MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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AGENDA PAGE

P R O C E E D I N G S

[10:48 a.m.]

DR. CHERNEW: Hello, everybody, and welcome to the October MedPAC meeting. We're very excited for all of the material, and I'm not going to make a big speech about it. So I think I want to go first to Dana Kelley for a few opening remarks, and then we are going to jump into our first session on skilled nursing facility value-based purchasing. Dana.

Dana, you're muted.

MS. KELLEY: Sorry about that. I just wanted to let our viewers know that we won't have an opportunity for public comment during the meeting, but we accept public comments on our website at any time. There is a link on the Public Meeting page on MedPAC.gov.

Go ahead, Mike.

DR. CHERNEW: Great. So with that and no further ado, I want to turn it over to the great staff, and I think we are going to start with Ledia. Ledia, you're up.

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

screen.

Today we'll continue our discussion of MedPAC's mandated report on the SNF value-based purchasing program.

PAMA required MedPAC to evaluate the VBP program. The statute requires us to review the program's progress, assess the impacts of beneficiaries' socioeconomic status on provider performance, consider any unintended consequences, and make any recommendations as appropriate.

Our report is due June 30, 2021. We plan to include it as a chapter in the June report.

During the September meeting, the Commission reviewed several flaws of the current VBP program. The Commission concluded that the SNF VBP needs to be eliminated and replaced with an improved program.

Today we'll present a proposed SNF value incentive program design that aligns with the Commission's principles for quality measurement and corrects the flaws of the SNF VBP. The proposed design is consistent with other designs recommended by the Commission to redesign the Medicare quality payment program for hospitals and MA plans. Sam will present results of our illustrative modeling of the SVF VIP design.

Now I'll walk through the five shortcomings of the SNF VBP we identified and outline how the proposed design corrects them.

Consistent with the Commission's principles for quality measurement, the SNF VIP would score a small set of performance measures tied to clinical outcomes and resource use. The current program scores a single readmission measure as required by statute. The measures in the SNF VIP would not be burdensome for providers to report, such as claims-based measures.

The SNF VIP incorporates strategies to ensure reliable results. The current SNF VBP has a minimum stay count of 25 which may be too low to ensure reliable results for low-volume providers, so it may not adequately differentiate performance across providers.

The SNF VIP would use a higher reliability standard to determine the minimum stay count to ensure reliable results. Policymakers could consider other techniques to increase counts for low-volume providers, like scoring multiple years of data.

The SNF VIP would establish a system for distributing rewards with no cliff effects. The current

SNF VBP performance scoring does not encourage all providers to improve. As required by statute, it awards points for either improvement or achievement, lowers payments for the bottom 40 percent of rankings, and its rewards top out for the best performers. The SNF VIP uses a simpler scoring based on achievement, where providers are always better off improving quality to achieve a higher level than not. By applying a continuous performance-to-points scale, every achievement in quality is recognized so there are no cut points or cliffs that need to be crossed in order for changes in quality to register.

Consistent with the Commission's principles, the SNF VIP would account for differences in patient social risk factors using a peer grouping mechanism. The SNF VBP currently does not consider the social risk of a SNF's patient population.

The SNF VIP would stratify providers into peer groups based on the social risk of their patient population. Within each peer group, payment adjustments are based on performance relative to peer facilities.

Finally, the SNF VIP would distribute the entire provider-funded pool of dollars back to providers.

Currently, the SNF VBP retains a portion of the incentive pool as program savings as required by statute. The SNF VIP would distribute all withheld funds back to providers as rewards and penalties and would not attempt to achieve overall Medicare budget savings as part of a quality payment program.

At the September meeting, the Commission discussed whether the size of the withhold of the VBP was sufficiently large to change provider behavior. Policymakers could consider different approaches to setting the withhold amount, for example, phasing up to a higher withhold.

It also was discussed that the current design mixes two policy goals: achieving program savings and implementing value-based payments. The Commission's previous value incentive programs were designed to be budget neutral. Separately, in the update discussions later this fall, you can discuss whether the SNF level of payment is too high.

Now that we have reviewed the overall design of the SNF VIP, I'll walk through our approach to model an illustrative SNF VIP using currently available data.

We modeled the SNF VIP using three claims-based measures.

The hospitalization measure counts all unplanned admissions, readmissions, and observation stays during the SNF stay.

The successful discharge to the community measures captures a patient's outcome after discharge from the provider. A successful discharge is one in which a beneficiary was discharged to the community and had no unplanned hospitalizations and was still alive during the next 30 days.

The third measure, Medicare spending per beneficiary, is a measure of resource use. This measure incentivizes providers to furnish efficient care and to limit its referrals to providers with low hospitalization rates.

We assume that a SNF VIP measure set would be revised as other measures become available, like patient experience, or as the accuracy improves for measures such as changes in patient function.

To establish reliable measures results, we calculated results using a minimum stay count of 60 cases

which represents a 0.7 reliability. We also pooled three years of data to include as many providers as possible.

To account for differences in the social risk of a SNF's mix of patients, we used peer groups so that comparisons are made across providers with similar mixes of patients at social risk.

To apply the peer grouping mechanism, we defined the social risk of a provider's mix of patients as its share of fully dual-eligible beneficiaries treated.

We assigned each SNF to 1 of 20 about equal-sized peer groups based on its share of fully dual-eligible beneficiaries. The peer groups' average shares of fully dual-eligible beneficiaries ranged from 3 percent for Peer Group 1 to 91 percent for Peer Group 20. This is an illustrative approach to creating peer groups. However, when implementing the VIP, policymakers could consider other approaches such as collapsing groups with more similar shares of fully dual-eligible beneficiaries.

