MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

VIA GoToWebinar

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P R O C E E D I N G S

[10:17 a.m.]

DR. CHERNEW: Hello. Thank you for everybody who is joining us online. This is the March MedPAC meeting. As I'm sure you know, we are coming towards the end of our annual MedPAC cycle, which means we have a lot of work to do this meeting, and so without further ado, we're going to jump into an issue that is important, I think, for all the Commissioners, which is access to care in rural areas. And to present the material, I am going to turn it over to Carolyn. Carolyn, you're up.

MS. SAN SOUCIE: Thank you, Mike. Good morning.

In this presentation, we'll discuss our work towards fulfilling a congressional request to study rural beneficiaries' access to care. Before I begin, I'd like to thank Alison Binkowski and Evan Christman for their assistance with this work.

Also, the audience can download a PDF version of these slides in the handout section of the control panel on the right-hand side of the screen.

The House Committee on Ways and Means submitted a bipartisan request for the Commission to update its June

2012 report on rural beneficiaries' access to care.

The committee also requested information on beneficiaries who are dually eligible for Medicare and Medicaid, reside in a medically underserved area, or have multiple chronic conditions as well as emerging issues that could affect beneficiaries' access to care. We'll come back to you in our next analytic cycle with more information on the specific groups of beneficiaries outlined and any additional, related issues.

An interim report is due in June 2021, and a final report is due in June 2022.

We have four parts to our presentation today. In the first part, I'll go over direct measures of rural beneficiaries' access to care.

We analyzed two sources of survey data for direct measures of access to care to supplement the information from claims data we will go over later in the presentation.

First, we used survey data from the MCBS, which suggests that rural and urban beneficiaries have similar satisfaction with access to care. The Commission's analysis of 2018 MCBS data found no substantive differences for several measures of rural and urban beneficiaries'

access to care, including identical rates of satisfaction with care, trouble accessing care, and forgoing care.

Additionally, the Commission's annual survey of Medicare beneficiaries suggests that rural and urban beneficiaries have similar satisfaction with access to care as well. A similar number of rural and urban beneficiaries reported never having to wait longer than they wanted for an appointment for illness and injury care.

While data suggest similar overall satisfaction, some differences do exist, and those differences tend to increase as rurality increases. Based on 2018 MCBS data, most rural beneficiaries are satisfied with their ease of getting to care, but a slightly larger share than urban beneficiaries were dissatisfied with the ease of getting to the doctor from their home, access to medical care on nights and weekends, and availability of specialist care. The higher levels of dissatisfaction may partially be due to the need to travel farther to access care, especially to receive specialty care.

Now we'll move on to analyses comparing utilization trends of rural and urban beneficiaries across several types of services.

Before we begin discussing information from our analyses of Medicare claims, I wanted to reiterate a subject from our November meeting. As discussed then, the utilization data we present are not risk adjusted nor were they risk adjusted for our 2012 report.

Using claims data to risk adjust our utilization analyses may create misleading results.

For example, MCBS data suggest that rural beneficiaries are slightly less healthy than their urban counterparts as a higher share of rural beneficiaries reported that their health was "fair" or "poor" in 2018. This finding is consistent with other research that found that, compared with their urban peers, rural beneficiaries have slightly lower life expectancy and have higher rates of smoking, lung cancer, and obesity.

However, rural beneficiaries have lower average risk scores than urban beneficiaries, which in theory would imply that they are healthier. This discrepancy leads us to believe that risk adjusting our beneficiary utilization using comorbidities from claims or risk scores could produce misleading results that suggest rural beneficiaries are in less need of care.

Now I'll walk through some of the results of our unadjusted numbers.

First, I will go over some of the results we presented to you in the fall.

Across our utilization analyses, we found that differences in utilization across geographic regions of the country were generally far larger than differences between rural and urban beneficiaries within the same region. However, we did notice a few larger trends as well.

Rural beneficiaries had similar inpatient use and higher outpatient use per capita compared with urban beneficiaries in 2018.

Rural beneficiaries had fewer E&M encounters than urban beneficiaries in 2018 driven mostly by fewer encounters with specialist physicians. By contrast, most rural beneficiaries had a similar number of primary care E&M encounters compared with urban beneficiaries.

Now Brian will go over the E&M data in closer detail with a focus on a new analysis we conducted, one which looked at utilization rates among frontier beneficiaries.

MR. O'DONNELL: In response to Commissioner

feedback in the fall, we refined our rural categories to include a frontier category. A handful of frontier analyses are included in your mailing materials, and I'll walk through this slide to demonstrate the issues associated with those analyses.

As you can see in the table, in 2018, urban beneficiaries averaged 13.4 E&M encounters with clinicians compared with 9.0 for frontier beneficiaries.

However, frontier beneficiaries are a small and distinct group of beneficiaries, and at least three factors complicate the interpretation of their service use. First, frontier beneficiaries disproportionately live in low-use states such as Montana and Wyoming. For clinician services, we found that state-level geographic variation explains nearly half the difference between urban and frontier beneficiaries. Second, frontier beneficiaries appear to be slightly healthier than other beneficiaries. And, third, frontier beneficiaries travel much farther to access specialty care, so they may choose to visit specialists less frequently or condense more issues into a single visit.

Looking further into the issue of travel

distance, in 2018 we found that the median distance an urban beneficiary traveled for an E&M visit with a specialist was 9 miles compared with 26 miles to 58 miles among rural beneficiaries. The difference between rural and urban beneficiaries for visits with primary care physicians was much smaller and, after accounting for travel time, could be negligible.

In addition to hospital and clinician services, we also examined two types of post-acute care: SNF and home health care.

We found that rural beneficiaries' use of SNF and home health care services per beneficiary was similar to or slightly higher than urban beneficiaries' rates.

From 2008 to 2018, SNF use declined among both rural and urban beneficiaries, although it declined about twice as fast among urban beneficiaries. Home health use over the same time period was relatively flat.

For both SNF and home health, geographic variation was larger than differences between rural and urban beneficiaries. For example, after trimming outliers, we found that SNF use among rural beneficiaries varied three-fold across states, and home health use varied eight-

fold.

Our next section focuses on the topic of rural hospital closures. The closure of a rural hospital can have a significant impact on access, given the central role they often play in delivering care in rural communities. Because of that, we carefully track the trends in rural hospital closures each year and have found that closures have increased in recent years.

So to better understand the causes and effects of rural closures, we analyzed a cohort of hospitals that closed between 2015 and 2019.

Among our cohort of recently closed hospitals, we found dramatic declines in inpatient admissions in the decade prior to closure. For example, from 2005 to 2014, all-payer admissions fell by 53 percent and Medicare admissions fell by 61 percent.

These large declines left our cohort of hospitals with an average of only 1.3 all-payer admissions per day prior to closure.

Most of the decline in admissions was due to beneficiaries bypassing their local hospital for inpatient care. This finding was consistently echoed in our

conversations with stakeholders from rural communities that recently experienced a hospital closure.

In contrast to our inpatient findings, we found that rural hospitals continued to be an important source of emergency and outpatient care prior to closure. Emergency department volume increased, and overall hospital outpatient volume declined slightly in the years prior to closure. This suggests that the loss of the hospital emergency department may have caused larger disruptions in access to care than the loss of inpatient services.

Now I'll switch gears a bit to discuss what happens after a rural hospital closes.

To study the effects among a group of hospitals that closed from 2015 to 2017, we conducted two analyses.

First, as seen in the two right-hand columns in the table, we analyzed changes in service use shortly before and after closures among beneficiaries who lived in rural markets with and without a closure.

We found that hospital service use declined faster in rural markets with a closure than rural markets without a closure. For example, inpatient admissions declined by an average of 1.4 percent per year in markets

with a closure compared with an average decline of 0.8 percent per year in rural markets without a closure.

However, in our second analysis, in the left-hand side columns on the table, we found that hospital volume was declining faster in the "closure" markets well before the closures occurred. This suggests that factors other than hospital closures may have affected service use.

In addition, some of the volume declines among hospital outpatient services may represent shifts to other settings.

To examine whether hospital outpatient volume shifted to other settings after a closure, we analyzed changes in E&M encounters with clinicians--across all settings--before and after closures among beneficiaries who lived in rural markets with and without a closure.

From 2014 to 2018, E&M encounters per beneficiary increased faster in rural markets with a closure than rural markets without a closure. For example, over that period, we found that E&M encounters at FQHCs increased 11.6 percent per year in markets with a closure compared with 6.7 percent per year in rural markets without a closure.

Similarly, we found that physician fee schedule

E&M office visits increased faster in markets with a closure compared with rural markets without a closure.

These findings suggest that some of the hospital outpatient declines we observed in markets with a closure was due to shifts in the site of care rather than beneficiaries forgoing care.

The last section of our presentation covers a couple changes enacted in legislation that was passed in December 2020 and discusses next steps.

First, the Consolidated Appropriations Act of 2021 created a new class of hospitals referred to as "rural emergency hospitals," or REHs. REHs will not furnish inpatient care and instead will provide 24/7 ED care and may furnish other services. Medicare will pay REHs a monthly payment to help cover fixed costs. In addition, Medicare will pay these hospitals OPPS rates plus a 5 percent add-on for each hospital outpatient service and standard rates for other provider-based services. To become an REH, a critical access hospital or other small rural hospital must have been furnishing care when the Consolidated Appropriations Act was passed.

The creation of REHs is consistent with the

Commission's 2018 recommendation on rural freestanding EDs. In addition, as discussed in the previous slides, rural beneficiaries have increasingly bypassed their local hospitals for inpatient care but continued to rely on them for ED and outpatient care. In that sense, the new REH designation adapts the Medicare program to changes that have already been occurring in the private market for many years and may allow rural hospitals to eliminate low-volume inpatient units while still meeting the needs of their communities.

In an effort to improve access to clinician care in rural areas, the Appropriations Act also substantially increased payment rates for certain rural health clinics. We discuss the details and implications of this change in your mailing materials.

So to summarize our findings, survey and claims data suggest that rural and urban beneficiaries have similar access to care.

Variations in service use across states were often large, but differences between rural and urban beneficiaries tended to be much smaller.

Rural hospital closures could disrupt access to

care, but Congress recently enacted provisions to maintain or improve access to ED and outpatient care in rural areas. These changes are substantial, and combined with other emerging trends, such as the expanded use of telehealth, could substantially bolster rural access to care in the future.

We are seeking Commissioner feedback on our current work and suggestions for the next cycle.

The findings we discussed today will be included in an interim report that is due to the Congress in June 2021. The final report is due in June 2022 and will include the congressionally requested stratifications listed on the slide.

With that, I look forward to your comments, and I turn it back to Mike.

DR. CHERNEW: Great. So thank you. That was really an outstanding presentation on a really important topic, and as the last slide indicates, we are going to continue to look at this area. There's so much going on in the delivery of care that making sure that people across the country, and in this case rural areas, have access to high-quality care is certainly a high MedPAC priority.

I'm going to turn it over to Dana Kelley to manage the queue. I know there is one person who has a Round 1 question. Dana?

MS. KELLEY: Okay. Bruce, I think you're first.

MR. PYENSON: Yes, thank you very much. I really like the report. I've got two questions perhaps for the next cycle of work, but I'll frame them as questions.

One is on the issue of risk scores for rural populations, and you've explained well the instability issue perhaps associated with small numbers or lower coding for a variety of reasons.

In the past, MedPAC has suggested basing risk scores on two years of data or perhaps more, and I'm wondering if in future -- if that's something you've looked at for this purpose or if that's something you could look at in the future if you think that would be worthwhile.

And my second question is on whether it makes sense to evaluate rural hospital closings from the standpoint of Medicare Advantage, whether the network adequacy rules for Medicare Advantage are affected by rural hospital closing or if there's -- if that's not an important consideration.

So, again, the two questions, on two years of codes for risk scoring and the effect of rural hospital closings on Medicare Advantage network adequacy.

DR. STENSLAND: I think we'll consider both those for the next round. I think they're probably both too big to discuss right now.

MR. PYENSON: Thank you.

DR. CHERNEW: There is certainly a lot here, and so I really appreciate the comments, Bruce.

Dana?

MS. KELLEY: Yes. I have Larry with a Round 1 question.

DR. CASALINO: Is there any thought for 2022 of looking at quality of care for patients, beneficiaries in rural areas? I couldn't quite figure out if that was requested by Congress or not, or whether we are planning to do that.

DR. STENSLAND: We --

DR. MATHEWS: Go ahead, Jeff.

DR. STENSLAND: Yeah. We looked at quality of care in the last report, and we are not planning to do it in this report. It does take a lot of time, and it is

controversial, and we thought to keep this manageable we weren't planning on doing that. For example, the last time around we did see higher risk-adjusted mortality at smaller rural hospitals, which is consistent with the volume outcome relationship, but exactly quantifying that again gets difficult to the extent that you think there are two different levels of coding in rural and urban. And so our current plan was not to expand the scope of this to include quality.

DR. CASALINO: Jeff, if I might suggest then, at a minimum, in the report at least to address that, you know, because I think some people will look through the report looking for some mention of quality and whether there has been anything on it or if there are plans to do anything on it. So just kind of stating what you just stated and referring people to the prior report might be useful.

MS. KELLEY: Okay. That's all I had for Round 1, Mike. Did you want to say anything before we move to Round 2?

DR. CHERNEW: No. Well, I don't. I think we should just move to Round 2. I will save my comments until

we get to the wrap-up.

MS. KELLEY: I have Brian first.

DR. DeBUSK: Well, first of all, thank you. I'm really glad that we're taking up this issue. I think rural health care and addressing parity in rural health care is obviously very important. I really enjoyed reading the report, so thank you to the authors.

First of all, I want to echo some of what Bruce was addressing over coding. You know, the coding disparity in rural health care really underscores the need to code all Medicare beneficiaries more completely and more thoroughly. It just struck me, from a larger perspective, what this means is that there are beneficiaries, disproportionately in rural areas, who have clinical conditions, who have medical complexity, that the program isn't even aware of, from a macro level. And so when we talk about population health, and when we talk about some of the things that we want to do, at a macro level, in Medicare, I don't see how we get that done if we don't even know the conditions that are there. So Bruce's comment about using two years of data I think would be an excellent step forward.

I also think that getting rural beneficiaries and all beneficiaries in general in fee-for-service coded more thoroughly also solves a lot of the other issues that we face in Medicare, because when you look at that ratio there is a numerator and a denominator, and when we talk about coding intensity adjustments and things, we tend to focus on the numerator but we forget, if we just bring the denominator up, you will actually get some of that same effect. I mean, you actually created these in coding intensity by simply making sure that the fee-for-service beneficiaries are more properly coded. So it would solve a number of problems.

But I would like to focus, really, on the issue of rural hospitals and rural hospital closures. One request for future work, as you study some of these rural hospitals that close, I would like to learn, did affiliation with the larger system help the hospital or did it actually accelerate the bypassing of the hospital? I think these affiliations are very well-intended, and I think in some cases they are absolutely necessary because the rural hospital has no choice.

But just empirically, my observations are it

seems to actually accelerate the hollowing-out of the hospital and the bypassing, just because those services are seen as attractive or lucrative or that they have the staffing in the urban area to perhaps do those procedures better.

And that really gets me to my final point, which is the bypass issue itself. I am really fascinated with this issue of bypass, because I would argue that a big part of that is staffing. I don't think we have the right geographic mix of physicians, and I think that is one of the huge problems that we are facing. I would love, for future work, for us to look at the rural versus urban beneficiaries and look at their distribution, and then compare that to rural and urban distribution of medical school students or residents, because I think that is terribly out of balance. I don't think it's reasonable to assume that a third-generation doctor doing a residency in dermatology in Nashville is going to be particularly excited about moving to rural Tennessee to perform health care.

So one of my points I would really like to stress is I think we need, in this analysis, to look at are we

producing physicians in the correct proportion to meet rural and urban needs? And if no, I think we should ask the question why, because Medicare is paying the vast majority of these medical education bills, and I can't think of any other aspect of the Medicare program where we simply give, say, a provider money and then tell them to do what they want to do. I mean, we don't go to a hospital and give them funding and say, "Now do the surgeries you want to do." It just doesn't work like that.

So I do hope, as we study the rural challenges, that we make sure that we are looking at workforce issues, particularly around physicians, and that we are educating and training the correct geographic mix of those physicians.

Thank you.

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

MR. PYENSON: Thanks, Dana. Thanks for the chapter, and Brian, for your terrific comments.

I'd like to push Brian's second comment just a notch further, which is I think we need to understand what it is about the relationship between the non-affiliated,

perhaps, rural hospital and larger systems, because I think he is right -- it can work from both directions.

I had the experience, obviously coming from a large health system, speaking the Texas Hospital Association some years ago, and following my comments someone stood up and said, "Let me tell you what your system did to our hospital." Well, I was prepared to say that, oh gosh, just the opposite. She said, "We would not be here without that because the telehealth type of services allowed the patients who needed procedural intervention to be transferred, yet allowed us to retain those patients who could be appropriately supported and cared for in community."

So my point being is that I think Brian is absolutely right. It can be detrimental or it can be helpful. But at the moment that we are given authority for the next level of inquiry, let's determine what it is that stabilizes or destabilizes. Thanks.

MS. KELLEY: Okay. I have Betty next.

DR. RAMBUR: Thank you so much. I appreciated the report.

A couple of comments. I really appreciated the

inclusion of Frontier counties. They are very different than other kinds of rural counties, and even though it is not a lot people, they do very important contributions to this nation in terms of farming, ranching, and oil production. So thank you for that.

I was excited to see the rural emergency hospital piece, so that people could have that Golden Hour to services.

And the issue of the challenge with keeping volumes high enough for competency is a real and serious one. So, you know, I don't know how we think about that, but that is definitely a challenge.

Brian, I appreciated your comments on the physician workforce. I would just like to also remind us that care is often disproportionately provided by nurse practitioners and PAs in these areas, often people who are from those areas and return to work in those areas.

And in terms of going forward, I would be very curious to understand better some of the outcomes of rural service areas that have looked at alternative payment models. So, for example, the rural hospital global budgets in Pennsylvania, Vermont, all-inclusive total cost of care,

obviously not for this report but I think that would have some important lessons for us.

And the other comment I would have is the report eloquently pointed out that there is less access to specialty care. What I am curious about and wasn't clear to me is how does that impact patients' health and outcomes. You know, across the nation we have a disproportionately specialist-focused system that could fragment care, et cetera, so we see that there is a difference there. But to what extent is there care being coordinated? Are they missing out on essential specialty services that would really make a difference? And obviously that is not for this round.

Thank you very much. I really appreciated it.

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

DR. CHERNEW: Yeah. Sorry. So that is the second time in this session that issues in some ways related to quality of care in rural areas came up. So first let me make a broad statement. Maintaining a high quality of care and access to care in rural areas is sort of a core goal of this entire discussion, and I'm really happy to -- the staff reported that the REH program follows

a lot of MedPAC recommendation, which, just for the record, were made prior to my being in the position I am in now. But it clear that there is a tremendous interest in the country and in the Congress on this point.

The thing that I think is a challenge, that Betty's comment raises, and Larry's earlier about quality, is that care in rural areas is always going to have some unique features. The volume issue is just going to be fundamentally different in rural areas than urban areas. That's sort of the definition which is why it is a challenge. That means the staffing issues that Brian raised are clearly going to be an issue.

Mitra Behroozi, if she is listening, a colleague when I was on MedPAC before, has pointed out there are also some unique challenges in urban areas, but I think we, in terms of travel and a bunch of other things, but in rural areas I think what is exciting is there are new care modalities that may really support quality and access in rural areas, and what we really have to begin to think through, and certainly we are thinking through, is how do we make sure that those new care modalities and other things that might be happening enhance quality and access

as opposed to siphon off care in a way that means certain things go away? And that is really the balance that I think we are going to have to try and face.

So your point, Betty, about staffing, your points about volume, the points about volume that you made, are really going to be a challenge, and I think we will be going there. But I did want to emphasize, to those listening, that we are aware of these issues and will continue to work hard about how to make sure that we can transform care efficiently without giving up anything on the quality and access side.

So I'm going to turn it back to you, Dana, to move on to the next comments.

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

MS. THOMPSON: Thank you, Dana, and thank you, Michael, and I appreciate this opportunity. I suspect this will be my last opportunity to comment on matters related to rural Medicare beneficiaries. It is a topic, as you all know, I am very close to and very passionate about.

And my intent here is to perhaps just connect dots of many topics that we have covered through the course of the past many years and how they might relate to this

chapter, and whether that be in the next cycle or however, and much work it takes. But I do think there are a couple of points that are worthy of mentioning.

I do like Table 2 very much in the reading. I would like it even better if it included information on the move to value, among our rural providers. There has been, and there continues to remain, many opportunities in the rural areas, and there is a lot of activity in the rural areas in work of moving to value, despite, I think, the focus on many of the urban models.

But this may be a comment for a later discussion, but I would love to further tease out what we are learning, in our rural communities in particular, just contrasting pure fee-for-service to the ACOs and then comparing them both to MA. I think it would be interesting to see these results and then compare them to analysis similarly in urban areas. Recognition of the work in the rural areas around ACOs I think might be an important comment here.

While the survey data suggests that rural and urban beneficiaries have similar access to care, we continue to note, in the reading and frequently in our discussion, that the MedPAC survey is a small sample.

However, in terms of the MCBS, the claims data does show that there are differences. The reading included a statement that stated, "We found that 4 percent of urban beneficiaries were dissatisfied with the ease of getting to the doctor from their home, compared with 7 to 8 percent among rural beneficiaries, and 10 percent among frontier beneficiaries."

This statement indicates that rural dissatisfaction rate is double or more of their urban counterparts, and yet the headline of that section in the chapter reads, "Survey data suggests rural and urban beneficiaries have similar access to care." There is a nuance there that I'm not sure we are capturing a central issue to rural access. And we've touched on it. Brian touched on it. Betty touched on it. Michael just commented again, and that's access to providers.

You know, I think that this issue of access to primary care, which we have covered over and over, is central to any discussion on rural access, and while the comments related to providers are scattered throughout the paper, there's a footnote around advanced nurse practitioners and PAs, it strikes me that perhaps in a more

prominent way or in the next cycle that we call out the topic of access to physicians in rural America. It just seems essential, and it seems to me to be central to so much of what we're talking about. We've commented on quality and our concerns about quality. This is an update to a 2012 chapter. If we would look at workforce issues between 2012 and 2021, in rural America, I would suggest there is a lot of change that has gone on.

And finally, there is a comment on expanding cost-based reimbursement for rural health care, that it is not an efficient approach to maintaining access to care. You know, the MedPAC principles about rural health care include access to care -- it doesn't necessarily mean equal travel time -- quality of care should be equal, and then special payments to rural providers should be justified by being targeted, empirically supported, and encourage efficiency.

My question is, should the price of access be judged by efficiency? Of the 40 hospitals that closed between 2015 and 2019, only 15 of them -- only 15 of those 40 -- were critical access or cost-based reimbursed. The other 25 were PPS, suggesting PPS may not be the answer

either, which brings us to this new model, which I know we are quite bullish on, the Rural Emergency Hospital designation. I would suggest it bears very close watching, and I think analysis in states that are rural to frontier need to be watched and conferred. It is consistent. The recommendation is consistent with our previous MedPAC recommendations, which I know we enjoy seeing, but the proof will be in the pudding. And I just strongly encourage us to keep a watchful eye on the implementation and the effect of that Rural Emergency Hospital designation.

Thank you.

MS. KELLEY: I have Jaewon next.

DR. RYU: Thank you. I think a lot of similar these. Just a few additional points. First of all, I really appreciated the chapter. I think it is a critically important topic, with a significant or more than expected share of the Medicare beneficiaries living in these environments, so it is very important work.

A few things that did pop out. I share Susan's concern and sentiment, and I also share her affinity for Table 2. And I thought that was a really illustrative

table. I think it would also be impactful to see what that has trended over time, because I think especially in the employer-sponsored, you know, if you look at the payer mix section, so to speak, the employer-sponsored is an area that it looks like there is a pretty significant difference between rural environments and urban environments, and it would be interesting to see what that has done over time. I suspect the gap has grown and not shrunk.

I also think that kind of analysis around the payer mix would be useful for the hospitals that have closed. If you go back, you know, three, five, whatever years prior to their closure, I suspect the payer mix may be another wrinkle that may have added to the equation.

I think it leads me to my second point, which is around the types of services and expectations of distance and travel to access those services. I think there are many services, and they may be on the more subspecialized area of the spectrum, where it is probably appropriate and reasonable that folks are traveling longer distances. You know, transplant might be a great example on the extreme end of that spectrum.

There are other services that I think we would

all consider to be more core, where you would hope that people aren't having to travel significantly far distances from home. Primary care is a great example of that. And then there are a lot of services that sit in between, but there are some specialty services that probably resemble more of core functions, that you actually need those programs to sustain a hospital, versus, you know, other programs that are not as core that we feel comfortable about people moving and having to travel farther for. It would be good to get to that level of granularity, just one step deeper, in terms of what are the types of services.

Cardiology is a good example. I suspect, with the closure of hospitals, I think the bypass dynamic, if we are really drilling into what created the consumer need to bypass and go farther for those services, I suspect it may be in terms of certain services that were no longer available at this platforms, at those hospitals. And as a result, folks had to go further. But being able to glean insights into what those services may have been, I think that may shed some light on that bypass dynamic and also shed some light on are we comfortable with those services not being available closer to home.

And I think the last point is the staffing issue that Brian and others raised, and Betty. I think that's exactly right. In many of these environments, I believe the hospitals are the ones that are best positioned to recruit and build programs around a series of providers. But in order to be able to do that, I think there is an interface or an interplay with the ambient payer mix and the ability to support those services.

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

DR. CHERNEW: I did just for a sec. I think that's exactly right, Jaewon. I think the challenge is to think about the connection between these services because they're obviously not always attendant. If you lose access to one, then maybe it's okay if you lose. There's ramifications for the availability of others that you would rather not lose, and that's sort of one of the issues around emergency -- the recommendation that led to the REH in some ways. You want to make sure that some services stay even if other services go. But your point about thinking about in a service perspective matters enormously. It's just the recognition of the connection between these service lines is analytically quite a challenge.

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

DR. GRABOWSKI: Great. Thank you. And thanks to the staff for this great work. I wanted to make just two brief comments.

First, both Betty and Sue mentioned alternative payment models, and Betty even touched on global budgets and the Pennsylvania program. It strikes me that the flexibility that global budgets and APMs would provide here might be interesting to think through further. I know MedPAC, we obviously have done a lot of work with APMs. We've obviously done a lot of work with rural areas. But trying to connect those threads in a greater way, and maybe we've done that and I've missed it, but I'm really curious going forward if there's opportunities to think about bringing those two threads together.

As a second comment, I was the one that had asked the staff to look at the post-acute care differences across urban and rural areas in terms of utilization. I was really struck by what they found, that on average there weren't big differences there. I hear a lot from folks about big gaps in rural areas in terms of post-acute care services, and maybe it was that final bullet that you had

up on Slide 10 that kind of connects the dots here between what I hear a lot from folks and what you're finding. On average, we don't see utilization differences, but we do have some areas out there where there may be big gaps. I think what you stated in that bullet was that the geographic variation was larger than differences between rural and urban beneficiaries in the same state. I'd be curious to know where are those kind of low areas of use in terms of SNF and home health agency. It was an interesting finding. I think that made me feel better that on average we're not seeing big differences. But I still worry about some of those kind of PAC deserts that may be out there.

A final comment. I guess I lied. I did have a third comment. I'm really looking forward to seeing what we're going to do on the duals for the last part of this. I think that is an important part of this with rural areas, so I'm excited to see what's to come there. But thanks for this great work, and I like the way it's shaping up.

Thanks.

MS. KELLEY: Okay. I have Pat next.

MS. WANG: Thank you, and I echo my praise for the quality of the chapter as well as the presentations and

the comments of my fellow Commissioners. I just had a couple of things.

I very much endorse the comments that others have made and that Sue led off with about incorporating more about the presence of value models, whether it's ACO, CMMI, Medicare Advantage, and just sort of whether that has had any impact or influence in these areas.

I wondered for the next round whether there should be a little bit more focus on sort of what I'll call like post-pandemic emerging trends in health care, which would include access to and use of telehealth, mental health in particular. Again, this is just anecdotal on my part, but I think that behavioral health issues in non-urban areas, rural frontier, might be something to have a particular focus on in terms of access and so forth.

And the final comment is just sort of I want to tuck it into the comments that Bruce and Brian have made around risk scores. I personally don't think that using two years' worth of information is going to help the situation, and I've noted this before. The fundamental problem in my view is that fee-for-service providers get paid by billing procedure codes. Risk scores are

determined by diagnosis codes. It is not the way that fee-for-service providers code, and, therefore, I mean, it has come up in a variety of different settings, whether you're an ACO or an MA plan, or what have you. Where HCC risk scores are important for payment, there will be more attention on trying to get providers to code differently. And I can tell you it's really painful, which is why you see a lot of emphasis on trying to correct coding or, you know, sort of augment procedure codes with diagnosis codes, because it's not the way that people in the fee-for-service system have learned how to code.

I think it's an underlying issue both with the expansion of ACO models that rely on HCCs, MA which rely on HCCs, and analyses like this to really get at underlying health condition. I think it is an issue going forward that we just need to be aware of. The fee-for-service system does not -- providers do not need to bill diagnosis codes in order to get paid. They get coached and they get trained in appropriate procedure code billing, and that does not drive accurate HCC scores.

MS. KELLEY: And the last person I have in the queue is Paul.

DR. PAUL GINSBURG: Thanks, Dana. I was very stimulated by the comment that Brian made about the affiliation relationships and what effect that has on care in rural areas. This might be worth looking into more in the next cycle.

My sense and my experience has been that probably affiliation does lead to more bypassing. I think it also leads to a beefing up of outpatient services and emergency services in the rural hospital or what was the rural hospital if it closes. And, you know, this actually might be a very -- you know, this is probably consistent with the direction that the Commission recommended in 2018 and which the Congress recently enacted in the appropriations bill to actually facilitate that process of having the rural hospital that did not have much volume becoming a stronger center for outpatient care and emergency services. So perhaps a couple of interviews as part of the next cycle might get us to think a little more carefully about, you know, what would be the ideal affiliation relationships when they happen.

MS. KELLEY: Actually, I have Jon Perlin with a comment.

DR. PERLIN: This is a comment that sort of intersects between Sue Thompson's terrific comments and Paul's. It gets at this issue of this tension between efficiency and access. You know, while we all hope that COVID is indeed ephemeral, I think we've seen a playout of the tension between efficiency and surge capacity.

One of the areas where -- you know, clearly we don't have the same level of expensability as in the area of rural health. So just as a general thought, as we do further work in this area, we need to think about how we -- or whether we, in fact, are prepared to fund some degree of inefficiency to support the surge capacity that builds the resilience essential for our population health.

Thanks.

DR. CHERNEW: Dana, is that the end of the queue?

MS. KELLEY: That is the end of the queue.

DR. CHERNEW: So I'll summarize briefly and then make one other point. We may end up moving to the value purchasing model on the SNFs sooner than on the schedule. But in any case, a few things I've heard.

One is a very strong acknowledgment of the importance of quality and access in rural areas and a

recognition that that's not going to mean that rural areas look exactly like urban areas, because it turned out they don't. But we really have to think about how to do that. We need to think about how that is influenced by new care delivery models.

I heard loud and clear the importance of systems and the roles that systems play both in supporting the viability of hospitals in selected areas, the change in the care package, and that I think is quite a valuable point.

The staffing issues go without saying. I think we talked about staffing in a whole variety of ways. Certainly the COVID issue is emphasized in many places, the staffing concerns.

Jaewon pointed out thinking about this in the service level matters a lot for all of these issues, access to what, quality for what, how they put it together, I think that matters.

We haven't talked a lot about in this section unique issues related to, you know, social determinants of health or other types of issues that affect rural areas that matter, so I think that might fit into some other types of thinking we have. And I will add another comment,

simply because we have some time, from discussions I've had with my friend from Arkansas, Joe Thompson, thinking about Medicaid and the Medicaid expansion and the role that that plays as a payer in support of these other things, also probably an important thing for us to keep on our radar.

But we have -- as was said, we are going to be continuing this work. We have a report that will -- this material will be presented in our June report, and then, of course, we will have the report in June 2022 that will do some more stratification. And so these comments have been really very useful as we get to prioritize how to deal with some of the added analysis. We won't be able to do everything, so -- but we'll deal with the added analysis in the June 2022 version.

So, again, I'm going to pause for a second and see if there's any other comments that folks want to make.

[No response.]

DR. CHERNEW: I'm seeing none, so I will thank the staff for their really outstanding work in this area. It combines both an enormous amount of quantitative analysis, a lot of more qualitative analysis, talking to different organizations. Really there's an incredible

wealth of knowledge about what's going on, and a real dedication. I need to give the appropriate shout-out to the staff that has been involved in that.

So, again, thank you all, those that presented, those that helped prepare the materials, and barring anything else, I think we're going to switch over to the SNF thing. Am I correct that Carol is going to kick us off?

MS. KELLEY: Yes, that's correct.

DR. CHERNEW: I get the order from the slides. Sometimes the names aren't in order. But we are doing the best we can.

DR. CARTER: So I'm ready. Can you hear me?

DR. CHERNEW: Yeah, okay. Carol.

DR. CARTER: Good. Good morning, everyone. Before I get started I wanted to note that the audience can download a PDF version of these slides in the Handout section of the control panel, that is on the right hand of the screen.

Today we'll continue our discussion of MedPAC's mandated report on the SNF value-based purchasing program. Its requirements are listed on the slide. We plan to

include the chapter in the June report.

This is the fourth presentation on this report. Last September, we reviewed the current program design and summarized the results for its first two years. You discussed the shortcomings of the design and concluded that the program should be eliminated. In October, we outlined an alternative design, estimated its potential impacts, and compared the impacts of the current and alternative designs. In January, we outlined policy options for your consideration.

MS. KELLEY: Carol. We lost your audio. Okay. Hang on one second.

MS. TABOR: I can take over if needed.

MS. KELLEY: Yes, why don't we do that, Ledia.

Carol, are you there now?

[No response.]

MS. KELLEY: No. All right. Ledia, why don't you go ahead. Thank you.

MS. TABOR: Okay. I will start where I think she was.

In October, we outlined an alternative design, estimated its potential impacts, and compared the impacts

of the current and alternative designs. In January, we outlined policy options for your consideration. Today we present the Chair's draft recommendations for your discussion, with a planned vote in April.

We'll start with an overview of the results of the current program. Since the January meeting, we have analyzed the third year of results, which are generally consistent with the first two years. In each year, about three-quarters of providers had their payments lowered by the program. Between 21 and 39 percent of SNFs earned back essentially none of the amount withheld, which was 2 percent.

Few SNFs, between 2 and 3 percent, received the maximum increases. Those increases were relatively small, ranging from 1.6 percent to 3.1 percent net of the withhold. The general consensus is that these incentive payments have not been sufficiently large to motivate improvement.

We also found that incentive payments tended to be higher for larger providers, for providers whose patients had lower risk scores, and for providers that treated fewer patients at high social risk, as measured by

share of fully dual-eligible beneficiaries. We also found that while the majority of providers were penalized under the program each year, the size of the payment adjustments varied across the three years. These findings helped identify the shortcomings of the current program and spell out the design features of a new one.

The next few slides outline each of the five flaws of the current program, how the new value incentive program corrects it, and how we incorporated the design feature into an illustrative model.

First, instead of the single measure that is required in statute, the alternative design should score a small set of performance measures focused on outcomes and resource use. The measure set should evolve over time. At earlier meetings, the Commission discussed the need to finalize measures of patient experience that could be added later.

In our illustrative model, we used three measures: rates of hospitalization within the SNF stay, successful discharge to the community, and Medicare spending per beneficiary.

A second flaw of the current program is that in

determining whether to include a provider in the program, it uses a minimum count that is too low to ensure reliable results for low-volume providers. Especially for low-volume providers, the measure is more likely to reflect random variation rather than actual performance.

A VIP would incorporate strategies to ensure reliable measure results, by using a higher reliability standard to determine the minimum stay count for inclusion in the program. To include as many providers as possible, the performance period could span multiple years, although there are pros and cons to this approach.

In our illustrative modeling, we used a reliability standard of 0.7 compared to the 0.4 used in the current program. This translated to 60 stays for each measure. We also expanded the performance period to 3 years.

Third, as required by statute, the current program includes cliffs for rewarding performance. As a result, some providers may not have an incentive to improve. The value incentive program establishes a system for distributing rewards with minimal "cliff" effects. All providers are encouraged to improve.

In the illustrative modeling, we assessed a provider's performance on each measure against a national distribution. The scales that convert performance to points are continuous, so every achievement is recognized.

The fourth flaw is that current VBP does not account for the social risk factors of the beneficiaries a SNF treats. Yet, it is harder for providers that treat high shares of patients at high social risk to have good outcomes. The VIP design considers social risk factors when tying performance points to incentive payments, by using peer grouping. Peer grouping is a way to compare the performances of providers with similar mixes of patients at high social risk. As the share of fully dual-eligible beneficiaries increases, providers have the potential to earn larger rewards for better performance.

In our illustrative model, we used 20 peer groups based on the share of fully dual-eligible beneficiaries. Within each peer group, incentive payments are distributed to each provider based on its performance relative to its peers. With this approach, performance scores are not adjusted, while payments are adjusted based on that performance.

In discussing the scoring and peer grouping, some Commissioners were concerned that the VIP design could reward the poorest performers of all SNFs, depending on their peer group assignment. A minimum performance standard would prevent this from happening and would be a way to set expectations about the quality of care that providers need to furnish to receive a reward. However, a minimum threshold is likely to disproportionality penalize SNFs that treat a high share of patients at high social risk because they are more likely to have lower performance on quality measures. Thus, a minimum standard would undercut the purpose of peer grouping, which is to counter the disadvantages of these SNFs face in achieving good performance.

