only visits actually have other kinds of
13 complexities, and I do think it should be lower than face-
14 to-face but not so low as to disincent providers from using
15 telehealth appropriately.
16 I have to give a shout-out for Dana for thinking
17 about the licensing issues cross-state. And just briefly,
18 a few years back, before COVID, a colleague and I did a
19 study on the nursing workforce in the state of Vermont, and
20 almost one-fifth of the nurses reported telehealth as their
21 primary practice, and they had licenses in as many states
22 because it was not a compact state. So this is going to

1 take some attention.

2 And then I just wanted to underscore what was

3 said by Jonathan, Brian, Larry, and perhaps others. If we

4 have an all-inclusive total cost of care model then we can

5 let those delivering the services, and their patients,

6 figure out what has the best outcomes and the lowest cost.

7 And so I do think that these conversations are tied

8 together.

9 So thank you all for your hard work and wonderful

10 comments from the other Commissioners.

11 MS. KELLEY: Jon Perlin?

12 DR. PERLIN: Yeah. Let me just add my thanks for

13 a terrific report. I'll be very brief. I think most of

14 the points have been made. I think this point about health

15 equity has to be succinctly and directly addressed as

16 digital health equity. And I've got to say, I think that's

17 not unrelated to home as the originating site. Betty has

18 just very eloquently spoken to the reasons why that may be

19 challenging in rural, urban, and other situations.

20 Second, on the facility parity aspect. It's

21 clear there are overhead costs that are not going away. I

22 think modifiers will help us understand how telehealth

1 becomes part of continuum of services.
2 Finally, I can't believe that Betty didn't beat
3 me to this comment. I think there's something that's
4 really interesting in the data presented in the chapter
5 about who is actually providing the mental health care.
6 It's licensed clinical social workers. And I think it's
7 important that they have the authority for reimbursement
8 under these programs, because that's frankly 95 percent of
9 who is providing the services. Obviously, this is also
10 part of the utility of working in the context of a larger
11 health program. Thanks.
12 MS. KELLEY: Lynn, did you want to jump back in
13 here?
14 MS. BARR: Yeah. And I'm still struggling,
15 trying to understand the policy, and I'm supposed to
16 understand this for a living.
17 So my understanding of the physician fee schedule
18 is it did extend telehealth for E&M and other types of
19 services, non-behavior, mental health through 2023. And
20 what I don't understand is whether or not an in-person
21 visit is required, but did I -- I mean, that's what was in
22 the physician fee schedule, right?

1 MS. TABOR: Perhaps also -- I'll speak for Jim,
2 if it's okay. We can talk to you offline if this is
3 helpful, as far as how we're interpreting the rules, but I
4 think what you're thinking of is that there was a group of
5 codes called -- that are on the allowable telehealth
6 services list, so during the PHE and then after the PHE
7 with the originating site requirement, can actually be done
8 by telehealth, can be billed by telehealth. And there's
9 some of those services that were not on the allowable
10 telehealth list prior to the PHE but were added during the
11 PHE, and now there's kind of thoughts that, hey, now that
12 we've been able to do this, we think there could be
13 clinical benefit in continuing to allow telehealth to cover
14 physical therapy is one of the examples.
15 And so now CMS has said we'll continue to cover
16 those until the end of 2023 to continue gathering evidence
17 about its potential effect on cost, quality, and access.
18 MS. BARR: Got it, and there have been no in-
19 person requirement. Okay. Because annual wellness visits
20 is on that list, right, as one of those extending -- and
21 that it concerned me because annual wellness visits is a
22 main driver of attribution to ACOs. So I'm trying to

1 understand how all these things fit together and could
2 potentially -- if there's no restrictions on who can do
3 them, then I will see Teladoc doing these really quickly
4 because they're super profitable if you're just, like,
5 trying to get in and get out, you know?
6 MS. TABOR: Well, although -- to one of your
7 earlier points, although there is no in-person requirement,
8 there is the originating site requirement. Let's say the
9 public health emergency ends this January.
10 MS. BARR: Mm-hmm. Oh, so then --
11 MS. TABOR: So that means we go back --
12 MS. BARR: There won't be -- oh, so it will be
13 back to the originating site. Okay. Thank you.
14 MS. TABOR: Exactly.
15 MS. BARR: All right. I'll call you.
16 MS. TABOR: Thank you.
17 MR. WINTER: And the rules are completely
18 different for behavioral health services?
19 MS. BARR: Got it.
20 MR. WINTER: It's more complicated.
21 MS. BARR: Got it. Yeah. Well, I think people
22 were reading the behavioral health and sort of

1 extrapolating that to a lot of the other policies, and it
2 just wasn't very clear.
3 Okay. Thanks.
4 MS. KELLEY: Mike, that's the end of the line.
5 DR. CHERNEW: That just sounds so final, Dana.
6 MS. KELLEY: It's the end of the day as well.
7 DR. CHERNEW: Yes. We are getting to the end of
8 the day, and we will come back and have a good day
9 tomorrow.
10 Let me give a little bit of a general summary and
11 state where I think we are. The first one is there's
12 obviously a ton of interest in this just as a general
13 point. There's a lot of interest in the need for access to
14 behavioral health.
15 As the discussions we had last time, last cycle,
16 we constantly struggle with the balance between access to
17 things that we know are good and important, overall, and
18 because of disparity, equity issues, and concerns about
19 program equity.
20 I will say -- and I haven't gone back through the
21 transcript -- the tone of this discussion was very
22 different in many ways in terms of the emphasis of that

1 balance than it was before, but that's a little bit beside
2 the point.
3 There was a lot of discussion about how to set
4 the right prices, just so you know. We are not, this
5 cycle, planning to come up with recommendations around
6 prices for telehealth services.
7 I'm looking at Jim in the corner of my screen. I
8 see a nod there.
9 So, just so you know, we're not going to come
10 back later this cycle and answer any of the Casalino
11 questions, surely to Larry's dismay. But, in any case,
12 that doesn't mean we're not thinking about them. It's
13 mostly a timing issue, and to wait, what happened last time
14 is we had said that we are going to wait for the evidence
15 to play out to understand what's really going on. This
16 chapter and the material in it is going to be integrated to
17 other things as we continue that monitoring process. That
18 includes, for example, how things interact with APMs and a
19 number of other issues that arose.
20 Jim, do you want to say anything on that
21 particular point?
22 DR. MATHEWS: No. Nothing more to add.

1 DR. CHERNEW: So --
2 DR. CASALINO: And, Mike, just to be clear --
3 just to be clear, I wasn't asking for recommendations right
4 away. I was just asking that the staff work on this in
5 terms of relative prices, so that we can move --
6 DR. CHERNEW: And we will do that.
7 DR. CASALINO: -- forward on these
8 recommendations at some point.
9 DR. CHERNEW: That's right. And some of the
10 things where I think there's certainly a lot of consensus,
11 like getting identifiers for audio-only, that may work into
12 one of the January-type recommendations of things that
13 we're doing. So stay tuned for that part. I think there's
14 probably a lot of consensus in that data-gathering point.
15 I will say a few things that -- had I been in a
16 different role, I would have said in Round 2 comments, but
17 I haven't -- the one that I'm most interested in is some of
18 these services were previously being delivered but not
19 necessarily being billed. So you could have called up your
20 doctor and asked for a bunch of things, ask questions, and
21 when we move them to being billed and as they grow, I think
22 it's untenable to not bill. As doctors do more and more of

1 their services delivered this way, it's untenable.
2 We really have to think about how they get
3 compensated for that. That creates a number of challenges.
4 It creates beneficiary copays. You run the risk to the
5 patient who had called up their doctor before and asked
6 questions about a range of things. Now that's getting
7 billed to the visit. There's a copay that might be
8 generated. So there's some complexities with how that
9 plays out when we take previously services that were
10 fitting into the nooks and crannies of medical providers
11 serving their patients and now begin to bill them.
12 I'll defer to Betty about how this is being
13 handled by the vast majority of to her providers in terms
14 of how they handle this issue, but I worry about that
15 interaction and how it plays out, and I worry about what
16 will happen when there's other types of communication, not
17 audio and video, but there's asynchronous types of
18 communication. There's more complicated email exchanges
19 with people. We are really changing. I think the pandemic
20 accelerated a growing technological transformation of how
21 certain types of care are being delivered, and our payment
22 models are simply not well suited to deal with a lot of

1 those things.

2 And, in the past, when it was small, it kind of

3 fit into the system in this sort of part of what it meant

4 to be a patient, and now it's becoming much more

5 formalized, which is raising all the questions, Larry, that

6 you raised. And, I think that is a challenge.

7 But the broader point -- that wasn't a summary.

8 That was a comment. The broader point here is this is such

9 a complicated area, and it's moving so quickly that where

10 we are now in our sort of Commission activity is tracking,

11 collecting data, thinking about what data we need,

12 analyzing that data. We had a set of policy options

13 before. We will undoubtedly at some point revisit those,

14 but for now, I think it's really useful to hear your

15 comments about what's happening and your concerns and where

16 you think we should go. So I have found all of that quite

17 useful.

18 I think I will pause there to see if there's any

19 parting thoughts.

20 Actually, Brian put a note in the chat which

21 reminded me of one other point that I had on my list, which

22 is I think we're going to need to also begin to track

1 services ordered through telehealth visits. We had a long
2 conversation about this before. There's concern that it's
3 not you're paying for the televisit. It's that the
4 televisit is being used to do a whole bunch of other
5 things.
6 It fits a little bit into the attribution issue
7 that you raised, Lynn, which has long been a concern -- we
8 had discussed that before -- and continues, I think, to be
9 a concern when we think about that, but also a range --
10 Bruce did not speak at length about comments that he had
11 spoken at length about, I think, in the past. But there's
12 a concern that if we open things wide open, we don't know
13 what we're going to get, and we're going to have to figure
14 out how to track and control that. And that is challenging
15 because of how important we acknowledge all of these
16 services are for a whole range of beneficiaries and for a
17 whole range of different services.
18 So I guess I'll pause there and see if anyone
19 wants to add anything before we sign off for the night.
20 Stacie.
21 DR. DUSETZINA: Mike, just to follow up on that
22 point you just made, I think collecting information on the

1 timing of the telehealth visits, either whether they occur
2 just before and how close to before an in-person visit and
3 then how quickly they're being billed just after an in-
4 person visit could help to shed some light on these
5 concerns about these normal conversations you might have
6 with your physician or your care team after a visit and not
7 being overbilled in those cases, but also the extent to
8 which a telehealth visit ends up being "Oh, you need to
9 come in person right away."
10 So do we want to be paying for both of those
11 things or paying differently when the visit is a stand-
12 alone service outside of this window of time? It would be
13 great to have data collected on that, and especially, as we
14 start to enter a more stabilize period where in-person
15 visits are more -- have a regular occurrence for people
16 again.
17 DR. CHERNEW: Yes. And, as an side, there's a
18 whole range of visits apart from telehealth where we've
19 bundled services and follow-ups as part of the actual
20 service, and I think this becomes complex.
21 The other challenges, of course, is when you see
22 telehealth used as an additive service as opposed to a

1 substitute, which you will see a lot of, it is unclear in
2 many cases. Are we solving a problem of underuse where
3 there were groups of people that were not getting enough
4 access, and we have now solved that, which is part of the
5 great benefit of telehealth, or are we adding additional
6 services that really weren't needed, but now for
7 convenience and for whatever other reasons, we are
8 delivering services that really weren't necessarily
9 providing the value that they were needed?
10 I don't know the answer to many of those
11 questions. We will continue to monitor this as we go
12 forward and continue to think about other policy options as
13 we continue to gather all of this data.
14 And I think it was you, Larry, who said we will
15 try our best not to be simply backward-looking but to
16 anticipate policies looking forward, because just because
17 we haven't seen something doesn't mean that we won't see
18 something.
19 Okay. So, again, thank you all today. Thank you
20 all today for coming. I learned a lot, and I think we had
21 three very important sessions. Thank you to the staff for
22 once again outstanding work. To the public, please reach

1 out to us at meeting comment -- is it "comment" or
2 "comments," Jim?
3 DR. MATHEWS: Comments. Plural, with an "s."
4 DR. CHERNEW: Plural. "Comments," plural with an
5 "s." Meetingcomments@MedPAC.gov. Please send us your
6 thoughts. We really do look forward to them, and again,
7 thank you, everybody for your time today. We will
8 reconvene tomorrow at ten o'clock. We will be talking then
9 about aligning payments across sites, followed by a
10 discussion of Part D in long-term care facilities.
11 So we hope to see you tomorrow. Thank you for
12 your time today, and everybody be safe and healthy. Okay.
13 Bye, everybody.
14 [Whereupon, at 5:15 p.m., the Commission was
15 recessed, to reconvene at 10:00 a.m., Tuesday, November 9,
16 2021.]
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MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Via GoToWebinar

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

COMMISSIONERS PRESENT:

MICHAEL CHERNEW, PhD, Chair
PAUL B. GINSBURG, PhD, Vice Chair
LYNN BARR, MPH
LAWRENCE P. CASALINO, MD, PhD
BRIAN DeBUSK, PhD
STACIE B. DUSETZINA, PhD
MARJORIE E. GINSBURG, BSN, MPH
DAVID GRABOWSKI, PhD
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AGENDA PAGE

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Part D for residents in long-term care facilities
- Rachel Schmidt.......................................69

Adjourn..108

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

2 [10:01 a.m.]

3 DR. CHERNEW: Hi, everybody. Welcome to the
4 second day of our November MedPAC meeting, a rare and
5 special Tuesday meeting. We have two great topics today,
6 and the first one we're going to jump right into is about
7 aligning fee-for-service payment rates across ambulatory
8 settings or known often for short, "site-neutral payment."
9 Dan, I am turning it over to you.
10 DR. ZABINSKI: Thank you, and good morning.
11 To start, I just want to say that the audience
12 can download a PDF version of the slides for this
13 presentation in the handout section of the control panel
14 that's on the right side of your screen.
15 All right. From 2012 to 2014, the Commission
16 evaluated the effects of aligning payment rates for
17 services provided in hospital outpatient departments with
18 payment rates for services provided in physician offices.
19 Today we will present an analysis that builds on
20 the Commission's previous work, with the most important new
21 feature in today's presentation being the addition of
22 services provided in ambulatory surgical centers.