For each peer group, we calculated a multiplier that would distribute rewards and penalties based on performance within the group.

The first step in translating performance to a

payment adjustment is to convert each SNF's performance for each measure to points using a continuous scale (from 0 to 10 points). The scale is based on the distribution of performances of all SNFs. This way, most providers have the ability to earn points. Each SNF's total score is the average of the points across the three measures.

Next, we pool all the points and payment incentives for the SNFs in each peer group. We used a 5 percent withhold to finance these pools. Using a peer group specific multiplier that converts points to payments, we distribute the incentive payments back to each provider based on its performance relative to the SNFs in its peer group.

As a peer group's average share of fully dual-eligible beneficiaries increased, providers in the group had the potential to earn larger rewards for higher quality.

This approach does not mask disparities by adjusting performance rates, but adjusts payments based on a provider's share of patients at social risk.

I'll now turn it over to Sam to review the results from our modeling.

MR. BICKEL-BARLOW: This chart shows the payment per performance point multiplier for each of the 20 SNF peer groups that we modeled with a higher peer group number indicating a higher average share of fully dual-eligible beneficiaries. The multiplier is applied to each provider based on its peer group to adjust its payment per SNF VIP point. The multiplier is calculated for each peer group based on the total pool of dollars and the total number of points in that peer group. As the chart shows, the multiplier increases in peer groups with higher shares of fully dual-eligible beneficiaries. This means that SNFs with a higher share of fully dual-eligible beneficiaries will receive more reward dollars per SNF VIP point they receive. This effectively counteracts the advantage providers treating a lower share of fully dual-eligible beneficiaries would otherwise have on quality metrics simply because they treat patients with fewer social risk factors.

Now we are going to look at the results of the payment adjustments of the VIP compared to the VBP.

This chart shows the average net payment adjustment -- under the VBP in grey and the redesigned VIP

in blue -- for facilities in five peer groups. For example, on the left, Peer Group 1 has an average payment adjustment of negative 0.43 percent under the VBP and - negative 0.04 percent under the VIP. You can see that under the VBP, the payment reductions were larger as the share of fully dual-eligible beneficiaries increased. In contrast, the average net payment adjustments under the SNF VIP are close to zero. As a result, the illustrative SNF VIP would make net payment adjustments more equitable for SNFs with higher shares of fully dual-eligible beneficiaries. This eliminates any program incentive for providers to avoid patients with more social risk factors.

Now we'll look at how payment adjustments are related to the medical complexity of a provider's patient mix. This chart shows the average net payment adjustments under the VBP (in grey) and the redesigned VIP (in blue) by average medical complexity. We used the average risk scores of the beneficiaries treated by a SNF as a measure of their medical complexity. On the left are SNFs with low average risk scores and on the right are those with high average risk scores.

Under the VBP, the payment adjustments became

negative as risk scores increased. In contrast, the average payment adjustments were not strongly related to the medical complexity of the patients. The SNF VIP is relatively neutral with respect to average clinical complexity and would, therefore, dampen incentives to avoid medically complex patients.

There was some variation in the SNF VIP performance based on provider characteristics. Nonprofit SNFs slightly outperformed their for-profit and government-run counterparts, and urban SNFs received slightly larger average payment adjustments than rural SNFs.

Hospital-based SNFs had much larger payment adjustments on average compared with freestanding facilities. Hospital-based facilities received more SNF VIP points for all three quality measures. This reflects better performance on all three quality measures. For example, hospital-based SNFs typically have lower readmission rates (which affects the results for hospitalization during the stay and MSPB measures) due to their higher staffing levels and physician presence and more timely lab results for patients. Though hospital-based SNFs on average have higher payment adjustments,

there are far fewer of them, so the aggregate amount of dollars going to them is smaller.

The proposed SNF VIP provides a workable design that will conform to the Commission's principles for value-based payment. The SNF VIP design also addresses the flaws of the SNF VBP. The benefits of peer grouping were as intended. As the average share of fully dual-eligible beneficiaries increased across peer groups, providers in those groups had the potential to earn larger rewards for higher quality. Compared to the SNF VBP, the VIP dampens the incentive to avoid beneficiaries with more social risk factors through peer grouping and to avoid more medically complex patients. The more equitable design ensures that SNFs with varying patient mixes have the opportunity to perform well.

We would like to hear your reactions to the design of the SNF VIP and the results of the illustrative modeling. In early 2021, we plan to present policy options for the Commission to consider as it contemplates recommendations for replacing the SNF VBP with an improved design.

Thanks.

DR. CHERNEW: Great. So in a moment we're going to go to the reactors and then have this discussion, but let me just say relative to the SNF VBP, I think this is a world of improvement and I appreciate all the comments we had in our last discussion about the concerns and the staff work that was done. But now we should open it up and, Dana, I think Betty is first in this discussion.

MS. KELLEY: That's correct.

DR. RAMBUR: Well, thank you so much, and I concur with you, Michael, and I just want to thank the staff for a set of beautifully developed materials.

So, first of all, moving to a small set of claims-based measures that are easily gathered through claims I thought was a very good solution. I like the ones that you picked. It provides a lot more nuance without a lot more measurement effort or fatigue.

You noted in there that CMS should develop a way to implement patient experience and other measures as they evolve, and I certainly concur with that, and I am not suggesting we put something in place or codify it here, but it seems like in the future it would be wonderful to have some ways of elegantly incorporating a systematic approach

to that that would really help providers have a sense of where things are going. But I think this is perfectly fine for now.

I was initially concerned about just achievement score, not improvement and achievement, and I realize I haven't been a part of those previous conversations. They both matter. Achievement matters, but so does improvement. And for some very high-functioning groups, it can be hard to improve, so I understand that. So I'll be interested in hearing what other Commissioners say about that.