Others of you said that it was important to have a design that counters the disadvantages SNFs that treat high shares of patients at high social risk face in achieving good outcomes. Both of these positions have merit and there are tradeoffs involved in meeting these two objectives.

Based on what we heard as the preponderance of Commissioner input, we focused the VIP design on improving

the equity across SNFs and did not include minimum performance standards in our illustrative model. There may be some consolation in knowing that in our model, all of the worst performing SNFs, those in the bottom 14th percentile of performance, were penalized.

The fifth shortcoming of the current program is that, as required by law, the amounts withheld from payments are not fully paid out as incentive payments. Rather, the program retains a portion as program savings. The Commission supports value incentive programs that distribute all withheld funds back to providers based on their performances. Each year, the payment adjustments would be calculated to fully spend out the incentive pools.

In our illustrative model, 5 percent of SNF payments were withheld and then redistributed back to providers based on their performance. The VIP is not used to achieve Medicare program savings. That said, because the performance measures would encourage providers to lower hospitalizations, for example, Medicare may, achieve program savings.

In December 2020, the Congress made changes to the SNF VBP. The Consolidated Appropriations Act of 2021

made changes that are consistent with what we've talked about: it gave the Secretary of Health and Human Services the authority to expand the measure set and requires that the data are validated—, which would apply to the provider-reported measures. It also bars the program from applying to providers who do not meet a minimum volume for each measure. Depending on how this provision is implemented, that is, if the current minimum volume remain the same, the results may still be unreliable.

The legislated changes do not address three other design flaws: the scoring "cliffs," the lack of consideration of social risk factors, and the program retains a portion of the incentive pool as savings. So while the changes are a positive development, there is more that can be done to improve.

The results of our modeling show that the design of the VIP has the intended effect of making payment adjustments more equitable for SNFs treating patients at higher social risk compared to the VBP.

On the left are the payment adjustments under the current program, and we show 5 peer groups, with low shares of fully dual-eligible beneficiaries in yellow and high

shares in red. On the left, under the current program, the incentive payment adjustments get more negative, that is, the penalties get larger, as the share of dual-eligible beneficiaries increases. In contrast, on the right are the adjustments under the VIP. Under this design, the average adjustments are much smaller and they are more equitable across peer groups. This would counteract the disadvantage these providers have in obtaining good outcomes.

We also looked at how the VIP design would affect providers treating medically complex patients compared to the current program. We divided SNFs into three groups of medical complexity based on their beneficiaries' average risk scores, with low in yellow, medium in green, and high in blue. On the left are the results of the current program and on the right are the results of the illustrative model.

Under the current program, providers treating the least medically complex patients have positive payment adjustments on average, while providers treating the most medically complex patents have negative payment adjustments. In contrast, under the alternative design, the average payment adjustments were not related to the

medical complexity of the patients. Therefore, compared with the current program, the VIP model would make payment adjustments more equitable across SNFs treating different mixes of medically complex patients.

Per the Commission's previous discussions, an improved SNF quality payment program with stronger incentives would be paired with other tools to encourage providers to improve. First, public reporting of provider performance, including the measures used in the SNF VIP, motivates providers to improve. CMS should also target technical assistance to low-performing providers so they can develop the skills and infrastructure needed for successful quality improvement. CMS could also enhance its Requirements of Participation and Special Focus Facility Program to more aggressively encourage providers to improve the quality of care they furnish.

In summary, the current program is flawed. The VIP design addresses these flaws. Compared to the current program, a replacement VIP design is more likely to motivate providers to improve their quality and would dampen the incentive to avoid beneficiaries with more social risk factors and more medically complex

beneficiaries. The recent legislation corrects some flaws of the current program but there is more opportunity for improving the program.

I will now present the chair's draft recommendations for your discussion today. We anticipate the Commission will vote on the recommendations at the April meeting.

First, the Congress should eliminate Medicare's current skilled nursing facility value-based purchasing program and establish a new value incentive program that scores a small set of performance measures; incorporates strategies to ensure reliable measure results; establishes a system for distributing rewards that minimizes cliff effects; accounts for differences in patient social risk factors using a peer grouping mechanism; and completely distributes a provider-funded pool of dollars as rewards and penalties.

This recommendation will not affect program spending. It would be budget neutral to current law.

We expect this recommendation to have positive impacts on providers and beneficiaries. Access may improve for beneficiaries at high social risk or who are medically

complex. Beneficiaries may experience an increase in the quality of care they receive from SNFs because the providers would have stronger incentives to improve.

For providers, the SNF VIP will improve equity across SNFs because it will not disadvantage SNFs that treat patients at high social risk or medically complex patients. We do not expect the program to affect provider participation in Medicare.

The second recommendation is that the Secretary should finalize development of and begin to report patient experience measures for skilled nursing facilities. This recommendation will not affect Medicare spending, but CMS may incur additional administrative costs.

We do not expect this recommendation to have adverse effects on beneficiaries' access to SNFs or on SNF participation in Medicare.

Beneficiaries may experience an improvement in the quality of care they receive from providers because SNFs will have an incentive to improve patient experience when these measures are publicly reported and scored in the SNF VIP. Consumers will have more information about providers when making decisions about where to get care.

SNFs will have higher administrative costs when the Secretary requires providers to collect and report patient experience surveys.

I will now turn it back to Michael, and look forward to the discussion.

DR. CHERNEW: Sorry. Thank you so much. That really reflects an enormous volume of work and an incredibly detailed chapter. I am going to turn it to Dana Kelley to start the Round 1 questions:

MS. KELLEY: Okay. And it looks like we have Carol back with us.

DR. CARTER: Yep. I lost my internet but I am back. Sorry about that.

MS. KELLEY: Great. All right. I have Dana Safran.

DR. SAFRAN: Thank you. Really adding to Mike's congratulations on this chapter. This has really developed so well and has really important recommendations in it, and really tremendous work, so compliments to the team on that.

I have a couple of questions. One is, did you explore, or are we allowed, or would current legislation allow the use of a VIP program that is rewards only versus

having reward and penalty?

MS. TABOR: The current legislation would only allow for reward and penalty.

DR. SAFRAN: Okay.

MS. TABOR: It is not currently written as a rewards-only program.

DR. SAFRAN: Okay. Thank you for clarifying that. And then I wonder if you could explain a little bit to us about, in Table 7, how points are set, because I think it has some important bearing on some comments that I have on your treatment of the issue of cliffs, but I want to make sure I understand correctly. So, for example, maybe it's helpful if we kind of have Table 7 in front of us, so I'm looking for my copy. I have way too many tabs open here, so it will take me a moment to surface it.

MS. TABOR: I just found it also, and it is the table that shows the points for each measure.

DR. SAFRAN: Yeah. So if you could just help us understand, you know, the 0 to 10. You say that performance to points is based on the data distribution, but I didn't see any more information. So does 0 points, for example, correspond to data binomial distribution of,

you know, 10th percentile? Give us some insight about how 0 to 10 points are defined.

MS. TABOR: So the 0 to 10 points is defined using the entire national distribution of performance, so we did not apply any amount of thresholds, and we did apply the data distribution to kind of smooth out some of the unevenness in that national distribution. But I think to your question, that performance to point scale is again based on national distribution with no kind of minimum threshold applied.

DR. SAFRAN: So then would I be correct in understanding, looking at that table, in the 0 row, I know that we don't have the ability to put it up in front of everyone, but that, for example, where you've got the hospitalization rate, 23 percent is the score that we see associated with 0 points, does that mean that's the score at the 0 percentile of the data distribution?

MS. TABOR: That is correct, yes.

DR. SAFRAN: And that, at the other end, 8 percent hospitalization rate would be what we'd see at the 100th percentile of the data, and that's associated with 10 points?

MS. TABOR: Correct.

DR. SAFRAN: Got it. Okay. Thank you.

DR. CHERNEW: I want to jump in on this, in part because I am very conscious that some people in the audience haven't had the benefit of seeing the draft chapter. And it's important that folks at least follow along for this somewhat technical part of the discussion.

The way the SNF VIP program works, as is noted, it scores a small set of performance measures. Three were picked. The ultimate score reflects an aggregation of points across each of those three measures. The analysis of how you go from a measure to points for that measure is discussed only briefly, and the question that Dana was asking for those following along was how we go from a score on one of those measures to the specific number of points.

The chapter -- the Commissioners will know this, but the audience may not. The chapter doesn't dwell a lot on the answers that Ledia just gave, and we will continue -- I think that's a useful point, Dana -- to think through that part of how this plays out. So I appreciate the answer, but I wanted the people to understand that what we're talking about now was the process of going from

measure score to the measure point, which then gets aggregated to get you a total score, and then the total score moves into the actual payment.

Now, did I say that clearly? And, Dana, did that capture where your question was?

DR. SAFRAN: It did capture where my question was. I think you said it clearly, but I'll ask Ledia to answer.

MS. TABOR: Yes, that was clear and correct.

DR. CHERNEW: Good. I hope everyone's following the many steps that are going on in this box. We think this issue of going from the performance to the point before you go to the actual payment is something that -- I'm glad that you clarified that not just for us, but also for the public. So thank you, Dana.

Dana Kelley?

MS. KELLEY: There are no more Round 1 questions. Are you ready for me to go to Round 2?

DR. CHERNEW: I am ready for you to go to Round 2, and I think it's indicative of both the good job the staff did and the hard work and the fact that we've seen a lot of this before that we're able to move as expeditiously

as we are. So that's great. I know there are some Round 2 questions, so, yes, Dana, you are in charge of the queue.

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

DR. JAFFERY: Great. Thanks, Dana.

First of all, I want to echo what Mike and Dana and others have said, that this was a great chapter and a great presentation, and just a great body of work. Like Mike said, this has evolved over the years, and I think it's great.

I want to put out there that I'm very supportive of moving in this direction. I feel like we certainly do need to move away from the current model as quickly as possible. And I 100 percent support most of the draft recommendations, the small set of performance measures, higher reliability, minimizing cliff effects, and the full rewarding of the provider-funded pools.

Since the last meeting, Dana Safran and I actually had a little bit of dialogue, and I'll certainly let her -- she'll be able to comment herself on this. But I still have some concerns about the social risk factor adjustment, and my concerns are based on it still feels

like what we're moving towards is a system that ultimately can reward providers as much or more for outcomes that aren't just good for their population of patients.

And this, of course, I think it has tremendous implications how we start to think about social determinants of health and how we account for them, which I think we all agree at this point -- it's safe to say we all agree that's crucial. And it has implications that go way beyond the SNF program and into other ones as well.

And so, again, I'm very supportive of this as our current step, but I'm hopeful that we could have more discussion perhaps in next year's session, and specifically thinking about is there an opportunity to, rather than pay on the back end this way -- or, rather, adjust for social risk on the back end, is there some method for adjusting payments up front, perhaps somewhat analogous to how we address medical risk in MA and in other areas. It feels like there may be some opportunity to create better incentives there, as long as we're combining them with the same accountability for outcomes in whatever value payments that we have.

And so I'm happy to talk about that more or

respond to that, but, again, I'm very supportive of this going forward now. But I do feel like we've got an opportunity to maybe think about this in a different way that would address it, again, from that payment model up front and not end up with a system where providers can be rewarded differently for different outcomes based on patient population characteristics of social risk.

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

DR. SAFRAN: Thank you. So I do express full support for the Chair's draft recommendation. I'm feeling much more comfortable with our treatment in the chapter of social risk factors. Importantly, the fact that a provider serving lower SES earns more for a given level of performance I think is a really important goal. And I don't think the chapter really makes that as explicit as it could, so I'll offer a couple of suggestions as I go, but let me just summarize my thoughts.

I also think the fact that in so doing we get a more equal distribution of the dollars. The reward is, of course, something we were looking to accomplish and very positive that we can.

I do have a few remaining concerns about it and,

number one -- and this one, you know, it's something I hope we can address in the chapter before we finalize it. The fact that we view there to be no lower bound on performance that's worthy of a reward continues to concern me, so I'll say a little bit more about that.

The other two are kind of longer-term things that we've talked about before, but just to underscore them here. One is I think we've all recognized that duals is really not an adequate indicator of social risk, and I really would encourage that we over the next year explore and maybe even test some methods that could improve upon this. And I know I shared some ideas for that in our last meeting.

The additional one for future consideration, not for this chapter, is, you know, what I think Jonathan just pointed to, and that is, potentially in addition to having this kind of multiplier on rewards that providers serving lower SES gets for a given level of performance, we could consider having an up-front adjustment to budgets based on social risk, you know, much as we do -- I think Jonathan said this -- for clinical status. Understanding that more resources are required for a sicker population, we would be

acknowledging more resources are required for populations who are at greater social risk. So I think that's an additional mechanism for us to consider in the future.

But now just turning back to the issue of cliffs, I would say that I think -- well, first, to say that on page 43 in the first paragraph, I think that the method that you have defined really does reward both achievement and improvement, but I would just ask you to take another look at the phrasing there, because as you describe moving away from the current model, I wouldn't not want a reader to be confused and think that this model doesn't still reward both achievement and improvement. Even though the previous model did those separately, this one very elegantly does it with, you know, a continuous curve. And I think that's really valuable to emphasize.

I continue to feel that we should have a lower score that we think is not worthy of reward. I have a different point of view from that expressed in the chapter, that that, you know, would be unfair to providers who serve a lower SES population or demotivating to them. My own experience in creating incentive programs along these lines for a commercial population was that, you know, before we

implemented a model very much scoring the way that you're describing, but setting a lower bound on what is performance for the other reward. If you looked at our population, we would have seen that there would have been no rewards being given to providers with lower SES. But we went ahead and set those lower bounds, and lo and behold, what happened was that those who were serving the lower SES population really rose to the challenge and actually grew to be among the top performers, exceeding performance of those serving more advantaged populations.

So I would urge us not to assume that by setting a reasonably high bar that folks would be unable to meet that based on who they're serving.

One suggestion is that in order to help, you know, just all of us be more informed about that, I think that expanding on your Table 10 -- or, sorry, Table 8 or possibly having a different table that shows us not just the average performance points by peer group, but also the range, maybe the inter-quartile range, maybe the min and max, would really give us a better understanding of the distribution of performance that we see at these different peer grouping levels.

But even if it's the case that we see, you know, uniformly low performance in Peer Group 20, I would still urge us to believe that that group is capable of delivering high performance when the incentive model urges them to do so.

And then I'll wrap up. I'm just scanning my notes to see if there was anything else I wanted to say here. Oh, I should have included this in Round 1, so I apologize. I did have a question about the discharge to community measure and how that treats patients at the end of life. Most notably, I'm questioning whether the measure disincentivizes discharge to home because if a patient who is at the end of life then passes away, that counts against that SNF, so I wanted to understand how that measure is treating the issue of patients who are known to be at end of life.

Thank you.

MS. TABOR: Unless Carol knows off the top of her head, Dana, we'll follow up with you afterwards about how hospice patients are treated with the measures. I don't have it at my fingertips.

DR. SAFRAN: Sure. Oh, I'm sorry, one final

thing that I did want to say for your consideration. One important way to handle this issue of setting a lower bound of performance that can be rewarded and your concern that that could lead to a kind of cliff or unfairness for those who have a score, you know, just a decimal place away from where that lower bound is set, a treatment of that that we used very successfully in my work was to just create a buffer score around that lower bound that is set in a way that states essentially a 95 percent confidence interval but just one-sided, so that we have -- you know, there is less than a 5 percent risk of misclassifying a provider as low performing and getting no reward if indeed they're so close to the cut point that, you know, we could just round up and assume that they make it. So I would just offer that as something for your consideration as well.

MS. KELLEY: Okay. So I had a couple of people who wanted to react to things that Jonathan and Dana said, so I'm going to let them get in here for a second, and then we'll move on with the queue. Larry, did you want to comment on something?

DR. CASALINO: Yeah, Dana, I had just a specific question for Jonathan, and then I had earlier asked to be

in the queue for comments. It turns out those comments are relevant to what Jonathan and Dana have been talking about. But I think there are other people in the comments queue before me, so I'm happy to just ask Jonathan the question now and come back later whenever my turn originally was in the queue to give my comments, although they are on the Jonathan and Dana topic. So however you want to do it.

DR. CHERNEW: Larry, I think you should just, again, as always, say what you need to say, try to be more concise than I usually am. You should probably try and wrap it in now as long as it's on point.

DR. CASALINO: Okay. Yeah, I think I can be quite concise. So my question for Jonathan -- Jonathan, it's an interesting point you made in terms of trying to deal with the SDOH issue. The recommendation is to deal with it through the rewards and the peer grouping, and you suggested that we consider, instead of giving the money to rewards potentially, giving it basically to higher up-front payments for patients with higher social risk. Is that correct?

DR. JAFFERY: That's correct, although I suppose they're not necessarily mutually exclusive, but, yeah,

that's correct.

DR. CASALINO: Can you just say a bit more about why you might prefer the latter to the former?

DR. JAFFERY: Yeah, I think probably two factors in general. I would say one I mentioned already in the concern, the ongoing concern that you could still as a provider have a greater reward, significantly potentially greater reward for worse outcomes and that masks some of that. But I think the other piece has to do with kind of investments and having been on the provider side both in ACOs and health systems in general and, you know, people's difficulty getting their heads around or overall reluctance or challenges to investing in things that will impact the social determinants, again, with proper metrics and accountability coupled with it, having those payments up front explicitly be tied to those kinds of investments I think made incent organizations and providers to actually move in that direction more. And part of it has to do with the ongoing cash flow issue, if you know as you're getting payments, you're getting greater payments specifically designed for these investments as opposed to tied to some outcome that comes, as you know, often two years later. So

it's often that the operators of these provider groups -- it's a little bit harder for them to connect to that cash flow issue that is coming so much further down the road. So those are some of the things behind that.

DR. CASALINO: Thanks, Jonathan. I'm not going to comment on your suggestion. I'd be interested to hear what others say, except as you were talking, it just occurred to me in the chapter we'll get to later on about alternative payment models, it is highlighted that the second investment model, where organizations were being given cash up front, basically organizations that were small or rural or whatever, actually was one of the most successful models in terms of improving quality and dealing with -- and generating savings for Medicare. So that could tend to support what you're saying. I haven't thought it through enough to have a pro or con myself.

What I originally wanted to say about SDOH -- and it's relevant to what you and Dana were saying -- is I think the issue of how to account for some provider organizations having more disadvantaged patients to care for, obviously that's not unique to this situation. It comes up again and again and again. And I would just like

to tie that to the public reporting component of the chapter, because I do think that public reporting is a way to -- the issue is we don't want to make the rich get richer and the poor get poorer by really penalizing organizations that take care of a high share of disadvantaged patients.

On the other hand, we don't want to permanently reward organizations that take care of disadvantaged patients for giving a lower level of performance to them. So the question is what to do about that.

I think public reporting -- I don't think there is a perfect solution, but I think that public reporting can help a bit with that. And the point there would be that if the reporting includes both the reporting within peer groups and reporting of performance compared to the national standard, I think that people then can see -- people in the community, for example, community leaders, organization leaders, they can see, okay, we did pretty well relative to our peer group; we're getting a nice reward here. But, actually, we're not that good if you look at us compared to the whole national sample, national population, and, therefore, we ought to do better.

So I do think public reporting can help with this conundrum, and to the point it was mentioned public reporting in the text box and then again in the last -- in the discussion, I think on the last page in the discussion. But I would suggest making the public reporting more prominent, not just relegating it to a text box, and possibly even elevate it to the level of a third recommendation, that these three measures should be publicly reported by CMS, and they should be reported both in relation to peer groupings of dual eligibles and in relation to -- nationally, in relation to all SNFs.

MS. KELLEY: Mike, did you want to get in here?

DR. CHERNEW: I just want to respond to one comment of Jonathan's and then we'll move through that. So first, thank you, Jonathan. I think your point about up-front payment and then form of payment is important, and we'll consider that.

I will just point out that one of the characteristics of the VIP as it's being reported is it's not only balancing out the money across organizations by the different peer groups, but it also gives peer groups in lower SES categories a greater marginal incentive to

improve. In other words, not only do they get more money for the baseline level in a particular way to battle down for payment so we're not pulling money away from those folks, but we're also increasing the marginal incentive to those groups to improve. And so I just wanted to point that out. The math is something hard to present in a public session, but that is the way it works.

Dana, back to you.

MS. KELLEY: I think Amol had something to say on this issue.

DR. NAVATHE: Yes. Thanks, Dana, and thanks, team, for the great work on this chapter, and I think in an ongoing fashion, I very much appreciate it. I do want to first just start out and say that I do support the Chairman's draft recommendation here.

I think, as the conversation has highlighted, this is relatively complicated issue. What I would say is I think I appreciate, and one of the reasons I am so supportive of the recommendation, is I think we have taken a relatively practical approach here, and I think the goal should be -- and I don't think we need to articulate this in the recommendation per se -- is that we have a practical

recommendation that is actionable, given the universe of data and methodology that we have currently, but that doesn't mean that it is a full stop, we're done here on this topic. As Larry and others have highlighted, this is an issue that pervades much of the work that we do. It is not restricted in any way to the SNF work itself.

And so I think sort of trying to solve it as part of this program would potentially be too challenging and kind of not the bar that we should be focusing on.

I think the approach around peer grouping and using dual eligibility and social risk is critically important. I think we should also acknowledge that it is not the perfect measure, as Dana points out. So yes, we should be seeking, over time, ways to get to better social risk measures. That being said, again, it is probably practical, and we should highlight also that it is not something that MedPAC has sort of generated itself but it's something that the ASPE report has highlighted is the best and most reliable indicators of social risk, based on the work that they have done.

So I think noting that we are kind of building on other work that's been done in this space is important, I

think, to contextualize why we use that measure, because certainly it is not a perfect measure and it certainly doesn't capture all measures of social risk.

The other point, I think, just to make on this is relatedly, I think -- you know, Jonathan and Dana both have highlighted that there are other ways that we could approach addressing this challenge around variation in social risk in patient populations. It seems, in this particular report, and I think particularly based on the request that Congress has made, we are, to some extent, living within the world of a value incentive program and the type of structure of a pay-for-performance kind of structure. And given that, again, not that this is a universal way we could approach it, but we are taking a practical approach to try to address it within that construct.

I do think that Larry's point about the public reporting is important and perhaps doesn't have to be a third recommendation per se but could actually be tucked in as a bullet point under the Chairman's draft recommendation number 1. It, I think, does touch upon this point that there are a number of different ways that we could try to

address social risk, challenges with social risk, that have been written about, again, by ASPE and National Academy of Medicine and others.

Publicly reporting and specifically even taking one step further, which we don't need to put right now but we could consider in the future is looking at populations that traditionally do face social disadvantages, and taking one step further in terms of public reporting those measures and, in fact, stratifying based on different groups, I guess in this context, duals versus non-duals, could be a way to actually try to push that forward, and something that we might consider, if not for this particular report, maybe in the next one as we continue to do work in the broad space around addressing incentives for social risk.

I do have one point of sort of personal reflection from work that I've done. As Dana has done a lot of work in the commercial space, I have also worked with a number of insurers on designing programs. And I think I agree with her point, generally, around the minimum threshold. It can actually also create a strong incentive to improve for groups that are facing greater social risk,

to actually be that impetus, if you will, that shot.

That being said, I think we should be careful or cautious about that, because we should be sure that it is something that is actually actionable. In other programs that we've designed, my team has designed, with other commercial insurers, including the managed Medicaid populations, in interviews we've done with providers they have noted that the minimum threshold that was previously used in one of the incentive programs was actually quite discouraging, and, in fact, disincentivizing because it felt unreachable, effectively, which is something that you've noted, I think, in the chapter.

So I think it an important concept that Dana brings up. I think, however, the bar for us to be confident around that being achievable should be actually relatively high, and given where we are now I think the approach that we've taken currently is one that I support.

So let me stop there, but thank you again for this very great work, and I support the work that we've done.

MS. KELLEY: Okay. I have David next.

DR. GRABOWSKI: Great. Thanks. And first, thank

you to Carol and Ledia. This reflects a large amount of really strong work, and I'll start by saying I'm very supportive of the Chair's draft recommendation.

I have sort of a long history with this program. I actually was part of the team that evaluated the CMS demonstration that this program, the SNF VBP, is based on. We were highly critical of what was then the nursing home value-based payment program. That program was flawed. CMS then took that and turned it into the SNF VBP, which is a current flawed program. So it's great to see this SNF VIP shaping up and actually correcting a lot of these longstanding issues.

Obviously, there are still some challenges here, and some of my fellow commissioners have already raised these. I wanted to touch on just a few points. One is obvious and that's the measure set. We have three measures included in the SNF VIP. I like all three of those measures. I'm really happy that we included the second recommendation about building a patient experience measure. That can be done. We have a lot of the work already out there in the field, and I don't think that is a big ask of the field, to actually develop that and move forward with a

patient experience measure.

In terms of other possible measures, I think we pushed the claims data here as far as we can. The only other candidate that I might see here would be mortality, and I think that's the wrong measure for this population. So I would discourage us from including mortality as a measure in this program.

Kind of the elephant in the room is that we are really not capturing, I think, what's most important to a lot of beneficiaries, and Carol and I have talked a lot about this over the years. But it is functional improvement, and that is really what everybody cares about. We have this instrument, the minimum data set, that measures that. The unfortunate part about this, and we always go in circles with this point, is that it's provider-reported, and obviously there are a lot of incentives around that reporting. I was really struck by Carol's work just showing how coding can really change even from being discharged from a SNF and going to an HHA, and within days, lo and behold, people's assessment changes dramatically, just based on who is doing the assessment and the incentives these different providers have.

So I wonder, is there an opportunity here, in addition, to kind of, Recommendation 2, is there a way to push on accuracy of the MDS? There is such rich information there. CMS bases a lot of their quality reporting -- if you go on Nursing Home Compare -- around the MDS. I wonder if there is an opportunity there, or is that just a lost cause? We've always been dismissive as a Commission of those data, I think because of their self-reported nature, and I just wonder if there's more than can be done there, whether it's auditing, whether it's other oversight activities, that we can improve that. I really think, at the end of the day, that is what we care about.

Two other more minor points. One, I really like that we're using multiple years of data in terms of rewarding facilities here. I don't like the thresholds of dropping facilities with low numbers out of the program. I do wonder, however, if we could think about some sort of weighting scheme, and you mentioned this in the chapter, but weighting the most recent year a little bit more than prior years. And I don't know how that then impacts just the sample that's needed, per facility, to make this work, but I like that a lot.

Finally, Dana and others have already spoken on the social risk factors. I think that is a priority not just for this work but more generally for MedPAC. I think, as Amol said, the share of duals is an improvement on nothing in the program right now in terms of adjustment, but going forward is there something more that we could do towards improving that? I think that should be an area of priority.

Final point. Jonathan, I was really struck by your comment about up-front dollars. I have evaluated several of these programs, in terms of SNF value-based payment programs. The only one we ever found a positive return around was this program in Minnesota. The acronym is PIPP. I am not going to be able the exact to spell it out for you right now. But what was exciting, it's the only program we've found that actually had a positive impact, and the dollars are largely paid upfront with a small withhold on the back end. I won't get into all the details of the program, but I was really struck by your comment. There's something about upfront payment that was really, I think, a big part of the success of that program.

Stepping back once again, I'm very supportive of

these draft recommendations and really excited about the way this work is shaping up. So thanks to Carol and Ledia, and I'll stop there.

MS. KELLEY: I have Jon Perlin next.

DR. PERLIN: Well, David is always so incredibly eloquent that I can almost say ditto. But the points are really very symmetric. Let me just be clear that I agree with the rationale, agreeing with the recommendations, and I agree with accelerating patient experience.

I do want to add my voice to the concerns on some of the methodology. You know, when you adjust the results it is really a transform function to payment, so effectively it's kind of the same thing. And I really like Larry Casalino's concept of publishing the performance data, both against peer group as well as in the context of national performance. I think that, in my experience, in the VA system, the public accountability and context was, frankly, the greatest driver in performance change.

I also think we've got to wrestle with this issue of small numbers, because what happens when you add the numbers together for multiple years is that you may come up with something that, on the analytic side, is technical

powered to answer the question, but on the predictive side mismatches the period of time that the data are garnered with the period of time that the beneficiary or family might be seeking to make judgment about the predicted utility of those data. In other words, you know, if a beneficiary's average stay is a quarter, having three years of data doesn't necessarily predict what will or will not occur in that specific quarter. So I think it's a bit of a finesse but a good one to heavily weight the more recent.

You know, I'm going to sound like a broken record on this, but I think David's point the limitations of claims data is a good one, and I want to make two additional points on this. First, you know, we're looking for outcomes data, and I subscribe to the utility of outcomes data and whether a patient in a nursing facility goes back to a hospital or is discharged to community, are wonderful outcomes. But, you know, we are pushing the limits of the administrative data. So we need to begin thinking about how we can get more clinical data, and whether those are emerging electronic data, that is one bucket. I want to reference my VA experience as well. We tracked functional status for all patients, and the VSF

inventory we actually got down to the SF-12 as a measure of function, and frankly it was the most compelling data, both in terms of trying to identify improvement opportunities and to mark progress.

The next aspect is that, you know, I know we have a sort of visceral aversion to process measures, but when they are tightly linked with outcomes, like seat belts, then there's a role and the good part is that they don't need to be risk adjusted.

I think we need to step back, in our next body of work, outside of this specifically, because the absence of data that more accurately reflect on social determinants, social vulnerabilities is increasingly problematic, and our proxies are so imprecise that at the risk of compelling providers to acquire more data or burdening the patient and/or family, we need a mechanism to really identify what those risks are so that we can stratify. And that gets back to Jonathan Jaffery's point, which I think is really well taken, which is the decoupling of reimbursement for a higher vulnerability population from normalizing performance on the back end.

And along those lines, one final point. I'm

worried about a circularity with medical spending per beneficiary. Think about this for a moment. If you take care of a more vulnerable population, the reason we are going through these permutations around trying to risk adjust is because it's our thought that it will be harder to achieve certain better outcomes and more resources may be necessary to achieve those outcomes.

So I ask the question, is MSPB really the key there, or are we introducing a problem that actually needs to be solved on the basis of data that help us better understand the social vulnerabilities and pay for that, as opposed to not confusing the issue circularly when that becomes an outcome measure rather than a part of the premise of what's necessary and what should be incentivized to take care of those patients.

Thanks.

MS. KELLEY: I have Marge next.

MS. MARJORIE GINSBURG: Yes, thank you. This is a fabulous report, great work, and very stimulating discussion.

Like so many of you, I was particularly focused on the peer grouping, and I'm really concerned about it,

concerned about it in that I support it. What I'm not sure of is what is the best way to make this a fair distribution of dollars tied to quality of work. And certainly Jonathan sounded like he wanted to dump it, if I may shorten your consensus. I think I heard Dana say if we compensate those with higher duals then is that not a way to even the playing field and then everybody can be evaluated in the same grouping, which also has appeal.

But my main reason for having jumped into the queue is that I think this is so important, and we've got five different recommendations that we are posing. Have we ever prioritized our recommendations in such a way as to really emphasize this one is really important? And at least to me, this one is really important. Without the peer grouping, however we do it, the rest of it just doesn't feel as impactful as it needs to be.

Thank you.

DR. CHERNEW: So I want to jump in quickly. I want to ask a few questions, just to make sure. First to Dana Safran. Dana, my interpretation of your comment was not to doubt where we are going but to consider changing the way we move from the performance on a particular

measure to the points associated with it. Am I reading what you said correctly?

DR. SAFRAN: Sorry, Michael. Can you say that again? You said it quickly and I didn't catch it.

DR. CHERNEW: Yeah. I'm sorry. Marge said something, sort of interpreting what you said, and I want to make sure that I am interpreting what you said correctly.

So my interpretation of what you said was that you are supportive of where we're going but you would like to give more thought to how we translate measures to points --

DR. SAFRAN: Correct.

DR. CHERNEW: -- around minimum standards, to which Amol responded. I just want to make sure that I understood you correctly.

DR. SAFRAN: Correct. I mean, just to be really explicit, if we think back to that Table 7 that I was talking about, I don't know that I would put the beginning of the continuum at the 0 percentile, as we do in that --

DR. CHERNEW: Actually --

DR. SAFRAN: -- yeah.

DR. CHERNEW: -- the key part for this discussion, frankly, was whether or not I should interpret what you said and dump it, which is not how I interpreted it.

DR. SAFRAN: Oh no, not at all. Not at all. I'm very supportive of this direction. I just was asking that we consider the idea of what the score too low to merit a reward.

DR. CHERNEW: I got it. And similarly, to Jonathan, my interpretation of what you said, and I'm just really trying to make sure that we're on the same page, is that you were supportive of the recommendation the way we were going and that we should consider, in addition, some amount of upfront payment in a way that helps achieve some of our other goals, but that wasn't a negation, if you will, of how we've set things up, or not. But the point is I want to make sure that I interpreted your earlier comments correctly, because obviously one of the key things that matters here is people's assessment of where the recommendation is, because next month we are going to get to vote.

DR. JAFFERY: Yes, that is correct, sort of

building on what Amol had said, this is, I think, a very practical approach to get us to significant improvements immediately, and what I'm getting at is hopefully some further discussion that impacts things beyond just the SNF value incentive program, but how we think about SDOH broadly.

DR. CHERNEW: I understand, and the idea of it in general, in this case and beyond, is, of course, some of it is both the timing of the payment and then some of it is what is the payment a function of, if that makes sense. But, again, given where we are, the point of the discussion, which has been very rich, is to not only help us get to where we need to be in April but to think about where we're going to go beyond. Certainly there's going to be more years of MedPAC, and I hope to be here, and certainly we will be continuing to discuss quality and quality measurement programs. They're obviously unbelievably important. CMS has done a lot of really thoughtful thinking about it. There's really great people there. And I think the more that we continue to do this, the more valuable our discussions can be. But at least where we are now, it's really important to understand what

you're all thinking about specifically at this stage, recognizing it's not the end, it's just a step in the process. So thank you, and, Marge, thank you.

Now, Dana, back to you and the queue.

MS. KELLEY: I have Brian next.

DR. DeBUSK: Well, first of all, thank you. Great chapter. And I do support the Chairman's recommendation completely. Carol, Ledia, Sam, I always enjoy your work in this area, so thank you.

I want to focus a little bit on the peer grouping mechanism and just take a moment to endorse our larger approach to SEC -- or SES adjustment in general. I'm a huge fan of peer grouping, huge fan of the compartments, and I want to mention -- and these are things that we've discussed in the past, but I want to take a moment and point out that there's a philosophical argument around using these peer groups and compartments, which is, you know, you wouldn't want to build a pass for poor-quality care into the regression models so that we actually have coefficients that give providers who treat -- who hold beneficiaries who are a more socioeconomic risk to lower standards. So I think there's sort of an obvious

philosophical issue here.

But I also want to point out I think there's a mathematical issue here, too, because the socioeconomic variables are so often confounded with clinical conditions. I mean, is someone an unstable diabetic because they are in a high socioeconomic risk group? Or are they in that high socioeconomic risk group because they are an unstable diabetic? And I think -- I'd like to just take a moment and appeal to the practicality of the approach that we've taken, because it does avoid the difficult philosophical issue, but it also avoids some of the difficult mathematical issues associated with confounded variables.

And beyond that, you know, when we talk about, well, do we do a minimum, do we do floors, do we do ceilings, do we base all this on improvement? You know, I'm going to take a moment and just think about the MedPAC staff and other policymakers who have to analyze all this data. Every time you introduce a floor or a ceiling or a minimum, you're introducing a nonlinearity analysis, which is going to make this data more difficult to tabulate, analyze, report. So I think there are a lot of issues there.

I do want to also support Larry's comments, and I think, Jon, you echoed them, on this idea of publicly reporting in absolute terms as well as providing the relative terms for the peer grouping and the mechanisms. I think publicly reporting both would be very important. So it's exciting to see that idea develop, as well as with the peer groups we did preserve the notion that we can tailor the specific remedies to each peer group.

For example, if you're in Risk Group 20, the highest socioeconomic risk, maybe you need technical support or additional funding; whereas, if you're in the least socioeconomic risk, you know, maybe you do need an even stiffer penalty. But the ability to tailor our treatment of each peer group I think is another really, really important feature of this broader mechanism that we're using to account for SES.

The final thing, I've noticed this discussion about making up-front adjustments or payment that incorporate SES, and what I'm assuming here is that we're talking about incorporating these measures into the minimum data set and you're using them, say, for the beneficiary's placement into a resource utilization group. The one thing

I wanted to point out here was to exercise some caution. If you look at functional measures and consider all the issues that we've had regarding functional measures, unless these SES measures are absolute -- you know, what Zip code do you live in, you know, family income, things like that -- it's going to be really, really difficult. You know, this may be the functional measures reporting problem all over again, because as we know, when you tie reporting to payment, unless you're absolutely objective, you're really inviting upcoding, for lack of a better term.

And those were my comments, and thank you.

MS. KELLEY: I have Betty next.

DR. RAMBUR: Thank you so much for an excellent report and excellent comments from the other Commissioners. I'll be very brief, just to say I believe that this is a very important step forward. When I look at Slide 13, it seems to me there is not only an imperative for change; it's an ethical imperative for change. So I strongly support this.

I support the public reporting of peers and then also in aggregate, and I think this is important information for families as well as information that can

spur behavior change.

I just would underscore David's comment about mortality not being a good measure. Death is not always the enemy, as we know.

I support having both achievement and improvement scores and more heavily weighing the later years.

And in terms of the up-front payment, I think that is a very intriguing idea, and I just would need more information to study it more, understand if there's differences by ownership of the facility, or whatever. So that's an intriguing idea that would be interesting to hear more about. But I strongly support these recommendations.