1 We also want to be clear that we're revisiting
2 this topic of site-neutral payments to get sense of how we
3 want to proceed on this issue, and we're not yet working
4 towards any recommendations.
5 Fee-for-service Medicare has distinct payment
6 systems for three ambulatory settings: physician offices;
7 hospital outpatient departments, or HOPDs; and ambulatory
8 surgical centers, or ASCs. And payment rates often differ
9 for the same service among these three settings.
10 In particular, the outpatient prospective payment
11 system, or OPPS, which is the payment system for most HOPD
12 services, has higher payment rates than the physician fee
13 schedule and the ASC payment system for most services.
14 These differences in payment rates across
15 settings for the same service raises the question: Why
16 does Medicare have these different payment rates when the
17 same service can be safely provided in more than one
18 setting?
19 The primary concern about these differences in
20 payment rates among ambulatory settings is that they result
21 in providers in higher-cost settings acquiring providers in
22 lower-cost settings, then billing at the higher rates. For

1 example, hospitals can consolidate with physician practices
2 and convert them to provider-based departments. Hospitals
3 can then bill for the physician services at the usually
4 higher OPPS rates with little or no change in the site of
5 care.
6 In recent years, hospital acquisition of
7 physician practices has led to an increase in the share of
8 office visits, echocardiography services, cardiac imaging
9 services, and chemotherapy administration provided in HOPDs
10 with an analogous decrease in the share as provided in
11 physician offices.
12 The Congress passed the Bipartisan Budget Act of
13 2015 to more closely align OPPS payment rates with
14 physician fee schedule rates. However, the effect of this
15 policy has been limited, as services affected by this
16 policy constitute only about 1 percent of OPPS payments.
17 On this table, we show how hospital acquisition
18 of physician practices has led to the billing of two
19 important services being shifted from offices to HOPDs.
20 From 2012 to 2019, the share of office visits provided in
21 HOPDs increased from 9.6 percent to 13.1 percent, and the
22 share of chemotherapy administration services has increased

1 from 35.2 percent to 50.9 percent.
2 And as services shift from ASCs to HOPDs,
3 beneficiary cost sharing and program spending increase. On
4 this slide, we have an example of why Medicare payments are
5 usually higher when a service is provided in an HOPD than
6 in an office and how the payment rates can be aligned
7 across these two settings.
8 The service in this example is a level 2 nerve
9 injection. The first column shows the payments that
10 Medicare makes if the service is provided in an office.
11 The middle column shows the payments if the service is
12 provided in an HOPD, and the third column shows the
13 payments if we adjust the OPPS payment rates so that the
14 total payment in the HOPD aligns with the total payment in
15 the office.
16 In all three columns, there's three payments to
17 the physician under the physician fee schedule: the
18 physician's work; the practice expense, or PEOPLE; and the
19 professional liability insurance, or PLI. Notice that the
20 payments for work and PLI are the same in all three
21 columns. However, the PE is higher in the office than in
22 the HOPD, making the payment going to the physician higher

1 in the office than in the HOPD.

2 However, there's an additional payment under the

3 OPPS when the service is provided in an HOPD that doesn't

4 occur when it is provided in an office.

5 And for most ambulatory services, the additional

6 payment under the OPPS is greater than the difference

7 between the non-facility PE and the facility PE, which

8 makes the service more costly to Medicare and beneficiaries

9 when provided in the HOPD.

10 In this case, the middle column shows the total

11 payment is about $701 when provided in an HOPD, while the

12 first column shows the total payment is $256 when provided

13 in an office.

14 In the third column, we adjust the OPPS payment

15 so that the total payment is equal across these two

16 settings.

17 Specifically, we set the OPPS payment equal to the

18 difference between the non-facility PE from the first

19 column and the facility PE from the second column, which

20 results in an OPPS payment of $154. When we add this $154

21 to the total payment to the physician, the total cost of

22 this service when it's provided in an HOPD is $256, the

1 same as the total when the service is provided in an
2 office. We used this concept of the difference between the
3 non-facility PE and the facility PE as the basis for
4 aligning payment rates across the three ambulatory
5 settings.
6 It would be great if we could just set all the
7 OPPS and ASC payment rates equal to the difference between
8 the non-facility PE and the facility PE from the physician
9 fee schedule and say that we're done, but there's some
10 important issues that must be addressed before we proceed
11 to align payment rates across ambulatory settings.
12 First, some services that are provided in HOPDs
13 can't be provided in offices or ASCs because they are not
14 covered under the physician fee schedule or the ASC system.
15 The most obvious of these are ED visits, critical care, and
16 trauma care, but there's also relatively complex services
17 such as some joint replacement procedures that are covered
18 under only the OPPS. And these services must continue to
19 be paid at standard OPPS rates.
20 Another issue is that the OPPS and the ASC system
21 have different payment units than the physician fee
22 schedule. That is, the OPPS and the ASC system have more

1 packaging of ancillary items in their payment units than
2 does the physician fee schedule, and we must account for
3 this additional packaging of ancillary items when aligning
4 payment rates.
5 And, finally, we should align payments across
6 settings only if it is reasonable to provide the service in
7 lower-cost settings for most beneficiaries. On the next
8 slide, we discuss how we make that determination.
9 We identified the services for which it is
10 reasonable to align payment rates across settings by first
11 collecting services into ambulatory payment
12 classifications, or APCs, which is the payment
13 classification system in the OPPS. The idea of APCs is
14 that CMS collects services that are similar cost and
15 clinical attributes into the same APC. All services in the
16 same APC have the same payment rate under the OPPS and
17 generally have the same payment rate under the ASC system,
18 and for each APC, we then determined the volume in each of
19 the three ambulatory settings.
20 When we found that offices had the largest
21 volume, we aligned OPPS and ASC rates with physician fee
22 schedule rates using the difference between the non-

1 facility and facility PEs, with an addition for greater
2 packaging under the OPPS and ASC payment system. But if
3 ASCs had the largest volume, we aligned the OPPS payment
4 rates with the ASC payment rates, but we kept the physician
5 fee schedule rates the same. Aligning OPPS rates with ASC
6 rates is straightforward because the OPPS and ASC system
7 have largely the same payment units, and ASC rates are
8 usually just scaled-down OPPS rates.
9 Finally, if we found that the largest volume for
10 an APC occurs in the OPD, we didn't believe it was
11 reasonable to align the payment rates for that APC across
12 the settings, so payments were unchanged in each setting.
13 The OPPS has 162 APCs for services, and we
14 identified 57 APCs for which we aligned OPPS and ASC rates
15 with the physician fee schedule rates. These APCs
16 constitute 22 percent of the total spending under the OPPS
17 and 12 percent of the total spending under the ASC system.
18 We also identified 11 APCs for which we aligned
19 OPPS rates with ASC rates, and these APCs constitute about
20 4 percent of the total spending under the OPPS.
21 And, finally, we did not align payment rates for
22 the remaining 94 APCs.

1 For the 57 APCs for which we aligned payment
2 rates across the three ambulatory settings, most are low-
3 complexity services, such as office visits.
4 More closely aligning the OPPS and the ASC
5 payment rates with the physician fee schedule rates would
6 reduce beneficiary cost sharing and program outlays. Under
7 the OPPS, cost sharing would decrease by $1.6 billion, and
8 program outlays would decline by $6.4 billion, a decrease
9 of about 12 percent.
10 Under the ASC payment system, cost sharing would
11 decrease by $70 million, and program outlays would decline
12 by $270 million, a decrease of about 6 percent.
13 For the 11 APCs for which we aligned OPPS payment
14 rates with ASC payment rates, all these APCs represent
15 surgical procedures, including ophthalmologic,
16 gastrointestinal, and musculoskeletal procedures.
17 Aligning the OPPS payment rates for these APCs
18 would reduce cost sharing by $260 million and program
19 outlays by $1.1 billion, which is about 2 percent of total
20 OPPS spending.
21 A concern we have about aligning OPPS payment rates with
22 ASC rates is that rural areas and some states have few

1 ASCs, and if hospitals would respond to the lower ASC
2 payment rates for these 11 APCs by reducing the provision
3 of these services, that could lead to access problems in
4 areas that have few ASCs.
5 Now, so far, we've seen that aligning payment
6 rates would have the benefit of reducing beneficiary cost-
7 sharing obligations and Medicare program outlays, but we
8 are also concerned that overall Medicare revenue for
9 hospitals that serve vulnerable populations would decrease.
10 For all hospitals, overall Medicare revenue would
11 decrease by 4.5 percent by combining the two payment
12 alignment policies, but the impact on overall Medicare
13 revenue would be greater for government hospitals and rural
14 hospitals.
15 Yesterday my colleagues, Jeff and Brian,
16 discussed policies that would be intended to ensure access
17 to care for vulnerable populations. With the goals of
18 their analysis in mind, we evaluated stop-loss policies
19 that would soften the impacts of the payment alignment
20 policies on hospitals that serve a relatively high share of
21 vulnerable beneficiaries, using DSH percentage to identify
22 hospitals that serve these populations.

1 The stop-loss policies that we evaluated included
2 -- for the policy for which we aligned payment rates for
3 the 57 APCs across all three settings, we evaluated a stop-
4 loss policy that would limit the loss in overall Medicare
5 revenue to the median decrease among all hospitals of 3.3
6 percent if the hospital has a DSH percentage above the
7 median of 28.1 percent.
8 Then for the policy for which we aligned OPPS
9 payment rates with ASC rates for 11 APCs, we evaluated a
10 policy that would limit the loss in overall Medicare
11 revenue to the median decrease among all hospitals of 0.7
12 percent if the hospital also had a DSH percentage above the
13 median.
14 In the end, we found that 28 percent of hospitals
15 would receive stop-loss relief under at least one of the
16 policies, and 10 percent of hospitals would receive stop-
17 loss relief under both stop-loss policies.
18 On this table, the first column shows the
19 combined effects of both the payment alignment policies
20 without any of the stop-loss policies for several hospital
21 categories.
22 We found out rural hospitals would have a

1 decrease in overall Medicare revenue of 7.6 percent, while
2 urban hospitals would have a smaller decrease of 4.3
3 percent. Note, though, that critical access hospitals
4 would not be affected by these payment alignment policies
5 because they are not paid under the OPPS.
6 In addition, nonprofit and government hospitals
7 would both have larger decreases in Medicare revenue than
8 for-profit hospitals.
9 In the second column, we show the decrease in
10 total Medicare revenue if we combine the two payment
11 alignment policies with the two stop-loss policies we
12 discussed on the previous slide.
13 Rural hospitals would still have larger decreases
14 in revenue than urban hospitals, but the difference between
15 rural and urban hospitals would be smaller than the
16 difference without the stop-loss policies. Also, the stop-
17 loss policies would reduce the difference in payment
18 decreases between nonprofit and government hospitals versus
19 for-profit hospitals.
20 So, in the final column, we don't want anyone to
21 forget about the benefits of the payment alignment
22 policies, because beneficiary cost sharing among rural

1 hospitals would decrease by a greater percentage than among
2 beneficiaries in urban hospitals. Also, it would decrease
3 by larger percentage in nonprofit and government hospitals
4 than in for-profit hospitals.
5 Okay. So far, we've shown that the potential
6 impacts of aligning payment rates across ambulatory
7 settings could be substantial, and with that in mind, it's
8 important to remember the purpose of this analysis.
9 First, we want to address the principle that
10 Medicare and beneficiaries should not pay more than
11 necessary for ambulatory services.
12 Second, we want to reduce incentives for
13 providers to consolidate, which typically leads to the
14 billing of services shifting from lower-cost settings to
15 higher-cost settings.
16 We also want to make it clear that the pool of money from
17 aligning payment rates does not have to be used to reduce
18 program spending. Possible alternatives include you could
19 use the funds to increase the OPPS payment rates for the 94
20 APCs for which we would not align payments, which include
21 services such as ED visits and complex surgical procedures.
22 Doing this would help hospitals maintain standby capacity.

1 Alternatively, the funds could be used for policies to
2 support safety-net providers.
3 So, for today's discuss, we'll address
4 Commissioners' questions and comments about this analysis.
5 We also have two questions for the Commission to consider.
6 First, should Medicare align payment rates across
7 ambulatory settings, and second, how should the savings be
8 allocated?
9 That concludes the presentation. Now I it over
10 to the Commission for discussion and questions.
11 DR. CHERNEW: Thanks, Dan.
12 This extends a long interest we've had in
13 basically site-neutral payment policies. There's a lot of
14 complexities here that you raised.
15 So I'm going to turn it over to you, Dana, to run
16 the queue.
17 MS. KELLEY: All right. I think Stacie had the
18 first Round 1 question.
19 DR. DUSETZINA: Thanks, Dana.
20 Dan, great job on this. I had a question about
21 defining the services. My understanding is you looked at
22 the service and where they were most often delivered across

1 the sites of care in 2019, and I guess my question is, does
2 this kind of implicitly bake in some of the shifts inside
3 of care delivery that we've seen over time, particularly
4 thinking about some of the information provided about
5 chemotherapy shifting to hospital outpatient departments?
6 So, when you're assessing the site of care in
7 2019, I guess I'm curious. Where did chemotherapy end up?
8 Does that end up looking like it should continue to be paid
9 under OPPS? And maybe there's a larger question of, is
10 2019 the right time to be looking at this, or should we
11 also look at a historical perspective to think about how
12 services have been shifted over time?
13 DR. CASALINO: Yeah, the chemotherapy would, in
14 general, be aligned with the physician fee schedule rates.
15 I will add, and this is kind of an offshoot, but the
16 chemotherapy drugs would not be touched, as long as they
17 are separately paid under the OPPS, and, you know, most of
18 them are. So from that respect there's kind of a partial
19 shift for chemotherapy. The service itself would be paid
20 under the physician fee schedule, but the drugs would be
21 paid under the OPPS.
22 Historical, that's an interesting angle to take.

1 I'm not sure what to make of -- okay, are you thinking of
2 in terms of trying to get back to where things used to be
3 in terms of where service is provided, or what?
4 DR. DUSETZINA: You know, I think it was sort of,
5 maybe it's the framing in the chapter or my read of it, of
6 trying to determine, you know, where services could safely
7 be provided. So like pulling from how services are used or
8 built across these different settings for determining
9 whether or not they could be provided in any of those
10 different settings. That was kind of my read of the way
11 that services were being selected. And if that's the case,
12 it seems like if we know that the site of care has shifted
13 for some services over time, that doesn't change maybe --
14 maybe it does. It probably depends on the service. But
15 maybe they could have been delivered in a different site of
16 care but just that practice has changed or site of care
17 shift has happened, so you're seeing them not as being
18 provided as often in some sites as others.
19 I don't know if that helps to clarify, but it's
20 really kind of about if the question is can they safely be
21 provided in any of these sites of care, we might to take a
22 longer time horizon than just looking at 2019, to make that

1 case.

2 DR. MATHEWS: If you don't mind I'm going to jump
3 in here, just to make a couple of points. One, Stacie, you
4 are correct. To the extent we are looking at volume by
5 setting in 2019, that does include prior waves, for lack of
6 a better word, where the setting has shifted from the
7 physician office to a hospital outpatient department.
8 Cardiology and orthopedics come to mind as having done that
9 migration in succession.