I'm very supportive of the case count 0.7 reliability. That was what I was taught was the measure when I was a graduate student, and I think that that's -- 0.7 percent reliability is -- or 0.7 is good.

In terms of public reporting of measures and outcomes, in general I am supportive of this. In my experience, it is really the financial rewards and incentives that changes behavior more than simply reporting. And there is always the potential for gaming and measurement fixation. I think it would be very important, if this happens, that it is very clear to the public that different kinds of organizations are serving

different kinds of populations, and that matters.

In terms of the pooling with different weights so that the more recent is weighed more heavily, I thought about that a lot, and I could not think of potential negative unintended consequences, and I'd be curious what my colleagues think. It seems to recognize that improvement is a long-haul issue.

And then in terms of fully distributing the financial rewards, absolutely yes, and 2 percent is clearly too low. Can it start at 5 percent? Should it start at 3 and ramp up? I would leave it to some of you to have thoughts about if it is too disruptive to start at a higher amount, but there definitely has to be enough financial incentive for people to really, you know, take these steps.

So I thought it was a dramatic improvement over the last version, and I just thank all of you for your thoughtful work.

DR. CHERNEW: Great. So I need to apologize. I didn't see clarifying questions, and so I jumped into the Round 2 questions. But now I realize that I don't get to see everything. So I think we should jump back to Round 1 questions. I think we have Larry, Marge, David, and Dana,

and then we'll pick it up again with David -- in fact, maybe David, we will make you last depending on other clarifying questions, and you can just jump right into your other comment.

But why don't we go to Larry for starters.

DR. CASALINO: Michael, just a process question. Either for Round A or Round B, should we just send a message to Dana when we have a question or a comment or on this point or circulate to everybody? I think we should be consistent about that. We're all doing it differently at different times.

DR. CHERNEW: I wish I was wise enough to know the answer, Larry. I honestly like seeing it. So my preference, I guess, is if you'd just send it to everybody, but if that's too burdensome on folks, I don't feel strongly about that view.

DR. CASALINO: I mean, it's actually easier. You don't have to switch where you're sending the message. So we could just do that. We'll just -- if we have a question or comment, we'll just put it where all the Commissioners and staff can see it.

MS. KELLEY: That's fine.

DR. CHERNEW: Thank you for the clarifying question.

DR. CASALINO: Well, that's for both, right? Also when we have comments later on --

DR. CHERNEW: Yeah.

DR. CASALINO: -- we'll just send it to everybody.

DR. CHERNEW: Absolutely. And, Larry, I'm sure that wasn't your clarifying question. So why don't you go ahead with that.

DR. CASALINO: Yeah. One very quick one and one almost as quick.

I think someone who looks at the slides or reads the report quickly might see where the recommendation proposed is to eliminate the 2 percent withhold, and the person might ask, "Well, how is Medicare going to save money on this?" And I think it's in there, the episode-based spending performance measure and also incentives to reduce hospital readmissions and so on.

But I don't think that that point is made explicitly anywhere, and it is an important point. So I would just suggest that you guys explain, explicitly how

this can save Medicare money, even without the 2 percent withhold.

My more substantive point or question is this. I don't want to be too technical, but on page 17 and 22 -- let me just go to page 17 of the report. This is similar in the slide. So there's a statement right at the end of the first paragraph on page 17, peer grouping should enable providers treating a higher share of beneficiaries with social risks to earn more of a reward for higher quality -- earn more of a reward for higher quality.

So I think, it seems to me, it's really important that -- this is an important point that this be absolutely crystal clear, so -- and this comes up again on page 22 and in the slides. So when we say earn more of a reward, do we mean they would earn more than they would otherwise have earned in the current incentive system? Or do we mean -- and/or do we mean that a SNF would earn more of a reward if they're in a high dual eligible peer group? A SNF in the high dual eligible peer group would get a higher reward, for a certain level of performance, than a SNF in a lower level dual eligible peer group which had the same performance score.

I think I know the answer to that, and there's some explanation on pages 30 and 31, which I won't go into now. But I think this is such an important point. I think everywhere it comes up, so page 17, page 22, and maybe elsewhere, that we be absolutely explicit which do we mean. Do we mean you'd get more than you would get under the current system, or do we mean you'd get more than someone else with the same score but that's in a different proportion of dual eligible peer group?

And maybe you could just answer that question, Ledia. I think I know the answer, but then I think the answer every time this gets mentioned, I think it needs to be explicit because if it's ambiguous, it could cause all kinds of trouble.

And by the way, as usual, terrific set of slides and terrific report. It's almost superfluous to say that. I don't know that there's even been a time when the Commissioners haven't felt like saying it.

MS. TABOR: Thank you.

The answer is the latter. So we look at the methodology in isolation without comparing it to the current VBP. So the way that the methodology works is that

we score providers on the same set of -- the same performance to point scale based on their performance, and then within each peer group, we convert their points to a payment adjustment based on a multiplier. And that multiplier is different by each peer group, and I think in Slide 12, that's where it demonstrates that, the peer groups with the higher share of duals have a higher multiplier, so therefore, they can earn more of a reward per performance than --

DR. CASALINO: For the same score.

And just one related clarifying question. Would the 5 percent withhold -- so the pool from which the rewards come in each peer group based on a 5 percent withhold, that pool could also vary in size across peer groups, more spending in a higher dual eligible peer group, for example?

MS. TABOR: We did assume that each peer group would have a 5 percent withhold to create the pool of dollars. The pool of dollars did vary by peer group because there was an effect basically of size of Medicare payments. So those -- we did find that those in peer groups towards the end with the higher shares of duals did

have slightly lower pools of dollars just because they have less Medicare patients.