MS. KELLEY: Okay. That's the end of the queue, Mike.

DR. CHERNEW: Great. So not all of you spoke, which is fine. I do think there is merit, as we're going to move towards the vote in April, to get people's general, even if very brief, reactions. So I'm going to ramble on for another second or two while people compose themselves and to give you some hint of what's going to happen. Then I'm going to ask -- we're going to start with Bruce to just give a very quick sense of, you know, you're okay with

where we're going, you don't have to make a long -- I'm really looking for --

MR. PYENSON: Yeah, I'm --

DR. CHERNEW: -- a comfort level, because, again, it [inaudible]. I wish we were truly in public. I guess we're virtually in public. But part of this is not just -- it's for us to express and me to express and give the public a sense of where we are.

So now I'm done rambling. Dana, I think I'll run through -- you can correct me if I misspoke, but, Bruce, did you have any just broad reaction?

MR. PYENSON: Yes, I'm very supportive of the recommendations as they stand and would echo Brian's comment about making sure that this is relatively simple for the reasons he said.

I also would remind Commissioners of our recommendations for the update for SNF in this context, that, you know, the SNF program has been a source of attention on an aggregate basis for the levels of payment. So for all of those reasons, I support these recommendations.

DR. CHERNEW: Bruce, thank you. Karen, can I ask

you for just a quick reaction?

DR. DeSALVO: Sorry, I was looking for my button. Yeah, I'm happy to, and actually it's a bunch of S's. I'm supportive of the Chairman's draft recommendations. I am in favor of the way this team has continued to try to take an overly simple process but keep it simple, meaning make a significant improvement and it's got some crispness and clarity that people could understand and articulate that I think resonates with some of the other quality program improvements that the MedPAC team has been doing. So thank you for that.

The social risk component is complicated. I very much appreciate how deeply you're thinking about it. I honestly think you're taking reasonable steps, and as others have said, I hope we continue to be leaders and understanding not only how to do stratification based on social risk of patient populations, but then begin to think about ownership, accountability, payment systems to address that social risk, not only in the context of the acute-care setting or the post-acute care setting, as the case may be, but also for those beneficiaries when they're not in institutions.

And then I just in particular want to call out the ongoing great work you've been doing to think about patient experience or self-report, and I appreciated that there's some discussion in the chapter balancing more complex measures, you know, up to 50 questions, shorter versions, four questions. What can we do that really makes it as easy as possible, reduce any friction to make sure we're hearing the voice of those being served and other family members?

So thank you, and that's all I have.

DR. CHERNEW: Karen, thank you.

Wayne, can I ask you for just a quick reaction?

DR. RILEY: Yes, Chairman. Fully supportive. I think these are two great recommendations. Nothing more to add.

DR. CHERNEW: Thanks, Wayne. Jaewon. Jaewon, I don't see you. I don't see everybody. Maybe Jaewon had to drop for a bit, so we will move

MS. KELLEY: Actually, yes, Jaewon did have to drop off for a moment.

DR. CHERNEW: Okay. So we'll catch up there. Sue Thompson.

MS. THOMPSON: Yes, and I too will be very brief. I'm very supportive of the Chairman's draft recommendations, and I'll take just a moment because I want to say a special thank you to Ledia and to Sam, but in particular to Carol Carter for her ongoing investment in time and energy around all of our work in post-acute, but particularly skilled nursing. So thank you, Carol. Your work is noticed and appreciated.

DR. CHERNEW: Great. So Pat.

MS. WANG: I'm supportive of the recommendation as drafted, and I am very keenly interested in our continuing the discussion around how to address social risk factors, social determinants of health. I don't think this is going to be an easy one if we really want to get it right. So I think we should invest the time in it. But I think that the recommendations are very good. Thanks.

DR. CHERNEW: And Paul.

DR. PAUL GINSBURG: Yes, I support the recommendations enthusiastically, and it was a great draft chapter. And I also support the fact that it's important to act soon on this, and I think we're doing very feasible, practical things now, and I support many of the other

thoughts about things we should be talking about in the future to go even further.

DR. CHERNEW: Great. So I'm going to wrap up in a second. I'm going to pause to see if anyone else is going to add something.

Okay. So in addition to my gratitude to the entire staff and recognition of the importance of this -- and I'll emphasize that I happen to know it's not just important to us; it's very important to CMS and, obviously, people in the field that we do this well. I think it's important that we do it well in a way that in many ways minimizes the administrative burden associated with doing that. But let me try and tell you some of the themes that I heard here.

First, I heard general support from the recommendations and where they're going, which is am grateful for. And, of course, a lot of the direction we went is because of the work that you all have done in addition to the staff, so I'm very grateful for that.

I've heard there's a number of things that we need to consider as we move forward. They include -- I should probably say include but not limited to. That

sounds too legalistic. One is thinking about the possibility of up-front payments, thinking about how we can include some clinical insight as opposed to statistical insight in the scoring, particularly around minimum standards of things, because I think it is very clear and I will emphasize we very much want to make sure that the payment mechanism adjusts for social determinant-type issues, SES issues, but we very much do not want to in any way give a pass to organizations to not provide high-quality care. And that is a challenging thing to do mathematically, and we will continue to do that, and I think the expertise of those on the Commission that know a lot more about that than I is really valuable. So that's a combination of understanding that this is not just the statistical, it is a clinical exercise, but it also is one that we have to think about, you know, what we're willing to reward.

I heard very clearly, I think starting with Larry, the point about public reporting that matters, and I think we'll think about how to incorporate that idea into the work flow. There's some challenges there. And the last thing that I would say -- hopefully I haven't missed

much -- is the role of data and measurement challenges, understanding that this is really a difficult analytic issue. And several of you have made really important points about essentially the right call on the outcomes and measurement.

I would just add one personal view related to some work we've done that I very much recognize and appreciate the shortcomings of claims data when you're trying to understand quality, and I think it's really frustrating for people that look at the world through a clinical lens to think that you're limited in claims data.

I do think it is not necessarily an either/or in some ways, and so certainly as a recommendation around things like experience measures matters, but there are other ways that some of the claims data might be used. For example, I think you could use it to target places that might need more attention. There's a bunch of other analytic things you could do with the data besides simply putting it into a measure and then creating a payment around that measure. And I think we will continue to ponder creative ways to use data.

For those of you in many environments, there's

been a real revolution in data science, writ large. A lot of that is around how to use existing data smarter in a bunch of ways. And I think with some advance analytics we may be able to do that in ways that are a little bit more advanced than the standard approach of here's our measure, here's your score, here's your payment. And that is much beyond where we are going to get to this cycle, so I want to be clear. You're not going to see a lot of that in the chapter or in any changes you'll see next month. But I think it is very clearly heard, and as we move forward to future cycles, understanding the role of some of our imperfect but easily accessible claims data and the role of more challenging to get clinical data, it's important to understand how we can incorporate and combine those two things together. But that is a future thing, so for now I think I'm going to stick with thanks.

First, Jim or Carol, Ledia or others want to add anything to this discussion?

[No response.]

DR. CHERNEW: I see some heads shaking no. Any other comments that Commissioners may want to make?

DR. CASALINO: Michael, I'd just like to

underscore David's comment about functional status. We didn't really discuss that much, but I'm very supportive of the recommendations, very enthusiastic about them. But I think, you know, going forward, it's an issue we might want to revisit, and I'd be particularly interested in knowing from staff and Commissioners who know much more than I do about how operationally feasible could it be and how effective could it be to have something like audits, for example, with pretty draconian penalties on self-reported functional status, because it is such an important measure -- everywhere, really, but particularly in the SNF context. And, you know, going forward, I'd hate to see us just give up on that, and so I think more discussion about whether there's any way it could be done that would get past the flaws of self-reporting, at least to some extent, would be valuable.

DR. CHERNEW: Thank you, Larry.

MS. TABOR: I can add one thing to that point. The Consolidated Appropriations Act of 2021 has called for the validation of the data, and they cited an example like how the current inpatient quality data is audited. So obviously there's a lot of questions of what the audit

process is going to look like and how it's implemented, but I think that there is potential for hope for improvement in those provider report measures based on the current legislation.

DR. CHERNEW: Larry, I think there's a lot of challenges in measuring functional status. It's a little bit different than measuring certain other things. We're not going to go through that point now, but I think your point and I think the first thing David said is what people really care about in many ways is functional status. And, by the way, I would argue it's not just improvement; it's halting a decline in functional status. People care about their functional status. As I age, I will tell you I care much more about my functional status. But it is a particularly challenging thing and it's a potentially very costly thing to measure well, so we need to think about how to build -- this might be a place where more advanced data science could help target our data collection in various ways.

We have a lot more thinking to do, and honestly, many of you are more expert than I in this area, and so this is going to be something that will persist. And I

would add this issue of quality measurement that is so incredibly important is going to persist across all of the different sectors we deal with. So I'm very glad to have you all so engaged in this discussion.

Okay. So this leads to the last part of the morning session, which is this is a public meeting. It is sometimes easy to forget that since we don't get to see the public in front of us as we do when we're actually meeting in person. But I am very aware that the public is here and am grateful for it. So I would like to say to those listening that we really do look forward to your comments. You will see a number of ways in which we listen to the things that you do and how the things that you say to us work its way into the work that we're doing and then into our chapters. So you can reach out to me; you can reach out to the staff; you can go to the website. There are many ways to reach us, and I really do want to encourage public feedback on the discussion we had here, both this one about the SNF VIP but also the rural health access chapter, access to care in rural areas chapter.

So, Jim, do you want to say anything else to the public, writ large?

DR. MATHEWS: No. I think you've covered everything.

DR. CHERNEW: So great. So, again, we are a little early, which is fine. I am hungry anyway. We're going to reconvene at 1:00 p.m. Eastern. So I look forward to that. Until then --

DR. PAUL GINSBURG: Mike, do you mean 2:00 p.m.? 2:00 p.m., Mike?

DR. CHERNEW: Oh, I'm sorry. Yes. Thank you, Paul. That is an important role for people to correct me when I'm wrong.

We're going to reconvene at 2:00 p.m. Eastern to continue today's meeting. So, again, I want to thank all of you. I want to thank the public for joining. I'm very much looking forward to the afternoon and very much appreciate all the comments we had this morning. But for now, we're going to get a little bit more time for lunch, and I'll see you all again at 2:00 -- count 'em, 1, 2 -- p.m. Are we good? Thanks, everybody.

[Whereupon, at 12:38 p.m., the Commission was recessed, to reconvene at 2:00 p.m. this same day.]

AFTERNOON SESSION

[2:01 p.m.]

DR. CHERNEW: Welcome back, everybody, to our afternoon session of the MedPAC meeting. I don't have a long intro, only to say that this first topic, alternative payment models, is one particularly close to my heart. I'm going to turn it over to Rachel and Geoff to present the analysis. Rachel, I think you are going first. All yours.

MS. BURTON: Thanks, Mike.

This afternoon, Geoff Gerhardt and I will continue our discussion of CMS' portfolio of alternative payment models, or APMs.

Today's presentation picks up from our January meeting, when Commissioners expressed interest in CMS pursuing a smaller, more coordinated set of APMs.

The audience can download a PDF of these slides from the control panel on the right side of their screen, under the "Handout" section.

Today we'll start out by recapping some background information on the Center for Medicare and Medicaid Innovation, or CMMI, which runs most of Medicare's APMs.

We'll then briefly summarize studies of the impacts of the three main types of APMs and touch on some barriers that may be preventing APMs from having larger impacts on spending and quality.

We'll then mention some unintended consequences of CMS implementing multiple concurrent APMs and consider the Chair's draft recommendation, which attempts to capture the Commission's thinking at the January meeting and recommends that CMS implement fewer, more coordinated APMs.

In your discussion, we'll be looking for feedback on what we've presented and any requested revisions to our draft paper.

We'll then be back in front of you at the April meeting for a formal vote, and our paper will appear as a chapter in our June report.

CMMI was established in the Affordable Care Act in 2010 to test innovative payment and care delivery models that reduce Medicare or Medicaid spending while preserving or enhancing care quality.

Congress included 27 potential models for CMMI to consider in its authorizing statute and appropriated $10 billion to CMMI every ten years, in perpetuity.

CMMI models are typically implemented for three to five years, but may be expanded into a permanent, nationwide program -- without requiring an act of Congress -- if they are found to decrease spending without decreasing quality or to increase quality without increasing spending.

CMMI has come up with seven categories to describe its models. Only three of these are what we might call "alternative payment models."

APMs focus on altering the way clinicians are paid and include CMMI's accountable care models, episode-based payment models, and primary care transformation models.

In contrast, CMMI's four other categories of models include efforts like testing new care delivery models funded through temporary fee-for-service billing codes or grants, technical assistance to providers, and new health plans or care coordination programs for beneficiaries dually enrolled in Medicare and Medicaid.

Five years after CMMI was authorized, Congress passed the Medicare Access and CHIP Reauthorization Act of 2015, known as MACRA, which created a new 5 percent bonus

for clinicians in advanced alternative payment models, which we call "A-APMs."

These models require providers to assume "more than nominal" financial risk. The models must also use quality measures comparable to those used in MIPS and must require providers to use electronic health records that meet federal standards.

The 5 percent A-APM bonus is available annually from 2019 through 2024 to clinicians with a sufficient percent of payments or patients in A-APMs. Starting in 2026, clinicians in A-APMs will qualify for higher annual updates to their fee schedule rates than clinicians not in these models.

CMMI has implemented 54 models over its first ten years, many of which have attracted large numbers of participating providers.

Only four of these models have been certified by CMS actuaries as having met the criteria to be expanded into a permanent, nationwide program.

Only one of these was an A-APM. It was the Pioneer ACO model. CMS incorporated lessons learned from Pioneer into the Medicare Shared Savings Program's Track 3,

which in turn evolved into the current "enhanced" track.

MSSP is the largest APM in Medicare and is not operated by CMMI; instead, it is a permanent program created by Congress.

In 2021, CMMI is expected to operate 13 APMs, involving over 30 tracks for providers to choose from. Most of these APMs have tracks that qualify as A-APMs, since their payment model involves financial risk for providers. Clinicians in these models can qualify for the 5 percent bonus I mentioned earlier.

According to federally funded evaluations of Medicare's APMs, as well as studies by other researchers of these and other models, APMs have not yet had the impacts on spending and quality that many would like to see.

ACOs have the best track record so far -- often producing gross savings, and sometimes producing net savings, although these savings are usually less than 1 percent.

Quality impacts tend to be small, when they are achieved, and most often consist of reductions in ED visits or increases in the delivery of some preventive services.

Episode-based payment models have had somewhat

less success. They often produce gross savings, but rarely produce net savings -- with the notable exception of hip and knee replacements, which have saved Medicare 2 percent among hospitals mandated to take bundled payments for these episodes. Studies generally find little to no impact on quality, although the mandatory model I just mentioned reduced rates of readmissions and complications.

Primary care transformation models have been studied to a much greater extent than ACOs and episode-based payment models, but have shown more mixed findings in terms of their ability to generate savings. This may in part be due to the wide heterogeneity in the models that have been studied so far. These models generally have little to no effect on quality, but when they do improve quality, they tend to influence the same types of metrics as ACOs.

I'll now pass things over to Geoff.

MR. GERHARDT: In addition to the impacts on spending and quality described in the previous slide, some observers theorize that APMs potentially have other positive impacts on the health care system, although some of these effects can be hard to quantify.

For example, improvements in care delivery patterns prompted by a Medicare APM may lead to changes in the way that providers treat patients insured by other payers.

In another example, reductions in gross spending associated with ACOs and other models may have resulted in lower spending on Medicare Advantage, since MA payments are tied to fee-for-service spending.

The APMs implemented by CMS also signals to providers that Medicare's ultimate goal is to transition away from purely fee-for-service payment incentives. This may, in turn, be helping to raise provider awareness of the costs they generate and the need to change care patterns to focus more on prevention and efficient utilization.

Medicare's pursuit of APMs might also have encouraged other payers to pursue alternative payment arrangements, which could have contributed to the slowdown in growth of national health care spending.

It's worth taking a moment to consider why more models have not generated net savings for Medicare or led to substantial improvements in quality.

Since many APMs are layered on top of fee-for-

service payment systems, the incentives in fee-for-service to increase provider revenue by maximizing volume may outweigh the APM's incentives to reduce volume.

And while incentives under fee-for-service are relatively easy for providers to understand and respond to, the incentives in APMs can be extremely complex and difficult for providers to fully understand. The complexity of models may be suppressing provider participation and limiting the effectiveness of incentives for providers to change behavior.

In addition, certain providers -- especially those who are employed by a large health care organization -- may be partially or completely shielded from the financial incentives in APMs.

Models where participation is voluntary or providers have choices about what services they are financially accountable for are likely to predominantly attract providers that expect to receive performance bonuses without substantially changing their behavior.

Infrastructure investments, such as care management staff and data analysis, may be needed to achieve APM performance goals. Some providers may not be

able to afford these investments or believe they won't pay off during the model's implementation period.

And, finally, beneficiaries attributed to an APM may not have any incentive to change their own behavior, placing the onus for improvement entirely on providers.

In addition to the potential barriers to success listed on the previous slide --

[Feedback.]

DR. CHERNEW: I think someone needs to mute.

MR. GERHARDT: I'll try again.

In addition to the potential barriers to success listed on the previous slide, there can also be challenges associated with CMS' practice of operating a large number of essentially independent, concurrent models, which we'll discuss on the next two slides.

CMS generally does not allow providers to participate in more than one ACO model, but providers and beneficiaries are often permitted to simultaneously participate in multiple types of APMs. For example, providers participating in the MSSP or the NextGen program may also participate in bundled payment models like BCPI Advanced, and beneficiaries attributed to an MSSP ACO may

be aligned to a practice in the Comprehensive Primary Care Plus model.

While overlapping model participation can increase the participation in APMs, it can also create problematic interactive effects.

One potential problem is that having providers participate in multiple APMs can dilute the effectiveness of incentives to bring down costs and improve care if the models present providers with differing financial incentives and operational requirements.

Another complicating factor is that performance payments made under a model are often included in the total spending performance of another model, thus making it more difficult to achieve savings relative to the second model's spending target.

Having beneficiaries attributed to multiple models can also weaken incentives to bring down costs.

To prevent savings -- or costs -- from being double counted, CMS has developed rules about how costs attributable to beneficiaries in multiple APMs are allocated between models. These rules can result in performance payments being divided between models in

unanticipated ways, potentially reducing the effectiveness of those payments to change provider behavior.

Finally, the prevalence of multiple overlapping models can complicate efforts to isolate and measure the effects of a given APM on spending and quality. With so many models being implemented simultaneously, it is often difficult for evaluators to construct a comparison group that have not been influenced by similar models.

CMS deserves credit for implementing a variety of innovative alternative payment and service delivery models over the last decade.

However, Commissioners have expressed concern that CMS' approach to testing a large number of independent APMs simultaneously may be inhibiting models' ability to reach their full potential. At the January meeting, many Commissioners were supportive of a policy option that would address this concern by urging CMS to take a more streamlined, integrated approach to implementation of APMs.

As such, the Chair's draft recommendation reads:

The Secretary should implement a more coordinated portfolio of fewer alternative payment models that support the strategic objectives of reducing spending and improving

quality.

By urging CMS to implement a smaller suite of models where financial incentives to reduce spending are better aligned, the recommendation could increase the degree to which providers change their behavior in response to model incentives. This could lead to greater reductions in Medicare spending, depending on how the recommendation is carried out by CMS and how providers respond to the smaller group of models.

Similarly, beneficiaries should benefit from the recommendation, assuming the smaller suite of models are more effective in encouraging providers to improve care coordination, health outcomes, and other factors important to beneficiaries. To the extent that the recommendation leads to reductions in spending, beneficiaries would also benefit from potentially lower cost sharing and premiums.

The recommendation is also likely to have benefits for providers through more predictable financial incentives, reduced administrative burden, and a more consistent set of goals and parameters across models.

We now return to the draft recommendation.

After we get your feedback today, we will return

in April for a formal vote and an accompanying chapter in the June report.

We look forward to your input and any questions your might have. I'll now hand things back to Mike.

DR. CHERNEW: I'm just a placeholder. I am going to hand things over to Dana Kelley to run the Round 1 queue and then the Round 2 queue. Dana.

MS. KELLEY: I think we have one person for Round 1, and that is Marge.

DR. CHERNEW: And Dana Safran actually, I think, Round 1 request. But go on, Marge.

MS. MARJORIE GINSBURG: Okay. This is a quickie. What we've identified, the problems, can't be blinded to CMMI. Have there been any discussions with the leadership there about these problems? Surely they know what we're suggesting, but it just seems so apparent that there are problems with this. I'm just curious whether staff have had conversations with CMMI about these particular issues.

MS. BURTON: We have not.

MS. KELLEY: Okay. Dana?

DR. SAFRAN: Yes, thank you. Just two questions for the team, and, first, thank you for this really

excellent work. This chapter has taken shape so nicely.

You have a new figure, Figure 3, and it looks like the source of the data for that are from the Health Care Payment Learning and Action network. But I did have a question about it, and that is, the categories of shared savings, upside only or bonus only shared savings, you know, two-sided, which, you know, the parenthetical says "with financial risk." And then there is a separate category of partial capitation, full capitation, global budgets. And I'm failing to grasp how we can be parsing those things since they almost always come in pairs, right? So you could have a global budget contract that has shared savings only. You could have a global budget contract that has two-sided risk.

And so can you just help me understand how we are differentiating the amount, whether it is one-sided or two-sided risk, from whether it is a capitated versus budgeted model?

MS. BURTON: When a payment model has multiple features, the instructions that the LAN gives to respondents is that they should assign the feature that I guess is the most prominent in the payment model. But we

can get back to you offline to discuss this further.

DR. SAFRAN: Okay, sounds good. I think we don't want to confuse our readers, because, you know, it could look like there's so much shared savings out there and not understand, you know, those are shared savings that are embedded in global budget models, et cetera. So it seems worth looking at that.

My other question was about the direct contracting text box, and in light of the announcement earlier this week about the geographic model, maybe this isn't so relevant anymore, but I'll ask it anyway. For the provider in global models, you noted, "Spending targets were discounted 2 to 5 percent." And then when you were talking about the geographic model, you talked about the rates being discounted 2 to 5 percent. And I just wanted to understand, is the discounting actually applying to different things in these models? Or if not, why are we using different language?

MR. GERHARDT: I think that it's based off the same basis, but there are some details about the geographic option that haven't been fully explained or the geographic model that haven't been fully explained. So we can go back

and try to clarify that, what the basis is or whether there's any difference between the two.

DR. SAFRAN: Okay, great. And I'll come back with Round 2 comments, but just while I'm mentioning this text box, I think it would be good to add something to it that just gives a little information about the level of participation that has been seen so far. So I'll just throw that in and come back later with Round 2.

Thank you.

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

Larry, we can't hear you.

DR. CASALINO: I'll never be able to say this as articulately as I just did. I wasn't going to say this, but Dana's comment made me think it's probably worth bringing up. I have found it always ambiguous when CMS talks about percentage of payments in alternative payment models that involve some financial risk, and I think that ambiguity also comes through into this chapter, which it goes without saying I think is great. Someday there's going to be a chapter that isn't great, but I haven't seen one yet. I mean that seriously, not facetiously.

But, for example, looking at Figure 2 -- one could do this looking at either figure -- where by 2025 supposedly 100 percent -- the goal is for HHS to have 100 percent of health care payments in traditional Medicare be in alternative payment models that involve some financial risk. At least for myself, if I tried to parse that and ask what does that mean exactly, does that mean that all fee-for-service providers are going to be in alternative payment models? Does it mean that every dollar that traditional Medicare pays has some financial risk attached to it? And I could think of alternative hypotheses about what it might mean as well.

So I wouldn't mind a comment on that now, but also for the chapter, I think it would be helpful to be as unambiguous as possible about that, because this is kind of an important point. And I think over the years, with HHS at least, it has led to -- the ambiguity has in my mind led to probably an exaggerated impression for some people of how much health care payment really is in alternative payment models now or has incentives tied to it.

MS. BURTON: I think that's something we need to do a little digging on, but we can address it in the next

version.

DR. CASALINO: Great.

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

MS. THOMPSON: Thank you, Dana. I do. Just to level set -- and maybe I'm the only one, but I want to be reminded of the relationship and the authority between CMS and CMMI, and as the recommendation is drafted, our recommendation is towards the Secretary. So, yeah, just clarify again the authority and freedom, if you will, of CMMI to act independently.

MS. BURTON: CMMI sits within CMS which sits within HHS. I'm not really sure how to answer your question. I'm wondering if maybe Jeff or Jim has something here.

DR. CHERNEW: Could I say my understanding? Although I would defer to Jim first.

DR. MATHEWS: Go ahead, Mike.

DR. CHERNEW: CMMI has a very specific charge about testing models and diffusing models in a very specific way. And so while at the end of the day I think they have a lot of authority in terms of what they do, they do have to be responsive to basically their charter, and

their charter is set out broader than what they do. And I think that is where -- in part, that is where some of the constrain may lie.

And I would say more broadly that's why this is a recommendation to the Secretary, although it doesn't mean that it couldn't be -- in fact, I think it would be coordinated with CMMI, but it's not completely clear how far CMMI could go with their existing legislative charter.

That's my sense, and, again, I am not an expert in this exact area, so maybe Rachel, Jeff, Jim, or anyone else on the phone may have some sense of that.

MR. GERHARDT: So I'll just say CMMI is, of course, a center within CMS. It was authorized within Title 18. CMS is within HHS, which is where we traditionally direct these kind of recommendations to. But I think part of the point that we're trying to make with this is that this is more than just something for CMMI to be thinking about because the largest APM program, MSSP, is not actually administered by CMMI. It's administered by CM, that CMS as an entity needs to be thinking holistically about how to do its APMs. So cross-cutting across both CMMI and other centers within CMS that implement APMs.

MS. THOMPSON: Thank you. I just remember at the outset CMMI, they had broad authority, and I just call it out. But thank you very much. That's my question.

DR. CHERNEW: I think they do have broad authority, but I do think they have some limits in their charge as to what they're supposed to do. In some ways, we're making a recommendation to have them scale back in a particular way. And so I do think that we'll continue to work through those administrative and logistical lines, but by making a recommendation to the Secretary in some sense we're at a level that subsumes what's below that, at least in my view. But with below, it doesn't necessarily subsume what's above it. I don't know if that makes sense, and I'm sure not an expert. So later when I ask for public comment, the public can send something to MedPAC on this.

So, Dana, am I right that that was the last Round 1 question?

MS. KELLEY: Yes.

DR. CHERNEW: So then, Dana, can we start with Round 2?

MS. KELLEY: Sure can. Paul, you're first.

DR. PAUL GINSBURG: Good. I really enjoyed

reading the chapter. I thought it was, you know, very succinct and covered a lot of ground.

After I read it, I start thinking about, you know, too many models, lack of coordination, or maybe just poor coordination, and I started thinking that perhaps coordination is a bigger problem than numbers. And, you know, the key to coordination is that we have our population models, plus the ACOs; we have our episode models; we have our primary care models. And it's the coordination among those categories that I think has been a real drag to the system.

I don't know that having too many ACOs is that big a problem. It is a problem with their voluntary and where a provider organization can select themselves into the flavor of ACOs that works better for them. But to the degree that coordination is the bigger problem, I think we need to make sure that comes through in the chapter.

The second of three comments I had is that when we make the recommendation, the Chairman's recommendation, which, you know, is fine with me, we just stop there. And, you know, this is -- as opposed to sketching out a bit about how CMS might actually go about doing this. And we

don't have to give them a blueprint, but just, I think, give them a little more than just, you know, this pronouncement that we need better coordination and fewer models.

The third comment I had was that I think it's really important to convey to the readers that this recommendation about numbers of models and coordination between them is really part of a broader strategy about bringing more care into these alternative payment models and in a sense, you know, remind people of the big picture at the beginning and then outline how this particular recommendation fits into this, and maybe even mentions, even though we're going to need another cycle, at least, to go through the other aspects of, you know, what else is coming and where this fits in with that.

MS. KELLEY: Mike, I can't tell if you're trying to speak here.

DR. CHERNEW: No. I thought -- I think we should keep going. I will have some wrap-up comments, but I think it's important that we get through the queue before I give my reactions.

MS. KELLEY: Okay. Dana, you're next.

DR. SAFRAN: Thank you. I had to step away for a brief moment, so I apologize if anything I say here is redundant to Paul without giving credit to Paul. I just didn't hear a lot of what you shared, Paul.

So the first comment I had was -- by the way, I should say I fully support the Chairman's draft recommendation. So the first comment I had was that I think that the chapter has come a long way. I really like the addition of Table 1. And in part what I like about it is it begins to share some granularity, not just broad sweeping statements about APMs and whether they seem to be working or not, but really like which kinds of APMs seem to be working and how much.

To that end, I think that the overall text needs to do a better job of mirroring that, especially in light of recommendations that are to develop a more coordinated and parsimonious set of programs, it really fits with that recommendation that we're saying, you know, not just something broad and sweeping about APMs in general and whether they're working, but which kinds appear to be working.

You know, when I looked at the data in Table 1,

what I saw which really was encouraging is four out of 15 programs had net savings, five programs had net losses, and six were indeterminant. That to me paints a very different picture from what people typically, you know, who are talking negatively about APMs would say. That's more than a quarter of these programs listed having net savings.

And it gets better than that, I think, when you look at the groupings because you see that two of three full-fledged ACO programs had net savings, and that's really differentiated from the episode programs that you list where one in five did, and then with the primary care where neither did.

So I think there's an intelligence that we get with that table about the groupings and which programs appear to be working and not that we just need to draw out a little bit better in this text. So that's my first comment, and also, you know, that would lead to some adjustments, especially in the executive summary and the final summary segment of the chapter.

Then just a couple other probably much smaller points from me. One is in the executive summary I think it will be very valuable to highlight and maybe even cross-

reference the work that we'll be publishing on Medicare Advantage. You know, in that work, which I know we'll be talking about later today, we're talking about a program that's 35 years old and has never showed savings. And to not reference that in a relatively new program where, you know, there, I think, can be tremendous skepticism and questioning about what values it's delivering, I think we have to just point to the issue that we shouldn't be holding these to different standards, or if we think we should, to be explicit about why.

And then a couple final things. I think on page 30 where you're talking about, you know, the various reasons that may have impeded success, in one paragraph we're talking about mixed incentives. I think it would be helpful to just clarify that part of what we're talking about is organizations versus physicians within those organizations, and in the case of organizations, that they likely have mixed incentives, not because the programs are laid on top of fee-for-service infrastructure, but because they have a combination of patients that they're seeing for which they have accountability for total cost of care, and other patients who they do not where, you know, they're

seeing them on a referral basis or they are somebody else's budgeted population, and that that creates some mixed incentives; and that, you know, as you point out in a separate comment, physician compensation may be completely divorced from the incentives. So I thought it would be helpful to tease that out.

And then, finally, I would just say when you're talking about the voluntary nature, I thought it is helpful to also point out that the ability of providers to opt out and, therefore, the attrition could also be leading to lower participation rates obviously than if the models were more mandatory.

So thanks for that, and, again, thank you for a really terrific piece of work.

MS. KELLEY: Brian.

DR. DeBUSK: First of all, I want to echo the comments. This was a really great chapter, and I think that the summaries of the various models that were done were particularly powerful. It was really grounded all in one place.

I do support the Chairman's recommendation. I think there's merit in streamlining the models. If

anything, CMMI might actually welcome the release because I'm sure they get pressed from a lot of different sides to pursue a lot of different programs.

You know, once we get past this recommendation, it's going to come down to which models make the cut, and I think that's an entirely different conversation. I think when we agree that there are fewer, that we should narrow the models down, it's sort of implicit that we all assume that our favorite model isn't going to get cut.

But I also want to agree with Paul's comments regarding coordination of those models. I do think there's a coordinating challenge, again, assuming that we have, say, a population health, an episodic, and a primary care model. The coordination is going to be really key, and I know we're going to have a conversation about do you allocate savings between models or do you follow more of a precedence where one model supersedes the other? I personally would favor savings an allocation model, but, again, that's something we'll do in the next cycle.

I also hope that we harmonize as many elements as we can, whether it's how we do attribution, how we do risk adjustments, how we allow risk adjustments to affect

benchmarks, how we measure quality. I think there's a great opportunity as we streamline and simplify the classes of models to also address harmonizing the various elements and standardize everywhere we can.

The chapter does touch on this, but I would also just for the record like to comment on the fact that all of these models or essentially all these models are still largely built on fee-for-service, and I think you have a very inductive chassis there. I think a lot of energy and effort is put into just simply containing the highly inductive effects of fee-for-service. So I do remain concerned that virtually all APMs are layered on top of that fee-for-service chassis.

The other thing I hope we get a chance to discuss is the issue that fee-for-service itself -- people do well in fee-for-service. I mean, you know, we're going to publish a report talking about the 6 to 7 percent operating margins that hospitals have. I just read an article the other day that was talking about physicians that, you know, one-third of all physicians are in the top 1 percent of income earners. And I don't think there's anything wrong with that. I actually think that's a good thing. But I

think it underscores the fact that fee-for-service is a comfortable place. There are a lot of people who really thrive and do well. And I think when you start talking about APMs, making the case for change and trying to drive change there is going to be very difficult considering how comfortable fee-for-service is.

And that actually brings me to my final comment, which I really appreciated what Dana had to say about the spillover issues. I think that's the other challenge. You know, normally when we talk about does the shared savings model even make financial sense, it triggers this esoteric conversation about, well, you know, what's the variable cost of the hospital or what's the percent of shared savings?

But here's an exercise that I think would be really interesting to look at. Let's say you have one ACO patient that -- or one patient or beneficiary that you could actually stop an admission or an ED visit on. And let's say you had 100 percent shared savings share and you had zero fixed costs, so it was completely variable cost. Even in that model, I think you would find that if that behavior spilled over say to another Medicare beneficiary

or to a commercial patient, I think what you would find is that the benefit of those shared savings, when it's layered on top of fee-for-service, quickly get wiped out. And just imagine sort of the context for ACOs in general then. You know, if they're successful in the Medicare compartment, in theory they would induce behaviors that would spill over into commercial patients, which instead of reimbursing at 91 percent of cost, like Medicare patients do, reimburse at typically double the Medicare -- 180 to 200 percent of Medicare. It wouldn't take a lot of that spillover to completely wipe out the financial benefit of ACOs.

So I hope as we go forward, we'll look at the financial backdrop as well and the fee-for-service chassis and realize that we're building all of these models, essentially all of them on a highly inductive chassis.

And those are my comments. Thank you.

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

DR. CHERNEW: I just wanted to say a few things to go forward. The first thing is, just for the folks listening, this is the first step in a series of steps in an arc of activity that will span many cycles and that much of what was discussed, to Paul's comment, for example, are

very well taken, about how we move forward is going to be a major endeavor next cycle. But again, as was mentioned, because we may not always agree, because we have haven't attacked all of the analysis, we haven't yet been ready to give very specific notions about how to go forward in substance or process, although certainly we plan to continue that work and to engage with stakeholders as that work is going on. So that's the first part.

The second part is, earlier drafts of this recommendation have language like "synergistic and coordinated models." That made the recommendation long and people thought, in discussions, that synergistic and coordinated were a little vague. We will give some thought to the exacting wording. It sounds like people are calling for synergic, coordinated models. So we will continue to think through the actual language here, but the key point is, it is not simply fewer models. It's the recognition that the models interact and the desire to have a portfolio that works together as opposed to a bunch of standalone models, because standalone models, in a world of many models, every model affects everything else.

So I'm going to leave it there for now, and I may

come back to this theme later. Yes, Dana, you can go on in the queue.

MS. KELLEY: David is next.

DR. GRABOWSKI: Great. Thanks, Dana, and thanks to Rachel and Geoff for this great work. And I'll start by saying I support the Chair's draft recommendation.

I'm going to keep it brief because Dana actually made my main point, and that point is that I think we've done a lot of the hard work in reviewing the prior programs, and that information is there. But I really agree with Dana. I don't know that we really rolled this up and summarized the success of the prior APMs and what's working. And if we're going to try to move to fewer models I think we want to do that in a thoughtful way and build on the literature. And right now it feels like, you go into the details of that table, and Dana already did this, of kind of going through and telling us which kinds of models work. I think things have been a little bit more successful than we characterize it.

I would point to Slide 7 in your presentation, with net savings sometimes a bit small, rarely, usually not measured, quality gains inconsistent, little to no impact,

inconsistent and small improvements. If you showed me that and said we're going to do fewer models or consolidate, I would say why even bother? We should probably pack this in. So I don't think that we are really kind of packaging this. I understand the sort of coordination of the models will ultimately, and fewer models will lead to better outcomes. I understand the spillovers argument that Dana and Brian made. But I really think we need to kind of message this a little bit better, especially around the ACOs and which of those ACOs have worked and why.

So I just think, in sort of summarizing the literature, we could do a better job of that, because ultimately -- I wrote it down and I hope I wrote down what you said right, Dana -- which APMs are working and in what ways, and I think that's what we want to ultimately know. And I think we've done the hard work in terms of the details here, but we need to synthesize this.

And I guess maybe this connects to a point Jon Perlin makes often, and I really like, that we need to be systematic in how we summarize the evidence and sort of come up with recommendations. And here's an example of that, where I think some of the better-done studies should

be weighted more than just this kind of vast denominator of work that's been done in this area.

So once again, thank you for this. I'm very supportive of the recommendation and like the way this is going. Thank you.

MS. KELLEY: Amol?

DR. NAVATHE: Thanks, Dana. So thanks, Geoff and Rachel, for all the work that you've put in here. I think it is clearly reflected in the direction of the chapter and very, very much appreciated.

I, too, would just like to register my support for the Chairman's draft recommendation here. I do think we are definitely headed in the right direction, and it is great to see that.