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

16 But another point I would like to make sure
17 punches through here is that when we are talking about
18 these shifts in setting, in many instances the shift in
19 setting is represented by a change in the sign over the
20 door. It is not that services have migrated from
21 individual clinician offices wholesale to a different pile
22 of bricks and mortar called a hospital outpatient

1 department. It is that the hospital has purchased the
2 physician practice and put, you know, St. Elsewhere, you
3 know, offsite outpatient department on the physician
4 practice. And that's something to not lose track of as we
5 are using terms like "shift in setting." In many
6 instances, this shift in setting is in name only.
7 DR. DUSETZINA: Yeah, and I completely agree, and
8 I think that's what I'm concerned you might miss by
9 bringing in 2019, specifically is this kind of slapping a
10 new label on the exact same practice, physician building,
11 et cetera. So I think that there could be something to
12 think about there, specifically around, you know, how do we
13 define this package of services.
14 And one of the other ways, I was thinking about
15 it, would be maybe there's a threshold where, you know,
16 like if over a certain percent of the services are provided
17 in one setting then we'd count it.
18 But thank you for that clarification, and I'll
19 let others jump in.
20 DR. CHERNEW: There are several comments on this
21 point. I don't know if that exchange answered some of
22 those questions, and we do have a somewhat longer queue to

1 go through. But, Dana, if you want to go through the on-
2 this-point set of questions and then we'll come back to the
3 queue.
4 MS. KELLEY: Okay. Larry.
5 DR. CASALINO: Yeah. Thanks, Dana and Michael.
6 You can take me out of the Round 1 queue, Dana, because I
7 think you raised exactly the point I was going to ask a
8 question about, and I think she expressed it very well, and
9 Jim's point just kind of put another nail in.
10 But I just want to emphasize again, let's suppose
11 that hospitals began to employ all cardiologists, or 90
12 percent of cardiologists. Then all or 90 percent of
13 echocardiograms would be done in hospital facilities,
14 right. And so, therefore, we'd say, oh, they should be
15 paid at the hospital rate. And that clearly is just wrong.
16 It has nothing to do with safety. It has nothing to do
17 with anything except that Medicare changed the payment
18 rates for these things and, therefore, you could do much
19 better as a cardiologist being employed by a hospital than
20 not.
21 So I think Stacie's idea is a good one, and the
22 question is really how to implement it, and I would be

1 interested, Dan, if you have any thoughts about that. You
2 know, I mean, in principle, to really do this right, it's
3 one that's going to use volume as the criteria. One would
4 have to go back to a year before wage consolidation, and
5 that could mean looking back quite far, which doesn't feel
6 right, although I'm not sure what's wrong with it. But I
7 think it would be more right than the current way of doing
8 it.
9 So I think this does bear more thought. I'd love
10 to hear more thought, Dan, from you, or Jim, or other
11 Commissioners. But this is really a big deal, because at
12 the limit, in this kind of thought experiment, everything
13 could be billed at the hospital outpatient rate, just
14 because hospitals have bought all the practices and
15 therefore have a majority of the volume of procedures.
16 MS. KELLEY: Amol, did you have something on this
17 point?
18 DR. NAVATHE: Yeah. So a highly related point.
19 I also certainly agree with Stacie's and Larry's point that
20 it's worth looking at, and I think we could look at what
21 services, if we use the same volume criteria we could just
22 simply use a threshold of where would we have seen a shift

1 because of what happened between, pick some year, 2015 or
2 2012, and 2019. We see some services that would have been
3 in another setting, and particularly an office setting,
4 that switched to an HOPD. That would be something that
5 would be worth looking at.
6 The point that I wanted to make is, it's just
7 highly related -- it's slightly adjacent to but highly
8 related -- is we also know that there's a lot of geographic
9 variability in ASC availability, and so I was curious, Dan,
10 if you had a chance to look at how this would look, the
11 relative volume, how that would look in markets where
12 there's ASC availability versus there is less ASC
13 availability, because that could potentially strongly
14 influence a ranking, if you will.
15 DR. ZABINSKI: I haven't, you know, explicitly
16 looked at the volume by area, but I really have thought
17 about the issue. I mean, it's clear that in rural areas
18 and a few states that ASCs are pretty sparse and pretty
19 rare. I mean, you know, the poster child on this is
20 Vermont. They have two ASCs and they're both in the
21 Burlington area, while hospitals are quite evenly
22 distributed -- well, somewhat distributed. There's a lot

1 more of them throughout the state than there are ASCs. So
2 access could be a real problem for ASCs in Vermont, but
3 also, you know, a few other states and also in rural areas.
4 So that's an issue to consider when particularly
5 aligning HOPD rates with ASC rates, if hospitals decide to
6 cut back on the extent to which they provide services if
7 they're going to get a lower ASC rate for a service.
8 DR. NAVATHE: Great. So, I mean, my recap of
9 that sounds like it may be worth looking at temporal shifts
10 in a highest volume setting and also in geographic
11 variation based on ASC availability. Okay. Thanks, Dan.
12 MS. KELLEY: Okay. I think we've cleared out the
13 related questions to Stacie's initial question, so I'm
14 going to move to Lynn with a Round 1 question.
15 MS. BARR: Great. Thank you. This is a very
16 complicated topic, and I think you guys did a really good
17 job, and I'm very much in favor of site neutrality, for a
18 variety of reasons. But it's complicated.
19 So there's a couple of things I wanted to bring
20 up. One of them is that under COVID, according to some
21 recent publications, now 70 percent of physicians are
22 employed. So it may be too late to stop consolidation. We

1 might have to figure out how to deal with it.
2 One of the issues that I'm thinking about here is
3 I see a lot of safety-net providers that are 340B, that are
4 converting physician clinics to provider-based HOPD, only
5 because that's the only way they can get 340B. And there
6 is a major policy disconnect between CMS and HRSA, because
7 this is guidance from HRSA and it was just easy for them.
8 They were like, hey, if it's on your cost report you can
9 claim it. So anything that's on their cost report makes
10 them eligible for 340B.
11 I can give you examples of many of our clients,
12 they are hospitals that have not converted their clinics to
13 HOPD because they don't like it, the patients don't like
14 getting two bills, they don't want to charge them more, and
15 they are foregoing $10 to $20 million a year in profit on
16 340B because of that decision. As we put more pressure on
17 them in other areas they are going to have to start
18 converting those clinics, and I would argue that the
19 biggest cause of the conversion to HOPD is 340B.
20 So my Round 1 question is, can you tease out all
21 this growth of physician hospitals and look for 340B, and
22 then if you took that out, do we really have a problem, or

1 is this a problem that we could solve with a policy at HRSA
2 that says, you know what, you don't have to convert it to a
3 hospital department. You can just make it a fee-for-
4 service clinic as long as you employ the docs. And that,
5 in my opinion, would be a much better way to prevent this
6 expansion of hospital HOPD.
7 So I want to make sure that we're not solving the
8 right problem, which is this stupid tie of these clinics to
9 340B that makes no sense to anyone.
10 The second comment I have is I'm very concerned -
11 -
12 DR. CHERNEW: Lynn? I'm sorry. I hate to
13 interrupt but I just want to make sure that this is a Round
14 1 question, not a Round 2 set of comments.
15 MS. BARR: It could possibly go into Round 2. I
16 apologize, Michael. It was about the 5.8 percent on rural,
17 so I could save that for Round 2.
18 DR. CHERNEW: Well, again, you should ask all the
19 Round 1 questions you have. Your point on 340B is well
20 taken. I don't mean to interrupt. I just want to make
21 sure we maintain the discipline between Round 1 and Round
22 2.

1 MS. BARR: Absolutely, Michael. I could have
2 been skirting on the edge of disaster there. I apologize.
3 DR. CHERNEW: Sorry to interrupt. We'll put Lynn
4 into Round 2. Again, I'm not sure she can stay, but put
5 Lynn in Round 2.
6 DR. ZABINSKI: All right. So you had that first
7 question?
8 DR. CHERNEW: Go ahead, Dan.
9 DR. ZABINSKI: Okay. Thank you. I would say
10 that at the current time, yeah, 340B is a big reason for
11 the conversion of offices to HOPD. I don't think it's the
12 only one. And probably if you went back six, seven years,
13 I don't think it was the main reason at that time. It was
14 more of a change in the physician fee schedule in how they
15 paid cardiologists. So things change over time.
16 But I also do think that the 340B is a very
17 relevant issue to this, and we could take a look at how
18 that all fits in and how much of a driver it is right now.
19 MS. BARR: I would love to see a recommendation
20 to HRSA about, you know, considering other ways of
21 qualifying providers, because it's a constant battle for
22 me. I'm trying to keep people from converting every day.

1 And it's only because of 340B and no other reason. So six
2 years ago may have been a different situation, but it's
3 really hard to tell a safety-net hospital, "No, you can't
4 have that $10 million."
5 DR. ZABINSKI: Yeah.
6 MS. BARR: Thank you. I appreciate that.
7 MS. KELLEY: Pat.
8 MS. WANG: I was going to ask a similar question
9 about 340B, and just to put a period at the end of the
10 sentence of the prior conversation, Dan, can you quantify
11 the increase in 340B spending since the beginning, or what
12 you might identify as like the beginning of the big
13 conversion to hospital-owned physician practices? I think
14 that would be an interesting point to add.
15 I have a question about Slide 5, and this is just
16 my ignorance about how OPPS rates are set. I see what you
17 did here on the OPPS payment line, and there was a lot of
18 detailed description in the paper, which was great. And
19 then on Slide 13, at the end, you made sort of, I think, a
20 policy option, sort of comment, that the savings from going
21 site neutral in what you described could be used to add to
22 the payment rates of the remaining procedures in OPPS, like

1 emergency room visit, or it could be used for other
2 purposes.
3 I guess I'd like to just ask a little bit more
4 whether there is an empirical connection between the
5 savings that would be thus generated and the remaining OPPS
6 rates that would not be reduced. And it goes back to this
7 Slide 5. I'm just really curious whether, for example, the
8 OPPS payment, which is this $600, roughly, on the last
9 line, includes some absorption of overhead costs in running
10 OPPS generally that would be shifted rather than disappear
11 if rates were brought down to kind of the freestanding
12 level.
13 In other words, is the notion of reinvesting
14 savings from this action a discretionary policy option or
15 is it something that empirically some of it should be
16 reinvested, because if you're dropping an OPPS rate to the
17 level of a physician office, for example, are you missing
18 something for the remaining services in the hospital?
19 Maybe the costs are higher because there's more overhead to
20 absorb.
21 I think that was my question, because it felt
22 like, for the services that were selected, it's paid less,

1 and leave everything else at its current level. And so I
2 was just wondering if you could talk about that a little.
3 DR. ZABINSKI: Yeah. This one is complicated.
4 Yeah, you're right. Okay, on the overhead, in the $598.81
5 on Slide 5, yeah, there's going to be general overhead for
6 standby capacity and operating the ER and all that sort of
7 thing. And my understanding of it, it pervades throughout
8 all the OPPS payment rates.
9 So when you align the payment rates, and if the
10 savings are plowed back into the services for which
11 payments weren't aligned, yeah, the overhead is going to be
12 reflected more in those services. And if you want to be
13 idealistic about it, they probably should be. If you want
14 to assign the cost to the services for which the costs were
15 incurred, like ED visits, all the costs of ED visits, it's
16 my understanding, aren't actually reflected in the ED
17 payment rates. They are spread through other services, and
18 aligning the payment rates would probably move those costs,
19 the costs incurred by ED visits, back into the ED payment
20 rates.
21 I hope that answers your question.
22 MS. WANG: It's helpful and I apologize. I just

1 have no idea how like this $598, for example, is
2 identified. Is this something that CMS goes through every
3 year in calculating that, or is it more formula-driven?
4 DR. ZABINSKI: Yeah. Yeah, they do. It's,
5 again, a pretty complicated process, but just the one
6 sentence is they take hospital charges, adjust them to
7 costs using cost-to-charge ratios, and then use those
8 charges adjusted to cost to set the payment rates.
9 MS. WANG: Okay. So is it possible then that
10 when they do that at least some of this savings is going to
11 disappear back into the balloon squeezing to increase rates
12 for the remaining OPPS services?
13 DR. ZABINSKI: Yeah. Well, if we take the route
14 of, you know, putting the -- or how to say it -- if we take
15 the route of using the savings to adjustment payment rates
16 for the non-aligned services, yeah, that would happen. And
17 I think, by law, I think that would be the default. Like a
18 few years ago, CMS did some reducing of 340B payment rates
19 for drugs in a lot of the hospitals, and they reduced the
20 payments for those 340B drugs but to make things budget-
21 neutral they had to increase the payment rates for
22 everything else in the OPPS.

1 MS. WANG: I see. I see. Okay. Thank you. The
2 only other question I had was on Slide 10. I appreciate
3 that you are pointing out that in rural areas where there's
4 a shortage of ASCs, changing the rates could affect access
5 if hospitals chose to kind of withdraw from what would then
6 be kind of less-profitable. Would you expect that to be a
7 reaction to some of the other services that would be
8 included in this change? I mean, would hospitals start
9 doing less primary care, for example, because it suddenly
10 became less profitable.
11 DR. ZABINSKI: I don't want to opine on that.
12 I'm not sure.
13 MS. WANG: Okay. Okay, thanks, Dan.
14 MS. KELLEY: Paul, did you have something on one
15 of Pat's questions?
16 DR. PAUL GINSBURG: Yeah, on the first point that
17 Pat made, I think that, you know, what we're getting into
18 is that the fact that some services easily produced in
19 physician offices get paid so much more in the HOPD is
20 really because of very crude overhead allocations that
21 hospital accounting systems use and, you know, the Medicare
22 cost report algorithms used. You know, it's not like

1 hospitals find it very expensive to produce physician
2 office visits. It's just the overhead that's allocated to
3 them. And on the other side, as Dan had mentioned, you
4 know, there are some services, like in the emergency room,
5 you know, consider a procedure that is not done very often,
6 but all the equipment and the training, staff's training or
7 the staff's presence needs to be around. So in a sense,
8 those services probably a hospital is losing a lot of money
9 on.
10 You know, so one thing you could do is go to a
11 more sophisticated accounting and overhead allocation,
12 which certainly could work. But the idea that Dan put
13 forward about taking some or all of the savings from lower
14 payments for services that the hospitals do not bring
15 unique capabilities of, and, you know, taking those savings
16 and apply them to other services that are not done in
17 physician offices, it accomplishes similar things. And I
18 have some more ideas which I'll come back to in Round 2.
19 DR. CHERNEW: So let me just jump in for a quick
20 second. There are two more people in Round 1, Amol and
21 Bruce, and there's nine in Round 2. I want to again just
22 emphasize I really -- I'm going to feel bad about this

1 later, but I will just say again it's important for us to
2 have these discussions. Actually, a lot of these comments
3 have been really, really spot-on. But I worry if we blur
4 the Round 1 and the Round 2 too much. It begins to create
5 challenges for people who are waiting patiently to make
6 their comments and then the comments are coming around.
7 And so, again, I wish, wish, wish, wish I could see you all
8 in person so we could sort of discuss this out, but
9 understand that I would really -- for the parts of these
10 questions in Round 1, they should be questions about
11 clarification and specific points, and there should be
12 answers, and we can save some of the more sophisticated
13 policy option things, like Paul was talking about, what we
14 could do or how we might do things. Those are wonderful
15 comments, and I really want to get them, but I want to make
16 sure everybody gets to say them. And so I'd like to keep
17 the more substantive policy discussions to Round 2.
18 So, again, I apologize. I'll put a separate
19 apology in the chat, but let's just go on to Round 1.
20 MS. KELLEY: Okay. Amol.
21 DR. CHERNEW: I think that's Amol.
22 MS. KELLEY: Yes. Amol, you said you have

1 another Round 1 question?