DR. CASALINO: Okay. So if you had a higher dual eligible peer group, the pool of reward dollars was actually smaller than in a low SES than a high SES peer group?

MS. TABOR: Yes. And that, we believe, is just a function of, again, Medicare payment. So it's likely that the SNFs in the higher peer groups were serving more Medicaid patients in those.

DR. CASALINO: Okay. I'm glad that you clarified that point too, I think, that the size of the reward pool isn't the same in every peer group.

MS. TABOR: Yeah.

DR. CASALINO: Thanks. That's all I have.

DR. MATHEWS: Larry, just to answer the first question you had about how if we are redistributing the entirety of the withhold, you used the phrase "eliminating the current 2 percent," how to save money. This was actually an explicit critique of the current SNF VBP. That's the statutory provision that 40 percent of SNFs are required to have a negative payment adjustment under the

VBP with something we had identified as a flaw in the system, and one should not use a quality improvement program in order to achieve savings. And if you felt that there were a need for program savings, one should do it through the form of an update recommendation or a rebasing or something that is more directly designed to produce those savings rather than doing it implicitly through a quality improvement program.

DR. CASALINO: Jim, that's really helpful context, but do we think that this would produce savings? And if so, should we say it?

DR. MATHEWS: I think the way we have set it up, just for purposes of this discussion, is that the program, the new program would be budget neutral to the current level of spending, which does include the net payment reductions to SNFs as a result of the current VBP.

But having set the aggregate amount at that level, at that point, the VIP would be budget neutral, that the entirety of the withhold, however it is scaled, would be given back on the basis of good or poor performance.

DR. CHERNEW: Yeah. And I just want to emphasize the general point that quality payment models aren't

necessarily going to be intended to save money or not. We have a lot of tools to deal with that issue.

I want to move to the Round 1 questions so we can get back to the Round 2 ones. So, Dana, who's next?

MS. KELLEY: Marge is next.

MS. MARJORIE GINSBURG: Great. Thank you. Fabulous report.

I have a couple broad questions, and then I have some really specific questions. So I think the easiest and fastest is for me to go ahead and lay them out and the get the response.

The first one, in general, did MedPAC have a role in designing the specifics of this SNF Act from 2014? And I'm encouraged that the act requires a report from MedPAC about the program. From your years of experience, is it more likely that our recommendations will be followed because they were requested as part of the act than how we typically make recommendations to Congress?

Those are my -- well, one more broad question. We have asked for a pause in this process, which is interesting, because I don't remember in my all of two years that we've ever asked for the process to basically

stop now. If we're asking that now but the report isn't coming out until June, is there a disconnect there, or is this request for a pause intended to go forward now?

Now just a couple of very specific nitty-gritty questions. On page 23, it says that the status is going to be based on Medicaid discharges rather than their status at admission, and I was just curious why they did that. Is that to account for the fact -- so you don't count people who have died, or is it to account for the fact that some people may come in not on Medicaid but exit on Medicaid; therefore, their Medicaid numbers would be higher? So just curious about that.

And part of that, then, is how to account for those who died in a SNF, or is it something simply where we're not going to deal with it all?

So thank you very much.

DR. MATHEWS: Ledia, if it's okay with you, I'll take a run at the first two questions, and then you can try to make a response to the second ones.

With respect to the first question, did we have a hand in designing the specifics of the current SNF VBP, the Commission has a long history of stating that fee-for-

service payments should not be indifferent to the quality of care that is provided, and so as a general principle, we have supported the movement towards VBP approaches. But we did not have specific input on the current SNF VBP design. So we take no responsibility for the specifics there.

With respect to your second question, yes, we did, indeed, hear loud and clear the consensus of the Commission at the September meeting that the current VBP is flawed enough that it should be stopped in its tracks, and that as soon as possible, a replacement, hopefully something that looks like this, could be implemented in its place.

The issue, as you point out, is that these things don't come together until we craft a formal recommendation that shows up in the spring of next year. At that point, the Commission will have an opportunity to refine the language, make any refinements, and then vote on the recommendation. So that is when things come together.

But in the interim, policymakers, congressional staff, the interest groups are all very much paying attention to what the Commission is saying on a month-by-month basis, and so to the extent the Commission is

signaling a preference here to stop the current VBP, that message is punching through, even in the absence of a formal recommendation that would appear a couple of months from now.

MS. MARJORIE GINSBURG: Thanks.

MS. TABOR: And just to clarify a question on your clarifying question, Marge, when you have the question on page 23 about looking at Medicaid status by discharge versus admitting, do you mean how we calculated the share of fully dual eligible beneficiaries?

So I believe that it was on discharge, but I do want to go back and check on this. So perhaps I can follow up by email whether it was based on admission versus discharge and any effects that would have.

MS. MARJORIE GINSBURG: So it was on discharge.

MS. TABOR: I do want to double check.

MS. MARJORIE GINSBURG: Okay.

MS. TABOR: I'll see if I can follow up by email. That's would be great.

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

DR. CHERNEW: No, I'm good. I already jumped too quickly to support Jim's point about saving money and

quality programs.

I think the next person is probably Dana for a Round 1 question, then Wayne. Then we're going to let David do his Rounds 1 and 2 kind of combined, and we're going to just seamlessly move into Round 2. So that's the plan. I hope I haven't missed anybody.

So, Dana, Round 1.

DR. SAFRAN: Thank you.

Two questions on Round 1. One is in the risk adjustment that you did when you were doing your modeling on the proposed new program, can you just clarify? Did you use the same set of risk adjustors for all three measures? If that's in the chapter, just point me to where that is but was curious about that.