I wanted to, I guess, offer a couple of consideration in terms of somewhat like what David was saying around framing early interpretation, and link it to where I think we are at the kind of arc of APMs in a broad sense, or Medicare programming, where we are headed.

So, for example, if we think about -- I really like the fact that on Slide 7 now, in that table, we actually articulate gross savings and net savings, and

actually differentiate the two things, because think sometimes they get kind of mashed together. And I think both are critically important, but they tell us two different things. In some sense, if you think about gross savings, the question is, did health care providers change their practice patterns relative to what would have otherwise just been the status quo under fee-for-service? So while gross savings doesn't mean net dollars to the Medicare program, it does indicate something pretty important in terms of the ability for a model to start to shift practice patterns over time.

The net savings part, of course, is, in some sense, the Holy Grail of the state Medicare program dollars, and that is clearly a higher bar in some respect. But, at the same time, that could also be interpreted, in part, about the program design, so the way the financial structure of the program itself is. So if we're successful in shifting practice patterns, then we could alter the financial formula, to some extent, to try to generate better savings or further savings, or move from not quite generating savings but to generating savings to the Medicare program.

So I just wanted to make sure that we are articulating that interpretation appropriately in our chapter, because I think it is a nuanced point, to some extent, but I don't think it's a subtle point that should be overlooked. And I think, in some sense, if we link this to the arc of innovation, if you will, for the Medicare program, I think had discussed in prior public meetings about this work, that the first decade saw a lot of innovation, just a ton of models coming out there, which I think was most likely very appropriate for where the innovation center was, kind of getting out of the gates. And perhaps now we're shifting more towards this approach that we are recommending, towards kind of synthesizing and coordination.

So in some sense, if we applied a yardstick of, are we generating savings to the Medicare program for every model, for each model category, that may, in fact, not be the right yardstick to measure. In fact, we might change the question a little bit and say, can we achieve gross savings, can we achieve practice pattern changes, can we achieve, even at times, net savings within a category? And if the answer to that, which I think at least for ACOs and

episode-based payments, the answer is yes for both of those things -- we can change practice patterns and, at times, we can generate net savings to the program as well -- then I think that gives us a lot of energy and direction to move toward, and say, okay, let's consolidate around those program designs and the flavors and design principles that are generating the kinds of practice patterns that we want to see, and then we can try to coordinate. We can try to simplify down, and we can try to coordinate amongst those models.

And similarly, on the quality gain side, I think we have to also remember that the goal here is either to keep spending static, and improve quality -- ideally, of course, improving both -- or, on the flip side, keep quality more or less the same and improve in terms of costs. So when we frame things around quality gains alone, I think it does mixed-message a little bit what we're trying to get at there, where if we can actually keep quality fairly consistent, if you will, and generate savings, that's also a really good thing. So we shouldn't lose sight of that.

So I think some reframing around that Slide 7

table and some of the interpretation there, kind of linking to where we are in this arc of innovation, I think will do us a service and actually creating a cogent argument, if you will, leading to the Chairman's draft recommendation.

But broadly speaking, let me echo the prior Commissioners' comments, which is I love the direction we're going in. I think it is clear that we are making a lot of progress in that direction. There is a lot of work for us to do yet, I think, in this space, and I'm excited to be headed in that direction, and Brian and Dana and others have mentioned some of these ideas of harmonizing and standardizing that could actually have impact that even extends beyond the Medicare program itself.

So thank you very much for all the work that you guys have done h ere.

MS. KELLEY: Paul, did you have a comment on something Amol said?

DR. PAUL GINSBURG: Yes. I'm really glad Amol brought up the issue about the importance of the growth savings estimates in these studies. And just a thought I have is that, you know, now often the net savings are a lot less than the gross savings because of all that's being

done to attract providers into these programs, to get them to try it.

I would imagine, down the road, when the models get better and there's more experience, and that there's more participation in APMs, you know, kind of the bonuses offered to coax participation likely won't be as important, so the net savings may come up closer to the gross savings as we move forward. So, you know, if it approaches solid gross savings, and even it doesn't have net savings today, that doesn't mean we should dismiss it.

MS. KELLEY: Okay. Betty.

DR. RAMBUR: Thank you. Thank you for an excellent report, and I appreciate the comments of the Commissioners. Probably my comments will come as no surprise but I'll say them anyway.

First of all, I am happy to see us making a recommendation to get at the dizzying array of different models. It's very confusing for people at the working surface to try to sort it all out.

When I look at Table 1, the one thing that, of course, immediately struck me is one of the areas that had the checkmarks all the way through is the mandatory, the

mandatory joint category, that had gross savings, net savings, and quality improvement. And I would like to see us have these recommendations -- I support these recommendations but more specificity, including more mandated and more risk bearing.

I will complement what Brian had said about the fee-for-service chassis, because if you are socialized and marinated in fee-for-service, every cell in your body has that as an instinct. And in the report it says the incentives are easy to understand and respond to, and they are. They are easy to generate a lot of services and a lot of revenue for the person billing fee-for-service, whether it makes an impact or not.

So I'm really supportive of this direction. I appreciated the comments on greater coordination. I am pleased to have been sort of illuminated about the importance of gross savings, what it means in terms of practice patterns, but I would like to see us having a little more teeth in it in terms of recommending more mandatory and more full risk bearing. Thank you.

MS. KELLEY: Jonathan Jaffery.

DR. JAFFERY: Thanks, Dana. Let me start off

echoing everyone's comments about what a great chapter and what a great evolution of this work is. It really feels like we are moving things down the road here, and I fully support the Chairman's draft recommendation. I think this is a great place for us to be now.

I will just maybe make a few comments about things that sort of signal some thoughts about what we can do, because as Mike has said a few times now, this is a multi-cycle process, and I don't think it's too early for us to be thinking about this with some more concreteness, how we're going forward.

So a few things that I would like to see. Betty just talked about one of them, these mandatory models. I think providers will -- we do see that they change behavior. Often they will when forced to and won't when it's optional, and as Brian pointed out, fee-for-service is actually really easy, and for those of us who sit in some of these health systems and talk to folks who have been doing this for a long time, it is just really, really straightforward to think about fee-for-service, when some of these other things are not as straightforward. So, given those options, you can sort of default to keep doing

what you've always been doing.

We've done a lot of work, over the last couple of cycles, about attribution, at least within ACO models. I think that's great. We've talked about the need to do some more here. And some of the things that I'd like to call out for the next year is really thinking about predictable benchmarks, particularly in ACOs, but I think that's going to be really key, and it probably leads us more down the road towards capitation of global budgets.

And then just one final comment about the coordination piece. I won't go on and on about things that others have said. I really appreciated how Paul brought this up, and it's clear, I think, that at least theoretically we could have lots of models and be coordinated and make that work, but if we're not coordinated even with a few models, that's going to be a problem. So the coordination is key.

And I think there was one other thing that we may want to explore as we tease things out in the next few cycles, not just thinking about coordination between models, as an example, ACOs and episode payments -- I think there is actually some concrete work we probably should

think about fleshing out there -- but it's not just about beneficiary attribution in those models or provider participation, but I think there's also a coordination piece in thinking about what are options for providers when they're going to have multiple groups of patients, or populations of patients, coming in that will be in different categories, and not just because of different payers but even within the Medicare population.

So what I really mean by that is thinking probably more about specialists, especially those who have a wide geographic catchment area, how do we get the incentives lined up properly for folks like that -- and actually this goes for hospitals too, and maybe some other providers -- but how do we get those incentives lined up if they've got one maybe sizeable portion of their patient population coming in, in some of these models now, but they're still getting fee-for-service coming from all sorts of other places? And how do we really get to kind of global risk or a situation where we've got 100 percent of payments in some sort of risk model when there are those kinds of arrangements still happening from somebody coming far away for services. So I'd like to see us explore that

a little bit too, and think about how that fits in with these.

But again, great work and fully supportive of where we're headed with this right now.

MS. KELLEY: Jaewon?

DR. RYU: Yeah, thank you, Rachel and Geoff, for a really neat chapter on a key subject. I would also echo the support for the draft recommendation. I think it makes a lot of sense for a whole lot of reasons, as folks have mentioned.

I do want to get back to something that Paul raised, because I think there is an opportunity, I would agree with Paul, in terms of how do you take the next steps on this. And, in particular, how do you streamline? How do you get to fewer of these programs? And it seems like there are a couple of different dimensions. We've talked a lot, and folks have mentioned the gross and the net savings, and I think keeping an eye on both of those and taking those into consideration makes a lot of sense to guide us to the programs that have been more successful.

At the same time, I just want to make sure, and hopefully if I could put in a request, on Table 1 it would

be neat to see how many beneficiaries are wrapped up in each of these programs, because I think the notion of uptake should also be a consideration. Which of these programs have had greater uptake? I think the ones with greater uptake, with gross and ideally even net savings, that seems like the sweet spot that we would want to focus on, as opposed to trying to introduce folks to a model that's totally new from where they currently reside.

And then the other dimension that might be useful in terms of how we get to a smaller number is we've talked before about categories of programs, and I think there are some categories that many of these fit into. Some are sort of population-based programs, like the MSSP, and then others are more episode-based. And I think there's some framework that we could perhaps offer in terms of are we shooting for a program from this category and a program on that category. I think there's just a little more that we can do to sort of frame out the skeleton, if you will, and then go from there.

MS. KELLEY: Larry?

DR. CASALINO: Thanks, Dana. Three quite quick comments on the report, and then a more substantive comment

about moving forward.

Compliments to the staff for the report. It is such a large and complex area and it is really hard to get one's hands around it. I think you guys did a good job.

I would make three suggestions on the report. One is, consider maybe putting in a bit of context about how it came about that CMMI initiated so many models. I think, as the report is written, this could be taken as an implicit, pretty strong criticism of CMMI putting in so many models, although I don't think that is what we intend. So maybe just little bit about that. It is quite easy to think of the reasons why so many models were put in place, and they are very understandable reasons. Probably, in retrospect, there were some mistakes made as well, but it is easy to be a Monday morning quarterback. So maybe just a little bit about, historically, why we got so many models. That's the first point about the report.

The second is, I agree with Dana and David. They didn't put this maybe quite as bluntly, but the report might be a little too negative, or maybe not quite positive enough about what APMs have been performing so far. Dana's count was pretty persuasive, and also the suggestion of

comparing to Medicare Advantage, which has never generated net savings, is probably worth a sentence or two. So I think it would be a shame if the report is framed as maybe a little too hopeless. It's a stronger word, but --

And then the third comment, and Dana mentioned this and I'll say it in slightly different terms, I think it is important to distinguish -- "providers" covers a lot of ground in this report, as it often does. You know, different kinds of organizations but also different kinds of organizations and individual clinicians. And leaving the different kinds of organizations out, I think it is really often very important to distinguish between the organization in which a physician, say, works, and the individual physician. I think the incentives for organizations can be different. They can be stronger. And their purpose is different. It's to get organizations to invest in processes to improve the care they provide, invest in infrastructure, and give them some return on investments for the millions of dollars they can spend on that. It's different for physicians. For physicians, we want to change their behavior, and that's best done within their organization.

And so I think, just in editing the report, it might be useful throughout, really, to think about organizations versus physicians when you talk about providers, and it might even lead to some new insights.

So those are three comments on the report. The last thing I want to say is just, going forward, I think this is going to be the hardest thing, at least since I've been on the Commission, that we've tried to do. I certainly support the recommendation. Having fewer APMs, models, is probably good, and certainly we want them to be coordinated. But I think we're going to have to discuss, very explicitly, what we mean by coordination. It would be great to coordinate on attribution rules and quality measure rules and so on, but I think we mean more than that by coordination. I'm not going to try to define it now, but just to ask a few questions, again, specifically and operationally, what does it mean to have fewer coordinated APMs?

Let's say that we had an ACO, and the big problem here, I think, is coordination between ACOs and programs that are aimed at specific specialties, like primary care, or oncology, or nephrology/end-stage renal disease, for

example, or orthopedists with joint replacement. I think that if we had an ACO -- let's imagine one that had very strong financial incentives but slowly capitated, let's stay. So very strong financial incentives to reduce spending, and given some good quality incentives in there as well. You would think that ACO would pick problem areas and work with them to generate lower costs and higher quality, whether that be joint replacement, whether it be oncology care, whether it be end-stage renal disease, whether it be primary care.

So what is the purpose of having, let's just call them specialty-specific models, like the ones I've just mentioned. Do we think that we'll need them permanently, for physicians who aren't in highly incentivized ACOs, or do we want to test how well episode payment works, in case ACOs turn out not to work, and we would rely on bundled payments for some things? Or within an ACO, the ACO might try to pay the providers or physicians involved in the particular specialty or a particular kind of disease, like ESRD, in a bundled way.

So thinking about it that way, you know, as long as there are ACOs and bundled payments, let's just say,

shorthand for these specialty-specific things, we're always going to run into the problem of -- it's going to be very hard to not have overlap between the physicians and hospitals who are in ACOs and the ones who are in bundled payments, unless we have very, very select sets of providers in bundled payments and then a separate set of providers, completely separate, in ACOs.

So I think probably what I'm saying could be thought about more deeply, but I think my point is we really need to think about coordination, and it isn't so obvious, to me at least, how easy it is to coordinate between ACOs and specialty-specific things, and even to address the question, what is our ultimate vision? Is it to have lots of multi-specialty organizations that take basically a global cap, and there's no need to bundle anything, or, do we envision some kind of permanent system in which there are ACOs but there are also bundled payments for various things, and primary care practices that have special programs for them that aren't in ACOs. So I think this is going to be very difficult.

MS. KELLEY: Pat. Pat, we can't hear you.

Can you try now, Pat?

MS. WANG: Yes. Can you hear me now?

MS. KELLEY: Yes.

MS. WANG: Okay. Great chapter. I support the recommendation. Comments that Paul started out with and others have echoed about kind of wanting to say more in the recommendation I think also resonate, but I think that this recommendation maybe less is more because it's almost like a downpayment on the next body of work, and this is the first step. That's the way that I see this, because I don't think we can get all of the comments, because I think we're racing ahead to try to solve the problem, and this is, I think, intended to be the first step conceptually.

The goals that I would hope that we could hear or in the next phase keep in mind, you know, Medicare is the gold standard payment system for the country, and to the extent that Medicare does something, it influences everybody else. It influences commercial payers. It influences Medicaid. And I hope that we can keep in our mind that the goal is what's on the screen here, but to me the goal is to promote payment models that start to pervade the entire health care system and that have influence, because all of the comments that people have made about

fee-for-service chassis, the two feet in different boats and all of that, the problem is that none of these payment models occupies enough of a provider's revenue world to really change the way they practice. That's the issue -- right? -- is getting over a threshold amount so that all of the incentives for a provider are more this way than that way. So I think that that's a concept.

People have talked about mandatory models, and I understand why you're talking about it in that language. I would think about it slightly differently, that one of the purposes of testing these things is to find out how to permanently change the payment structure of Medicare. So if it's joint replacements that have been experimented with and it's a good idea, that's the new way that we -- there is no other way to pay for joints. And whether it's, you know, bundling specialty payments or what have you, I kind of feel like that should be an ultimate goal of testing these models, is to permanently make them part of the Medicare lexicon.

I hope that as we go forward we can include in our conversations the importance of beneficiary engagement. The other thing that is very special about Medicare,

remember, is that the insurance coverage status is stable. Unlike Medicaid where it's in and out based on eligibility recertification, commercial, you change employers, you have a completely different structure around you, Medicare, once you're in, you're in for good. And, you know, that's very, very precious, and I think it gives much more opportunity to engage beneficiaries in a consistent way with consistent signaling.

The final comment is I agree with some of the comments about trying to emphasize a little bit more of the positive in the chapter with the language of the chapter pointing out some of the things folks have said about Table 1, just noting the success of some of the models. I think it's really quite important because this is very hard work.

That said, I find the comparison in service of let's support APMs by saying, oh, but, you know, like we don't hold Medicare Advantage to the same standard because they've never saved the program money is an apples-and-oranges or maybe an apple-and-pomegranate comparison that I would just -- I don't think it's a good one. MA is an insurance program. They're insurance companies. This is a provider sort of redesign payment policy thing. To the

extent that an MA program uses APMs, that's an apples-to-apples. But if you want to just toe to toe on who is saving money on delivering the A-B benefit, MA is going to win. So I would be very careful about that. The reason that MA is more expensive, which we're going to talk about next, is because of all the supplemental benefits. They're actually delivering the A-B benefit for less, as the past work has shown. So I'd be careful about using that. I think it's an apple and an orange. I think the APM chapter can stand on its own as having a lot of value, and our support for APMs does not need to be compared to an insurance company program to say that it has value.

Thanks.

DR. CHERNEW: Let me just say really quickly we're almost at time. We have two more people. I would like to wrap up afterwards, so for Bruce and then I think Marge, can you please be conscious of being concise? I'm sorry. We are where we are in terms of the time. I think Bruce is next. Is that right, Dana?

MS. KELLEY: That is correct.

DR. CHERNEW: Oh, and Sue. Sue, I think you're on the list, too. Okay, concise. Bruce.

MR. PYENSON: Well, thank you very much. I'm supporting the Chair's draft recommendations, and we've heard a lot of really great, great comments.

Overall, I think the chapter is not nearly aggressive enough. I would like to see much more direct statements and I think whether we can get that in this round or not is not clear to me.

In my view, APMs are the latest version of a great experiment on whether the health care system can be improved and its cost reduced by encouraging providers and organizations to be smarter. It's an experiment. I keep remembering Uwe Reinhardt's statement, "It's the price, Stupid." And APMs are the alternative to that, and it's an experiment. And we're seeing if it's going to work or not.

Looking at the list of obstacles on Slide 9, I think the first obstacle there is overwhelmingly the most important. And if that's not addressed -- which is providers in APMs may continue to have incentives to maximize utilization. They may have fee-for-service incentives that are bigger than the incentives of the APM. If that's not addressed in anything CMMI produces, it will be a failure.

So I think the other arguments there are either derivative or, frankly, wrong. In particular, saying that models' incentives can be hard for providers to understand strikes me as not very realistic. You could think of physicians at the top of their class. You could give them a multiple-choice question. Here's the design for reimbursement. A patient comes in with back pain. In the context of this design, do you send them for imaging? Do you send them for physical therapy? Do you send them to the orthopedic surgeon? You know, I'm sorry -- I'm not a clinician -- if that's awkward choices. But I don't think the evidence is there that the incentives are too hard to understand. And let's keep in mind, as others have said, Jonathan in particular, that we're dealing with organizations, not individuals.

So, overall, I find myself -- this is key work. It's terrific work. I support the recommendation. But I think we have to be more aggressive and think more poignantly about making this work. Thank you.

MS. KELLEY: Sue.

MS. THOMPSON: Thanks, Dana. And building on those comments Bruce just made in terms of complexity, you

know, while the incentives may seem simple, simply even managing the quality metrics and being clear with providers and up-to-date with providers on the variation in quality metrics of the various plans that exist within a network, that an ACO holds, in the reading, I mean, we know that most consistently ACOs are reducing emergency Department visits, increasing delivery of preventative services and chronic disease management. That's good, but those are not measurements in Medicare's 2021 quality measures.

So, you know, I just think it's really important to recognize what incentives seem simple is not so simple for the practicing physician and provider.

Also, I want to call out in the reading the comment made about success by a few private insurers with primary care transformation models. Assuming success means reducing cost and improving quality, it would be interesting to understand what's the common thread. What's happening in integrated health care systems that enabled them to success for those commercial plans? But I think that goes into the category of what are we learning and whether we need to continue to roll out and perhaps move into the mandatory discussion, which I have to tell you, as

I listened to the discussion today around mandatory, I had a little bit of palpitation thinking about those providers out there who many ACO networks would not necessarily be very interested in taking into their ACO network. So if this becomes mandatory and assuming ACOs survive as an alternative payment model in some way, shape, or form, do not underestimate the challenge of some providers finding a home and participation in APM.

So, you know, with that, I wish everyone all the best. I will watch this conversation carefully into the next season of discussion. Thank you.

MS. KELLEY: Marge, I think you're the last one.

MS. MARJORIE GINSBURG: Yes, and I raised my hand, and then Pat spoke before I did, so I just wanted to say I completely agree with Pat regarding leaving the MAs out of this. Not only is it apples and oranges, MAs do save money; it's just that we haven't captured it yet. It's all going to them. So it really should not be part of this chapter at all.

So, anyway, thank you, Pat, for mentioning that.

DR. CHERNEW: Okay. I think we're at time. I am going to wrap up briefly. Then we're going to move on to

the Medicare Advantage chapter, which does indeed save money growth but not net. But, in any case, we'll save that.

Here's what I heard. There's some discussion about the language of the recommendation, and I think Larry's comment about what is coordination and a whole slew of other things really highlights why we ended up with the recommendation draft that we do, is that as soon as you begin to say more in that, it becomes very complicated. You have to define a bunch of general terms, which gets to a broader point, which is while I hear -- and, believe me, I've heard from a lot of you. While I hear there's a desire to say more and do more, I guarantee there are differences amongst us that we haven't yet done the analysis, the hallmark of our work, to know exactly what we want to say about things like population-based versus episode, how benchmarks evolve, what should be mandatory versus what should not be mandatory, a whole slew of things like that.

We will, I promise you, get to those topics, but I fear that in this particular sense I don't want to go give a sort of shoot-from-the-hip guidance about what

should happen. I think it's much more complicated when you get into the details, although we will work in the wording of the chapter to try and do that.

The last thing that I heard that we will work on is -- and, actually, I think there was actually quite a lot of consensus on this point. And I actually believe that the staff and folks understand there are a lot of pockets of success in APMs. It is sometimes diluted by things that haven't worked, and, Jon Perlin, I think he would probably say something like we have to call out those things as well, to give Jon credit for what I suspect he would say.

In any case, that is all true, but I do think we can work on the tone of how we present the evidence, because I really do think there is not only success; you will see in some cases, for example, the success grows over time. I think you will see the success is concentrated in some models in sort of types of organizations. And so one might think about a portfolio of models where different payment models are designed for different types of organizations.

There's just a lot, a lot -- maybe I should emphasize -- I don't have enough time since we're out

enough -- a lot to be done. But we will work very much on that. I think this is the first step towards changing the thinking about how we're going to transform payments so things work together as opposed to just test and diffuse, test and diffuse. But there is a lot of uncertainty and a lot of work to be done on exactly how to make those things work.

So, again, you know it's a passion of mine, and we will get to it. I could not be happier to have you all along on this journey. But with that said, I think it's important that we turn to the next session, which is on Medicare Advantage. So, Andy, are you going first?

DR. JOHNSON: Yes.

DR. CHERNEW: Okay. So I'm turning it to Andy, and we're going to talk about MA.

DR. JOHNSON: Good afternoon. This presentation addresses the system for setting benchmarks, used in calculating payment rates for Medicare Advantage plans.

The audience can download a PDF version of these slides in the handout section of the control panel on the right side of the screen.

Today we will discuss how the current benchmark

system results in inequities in payment rates and in the availability of extra benefits. Unlike our payment adequacy analysis for Original or fee-for-service Medicare, where we consider the direct financial pressure necessary to constrain providers' costs, the MA payment system passively tracks changes in fee-for-service spending.

Despite long-held expectations that private plans would achieve savings relative to fee-for-service Medicare, over 35 years no aggregate savings have been realized.

In light of prior Commission discussion in November 2019 and October and December of 2020, we have worked with the Chair to develop a recommendation for a new approach to establishing MA benchmarks that reflects the Commission's discussion.

In today's presentation, I will provide some background comparing MA and fee-for-service programs, including differences in the two programs' benefit structures and levels of Medicare spending.

I also will review the current MA payment system and describe issues with its method of setting benchmarks.

Luis will discuss an alternative approach to setting benchmarks and will present the Chair's draft

recommendation for replacing the current benchmark system with the alternative approach.

We start by looking at Medicare payments over time. Studies find that although private plans have generated savings in some high-spending regions of the country, no private plan program has ever yielded aggregate savings to Medicare.

Prior to 2004, including the early period when payment rates were set at 95 percent of fee-for-service spending, payments to private plans were biased due to favorable selection such that payments averaged 5 to 7 percent above fee-for-service costs for similar beneficiaries.

Although an improved risk adjustment system was introduced in 2004, the Medicare Modernization Act introduced a new benchmark policy that significantly increased payments to MA plans, reaching a peak in 2009 at 17 percent above fee-for-service spending.

Subsequently, the Affordable Care Act revised MA benchmark policy and payments declined. With the ACA revisions fully phased in, average MA plan payments have been steady for the past few years, with plans receiving

about 3 to 4 percent more than fee-for-service costs for similar beneficiaries.

Before we move on, I want to address an industry blog post that misrepresents MedPAC's assessment of MA and fee-for-service spending levels and offer some clarity. The blog focuses on a slide presented in our Context for Medicare Payment Policy September presentation. The context chapter focuses on relative spending growth rates among the different parts of the Medicare program -- MA, fee-for-service, and Part D, and is not intended for comparing MA and fee-for-service spending levels.

MedPAC does compare MA and fee-for-service spending levels and since 2004 has reported the results in the Medicare Advantage status report chapter that appears in our March report to the Congress. The result of these annual comparisons are aggregated on the previous slide. Our analysis accounts for differences in health status, the geographic distribution of enrollment, Medicare spending for hospice and graduate medical education, and diagnostic coding that inflates MA risk scores.

Separately, MedPAC has recognize that the CMS method of calculating fee-for-service spending when setting

MA benchmarks could be improved.

In 2017, the Commission recommended that, for setting benchmarks, fee-for-service spending could be calculated exclusively using beneficiaries who have both Part A and Part B Medicare, which aligns with the enrollment requirements from MA. We estimated that making this change would increase estimated fee-for-service spending by one percentage point and would move the line in the previous slide down by about one percentage point. Anything for all of these factors is necessary for an apples-to-apples comparison of MA and fee-for-service spending, and our conclusion continues to be that, when compared fairly and accurately, Medicare spends more for MA than for fee-for-service Medicare.

Now we move on to a more broad view of the MA program. Some predicted that the MA plan offerings and enrollment would decline under the ACA payment reductions. Instead, MA plans were able to reduce costs and increase benefits. The MA program hosts a robust set of plan offerings and has been growing steadily.

Between 2016 and 2021, the share of Medicare beneficiaries enrolled in MA rose from 33 percent to 46

percent, and the average number of plan choices increased from 18 to 32 plans, and the availability of a zero premium plans rose from 81 to 96 percent of Medicare beneficiaries.

Extra benefits include reduced cost sharing, reduced Part B and Part D premiums, and a wide range of health-related benefits, including vision and dental coverage, gym memberships, food assistance, and pest control. The annual value of all extra benefits increased by more than 70 percent over the past 5 years, reaching nearly $1,700 for 2021 and accounting for 14 percent of all MA payments.

All of these metrics are near or at record levels in the MA program.

When choosing between a Medicare Advantage plan and fee-for-service Medicare, beneficiaries consider whether they prefer the unrestricted provider networks and less utilization management in fee-for-service Medicare or the reduced cost sharing and health-related benefits that plans offer, often at no additional cost to the enrollee.

In fee-for-service, reduced cost sharing and additional benefits are available to some through an employer-sponsored plan, while others may purchase a

Medigap supplemental coverage plan. These plans, however, can have significant cost and access limitations.

Noting the record high level of extra benefits available in MA, which are not available in fee-for-service, we consider whether the tradeoff is equitably balanced for beneficiaries.

Furthermore, among MA enrollees, the availability of these extra benefits varies across the country due to differing benchmark levels. These inequities could be reduced under the alternative benchmark system we will discuss today.

Next we consider the substantial efficiency MA plans demonstrate relative to fee-for-service Medicare. 2021 MA plans bids for Part A and Part B services are 87 percent of fee-for-service spending, and 91 percent of projected MA enrollees are in plans bidding below fee-for-service spending.

However, for the same year, Medicare will pay MA plans 4 percent more than fee-for-service Medicare would spend for similar beneficiaries. Quality bonuses partially account for the high MA payment levels, but even after

excluding the effect of quality bonuses, base benchmarks are 3 percent above fee-for-service spending.

Without reforms to the benchmark system, Medicare will continue to pay more for MA than for fee-for-service Medicare. In considering the alternative approach to benchmarks, the Commission should consider the level of Medicare savings we should expect from the MA program.

We note that inequities on the previous slide and the high payment levels noted here exist in the current system where MA plan quality is not meaningfully measured and encounter data limitations hinder our ability to understand plan efficiency.

Next let's review how Medicare currently pays MA plans.

Each plan calculates a bid, which represents the plan's needed revenue to cover the Part A and Part B benefits for a beneficiary. The bid is compared to a benchmark, which is a bidding target based on average fee-for-service spending. I will explain how benchmarks are set on the next slide.

If a plan's bid is below the benchmark, which is

the case for almost all plans, Medicare will pay the plan its bid plus a share of the difference between the bid and the benchmark.

This share, called a "rebate," ranges from 50 and 70 percent of the difference and averages about 65 percent. Plans must use their rebate to provide the extra benefits I mentioned earlier. The remainder of the bid and benchmark difference is retained by Medicare.

In the rare cases that a plan bids above the benchmark, Medicare pays the plan its benchmark and enrollees must pay a premium to make up the difference.

Now let's look at the current system for setting benchmarks. A benchmark is established for each county based on per capita fee-for-service spending.

Counties are ranked lowest to highest and divided into quartiles. For counties in the lowest-spending quartile, benchmarks are set at 115 percent of local fee-for-service spending.

Moving up the quartiles, county benchmarks are set at 107.5 percent, 100 percent, and in the highest-spending quartile set at 95 percent of local fee-for-service spending.

In counties with low fee-for-service spending, benchmarks are set above fee-for-service to help attract MA plans, and in counties with high fee-for-service spending benchmarks are set lower than fee-for-service to generate Medicare savings.

As noted earlier, the 2021 benchmarks average 103 percent of fee-for-service spending, if you ignore the impact of quality bonuses, which the Commission has recommended eliminating.

I will briefly mention a few issues with the current benchmark system that are described more thoroughly in your paper.

First, areas with benchmarks set 15 percent above fee-for-service have attracted a disproportionate share of MA enrollment.

Second, the quartile system creates benchmark cliffs where small differences in county fee-for-service spending result in large differences in benchmarks.

And, finally, despite plans' demonstrated efficiency relative to fee-for-service, with bids averaging 87 percent of fee-for-service spending, the current system of benchmarks results in payments to plans that are higher

than fee-for-service spending would be for similar beneficiaries.

Now I'll turn it over to Luis to discuss a new approach for establishing benchmarks.

MR. SERNA: Some issues with MA benchmarks could be more fully addressed with major changes to the MA program, such as uniformity in benefits. Changes like this would likely entail more extensive changes to the MA benefit structure. Over the long term, the Commission could discuss these kinds of issues.

In the short term, alternatives exist that could be implemented immediately. A short-term alternative would not preclude any longer-term structural changes to MA.

A revised benchmark system should have attributes that leverage the efficiency of MA plans and support their wide availability.

Over the course of multiple public meeting discussions, attributes of a benchmark alternative that Commissioners have generally favored are: one, eliminating benchmark cliffs; two, bringing benchmarks closer to fee-for-service spending in the 115 percent and the 107.5 percent quartiles; three, putting at least some additional

pressure on some benchmarks in the 95 percent quartile; and, four, an immediate change in benchmarks that is not overly disruptive to basic supplemental coverage.

In October and December, we presented an alternative system for establishing benchmarks that conforms to these improvements and immediately replaces the current quartile structure. This system removes the quartile-based payments by blending local area and national spending. It achieves savings by applying a discount factor to benchmarks. We simulated benchmarks and payments for this alternative relative to current policy.

Building on Scott Harrison's work last cycle, we compare our simulations with 2020 base benchmarks, which do not include quality bonus and are an estimated 103 percent of fee-for-service. Including quality bonus would have increased benchmarks by four to five percentage points.

A blended benchmark alternative would also include prior MedPAC recommendations, which we have incorporated into our simulations where applicable.

We simulate a blended benchmark with a 75 percent rebate. More detail on the underlying assumptions used for our simulations can be found in your mailing material.

First, we turn to the weighting of local and national fee-for-service spending. We rank-ordered counties by local fee-for-service spending as seen by the light blue line.

When we plot current base benchmarks, we see several discontinuities relative to local fee-for-service spending -- as seen by the gray line with pervasive peaks and valleys.

After modeling various local and national weights, we found that blended benchmarks under a 50/50 weighting structure conformed to the Commission's guidance of better leveraging plan efficiency without constraining beneficiary access to plans.

Overall, an equal blend of local and national spending was the only option that moved benchmarks in the lowest spending areas much closer to fee-for-service, while also applying modest additional pressure on the highest spending areas.

We simulated blended benchmarks using MedPAC areas and found that nearly all MA markets had an average bid below the blended benchmark; 90 percent of MA market areas had an average bid more than 5 percent below the

blended benchmark. Thus, plan efficiencies could be further leveraged through a discount rate.

Without applying a discount rate, the program is unlikely to share in plan efficiencies and achieve savings. We simulated a 75 percent rebate and compared payments using a discount rate of 0 percent with a discount rate of 2 percent. Lowering all blended benchmarks by 2 percent yields savings of 2 percent.

While a blended benchmark structure would remove the payment quartiles, we examined payments by quartile of fee-for-service spending to compare with current policy. As seen in the cells on the right-hand side circled in yellow, a 2 percent discount rate helps ensure modest savings of 1 percent in the two highest quartile areas.

We also simulated plan availability under a 2 percent discount rate. Assuming no change in 2020 bids, which is likely conservative given that bid levels decreased in 2021, nearly all beneficiaries would continue to have an MA plan available with enough rebate dollars to cover 2020 levels of cost sharing. On average, even beneficiaries in the lowest-spending quartile areas (indicated in yellow text) would have access to six

different plan sponsors offering 15 plans that could provide 2020 levels of cost sharing.

Results were similar when we examined the ability of plans to provide 2020 levels of both cost sharing and premium reductions. Taking these measures together, a 2 percent discount rate would have a relatively modest disruption to beneficiary access to MA basic supplemental coverage.

In summary, the MA sector is extremely robust, but the MA benchmark system is flawed and has not yielded aggregate savings to Medicare.

An alternative benchmark approach would better balance efficiency with equity.

Payment would be set on a continuous scale of local fee-for-service spending.

Benchmarks currently above local fee-for-service spending would be brought closer to local spending levels.

Additional modest efficiencies would be leveraged in areas where plans bid far below local fee-for-service spending.

And there would be minimal disruption to basic supplemental coverage, such as cost-sharing reductions.

That brings us to the Chair's draft recommendation, which reads:

The Congress should replace the current Medicare Advantage benchmark policy with a new MA benchmark policy that applies: a relatively equal blend of per capita local area fee-for-service spending with price-standardized per capita national fee-for-service spending; a rebate of at least 75 percent; a discount rate of at least 2 percent; and prior MedPAC MA benchmark recommendations -- using geographic markets as MA payment areas, using the fee-for-service population with both Parts A and B in benchmarks, and eliminating the current pre-ACA cap on benchmarks.

Relative to current law, this recommendation would lower program spending.

Based on our simulations, we do not expect this recommendation to have adverse effects on beneficiaries' access to plans. MA would continue to be a viable alternative for beneficiaries seeking supplemental coverage of cost sharing and lower premiums.

Beneficiaries would likely see reduced coverage of extra benefits because plans will have lower payments; the magnitude of change in extra benefits depends on plan

response; plans may choose to reduce profits or otherwise lower their cost of providing the Medicare benefit -- that is, they would become more efficient through lower bids.

Our simulations indicate a small effect on plan participation in MA, with little constraint on the plan options currently available. Without any change in bidding behavior, nearly all plan sponsors would be able to offer plans with enough rebate revenue to maintain the same level of cost sharing and premium reductions as currently exists.

Now I turn it back to Mike.

MS. KELLEY: Mike, we can't hear you.

DR. CHERNEW: Sorry. I had to switch to my phone because I was having some technical issues.

So wonderful. That was a terrific chapter. I know we started late, so please, everybody, be concise so everybody who wants to talk can talk. And I'm going to turn it over to Dana to start the Round 1 questions.

MS. KELLEY: I have Larry first.

DR. CASALINO: Two quick questions for Andy and Luis. By the way, great job of making a complicated subject very clear. Could you show Slide 9 again?

I must be missing something extremely obvious

here, but if each quartile has the same number of counties in it and you want to get the average benchmark, would you just add the four percentages in the current benchmark column and divide them by four? Which wouldn't come out to 103 percent, so I must be missing something here.

DR. JOHNSON: There is an equal number of counties in each of these four quartiles with the exception of the territories are included in one alone, but the number of beneficiaries in each is not the same. And as the counties have changed their ranking and the lowest to highest fee-for-service spending ranking, some of the larger counties in terms of enrollment have moved up towards the 115 percentile and changed the average bid -- excuse me, the average benchmark.

DR. CASALINO: So you got the 103 percent by basically an average weighted by the number of beneficiaries in each county?

DR. JOHNSON: That's right.

DR. CASALINO: Okay. Great. Maybe that's explained in the report, but if it's not, maybe it ought to be in case you have people like me reading it.

Then could we just look at the last slide again?

Is there a slide after this? Maybe it slide -- yeah, this one. So the next to the last bullet point, beneficiaries would likely see reduced coverage. It depends on plan responses. Is that possibly too strong a statement, the reduced coverage? I mean, there's a lot of competition in Medicare Advantage right now among plans, and the plans are very profitable. So if they have -- if plans are receiving somewhat lower payments, can we really predict that they're going to reduce benefits? Or might they just not reduce profits because they are profitable and because there is pretty intense competition? So I don't know exactly how or why we would make a firm statement like they'd likely see reduced coverage of beneficiaries.