2 DR. NAVATHE: I do, yeah, and hopefully this is a

3 good Round 1 question for Mike's criteria.

4 So, Dan, when you were in the chapter discussing

5 the ancillary items that get packaged and the differences

6 between OPPS and others, on page 15 of the paper there's an

7 example that is given for APC 5012. The question I had is:

8 The logic that was used was that the cost of the packaged

9 items was 13.3 percent of the total cost, and so then we

10 used basically a multiplier of 1.13. You're sort of

11 inflating the new base rate by 13 percent. And I was

12 wondering if the cost of those items, we actually know the

13 cost was $18.49. Is there a reason that we chose to use

14 the 13 percent rather than the absolute dollar value of

15 $18.50, which to me seemed like it would be a fairer way to

16 do it. I was just curious if there was a particular reason

17 or if this was just more of a simulation exercise.

18 DR. ZABINSKI: This was a -- I thought about both

19 approaches. In fact, the other approach that you mentioned

20 is the way we did it, you know, back eight years ago, or

21 whenever that was. You know, this time around I just felt

22 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

1 disproportionately using HOPDs. Well, I think that --
2 okay. It's -- I guess, you know, the DSH percentage that I
3 used to identify hospitals that qualify for these stop-loss
4 examples is sort of like that sort of beneficiary wasn't
5 mined. You know, they have some -- they use the HOPD a
6 lot, one, to identify hospitals that might serve a high
7 share of that type of beneficiary. We used the -- you
8 know, those were the high DSH percentage to identify those.
9 I recognize that's not perfect. Probably want to use
10 something better in the future.
11 MR. PYENSON: Maybe I can clarify the question.
12 In terms of the distribution of services, the HOPD
13 dominance as the site of service might be influenced by the
14 lack of availability of physician specialists, so there
15 might be some skewing there. But I think you got the gist
16 of my question.
17 Another question. On page 5 of the document,
18 there's a comparison between physician office and HOPD of
19 first hour of chemotherapy and the transthoracic
20 echocardiogram with the report, and the percentages are
21 quite different. Do you have any insight into why the
22 differences between the two settings are different for

1 those two procedures?
2 DR. ZABINSKI: My thoughts on this are exactly
3 like yours, but I don't have an answer to it. You know,
4 there's a lot -- I could throw out any number of examples
5 where it sort of scratches your head about why is this kind
6 of closely aligned with the -- between settings, and that
7 not, even though it seems like, you know, it should be the
8 other way around. And I don't have an answer to that, and
9 I guess the reason is that, you know, there's so many
10 examples of it. I don't think there is one good answer.
11 MR. PYENSON: My last question is: The analysis
12 that you've done is done on a procedure basis or an APC
13 basis, but there's some services such as chemotherapy that
14 are repeat; or if radiation therapy is an APC, that comes
15 in fractions. Do you think it's worthwhile examining
16 whether physician office, for example, freestanding, does
17 more of them versus hospital outpatient or does less of
18 them for a given patient? Because I think that might give
19 a fairer view of potential savings.
20 DR. ZABINSKI: I had thought about that. Yeah, I
21 think it would be worthwhile looking into it.
22 MR. PYENSON: Thank you. Those are my questions.

1 Thanks, Dan. Terrific report, by the way.

2 MS. KELLEY: Okay. Shall we hop right into Round
3 2, Mike?

4 DR. CHERNEW: Absolutely, and now everything
5 goes. I will watch the time. We have a long queue, so I
6 will watch the time. You can talk about, you know,
7 whatever it is that you want, so go ahead.

8 MS. KELLEY: Brian, you're up first.

9 DR. DeBUSK: Thank you. First of all, I was
10 really excited to see this chapter come through. It's been
11 difficult doing the ASC updates over the last five years
12 without wanting to have a discussion around ambulatory site
13 neutrality, so thank you.

14 I also want to compliment the staff, Dan, on an
15 excellent chapter. I think you used the data that was
16 available very well. I think the analytics were well
17 thought out and well presented. And I do -- I like the
18 idea to turn the APCs that are associated with ED and
19 trauma into comprehensive APCs, because I think that does a
20 better job of aligning the payments with the higher standby
21 cost associated with emergency care. So I really enjoyed
22 that part. But I am concerned that payments being sent

1 largely by where the procedure is most frequently performed
2 is a problem. I do think that we need to incorporate a
3 little bit more information, and that information would
4 take the form of an acuity adjustment.
5 I do appreciate that it was mentioned in the
6 chapter, so thank you for calling that out, but I also want
7 to point out we don't have to do a full risk adjustment.
8 This isn't MA risk scoring all over again. We could use a
9 more general measure of surgical risk, something like the
10 ASA score, which is really a pillar of surgical
11 anesthesiology prep work. So we could use something like
12 an ASA score to create two or even three levels of APC
13 severity adjustment. And there are several arguments that
14 would support doing a modest acuity adjustment for APCs,
15 and I just want to go over a few.
16 The first one, I think there are a broad range of
17 patients that may need a specific APC. Picture an
18 otherwise healthy beneficiary with a fairly complex distal
19 radius fracture. They may be well served in an ASC, but
20 then you contrast that with a highly clinically complex
21 beneficiary with a relatively simple distal radius
22 fracture. They may need this HOPD level services.

1 So falling back on this idea that Medicare should
2 pay similar rates for similar care, I do think that similar
3 care is an amalgamation of the patient's immediate clinical
4 need and their overall characteristics.
5 And I think that leads me into a little bit of a
6 philosophical issue, and that's the issue of alignment.
7 The method proposed in this chapter really sets up on three
8 diverging payment philosophies. In the IPPS, we look at
9 the DRG based on the immediate beneficiary need and then
10 adjust it for severity. A unified post-acute care approach
11 is similarly based on the immediate beneficiary need, and
12 then we adjust it by the patient characteristics. But then
13 based on this chapter, we would find ourselves setting the
14 ambulatory payment really primarily based on where the
15 procedure's performed the most.
16 So I just want to mention, with an acuity-
17 adjusted APC, we would have the freedom, just like we want
18 to do in post-acute care, to allow the different ambulatory
19 settings to pursue their own strategies.
20 You know, I have been in ASCs, for example, that
21 are in many ways nicer than most rural hospitals. But,
22 similarly, we might have hospitals that want to pursue

1 lower-acuity beneficiaries by keeping their operating cost
2 low. So, ideally, an acuity-adjusted ambulatory payment
3 system would lay the groundwork to really a unified
4 Medicare where we look at immediate beneficiary need and
5 those beneficiary characteristics.

6 The other thing I want to mention is the proposed
7 method has two additional problems, and I think some of
8 this came up in Round 1. We run the risk of creating APC
9 deserts. Imagine a rate that's set from an ASC being
10 pushed into the OPPS in geographies that don't have good
11 ASC access. We know ASCs are typically located in more
12 affluent areas, so there may be a disproportionate impact
13 on our socioeconomically disadvantaged beneficiaries. And,
14 second, it doesn't align well with the emergent strategy
15 that we're witnessing in MA. For the procedures that do
16 remain at the HOPD rates, MA plans are going to be able to
17 identify and select a subpopulation who are ASC eligible
18 and game that margin. So that creates found and
19 essentially free money for MA as well.

20 But, again, I believe the staff used the data
21 that's available very well, and I enjoyed the analysis.
22 But I do believe the ambulatory payment system needs at

1 least a modest acuity adjustment.

2 Those are my comments. Thank you.

3 MS. KELLEY: Lynn.

4 MS. BARR: Thank you. So, again, great chapter,

5 Daniel. Thank you so much for this.

6 So the slide where we talk about the 5.8 percent

7 for rural is obviously of great concern given there are

8 thin margins. And, also, you know, we have to think about

9 -- so if -- where are they going to go if they can't go to

10 the hospital, right? And knowing that rural hospitals, 75

11 percent or more of their revenue is outpatient, right? And

12 so they are very, very skewed towards the outpatient side,

13 as you are well aware. So a 5.8 percent cut in 75 percent

14 of their revenue when they've got like an average of 1 to 2

15 percent margin means they're going out of business. So I

16 think that we need to think about that and maybe just

17 exempt rural hospitals from this because there's really --

18 I mean, it's beneficiary access. Where else are they going

19 to go, right? Everything's there, and that's the only

20 place it is, and that's kind of the way it needs to be, and

21 it does create some efficiency. So I don't know where you

22 go with that.

1 The other question about, you know, how should
2 the savings be allocated, you know, as we think about
3 disparities in care, one of the biggest concerns I continue
4 to have is that rural beneficiaries pay huge cost sharing,
5 about 50 percent average cost sharing, for outpatient and
6 rural hospitals. So I would say that if you have any
7 savings from this, you should apply it to the rural
8 beneficiary cost sharing so they pay the same 20 percent
9 cost sharing that every other beneficiary does in the
10 country.
11 Thank you.
12 MS. KELLEY: Paul.
13 DR. PAUL GINSBURG: Yeah, thanks. You know, like
14 Brian, this was excellent, an excellent piece of work and
15 presentation that's really help moving us into this
16 discussion very well.
17 I want to point out, before I get to what I plan
18 to say, that I really liked Brian's comment about an acuity
19 adjustment. I think it brings out all these issues. The
20 last time I had a colonoscopy, I was told that, well,
21 you're having it done in the hospital outpatient department
22 because you're over 65. And so, you know, I could see

1 presumably there was standby capacity there that, you know,
2 for the average person of that age -- I'd like to think
3 that I didn't need it -- would be significant, not often
4 used, but needs to be paid for. So I think there's a
5 compelling argument to have acuity adjustments.
6 I wanted to bring some history. The Commission
7 first took this up during the last -- I guess early in the
8 last decade, and, you know, with what's really close to
9 current law, and it got a good policy reception in the
10 sense that Congress enacted a less aggressive but
11 consistent approach, and the previous administration was
12 particularly aggressive in pushing the legislative
13 authority as far as it could.
14 What you've done here is kind of the next logical
15 step in identifying a lot more services besides office
16 visits that -- where site-neutral payments could be
17 prepared. But I think as we proceed, we ought to be
18 thinking in terms of doing this not for savings but in a
19 sense to get closer to our longstanding principles about
20 relative payments reflecting relative costs, that we work
21 on in such detail with the physician fee schedule, and then
22 apply it in the hospital outpatient department, which means

1 higher payments for services that are underpaid today. And
2 I think the importance of doing this, site-neutral
3 payments, has really been increased by the changes in the
4 delivery of care, the changes in concentration, because the
5 incentives from these distortions in payments seem to be
6 much more problematic than they might have been ten years
7 ago and they'll probably continue to get more problematic,
8 so a kind of more compelling reason to work on this. I'm
9 really glad we're working on it. But I think we need to
10 focus not so much on savings but on the matter of more of a
11 thorough overhaul of paying more for services that are
12 unique to hospital outpatient departments, the cost of all
13 the standby capacity, et cetera. And perhaps even this
14 would make it more politically feasible to move forward,
15 would be somewhat less of a threat to the viability of
16 hospitals.
17 MS. KELLEY: Jon Perlin.
18 DR. PERLIN: Let me add to the chorus of
19 appreciation for this chapter.
20 I also want to add an appreciation for the very
21 thoughtful discussion around this. It strikes me that our
22 conversation remains very institution-focused, not patient-

1 focused, and we put the focus on the patient. Then issues
2 such as those Brian raised and Paul just enunciated about
3 patient acuity make a pretty good -- a big difference.
4 You know, I know the chapter is somewhat
5 dismissive of the data, but this point about a broken -- as
6 Brian used, a broken arm with complexity, it is a good
7 point.
8 Consider this example. If you're a 68-year-old
9 and you have a cough, you might not care where you go, and
10 the closest place that's convenient might be your first
11 choice. If you're a 68-year-old and you've had coronary
12 artery disease, you have heart failure, you have diabetes,
13 you know that a cough may not be a cough, and the
14 environment you choose may actually be the higher-
15 complexity environment. And so they are both factors that
16 have to do with the just inherent complexity of need
17 itself, but there's also a degree of self-sorting that a
18 broader data would identify. We've discussed that before
19 in terms of our emergency department conversations in past
20 years. So I think we do need to invoke the patient acuity,
21 recognize the differences and complexity.
22 While it's attractive to want to just align

1 those, I think a number of the points that have been made
2 about the history are different than the fundamental
3 aspects of what it takes to be able to provide those
4 standby services. So, if you're a hospital, you are
5 required to be prepared for EMTALA; if you're a trauma
6 center, level 1 or level 2. You've got to have
7 orthopedics, anesthesia, hand surgery, neurosurgery, et
8 cetera, on call, 24/7/365 to maintain that. And if you're
9 that patient for whom a cough may not be a cough and you're
10 choosing an environment that has that standby capacity --
11 and so the focus through the lens of acuity makes all the
12 sense in the world.
13 I think it's also important to juxtapose today's
14 conversation with respect to yesterday's conversation about
15 safety-net institutions, and a number of comments were
16 really well made, in particular, a moment ago about the
17 concern on rural institutions. And I just have to toss out
18 if a policy requires a fix in the form of a stop-loss, is
19 it the right policy structure to begin with? Or, if you go
20 a different direction in terms of patient acuity, do you
21 end up with a policy that's more internally coherent? And,
22 as you think about the broader picture of the policies that

1 we're trying to align, a world that encompasses, areas
2 where rural is going to have a residual fee-for-service,
3 where MA operates through a chassis, where reference
4 pricing is useful but also accommodates an acceleration
5 through advanced payment models, then maybe we need to
6 think again about the patient as the center of that
7 universe and really build out from that patient complexity
8 as opposed to institutional footprint.
9 Thanks.
10 MS. KELLEY: Amol.
11 DR. NAVATHE: Thank you.
12 Dan, thanks for this fantastic work. I think
13 it's just a fundamentally critical issue. I'm so glad to
14 see that we're pursuing it with a level of rigor and level
15 of comprehensiveness here.
16 So I guess in that sense and that same statement,
17 I guess I should add that I'm supportive of the idea of
18 moving to site neutral for the reason that Paul and others
19 and a lot of mentioned around alignment.
20 I think we should also be very mindful, should be
21 very front and center. This is also a beneficiary cost-
22 sharing issue. It was really striking to me in reading the

1 materials. I don't think it made it into the PowerPoint
2 slide that there are hundreds of millions of dollars of
3 cost-sharing savings to the beneficiaries. So this is not
4 just about the Medicare program as a whole. This is truly
5 about affordability for patients, and let's not lose sight
6 of that. I think that's a really fundamental point.
7 I think there are some complexities, some of
8 which have already been highlighted. So I'm going to try
9 to not duplicate.
10 Generally speaking, I understand. I agree with
11 Brian that we've done -- Dan, you've done what you can with
12 the data that we have access to. I am concerned about this
13 notion of using the highest-volume setting as the primary
14 mechanism or method to identify the services that can be
15 most effectively produced or delivered across different
16 settings. I think it might be worth pushing a little bit
17 deeper on this. We suggested some analyses that look at
18 the temporal shifts over time, also the cross-sectional
19 shifts because of ASC. I think those are worth pursuing.
20 I also wonder if there's more work that a
21 Commission can do in this space by talking to MA plans.
22 There are also commercial insurers. Many of them use

1 fairly sophisticated utilization management, health plan
2 functions, prior auth-type techniques to actually
3 rationalize where the site of service should be, and so it
4 would be interesting to learn about what are the methods,
5 what are the data that they might consider as part of that,
6 in some ways, kind of fee-for-service program, learn from
7 MA that way. I think that would be actually very helpful
8 to do.