Then I was pleased, of course, to see attention to the 0.7 reliability, but a little perplexed that 60 residents was the required sample size to get to 0.7 reliability for all three measures. In my experience with measures like these, especially resource use measures, they're typically so noisy that you need a larger sample to get to 0.7. So I just wonder if you could clarify that the work was done measure by measure and that it does show you

that 60 is what's needed for 0.7 there.

Thanks.

MS. TABOR: Sure. So for the risk adjustment, we did generally apply the same variables into the risk adjustment model. They're mainly clinical conditions -- age, sex -- but maybe some nuances, and that's, I would say, in general, the same. I'm happy to follow up with any kind of, again, nuances and the differences in the variable being used.

Partly, you know, one reason maybe is that for the successful discharge, the community measure, we did use the CMS specification for that piece. So there may be, again, some slight differences, and I'm happy to follow up on that.

Regarding the 0.7 reliability, we did find that 60 was what was needed to achieve 0.7 reliability. I don't know if Carol wants to speak more since she led that MSPB work.

DR. CARTER: Yeah. Your question was whether we calculated it for each measure, and we did. And it was 60 for all three measures.

DR. SAFRAN: Thank you.

DR. CHERNEW: Wayne, I think you're up.

DR. RILEY: Yeah. Thank you.

Ledia, a couple questions regarding the model specifically. There's mention that the model provides more equitable payments to SNFs with higher shares of low-income Medicare beneficiaries. Can you talk a little bit about how that more vulnerable payment result has been teased out?

And then a second closely one -- closely allied to that is there's mention that there will be less incentive to admit less clinically complex beneficiaries, and could you give a little detail on that as well?

MS. TABOR: Sure. If I could go, Molly, turn to Slide 13, I believe, 13 or 14.

So, basically, we believe mainly because of peer grouping that the VIP treats SNFs that treat more dually eligible patients or those with more social risks more fairly. I will say our VIP program design is so different from the VBP. It's hard to say whether it's just the peer grouping effects. It could be because we're using more measures. It could be because we have a high reliability standard and also the peer grouping and even just the fact

that we're scoring, having a continuing achievement scale. So we believe that all of the design elements lead to more equitable treatment in the VIP because, as you can see in the blue bar, there's not as much of a difference between the different providers treating different shares of fully dual eligible beneficiaries.

And then on Slide 14, it's the same concept of looking at the clinical risk of patients because we did find in the VBP that SNFs who treat patients with lower clinical risk do better in the program, and because we kind of narrowed the blue bars, they're not as starkly different between these average groups. That's how we think about the VIP. Because of all the various design elements, it's more affordable.

DR. RILEY: Thank you.

MS. KELLEY: So I think next, we're going to do David with a combined Round 1 and 2, Mike; is that right?

DR. CHERNEW: That is right, and then we're going to go to Dana to continue Round 2. And we'll get everybody in the queue for the Round 2 questions following what Dana has to say next, but for now, we're with David.

DR. GRABOWSKI: Great. Thanks. And first thanks

to Ledia, Sam, and Carol for this great work. I wanted to ask Ledia first, for my round one question, about Slide 9. I'm curious about the Medicare spending per beneficiary measure. How much of the variation, or tell us more about -- is that largely SNF spending with a little bit of hospitalization spending? Like what's the breakout there of that measure? I'm just trying to think about how that measure differs from the other two measures we have here. Can you give us a little bit more background on just what share of the spending is in SNF and what is readmissions and post-SNF spending? Do you have a sense of that?

DR. CARTER: So we did look at this but it was a while ago so I'd have to get back to you. But you're right, this measure does capture all of the spending during the stay in 30 days. And I would say, off the top of my head, that about half of the spending is for the SNF stay, but I would have to get back to you to confirm that. But then it also includes, you know, Part B spending and any subsequent PAC use. So any home health use where patients are discharged from the SNF and then go on to use home health it's going to scoop up the home health spending for the episode that was triggered with home health. So it's

including all of that.

So in that sense it's a broader measure of resource use than just kind of the resources used during the SNF stay.

DR. GRABOWSKI: Great. Thanks. I think going forward maybe in the chapter to work some of that information in would be helpful, just so we can get a sense of how this maybe works alongside the other two.

Maybe I'll transition then into my round two comments. Let me say kind of broadly that I'm on board with this direction. I believe this new SNF VIP model improves a very broad SNF VBP program. This is definitely a step in the right direction.

In particular, I really like these three quality measures together. I think moving from just a single readmission measure to this set of hospitalizations during the SNF stay, successful community discharge and Medicare spending per beneficiary, is a positive step. And although I believe this is a really good starting point, I hope this isn't ultimately where the program ends up. I'm very supportive of moving forward with these measures but I do believe we have to build the measure set.

As someone who has studied SNF quality for 20-plus years, I wish there were other good measures that I could point you to right now. I don't think they're out there, unfortunately. I do believe we need to continue to push CMS on improving the MDS-based measures. When I think of SNF care what matters most to our beneficiaries in terms of quality is really functional improvement. Yet we can't trust this measure in terms of including it in a SNF VIP program because it's self-reported by the SNFs themselves. And so going forward how do we improve the auditing or otherwise improve the quality of that measure such that it could be part of this measure set?

The other key measure is patient satisfaction, and the fact that we don't have a national measure, as the chapter discusses, is really unacceptable. And so that's another place where I really think we need to push on improving the data such that going forward we can include a patient satisfaction measure in the program. So auditing the MDS and improving patient satisfaction are certainly two areas.

In terms of other tweaks, similar to Betty I like the idea of using multiple years of data, even with some

weighting, maybe 50 percent in the prior year and then 25 percent going back two and three years. Something like that could be really nice in terms of improving sample sizes but also weighting the most recent experience heaviest.