MR. SERNA: That's definitely an issue. It depends on client response to lower benchmarks. So I think when we simulate this we assume no change in bidding levels, which, of course, we know that at least some plans can lower their bids relative to 2020 levels. But that is correct, and we said that in the narrative, but on the slide, we could definitely tone down the language or make it seems less clear how plans would actually respond.

DR. CASALINO: Yeah, I think that might be wise.

If I was a health plan executive, I really want you to sign up with my plan, and I was making a lot of money from MA, I might be willing to make a little less money than have you switch to another plan.

MS. KELLEY: I have Pat next, with a Round 1 question.

MS. WANG: This is just real quick. Luis, I think I heard you say, when you were explaining the 103 percent, you said it excludes quality, which if you included quality would add another 4 to 5 percent?

MR. SERNA: That's correct.

MS. WANG: Did I hear that correctly? Okay. You see, that 4 to 5 percent, is that apples to apples to what's in Table 11 in the Appendix, because it estimates the impact of the MedPAC recommendation to eliminate the quality bonus as 2 percent.

MR. SERNA: So that's level of payment. So when we calculate the level of payment, not the level of change in benchmark.

MS. WANG: Oh, oh --

MR. SERNA: So level of payment will be based on the rebate, which is the difference between the bid and the

benchmark.

MS. WANG: So the benchmark goes up 4 to 5 percent, but after you go through all the bid mechanics, the actual payment is 2 percent.

MR. SERNA: Two or 3 percent, yeah.

MS. WANG: Two to 3 percent to the plan. Okay. Got it. Thank you.

MS. KELLEY: Bruce?

MR. PYENSON: I have a question on Slide 18. Thank you. Is part of the recommendation the elimination of the bonus, is one question. And another question, I thought earlier in our discussions we had consideration of standardization of supplemental benefits. Is that something for a later consideration, and we sort of put that off? So two questions, the elimination of the bonus and the standardization of supplemental benefits.

MR. SERNA: So the elimination of the bonus is not explicitly part of the recommendation as currently stands. If you all want that included in the last bullet, that can be included. Of course, part of this is a continuation of the recommendation on eliminating the quality bonus and replacing it with the MA value incentive

program, which left rebates open. So in this case we said, in our draft recommendation, we have the rebates would be at least 75 percent. But if you want it explicitly -- for that recommendation to be an explicit part of the late bullet here, I think that would be for you all to discuss.

On the second point -- oh, go ahead.

DR. CHERNEW: No, you finish, Luis, and then I will jump in.

MR. SERNA: On the second point, for standardization of supplemental benefits, that is something that could potentially explore in another cycle but it is not something that we're addressing this go-around.

DR. CHERNEW: Jim, did you want to say something?

DR. MATHEWS: I do, but I don't want to conflict with whatever you might have on deck.

DR. CHERNEW: That's funny because I don't want to conflict with what you might have on deck. You guys get to see the deliberation real time.

So the recommendation that you guys made prior to my being in the current position stands already as an independent recommendation, and we have not discussed incorporating them per se, because what you are alluding

to, Bruce, I think it is a reasonable point to have some recognition in the chapter of the relationship between them or not. But this recommendation does not subsume the previous recommendation, just to be clear. I wasn't part of the Commission when that previous recommendation was made, and there's issues with the interaction, I understand.

And regarding your second point about standardization, that would have to be something for another cycle. There is, of course, a process by which we get to recommendation, going through a policy options meeting and then the meeting we're having now, which is the draft recommendation, you know, the meeting on the recommendations. So it takes a while to do, for example, the analysis behind something like that, and that would have to be some different cycle, and certainly I am open to some discussion about that. Of course, just pros and cons, that would have to be discussed. And because they're pros and cons we're not really ready to cycle to think about any standardization issue.

Jim, how did I do. I've got move this cat so I can see your face.

DR. MATHEWS: Yeah, no worries. So I agree completely with your comments on standardization of extra benefits. It is something we can contemplate next cycle. With respect to explicitly including the QBP recommendation as part of this package, for myself, for whatever it's worth, I would urge the Commissioners to regard that as a separate standalone recommendation, and to the extent we have scooped up prior recommendations as the last clause of this bullet, they are recommendations that pertain directly to how Medicare calculates benchmarks and thus are directly relevant to this question at hand. And that is the distinction I would make as to why some of our prior recommendations are here and others are not.

MR. PYENSON: Okay. That was a nuance I hadn't appreciated. Thank you.

MS. KELLEY: I have Marge next with a Round 1 question, if we're ready to move.

MS. MARJORIE GINSBURG: Yes, and this is such a basic question I'm embarrassed to ask it, but I'm finally getting up my nerve to ask it.

So the quartile chart that shows low spending fee-for-service folks equates then to a much higher

benchmark, would you explain to me why? If they're in a low-spending area for fee-for-service, why would we not assume that it's a low-spending area for MA plans? Why would we give them so much more? I don't get it. Anyway, thank you.

DR. JOHNSON: At the time that ACA was passed, I think the thinking was that there was a balancing of two goals. One is availability of MA plans as an option for beneficiaries broadly across the country, and another was to bring the benchmarks down from where they were at much higher earlier levels. And so I think the higher benchmarks for low-spending fee-for-service areas is part of the goal to allow for a broad plan availability to beneficiaries where the benchmarks are below fee-for-service spending in high-spending areas and an attempt to balance it, but as we've noted, the balance is not perfect and there isn't a stabilizing mechanism that maintains that balance over time, so the benchmarks have actually risen up to 103 percent now.

MS. MARJORIE GINSBURG: Thank you.

DR. CHERNEW: Marge? I think part of the issue is there was some concern generally about beneficiaries in

areas that were officially practicing medicine being disadvantaged because they wouldn't have access to the added benefits that beneficiaries in higher-spending fee-for-service areas would have access to. So it wouldn't be particularly valuable for a bunch of people in some places to get free vision or dental care, for example, and other places not because they happened to be in places that are practicing more efficient medicine. I don't know if that's redundant, but Andy and Luis, that's my understanding. Again, it wasn't our thinking, just to be super clear. I think that was the thinking of Congress, and I hesitate to put myself in the shoes of what they actually doing or thinking. So that's just one guy's interpretation.

MS. MARJORIE GINSBURG: I realize that what we're offering now is a way to start bringing that difference down, and probably at this point it would be futile to try to put a little more juice into that, even though that would be my inclination. But I will leave it at that. Thank you.

DR. CHERNEW: Okay. So, yeah. I believe now we are ready to start Round 2.

MS. KELLEY: All right. Pat is up first.

MS. WANG: Thanks. So, Andy and Luis, thank you again. The content in the chapter is always top-notch. I think it's really clear, and you did manage to explain something with a lot of moving pieces. It's incredibly complicated.

I am generally supportive of the direction in the recommendations because I think that it is time for benchmarks to be rationalized from the quartile system, as Andy noted, the quartiles were set that they were at a different time when people were trying to incentivize different things happening in MA. Those things have more than happened, there are cliffs, and it's important to replace it.

I think that there is an elegance to what you have developed, and the way that I view it as kind of a framework that has a lot of levers that policymakers ultimately can toggle when they decide the ultimate level of how they want this to play out in different geographies.

Having said that, I do want to make a couple of comments. You know, we've spent a lot of time, and we just had a conversation about this in the last session, about this thing about MA has never saved money, MA is more

expensive than fee-for-service. And a couple of things, okay. It's kind of like a starting rallying cry for this kind of work. In my opinion, the wording of the chapter overuses that rallying cry, because if really all we wanted to care about was MA costing less than fee-for-service then we would bring down the counties that are over 100 percent in benchmark, and then that problem would be solved, right? As you pointed out, Andy, half of the counties have always saved money compared to fee-for-service, even with the supplemental benefits.

That's not really the problem that we're trying solve here. So I just offer that, as I think you're kind of overselling the need for benchmark reform by relying a little bit too heavily on that kind of rallying cry.

And really, I think that the issue around it's more than fee-for-service, we're not getting money back from it, I think that the question that ultimately gets posed by looking at MA is what is the value of the program. As you point out, when it comes to bidding on the A/B benefit, MA plans are efficient. What is happening to the rest of the money, though, is that it is being spent on supplemental benefits. Yes, there's profit for the plans -

- I know that people focus on that -- but 14 percent of the payments now are going to supplemental benefits, which are going to beneficiaries, not to line a CEO's pockets. Okay?

And so when we talk about the value of the program, there's like, okay, if we just want it to cost less to deliver the A/B benefit, that's one statement. Can you get that without having a market incentive in there? I would say no. And so supplemental benefits are important, and you have built that into your modeling.

But I would just be a little bit careful about the broad-brush statements about the program is costing too much, because the value of the program to a lot of people is in the supplemental benefits, and that's why it's costing more.

I wish that we could compare things like quality and consumer satisfaction more directly between MA and fee-for-service, and, you know, the MedPAC recommendations in the past around encounter data and things like that are really important, and I hope that we can keep pushing in the direction of comparing quality and satisfaction, because I think that there will be additional value that emerges in the MA program.

On the issue of supplemental benefits, I also just want to offer this sort of suggestion for the wording in the chapter. There's a lot of focus on cost-sharing reductions and premium buy-downs, as kind of the worthy benefits, and more skepticism that is applied to other kinds of supplemental benefits -- dental, vision. Gym membership always highlights it. You know, get them off the screens. It's just like a hot-button issue for people so you take a couple of bucks off of the bid.

The point is that supplemental benefits are very, very valuable to people who join MA. People who join MA are lower income and non-white, compared to who is left in the fee-for-service system. Dental benefits, vision, non-emergency transportation, which I can tell you a lot of plans are using right now to transport their members to and from vaccination sites, because they are not taking Ubers, you know, they have real value.

And so I think there's a tone that comes out in the writing that's very dismissive of supplemental benefits. Look, if people say nothing can be offered in MA that's not offered in fee-for-service, that's a big policy statement. But I don't think people have said that yet, so

I would just be a little bit more careful the way that we talk about that.

Also, I mean, I just have to say this. I said this the last time, and I may be just off. But I find the use of the word "equity" as a driving force for the chapter to be -- it just lands wrong with me. I know what you're trying to say, that benefits are uneven, depending on where people live and what quartile their plan might be in. But the ultimate result of this is that, you know, plan rates are going to get cut, so benefits, whether you believe they'll come down or not, they will be pressured. I happen to think that there will be some depression in extra benefits. So it kind of doesn't sit right, the way you achieve equity is to cut benefits for everybody. And some of those benefits might be falling -- those benefit reductions might be falling on very underserved populations.

So, you know, I'm uncomfortable with the word "equity." If we wanted to talk about equity and benchmark policy, maybe we would be talking about calculating the social vulnerability index for different counties and making the benchmarks higher because it's where underserved

people live. That, to me, is the better way to talk about equity and benchmark setting. It's just, no, I just want to share the reaction.

The last thing that I want to say is that I completely endorse what Jim said in response to Bruce's question about quality. If you look at the other recommendations and the impacts that are listed in the appendix of the paper, you know, just between the risk score recommendations, which I support, by the way, and the quality, which I have some concerns about, it's 4 to 5 percent of payment. If I think it's very important for me to view this chapter as a standalone chapter, to try to rationalize and improve the benchmark system, I do not at all support this thinking that it somehow pulls in all of these other recommendations.

And I would even suggest, and request, actually, that there be consideration of putting a text box in that explains that all of these recommendations do interact with each other. They're not just like, you know, blocks that you snap together and then you have a whole new payment system. Folks who look at these and are thinking about reforming the MA payment system need to be aware that there

are many, many moving pieces, and what they decide to do here is going to affect another recommendation that we have made in the past that is freestanding. So that would be my request.

Thank you.

MS. KELLEY: Jon Perlin, did you have a reaction to this?

DR. PERLIN: Let me first express my general support of the direction. On Pat's point about the use of supplemental benefits, it sure would be helpful to have some additional analysis around how beneficiaries are using a portion of particular benefits that are used, et cetera. Thanks.

DR. JOHNSON: To my knowledge there isn't really any data on what the utilization is of specific benefits. We do have information about the benefits that are offered in the health-related benefits category, but we don't have information about how much they're used, and I haven't been able to study what effects they might have on either quality metrics or changing spending levels, and things like that. But just something we would like to do.

DR. PERLIN: No, I appreciate that, Andy, and it

maybe something that you have to go to the MA plan to actually find out, and that may be highly proprietary, but it sure would be illuminating to see how those supplemental benefits are used. Thanks.

DR. CHERNEW: Can I say one thing that's related to that? This is a little bit of a clarifying question and I realize is out of bounds. But one of the key issues of how the supplemental benefits are valued when you're sort of buying down the rebate dollars -- so the plans get a certain amount of rebate dollars and then they offset a benefits, and the benefits have a sort of dollar value assigned to them which is based on some assessment of how expensive they would be to offer and how much they are used. Is that basically a correct assessment, Andy, and do you have a sense of how well CMS values those benefits in particular ways when they get offered? I'm not sure that question made sense, but I think that speaks to Jon's comment, because the use would influence the dollar value tied to them, at least on average.

MS. WANG: Michael --

DR. JOHNSON: I think that is generally right. We haven't gone through on an extra benefit by extra

benefit basis to figure out how closely linked they are, and depending on things like membership that are not utilization-based but might be available for anybody to use, whether or not they are used, the plan might incur an expense either way.

But, Pat, why don't you go ahead.

MS. WANG: I'm sorry. I was going to say I believe I'm correct. When a plan files a bid, like when I file my bid for 2022, I'm going to have to list the actual utilization of the dental benefit, like the actual value. I'm going to project an actuarial value for that but I'm going to report, you know, based on past experience so that CMS can test the validity of my bid, and Bruce probably knows that. You have to report what actually happened.

I also want to say, you know, I realize -- and I think Luis and Andy, you kind of underscored this in the paper -- that when it comes to a premium buydown for B or D, it's a fixed-dollar amount. You know exactly how that is. When you put a dental or vision or non-emergency transportation, hearing aids, you don't exactly know what the actual take is going to be, based on who is in your plan, what have you. But as I said, there is a sort of

like a reconciliation year by year to actual, and I think it's really not any different than when any insurance company is putting together their package of benefits with these kinds of things, like for a commercial carrier. They don't know how many people are going to use them, so you do your best, based on past experience, to forecast the actuarial value, and that's what goes into your bid. I think I said that right. I'm looking at Bruce, because he might know.

MR. PYENSON: Yeah, I agree with you on the bid side. The question is, is there an ultimate settlement that shows up publicly for the line items, so that the bid is a projection and that gets scrutinized by the auditors of the bids, before the bid gets approved. But I think the question is, there's also a question on is there scrutiny in some sort of public way on whether what was put in for the bid turned out, you know, a year and a half, two years later, to be right, and I think that's where there's less information.

MR. SERNA: Yes, and I just want to make one point of clarification. In the bid data we don't know specifically for an individual supplemental benefit what

the base use is or what the projected use is, on any of the supplemental benefits. So that information is aggregated and base-year data does not have it at the supplemental benefit level, so we wouldn't know the uptake of vision or dental.

I will say that the one study that we did find looked at sample of 1.9 million MA beneficiaries that had dental coverage in 2018, and found that 12 percent of the beneficiaries with dental coverage actually used that coverage in that year.

MR. PYENSON: I think, could MedPAC request the bid workup, the details?

MR. SERNA: To my knowledge that data isn't available. What we have available is what's reconciled by OACT.

MS. KELLEY: Okay. I think Paul is next.

DR. PAUL GINSBURG: Thanks, Dana. You know, when I think about this issue of where to set the benchmarks, I want to go back to the beginning of private health plans in Medicare, which goes back to the 1980s. And there was a vision that these plans would be more efficient and there would be some type of sharing of the benefits, of the

efficiencies between the beneficiaries and the Medicare program, the taxpayers. And, of course, it took a long time before it was clear that there were efficiencies. But now it's very clear, just from the measurements that we've made, into our efficiency, and it's clear from how low the bids are in relation to the benchmark.

So we are really talking now about, okay, how should we share these efficiencies between the program and the beneficiaries, and clearly if we're paying more, if the Medicare program is paying more than it pays the fee-for-service, you know, then it's not getting any of the efficiencies, and in a sense it's losing money, despite the presence of substantial efficiencies.

So we're really talking about how to bring it down, and in the administered pricing system, probably the way these things happen is, so you push it down somewhat and you look around, and you look around to see, well, you know, how many choices are available to beneficiaries? Is the enrollment growing or is it shrinking? And at this point, all of that type of evidence that you see in the market is consistent with the fact that the Medicare program is paying too much.

So it's not a matter of whether it should be at parity. It likely should be substantially below parity, and, of course, the Chairman's draft recommendation, which I support fully, basically suggests let's start with a 2 percent discount rate. Maybe we should reach even further, but the important thing is that we should go below parity and not think that we're taking something from anyone. It's just a matter of the Medicare program is becoming extremely fiscally stressed. The whole Federal Government is becoming extremely fiscally stressed. So the notion of this sharing of the gains from efficiency between the beneficiaries and the taxpayers I think is more important than ever.

MS. KELLEY: Bruce.

MR. PYENSON: Thank you. In looking at the recommendation, I agree with Pat that there's a disconnect between this recommendation and the historical analysis that says MA has not saved money, and Paul's point. When I look at the combined package, this is, I think, pretty close to budget neutral. The discount rate of 2 percent is probably countered by the increase in the rebate. It's also probably countered, to some extent, by the prior

MedPAC MA benchmark recommendations, using both Part A and B would actually increase the benchmarks, as I think was noted.

So I think this is a needed fix to an overly complex benchmark approach, but I don't view this as addressing the issue of the Medicare program getting much more value out of the MA program. So I'm not opposed to the draft recommendation. I would prefer to see something more aggressive as far as the discount rate goes.

MS. KELLEY: Jon.

MR. SERNA: I'm sorry. Just one point of clarification. The 2 percent rate, in our simulation, would equate to 2 percent reduction in [inaudible]. So without the discount rate, that everything interact as close to budget neutral but with the 2 percent discount rate you would achieve savings of 2 percent.

MR. PYENSON: And maybe I missed this, and I apologize, but increasing the rebate from whatever the average is now, which is below 75 percent, to above 75 percent, how did that interact?

MR. SERNA: Right. So what you have is you have benchmarks being a blend of location and national fee-for-

service spending. So you are reducing benchmark levels in that sense, and that is then offset by the 75 percent [inaudible] an average of 5 percent rebate to a 75 percent rebate. And so that gets you to basically 0 percent. So you need the discount rate to achieve savings.

MR. PYENSON: Okay. So the 2 percent -- but the other, the prior MedPAC recommendations, I don't recall -- I think we're assuming the geographic markets is a wash, makes sense. It's not a money-saver but it makes sense. The Parts A and B is 1 percent higher. And I don't remember if there was any estimate for the pre-ACA cap, eliminating that.

DR. JOHNSON: Eliminating the cap would increase spending a little bit. I don't remember the number off hand, and I'm sorry, Luis, I was getting some cutting out when you were explaining. But I think the net effect, as you just said, Bruce, is that using both A and B for benchmarks would increase spending. Eliminating the cap would increase spending. Increasing the rebate from 65 percent to 75 percent would increase spending. But all of that roughly nets up 0 when you consider the 50/50 blend of local and national, the new setup for the benchmarks,

before the discount rate.

MR. PYENSON: So we built in the prior MedPAC, the benchmark recommendations into our simulation?

MR. SERNA: That's correct.

MR. PYENSON: Okay. Thank you. Somehow I missed that. That was a Round 1 question. Thank you.

MS. KELLEY: Okay. I think it's Jon Perlin next.

DR. PERLIN: No. I'm all right.

MS. KELLEY: All right. Then we'll go to Marge.

MS. MARJORIE GINSBURG: Yes. I'm troubled by the supplemental benefits for MA, and even though I fully appreciate their value, particularly the non-emergency medical transportation -- great -- remember, I'm a shift counselor so I deal with this stuff a lot.

But what I'm troubled by, go to the bottom line, is that these extra benefits are being paid for by taxpayers. That's all the taxpayers. And that continues to trouble me that this is a system that makes sense. Now if the MA plans can figure out a way maintain the extra benefits and still bring money back into the coffers, great. But if the extra benefits is what's causing the total cost of MA plans to continue to be above the cost of

fee-for-service, I think there's a philosophical problem I have with that.

So I just wanted to share that.

MS. KELLEY: Larry.

DR. CASALINO: Yeah, Paul's comment a little while ago was so simple and clear, as usual, Paul, it made me think. And it made me start to think along the same lines as what Marge just said. I mean, maybe someone could tell me if this experiment is wrong. Let's say that I'm a particularly sophisticated beneficiary in an area where the benchmark is well above fee-for-service, and I say, "Gosh, my friend, Jon, gets all these benefits from Medicare and I don't get them." We're paying the same taxes for it, and I understand that Medicare is actually paying more for Jon than Medicare is paying for me. So that's how I can get the equal benefits. How is that fair? Is this an inaccurate way of thinking about it, or how would one respond to that sophisticated beneficiary? I think I'm saying the same thing Marge just said.

DR. CHERNEW: Can I jump in, or Andy and Luis, do you want to go first? I have a response.

Okay. I'm going to jump in. I wish could see

you all better. You're very small on my screen.

So I think there's sort of two issues that tie in your comment, Marge, and Paul's much earlier comments. I think there's a general sense that on the Commission and the recommendation that we don't think Medicare Advantage should pay more than comparable fee-for-service, pay more for a comparable beneficiary. Then there's the question that Paul raised, and I heard from several others of you, which is, actually, Medicare Advantage is much more efficient, and the program should share the savings exactly as we think about this, for example, in alternative payment models, that the saving should be shared. How much and how quickly is a separate issue.

So I don't think the issue now is justifying or not why MA should be paid more than fee-for-service. I think there's a general sense, and I think this recommendation reflects it, that they shouldn't. It is really, additionally, there's a lot of savings and maybe we can balance some of those out, which is very much in the spirit of what Pat said in her comment.

And I don't know if that answers your question, Larry, but our response to the person you're talking about

would be, yes, we understand. That's one of the reasons why, one of the considerations for why we're recommending the changes that we're recommending.

DR. CASALINO: But, Mike, going back again to my beneficiary, if Medicare Advantage is giving my friend the extra benefits, if Medicare is paying the exact same amount for Jon and for me, but Jon is in Medicare Advantage and his Medicare Advantage plan is so efficient that it's giving him these benefits, without getting extra money from Medicare, then I said, "Gosh, I want to join too," right? But if, in fact, Medicare is actually paying more for Jon than Medicare is paying for me, and the benefits are being finance out of that, at least in part, than I would say how is that fair?

DR. CHERNEW: Yeah, and I understand, and in some sense I think we are agreeing. Yes, that's right. We're not advocating that Medicare Advantage be paid more.

DR. CASALINO: Well, but in certain counties Medicare Advantage would be paid more, right?

DR. PAUL GINSBURG: If I can jump in here.

DR. CHERNEW: Go ahead, Paul.

DR. PAUL GINSBURG: I think Larry is bringing up

the "it's a geographic variation" issue.

DR. CHERNEW: Yes. Right. I understand.

DR. PAUL GINSBURG: The concept of sharing the savings between the beneficiaries, and, of course, they come in the form of extra benefits in the program, but that the way Congress did this, with 115 and the 95 percent, now is it basically deliberately giving too much to the beneficiaries that live in the low-cost fee-for-service area for political reasons. It's not what I would call a rational policy. But, you know, we understand it for what it is.

So I think Larry's point, you know, is a way to demonstrate the problem with that policy of not trying to do this as a rational sharing thing but just saying, oh, we have some goodies. Let's throw them around in a way that makes most sense politically.

MS. KELLEY: Mike, we have come to the end of the Round 2 queue.

DR. CHERNEW: Can you hear me?

MS. KELLEY: Yes.

DR. CHERNEW: Okay. So in a moment I'm going to -- we have a bit more time -- I'm going to go, at some

point, around and get people's views, because we haven't heard from many of you, to get a sense -- and it can be very brief -- about your general reactions. It's important for us to highlight what those reactions are.

I agree, Paul, you answer was much better than mine, to Larry's question. I think the only thing I would note is in any of the markets, if someone wanted to get the benefits they could join MA, and typically they have to give something up in those areas, in terms of maybe subjecting themselves to a different network or some other thing. But I think your view about the way it came to pass, which is, I think, broadly a recognition of people wanting some similarity in benefits, availability of extra benefits across areas, is probably accurate.

I'm going to pause for a second to see if anyone wants to jump in.

DR. DeSALVO: It's Karen. I was going to jump in on two points, if I could.

DR. CHERNEW: Go ahead, Karen.

DR. DeSALVO: Okay. I think, first is that I'm not trying to mince words, but I definitely agree with what Pat said about equity. The use of that word, especially in

2021, doesn't seem fitting. And so I understand where you were trying to go, but I would be careful about using it because it implies that there's an interest at really looking at disparities in care and access and outcomes, based on color of skin, other characteristics, and that's not really exactly what the chapter is about.

I think the second thing I just wanted to raise is a suggestion going forward, that perhaps the team has done but I'm not sure I remember, is hearing from beneficiaries who have been in and out of MA and fee-for-service, to understand this notion of supplemental benefits or how it's been different for them, in the good or bad, because I think there are a lot of presumptions that we may be making, and it would probably be helpful to hear directly, especially if we could find beneficiaries who had been in both system and could have some reflections. Thank you.

DR. CHERNEW: Jaewon -- I'm just going to start going around, by the way. You can be very brief if you want. Jaewon, I'm turning to you.

DR. RYU: Sure. Thanks. I'm generally in support of the draft recommendations. I think conceptually

they make sense. I get the need for the discount rate. I also understand and appreciate that the current system with the quartiles as clunky at best and probably not sustainable long term.

I would hesitate before going any more aggressive than the 2 percent, however, without understanding how much of the extra payments are fueled by the supplemental benefits. I think that normalization comment that Pat made earlier is an important one in understanding exactly how much of the payments are going towards the supplemental would be helpful before we went any more aggressive on the discount.

DR. CHERNEW: Thanks, Jaewon. Betty? Betty, can you hear me? We can't hear you, Betty.

DR. RAMBUR: There. Thank you. For some reason it wasn't unmuting. Maybe that's a message. But thank you for the report, and I really appreciate the conversation to help flesh this out, because this is not an area I've had a lot of responsibility before, so I found it really helpful.

I am generally in support. I do think it is a needed fix, and I really resonate with what Paul said about the fiscally stressed situation that we're in. I thought

the questions of fairness are really an interesting one.

I don't know whether it should go further than Bruce suggested, or maybe as Jaewon just suggested, this is far enough, but I'm supportive and would look forward to see if there is more that could be done in the future, or recommended in the future.

DR. CHERNEW: Betty, thank you. Dana Safran?

DR. SAFRAN: Yes, thanks. Really good, rich discussion, and really excellent content, well written, in the chapter.

I am in support of the draft recommendation, but I will be brief. I think Paul's comments, for me, really were very valuable, you know, the idea that there is no argument that there are efficiencies. It's a question of how those are getting allocated and who gets to share in them.

And in the subsequent conversation about supplemental benefits and the fairness or appropriateness of those, I guess in my own mind I think particularly in 2021, where we've evolved so far in this program and so far in our thinking about health and health care and social determinants of health, I kind of recoil at the idea of

questioning the kinds of supplemental benefits that are being provided, because I think they start to go at some, not all, social determinants of health.

And so I sit here kind of rather liking the fact that beneficiaries have a choice between system, and that when they choose the MA plan they are getting the benefits, and that could inform that choice. It does inform that choice.

I do understand, though, the concern about whether that is potentially creating -- I don't think it was said this way, but potentially creating a two-tiered system, where those who really are sicker and need every bid of the medical benefits don't get the opportunity to have those supplemental beneficiaries that are available through MA, and that does give me some pause.

So those are just my observations. Overall, I do think that we need to continue to have an effort in this program to be sure that some of those efficiencies turn into savings for the program, and I think that the draft recommendation gives us a good start on that road. Thanks.

DR. CHERNEW: Dana, thank you. Wayne, do you have any thoughts?

DR. RILEY: Yeah, no. I think we've had a wholesome discussion on this. This is a program, just personally, I have struggled with, with some of my own relatives. The thing that is alluring to them is something we've already highlighted, is the benefits -- hearing aids, transportation, dental, et cetera -- but I share the concern, the asymmetry in terms of how Medicare beneficiaries experience their care vis-à-vis the Advantage program versus regular Medicare. And Karen is right. We've got to be careful how we use the word "equity" in the context of this discussion.

DR. CHERNEW: Wayne, thank you. Sue Thompson.

MS. THOMPSON: Thank you, Michael. I am supportive the Chair's draft recommendation. I'm supportive of the new benchmarking calculation proposal. I am struck by the contrasting opinions of Pat and Marge, who I consider both of whom to have had a lot of experience working with the beneficiary community, in MA. And, yeah, I was really taken by both of you in these comments, and I think there's a lot of further discussion to have here, and would love to hear from each of you more. Because it does seem like our primary goal should be to right-size MA costs

with fee-for-service, and when and how we play these supplemental benefits, you know, should they be funded after the cost, equivalent to fee-for-service? There is some synchronization there around those benefits in the broader context of, you know, what I've heard Marge say before, that MA is the poor man's Medicare, and yet these social determinants of health that we are just beginning to get our arms around, seem to be, intentioned to be addressed by these additional benefits.

So again, no answers in my comments here other than to say I love the tension in that question, and I just think it's worthy of a lot more discussion and good thinking. So those would be my comments. Thanks, Michael.

DR. CHERNEW: Sue, thank you so much. Brian. Brian, we can't hear you, and I know you, and usually we can.

DR. DeBUSK: Sorry, I was muted. Yeah, this is a really complex issue, and I do support the recommendations as written. I think there's some really good technical fixes in this chapter, removing the quartiles, standardizing the rebate, and addressing the frailty

associated with county-level calculations. I also think the philosophical discussion on spending levels, expecting this program to general program savings seems reasonable. The 2 percent amount seems appropriate.

What I hope we continue to do, though, is understand plan-bidding behaviors and the behavioral response when we make these changes, because I'm a little fascinated. For example, you noticed as the rebates continue to grow, the cost-sharing reductions seem to level out. And I think these MA plans have really figured out how to balance plan attractiveness, you know, where you certainly don't expose the members to full Medicare cost-sharing, versus induced volume. And I think they know and understand some things around how much cost-sharing is too much or too little, and I hope we study that, because if these changes would get implemented, I think there's an opportunity here to try to figure that one out, and also to tease apart extra benefits. Because again, not all extra benefits are the same. Someone who desperately needs transportation assistance to get to their doctor is very different than someone who has been given a gym membership 25 miles away from their home. So I hope we tease apart,

too, the notion of maybe standardizing the extra benefits is good step.

The other thing that I've seen the staff work in the past on something that's always fascinated me -- studying the behavioral response of plans that lost bonus status. So what happens when there's a shock to a play and their benchmark changes dramatically, for example, if they lose bonus status? Based on what I saw before, it looked like the majority of that reduction, they did reduce their bid, but then it looked like that reduction in the bid simply got passed on to providers, or the bulk of that did. And as we prepare to publish this chapter, if there's any more information on studying how plans respond when they lose their quality bonus, and who gets the cuts, we may be able to glean some insight into how plans would respond to the changes that we're discussing in this chapter.

Those are my comments. Thank you.

MS. KELLEY: Mike, we can't hear you.

DR. CHERNEW: I'm sorry. We're having mute problems today. I noted a few more people on the list that I wanted to hear from, David Grabowski and Jonathan, but I know that Paul and Bruce wanted to say something on

supplemental benefits very quickly. So if you guys could go really quick to make sure we have time for David and Jon, then that would be terrific. Paul, you, then Bruce, very quickly, and then we'll go from there.

DR. PAUL GINSBURG: I wanted to help reconcile the perspective between Pat and Marge on supplemental benefits. To me, when there is a lot to be shared with the beneficiaries, which is where we are now, most of it comes in the form of supplemental benefits, and some of them everyone thinks is great, like not charging the beneficiaries a premium for the catastrophic benefit that plans are required to provide, or having drug benefits and not having a premium for them.

It's just that there is so much surplus to distribute to the beneficiaries that I remember Andy, some meetings ago, making the comment about plans running out of ideas as to how to give supplemental benefits, and obviously this is, I think, what Marge is picking up on. Some of them just don't seem worth the resources that go into them.

So I suspect some of these issue about, you know, are some supplemental benefits not worthwhile, will go away

once we stop overpaying by so much, because there won't be as much to find ways to transfer.

DR. CHERNEW: Paul, thank you. And now we had, I'm sorry, I think it's Bruce.

MR. PYENSON: I agree with Paul. I want to point out the work that MedPAC did, I think about 10 years ago, that identified the induced utilization of Medigap plans. I think the number at that point was close to 20 percent, because Medigap plans take away substantially the cost-sharing of the 20 percent co-insurance in Part B and cost-sharing in Part A.

Now, what has the net effect of, of course, is increasing the underlying cost of Part A and Part B, and that raises the benchmark. So we have an artificially -- perhaps I'm using the term "artificially inflated benchmark" because of Medigap, which then is passed on to the MA plans, who are obligated to just cover the core benefits of Medicare plus, you know, catastrophic, things like that.

So I think if we're going to open this up, I hope very soon we could revisit the work that MedPAC did on Medigap, and start to reframe both sides. Now, it's not

obvious. There's real benefits of both. There are people who don't buy Medigap as well. But I think opening that up would be very helpful.

DR. CHERNEW: Great. Bruce, thank you very much. And now we get to David, and then we're going to close out with Jonathan. David?

DR. GRABOWSKI: Great. Thanks, Mike. I just wanted to first start by saying I'm supportive of the draft recommendation. I really like how this work is shaping up. I like the language Brian used, that we have a set of great sort of technical fixes here, and I'm supportive of all of them. If ever kind of a Medicare policy was ripe for a MedPAC recommendation it's these sort of quartiles and the cliffs there. That seems right in our wheelhouse to fix.

I think Brian is correct, however, that there's kind of philosophical set of issues going forward around kind of putting dollars into the system, and I like Sue's term of how to right-size this system. So I hope -- and, Mike, you've already said it, but I think this is the start of a workplan for us. These are a great set of recommendations and kind of getting some of the technical aspects of the program right, but we have more work to do.

So thanks to the staff for this great work, and I look forward to seeing where this goes next. Thanks.

DR. CHERNEW: Great. David, thank you. Jonathan, you're going to get the penultimate word, because I'm going to say something when you're done. Jonathan.

DR. JAFFERY: Great. Thanks, Mike. And so I'll just start off with I, too, am very supportive of the draft recommendation. I think it's a great package of things put together and culminates a bunch of work.

Since I'm going almost last I'll just take a moment to reflect on the conversation so far. It's pretty clear that the issue about supplemental benefits has generated a lot of discussion and a lot of thinking, I think for all of us, but certainly for me. I guess my takeaway right now on it is it pulls together a number of things that folks said. Dana pointed out, rightly, that there's a real opportunity for these benefits to fill some of the needs around social determinants that we all recognize are important. And, of course, as Brian pointed out, there's a balance there because some of these may address those more than others.

But, Jon, you brought this up early, and Andy,

you spoke to it as well, that despite having supplemental benefits for years, we don't really have a good sense of which ones are even used, and by which populations, and how they have an impact on spending or outcomes. To me that's not only important to know, it's a really key opportunity. If we can use that information to understand where those taxpayer dollars are being spent and how they actually improve outcomes or not, then we should be thinking about how we would build that into the program more broadly, particularly as it gives us an opportunity to address the social determinants of health.

So thanks, Mike, and back to you for the final, final words.

DR. CHERNEW: Yes, so I'll try and follow quickly. So first of all, again, my thanks to the staff and all of you for your comments.

First let me note that this in many ways is a good problem to have. The fact that we have a program which, at least in a growth sense, can produce savings of the magnitudes that we think exist in MA is, I think, by and large, due to the good thing, and should be viewed as a success, particularly our goal, in many ways, is to design

an APM program that could come close.

The challenge, which is one that I won't take a strong position on, at least right now, in many ways, is exactly how the potential savings should be distributed between the beneficiaries and the programs, in a range of ways, and the formulas that we're discussing do that.

What I hear -- I'll start with Pat's comment, that parity isn't the goal, that we're trying to design an efficient system, and I think that resonates well with me, Pat. I'm watching you. The light looks great coming in from your window. But I think that was a really good way to start out this discussion. And that was followed up by sort of the comments that Paul and others made, Bruce, about how we share those efficiencies, both within the particular counties and then across the particular counties. This formula, I think, is a starting point to get there. We are going to try and do a better job in the chapter of acknowledging how different recommendations interact.

I would be remiss if I didn't acknowledge that I was coming in on top of a bunch of outstanding work that happened by the Commissioners, some of which includes you

all before me, and of course the staff before me. But we are on a journey, and I do think we will work in a way to both maintain the efficiencies of MA -- it's a really important program -- and give some thought as to how those efficiencies get distributed across geographies and across the program and beneficiaries, et cetera.

So I'm glad to hear the general support for the direction we're going in, and I am really looking forward to continuing to work on this chapter.

So with that we are now essentially exactly on time, and we're going to -- I think Dan, or Shinobu – I'm not sure who is going to be speaking first. I usually say Dan because the name is first on the screen that I see. Dan, is it going to you?

DR. ZABINSKI: Yes, it is.

DR. CHERNEW: Okay. So to discuss the relationship between clinician services and other Medicare services. So, Dan, take it away.

DR. ZABINSKI: Thank you, Mike. Good afternoon.

Shinobu and I are going to present our results from an analysis that was mandated by the Medicare Access and CHIP Reauthorization Act, or MACRA.

For the broader audience, PDF versions of the slides are available on the webinar control panel on the right side of your screen.

Now, MACRA requires MedPAC to submit reports to the Congress that evaluate the relationship between physician and other health professional services and services provided under Parts A, B, and D of Medicare.