9 I noted the rationale around the next topic is
10 kind of around this question of illness severity. I think
11 we've touched on it in the context of acuity adjustment.
12 I'm generally in favor of that, in part, because some of
13 the comments and language in the chapter describe
14 overlapping risk score distribution as a way to justify or
15 rationalize in some sense that there's good overlap.

16 That being said, I think there's a whole number
17 of factors. One, overlap doesn't mean that there's perfect
18 overlap. There's obviously differences that might use this
19 on the ends of the distribution, and then there's also
20 these unobservable aspects around other challenges that we
21 might worry about, rural settings and underserved urban
22 settings, social determinants of health. That may also be

1 at play here. That may be part of the decision-making
2 function of clinicians and hospitals as they try to match
3 patients, to some extent, with an appropriate site of
4 service. So I think we should also not lose sight of that.
5 But let me also just restate I am in support of exploring
6 an acuity adjustment.
7 I think a couple other last points I wanted to
8 make, one, I think if we were able to move in this
9 direction of site-neutral payments, I believe we have made
10 this point a little before, but in many settings, we
11 acquire s cost report. Medicare acquires cost reports as a
12 way to base some of the payment adjustments. I believe we
13 don't get that for ASCs. As part of this type of work, it
14 might be nice to reemphasize that if we're able to get the
15 policy recommendations.
16 And the last point I wanted to touch on is a
17 point that Jon Perlin also touched on, which was this
18 question of the rationale behind the policy and its
19 potential effects on safety-net institutions, on rural
20 institutions, on a variety of different institutions. I
21 think it's been incredibly important to be mindful of the
22 impact.

1 I may disagree a little bit with Jon here in that
2 the notion of a stop-loss provision to me suggests that
3 there was some legacy way of doing this, and that we want
4 to mitigate the impact in the short term and may want to
5 roll it out over time. But I think it's also important to
6 recognize that from a policy rationale perspective, it may
7 make much more sense to focus on what works from a broad
8 economic policy incentive perspective in terms of a site-
9 neutral payment a la what Paul was saying around alignment,
10 and then separating out the point that we should absolutely
11 be supporting institutions in rural areas and safety-net
12 institutions that are serving underserved urban
13 populations. But that doesn't mean that it has to happen
14 through this mechanism of how we think about site-based
15 payments. I would argue that, in fact, we should think
16 about it that way. We should think about site-neutral
17 payments in the context of how we pay for the right setting
18 of care, and then we should absolutely take some of those
19 funds, if there are savings from those funds, to then prop
20 up and help to support our safety-net institutions. But
21 that should be a separate policy level that we are pulling
22 there, so that we're not muddying the water and making it

1 very hard to design an efficient Medicare program, because
2 we're beholding to some of the legacy designs that came out
3 from good intention.
4 So I will stop there. Thank you so much.
5 MS. KELLEY: Bruce.
6 MR. PYENSON: Thank you.
7 I want to support a number of the points that my
8 colleagues here have made, especially Amol's point about
9 learning from MA and Brian's point on acuity adjustment and
10 the issues of legacy.
11 I want to make two pretty big-picture points.
12 One is how stop-loss is treated or maybe how it should be
13 treated in general, and I think it's important to recognize
14 that stop-loss comes with a cost. And that cost should be
15 explicitly identified. Typically, in the commercial world,
16 stop-loss comes with a charge, and that's a charge that's
17 applied to the purchasers. And that's one way of doing it,
18 but I think that being very specific about stop-loss and
19 who pays for it and the different ways could be paid for is
20 important, in general.
21 And I might support some of Amol's -- one of his
22 points about using funds to support particular programs,

1 for example, safety net.
2 Another, perhaps, bigger point is we often hear
3 about the intents for surge capacity or emergency or other
4 kinds of capabilities like that, and that's been an ongoing
5 big investment for decades.
6 And we've just had a case test in the public
7 health emergency of how well that performed, and I think
8 before we get too much further, there needs to be a
9 reckoning of how well did that investment work. The recent
10 studies of mortality, BMJ came out recently with an article
11 on comparing countries' mortality in 2020, the increase in
12 mortality, and it doesn't look good for the United States
13 of the 30-some countries that were evaluated. The U.S. had
14 about the biggest increase in mortality, not quite as big
15 as Russia.
16 So I think there is a question of whether our
17 assumption about our investment in the kinds of capacity in
18 emergency and standby perform the way it should or whether
19 we should perhaps stop referring to it in the way we are.
20 Thank you.
21 MS. KELLEY: Larry?
22 DR. CASALINO: Yeah. Dan and Jim, I'm really

1 glad that you guys are tackling this topic. I think it's
2 such an urgent topic because we have so much consolidation
3 going on. It's already far advanced, and in an economy
4 that was our health care system that was functioning well,
5 consolidation would be driven by efficiencies, not by the
6 ability to -- not because you can get higher rates because
7 you're a consolidated entity in through a variety of means.
8 So I think this is urgent. This is not something
9 that can wait 10 years. By then, it will be kind of
10 irrelevant in terms of the amount of consolidation that
11 will have happened.
12 I'm going to jump actually to my last point first
13 and then go back and add a couple of other things I can say
14 quickly. I think it may be a mistake to try to say what
15 should be done with the savings. That really kind of gets
16 into how what hospital should be paid and how much should
17 they be paid for standby capacity, what's the best way to
18 get them that money and so on. So I think that to give
19 kind of almost off-the-cuff recommendations about how the
20 savings could be used to kind of give back hospitals some
21 of the money that they're losing is a mistake, first of
22 all, because I'm not sure the ideas will be the best

1 because it really is like talking about how should
2 hospitals be paid, and secondly because it would generate
3 so much controversy because it is about how much should
4 hospitals be paid and how should they be paid more
5 generally, that the points about site-specific neutrality
6 could be lost.
7 So I think if we show that hospitals are going to
8 lose some money, if the kind of changes that we wind up
9 recommending, if any, were put into effect, I think we
10 could acknowledge that, quantify the losses, and point out
11 that society may want to find a way to give some of this
12 money back to hospitals. But I don't think it's our job
13 to, in this case, talk about how hospitals should be paid.
14 Dealing with rural hospitals is a tricky
15 question. They could just be exempted, as I think it might
16 have been Lynn suggested. That wouldn't necessarily be a
17 bad thing. There's some reasons to think that physician
18 hospital consolidation in rural areas is not bad. For one
19 thing, it's a way to get some physicians in rural areas and
20 keep them there. But then it would keep beneficiary co-
21 pays on it. So, anyway, that's that point.
22 The other point I wanted to make is about the

1 cost of running practices after you acquire them and then a
2 point about the volume criteria.
3 There's no question that it costs more for
4 hospitals to run practices after they acquire it and then
5 the practices were using them. Some of those costs may be
6 higher than they need be. I personally have had that
7 experience of having my practice, my physician practice
8 purchased by an active medical center, not the one that I
9 work for now, and then three months later being told that a
10 practice that was profitable is now losing $400,000 a month
11 for the hospital or something like that. And this is the
12 common story. It's partly because of higher costs, partly
13 because of other things, but I think it's important to
14 remember no one is putting a gun to hospitals' heads and
15 saying you have to buy these practices. If hospitals make
16 the decisions to buy practices, that doesn't mean that
17 society has to subsidize their higher cost, and I think
18 it's important to realize that.
19 The last point I want to make is about the volume
20 criterion for judging where it's safe to provide a service
21 and in what setting should set the rates that are going to
22 be paid. I think Stacie and others have made pretty clear

1 that just using 2019 would be problematic because there are
2 so many changes that have already been baked in that came
3 about not because something is done better or safer
4 necessarily in a given environment because of Medicare
5 payment policies that were changed.
6 On the other hand, looking back to when -- I'm
7 trying to remember when the cardiology imaging payments
8 changed. It might have been 2008, something like that.
9 This is a long way to look back. And then looking forward,
10 it's true that a lot of kind of major joint replacement
11 surgeries are probably going to be increasingly moving to
12 ASCs. So, for those procedures, if we look back even to
13 2019 and maybe farther back than that, we say these have to
14 be done at hospitals and pay at the hospital rate, when, in
15 fact, they probably could be done, can be done safely in
16 ASCs, although there should be an acuity adjustment. This
17 is a good example of where that would be important, I
18 agree. For some sicker patients, you wouldn't do in ASCs.
19 You would do them in hospitals.
20 So I think a lot more thinking probably needs to
21 go into how to select, which of the three settings should
22 set the pace for the payment rates. I'm not sure we can

1 just pick a year and leave it at that permanently.
2 Obviously, this is critical, and it can't seem arbitrary.
3 But just picking any year, I think it's probably going to
4 be wrong. To me, the whole thing kind of hinges on this.
5 If we're using the method we used to determine which of the
6 three sites would set the payment rate, it's obviously
7 critical, and I think probably deserves plenty more thought
8 and, again, sooner rather than later because I think this
9 is a process that's already far advanced to consolidation,
10 and it's moving rapidly.
11 That's it.
12 MS. KELLEY: Stacie.
13 DR. DUSETZINA: Thank you. I want to also kind
14 of answer this, how should the savings be reallocated or
15 allocated. In general, I am very much a fan of trying to
16 get to a more site-neutral payment situation, recognizing
17 how complex it is, and I completely agree with Jonathan's
18 and Brian's prior points about acuity adjustment.
19 You know, I think if the savings could be
20 reallocated -- and this goes to Lynn and Amol kind of have
21 touched on this -- back into beneficiary cost share, that
22 seems like it would be a really nice way for services that

1 really do need to be performed, for example, in hospital
2 outpatient departments or in other more expensive settings.
3 If we could make that less expensive for the beneficiary or
4 at least not more expensive than if getting it at another
5 site of care, that would be nice.
6 And it strikes me that maybe potentially there is
7 an opportunity to pick up the cost share that would have
8 been there for the duals, to help with some of the access
9 challenges we talked about yesterday, thinking about
10 Medicaid not picking up the 20 percent, for example. But I
11 really like the idea of trying to recycle any potential
12 savings into helping beneficiaries have more stabilized
13 costs for getting the same procedures, even if they are
14 going to a more expensive site of care.
15 MS. KELLEY: Betty.
16 DR. RAMBUR: Thank you. Thank you for the
17 opportunity to comment. In the interest of time I will be
18 brief and a little bit high level. I greatly appreciated
19 the chapter and the comments of Commissioners.
20 I strongly support the need to align across
21 ambulatory settings, and I have certainly found the
22 empirical evidence that when hospitals acquire physician

1 practices and there is market consolidation, prices go up.
2 I have found that to be very compelling, and, in addition,
3 the challenge that the FTC has with overseeing vertical
4 integration rather than horizontal.
5 Jim mentioned the issue of the sign out the door,
6 and a couple of mentioned the issue of beneficiary cost-
7 sharing. I would just like to also underscore that. It is
8 entirely baffling to patients when they receive a service
9 at one time, at one place, and they receive the exact same
10 service a very short time later, and there's a dramatic
11 difference in the cost. And it's just not rational, and I
12 think we need to address it.
13 I strongly support Amol's statement, and maybe
14 others said as well, of the need for the cost report data.
15 And since Vermont was brought up in the materials as well
16 as in the conversation, I will just very briefly sketch a
17 tiny bit of that history. The state had a longstanding
18 policy, or they had a longstanding practice whereby the
19 large academic medical center was able to argue that
20 ambulatory centers would cherry-pick and they would
21 undermine their ability to survive. And you could go on
22 that side of the argument or you could say, well no, that

1 actually was a large market player, preventing others from
2 entering the market. And indeed, I believe it was in 2017,
3 it was finally allowed. The first center, which the report
4 mentioned, is in Burlington, which is the largest city, and
5 then shortly after that a second, which was, you could
6 argue, a competitor, coming from the academic medical
7 center that previously was opposed to an entry of a new
8 player in the market.

9 The reason I bring this up is I think it's really
10 important that we don't think that all rural areas are
11 homogenous, and I'm not suggesting that we do. And I
12 strongly support the notion that we separate out this very
13 important issue, site neutrality, with the special needs of
14 safety-net facilities. And I don't have the answers of who
15 we would do that but I am very confident that there could
16 be some excellent recommendations.

17 In terms of the savings, I tend to agree that the
18 most important thing is that we get this to be a more
19 rational system. But if there are savings, I think it
20 would be very important that they go to savings to the
21 beneficiaries and to the Medicare program, and then also to
22 address the safety net issue.

1 So thank you. I think this is extremely
2 important that we're taking it on. And I know it will take
3 perseverance to get to the other side, but I'm very
4 grateful we are doing it, so thank you.
5 MS. KELLEY: Paul, did you want to add an
6 additional comment?
7 DR. PAUL GINSBURG: I just wanted to make a pitch
8 for, you know, one of the ideal ways of perhaps
9 reallocating the prices to other services is to look into
10 bringing the hospital cost accounting norms up to the
11 modern era so that, in a sense, some of the reallocation
12 could actually be done on a true cost basis. And, you
13 know, I'll talk to the staff offline, and I have a couple
14 of PhD accountants to suggest that they might be able to
15 talk to on it.
16 DR. CHERNEW: Thanks, Paul. Dana, if I
17 understand correctly, that is the end of the queue. Is
18 that correct?
19 MS. KELLEY: yes.
20 DR. CHERNEW: Okay. Anyone want to add anything
21 else before I wrap up? Then I'll ask if you want to say
22 anything after my wrap-up.