I also liked Betty's comment, and I had a similar thought, about growing kind of the size of the program. I think initially 2 percent is a really good number, but going forward if we find that the program is working as intended, I do like the idea of growing it. SNF VBP, as we've talked about, needed to be shrunk or even put on hold or eliminated, but a strong SNF VIP program could actually increase over time in terms of the weighting there.

I think I'll stop on that comment, but just to reiterate I'm very supportive of this new direction and I really like where this is headed. Thanks.

DR. CHERNEW: Great. Thanks David, and I think that sends up Dana for round two now, Dana.

DR. SAFRAN: Yeah. Thanks very much. And just echoing both Betty and David's compliments about the chapter overall and about this new composed parsimonious but really strong measure set. I really like that you've

kind of covered the issues around hospitalization, not just readmissions but admissions and observation stays. Of course, successful discharge to the community, that's part of the heart of the matter, and then spending per beneficiary.

Like David, I'm sort of regretting that the remaining piece of the heart of the matter, which would be functional improvement, can't be captured, so I'd like us to keep that on our agenda to pursue. But there are no easy answers here. You know, we know that SNF self-reporting is not a good answer but we also know that with this population patients self-report measures about health and functioning or about care experience are difficult, and it gets really complicated if we try to use proxies.

So I don't know what good answers we have for getting measures of functional status and improvement or patient experience, but I'd really like us to keep that on the agenda. Not hold up moving forward, I think this is a very strong measure set.

I also really like some of the other changes that you've made, some of which have been highlighted. I think that because of the strong measure set moving to a higher

percentage withhold and aiming to get that fully distributed is the right goal. I am fully supportive of that.

I also am supportive of the idea of three years, potentially, of rolling, particularly with strong weighting toward most recent experience. You know, again, a rock and a hard place on that issue always. You don't want a provider to have as an anchor on their ability to earn reward their performance three years ago. But I think handling that through weighting, as you suggested, is the best way to go.

The 60 beneficiaries per provider maybe starts to be fairly doable.

I also really like the fact that there's no cliffs, that you've adopted the same kind of approach to the payment that we have in our other value-based payment programs, and that methodology really allows us to reward both performance and improvement in the same framework. So we don't need separate measures, et cetera, which gets complex and difficult. So I really like that.

My one concern, and it is a sizeable concern, I will say, is about the social risk factor stratification,

and this is a concern that I know I raised over a year ago when we first started to introduce this methodology. And so what I'm going to say really applies to our use of this approach across the board for our value-based incentive programs. For those who were around at the time I expressed a concern that would stratification mean that we were creating a different standard of care for providers who serve different populations? Because, you know, I think there are a couple of principles that we should have. One is we don't want to disadvantage providers who are serving lower SES populations, and you really show beautifully in this chapter how by introducing stratification you serve that principle, and that's really important.

I think our other principle has to be a kind of universalism, that we have the same standard of care regardless of who you are or what provider you're attending and whether that providers serves a low or SES mix. And there I think we are violating that standard, and, in fact, I think all of us would be uncomfortable to face out to Medicare beneficiaries and say, "We've set a lower bar for you because of your social risk factors or the mix of the

provider whose care you're under." And I think we can serve both the principles that I named.

And I'll just say one more thing. Besides the optics, not want to face out and say that, the other big concern I have about having the stratification, and within stratification you're really just competing for performance against others in your own strata, is that I think it will serve as a constraint on the improvement we will see in providers who are serving a lower SES mix.

I saw that in the work that I did leading performance incentives at Blue Cross Massachusetts, where we did set a universal standard of where we saw providers who were serving the lowest SES mix move from the bottom of our network in terms of performance to the top, exceeding those who were serving a more advantaged mix, and stay there. And I'm quite sure that never would have happened had we not had the same bar for everyone.

So what I'd love to see us do is find a way to meet both principles, and I think we can do that by having higher rewards for those who serve a lower SES mix, or those with more social risk factors and/or having additional sort of support payments that go to those who

might have more challenges in achieving our universal standard. But I'd like us to have a universal standard for performance, not adjust that but adjust the payments that we make based on the mix of patients that you're serving, so that we reward those who have a more difficult task.

Thanks. Those are my comments.

MS. KELLEY: I have Amol next.

DR. CHERNEW: Great.

DR. NAVATHE: Hi, everyone. So first off, great work. I commend the rigor and yet the simplicity of the way that this has been explained and the exhibition, both the chapter and the slides. So thank you very much to Ledia, Carol, and the team.

So I have several comments that I'm going to run through, some more philosophical, a few that are very specific to a couple of more minor points, if you will, that were raised in the chapter, the paper, and then I'm going to touch on the social risk set being addressed as well.

So a couple of bigger points. So one thing that struck me is I generally support -- so I generally support the approach. Let me just say that first. I think it's

definitely a step in the right direction, a big step in the right direction. One thing that struck me is we talked about the budget neutrality of this. I think that's been part of the question and part of our conversation thus far. And I personally support the idea of a budget-neutral program here, meaning that this program is not the way for Medicare to take a haircut on the spending for post-acute care and SNFs.

That being said, I think one thing that's interesting is that we are calling this value, and to the extent that it was originally called a VBP program, I think in that sense there is a collection that if you end up using a budget-neutral approach that's more of a pure quality type of program and less about value per se. So I would be very comfortable with that but I think it might be worth us explicitly seeing that the intention of this program then is to reward higher quality, and that there are other mechanisms, as Michael Chernew has said, that we could actually deploy savings in the context of set payments.

So I just wanted to make sure that we are very clear about that because I do think oftentimes we get

confused between what is value and what is quality, and conflating those things make everything more confusing.