We are directed to evaluate the relationship of both program spending and service use. Note that for the rest of this presentation, we will refer to services that are provided by physicians and other health professionals as "clinician services."

MACRA indicates that an initial report for this study was due July 1, 2017, which we submitted as part of the Commission's June 2017 Report to the Congress.

MACRA also requires a final report due July 1, 2021, and that is the analysis we present today.

In this final report, we're largely repeating our initial analysis using the most recent data. The Congress requested information but did not ask for policy guidance; therefore, the initial and final reports are strictly informative and don't include any policy recommendations.

The analysis we present today has two broad parts. I will discuss the relationship between clinician services and non-clinician Part A and Part B services. And Shinobu will discuss the relationship between clinician services and Part D drugs.

A key concept throughout our discussion is the correlation between clinician services and all Part A, B, and D services.

A positive correlation suggests that clinician services and all other services are complements, which means that as clinician services increase, all other services also increase.

A negative correlation suggests that clinician services and all other services are substitutes, which means that as clinician services increase, all other services decrease.

MACRA requires that we look at both program spending and beneficiaries' service use, and we emphasize that these are different measures.

Program spending is monetary outlays by Medicare, and we made no adjustments to our spending data.

It's important to know that spending will differ

between regions or years because of differences in Medicare prices, demographics, and beneficiaries' health status.

In contrast, service use reflects volume and service intensity, meaning that basic things like simple X-rays have lower service use than more complicated things like CT scans.

To measure service use, we start with spending data, and then we arrive at service use by removing from the spending data geographic differences in Medicare prices, beneficiaries' demographics, and their health status.

In our analysis, we focused on beneficiaries in fee-for-service Medicare and excluded Medicare Advantage enrollees because MACRA directs us to evaluate Parts A, B, and D of Medicare but not Part C.

We evaluated how the relationship between clinician and non-clinician services changed over time at the national level.

We also evaluated the relationship between clinician and non-clinician services at a point in time at the level of what we call MedPAC units.

The MedPAC units are our attempt at defining

health care markets and are largely based on metropolitan statistical areas, and there are 484 MedPAC units in our study.

We started our analysis by evaluating how Medicare program spending on clinician services as a share of program spending on all Part A and Part B services changed over time. This is a national-level analysis, and we used data from the Medicare Trustees' reports.

On this diagram, the lower blue line shows that spending on clinician services as a share of program spending on all Part A and Part B services fluctuated over a 10-year period from 2009 through 2019.

The maximum share for clinician services during this period was 19.6 percent in 2011, and the minimum was 17.6 percent in 2018.

In addition to the services they provide, clinicians also have substantial control over their patients' drugs and lab tests. So for the upper red line, we added the Part B drugs and labs furnished in physician offices to the clinician services. This measure shows less fluctuation than the lower blue line that represents only clinician services, with a maximum of 23.8 percent in 2014

and a minimum of 22.8 percent in 2009.

A caveat is that we believe service use is a better measure than the spending data presented on the slide because spending is affected by prices, demographics, and health status, which can distort perceptions of providers' practice patterns and how service use differs between years and between regions.

For example, during the 2009 to 2019 period, updates to clinician payment rates were smaller than the updates in the other fee-for-service payment systems.

Because we view service use as the better measure, the rest of our analysis of Parts A and B focused on service use rather than program spending.

We started our analysis of service use with a national-level time-series analysis that evaluated how use of clinician services as a percent of all Part A and Part B services changed from 2013 to 2018.

We found that use of clinician services as a share of all Part A and Part B services decreased only slightly from 24.3 percent in 2013 to 23.8 percent in 2018.

In addition to evaluating service use at the national level, we evaluated use of Part A and Part B

services at the level of our 484 geographic units.

For the geographic units, we measured the correlation between the percent change from 2013 to 2018 in use of clinician services and the percent change in use of all non-clinician Part A and Part B services.

We performed a regression that had percent change in clinician services as the explanatory variable and percent change in the non-clinician Part A and Part B services as the dependent variable. The regression results include a very small coefficient on percent change in clinician services and a low R-squared of just 0.01.

This diagram shows the relationship between the percent change in use of clinician services and the percent change in use of non-clinician Part A and Part B services for our 484 geographic units.

If there was a close, strong relationship between these two measures, you'd see these data points clustered tightly around a straight line.

But we see a loose relationship, without clustering around any line, indicating little or no correlation.

Our final evaluation of Part A and Part B

services was a cross-sectional analysis of the correlation between the per capita use of clinician services in 2018 and the per capita use of non-clinician Part A and Part B services across our 484 geographic units.

A regression that has per capita use of non-clinician Part A and Part B services as the dependent variable and per capita use of clinician services as the explanatory variable reveals a slight negative correlation as the coefficient on use of clinician services was negative 0.15.

However, the R-squared from this regression was just 0.01, meaning that little of the variation in use of non-clinician services is explained by differences in the use of clinician services among our geographic areas.

Finding low explanatory power reinforces what we just discussed, with little relationship between use of clinician services and use of non-clinician services.

On this diagram we show the relationship between the per capita use of clinician services and per capita use of non-clinician Part A and Part B services. As you can see, there really isn't a clear, discernible relationship between these two measures.

Now I'll turn the presentation to Shinobu, and she'll discuss the relationship between clinician services and Part D drugs.

MS. SUZUKI: The analytical framework generally follows the method Dan just described for the analysis of Parts A and B service use.

One main difference is that, for this part, we focus on a subset of fee-for-service beneficiaries who are enrolled in Part D. Beneficiaries who receive drug coverage from sources other than Part D are not included in the analysis.

We adjust gross drug spending for demographic characteristics and health status to arrive at a measure of prescription drug use, and we used the same regression-based correlation analysis.

The patterns of Part D enrollment among fee-for-service beneficiaries have changed over time.

First, more fee-for-service beneficiaries were covered under Part D in 2018 than in 2013.

Second, a smaller share of Part D enrollees were in stand-alone PDPs in 2018 than in 2013.

You can see this in the table: Fee-for-service

beneficiaries covered under Part D grew from 24 million in 2013 to 27 million in 2018. As a share of all fee-for-service enrollees, the share with Part D coverage increased from 61 percent to 67 percent.

But as a share of all Part D enrollees, these beneficiaries accounted for 58 percent in 2018, down from 64 percent in 2013. This reflects the underlying trend that has increasingly shifted enrollment towards Medicare Advantage. So more beneficiaries are getting their drug coverage through Part D drug plans operated by MA plans.

In part, due to this change, demographic characteristics for the study cohort were somewhat different between the 2013 and 2018 cohorts.

For example, compared with 2013, a smaller share of beneficiaries were disabled beneficiaries under age 65 and receive Part D's low-income subsidy.

When we looked at per capita spending, we found that growth rates in these two sectors diverged after 2013.

In the second column of the table, you can see that spending on clinician services and Part D drugs grew at similar rates between 2008 and 2013 -- by 12 percent and 10 percent, respectively. But for the 2013 to 2018 period,

it's 1 percent for clinician services compared with 26 percent for Part D drugs. This 26 percent growth is notable because of the magnitude relative to the period before 2013, but also because of what drove that growth.

For the 2008 to 2013 period, the growth in Part D spending was mostly due to increase in the number of prescriptions filled.

In contrast, for the 2013 to 2018 period, spending growth was mostly due to higher prices, driven primarily by new drugs and biologics launched after 2013.

In our analysis of service use -- that is, spending adjusted for demographic and health status -- we found a positive relationship between clinician service use and prescription drug use.

Looking at the change in service use between 2013 and 2018, we found a positive correlation between clinician service use and drug use, with a coefficient of 0.36. But the R-squared was about 0.08, meaning that clinician service use explained only 8 percent of the variation in Part D drug use. This suggests that there is very little relationship between the growth rates in service use in these two sectors.

When we looked at the level of service use across geographic areas, we found modest positive correlation between clinician service use and drug use in both 2013 and 2018 -- a coefficient of about 0.3 and R-squared of over 0.2 -- suggesting they may be complements. This finding is not surprising given that most prescriptions are written by clinicians during office visits.

To summarize, our findings suggest clinician services are neither clear complements to nor substitutes for other Parts A and B services, and they may be modest complements to Part D drugs,

However, our analysis cannot be used to draw conclusions about causality as our analysis only examined the existence of correlation between service use.

Our findings are aggregate results, based on comparisons of service use across geographic areas. As a result, they may not represent any individual circumstances or specific geographic areas.

As Dan mentioned at the beginning, this is a congressionally mandated report due no later than July 1st of this year.

We plan to incorporate your comments from today's

discussion and include this material in our June 2021 report.

With that, we'll turn it back over to Mike.

DR. CHERNEW: Shinobu, thank you very much. There was a lot of work that went behind this, and I understand there's intense interest in this. I'm going to see if there's any clarifying questions for a moment.

[Pause.]

DR. CHERNEW: So we're going to go to Betty. Betty, you're up.

DR. RAMBUR: So I have a really naive question, and maybe I just couldn't understand it from the materials. So I understand the answer here to the question, but it would help me to better understand the context of what was Congress trying to understand about this, because it was related to MACRA, it seemed, from the material. So I felt like antecedent to this answer that there is something that I'm not understanding.

DR. ZABINSKI: Jim, do you want to take that or --

DR. MATHEWS: Yeah, I was going to say either Mike or I might want to take this one. Mike?

DR. CHERNEW: I was not around when we were asked to do this, so I do not have any line of sight on the answer. So I'm going to turn it over to you, Jim.

DR. MATHEWS: Yeah, basically this was driven by one of the major medical society organizations who were making the assertion that an increase in utilization of physician services would result in decreases in other services and, therefore, that extra spending on physician services might actually produce savings for the Medicare program. I believe that was one of the, you know, subtexts underlying this legislation.

DR. RAMBUR: Thank you. I knew there had to be an antecedent. Thank you.

DR. CHERNEW: I'm going to turn it over to Dana to manage at least the Round 1 queue. Dana.

MS. KELLEY: Okay. I see we have Marge next.

MS. MARJORIE GINSBURG: Yeah, and this may actually be related to Betty's question. The first thing that occurred to me is that this is a report about number crunching, and it seems to me usually when we get a request to do a report outside of our usual work, it's a little more nuanced, more policy-ish. Why didn't this assignment

just go directly to CMS? Is there really something more meaningful about asking MedPAC to do this rather than asking CMS to do it?

DR. MATHEWS: I don't have an answer to that question. Sometimes, you know, the congressional committees make a determination about who is best poised to do a particular analysis. Sometimes it's CMS, sometimes it's GAO, and sometimes it happens to be us, and we drew the straw here.

MS. KELLEY: Pat.

MS. WANG: Thanks. Can you hear me?

MS. KELLEY: Yes.

MS. WANG: Okay. Betty, thank you for asking the question because I was also puzzled, and, you know, the fact of the matter is that there was a huge amount of very careful analysis, and it's just that the result doesn't seem earth-shattering that makes us puzzled, but the fact of the matter is that until you do the work, you don't really know.

I guess that I had a question whether a similar analytical endeavor has ever been undertaken to evaluate the same question, but restricting it to primary care

clinician services and whether there is a relationship, because that's the more common wisdom, right? Better primary care, more primary care results in lower overall spending because you eliminate unnecessary stuff. I just am curious, because this study, you know, presumably involves every specialist, super-specialist, provider type that there was, and so maybe there's still some gems inside of the work that just need to be isolated and pulled out.

DR. ZABINSKI: Well, I'm not aware of any specific study that has done that. It's a good question, and it would be nice to find out. But I'm not aware of any that exist.

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

DR. CHERNEW: Yes, so I again will speak for a bit, and please, folks, if you have comments -- I said raise your hand -- send a note to the Organizers and Panelists. But in any case, so this question about tradeoffs is one that actually has been looked at a lot in the academic literature. I won't speak to all of it. The analytics are obviously complicated because of the potential for confounders. I think Dan and Shinobu were very clear that we aren't making causal statements in this.

There's sort of complexities. If you have a surgery, you need both a physician and a hospital most of the time. There's another complexity that maybe, Dan or Shinobu, you want to talk to about how this is affected by consolidation. I know there's some stuff in the material about that. In other words, you could get a change in clinician utilization and facility utilization or other services based on the industry structures, so consolidation can have an effect, which is another thing that you might want to discuss.

But before I let you do that, there has been, going back at least to the RAND Health Insurance Experiment, some work that speaks to this. For example, in the RAND Health Insurance Experiment, they had randomized people into one plan that made inpatient care free but charged a lot for outpatient care. And if you compare that to when both are free, they found indeed that there was less outpatient care in the plan that charged for outpatient care. So chalk up a piece of evidence for downward sloping demand curve.

The more surprising thing was, in fact, they found in that plan that charged more for outpatient care

that use of inpatient care also went down. And there seems to be a real connection in many ways because when people get brought into the system, say through outpatient care, clinical care, a lot of things are found, critical things are found, and they ended up finding their way into other types of care. And I think that that basic finding that many people in the world view clinical care how your -- not clinical care -- how your care by clinicians and care by other types of more expensive care as substitutes, more often than not the literature I think has found that there are complements, for better or worse. It's not an area that I've done a lot of work in, but I think we can continue to think through that given our ability to really get at some of these very complicated analytic issues.

But that's my take on where much of the literature is. By the way, the RAND Health Insurance Experiment also looked at better mental health coverage, so there's a subset of this analysis about the relationship between mental health and other service use. And, frankly, there's analysis going the other direction. If you adhere to your drug regimes more closely, you save through some often, and, in fact, the CBO does assume an offset

assumption related to use of services to manage chronic conditions.

In any case, that's a long-winded comment that can be summarized that there's a lot of complicated connections here, causality is really hard to get at, but if you want to react to some of the points, like consolidation or the past literature, Dan or Shinobu, I'm all ears.

[No response.]

DR. CHERNEW: Or maybe you don't want to comment.

DR. ZABINSKI: Well, one thing I'll say is that past work that we've done on geographic variation, we have found -- how do I say it? The only real, you know, substitution effect we found was between physician offices and hospital outpatient departments, and I think that's what's showing up on that one slide where we have this slight negative coefficient of minus 0.015. I think that's what's going on with that. And so, you know, like I said, that's the only area in our own work that we've ever found that there's really any substitution effect going on.

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

DR. RAMBUR: I was just going to say, given that

it seems that some of us had a question about how -- you know, the antecedent to this, maybe just a little bit of context in the report would be helpful so that anybody picking it up could, you know, understand a bit of the background and the rationale for why the work was done.

Thank you.

MS. KELLEY: Brian.

DR. DeBUSK: The one comment I wanted to make, and, you know, others have alluded to this, but you can see in underlying questions that Congress was trying to tease apart in asking these questions about the relationship between clinician services, and they're good questions, but I think this is an opportunity or maybe this is an opportunity in the report to point out that there are serious limitations in our claims infrastructure. And, you know, maybe this could also be the start of a road map to how we could improve claims and produce more meaning for data in the Medicare program over the next several years.

Thank you.

MS. KELLEY: I think that's it, Mike.

[Pause.]

MS. KELLEY: Mike, we can't hear you.

DR. CHERNEW: When I'm on my phone, I forget when I'm muted or not. So I thought that as well. So it's been a long and very productive day, I think, and I'm not going to push everybody on this because we don't have a recommendation. Now, I'm sure we'll have other chances to think about this type of issue, and certainly the connection between services is an important topic, so, Dan and Shinobu, I very much appreciate the work.

So that brings our day to a close. I will make the comment I always do at the end of each morning or afternoon session, which is to reach out to the public and say these are very important issues. I really thank everybody in the public who has listened to this discussion. I hope they found it useful. We very much would like to hear from you in the public, so please reach out to the staff on the website. There's a lot of ways that you can get a hold of us to give your feedback and your insight into the topics we've discussed. So I hope that that part is clear, our desire to hear from folks.

To the Commissioners, I'd like to thank you all for your time today and your insights on all of these topics. We are a little early, and so I think we're going

to -- I'm going to turn to Jim in a minute. I think we're going to move our virtual happy hour to 5:30 from 6:00 if that's okay. So I hope that works with everybody's schedule.

Jim, do you need to do anything logistically in order to do that?

MS. KELLEY: We'll take care of it, Mike.

DR. MATHEWS: Yeah, yeah.

DR. MATHEWS: Yeah, we'll just send around an updated appointment with the link, so it should be fairly easy.

DR. CHERNEW: Okay. So, everybody, look for that. And, again, does anyone want to add anything before a hearty thank you and good-bye?

[No response.]

DR. CHERNEW: So here's the hearty thank you and good-bye. Thank you and good-bye, and thanks to the public. We will see you again tomorrow morning for our Friday session. Have a good night, everybody.

[Whereupon, at 5:15 p.m., the Commission was recessed, to reconvene at 9:30 a.m. on Friday, March 5, 2021.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

VIA GoToWebinar

Friday, March 5, 2021
9:32 a.m.

COMMISSIONERS PRESENT:

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PAUL GINSBURG, PhD, Vice Chair
LAWRENCE P. CASALINO, MD, PhD
BRIAN DeBUSK, PhD
KAREN B. DeSALVO, MD, MPH, Msc
MARJORIE E. GINSBURG, BSN, MPH
DAVID GRABOWSKI, PhD
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P R O C E E D I N G S

[9:32 a.m.]

DR. CHERNEW: Welcome, everybody, to our Friday morning session of the March MedPAC meeting. I think we had a very constructive and interesting day yesterday, and I hope to continue that dialogue today.

We're going to start this morning with the discussion of indirect medical education payments, so I am, without further ado, going to turn it over to Alison. Alison, you're up.

MS. BINKOWSKI: Thanks, Mike.

Good morning, everyone. I am excited to continue the Commission's discussion of revising Medicare's indirect medical education payments to better reflect teaching hospitals' costs. As a reminder, the audience can download a PDF version of these slides in the handout section of the control panel on the right-hand side of the screen.

Today's presentation builds off work presented in September 2019 and October 2020, with modifications in response to Commissioners' comments and newer data. In particular, we updated our illustrative model to use an inpatient and outpatient measure of teaching intensity: a

hospital's ratio of residents to patients.

At the end of this presentation, we will present the Chair's draft recommendation for the Commission's consideration.

We anticipate that the information in this presentation and your mailing materials will form the basis of a chapter in the Commission's June 2021 report.

As a reminder, Medicare makes two types of additional payments to the roughly 1,100 IPPS teaching hospitals for the provision of graduate medical education.

The first type is direct graduate medical education payments, which totaled nearly $4 billion in fiscal year 2019. These payments support teaching hospitals' direct costs of sponsoring residency programs, such as resident stipends and physician salaries, and are made outside of Medicare's prospective payment systems.

The larger type is indirect medical education payments, which totaled over $10 billion. These IME payments support teaching hospitals' higher costs of inpatient care that are not otherwise accounted for in Medicare's inpatient prospective payment systems, such as unmeasured patient severity and additional patient care

costs associated with the teaching of residents, and are implemented as a percentage adjustment to IPPS payments. Together these medical education payments supported the training of about 90,000 residents.

Medicare's treatment of teaching hospitals' IME costs varies across the three hospital prospective payment systems, as does the flexibility granted to CMS.

While there are numerous differences, a key difference is that the Congress specified the IME adjustment in the inpatient operating PPS in statute, but left flexibility for the other two hospital PPSs. HCFA -- the predecessor to CMS -- added an IME adjustment to the inpatient capital PPS but to date has not added an IME adjustment to the outpatient PPS.

The Commission has raised two main concerns with Medicare's current IME policy.

First, Medicare's IME policy is inpatient-centric and does not reflect the current range of settings in which residents train. This inpatient-centric approach is reflected both in the lack of IME payments for outpatient services and in primarily measuring a hospital's teaching intensity as its ratio of residents-per-inpatient beds.

Second, the current levels of the IME adjustments do not reflect teaching hospitals' additional costs of treating fee-for-service beneficiaries, including higher than empirically justified levels for inpatient services and zero for outpatient services.

As a result, Medicare overpays teaching hospitals for their indirect costs of medical education in inpatient settings and underpays for those costs in outpatient settings, creating financial incentives that may slow the movement of resident training and patient care from inpatient to outpatient settings.

In addition, Medicare's IME policy is inconsistent in its treatment of MA beneficiaries. The Medicare program directly makes inpatient operating IME payments for the care MA beneficiaries (and these are carved out of MA benchmarks), but does not do so for inpatient capital IME payments.

Based on these concerns and the Commission's October 2020 discussion, we identified a set of principles for IME payment reform.

First, IME policy should reflect the range of settings in which residents train. To do so, Medicare

should: make IME payments for both inpatient and outpatient services; and base IME payment adjustments on hospitals' ratio of residents to patients across inpatient and outpatient settings

Second, IME payments should better reflect teaching hospitals' additional costs in each setting, without reducing aggregate IME payments relative to current law. To do so, Medicare should transition to empirically justified levels of inpatient and outpatient IME payments by initially applying a budget-neutrality adjustment, such that aggregate IME payments are budget-neutral to current law. Once empirically justified IME payments matched and then exceeded those under current law, IME payments should be set at those levels. The revised policy would, therefore, maintain aggregate IME payments in the short term and increase IME payments relative to current law in the long term.

Lastly, IME policy should support the care of both fee-for-service and MA beneficiaries, with the Medicare program consistently making IME payments for MA beneficiaries (and carving these out of MA benchmarks).

For the purposes of illustration, we modeled a

budget-neutral inpatient and outpatient IME policy consistent with the principles outlined in the prior slide. The key aspects of the revised IME policy included:

Expanding the set of services that receive IME payments to include all inpatient and outpatient services provided to FFS or MA beneficiaries, exclusive of separately payable drugs and devices;

Updating the measure of teaching intensity to a hospital's resident-to-patient ratio, which would better reflect hospitals' level of teaching intensity across inpatient and outpatient settings. In addition, this measure would avoid creating an adverse incentive for hospitals to acquire physician practices, as doing so would simultaneously increase the volume of outpatient services the IME adjustment is applied to and decrease the magnitude of the IME adjustment for all services due to the increase in a hospital's patients;

Setting each IME adjustment at the empirically justified estimate of teaching hospitals' additional costs not otherwise accounted for in each PPS;

And, lastly, adjusting the empirically justified IME payments such that aggregate IME payments are not

reduced relative to current policy.

Revising IME policy to better reflect teaching hospitals' additional inpatient and outpatient costs while not reducing aggregate IME payments would, by construction, maintain aggregate IME payments but shift them towards outpatient care.

As shown in the left-most bar, under current policy IME payments totaled $10.1 billion in fiscal 2019, all of which were for inpatient care.

As shown in the middle bar, under the illustrative empirically justified IME policy, aggregate IME payments would have decreased and shifted towards outpatient settings, with the share of IME payments from adjustments to outpatient payments increasing from 0 to nearly 50 percent, and inpatient capital IME payments being eliminated.

Finally, as shown in the right-most bar, under the budget-neutral policy, these empirical payments were proportionally scaled such that aggregate IME payments equaled those under current law but better reflected teaching hospitals' additional costs in each setting.

For the majority of teaching hospitals, a budget-

neutral inpatient and outpatient IME policy would result in a small change in their total inpatient and outpatient fee-for-service payments.

As shown in the figure, under our illustrative model, a majority of teaching hospitals would see a less than 0.5 percent change in their total fee-for-service payments and nearly three-quarters would see a less than 1 percent change.

While the budget-neutral inpatient and outpatient IME policy would maintain aggregate IME payments, it would redistribute them towards hospitals that are underpaid under the current inpatient-centric policy. This includes teaching hospitals that both provide a relatively high share of their care to Medicare beneficiaries in outpatient settings, as these hospitals would see relatively large gains in the set of IME-eligible services that IME adjustments would be applied to; and have an inpatient and outpatient measure of teaching intensity (i.e. resident-to-patient ratio) that is relatively high compared to the primary inpatient-capacity measure used in current policy (the resident-to-bed ratio), as these hospitals would see a smaller decrease in their inpatient IME adjustment

percentage and have a larger outpatient IME adjustment.

In other words, the revised IME policy would shift IME payments towards teaching hospitals that are, or will become, more outpatient-centric in their care of Medicare beneficiaries; and have a high ratio of residents to patients, relative to residents per inpatient beds.

For most groups of teaching hospitals, the budget-neutral inpatient and outpatient IME policy would result in a small change in total inpatient and outpatient fee-for-service payments. This is because while certain groups of hospitals tend to be more outpatient-centric in their care of Medicare beneficiaries, these same groups of hospitals tended to also have a larger percentage decrease in their calculated measure of teaching intensity from the switch to residents per patient.

One exception is that the revised IME policy would shift IME payments towards small teaching hospitals with less than 150 beds. We estimate that these hospitals' total fee-for-service payments would increase 0.6 percent, as they were generally more Medicare outpatient-centric, but had a similar decrease in teaching intensity as the typical teaching hospital.

In summary, current IME policy is outdated and does not reflect the contemporary range of settings in which hospitals train residents and treat patients; nor teaching hospitals' additional costs in each setting. Transitioning to an empirically justified inpatient and outpatient IME policy would update IME payments to better reflect teaching hospitals' additional costs while not reducing Medicare's aggregate support to teaching hospitals.

Within the broad principles outlined in this presentation, Congress could grant CMS flexibility on implementation of the revised IME policy, including whether to phase in the revised IME policy for the subset of teaching hospitals more substantially affected or exempt new outpatient IME payments from beneficiary cost-sharing requirements and calculations of Part B premiums.

The Chair's draft recommendation reads:

The Congress should require CMS to transition to empirically justified indirect medical education adjustments to both inpatient and outpatient Medicare payments.

As aggregate IME payments would initially be

budget neutral, the revised IME policy would initially not affect Medicare spending, but would reduce Part A spending and increase Part B spending; however, over time it is likely the revised policy would facilitate the continued shift to outpatient care, which would eventually increase Medicare spending on IME relative to current law, but decrease Medicare spending on inpatient services.

We do not anticipate the revised IME policy to affect Medicare beneficiaries' access to care or hospitals' willingness to treat Medicare beneficiaries.

Depending on implementation, the addition of outpatient IME payments may cause slight increases in Medicare beneficiaries' Part B cost sharing and premiums.

Lastly, the revised IME payments would be more equitable to teaching hospitals that have already, or will in the future, shift to providing more resident training and care of Medicare beneficiaries in outpatient settings.

And with that, I turn it back to Mike.

DR. CHERNEW: Terrific. Thank you. This has been a topic that MedPAC has been working on for a long, long time.

I'm going to turn it over, again, like yesterday,

to Dana Kelley to go through the Round 1 and the Round 2 questions, so, Dana, who is first up? Dana?

MS. KELLEY: I am sorry. I have Brian first.

DR. DeBUSK: Thank you. Thank you for the really good presentation.

I wanted to mention, on page 5 of the reading material, Table 1, the add-on payment itself uses an exponential function using that ratio of residents to beds. It's actually allowed residents, I presume. So that's a constant in a capped program.

But here's my specific question. Have the staff modeled the relationship -- because presumably if you did more inpatient volume, you would need more inpatient beds, which would dilute the numerator -- or the denominator of that exponential. But then the payment, the add-on payment that you get would be applied to all of your inpatient cases. Can you speak to that formula just a little bit? Because it seems like there should be a way to optimize that. I wouldn't necessarily say "game," but there should be a mathematical way to optimize that yield, maybe through reducing length of stay or sending them on to SNFs sooner or PAC. Could you just speak to how the math of that

specific function meets the operation in a hospital?

MS. BINKOWSKI: I can speak a little bit about that function. I think you're referring to the inpatient operating PPS function.

DR. DeBUSK: Yes.

MS. BINKOWSKI: Which is 1.35 times one resident-to-bed ratio to the exponent 0.405 minus 1, for those that don't have the benefit of Table 1 from the mailing materials in front of them. So, yes, there are different ways that hospitals can be incentivized to try to maximize those payments. One of those involves reducing the number of beds that you have. However, there are also other IME polices that we don't discuss in this paper that in most cases cap a hospital's resident-to-bed ratio at their level in the prior year. So there are other policies that try to prevent certain forms of gaming.

I can go into more details, but I don't want to sidetrack us.

DR. DeBUSK: No, that's okay. So there are other safeguards. That formula just struck me as particularly vulnerable.

On page 7 of the reading material, Figure 2, you

have a whisker plot, and it looks like the nominal adjustment's around 6 percent. But I notice on that plot you've got hospitals that are running that all the way out to the 25 to 33 percent range. Can you speak to those? Is that linked to the vulnerability in that formula? Or is there something else that we need to know?

MS. BINKOWSKI: So for those that don't have the mailing materials, Figure 2 shows the wide distribution in the range of IME adjustments across teaching hospitals, and, yes, the median adjustment is about 6 percent, but it can be over 40 percent for the top 5 percent of teaching hospitals, and that is true and is a reflection of two factors, one of which is that some hospitals really do have a high level of residents relative to inpatient beds. For example, think of certain eye hospitals, and there's also incentives for hospitals to maximize their policy. So on the inpatient capital side, there is an absolute cap on how high the IME adjustment can be and on the inpatient operating side there is no. In our illustrative policy, we did apply a cap.

DR. DeBUSK: Okay. So we wouldn't necessarily say hospitals that are, say, 33 percent add-on payments

doing, you know, half a billion in inpatient volume, you would say these are probably outliers where there's circumstances, like you said, an eye hospital where you're doing -- where you have a very skewed ratio.

MS. BINKOWSKI: Yes, I'd say --

DR. DeBUSK: Or are there --

MS. BINKOWSKI: -- those hospitals that are more unique circumstances about them.

DR. DeBUSK: Okay. And then, finally, you know, on the presentation, on Chart 8, I had a question. These hospitals that had this greater than 3 percent change, are those the same hospitals we've been talking about?

MS. BINKOWSKI: Many of them are, but these are a heterogeneous group of hospitals. I don't have specific characteristics off the top of my head to list them. I can follow up with you after the meeting.

DR. DeBUSK: Well, thank you. I'll save the rest for Round 2, but thank you.

DR. CHERNEW: Dana?

MS. KELLEY: Yes, I have Pat next.

MS. WANG: Thank you, Dana. Actually, just picking up on Brian's last question, does it make sense to

add a column or a new table that is similar to Table 4 that shows sort of the change from the current IME fee-for-service -- you know, the impact on current IME fee-for-service payments by bed size, location, et cetera, to do one that cross-walks under the current system, hospitals' intern- and resident-to-bed ratio under the current formula to their new teaching factor, whatever we're calling it? Does that even make it -- you wouldn't call it an IRB anymore, but you'd call it something, just to get at Brian's question about is it -- which are the hospitals that are being most affected by the policy? And is that related to the current teaching intensity? Is it related to something else? I mean, you have it cut by sort of number of beds, but I just wonder whether that could also be informative.

I wanted to ask you a couple of questions about the definition of sort of outpatient services and residents who count. Could you just address would outpatient equivalence be calculated for observation unit stays, telehealth? I don't even know how that's treated today, but we know that that's going to be a little bit more prevalent going forward for ambulatory care. And if you

could remind us if a teaching hospital has a relationship with a community health center, for example, or an FQHC and residents rotate through there, how would that kind of situation be handled? Does the hospital have to sort of own the outpatient site, or if it's rotating residents through, how does that factor in?

MS. BINKOWSKI: So as we mentioned in the paper, one of our recommendations, or aspects of the potential principles, is that the IME adjustment for outpatient sources should only apply to locations where residents rotate. Currently, CMS does not collect information at that level, so we were not able to model the extent to which residents currently rotate to some of these locations, such as community health centers. But they could start collecting it.

MS. WANG: Okay. So this is the modeling. So we're not making specific recommendations about the types of non-inpatient settings? Would the definition just be any place where a resident is?

MS. BINKOWSKI: So in terms of our outpatient adjustment it would be anywhere where OPPS payment applies and the resident rotates.

MS. WANG: OPPS. Okay. Interesting. Okay.

The other question I had was, would it be necessary for this kind of policy to be paid for from Part B? Is there sort of a statutory requirement that the cost would have to be borne by Part B, and therefore individual beneficiaries as opposed to remain in Part A and be funded more generally through taxes?

MS. BINKOWSKI: That's something we'll need to continue to consult with CBO and others on.

MS. WANG: Okay. Thank you.

MS. KELLEY: I have Larry next.

DR. CASALINO: Yes. Three pretty quick questions. One is, so you've arranged the recommendation so that the policy would be budget neutral relative to existing law, and I think you said, at one point, and the chapter says that over time, relative to existing law, it would actually give more IME money to teaching hospitals. Is that statement going to be questioned in the sense that, are people going to say, potentially, yes, compared to existing law but the law does usually change over time to, to give them more money over time, so that the effect over time, in that case, would be unknown whether it would

reduce or increase or keep budget neutral the IME payments to teaching hospitals. So that's my first question.

MS. BINKOWSKI: If I understand your question, our statement is specific relative to current law. Our crystal ball is as good as yours and everyone else's as to how a law might change in the future.

DR. CASALINO: Fair enough. And then I actually also was going to ask the same question as Pat and Brian asked. It would be nice to know a bit more about the types of hospitals -- I think you said they're heterogeneous -- who get the plus or minus 3 percent or more. You know, that's a fairly significant hit to margin, probably, for a lot of hospitals. But I guess that's a statement and not a question, since it's already been asked. But it would be nice to know a little bit more about who they are.

And then the last question is, the draft recommendation doesn't say anything about the budget neutrality, although the report is pretty explicit about that, the chapter, and that, of course, is going to be something that is going to be of concern to affected hospitals. Can you say a little bit more about that?

MS. BINKOWSKI: I will refer to Mike on that.

DR. CHERNEW: This is a complicated question, Larry, and your thoughts are useful. What you say is actually completely true, that the recommendation is short and is a little bit vague in that it says transition. It doesn't explain, in the actual recommendation, what transition means. I think the chapter is pretty clear about what we mean by that.

And so, you know, I'm a little six of one, half dozen of another on the nuance in the wording, but I think the point you raise is a valid one, and I'll discuss with Jim and the staff if we want to tweak the wording. But your point is correct, and there is a bit of a semantic issue about how broad we want the recommendation to be, and frankly, how constraining we want it to be for CMS. By keeping it this way, we give it a little more flexibility than we would if we made the recommendation really very precise.

I personally like that level of flexibility. I have a sense that there's people that think we should transition quicker than might happen if we said that. There might be some people who think we just transition slower. So, Jim, do you want to react?

DR. CASALINO: Michael, these are not rhetorical question, by the way. They are real questions. I'm not trying to sneak an argument into Round 1 here. But actually what you just said makes me realize that there's something that I thought I understood but maybe I don't, and it could be important.

So I think my read of the chapter was transitioning to empirically-justified, if that was taken absolutely literally, would not be budget neutral but would lower payments now relative to current law. And so I thought that the recommendation to transition to empirically-justified and the recommendation in the chapter, where the modeling in the chapter of keeping things budget neutral, are not the same thing, and, in fact, conceptually are a little bit in conflict with each other. Both can be done, but the empirically-justified wouldn't lead to budget neutrality, I don't think, if I understood correctly.

DR. CHERNEW: Jim is going to say something in a minute, but I think the issue is what you mean by the word "transition," or what we mean by the word "transition," right? It is the budget neutrality, keep it budget-

neutral, relative to current law during this sort of transition, and then you get to an empirically-justified rate after that point. So I'm not completely sure if that's clear. Just for timing, because I don't want to dwell on it too much now, but the intent was to have a little more flexible recommendation, but the chapter, I think, is pretty clear in what we're pushing for.

But, Jim, I see your head nodding. Do you want to jump in?

DR. MATHEWS: Sure.

DR. CHERNEW: Jim, you go, then Larry.

DR. MATHEWS: Okay. The intent of the policy as described in the paper and as illustrated on Slide 7 is that at the outset of the redistribution of IME dollars the current levels of IME adjustments would be maintained at the roughly $10 billion level. Over time, on a year-over-year basis, IME spending would be maintained at that level, but given historical trends we see very slight year-over-year declines in hospital inpatient care and relatively robust year-over-year increases in hospital outpatient care.

So eventually the empirically-justified indirect

costs of medical education will rise to the level equivalent to the current aggregate spending amount, and at that point it will increase at the empirically-justified level, and because outpatient services are growing faster than inpatient, that is what causes this to cost more over the long term.

Does that help?

DR. CASALINO: Very much, and now that you're saying it, that is actually fairly clear in the chapter. It's written as clearly, I think, as it can be, now that you mention it. It isn't easy to understand in one quick read, but yeah.

DR. MATHEWS: Understood, and I agree with Mike. We would like to keep the recommendation language as parsimonious as possible for the reasons he mentioned, but in our conversations with CBO, who is going to arbitrate the score here, we've been very clear about the intent, and, you know, are walking through the rationale with them in close detail.

DR. CASALINO: Thanks, Jim.

MS. KELLEY: Paul, did you want to get in on this point?

DR. PAUL GINSBURG: Yes. I was going to hold this for Round 2, but I had this reaction to the draft recommendation that's, I knew that this issue, about wanting to give some flexibility on the budget neutrality issues, but I find just the entire recommendation sounds more like a goal than a recommendation, for a policy change, you know, just saying that we should pay both on inpatients and outpatients. I think we need to say more, perhaps in a subpoint, about what we're actually talking about [audio break - inaudible] just adjustments to both inpatient and outpatient Medicare payment. See, to me that just doesn't give me enough about what the Commission really has in mind.

DR. CHERNEW: So in some sense that's the comment, and the spirit of Larry's comment, about the wording of the recommendation as opposed to the substance of where we're trying to go and how specific we want to be. So I think in the interest of time we'll have a discussion about the wording again. The intent is to allow flexibility. We don't have a specific -- I don't know what the right word is -- we didn't want to be as detailed as is in the chapter about specifically what got modeled, to

allow some flexibility, but we probably can think through the actual wording so people get some sense of what we're talking about. The goal, that I agree, to your point that this part of it is aspiration, is to make the IME payment system less inpatient-centric, and do so in a way that doesn't take a lot of money out of the system to start with.