1 So let me summarize this very rich discussion.
2 The first point -- I'll make a very broad point -- and I
3 don't want everybody to think that my answer to every
4 question is alternative payment models. But I must admit
5 this is an area that seems to arise because they're trying
6 to set somewhat micro fees in places where we don't observe
7 costs, we don't observe patient traits, we don't observe a
8 whole bunch of things going on where efficiencies and
9 there's heterogeneity across services, patients, sites,
10 locations, and a whole bunch of other things.
11 So at least the place where I think the phrase
12 "alternative payment models" might be thought of as
13 something, but we're certainly not going to solve this
14 problem in the near term with alternative payment models,
15 so we have to address this. And I might add, because
16 almost all alternative payment models are based off a fee-
17 for-service chassis, even if everyone was in an APM we
18 would still need to try and get payment better, even though
19 it wouldn't quite be potentially toxic.
20 So I think there are a lot of comments. I think
21 this might have been raised by many of you. I think Paul
22 raised it. Our goal here, in many ways, is to incent care

1 to go to the most efficient provider, and so we don't want
2 to overpay in some places. The problem is we don't know
3 what efficiency is. It's hard to observe. The service
4 definitions are a little bit different. Dan mentioned
5 several reasons, not just in terms of what's bundled into
6 the service but also the need for backup capacity.
7 And Brian, I think, mentioned there's a lot of
8 patient heterogeneity, so some sense of how we deal with
9 that, acuity differences within services matter. I also
10 think there's an average versus marginal cost issue. When
11 we say a site is very expensive, are we talking about
12 average costs or marginal costs? If we have a lot of
13 backup capacity it might not be bad to use it in a place if
14 it otherwise would go to waste. So we have to think
15 through some of those issues.
16 All of that said, as we go through this, our
17 intent is not simply to save money or even to reallocate
18 money. We are going to have to give broader thought as to
19 where compensation is needed if revenue goes away, and how
20 well we can target that any additional compensation.
21 What I fear would happen -- and maybe "fear" is
22 the wrong word -- is we're about to, in December, embark on

1 the beginning of our normal update chapter. If we took 4
2 percent, or whatever number you wanted, 3 percent, from
3 some center providers, that would inevitably play into our
4 update criteria and lead us to do an across-the-board
5 increase, I believe, in our update recommendations, because
6 profitability would be substantially worse. How much so
7 would depend on the site and a whole bunch of other things.
8 I very much worry about places where there are
9 fewer alternative and how we deal with changes in payments
10 that might restrict access in those places. That is
11 partly, but not exclusively, a disparities and equity
12 comment, and I worry about how we can get the right amount
13 of information to target these sort of any extra payments
14 where they're needed. Our goal is not to pay too much
15 broadly in order to achieve access in some selected places.
16 So how we do that is clearly going to be a challenge.
17 My biggest takeaway, past all those substantive
18 points, is that there remains a lot of interest in the
19 Commission for continuing down this path. There's been a
20 lot of suggestions about things that we might do. Dan, I'm
21 pretty sure you said this at the offset. We are not moving
22 towards a recommendation this cycle, so we will not see

1 this all come to resolution in the chapters this cycle. We
2 are really moving forward in this area, and we will try to
3 tie up many of these loose ends, often along the ways that
4 you suggested, both analytically and otherwise.
5 So let me pause to see if I've missed any main
6 themes, and then I'll ask Dan for any last words before we
7 move on to the next topic.
8 [Pause.]
9 DR. CHERNEW: Anything you heard that I didn't
10 summarize, or anything I summarized that you didn't hear?
11 Again, it would be nice to see you in person. We could
12 hash this all out. But in lieu of that, let me get a sense
13 of what you think.
14 DR. ZABINSKI: No, I thought this was a great
15 discussion. I have a good sense of where to go from here,
16 so I'm feeling good.
17 DR. CHERNEW: Okay. Wonderful. If Dan is
18 feeling good that means you all did a good job. That's
19 sort of the main goal.
20 So I think now we're going to switch to the last
21 topic of this month, which is some nuanced issues on how
22 Part D works for residents in long-term care facilities.

1 So with that I am going to turn it over to Rachel.
2 Rachel, you are up.
3 DR. SCHMIDT: Good morning. In our last session
4 we're going to look at how Part D benefits are provided to
5 beneficiaries who live in long-term care facilities.
6 Within nursing facilities, we're focusing on long-stay
7 residents rather than those with a post-hospitalization
8 skilled nursing stay. Only about 3 percent of Part D
9 enrollees live in nursing facilities, but they are a
10 population of interest because, in addition to needing
11 considerable help with activities of daily living, they
12 often have cognitive impairments. There is little
13 information available about how well Part D has served
14 them.
15 Before we dive in, I would like to thank Beth
16 Fuchs and Jack Hoadley, who organized and led stakeholder
17 interviews for this project, as well as my colleagues
18 Shinobu Suzuki, Eric Rollins, and Kathryn Linehan. As a
19 reminder to the audience, you can download a PDF version of
20 these slides in the handouts section of the control panel
21 at the right-hand side of your screen.
22 The Commission last looked at this issue shortly

1 after Part D began. That work examined the major changes
2 that were under way in financing and delivery of drug
3 benefits in long-term care. Previously, most long-term
4 care residents had their drug benefits paid by Medicaid,
5 but with the start of Part D, Medicare took over this role.
6 At the time, we had concerns about conflicting interests of
7 stakeholders and how that might affect beneficiaries. We
8 also discussed whether Part D's consumer choice model, in
9 which beneficiaries select among competing private plans,
10 was appropriate for the long-term care setting.
11 Last year, with the help of a contractor, we
12 interviewed stakeholders to get an update on how Part D
13 works today in long-term care. One thing we heard
14 immediately is that some beneficiaries who, in previous
15 years might have stayed in a nursing home, today live in
16 assisted living facilities and other types of residential
17 care centers. So, we expanded the scope of questions to
18 include assisted living.
19 We know more about residents of nursing homes
20 than residents of assisted living because nursing homes are
21 subject to federal regulations, surveys, and
22 certifications. In contrast, assisted living facilities

1 are regulated at the state level, and there is variation in
2 their definition and requirements. This table compares
3 characteristics of the two groups of beneficiaries, based
4 on residence codes from their Part D claims. However, note
5 that these data should be interpreted cautiously,
6 particularly for assisted living facility residents.
7 In 2019, about 3 percent of Part D enrollees
8 lived in nursing homes, and their drug spending accounted
9 for about 5 percent of all Part D spending before rebates
10 and discounts. An additional 2 percent of Part D enrollees
11 likely resided in assisted living facilities, and their
12 spending made up about 4 percent of gross Part D spending.
13 Part D enrollees in nursing homes and assisted
14 living facilities share certain characteristics. During
15 2019, they were more likely to be enrolled in a stand-alone
16 prescription drug plan, and thus in fee-for-service
17 Medicare, compared with all Part D enrollees. They were
18 much more likely to receive Part D's low-income subsidy,
19 and many of those individuals are dually eligible for
20 Medicaid. You can see there's much higher prevalence of
21 Alzheimer's disease or other dementias, and anxiety and
22 depression in both settings.

1 However, there are differences between the two.
2 In 2019, among assisted living facility residents, a higher
3 share was under age 65, and a much higher share had
4 diagnoses of serious non-dementia mental illnesses such as
5 schizophrenia.
6 The regulatory environment in which nursing homes
7 provide medications is complex. By law, nursing homes must
8 provide residents with all needed care in a timely manner
9 including prescription drugs, even when the source of
10 payment is unclear. Nursing homes must use licensed
11 pharmacists, and they typically do this through an
12 exclusive contract with one long-term care pharmacy. Long-
13 term care pharmacies must be able to provide specialized
14 services such as 24-hour drug delivery, and dispense drugs
15 in packaging that helps to reduce medication errors.
16 Nursing homes must also provide the services of
17 consultant pharmacists who are responsible for managing the
18 clinical side of medication dispensing as well as
19 regulatory compliance. Consultant pharmacists must conduct
20 monthly medication regimen reviews of each resident.
21 State regulations differ with respect to how
22 assisted living facility residents receive help with their

1 medications, but often assisted living facilities don't
2 provide the same types of dispensing and medication review
3 services as in nursing homes. Assisted living facility
4 residents often have a choice between using community
5 retail pharmacies and a long-term care pharmacy. Most
6 assisted living facilities provide help with or
7 administration of medications, for example, by having a
8 medication technician hand a beneficiary her dose to self-
9 administer.
10 Here's a diagram to help understand the flow of
11 funds and medications and the relationships among
12 stakeholders. Medicare makes payments to private Part D
13 plans toward the cost of basic drug benefits for each
14 enrollee, as well as for low-income premium subsidies and
15 cost sharing subsidies for LIS enrollees. The role of the
16 long-term care pharmacy is to acquire drugs, dispense the
17 medicines for the facility, and provide other services to
18 help with medication management, billing, record keeping,
19 and so forth.
20 Plan sponsors and their PBMs need to set up a
21 network of long-term care pharmacies to meet Part D access
22 standards. Most long-term care pharmacies use the services

1 of a pharmacy services administrative organization, which
2 is often an affiliate of a group purchasing organization,
3 to negotiate with plans and PBMs over prescription payment
4 rates and dispensing fees. Long-term care pharmacies also
5 use GPOs to help them aggregate their purchasing power when
6 they buy drugs from manufacturers and wholesalers. Part D
7 plan sponsors negotiate with brand manufacturers for
8 rebates in return for preferred placement on the plan's
9 formulary.
10 Let me quickly review how enrollment and cost
11 sharing work under Part D for long-term care residents.
12 Beneficiaries who are dually eligible for Medicaid, as well
13 as others who receive Part D's low-income subsidy, are
14 auto-enrolled into a qualifying Part D plan unless they or
15 their family pick a plan themselves. Last September, Eric
16 explained the process CMS uses to set LIS premium
17 benchmarks and determine which plans are qualifying plans.
18 Under Part D, dually eligible enrollees at nursing homes
19 pay no cost sharing, while those at assisted living
20 facilities pay nominal copayments. Other residents without
21 the low-income subsidy may choose to enroll in a Part D
22 plan, and pay the plan's full premiums and cost sharing.

1 While long-term care facilities may educate
2 residents and families about Part D plan options,
3 facilities may not steer beneficiaries into specific Part D
4 plans. You can understand why some facilities might want
5 to do this. Any one facility has beneficiaries who are
6 enrolled across lots of different Part D plans. If, for
7 example, certain plans require more prior authorization for
8 drugs commonly used in long-term care settings than others,
9 a facility might prefer to avoid that plan. However, CMS
10 is trying to prevent conflicts of interest by prohibiting
11 steering. Under Part D regulations, nursing home residents
12 may switch plans once a month.
13 With the help of a contractor, we interviewed 29
14 stakeholders including representatives of nursing homes,
15 beneficiary advocates, plan sponsors, long-term care
16 pharmacies, consulting pharmacists, and so forth.
17 Interviewees did not report major problems with
18 access to medications for beneficiaries living in nursing
19 homes. Cost sharing has not been a barrier because most
20 residents are dually eligible and receive the low-income
21 subsidy, and so they pay no cost sharing. If their drug
22 needs are not met by their plan's formulary, they can

1 switch plans relatively easily. Nevertheless, a few
2 interviewees reported challenges navigating plans'
3 utilization management requirements.
4 Interviewees told us that individuals living at
5 assisted living facilities could benefit from services that
6 long-term care pharmacies provide. State regulations vary,
7 but often assisted living facilities do not provide the
8 same level of services as in nursing homes. Stakeholders
9 said that the clinical acuity of some assisted living
10 facility residents can be similar to that of nursing home
11 residents, and services such as medication regimen reviews
12 and specialized packaging may be important for them.
13 Along the same lines, several stakeholders would
14 like CMS to set standards of payments for pharmacy-at-home
15 services for frail beneficiaries who want to continue
16 living in their communities but need help managing their
17 medications. This model would incorporate services like
18 medication therapy management and convenient packaging,
19 with counseling, to help patients at home or just after a
20 transition to home to reduce medication errors and
21 polypharmacy.
22 Many interviewees told us that they believed Part

1 D plan sponsors include most long-term care pharmacies
2 within their network for two reasons. First, CMS has long-
3 term care pharmacy access standards that plan sponsors must
4 follow. And, second, nursing homes generally use an
5 exclusive contract with one long-term care pharmacy.
6 However, stakeholders from smaller long-term care
7 pharmacies and their GPOs and PSAOs believe that plan
8 sponsors have more leverage than they do, resulting in what
9 they perceive to be inadequate payments. Of course, plan
10 sponsors disagree with this.
11 In 2007, when we first looked at this topic,
12 long-term care pharmacies were negotiating rebates from
13 brand manufacturers separately from Part D plans. However,
14 this time interviewees told us that today long-term care
15 pharmacies do not seem to be negotiating significant
16 rebates.
17 We heard concerns from some interviewees that
18 within Part D, dispensing quality and medication management
19 need greater attention in both nursing homes and assisted
20 living facilities.
21 Medicare requires Part D plans to carry out
22 medication therapy management programs for enrollees who

1 have multiple chronic conditions and take many medications.
2 Several interviewees viewed plans' programs as duplicating
3 the medication reviews that consulting pharmacists conduct
4 for nursing homes.
5 Historically, nursing home residents have been
6 overprescribed antipsychotic drugs, typically on an off-
7 label basis for behavioral issues. Beneficiary advocates
8 still have concerns about antipsychotics dispensed with no
9 diagnosis of a psychosis. Some told us that medication
10 regimen reviews are not sufficiently robust with respect to
11 antipsychotics, and they are concerned that nursing homes
12 that have reduced antipsychotic use did so by substituting
13 other sedating drugs.
14 Because of the nation's opioid epidemic, CMS has
15 taken steps to limit misuse and overuse within Part D.
16 Interviewees reported reduced opioid use in long-term care
17 settings, due in part to CMS' attention and plans'
18 subsequent quantity limits. However, we also heard that
19 the focus on opioid use risks creating problems for
20 adequate pain control in long-term care settings.
21 With respect to Part D plan star ratings,
22 interviewees told us that some of the measures,