My second point, somewhat related, is when we look at Slide 12 it does look -- and this is the one where four of the providers that are taking care of more dual beneficiaries, the payment rate per unit of quality, if you will, seems higher. So this, I think, highlights by itself, if taken alone, the way that, in some sense, this slide looks. It makes it seem like there's an inequity that we're instituting. But I think the context is very important, that on average the quality performance in this group is lower, likely related to the other social characteristics of the population.

So I think we should be crystal clear in our exposition, and I know others like Larry also feel the same way, that we should make sure that we are very clear about what the intent of this is. And as you guys do, I think, as we've done later in the slides and later in the chapter, talk about the ultimate impact, I think that should be up front.

The other thing that I think is important to recognize is that this is presumably not a static

adjustment, so these multipliers will adjust. If we see, hopefully, as Dana was saying, if we see that performance in the higher number of peer groups here improves, then we would actually get closer to the lower number of peer groups here, we would actually see this difference go away.

So this is not something that we are systematically mandating into the program. Rather, it's something that we are inferring from the performance to try to create a more equitable deployment of the incentive program resources. I think that's particular important, because I think we don't want to say that we're systematically introducing such as "bias."

And then I think that begs the question, so how often will we do that updating? How often do we recommend doing that update? Is that updating supposed to happen on a yearly basis? Is it supposed to happen every two years? I think we need to put a stake in the ground on that to give a specific anchor on how often these multipliers will actually be updated. In some sense, obviously, the more frequent that is practicably possible would be better.

A couple of points. I just wanted to echo other Commissioners. I just wanted to sort of vote behind them.

So David and Dana I think talked about the importance of the assessment data and the patient experience data. I know David talked about that. I wanted to say that we should double down on that. You know, there are problems with that data. There are some challenges. But it's intrinsically important because it gives us a much finer ability to understand what's happening at the beneficiary level, in terms of their functional status and in terms of their patient experience. So I think that's fundamentally important and I think we should continue to push that very strongly.

Another point is to back up David's point about the measures here. So I like these three measures. I think they are, as you guys have articulated, meant to be illustrative. You should think about a broader measure set related to the assessment data of patient experience, and potentially provide a more explicit roadmap of where we would like to measures to go. So that way we don't accidentally get people anchoring, policymakers anchoring on the three measures that we use as illustration and then we don't get that advancement in the quality measure sets.

A couple of minor points that I want to make and

then I'll move to the social risk piece and the peer grouping. So there was a line in the chapter that talked about having SNFs that are small in size select their own providers to be grouped with. I thought that was probably not a good idea, because that will institute the opportunity for some sort of gaming, perhaps. I think rather we would to, again, as we're doing the peer grouping, so think about what are the cohorts that are similar to them and think about doing grouping in that way, if at all, if at all we do grouping. I do support David's recommendation that we look at multiyear rather than group SNFs, to preserve that individual organization piece.

And then another thing, you know, with 20 peer groups it feels like there's probably quite a bit of stratification and we don't end up with cliffs at the peer group thresholds. I think it's important that we make sure that that's true. Otherwise you could imagine somewhere in the distribution you get a group that's in peer group 10 and another one in peer group 11 that are essentially identical but who have different payment rates, as we're seeing, in the context of the value programs. I think we should just be mindful of that, to the extent that there

are natural cutoffs for distribution that would be more ideal, which you guys did highlight in the chapter.

Okay. Last point is on the peer grouping and social risk point. So I agree with Dana that it's fundamentally a very important topic. I think we have to recognize that there is no perfect solution here. In some sense there is a tradeoff between allocating more resources and recognizing the complexities that there are facing SNFs or any provider that's taking care of a lot of low SES or dual-eligible beneficiaries. At the same time, virtually anything that we do to try to acknowledge that will, in practice, whether we call it that or not, set a different standard, if you will.

And so I think what we have to state very clearly in our principles, as MedPAC, in terms of wanting everybody to attain high standard of quality regardless of what type of population they provide their service, and that we also want to make sure that we're not perpetuating any disadvantages that exist already in our payment systems and our nonpayment systems around these providers that are in communities serving a lot of low SES populations.

I think stating those two things is extremely

important. I'm supportive, in general, of the peer grouping methodology because I think it does do a lot more benefit than it does harm, as long as we're clear about stating our values around this.

And the one last point I will say is that like Dana I have had experience of designing programs around this, around performance, and in Hawaii where we designed a new program, we also found that the lower performing, if you will, providers actually disproportionately improved. In that case, we actually had recognition of improvement as a very important feature, and that was the way we addressed it.

So I think there are multiple ways -- my point here is there are multiple ways to address this. I think it's important that we state our values very clearly. Thank you.

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

DR. CHERNEW: Yeah. I just want to say one quick thing in response to Amol's early point on budget neutrality. I think in many things that MedPAC does, there's sometimes an effort to get the level of payment right, save money or not, and other times there's an effort

to get the form of payment right, get the incentives right in those type of ways.

In many, many cases, I think it's useful not to conflate those, and budget neutrality is an easy way of doing that to get us to focus on sort of the form of payment, which I think really is the main thing in this particular area right now. Later, there are those other tools where we can do that. So I think it varies. I would view budget neutrality often as motivated by a desire to get us to focus on the form as opposed to the level of payment and things. But since we have got to keep moving -- we've got 25 minutes left -- I think we should move on to the next Round 2 speaker.

MS. KELLEY: All right. That's Brian.

DR. DeBUSK: Thank you, and I'd like to echo the other comments. I think this is a great step in the right direction. I think it's very consistent, methodologically consistent with some of the other incentive programs that we have done, so I just want to compliment the staff for some excellent work.