I think those are the sort of main points of what we were modeling.

DR. PAUL GINSBURG: That's right. So that would be a kind of a first statement, and then there could be follow-up statements to bring some of the precision in the chapter and be very specific about where we think flexibility should be given, et cetera.

DR. CHERNEW: Yeah, and the movements from things like residents to bed residents to patients, for example, is something that we model but is not in the rec. I understand that. So we will have a broader discussion about what I'm hearing from both you and Larry, and I realize we are in a Round 1 situation so maybe I'm just screwing things up. But some more specificity in the rec we will consider, and then we will obviously come back to

when we get to next month. Jim, are we onboard with that?

DR. MATHEWS: Sure.

DR. CHERNEW: Okay. We're still in Round 1, and so I want to be conscious that this is an hour-long session, so I will try and be briefer. But Dana, why don't we move along, if everyone else can be concise.

MS. KELLEY: I think we have one last Round 1 question from Bruce.

MR. PYENSON: Thank you. I'll be brief. These are questions about Figure 7, and just noting that the inpatient capital seems to disappear, I think. I know there is some discussion in the write-up that MA plans are not tabbed with inpatient capital for IME. It looks like that would continue to be the case because nobody would get that. It would be redistributed. Am I interpreting that correctly?

MS. BINKOWSKI: Correct. We found no empirical justification for an IME adjustment to patient capital payments.

MR. PYENSON: Thank you. Just another question about this. There are several different figures for the percentage of current IME that is empirically justified

that are in the text. This chart looks like it uses roughly 70 percent. Am I correct in assuming that that's illustrative?

MS. BINKOWSKI: Yes, it does depend on a specific modeling decision, the exact percentage, but the main points are consistent, that inpatient operating IME payments are roughly 40 percent empirically justified, which is consistent with what we've presented in the past, and that when you add outpatient you're in the ballpark of 70 percent.

MR. PYENSON: And maybe this is a failure on my part to understand. I can see going from 10.1 in Figure 7 to the, looks like, 3.8, that's roughly the 40 percent, but we're adding on top of that -- so the empirically justified portion of the middle bar of Figure 7 is really only the two bottom blocks. Is that right?

MS. BINKOWSKI: That's the empirically justified IME payments for inpatient services, are the bottom blocks.

MR. PYENSON: So I guess I'm confused about what empirically justified means. I thought it was the expense of residents, but maybe I was wrong about that.

MS. BINKOWSKI: It's teaching hospitals'

additional patient care costs from having residents that are not otherwise accounted for in the prospective payment systems.

DR. CHERNEW: It's the outcome of the regression, essentially, that looks at total cost of the residents to beds. Am I right with that, Alison?

MS. BINKOWSKI: Yes, except that there are two different regressions, really three with inpatient, and one for each setting, and so that's why --

DR. CHERNEW: So basically it's the regression that's looking at costs of residents to beds. It's not a direct reimbursement for anything. That's in the direct part.

MR. PYENSON: Right. So you're saying there's data on residency costs. There's residency costs that are evident in the data, but are not associated with inpatient.

MS. BINKOWSKI: They are associated with outpatient care, is what the top two bars are.

DR. CHERNEW: There's an impact of residents on overall outpatient spending. I think that's the way you'd say it, Alison. In other words, the key point here is indirect, so it's a question of having a teaching program

on broad expenses, not expenses like resident salaries or whatever. It's expense overall for care delivery. And I think, Alison, what you're saying, at least my understanding is, if you have residents there's an empirical increase in your expenses for care delivery, outpatient care delivery.

DR. STENSLAND: I think intuitively we can kind of think of that lower $3.8 billion, is these are the extra inpatient costs. You have residents running around and they're ordering extra tests for your inpatients. This increases the cost of care. That's in the $3.8 billion. And then the upper part, the $3.5 billion, is on the outpatient side, and that means you have residents running around, and maybe you're having some outpatient visits, but maybe it slows things down when the patient first sees the resident. Then the attending comes in and talks to him, so there's some extra costs on the outpatient side also. Just the cost per unit of output seems to increase when you have the residents running around in both these settings, and that's what the addition of all of those four bars are.

DR. CHERNEW: We should move along because we have a lot of Round 2 questions, and we don't have a lot of

Round 2 time. So I'm sorry for pushing us forward but I think we have got to move.

MS. KELLEY: Okay. I have Paul with a Round 2 question.

DR. PAUL GINSBURG: Sure. You know, I think everybody knows that there's a lot of teaching activity that happens in the outpatient setting, and that this has been growing for decades, over time. But I find that this chapter, the only evidence it presents are the results from the model, the model of costs. And it seems as though there is a call for putting some descriptive information, just at the beginning of the chapter, to give people a sense of the magnitude of this change in graduate medical education over time, or just, in a sense, how much education is going on in the outpatient setting today. I know there are some specialties that have almost no inpatients at all, so presumably most of their training of residents is happening in outpatient settings.

So I think it would make it easier for the reader to see evidence beyond the regression that we report.

Another comment, and I'll be quick about this, is that it would be better if we allocated funding to

outpatient training beyond the hospital outpatient departments, you know, in community health centers, in independent family practices, and maybe there are practical reasons why we can't do that. But it would be, I think, desirable to do that, particularly to remove some of the additional incentive for hospitals to acquire practices to the degree that they can get compensation for indirect medical education, even if they don't own the outpatient facility where it's being done.

MS. KELLEY: Okay, Jon Perlin.

DR. PERLIN: Thanks. Let me just build on from Paul.

This does redistribute funds obviously, but I'm not sure -- and this is spoken as someone who started his administrative career running a residency program and through my leadership at VA had relationships with nearly every residency program. It's not clear that it achieves the objective of incentivizing more outpatient training.

Building specifically on something Paul said, the ability to go and do outpatient care is obviously very specialty-dependent. Re both Brian's and Paul's comments that may have unintended consequences, I think it lays the

course to create a desirability of practice acquisition, which is obviously something our Commission has had concerns about. And I'm not sure how the transition from a ratio of residents to beds to residents to patients thwarts that. In fact, it likely incentivizes that specifically because that's actually how you get patients into the environment.

Third, two or more hospitals that have very similar patient ratios, but very different service mixes and patient complexities, contrast to the general role that complexity varies with scale, the hospitals serving the higher-acuity needs, albeit even adjusted by CMI, could be disadvantaged, and that disadvantage may be exacerbated particularly in areas where there are more vulnerable patient populations or another scenario where there's a high density of training programs. Take, for example, New York City where a region that is actually over-bedded and the number of new patients is beyond capacity, but you've now just changed the capacity to create what I think we'd have to acknowledge is not a local good but a national good, and that's the production of trained physician care providers.

The fourth point is really the training takes place at the sites where the critical experience is available to meet the board requirements, and the ability to shift clinical experience to the outpatient, for example, for OB or surgical specialties is decidedly limited. And, you know, the complex cases that one needs to train with are available primarily in the inpatient setting. So if you create a pressure against that, it is clear that we will have specialties training decreasing, but you also may exacerbate problems like the well-known crisis in the production of general surgery as an example.

Beyond that, in a more colloquial sense, we all need to train for the more complex case and scale down, not the less complex and scale up.

I want to come back and agree with Larry on the point about transparency and making the modeling available for examination. It would be helpful to understand how these redistributions work and have the ability to assess whether or how they impact the stated goals.

And, finally, a couple points. Yearly numbers may vary. You know, while this past year was obviously an extraordinary and catastrophic outlier, and even smoothing

with three-year rolling average, it's incredibly disruptive and entities hosting graduate medical education, the year-over-year uncertainty to host graduate medical education at scale; otherwise, they will cut back in the number of slots, especially at times where the physician need is increasing, not declining.

So all of that said, it leads me to think that we have some more work to do, and that we should consider a pilot program at a limited site to see if it actually does incentivize behaviors that appear to be beyond really what's more of a sort of gestalt goal than, I think, a fully featured recommendation at this juncture.

Thanks.

MS. KELLEY: Brian.

DR. DeBUSK: Thank you. Well, I was really glad to see this chapter appear in the reading material. You know, from a big-picture perspective, you look at the things that could impact the Medicare program and our beneficiaries, medical education is probably one of the largest influences on the future of the program and the trajectory of the program and its beneficiaries that we could have. So I'm really glad that we took this up, and I

think this is very important.

I do agree, I like Paul's comments, and I want to build on that, about illustrating some of the various effects. I would love to see, you know, how does the existing formula break down, say, in an eye hospital that has almost no inpatient procedures. What range of adjustments can be made to the formula? What opportunities are there to manipulate or manage that formula?

As far as the recommendation in the chapter, I wholeheartedly support making the fixes that are addressed in the chapter. To me, these are very much technical fixes, and this is a core payment accuracy issue. I mean, this is really exactly -- you know, the charges that we have been given is to make sure that payments are accurate. And here we have a theoretical discrepancy. I mean, we're paying on inpatient volume. We're not paying on outpatient volume, and it's growing quickly. But we're seeing that discrepancy in the empirical data. I mean, we are watching this discrepancy unfold in front of us. And I think there's a little bit of a burning platform here because, over time, as we don't recognize outpatient procedures, and as that portion grows, eventually the overpayments that are

here are going to be consumed, and they're going to turn into underpayments unless we develop a way to incorporate outpatient medical education into these formulas. So I think the status quo of not doing anything is unsustainable. At some point we're going to have to make this correction.

The other issue -- and, again, this builds on the questions earlier -- to me, looking at that formula, the RVR, the exponentiated formula, it does look like that would also be vulnerable to a hospital's specific post-acute care strategy. And I would suspect that hospitals that minimize lengths of stay by turning to post-acute care or hosting their own post-acute care would have materially higher add-on payments just simply by adopting that strategy.

So, again, that's another issue that really concerns me. I think this is a big, big payment accuracy issue, and I'm really glad to see that we've addressed it.

My final point, because the recommendation that we made -- and, gosh, it's probably been over ten years ago, well over ten years ago now. I also think the program needs to account for the need -- or medical education needs

to account for the geographic and specialty needs of the Medicare program. Right now this notion that we're just going to simply give a group of Medicare providers money and they're just going to make the combination of physician specialties and geographic specialties that they need really strikes me as a little bit absurd. I mean, we do not do that in any other Medicare program. We don't simply pay a hospital for drugs and say now go administer the drugs you like or want to administer. We don't let physicians pick and choose the mix of procedures they want to do.

So it seems like part of this ongoing work, I hope that we do recognize the need that with Medicare paying the vast majority of medical education bills, that Medicare should have some say in what specialties and what geographic mix of physicians are produced by the program.

And those are my comments. Thank you.

DR. CHERNEW: Okay. Given the time where we are, we will continue this discussion, but I do want to keep going along quickly. I think we're going to go over a little bit this session for sure. Hopefully we can minimize our overage. Dana.

MS. KELLEY: Jonathan Jaffery.

DR. JAFFERY: Yeah, thank you, and given the time crunch, I'll try and be pretty brief. Clearly, this is an important topic that MedPAC and Congress has been grappling with for quite a while, so I'm glad we're taking it up. And I largely appreciate the many points that fellow Commissioners have made.

There are two specific concerns I just wanted to call out. One relates to Paul's initial comments about being a little bit more direct, perhaps, in our language in the recommendation. And if you look at Slide 11, we talk about Congress granting CMS flexibility, and I understand the idea of trying to allow that flexibility. But in particular, the penultimate bullet point on the slide where we talk about maybe allowing CMS flexibility to include -- whether to include a phased-in policy for substantive teaching hospitals, maybe I'm not remembering this correctly, but I feel like in our previous discussion this cycle, we're a little bit more specific about that. And to me that's quite important that we don't see large swings for individual hospitals in either direction in a given year.

And so I think that's an important policy point that we should be more declarative about, and CMS can still get some flexibility on how to implement that, but I don't think the -- to me, whether to implement it, we should be more direct about that.

And the second concern I have is more of a practical one, and this notion that outpatient IME ultimately would be determined based on where residents do their -- have their rotations or what-not, I guess I'm just not clear how that will work practically because that can change -- unlike the inpatient setting, where it probably doesn't change quite as much, and you've got these formulas, even flawed, about resident-to-bed ratio, that might be very, very fluid. And so I'm just -- I haven't figured out and I'm not sure I saw anything in the reading that explains to me how we would make that work or how CMS would make that work.

So I'll leave it there with those comments, and thanks for the opportunity.

MS. KELLEY: Betty.

DR. RAMBUR: Thank you. In the interest of time, I'll only share my most burning comments.

First of all, I have been very concerned about the mismatch between this enormous workforce creation subsidy and the needs of Medicare beneficiaries and taxpayers. And perhaps I'm just not tracing this particular piece, but in terms of empirical justified, the arguments don't seem to always recognize the revenue generation that these residents create, or at least I'm not understanding how that's included. And I'll just briefly comment on the study by Chandra, Wilensky and others that talked about the substantial amounts of services to patients, thereby generating substantial revenues for hospitals, particularly after the first year of residency. So that's one piece that I'm still trying to struggle with.

I want to comment on Brian's comment, which I very much appreciated, in terms of Medicare subsidizing this education and is it really geographically and specialty-wise getting us where we want to go. Just this month in JAMA, Royce traced out the relationship between GME growth and specialty growth with a 209 percent increase in plastic surgery, 190 in neurosurgery, 153 percent in dermatology, and not a corollary growth in primary care. So I would hope, whether we think about it this cycle, next

cycle, or multiple cycles, I think we really have to think about how do we get the primary care workforce that we need.

Someone earlier talked about specialty -- the difficult specialty care, the intensive education. I would just say procedural intensity is one thing, but primary care is complex, it's difficult, as you know. And I'll conclude by saying we hear over and over again about NPs and PAs playing an increasing role in delivery of primary care in ACOs, in rural areas, and in underserved areas. And, of course, these rules were set before these disciplines had even emerged. And so these arcane rules really limit our ability to use these resources to prepare the workforce that we need in primary care, and I'll just comment that the graduate nurse education demonstration program has important implications for Medicare policy in terms of enhancing access to primary care.

Thank you.

MS. KELLEY: Okay. Jaewon, you're next.

DR. RYU: Yes, thanks, Dana. I generally like the draft recommendation. I do think there's a -- and others touched on this earlier. I do think there's a

little bit of a dissonance between how the chapter frames it up and then the draft recommendation itself. I appreciate and see the benefit of the flexibility, but I wonder if it's a matter of framing of how we tee it up in the chapter so that it doesn't feel like, you know, we're focused so much on budget neutrality and then silent on it in the recommendation.

I see the validity of not changing the recommendation approach and affording that flexibility. Maybe it's a matter of just shifting the framing in the chapter itself.

I like the transition approach to getting to an empirically justified model, and I like in particular sort of the budget neutrality to allow the costs to sort of catch up to what current law provides for. I think that is a clever and less disruptive way of transitioning into the model.

I also think the transition to outpatient is important, and I couldn't agree more with a comment that Paul made around some value of having some description in the chapter. I think this is one place where there might be value just to illustrate where and how extra cost gets

baked in, especially on the outpatient teaching side. I think people are more intuitively familiar on the inpatient side. There may be ordering of more tests and so forth.

On the outpatient side, teaching significantly slows down a clinic, I would even argue more so than the inpatient environment. So I think that would also be helpful.

And then, lastly, I share some of the comments made in Round 1 where it would be helpful to have a little more detail on how the impact would cut differentially across different segments of the teaching hospitals that are out there.

MS. KELLEY: Karen.

DR. DeSALVO: So, first of all, thank you for addressing this important topic. I'll just start by sharing that I do think Jon's right that having opportunities to train in the inpatient environment with really highly acute patients is important and scaling, as we described it, down or upstream or however you want to share it. And I could support the general direction of the draft recommendation. I do want to flag that, in general, I am concerned about continuing to anchor GME resourcing on

hospital-based systems and on a system that may inadvertently drive increase in services to increase -- to show that there's more need as opposed to a population level indicator. So within the hospital framework, if we could get to a world in which there is an accountability for a set population, that would certainly not -- that would be preferable than just services, which I think we could imagine you'd start to turn up if we couldn't identify new patients.

And then I want to just ask that somewhere in the future that you consider a complete shift, which would be to anchor the training dollars into the medical schools or the nursing schools rather than through the hospitals. And I'm sure I'll get a lot of emails about that, but if we really wanted to think about how to train a workforce for beneficiaries' and not for a health care system's needs, that might be an important consideration to go back in history and think about how we used to do it and that there might be a better way.

Thanks.

MS. KELLEY: Pat.

MS. WANG: Thanks. This echoes some of the

comments that have been made. Just in general, it's unfortunate that we have to anchor so much of payment policy, especially for something like IME, to units of service. And so we're shifting from inpatient units of service to OPPS paid units of service, but some of the underlying concerns that Karen just mentioned I think get created.

I'll go a step further. I have concerns -- you know, I think it's very important to recognize teaching in non-inpatient services, so I'll just start there. The work is very important. But I actually have a concern that the linking -- so today IME is linked to inpatient care and resident-to-bed ratios. I think that teaching hospitals sort of manage that relationship in a way to ensure, you know, that payment is where it's supposed to be. And then if they want to subsidize residents rotating through an FQHC, they can kind of do that because their ratio's -- you know, they can sort of subsidize that.

I'm worried a little bit that shifting now to the unit of service OPPS is going to create a disincentive to send people out because, again, it's make every unit of service count. I worry that it could cause folks to sort

of kind of bring people more inside as though we have to stick to OPPS paid services because that's the only kind of ambulatory care that we're going to get credit for. And so I'm a little bit nervous about that.

And so in the chapter, I think it would be -- in an ideal world, at some point, you know, I think, one, I agree with Karen, a more population health-based budget. I don't know about medical schools, but even if you anchor it in the teaching hospital, maybe it's something that CMMI can consider in the future to set sort of prospective IME budgets to allow teaching hospitals to have some flexibility in where they send residents without fear that because it's not OPPS paid and it's in an FQHC, that they're somehow going to lose money from it.

I would really like there to be something in the chapter or consideration of recommending that IME continue to be paid from the Part A trust fund. I am nervous given the stress that Part B premiums are already placing on beneficiaries, that this shift of IME to outpatient settings is going to fall on beneficiaries directly to subsidize through increases in their Part B premiums, even if they never use the services of a teaching hospital. You

know, having it more generally supported through the Part A, more broad-based, you know, sort of taxing mechanism I think is preferable, and I think that we should say that.

The third thing is this reminds me a little bit about the conversation yesterday about MA benchmarks. Obviously, this recommendation has lots of interactions with other parts of payment policy. It has implications for update factors. If the array of impact remains the same, then the update factors that we just all voted on, and the information we saw, might need to be -- that analysis might need to be changed somewhat.

It also might have an impact on how direct GME is calculated because I believe that that is still tied to inpatient days. I may be wrong about that. But, you know, without trying to solve all of those problems, I think it might be helpful to again include a text box or something in the chapter itself that recognizes that this policy and the shifts that it would create do have interactions with other parts of Medicare payment policy that need to be recognized and taken up.

Thanks.

MS. KELLEY: Wayne? Is Wayne with us?

DR. RILEY: Can you hear me now?

MS. KELLEY: Yes, we can. Thank you.

DR. RILEY: Great. Great discussion. Just a comment, philosophically, about the whole discussion. You know, I was just thinking through the breadth of my career we've always aspired for some sort of all-payer GME program, which is a pipe dream, and it remains a pipe dream in some respects because many of us felt that the Medicare program alone should not bear the total burden for graduate medical education. But given that headwind, you know, we have to be careful not to do anything that sort of harms inpatient training. You know, I'm a primary care internist, but, you know, as someone just said, and I think it was Jonathan, it is very time-consuming to train young doctors in outpatient settings. It's one of the best training sites, but it's labor intensive, it's slow, it lowers productivity and patient throughput, et cetera. So we have to be sort of careful.

And then on a daily basis, you know, those of us who have residency training programs, I don't think I've ever been in a meeting where my GME folks have come to me and said, "We have to make a change in the way we're

training some of our residents, based on Medicare policy." It's generally based on residency review committee policy, and ACGME, the accrediting body for residency. So that's been the other historical headwind, to even more of what Paul alluded to, you know, movement to training in outpatient settings is the accrediting bodies for the specialties.

So again, I think this is great work. I know this is not going to be our first bite at the apple in terms IME and GME, in general.

MS. KELLEY: And the last comment from Bruce.

MR. PYENSON: Thank you. I think the discussion has been terrific. As I think Jaewon mentioned, I support the Chair's draft recommendation as written, because I think the flexibility is needed there. This is a seminal document. There's a lot of really wonderful work in there, but it's obviously not the last statement, and I worry about paralysis with more and more analysis, that we're not going to be able to perform in this session.

So my comments are mostly about the choice of further work, and I agree with Brian and Betty. The influence over the choice of specialty and the geomix is

critical. I would point to Slide 8 for people who might be concerned about the impact of these changes on hospitals, and point out that this is just the impact on Medicare fee-for-service, that the actual impact on hospital revenue as a whole would, for most organizations, be much, much smaller, and some of the specialty hospitals are not known for catering to Medicare patients. So my view is this is pretty convincing that I'm not especially worried about disrupting hospitals and their revenue.

Betty mentioned evidence of billing by residents. I would ask if we can, in this document, to reference MedPAC's proposal on incident-to-billing, and I think that is a standing proposal. Presumably it would apply to residents as well as NPs and PAs. And I think that would create a lot more transparency on what's going on with residents and the revenue they might be generating.

And finally, I appreciate Karen's comment and others on anchoring to hospital. I think that is a great topic for the future, so I appreciate you raising it.

But just to summarize, I really do support the recommendation as written. This is just terrific work. I don't agree with all the different nuances. There's a lot

more to do, but I think this is just really terrific foundational work.

DR. CHERNEW: So I'm going to try and be brief in my summary. Just for the audience at home, I did not plant Bruce as the last word on this, and per what Wayne said, this is not certainly our only bite at the apple. I feel like we've been eating this apple for a long time. We've been here, even when I was on the Commission before, which you can't see me in person but I look old, and it's been a long time.

And I do think, again, to what Brian said, given the trend to inpatient care we are going to need to change. I think it's important to point out that over time this actually putting more money into the system of educating folks and putting them into a place we think is important.

All of that said, I very much hear two comments. One of them is, there's a lot of operational nuance behind this, which was understood, and then there are some concerns and then some support for the exact wording of the recommendation. Again, the core issue there, in the recommendation, was recognizing some of these concerns to be a little bit more, in Paul's words, aspirational, less

precise, as CMS begins to figure out how to put a new model in place. And I think in the original recommendation, the one you see here, we did not want to be too prescriptive, recognizing some of the issues that have been raised.

So I guess we're going to move on now. I believe -- sorry, I've been listening to this -- I believe that vaccines are next, and we will come back after some conferring with the staff on where we are exactly on the recommendation. But this was a very rich discussion.

So we are now going to go to the vaccine chapter. We are going to be a little pressed for time, so please keep that in mind, but I do want to hear from everybody as we go forward. And I think, Nancy, are you leading us off.

MS. RAY: That is correct. Thank you, Michael.

Good morning. The audience can download a PDF of the slides on the right-hand side of the screen.

Today we are going to continue our discussion from the September and January meetings about policy options that would improve Medicare coverage and payment for preventive vaccines. There was good consensus among Commissions for both policy options. Now we are at the stage to present a draft recommendation. The goal for

today's session will be to solicit feedback on the chair's draft recommendation, with the intent of having a final recommendation for you to vote on in April and publication of this work in the June 2021 report.

Medicare's coverage of vaccines and administration of the vaccine is split between Part B and Part D. Part B covers preventive vaccines that have been specifically named in the statute, that is flu, pneumococcal, and hepatitis B for beneficiaries at medium or high risk. The CARES Act added Part B coverage of COVID-19 vaccines.

In limited circumstances, Part B also covers certain other vaccines when used in response to an injury or direct exposure, for example, to rabies or tetanus.

Part D covers all commercially available preventive vaccine not covered by Part B. Shingles accounts for the vast majority of Part D vaccine doses. When Part B or Part D cover the vaccine, they also cover the vaccine's administration.

A few differences between Part B and D coverage. Part B-covered preventive vaccines and the vaccine administration are not subject to cost-sharing, whereas

Part D plans are permitted to charge cost-sharing for vaccines the associated administration. These amounts vary by plan and benefit phase.

Part B vaccines are administered in a variety of settings. Mass immunizers such as pharmacies and physician offices are the most common sites of administration but hospitals, skilled nursing facilities, home health agencies and dialysis facilities also bill Part B for vaccines.

Part D vaccines are mostly administered in pharmacies, but a system referred to as clearinghouses have been developed so physicians can generally bill Part D for vaccines.

In June 2007, the Commission recommended that all Medicare vaccine coverage be moved to Part B. One of the factors motivating that recommendation were concerns that physicians would have difficulty billing Part D plans and concerns that patients would have to pay for vaccines up front and seek reimbursement from plans afterwards, potentially deterring access. Since then, steps have been taken to lessen these billing issues under Part D. However, there continues to be strong rationales for moving coverage of all preventive vaccines to Part B.

Moving all vaccine coverage to Part B would promote wider access to vaccines. More beneficiaries have Part B coverage than Part D coverage. Part B vaccines are administered in a wider variety of settings than Part D vaccines. It may also be less confusing to beneficiaries and providers to have all vaccine coverage under one part, instead of split across Part B and D.

No cost-sharing for preventive vaccines and the vaccines' administration would ensure cost is not an access barrier for beneficiaries. When the Congress covered prior preventive vaccines, for flu, pneumococcal, and hepatitis B, under Part B it did so without cost-sharing for the vaccine and the vaccine's administration.

MS. NEUMAN: Next we'll discuss how Medicare pays for vaccines. There are number of pricing metrics involved in vaccine payment, so this first slide has a quick review of the pricing terminology. First there is average wholesale price. This is a list price, and the analogy often made is that it is like the sticker price on a car and it doesn't necessarily reflect actual prices.

A second concept is wholesale acquisition cost. This is the price at which the manufacturer sells to the

wholesaler or directly to customers, and it does not incorporate discounts or rebates.

There is also average sales price. Is the average price realized by the manufacturer for sales to most purchasers, net of rebates and discounts, with some exceptions. Medicare uses ASP+6 percent as the basis payment for most Part B-covered drugs and biologicals that are not vaccines.

Now turning to how Medicare pays for vaccines. For Part B-covered preventive vaccine, like flu and pneumococcal, Medicare pays most immunizers like physicians and pharmacies at a rate of 95 percent of AWP. A small portion of vaccine doses furnished by certain types of providers are paid reasonable cost.

For the vaccines that Part B covers in limited circumstances in response to an injury or direct exposure, like rabies, tetanus, and hepatitis A, Medicare pays 106 percent of the average sales price. Part D pays for vaccines based on plan-negotiated rates with pharmacies. Part D plans may also negotiate manufacturer rebates, although we don't know whether that occurs for vaccines.

In addition to paying for the vaccine, Part B and

D also make separate payment for the administration of the vaccine. Note that in situations where the Federal Government directly purchases vaccines, like is occurring with the COVID-19 vaccines, Medicare only pays for the administration of the vaccine, not the vaccine itself.

We have analyzed how Medicare's various payment rates for vaccines compare to wholesale acquisition cost. What this analysis shows is that for Part B preventive vaccines, Medicare's 95 percent of AWP payment is substantially above wholesale acquisition cost, and you can see that in the column on the far left of the slide. For vaccines covered by Part D, the median plan payment rate is typically a couple percentage points above WAC, and you can see that in the column on the right.

For the few vaccines covered in limited circumstances by Part B at a rate of 106 percent of ASP, we see that 106 percent of ASP is substantially below WAC for those products for which we have data.

The prior analysis suggests that there are opportunities to improve Medicare payment for vaccines. WAC is a better measure of drug prices than AWP. Payment for Part B vaccines based on WAC, for example, at 103

percent of WAC, would moderately lower payment rates from 95 percent of AWP, but would do so in a way that would be expected to ensure that all immunizers can obtain the vaccine at prices within the Medicare payment amount.

Although WAC is a better measure of drug prices than AWP, it does not reflect discounts or rebates. Ultimately a payment rate based on ASP might be most appropriate, as it would reflect the average actual market price. However, it would be helpful to have more data before considering an ASP-based payment for vaccines, for several reasons.

With vaccines, there is uncertainty about how the two-quarter lag in ASP would affect Medicare payment rates, especially given the seasonality of the influenza vaccine. Because ASP is an average, we do not know how much vaccine acquisition prices vary across purchasers. Understanding that price variation could help inform whether 106 percent of ASP or an alternate add-on to ASP is appropriate.

In light of the issues discussed today about vaccine coverage and payment, the Chair has the following draft recommendation for your consideration. It reads:

The Congress should cover all appropriate

preventive vaccines and their administration under Part B instead of Part D without cost-sharing, and modify Medicare's payment rate for Part B-covered preventive vaccines to be 103 percent of wholesale acquisition cost, and require vaccine manufacturers to report average sales price data to CMS for analysis.

The first part of the draft recommendation is intended to improve access to preventive vaccines by moving all coverage to Part B and eliminating cost-sharing. This is similar to the Commission's 2007 recommendation, except that the 2007 recommendation did not address cost-sharing. The second part of this draft recommendation is intended to improve payment accuracy for Part B preventive vaccines.

The implications of the draft recommendation are, in terms of spending there are several dynamics and the overall effect is uncertain. With respect to the first part of the draft recommendation putting all preventive vaccine coverage under Part B, on the one hand, the policy may increase spending by improving access and reducing cost-sharing for the shingles vaccine, the predominant vaccine covered by Part D. On the other hand, if shingles vaccination rates increase as a result of the policy, fewer

beneficiaries may acquire shingles and Medicare spending on services to treat shingles may be reduced.

With respect to future vaccines not yet developed, there is more uncertainty about effects, but the same general dynamics would be at play.

With respect to the second part of the recommendation on payment for Part B vaccines, the policy would reduce Medicare program spending, due to savings from paying 103 percent WAC instead of a higher rate.

In terms of beneficiaries and providers, we expect that this policy would improve beneficiary access to vaccines because more beneficiaries have coverage under Part B than Part D and because beneficiaries would face no cost-sharing for vaccines under Part B.

In terms of providers, covering all appropriate preventive vaccines under Part B would facilitate the administration of vaccines by a wide variety of providers, and we do not expect the draft recommendation to adversely affect providers' willingness or ability to furnish vaccines.

So that brings us to the end of the presentation. We would be happy to answer any questions and we look

forward to your discussion today of the Chair's draft recommendation. Going forward, as Nancy said, the plan is come back in April with a vote on a final recommendation and to have a chapter on Medicare vaccine coverage and payment in the June report.

DR. CHERNEW: Great. Thank you both. That was wonderful. Dana, I think we should start the Round 1, and remind everybody if you have comments, get in the queue.

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

DR. PAUL GINSBURG: Sorry. Two quick things. One is that as far as the low take-up of the Shingrex vaccine, I think the data were from 2018, and my recollection is that there was a huge supply and demand imbalance at that point, where people were looking all over to get it, and that probably take-up would have been a lot higher if the supply had been there. So anything you could do to get a more recent number might be relevant.

Speaking of recent numbers there was something about intentions to take the COVID-19 vaccine, and I just want to mention that this is changing rapidly from month to month. The latest Kaiser Family Foundation poll is much more stronger intents to take it. So we should plan to

update this with the latest information before we go to press.

MS. KELLEY: That's all I have for Round 1, unless anyone wants to jump in.

[No response.]

MS. KELLEY: All right. Then we'll go to Round 2, Mike?

DR. CHERNEW: Are there people in the Round 2 queue, Dana? I haven't seen them.

MS. KELLEY: I have one person, Bruce.

DR. CHERNEW: Bruce, you're up.

MR. PYENSON: I support the recommendation as written. On a longer-term basis, I think that vaccination topic, along with a handful of other topics such as telehealth, are moving into the public health realm and are perhaps not best treated as part of an acute care medical system, which is what Part B is.

So I think for future work of the Commission I would put that concept out there, that medicalizing some aspects of public health is probably not the best way to address them, but I do support this shift, this recommendation.

DR. CHERNEW: Thank you. Dana, I don't know if there's anyone else in the queue. I see Karen. Actually, Dana, I'm giving it back to you, since I'm only seeing part of the queue.

MS. KELLEY: Okay. I think Karen is next.

DR. DeSALVO: Thank you. Bruce, I just want to say thank you for that comment about how important it is to not medicalize what is a public health good, and we certainly have done that in the vaccine realm, for adults and children, and it creates added complexity. And in this case, for example, if a beneficiary maybe doesn't have Part B or Part D, then that creates additional struggles for them to access vaccinations, and what we really want is for those to be as easy as possible to get, due to the preventive nature of vaccines. So thank you for raising it.

It would be great to have the time to sort out how this could be less of a reimbursement schedule and more about a public health good.

MS. KELLEY: I think that's it, Mike.

DR. CHERNEW: Okay. So surprisingly, we now have a little bit of time, and so given that we can at least

have a quick go-around, or maybe, Dana, you can go around, just to get people's general sense. Betty do you want to start? Again, I'm not looking for a lot of comments. Just a general gestalt of where people are.

DR. RAMBUR: I just wanted to say that I support this strongly, and I also concur with the previous comments about public health. I just wanted to really compliment the staff, because as a new Commissioners, when I first got this I really couldn't muddle my way through what the differences were, and it's very clear to me now. It's very clear to me that this is the right recommendation, so thank you.

DR. CHERNEW: Betty, thank you. I'm going to jump in. I'm basically going to go alphabetically, so you will be able to figure out where folks are. So Larry?

DR. CASALINO: Yeah. I think this is very nice work and strongly support the recommendation.

DR. CHERNEW: Brian?

DR. DeBUSK: I agree with Larry. I think this is very good work and I completely support the recommendation. Thank you.

DR. CHERNEW: We'll do Marge and Paul. Marge?

MS. MARJORIE GINSBURG: Yes, I concur with the others as well. I wonder, on the recommendation, and there are really two issues. One is move them all to Part B and the other is the 103 percent wholesale acquisition cost. And I guess my only suggestion was whether those should be two separate bullet points. They're two very distinct issues and I want to make sure that they don't get lost in the word shuffle. Thank you.

DR. CHERNEW: Paul.

DR. PAUL GINSBURG: Yeah, sure. Very good work. I want to praise the staff, and I support the recommendation. Perhaps this really should be two recommendations rather than one, but that's a detail that can be worked out between the meetings.

DR. CHERNEW: Thanks, Paul. David.

DR. GRABOWSKI: Yes. Thanks, Mike. I also support the draft recommendation, and I actually like what Marge and Paul just suggested, of separating this out, because I don't think they're necessarily -- they're both very important but they don't need to be bundled together. So separating them into two recommendations makes a lot of sense. Thanks.

DR. CHERNEW: Thanks. Jonathan.

DR. JAFFERY: Yeah. I echo my fellow Commissioners' comments that this is great work, and I fully support the draft recommendation.

DR. CHERNEW: Okay. Jon Perlin.

DR. PERLIN: I also agree with my fellow Commissioners, but I don't disagree with Bruce in theory, but I do just not want to miss the opportunity to note, if you look at the December 19th American Journal of Managed Care study, for all Americans vaccines reduced health care spending by about $27 billion. There's another study that has perhaps a different type of rigor, and it looks at the adult population, November 16, and it finds for the adult population vaccines are an unmitigated need for $9 billion of care a year, or $4.7 to $15.2 million. Now it didn't break it out specifically for Medicare beneficiary population, but obviously older, more chronic disease-burdened, more vulnerable, so some significant piece of that.

So this is one of the areas where I find the math really compelling in terms of the purview, and would hope that, in some larger standards, a greater rationalization

of the public health infrastructure. But in terms of our opportunity to influence across quality and access within the Medicare program itself I think this one is an absolute winner, so I strongly endorse. Thanks.

DR. CHERNEW: Thanks. Betty, I believe you spoke on this. I want to see your head. Am I right about that? Then I'm going to go on to Wayne.

DR. RAMBUR: You already called on me. I mean, I've already commented, yes. Yes, I have spoken. I'm good. I support it.

DR. CHERNEW: We are going to Wayne.

DR. RILEY: Yes, I support, Chairman, and I agree with adjusting it to two separate -- can you hear me?

MS. KELLEY: Yes, Wayne, we can hear you. Go ahead.

DR. RILEY: Yes. Just I support fully and I like the adjustment to make two separate, very strong recommendations around this.

MS. KELLEY: Mike, we're having some trouble with your mic.

DR. CHERNEW: [Inaudible.]

MS. KELLEY: Mike, we can't hear you. I'm sorry.

I think you were going through alphabetically, so I think perhaps Sue, we haven't heard from Sue yet.

MS. THOMPSON: Thank you, Dana. Yes, I too support the recommendations, and also agree --

DR. CHERNEW: -- Jaewon, then we'll have Dana --

MS. THOMPSON: Can you hear me, Dana?

MS. KELLEY: Sorry, Mike. We're still having trouble with you. I will try and roll through the rest of the commissioners. Okay? So we'll let Sue continue.

MS. THOMPSON: And I'll conclude. I support the recommendations. Thank you.

MS. KELLEY: Dana Safran?

DR. SAFRAN: Yes, I fully support the Chairman's draft recommendation and like the idea of splitting into two recommendations. Thank you.

MS. KELLEY: And with my kind of wacky alphabetical order here, Pat is next.

MS. WANG: No problem. Thanks. I support the recommendation. I guess that if there were any -- and perhaps I should have put this in Round 2 -- I'm not facile with WAC versus AWP versus ASP. I guess the one thing, you know, the chapter concluded that the impact on cost was

uncertain. You know, I think that this is the right proposal to, you know, really streamline the distribution of vaccines for beneficiaries.