1 particularly those that focus on adherence or beneficiary
2 experience, were less relevant or sometimes even
3 inappropriate for the long-term care population.
4 At this point, I'm happy to take your questions
5 and feedback, and we plan to include this material in next
6 year's June report.
7 DR. CHERNEW: Okay. Dana, I think we have a few
8 in the queue, so why don't we get going?
9 MS. KELLEY: Okay. I have David Grabowski first.
10 DR. GRABOWSKI: Great. Thanks. So first of all,
11 Rachel, this is great work. I'm really excited that we're
12 looking at this. I've used those early reports you
13 referenced from MedPAC a lot in my research, and so it's
14 definitely time to revisit this issue.
15 My question really comes to the issue you raised
16 around negotiating the dispensing fees, and in the chapter
17 you talked about both the long-term care pharmacies and the
18 plans telling you the other side had leverage. And maybe
19 that's always to be expected in these kind of reports or
20 stakeholder interviews. But on page 19, you wrote, "It's
21 not uncommon to hear from the GPOs that plans have all the
22 leverage in negotiations," and then on page 20, a plan

1 respondent said to you, "The long-term care pharmacies
2 bring a lot of leverage to the table."
3 Do we have any data on this? And that's my first
4 question. I have a follow-up as well, but I found this --
5 I don't know. It wasn't very satisfying, and maybe that's
6 why we're going to have to leave it because this is
7 stakeholder interviews. But I think, Rachel, it would be
8 nice -- and maybe there is a data source we can sort of
9 bring to bear on that.
10 DR. SCHMIDT: So you are right, this is kind of a
11 first crack. It was mostly doing the stakeholder interview
12 approach, but there are a lot of claims obviously behind
13 all this, and it would be possible to try and take a look
14 at things like average dispensing fee and that sort of
15 thing.
16 I think there's going to be a variety of
17 situations. You have a couple of really large long-term
18 care pharmacies, and they're obviously bringing more
19 leverage to the table than the smaller guys. So it's going
20 to be, you know, a complex situation, I imagine.
21 DR. GRABOWSKI: I appreciate that, and the second
22 question that's related to that answer is just the vertical

1 integration here, and I want to come back to that in Round
2 2. But how do we think about these dispensing fees in, you
3 know, the kind of big two long-term care pharmacies are
4 vertically integrated? I guess you just said this, that
5 the big guys have a lot of leverage, but the big guys are
6 also the players that are vertically integrated. So it's
7 beyond just being big. They're integrated. So any
8 thoughts there? And I'll come back to that point.
9 DR. CASALINO: David, when you say "vertically
10 integrated," what do you mean?
11 DR. GRABOWSKI: Yeah, so I was going to talk
12 more, and Rachel could answer that, but Omnicare, the
13 largest pharmacy, is vertically integrated with CVS Health.
14 PharMerica, which is the second largest long-term care
15 pharmacy, is connected to Walgreens, Boots. So there's
16 definitely -- Larry, these are not stand-alone entities.
17 DR. SCHMIDT: So as we've talked about more
18 broadly with vertical integration, it's kind of hard to get
19 a lot of visibility into what happens in those
20 relationships, right? And we can look at things like
21 dispensing fees and claims data and that sort of thing.
22 But in terms of other transactional fees and transfer

1 prices, we're not going to have much visibility into that.
2 So it's not a very satisfying answer. I'm sorry, David.
3 But, yes, you do have this one very large organization that
4 is extremely vertically integrated, and we can try and take
5 a look at it, but I'm a little skeptical about how much
6 detail we'd be able to find, frankly.
7 DR. GRABOWSKI: Great. Thanks, Rachel. Once
8 again, great work, and I'll follow up in Round 2 here with
9 some further thoughts. Thanks.
10 MS. KELLEY: Marge, did you have a Round 1
11 question?
12 MS. MARJORIE GINSBURG: Yes, I do. I have one
13 question and one suggestion. My question is on page 10,
14 Table 2, where MA enrollees, the cost of MA enrollees is
15 significantly less in Part D spending. And is that just
16 because the MA plans negotiate the drug prices so
17 successfully? Or is there some other reason why it's so
18 much less?
19 Let me go ahead and give my other suggestion,
20 which is on page 15 where we start getting into -- and this
21 is a relatively new field for me in terms of all the
22 organizations. I'm very visual. If there's any way that

1 you can take this text box and convert it into an org chart
2 so we can actually see how these different entities relate
3 and when and that sort of thing, that would be great.
4 So, anyway, that's it -- one question, one
5 comment. Thank you. Great report.
6 DR. SCHMIDT: So in terms of your question, I
7 think you're looking at the table that has the aggregate
8 amount of spending, right?
9 MS. MARJORIE GINSBURG: Yes.
10 DR. SCHMIDT: So it's mostly just a function of
11 there are fewer enrollees in Medicare Advantage plans. The
12 majority of the folks in nursing homes and in assisted
13 living facilities for which we have claims are in stand-
14 alone prescription drug plans and, therefore, in fee-for-
15 service Medicare.
16 MS. MARJORIE GINSBURG: Oh. So this is just
17 about the numbers. It has nothing to do with the average -
18 -
19 DR. SCHMIDT: Right, it's cost per person.
20 MS. MARJORIE GINSBURG: Okay. Got it. Thanks.
21 DR. CHERNEW: I think that was the end of the
22 Round 1 queue. Is that right, Dana?

1 MS. KELLEY: Yes, that's correct.
2 DR. CHERNEW: I think David is going to be the
3 first one in Round 2, and given he foreshadowed -- oh,
4 Bruce is jumping into Round 1, late-breaking. So, Bruce,
5 why don't you ask your question? But, Rachel, I think it
6 might be useful, in anticipation of what David might say,
7 to go back to your graphic about how the money flows. I
8 think that's going to help people think through exactly
9 what the vertical integration looks like on that picture.
10 But maybe Bruce is going to take us in a completely
11 different direction, so Bruce.
12 MR. PYENSON: I'll just say a couple of technical
13 issues. One is that another long-term care setting is
14 group homes, and I'm wondering if that's -- if you've
15 thought about adding that to the analysis. That's one
16 question.
17 The next question, which might be a question for
18 Carol Carter, is that there has been enormous consolidation
19 of the nursing home industry, but it has proved to be in
20 the past remarkably difficult to understand that. I'm
21 wondering if there's any opportunity to bring that into
22 this work.

1 DR. SCHMIDT: Okay. On the group home question,
2 we did -- there's a code that pharmacists are supposed to
3 fill out on Part D claims, and I did look at the group home
4 one. It was a relatively small share of the claims, so for
5 purposes of this exercise, I did not include it. But we
6 could go back and include it in the analysis.
7 I don't know if other colleagues want to jump in
8 on your second question, but when we were doing the private
9 equity work, I think we found that it's kind of difficult
10 to identify common ownership across some of these nursing
11 homes. And so I'm not sure the degree to which we could
12 identify the common owners.
13 DR. CARTER: Yeah, and the only thing I would add
14 is that some of the consolidation has still been in pretty
15 small and regional operators, and to the extent -- I don't
16 know how they contract with large or small companies to
17 manage the drug benefit, but that would play in as well.
18 We don't know how much consolidation, and the consolidation
19 that we see tends to be in the smaller operators.
20 [Pause.]
21 MS. KELLEY: Mike, we can't hear you. You're on
22 mute.

1 DR. CHERNEW: Oh, sorry. I'm going to ask a
2 Round 1 question, but I think it's intended to lead into
3 what I think David's going to ask about. On this slide,
4 under the GPO/PSAO icon, you note that they negotiate
5 purchase discount payment rates and dispensing fees on
6 behalf of the long-term care pharmacy. From the picture,
7 it looks like they're negotiating with the plan sponsors.
8 Is that essentially correct? Or are they also negotiating
9 with, say, brand drug manufacturers, for example, or
10 negotiating with wholesalers? I'm just trying to make sure
11 I got all the lines right. There's a lot of people on here
12 if you just get drugs from a drug manufacturer to a nursing
13 home resident. I just want to make sure I know who's
14 negotiating with whom for what and what their leverage is
15 in that negotiation.
16 DR. SCHMIDT: Right, and, you know, in
17 retrospect, I wish I would have changed the title, because
18 it's not really flow of funds; it's flow of drugs as well.
19 We were trying to avoid too many lines on the diagram. But
20 the GPO is essentially helping the smaller long-term care
21 pharmacies negotiate acquisition of drugs, and often they
22 have a PSAO arm that is negotiating with the plan sponsors

1 and the PBMs for the contract to be a network provider and
2 also dispensing fees and payment rates from the plan.
3 I don't know if that helps clarify things.
4 DR. CHERNEW: I'm going to ask again for a
5 second. So they're negotiating with the plan sponsors
6 because they want to be a network provider, if you will, so
7 they basically need to lower their dispensing fees to
8 attract the plan sponsors. That's sort of part of it.
9 You also mentioned, though, they're negotiating
10 for drug acquisition. I believe that's going a different
11 place on this. That's negotiating with the wholesalers or
12 the brand -- who are they negotiating with to get the
13 acquisition of the drug?
14 DR. SCHMIDT: In most cases, wholesalers. It's
15 mostly generics being dispensed in terms of the dollar
16 value. So a whole lot of this is -- you're right. There
17 should be an arrow to the wholesalers and to the brand --
18 but there's some negotiation with brand manufacturers as
19 well. But it doesn't seem to be for rebates. That
20 negotiation just seems to be between the plan sponsors and
21 the manufacturers.
22 DR. CHERNEW: Right, and I guess the challenge I

1 would have is that this again is -- when the long-term care
2 pharmacy says, you know, to a wholesaler, "I want lower
3 prices to get the drugs," if the wholesaler said no, they
4 could buy the generic somewhere else, because it's a
5 generic. Is that the basic -- there's multiple
6 wholesalers.
7 DR. SCHMIDT: Right.
8 DR. CHERNEW: I got it. Okay. So I think David
9 was number one in the queue. If no one else is jumping in,
10 I think -- I'm going to defer to Dana Kelley, but is that
11 right, Dana?
12 MS. KELLEY: Yes, that's right.
13 DR. CHERNEW: Okay, David.
14 DR. GRABOWSKI: Great. Thanks, Mike. And once
15 again, Rachel, I really enjoyed this chapter. Great work.
16 I want to start with this issue -- and I think I
17 touched on it in Round 1 -- around horizontal and vertical
18 consolidation. I think it's something you want to draw out
19 more in the chapter. I know it's there, but I really think
20 it's a central part of thinking about long-term care
21 pharmacies. The largest long-term care pharmacy, Omnicare,
22 accounts for about a third of the market; the second is

1 about 13 percent, and the third is about 2 percent. So
2 that's about half the market in terms of horizontal
3 integration.
4 That sounds like, well, there's the other 50
5 percent of the market, but as Rachel's diagram here shows,
6 those GPOs and PSAOs, they actually help sort of
7 consolidate that part of the market. It's really dominated
8 by three large organizations. So the market is more
9 consolidated, even on the GPO and PSAO side.
10 And then in terms of the vertical consolidation,
11 Larry already pushed me on this point, but Omnicare, once
12 again the largest long-term care pharmacy, was acquired in
13 2015 by CVS Health. I don't think I need to explain what
14 CVS Health is. And then in 2017, PharMerica, the second
15 largest long-term care pharmacy, was acquired by a
16 partnership between a private equity firm and an affiliate
17 of Walgreens, Boots Alliance.
18 So we have, you know, both horizontal and
19 vertical consolidation, and, Rachel, what I would encourage
20 you in the chapter is, is there a way to think through --
21 maybe we don't yet have the data on this, but what are the
22 implications of this consolidation for patient outcomes?

1 What are the implications potentially for Medicare
2 expenditures, you know, in thinking through this?
3 It may be early to speculate on that. I
4 appreciate dispensing fees and other data could help maybe
5 shine more light on this. But at least in the short term,
6 could we at least add some text potentially drawing some of
7 these issues out, recognizing how this market is
8 structured.
9 The second point I really wanted to raise is
10 long-term care pharmacies are often kind of pushed as a way
11 of sort of quality control. I have a series of papers. I
12 imagine Stacie has done some work on this topic as well.
13 Quality issues are rampant in terms of medications in long-
14 term care settings. The chapter mentioned polypharmacy.
15 There was a recent New York Times piece many of you
16 probably saw on overuse and misuse of antipsychotics. This
17 is especially true for individuals -- long-stay residents
18 with dementia. Pain management has often been found to be
19 inadequate. Medication management more generally has been
20 fairly poor.
21 And so something else -- and once again you raise
22 it in the chapter, Rachel, but is there a way to kind of

1 make this point more directly? I think you heard it from
2 some of the stakeholders, but why aren't long-term care
3 pharmacies doing a better job of sort of ensuring quality
4 in terms of medications in this area? Obviously, it's
5 potentially more complicated than that. They have a role.
6 So do the other players here, including the nursing homes.
7 But I think we can -- when I was reading it, I felt like
8 that issue didn't receive enough attention.
9 A final point, and I was really interested -- I
10 hadn't ever really thought of this model that you heard
11 from the stakeholders around pharmacy-at-home, basically
12 taking the long-term care pharmacy model and bringing it
13 into the community. And I get bringing long-term care
14 pharmacies into assisted living. Bruce mentioned group
15 homes. Those sound like logical next steps. The pharmacy-
16 at-home model sounded like a big step to me. I would want
17 to think more about how we tie this more generally to our
18 work on Part D, access to medications for community-
19 dwelling elders. Are long-term care type pharmacies the
20 right model for individuals who are receiving long-term
21 care in a home or community-based setting? I don't know
22 the answer to that, but these kind of models make a lot of

1 sense. And I'll just -- you know, assisted living right
2 now, you know, even thinking about this in the context of
3 COVID, you know, think about the booster shots. We have
4 the long-term care pharmacies. That's an easy roll-out in
5 nursing homes. It's much more complicated in assisted
6 living. It's kind of non-existent in the community.
7 We have a lot of issues with access to -- you
8 know, in terms of Part D in the community potentially. I
9 just don't know if pharmacy-at-home is the next step. And
10 that was kind of -- I know you heard that from the
11 stakeholders, and that received a lot of attention in the
12 sort of concluding section of the chapter. I think we want
13 to be a little more cautious about that model. And I know
14 this was just reporting what the stakeholders told you, but
15 I don't know that that's the next place.
16 I'll stop there. Once again, great work, and I
17 look forward to continued kind of research on this topic.
18 Thanks.
19 MS. KELLEY: Stacie.
20 DR. DUSETZINA: Thank you, Rachel. This is a
21 really great chapter, and it's a throwback to my postdoc
22 days which is kind of the last time I spent much time

1 thinking about nursing home and Part D.

2 Surprisingly, I don't want to talk about the
3 figure that Mike had us look at before, despite my interest
4 in general flow of funds like that.