If it were possible to understand more about, you know, switching to Part B and then, in addition with this, like where is the money shifting? Is the manufacturer of the vaccine -- I mean, I don't think any manufacturer of vaccine counts on vaccine production to make their bottom line, but it's an important part of their business. Are the winning or losing under the shift to Part B and then the further shift to 103 percent of WAC? There are rebates in the ASP calculation, I guess. Those go away under this AWP. It's just, there is some money that is moving around. I just don't know if it's possible to understand more about that. If it's too esoteric and too much work, forget it, but it is, for me, something that is kind of missing in shifting these around. Maybe it's cost-neutral to the system, but are there components of the system that are gaining or losing? I don't know.

DR. CHERNEW: Okay.

MS. WANG: I don't know if Kim or Nancy, you can just say it's negligible, and that would answer my

question.

MS. NEUMAN: As far as the effects on the manufacturer?

MS. WANG: I guess so, yeah, or pharmacies' reimbursement for administering vaccine. They are getting paid, I guess, at a negotiated rate from Part D for the ones that they are administering. It just might be a little bit helpful to have a tiny bit more insight into that.

MS. NEUMAN: So I could speak to the pricing of the vaccine and Nancy could speak to the administration piece, I think.

So on the vaccine piece, we saw, in one of the slides, how currently under Part D shingles is paid at about 101 percent of WAC at the median. So if you went to 103 percent of WAC under Part B it's pretty close to the same rate. So pharmacies should feel about the same under the two scenarios, at least with regard to shingles, which is the predominant Part D vaccine that would be moving.

In terms of administration --

MS. RAY: In terms of administration we found that the admin fee across all providers under Part B, the

average was roughly $20, and that across Part D, which is primarily at pharmacies, it was also $20. So in terms of admin fee we don't see a big impact.

MS. WANG: Thank you.

MS. KELLEY: And I believe the last person is Jaewon.

DR. RYU: I support the draft recommendation as well.

MS. KELLEY: Okay, Mike. I think we've heard from everyone.

DR. CHERNEW: And I think I'm back. I'm sorry I had an internet snafu. Can you hear me?

MS. KELLEY: Yes, we can.

DR. CHERNEW: Somehow GoToMeeting gets sick of my voice after a while. I start with clarity and then when it's tired of me it stops. But in any case, I am back, which is good.

I think that was a very useful discussion. I'm glad there seems to be a lot of consensus, so I think we can now move ahead. We have our last session coming up on separately payable drugs, I think, and that is going to be Dan, who earlier this morning was having some internet

issues, but Dan, I hope you're with us.

DR. ZABINSKI: Can you hear me?

DR. CHERNEW: Yes, I can hear you.

DR. ZABINSKI: Should I just start?

DR. CHERNEW: Yes, you should just start.

DR. ZABINSKI: Okay. Here we go. Today we're going to talk about how drugs are paid in the hospital outpatient prospective payment system, or the OPPS, and how the drug payment in that system could be improved.

For the broader audience, PDF versions of the slides are available on your webinar control panel on the right side of your screen.

Previously, we had produced analyses of how to improve the system of drug payment in the OPPS in the Commission's June 2020 Report to the Congress and in a presentation at the November 2020 public meeting, and responses to Commissioner's thoughts and comments on those analyses has led us to today's presentation.

The analysis that you're about to see and the work that has been done by Nancy Ray and Kim Neuman on drug payment are the start of an effort to develop a consistent approach of paying for drugs throughout fee-for-service

Medicare.

I'd also like to thank Kim and Nancy for their guidance and assistance on today's presentation.

I think it will be helpful to provide an overview of what we'll be talking about today. We'll start by discussing the unit of payment in the OPPS, and that will be followed by an explanation of how drugs are paid.

In the OPPS, some drugs are paid separately, and we'll talk about the current policies for separately payable drugs, including concerns we have about those policies, and then we'll talk about how Medicare payment for separately payable drugs in the OPPS could be improved.

To get a full understanding of the issues that we'll discuss today, it's important to have a general understanding of the unit of payment in the OPPS.

Now, most Medicare payments in the OPPS are for primary services, which are usually the reason for an HOPD visit such as a surgical procedure or an emergency department visit.

The OPPS uses bundled payments in which the cost of most ancillary items are packaged with the primary service into a single payment unit.

For example, suppose someone injures their arm and goes to an ED. In this case, the physician may order an X-ray, and the ED visit is the reason the patient is there, so it's the primary service and paid separately, while the X-ray is an ancillary and its cost is packaged into the payment rate of the ED visit.

It's important to understand that when an item is packaged, that does not mean there is no reimbursement for the item. Instead, the cost of the item is reflected in the payment rate of the related primary service.

The benefit of packaging the primary service and its related ancillary items into a single payment unit is that bundles provide powerful incentives for providers to seek the lowest-cost, most efficient method to furnish a primary service. Given the strength of these incentives, payments outside the bundle should be carefully considered.

Like services, many drugs covered under the OPPS are supplies to primary services, and others are the reason for a visit.

In general, drugs that are the reason for a visit are those in which the only service provided with the drug is the drug administration, and many of them are for cancer

treatment. All other drugs are supplies to a service.

Under the OPPS, there is a similarity in how drugs and services are paid because many drugs are packaged and some are paid separately.

The importance of separately payable drugs in the OPPS has increased as program spending on separately payable drugs has increased rapidly from $5.1 billion in 2011 to $14.8 billion in 2019. Most of this growth was for high-cost cancer treatment drugs.

The OPPS has two policies for separately payable drugs. One is the pass-through policy, which was created by the Congress, and the other is the policy for separately payable non-pass-through drugs, which was largely created through regulation. And even though both policies offer separate payment for drugs, they serve somewhat different purposes.

The pass-through policy focuses on drugs that are new to the market. It exists because during the development of the OPPS there was concern that for new drugs the needed cost and use data would not be available to include their cost in the payment rates of the related services.

In response, the Congress created the pass-through policy. The central purpose of this policy is to provide separate payments for a limited time for costly new drugs, to mitigate providers' financial risk, and to encourage use of those drugs.

The pass-through policy includes both drugs that are supplies and those that are the reason for a visit. Pass-through drugs that are supplies to a service become packaged drugs when their pass-through status expires, but those that are the reason for a visit can become separately payable non-pass-through drugs.

The policy for the separately payable non-pass-through drugs focuses on drugs that are established on the market rather than new drugs. The intent is to provide adequate payment for relatively costly drugs to ensure their use, which, again, mitigates providers' financial risk.

Through regulation, CMS has established that drugs that are supplies to a service cannot be separately payable non-pass-through drugs. Therefore, it's implicit in this policy that separately payable non-pass-through drugs are drugs that are the reason for a visit.

These two policies for separately payable drugs have different criteria for eligibility.

For a drug to be eligible for the pass-through payments it must be new to the market and have a cost that exceeds three thresholds that are related to the payment rate of the related primary service.

Having pass-through status has a definite time limit; drugs can have this status for two to three years. When pass-through status expires, a drug can become a separately payable non-pass-through drug or it is packaged.

For a drug to be eligible for the separately payable non-pass-through policy, it, first of all, must not be a pass-through drug because the program is for established drugs, not new drugs. It also must have a cost per day that exceeds a threshold, which CMS has set at $130 for 2021, but CMS updates that threshold for drug price inflation each year.

Once again, CMS has established that drugs that are supplies cannot be separately payable non-pass-through drugs.

Finally, there is no specified time limit for these drugs. They can hold this status as long as cost per

day exceeds the required cost threshold.

A concern that we have about the drug payment policies in the OPPS is that both the pass-through and the separately payable non-pass-through policies include drugs that are the reason for a visit.

A small issue is that this makes the administration of the OPPS system of drug payment more complex than it needs to be. But a more substantive issue is that for hospitals that obtain their drugs through the 340B program, there is financial advantage for using some pass-through drugs rather than similar separately payable non-pass-through drugs.

Specifically, by statute, OPPS payment rates for all pass-through drugs must be ASP plus 6 percent. In contrast, through regulation, CMS has established that payment rates for separately payable non-pass-through drugs must be set at ASP minus 22.5 percent if it is obtained through the 340B program and at ASP plus 6 percent if it is obtained outside the 340B program.

Therefore, 340B providers have different payment rates for pass-through and separately payable non-pass-through drugs. So in some instances, 340B providers have a

financial incentive to use pass-through drugs over therapeutically similar non-pass-through drugs.

We also have a couple concerns specific to the pass-through policy. One is that it is not restricted to drugs that are supplies to a service. And, second, it does not include a clinical superiority requirement.

The lack of a clinical superiority requirement is especially important. Without one, Medicare can make additional separate payments for a new and potentially much higher-cost drug that is no more effective than a similar competing drug that's already on the market.

Medicare payments for drugs that are supplies to a service could be improved by restricting the pass-through policy to drugs that are supplies to a service, which would mean that the policy would exclude drugs that are the reason for a visit.

This change would level the payment rates among drugs that are the reason for a visit, which would mitigate the financial benefit among 340B hospitals from using pass-through drugs over separately payable non-pass-through drugs and would reduce Medicare spending on drugs.

In addition, payment for drugs that are supplies

could be improved by adding a clinical superiority requirement to the current criteria for pass-through eligibility.

Adding a clinical superiority requirement would raise the bar for drugs to qualify for the pass-through payments beyond simply being high cost. Also, manufacturers would have incentive to devote resources to develop drugs that offer better clinical performance.

CMS would have to make the final decision about how to determine whether a drug is clinically superior to similar products, but we believe the criteria that CMS uses to determine whether drugs show clinical superiority to qualify for the NTAP Program in the inpatient PPS are a viable option.

To improve Medicare payment for drugs that are the reason for a visit, the policy for separately payable non-pass-through drugs could be expanded to include new drugs that are the reason for a visit. Currently, these drugs are paid largely separately under the pass-through policy.

As we just discussed in regard to the pass-through policy, this would mitigate the financial benefit

for 340B providers to use some pass-through drugs over similar separately payable non-pass-through drugs.

For the separately payable non-pass-through policy, we should continue have a policy that requires a drug to have costs per day that exceed a threshold, but we're not certain if the current threshold of $130 per day is the right one.

Also, the policy should continue to exclude drugs that are supplies to a service.

On this slide, we have the eligibility criteria that would occur for the pass-through and the separately payable non-pass-through policies if the modifications to these policies that we just discussed were implemented. We have bolded the criteria that would be new or modified.

For pass-through drugs, they would still have to be new drugs, but the policy would exclude drugs that are the reason for a visit.

In addition, a drug would have to show clinical superiority over similar drugs that are used in the same primary service.

Finally, drugs would still have to have costs that exceed three thresholds related to the outpatient PPS

payment rate of the applicable service.

For a drug to qualify for the separately payable non-pass-through policy, the drug would have to be the reason for a visit.

The policy would be expanded to include both new and established drugs. Currently, new drugs that are the reason for the visit typically obtain separately payable status through the pass-through policy.

Lastly, drug cost per day would still have to exceed a cost threshold.

And a final note: Drugs that don't fall into either the pass-through or the separately payable non-pass-through categories are packaged.

Now, on this slide, we have a summary of the key effects of the changes that we've discussed, and I want to emphasize that the first bullet and the last sub-bullet really summarize the effects.

In particular, the clinical superiority requirement would raise the bar for drugs to have pass-through status beyond simply being high cost.

In addition, the changes that we propose would result in drugs that are the reason for a visit no longer

being eligible for the pass-through policy.

Therefore, all drugs that are the reason for a visit would obtain separately payable status under the separately payable non-pass-through policy.

This change would level the payment rates among drugs that are the reason for a visit because under current policy, for drugs obtained through the 340B program, pass-through drugs have payment rates of ASP plus 6 percent, while the separately payable non-pass-through drugs have payment rates set at ASP minus 22.5 percent.

So in light of our discussion today, the Chair has two draft recommendations for the Commission's consideration.

The first of these draft recommendations is related to the pass-through policy: The Congress should direct the Secretary to modify the pass-through policy in the hospital outpatient prospective payment system so that it includes only drugs and biologics that function as supplies to a service and applies only to drugs and biologics that are clinically superior to their packaged analogs.

This draft recommendation is directed toward the

Congress because congressional action is required to make these changes to the pass-through policy.

The second draft recommendations is related to the separately payable non-pass-through policy: The Secretary should specify that the separately payable non-pass-through policy in the outpatient prospective payment system applies only to drugs and biologics that are the reason for a visit and meet a defined cost threshold.

This draft recommendation is directed toward the Secretary because the separately payable non-pass-through policy was largely developed through regulatory action.

And, finally, implications of these two draft recommendations include:

For spending, over the short term we anticipate no direct effect on program spending due to budget neutrality requirements in the OPPS. Over the longer term, there may be lower program spending from a similar pass-through policy giving providers incentive to alter their drug choices and limits on the inflationary effects of current policies for separately payable drugs.

For providers, they could change drug choices within groups of clinically similar drugs, but we

anticipate no effect on beneficiaries' access to needed drugs, and beneficiaries may benefit from improved efficacy of drugs used with outpatient services.

That concludes the presentation, and I turn things back to Mike.

DR. CHERNEW: Dan, thank you. We're about to jump into the Round 1 and Round 2 questions, so to my fellow Commissioners, please jump in the queue.

In the meantime I will say that, like many things, this is really the first bite of a very, very complex apple about how to deal with new innovations given the payment models that we have and encourage both efficient purchasing and the needed innovation. So, Dana, I'm turning it over to you to manage the queues.

MS. KELLEY: All right. We have Pat first.

MS. WANG: Thanks. And, Dan, thank you for a report that makes this very complex issue, you know, as clear as possible.

I'm going to -- because I can't say all of the syllables, I'm going to refer to these as "pass-through drugs" and "spin-tip" (SPNPT) drugs, the separately payable non-pass-through as "spin-tip" because I just can't get all

of the syllables out.

I just wondered if you could talk a little bit more about the relationship between these two categories. You had mentioned pass-through drugs, once they kind of reach [audio break - inaudible] SPNPT category, but they remain there. Under the proposed recommendation, I suppose that drugs that are the service would just start there and stay there.

Is there anything that is gained today from having a drug in pass-through status and then moving to SPNPT? Is there anything that is learned in terms of clinical efficacy or what have you? Are there drugs that start in pass-through status that never make it to SPNPT because something else happens to them? Would we be losing anything by just sort of separating them?

The second question I have is: With the new clinical superiority requirement for pass-through drugs, once you effectuate this recommendation and many more drugs just start in SPNPT, is there much left in the category of pass-through to apply a clinical superiority requirement? I guess I'm kind of wondering about the nature of these drugs. Are these specialty drugs that have no

alternatives? Is clinical superiority meaningful? Is it something that CMS could easily apply? You had cited the NTAP process, which seems to, you know, sort of weigh the efficacy of alternatives to see what's best with that, what these pass-through drugs are? I guess I'm just curious. It sounds right to apply a clinical superiority requirement. I'm just wondering about the feasibility of it.

So those are sort of the two buckets of questions of the relationship today and whether there is any benefit of something starting in pass-through before it gets to SPNPT in terms of clinical efficacy that would be lost; and, second, after this recommendation, in the remaining pass-through drugs, what the practicality of a clinical superiority requirement would be.

DR. ZABINSKI: Okay. I don't think anything gets lost, you know, moving a drug, instead of having a drug start out in pass-through and -- I like this idea of "spin-tip." I've been thinking of a way to, you know, make it short and sweet. You know, how to say it? Most of the drugs that would be affected, you know, it's going to be -- you know, probably three-quarters are cancer treatment

drugs. And, you know, it's pretty unusual for a drug that is in that group, that being the cancer group, that, you know, they can start as pass-through and then they're not able to make it to separately payable non-pass-through. It's just pretty infrequent. So I don't think anything's going to get lost in that sense.

And then on the pass-through, you know, what would be left is -- it's things that really -- things, you know, that would be left would be skin substitutes used in skin repair services and anesthesia, you know, some analgesics that are sometimes used in surgeries and contrast agents. And, you know, what we're looking to do is to make sure that, you know, for that type of drug, that they actually offer something better than what's there already in order to get this separate payment for a limited time before the necessary data are collected to include their cost in the related service.

Does that answer the question?

MS. KELLEY: Pat, we can't hear you.

MS. WANG: I'm sorry. Of the costs that would be left in pass-through, are there alternatives that could be considered? I just don't even know. It sounds like what

would be left is a relatively small number?

DR. ZABINSKI: Yes.

MS. WANG: Okay.

DR. ZABINSKI: And, you know, I will add that if you read the language, the legislative language, and the regulations that came out during the development of the OPPS, the real intent of the pass-through status initially was for these drugs that are supplies to a service, mostly just for the fact that at that time this idea of the drugs that are the reason for a visit, there weren't many of them at that time so they were really an afterthought. And then when they came into broad being there was no real place to put them, and so that's where they ended up. But I think it's time to move on and develop something better.

MS. WANG: Thank you.

MS. KELLEY: Okay. I have Jonathan Jaffery next with a Round 1 question. I see that Jonathan said he is covered.

DR. JAFFERY: Yeah, I'm covered.

MS. KELLEY: Larry, it looks like you are covered now also?

DR. CASALINO: Yeah.

MS. KELLEY: Okay. Then we'll move to Jon Perlin.

DR. PERLIN: Let me also add my thanks for a very clear presentation on an incredibly complex topic. And this may reflect my continuing lack of understanding one nuance, but you had a slide that said that for 340B providers, financial advantage using some pass-through drugs rather than a similar separately payable amount of pass-through drugs, et cetera. Does this recommendation address that issue?

DR. ZABINSKI: The attempt is yes. You know, the idea is that right now you've got a lot of these drugs that are the reason for the visit. They make their first stop in the pass-through policy. They stay there for two to three years and get paid at ASP+6, and there's a small advantage that for 340B it's advantageous in a lot of cases to use those drugs rather than a similar drugs that's already established on the market, but it's a separately payable non-pass-through policy. So the payment rate is ASP-22.5 percent.

DR. PERLIN: Thanks.

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

question?

MR. PYENSON: I did. My question relates to biosimilars, and in particular, perhaps an interpretation of the second bullet of the Chair's recommendation. There is perhaps often the case where a biosimilar would fall underneath the threshold for the special payment, and since the scientific and medical issues of equivalency have been settled, I'm wondering if the clinically superior would serve to encourage the use of biosimilars. That's one question.

The second question related to biosimilars is that the idiosyncrasies of 340B pricing mean that some expensive products that have been around for a while might be what's called "penny priced." And the 22.5 percent discount doesn't come close to reflecting what the acquisition cost. And I'm wondering if this discussion, if our framework can incorporate fixing that in the context of OPPS.

DR. ZABINSKI: Okay. First one. I think, yeah, the requirement of a clinical superiority, I think it would encourage the use of the biosimilars. You know, say a biosimilar comes along and it's supposed to be somewhat

equivalent to the reference biologic, and if it's not found to be any better in any way then, yeah, it's going to encourage their use, I think.

Now on 340B, I think what you're getting at is, you know, you have a drug that's been around awhile, and through the 340B setting of the ceiling prices you're going to end up with really high inflation adjustment and possibly even penny pricing. And so there's still a real advantage to using the drug that's been around awhile.

And so, yeah, setting the payment rates on the same basis for new and established drugs doesn't necessarily encourage the use of the new drug because of this, but in general it's going to, I think, be beneficial to leveling the payment rates and encouraging less use on the basis of just financial considerations.

And I hope on this last part, I hope I'm answering your question.

MR. PYENSON: My question is more on -- I agree the incentive is to use the penny-priced drug, or the lower priced, because the mark-up would be significant. But I'm wondering if the framework we are proposing here would be a way to move to acquisition price as opposed to the -22.5.

DR. ZABINSKI: No, it would not aim at that acquisition price, no. The established right now by CMS is ASP-22.5 percent, and that's what the draft recommendations would head to.

MR. PYENSON: Okay. Thank you.

MS. KELLEY: I have Sue next.

MS. THOMPSON: Thank you, Dana, and thank you, Dan, for taking on this complicated work.

My question is, if we would adopt the Chairman's draft recommendation, have we quantified savings to Medicare? Do we know what the value is associated with these changes?

DR. ZABINSKI: Quantified it? No. Our best guess -- it gets pretty complicated. You know, in all likelihood, providers are going to change their drug choices, and that's going to also, in all likelihood, save the program some money. How much is really difficult to say. So I'm really not certain.

DR. MATHEWS: Yeah, let me jump in, and maybe, Sue, I could provide a little more detail. Looking at the qualitative impacts on Slide 5, we wouldn't expect any immediate change to Medicare spending given the way budget

neutrality governors pricing under the OPPS, so in year one, nothing.

But the most significant part of the recommendation, as it's currently structured, is the inclusion of the clinical superiority requirement for pass-through drugs, and the idea here is that under current policy, in order to get pass-through status and for something to be paid outside of the OPPS bundle, all it has to do is be new and it has to meet a couple of cost thresholds, which create strong insulationary incentives. You know, the higher cost it is, the more likely you'll get separate payment for it.

By imposing a clinical superiority requirement, however it's defined, we would ostensibly impose some drag on Medicare paying more for something just because it is high priced over the longer term. That's the expectation here.

Does that help at all?

MS. THOMPSON: Yes. Short answer, yes. Thanks, Jim.

DR. MATHEWS: Nancy, you wanted to get in on a prior comment?

MS. RAY: I just want to address Bruce's comment. Bruce, we had a recommendation back in our June 2017 report that called for use of consolidated billing codes for the reference biologic and its biosimilars, so that policy implemented would address, I think, your question.

MR. PYENSON: Thank you, Nancy. I recall that.

MS. KELLEY: That's all I had for Round 1 questions, and I have Bruce with a Round 2, unless I missed someone.

DR. CHERNEW: Bruce, you're up. I think Bruce is up.

MR. PYENSON: I support the recommendation. I would suggest that we expand the superiority clause to say in the case of equivalency that the billing entity has to use the lower-priced product, or else we could reference the earlier recommendation that Nancy just mentioned. But because I think that would create pressure, some of the most widely used biologics have biosimilars available, and I think we can get more value by encouraging their use.

DR. MATHEWS: First, do you mind if I ask a clarify question in response?

MR. PYENSON: Sure.

DR. MATHEWS: All right. So the basic construct of the policy is currently the OPPS packages certain things. Dan mentioned a couple of them -- anesthesia used in surgery, a couple of other packaged pharmaceutical products. Currently, things can be paid outside of the OPPS and separately payable, if they meet the cost criteria. What we are saying, through the imposition of a clinical superiority requirement, is that if the thing doesn't demonstrate clinical superiority it does not get separately paid, and if a provider wants to use it, they have to do so under the otherwise applicable OPPS payment amount.

And so in that scenario, when there is no separate payment because the thing is only equally effective as the thing in the bundle that it replaces, the providers has an automatic incentive to use the older, lower-cost product that is priced as part of the bundle.

Does that make sense or did I miss something.

MR. PYENSON: It makes sense. So if there is a similarly priced superior product that is historically separately priced, and a biosimilar comes along, how does that interact? And the issue I'm trying to address.

DR. CHERNEW: I think, Bruce, if I can just ask a somewhat clarifying question to your Round 2 question. You are talking about what happens if when something comes along, the new thing is less expensive -- this is designed to prevent inflation of things that are more expensive but not better. That's what the intent of this is. There is a separate question, what happens if a biosimilar comes along and we have, as I think Nancy pointed out, a recommendation to deal with aspects of that portion of it. In this discussion, Jim, and maybe if someone else wants to jump in, is how this deals with when a new thing comes along which is less expensive.

Is that essentially the issue you're talking about, Bruce?

MR. PYENSON: Yes, and if it's nuanced in the way the clinical superiority would no longer apply to the originator. So, Michael, you're right. It's not just the price but the equivalence is there.

DR. CHERNEW: Right. So if something was clinically superior and higher priced and got separately passed-through, and something else came along that was lower-priced but the same as the first thing, what happens?

I realize that's a nuance that I think is important, that we will have to ponder. Jim, do you want to add to your question?

DR. MATHEWS: I'm okay.

DR. ZABINSKI: Can I throw something in here? I mean, if it's lower priced and the original product is packaged, and this thing is lower priced than the packaged one, this item is going to be packaged as well, and the provider is going to look at the situation and say, "Well, let's see. We've got a better product and, you know, if it's packaged it actually saves us money to do it." So there's going to be an encouragement. There's going to be an incentive for the provider to use that new item, that's both cheaper and better.

MR. PYENSON: And that makes sense if the originator is packaged as well.

DR. CHERNEW: Right. That was Bruce's point. Bruce is asking, if I understand correctly, and then we will move on, is if the originator is not packaged, what happens?

DR. ZABINSKI: Well, then the question gets -- my question is, are you talking about the drugs that are

supplies or drugs that are the reason for a visit?

MR. PYENSON: Well, assuming it's the reason for the visit and hence it would qualify under this recommendation for separate payment.

DR. ZABINSKI: Well, then they are both going to be paid separately. They're both going to be paid separately, and, you know, then it's up to the provider to choose which one they want to use. But the basis for pricing, you know, the payment rate is going to be ASP-22.5 percent if obtained through 340B.

DR. CHERNEW: And again, I do want to push us along, but just to reiterate what I think Bruce was saying, if they're both paid separately but one of them is less expensive than the other, I think Bruce would rather have some way to force the use of the less-expensive one. Is that the spirit of what you're saying, Bruce?

MR. PYENSON: Correct. And because the originator is not clinically superior, maybe that gives a way to interpret it.

DR. CHERNEW: Yeah. So I understand it. We will continue this discussion. I think what I would say is that we tried, back when I was on the Commission before, for

example, to deal with a least costly alternative recommendation, which is very much in the spirit of what you're talking about, Bruce. It became actually quite complex for a whole number of reasons.

So this recommendation is admittedly more limited to deal with a separate issue, but it certainly does not deal with all of the issues associated with the introduction of biosimilars, for example. And I think it was Nancy -- I'm sorry, your face, Nancy, was cut out -- or it may have been Dan. Someone said there is a separate recommendation about what to do when biosimilars come along and how they get packaged in with other prices. So that's a somewhat separate issues. I think we are a little bit more limited here, but what I hear you say, Bruce, is we maybe could go further but you're okay with where we've gone.

MR. PYENSON: Correct.

DR. CHERNEW: That's a big sigh on the Zoom, on the GoToMeeting. I apologize for that long back-and-forth.

Okay. I think we're ready to move on, if Dana will move us on.

MS. KELLEY: Marge.

MS. MARJORIE GINSBURG: Great, thank you. Great report, interesting, and, actually, I could understand it.

To me, the most significant piece of this is the clinically superior and also the most difficult. The report does a great job, I think, of explaining what "clinically superior" means, how you actually translate that into a real comparison.

If this gets adopted, are we expecting the folks who have produced this new drug or biologic to adhere to certain criteria that clearly show that it's clinically superior? In other words, they've got to meet some standard to meet this particular criteria we're putting out, and that also seems to me it might be a big leap.

So I don't know whether we need to add in here what that means in real life. What do they actually have to show before it gets accepted?

Thank you.

DR. MATHEWS: So, Marge, I'm happy to try to make an answer there unless, Dan, you want to. But we have to some extent deliberately avoided being too specific with respect to which clinical criteria might apply here.

For myself, I am not a clinician. I know we've

got a lot of clinicians on the screen here, but I don't count myself among that esteemed group. But one could arguably define "clinical superiority" in a number of different ways -- you know, greater effectiveness, fewer adverse side effects, broader applicability to a wider population. And we would expect that CMS would be in a better position to establish specific criteria, and they've already got a couple of parts of the program where they have now implemented such requirements. You know, the NTAP's under the IPPS and the TPNIES is under the dialysis facility PPS. The main point that we don't want to lose here is that, you know, the imposition of any clinical superiority requirement would probably be better than no clinical superiority requirement, and you could implement it in a number of different ways where CMS is probably the entity best positioned to figure out what those ways are.

MS. KELLEY: Okay. I have Sue next.

MS. THOMPSON: Thank you, Dana. My comments may go into the same category as the dreamer comment by Wayne earlier where he was recalling hoping for other payers to support the IME program.

So with that as a backdrop, I think somehow from

a standpoint of the providers who are working in this environment and trying to manage all this information, we need to somehow influence the PBMs to utilize what CMS has established as these clinically superior medications so they're not practicing with multiple interpretations by payers of what is the superior drug. And the PBM may have a different drug than CMS as what is superior and what their evidence supports. So I just think, again -- and I hate to go down a rabbit hole here, and I won't. But in the world of practice, there's another element out there that I wish we could influence as we move forward with these recommendations.

MS. KELLEY: Mike, that's the last comment that I have on my list. But it --

DR. CHERNEW: Okay.

MS. KELLEY: -- looks like Pat --

MS. WANG: I'm sorry. I didn't show up in the queue. Can I make a comment? I don't know why I didn't show up.

DR. CHERNEW: Okay. Pat will go ahead, and then it's nice, Pat, because what I was going to do is go in reverse alphabetical order, and it turns out that leads

with you. So it's just unbelievably synergistic. Thank you for your name. Go ahead, Pat.

MS. WANG: Just a lifelong wish that people would start at the end of the alphabet rather than at the beginning.

I support the recommendation, but I wanted to say that I think that it would be -- I understand that the purpose of the recommendation is to address this specific issue. But I think that Bruce's comments and the back and forth was very valuable, and I would support continuing to think about that. And the way that I interpreted what Bruce was saying was that, especially in the pass-through situation, if there is a clinically equivalent that costs less than the drug that was approved for pass-through status, then what is reimbursed is the cost of the lower drug. It's not to say that the clinician has to switch their clinical preference, but just what Medicare will pay for it is based on the sort of more -- the lower-priced clinically efficient drug. And I realize that a lot of these things become packaged, but there's still a period of time that they're pass-through, and you wouldn't want to be held hostage to high launch prices or price increases from

a drug where there are good clinical equivalents that are cheaper. So I would encourage us to keep looking at that.

DR. CHERNEW: Yeah, so let me just jump in. We're about to go to Dana Safran. This will be, as I think I said at the beginning, an early foray into this issue about how to deal with new products. I think we find ourselves with a big challenge in general -- and, by the way, it's not just drugs. We want to make sure we encourage innovation and a lot of creation of high-value products. We also want to make sure that we have the appropriate incentive not to overpay for those things. This is complicated in general. It's very complicated in the way that it worked with bundling. There are some things we've already done, like recommending biosimilars and the originating product be bundled together. There's other complexities that are coming up in this recommendation between pass-through and separately payable drugs. I think this recommendation virtually moves us in the right direction. It doesn't solve all our problems.

And then there's broader issues around how we deal with bundling of new products overall and things that are equivalent. Sometimes they're like a biosimilar.

Sometimes they would be in a non-biosimilar context. A drug that's somewhat different but in the same class, how do you deal with that? There's a lot of nuances here, so we will think through as we move forward how to deal with some of these types of issues that become very challenging for our bundled payment models when there's very high-priced things that are hopefully better, but the bundle has a hard time figuring out how to recognize that.

I will promise myself never to read the transcript, but what you should hear is this is a complicated issue, we are trying to make a stab at it here. I hope we will come back again next cycle with a more comprehensive way to deal with a challenge which, frankly, in many ways is a good challenge to have, which is new, high-value things, when they're expensive.

That is my second sigh today, and that's the lead-in to Dana Safran.

DR. SAFRAN: Yes, I'll be very quick, just to say I am in support of the Chair's recommendation. All of us here really appreciate the rich discussion that we've just had. Thank you.

DR. CHERNEW: Dana, thank you. Jaewon.

DR. RYU: I'm supportive as well.

DR. CHERNEW: Jaewon, thank you. Wayne.

DR. RILEY: Yes, I support.

DR. CHERNEW: Wayne, thank you. Betty.

DR. RAMBUR: I support. Thank you.

DR. CHERNEW: Betty, thank you. Bruce, you have had a lot to say. This is a good opportunity to allow you to either summarize or clarify some of the things that you think your fellow Commissioners, myself included, might be confused about.

MR. PYENSON: I support the recommendation.

DR. CHERNEW: So little clarification. Jon Perlin?

DR. PERLIN: I was really hoping for Bruce's clarification. I support the recommendation. But I do want to point two things out.

One, anytime we try to establish clinical superiority, there are many dimensions of that. It's terribly complex. So I know I'm stating the obvious to the group, but, you know, there will be attributes, and that is something that will be somewhat contentious in certain quarters.

Second is I still am not sure that I fully understand how this resolves the 340B issue, and, you know, I think Bruce had commented on that in a way that offered an alternative toward a lower-price approach. But that may just be my lack of understanding. Thanks.

DR. CHERNEW: Dana points out that I skipped Sue. Sue, I am so sorry. I don't know why.

MS. THOMPSON: I do support the recommendations, and I have no further comments than what I made earlier. Thanks, Michael.

DR. CHERNEW: Again, Sue, I am sorry. So now we're at Jonathan Jaffery.

DR. JAFFERY: Yeah, thanks, Mike. I support the Chair's draft recommendation.

DR. CHERNEW: And, David Grabowski.

DR. GRABOWSKI: Thanks, Mike. I also support the draft recommendations.

DR. CHERNEW: Marge.

MS. MARJORIE GINSBURG: I support it as well.

DR. CHERNEW: Okay. Karen.

DR. DeSALVO: I support the Chairman's draft recommendations, and I do hope that in future cycles we'll

get additional clarity on how to balance clinical efficacy with cost to make sure that we're driving the right out.

DR. PAUL GINSBURG: Mike, I think you skipped me.

DR. CHERNEW: Oh, yes, because you're in a different place on my list of things. Again, I didn't mean to skip you. I think people can hear the end of a long MedPAC meeting in my voice. But, nevertheless, a good MedPAC meeting, and now Paul.

DR. PAUL GINSBURG: Thanks. Yeah, I support the recommendations. I also want to praise Dan for the clarity with which he helped us understand this topic.

I do have some thoughts about the issue Bruce raised about a separately payable drug and, you know, a similar comes out. It seems to me we could handle this very simply by just reminding the reader about our 2017 recommendation and, thus, you know, that would imply that when a biosimilar comes in for a separately payable drug, the Medicare payment goes down to the biosimilar level and it continues to be a separately payable drug.

DR. CHERNEW: Dan, do you want to comment on that and how it fits with our other recommendation? Because I think our previous recommendations get bundled with the

originator. I'm not sure, Dan, if you want to say anything about that.

DR. ZABINSKI: Yeah, I think that's right. I'm wondering if Kim's available or Nancy, they might actually be able to speak to it a little better. They're the ones who --

DR. CHERNEW: The issue I have -- so I'm going to ask a clarifying question on Paul's comment. When the biosimilar is bundled with the original drug, does the price drop to the biosimilar price or does the price end up in the bundled and become sort of average? I had thought it should actually drop, by the way, in a previous conversation I had had, and my understanding was that's not necessarily how it works mechanically if they're bundled together. It may eventually work that way through competition, but that's a little bit beside the point. So if you have a moment, some clarity might illuminate me, maybe the rest of our audience at home. Otherwise, we'll move on.

DR. PAUL GINSBURG: Yeah, actually, I'm not sure if it's the two of them are priced together and an average or if it's -- I think it might be. I think the key thing

that we want to get across is that there's a separately payable innovator drug, a biosimilar comes along, and a biosimilar's price should go into the calculation as to how much Medicare pays for, you know, either the innovator or the biosimilar drug that is still separately payable.

DR. CHERNEW: Yes. And I believe that is true, and I believe there's a recommendation prior to my current role on that point. So reminding people of that I think is a fine view, and that's work that you all did, so I'll just commend you and move on.

Are we okay, Paul?

DR. PAUL GINSBURG: Yes.

DR. CHERNEW: Okay. So this turns us to Brian.

DR. DeBUSK: I support the recommendation as written.

DR. CHERNEW: And, Larry, you have the last word.

DR. CASALINO: Yeah, I strongly support the recommendation. Great work, Daniel and Kim and Nancy.

Just one suggestion which I think makes sense. There's a nice schematic in the chapter, Figure 1, with a kind of flow chart of how CMS pays for pass-through drugs. I don't have this fully formulated, but I wonder if one or

more schematics in the final chapter could be flow charts that would show how things would work if our recommendation was put into effect. I don't know if that could be done in one schematic or kind of an overview that would include both -- you know, whether it goes through pass-through or separately blah, blah, blah. And then two more schematics, you know, one for each of those categories. But I think that would be very, very helpful and probably pretty easy for you guys to do.

DR. ZABINSKI: Yeah, I think so. I don't see a problem right now, so yeah.

DR. CHERNEW: All right. So this brings us to the end of this session. I'm going to pause to see if anyone wants to add anything to this discussion.

[No response.]

DR. CHERNEW: Okay. So I'll thank my fellow Commissioners for the time this morning. I want to reach out to the audience joining us on the GoToWebinar meeting and again remind them that we very much look forward to your input. You can do that in many ways. Contact the staff. I think there's a way to reach us through the website. But please don't be shy. These are important

issues, and since we cannot meet physically and we're doing this virtually, it is very important that we make sure to find ways to capture input from the public. So I want to make sure to call that out.

As always, I will commend the staff on really very thorough presentations for the meeting, both yesterday and today. It is always really inspiring to see all the work that is done, and, again, thank you to all the Commissioners for your great comments. We're very much looking forward to moving ahead, and I will just speak personally how grateful I am for the tone and the constructiveness of all the feedback that we've been given.

So, with that, Jim, do you want to say anything further?

DR. MATHEWS: No. We are good.

DR. CHERNEW: It's always nice to end knowing we're good, so, again, thank you all, and I look forward to our continued discussions on these topics next month.

[Whereupon, at 12:09 p.m., the Commission was adjourned.]