5 I wanted to bring up two things that I think are
6 really worth maybe thinking about how do we get better at
7 this, and you bring up both in the chapter. One is the
8 issue pain management and how absolutely critical that is.
9 So, you know, I think the nursing home residents, this is a
10 place where we have dramatically overcorrect and are
11 probably causing harm to people for appropriate pain
12 management because of rules that make sense for people who
13 are in the community, that maybe don't make as much sense
14 when someone is being served by, you know, a pharmacy in-
15 house who is really strictly controlling how much
16 medication is available to a person at a given time.

17 So it would be nice to think about, you know, how
18 do we move towards a space where some of those restrictions
19 on, you know, maybe it's quantity limits or other things
20 that are creating problems, can be resolved for business in
21 this setting.

22 The other is kind of related, around the issue of

1 quality measures, and I couldn't agree more that, you know,
2 like penalizing plans because of lower adherence to things
3 that we actually don't think that people should necessarily
4 be using. So maybe we want to discontinue statins or we
5 want to discontinue other medications to lower the burden
6 of polypharmacy. And so having the same sets of measures
7 for people who are in the nursing home versus outside and
8 same set of rules maybe doesn't make a lot of sense.
9 So I think, in general, what this chapter had me
10 thinking was, you know, should there be a population-
11 specific set of measures that we really take into account
12 for what does quality look like, should we add measures of
13 adequacy of pain management, or use of antipsychotics,
14 which has been a long-term problem, but really would get at
15 more of the issues we are most concerned about for nursing
16 home residents, and not accidentally penalize people for
17 doing the things that we would consider good care.
18 But thank you very much. This is really
19 excellent work, and I'm excited to see this chapter
20 developing.
21 MS. KELLEY: Betty.
22 DR. RAMBUR: Well, thank you so much. This was

1 an absolute education for me, and I just wanted to say
2 thank you so much. It was fascinating. And I just wanted
3 to embellish on a point that was made about the inadequate
4 staffing leading to unnecessary prescribing or
5 inappropriate medications. David just talked about overuse
6 and misuse, and Stacie about underuse.
7 This absolutely resonates with my own experience
8 as a nurse and as an educator, and I'm again struck how the
9 tentacles of the nation's underinvestment in workforce is
10 laced through everything we do and talk about. It's laced
11 through this, it's laced through the things we talked about
12 yesterday. And I know that that's not a foreground piece
13 in this, but I am really concerned and wondering who is
14 going to be thinking about the development of the nation's
15 workforce.
16 In the end, so much of this is all about people.
17 So I know it's a bit of a tangent -- well, not a tangent.
18 It's easy to forget about the working surface, and Medicare
19 certainly has invested in preparing the physician
20 workforce. At one time it did a lot in the nursing
21 workforce, but who is actually thinking about workforce
22 development? So I don't know where that goes in a parking

1 lot, but I think it's an important consideration.

2 Anyway, thank you for the brilliant information,

3 and I look forward to hearing what comes next.

4 MS. KELLEY: Brian.

5 DR. DeBUSK: Yes. Thank you. Thanks to staff

6 for an excellent chapter. I wanted to first of all echo

7 some of David's earlier comments about learning more about

8 vertical integration and how some of these relationships

9 are arranged.

10 You know, just as a specific, what does even

11 having a risk corridor in the Part D plan mean when the

12 plan also owns the pharmacy, the wholesaler, the PBM, and

13 the GPO? So understanding those interworkings, what

14 transactions, if any, have to be arm's length, is there

15 really any governance, or are there regulations around how

16 some of these interactions have to be done?

17 The other thing I'm really interested in is,

18 especially with the new rebate data that we've gotten, do

19 we better understand how drugs are tied together, number

20 one, through manufacturers' rebates. You know, do we see

21 examples where Drug A is linked to Drug B. And also, I

22 want to understand the role that these curated generic

1 formularies play. I know all of the wholesalers have
2 basically their own set of preferred generics, and it's my
3 understanding that they tie, for example, the markups to
4 the individual pharmacy's participation in those generic
5 formularies. And any transparency there, any insight or
6 understanding would be greatly appreciated.
7 But again, thank you for a very interesting
8 chapter.
9 MS. KELLEY: Pat.
10 MS. WANG: Thanks. I just wanted to pick up on
11 David's comment about long-term care at home, to suggest
12 additional areas of exploration going forward. Because
13 with the increasing emphasis and value placed on home and
14 community-based services I suspect that there has already
15 started to be a shift, at least in regions of the country,
16 where Medicaid programs have invested in HCBS to keep folks
17 who might otherwise have met criteria for nursing facility
18 admission at home, with aides and support to the extent, to
19 Betty's very good point, that the workforce is in deep
20 shortage right now.
21 To the extent that folks who might have been in
22 nursing facilities in the past are increasingly going to be

1 at home, they might be more likely to be enrolled in some
2 sort of managed care program, whether sponsored by Medicaid
3 or if they're duals, the fully integrated dual-eligible SNP
4 programs, you know, similar to the MMPs, the demos of the
5 Medicare and Medicaid programs for folks who meet long-term
6 care criteria.
7 If that's the case, then I think that there could
8 be some sort of inventory, I guess, of the sorts of
9 requirements that those payers are placing on those
10 responsible for managing the care, at least of folks who
11 are eligible for government coverage. You know, I can tell
12 you my experience. There are specific requirements, and
13 the quality metrics would reflect some of the issues that
14 were raised here and of concern.
15 I think that the other implication of this, and,
16 you know, maybe this is longer term, and David would know
17 this better than anybody, is whether we do expect a shift
18 in the type of resident who is going to be in long-term
19 care living in a nursing facility. From what I have seen,
20 this is going to tend to be folks who cannot be safely
21 cared for at home any longer and who might have quite a bit
22 of home support, but, you know, because of dementia,

1 Alzheimer's, things of that nature, really are not safe at
2 home, they are finally going into a nursing facility, you
3 know, and families get involved, and so forth and so on.
4 I just wonder whether longer term, we should keep
5 a focus on the needs of what is going to become the more
6 intensive nursing facility population. I don't know if
7 we've seen these trends, but there's so much emphasis, at
8 least in my state, on trying to keep people home, where
9 they can stay home. It is going to shift who winds up in a
10 nursing facility and has different implications for who is
11 keeping an eye on medication management and other things.
12 DR. GRABOWSKI: Really quickly, Mike and Dana, on
13 this, just because Pat called me out there, on this.
14 You're exactly right, Pat, and we have seen that trend
15 nationally. Acuity is increasing, and Rachel even
16 mentioned this in the chapter, that in assisted living
17 we've seen a similar trend, as individuals who were
18 previously in nursing homes are now in assisted living, and
19 the whole continuum has shifted. So we're going to see
20 greater medication needs, not just in assisted living but
21 also out there in the community.
22 And so I definitely think it should be a MedPAC

1 area of focus. It's an open question to me as to whether
2 long-term care pharmacies are the right answer for that
3 population, or whether it's something that can be managed
4 through a standard pharmacy.
5 MS. WANG: Yeah, and if I might, just on that
6 point, to the extent that there is some sort of capitated
7 organization who is responsible for organizing that care,
8 you would expect those care managers, those pharmacy techs,
9 and those medical directors to be keeping an eye on what's
10 going on with the member at home.
11 MS. KELLEY: Bruce.
12 MR. PYENSON: Thank you. Terrific chapter.
13 There are a couple of items that are database explorations
14 I'd like to suggest. I'm not sure if we have the resources
15 or time to do them for the June chapter. But one item that
16 historically has been a challenge for Part D plans has been
17 the transcriptional scripts of people in long-term care,
18 because transitional scripts were a drug that's not on
19 formulary or fell off formulary or was being used by a
20 beneficiary before switching plans, is much more generous
21 for people in nursing homes than for people not in nursing
22 homes. And this has been a significant issue in the past.

1 It has been a significant issue for Part D plans. And I
2 think that might be something worth evaluating. I believe
3 you can find those in the PDE information.
4 DR. SCHMIDT: Can I respond, Bruce, because we
5 actually asked about that in our stakeholder interviews. I
6 think that you've raised the issue before, which caught our
7 eye. And among the stakeholders -- well, first of all,
8 there's been a change in the policy. It used to be that
9 folks in nursing homes would get a 90-day supply, and
10 that's been reduced to a 30-day supply. So that may
11 address some of the problems that you've seen in past
12 years, or it may still be playing out. I don't know fully.
13 But when we asked stakeholders as to whether this
14 has been kind of a way of gaming to get around plan
15 sponsors' formularies, we didn't hear much in the way of
16 yesses from the stakeholders. We can continue to monitor
17 the issue.
18 MR. PYENSON: Thank you. I appreciate your
19 comment on that. Another question I have is whether
20 there's concentration of particular Part D plans, LIS
21 plans. It seems unusual that we're in an era of active
22 campaigns by enrollment brokers and others, and I think it

1 would be fairly easy to look in the data, even though we
2 can't quite capture the horizontal consolidation of nursing
3 homes, but within some of the larger ones, whether we see
4 clustering.
5 Some of the issues, I think, that have been
6 raised are part of the MDS reporting, and I think it might
7 be helpful to talk about the relevance, perhaps strengths
8 or weaknesses, but just the existence of the minimum data
9 set and how may or may not address some of the quality
10 issues that you and others have identified.
11 And finally, the Part B drug issue might be very
12 interesting. It might relate to some of the same long-term
13 care pharmacies. I would not, in particular, there appears
14 to be the emergency of very long-acting antipsychotic drugs
15 that would probably fall under Part B. So understanding
16 how that interacts with the long-term care pharmacies, if
17 it does, might be helpful information.
18 Thank you. I know maybe all of these are not in
19 scope for June, but I really appreciate the chapter.
20 MS. KELLEY: Amol.
21 DR. NAVATHE: Thanks. So I want to make a
22 comment and then I had a quick question as well. My

1 comment is really just echoing Stacie's point that I think
2 it would be nice to see how we could support additional
3 quality metrics, or even revisions to the quality metrics,
4 to be more suited to these settings relative to the sort of
5 general Part D beneficiary. Some of the pieces around
6 antipsychotic use, opioid use, et cetera, I think could be,
7 at least in part, addressed, or included in how we think
8 about quality.
9 The second point is a question which is, so it
10 seems like relative to, you know, standard Part D here
11 there might be opportunities for multiple organizations
12 that are negotiating with the basic manufacturers, namely
13 here the long-term care pharmacies. So Rachel, I was just
14 curious, in the rebate data that we have, that we at MedPAC
15 have received, is that also covered and/or are there
16 reasons to believe that the types of medications that may
17 be disproportionately used in these facilities, is there
18 sort of a differing strategy for the manufacturers on the
19 rebates and/or for the plan sponsors?
20 DR. SCHMIDT: So in terms of the data that we
21 have, it's what plans are reporting to CMS that they are
22 receiving from manufacturers. The plans should be

1 knowledgeable if their long-term care pharmacies are also
2 getting rebates, but I don't know for certain that is the
3 case. If they're aware, they're supposed to be reporting,
4 I believe, and I don't know what's in there yet. We're
5 still kind of getting that underway.
6 I'm sorry. Remind me of the second question, the
7 second part of that?
8 DR. NAVATHE: My second question is so clinically
9 my hypothesis would be that there's different medications
10 that tend to disproportionately get used in this facility
11 setting, and so are we likely to see -- would you
12 hypothesize that there would be different rebates,
13 basically, from a strategy perspective, from either
14 manufacturers or plan sponsor?
15 DR. SCHMIDT: We're definitely seeing, I think as
16 I said before, mostly generic use. I mean, in terms of the
17 quantity of prescriptions dispensed there are a lot of
18 brand-name drugs, but they tend to be smaller, lower-priced
19 brand-name drugs relative to Part D enrollees as a whole.
20 So it may be the case that it's not the drugs for which
21 there are large rebates associated. There's also less
22 dispensing of specialty drugs in the long-term care

1 setting. Many of those do not necessarily have large
2 rebates, but some do.
3 I don't know if that helps answer your question.
4 DR. NAVATHE: Yep. No, it does. Thank you.
5 MS. KELLEY: Mike, that's it.
6 DR. CHERNEW: That's what I was going to ask
7 about. Wonderful. I will pause, as always, to see if
8 anyone wants to add anything.
9 [Pause.]
10 DR. CHERNEW: Okay. Hearing no comments, I think
11 I'll summarize this briefly. First point is there, I
12 think, unanimous interest on the part of all of you to
13 understand how the quality of care is working in long-term
14 care facilities and the prescription drug aspect of that is
15 just one part of it, but I think that interest transcends
16 that. Certainly there are probably measures related to use
17 of drugs, diagnosis of conditions for which there are
18 effective drug treatments, and how the market around that
19 works.
20 One of the things, I think Stacie [inaudible]
21 matters [inaudible] assessment for quality measures may not
22 all be appropriate in the context of different types of

1 care for different types of patients, and I think we need
2 to think through that.
3 That general theme, I think, dovetails with, I
4 think, some of the points [inaudible] was mentioning, and
5 it came up in Brian's comments, and it was clear in that
6 picture that you showed, Rachel, that I asked you to put
7 up, which is this is a very complicated market. We're
8 trying to do something relatively simple, which is getting
9 drugs from a manufacturer to a beneficiary, and there a
10 number of different steps that both the money and the drugs
11 flow through in order to get there, and there are payment
12 issues in a whole range of different junctures in that
13 space. And when the different organizations have complex
14 ownership relationships it makes understanding those
15 junctures difficult, even if we had all the information,
16 which, by the way, we don't always have.
17 So that is my way of saying that I think, Rachel,
18 there's widespread appreciation for the work you've done
19 here. I think it fits well into the type of stuff that
20 MedPAC looks into. I think it emphasizes our willingness
21 to do both quantitative and qualitative work, to get a
22 sense of what industry stakeholders think is going on in a

1 range of places. This is certainly a place that is
2 complicated enough that we need both the quantitative and
3 qualitative work.
4 So I will just close by adding my thank you for
5 all of this work, and thank you to the Commissioners for
6 all of their related comments.
7 Again, one more pause before I say goodbye for
8 the month.
9 [Pause.]
10 DR. CHERNEW: All right. Hearing no other
11 comments, let me thank all of you for the time you spent
12 this month. I thought we had a set of really interesting
13 and important discussions. I, of course, as always, will
14 follow up with Jim, and we will circle back as each of
15 these chapters moves to the next phase.
16 In the meantime, I wish you all a healthy and
17 happy thanksgiving, and we will see you all again in
18 December. So thank you.
19 Jim, do you have anything to add?
20 Oh, actually, sorry. Before you all go, to the
21 public, if you have comments on any of the topics today
22 please reach out to us at meetingcomments@medpac.gov. I

1 almost missed that.
2 So we are grateful to all of you that could join
3 us. You also should have a healthy and happy Thanksgiving.
4 Please reach out to us. And again, thank you, and we'll
5 see you all in December.
6 [Whereupon, at 12:24 p.m., the Commission was
7 adjourned.]
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