I want to take a moment and focus on peer groups. I agree with some of the other comments. Amol, I really

liked your term "tradeoff." I mean, it's the peer grouping versus incorporating the social risk variables into the model is clearly a tradeoff. I lean toward peer grouping just because it acts like a firewall between different levels of social risk and contains the conflation, I would say, to a compartment.

The other thing I like about peer groups, though, is it allows us to treat different peer groups differently. So, for example, in the lowest-risk peer group, we may want to just deal with financial penalties. As you get into the higher and higher degrees of social risk, the answer there may not be penalties for that peer group. The answer there may be technical assistance and other forms of socioeconomic support.

So I want to applaud the work, and, again, I loved the treatment of this chapter. But I hope we do not -- I hope we recognize in the chapter that we can tailor our response to good and bad performance based on peer group.

The other thing I wanted to mention -- and, Larry, I think you had made this point earlier, and Dana -- I think it's important that we report performance

nationally, even if we do financial rewards and penalties within the peer group level, because we wouldn't want anyone thinking that they're in a high-quality or low-quality SNF when in reality it's just a function of their relative rankings within a relatively narrowly defined group.

The final thing I want to mention is the time sensitivity of this. On page 35 of the reading material and it was also on Chart 14 of the presentation, you talked a little bit about how the SNF VBP that's in place now seems to have a bias to offer penalties associated with higher risk score beneficiaries. As we've seen in the SNF segment, these providers are very fluid. They're very responsive to changes in incentives, and they've just undergone one major change. Today might actually be the anniversary of the most recent change that shifts payments away from rehabilitation and toward non-rehabilitative -- the ancillary services.

My concern is I'd hate to see the industry recrystalize around this new norm under the existing SNF VBP where they do shy away or avoid the higher-risk patients. Again, the industry is in a lot of flux right

now, and I think pausing this program -- I do think there's a sense of urgency and a sense of immediacy here to pause this program because we could inadvertently create an incentive to stay away from those beneficiaries, and I don't think we want to do that.

Thank you.

MS. KELLEY: Larry.

DR. CASALINO: Yeah, two points. On the budget neutrality/savings issue, clearly this is budget neutral -- would be budget neutral in the sense of the entire withhold is returned as rewards to SNFs. But I actually think that the program, if it works, would save money for Medicare, maybe quite a lot, because all three performance measures, you know, to the extent that SNFs score highly on the performance measures, they're going to be saving Medicare money by reducing hospital admissions and so on.

So unless there's some reason that I'm not aware of for not making this point clearly, I think it would be worth making. Withholds match incentives, that is budget neutral. But, in fact, this could save a ton of money for Medicare if the SNFs do well on the performance measures. If they do well on the performance measures, it has to save

money. So, in my opinion, that's pointing out.

But what I had first raised my hand to address was the issue that Dana has so well raised, and Amol and Brian spoke to well, I think. There is a tradeoff -- right? -- between rewarding everybody equally for an equal performance score, in which case SNFs that take care of poorer patients are going to be disadvantaged because they'll have a harder time getting a good performance score, and so perhaps this can lead to the rich getting richer and the poor getting poorer, so to speak, and increase the status. But Dana's right that if we reward unequally for the same performance score, then one could argue that, in effect, we're saying, okay, you can take worse care of dual eligibles forever, and we'll continue to reward you.

So these are conflicting principles. This comes up in every value-based program, and as several people have said, there's no perfect solution. But I want to say that I think we can maybe elaborate a little bit more on this in what we wind up proposing.

There's basically three tools that we have for trying to increase performance: we can give financial

incentives, we can give technical assistance, and/or we can do some more public reporting, right? And I think by kind of jiggering our use of those three tools, we can do the best we can to resolve something that has no perfect solution, the problem I just mentioned.

So I would support the financial incentives as proposed in the staff's report, and I totally agree it is better to do it by peer groups than by putting a risk adjustment parameter into a formula because that is totally nontransparent then. Then you have no chance to see what the actual performance is.

But, you know, in response to Dana's very valid concern, I think technical assistance for the poorer or SNFs -- or the SNFs that take care of poorer populations would be a good thing. I don't think that's enough, though. I don't think just technical assistance without some adjustment in the financial incentives would be enough.

So I support the higher pay for the same performance score in high dually eligible peer groups, but I think that we can counteract the argument that this would reward people for taking worse care for dual-eligible

patients forever with public reporting, which I think does have some impact. So I would argue that this program should include public reporting of the performance of SNFs both in relation to all other SNFs in the country, in relation to all other SNFs in their geographic area, however we define that, and in relation to others in their peer group. And that way anybody who wanted to, whether it is a patient, a family member, or policymaker, a SNF executive, a referring physician, a referring hospital, would be able to look and see how is this SNF doing. So you could have a SNF that's not performing all that well, but because of our peer group stratification it's getting decent financial incentives, but it would still be visible, but that SNF is not providing that great care, and hopefully that would provide some incentive to improve, and also patients, family members, referring physicians, and hospitals could take action based on that public reporting.

So that's as close as I can get to solve what is a problem that has no perfect solution.

MS. KELLEY: Jon Perlin.

DR. PERLIN: Well, Larry Casalino, as always, teed up my comments very well. I appreciate it and I

appreciate the great work.

Let me just thank the team. I'm strongly in favor of moving forward, but I think we have to recognize that this is a journey, not a destination.

My hesitancy is around the need to go back for three years of data of the creation of what are lagging indicators for a couple of reasons. First, as has been brought out, improved performance or deteriorated performance, even if weighted more heavily toward more recent data, still makes it long to convert into the actual metric. But that's actually the lesser of my concerns.

The greater of my concerns ties to Larry's point, which is about the signal. That is, when you go for three years, for example, to accrue the data necessary to get reliability, one of the things you inadvertently created is a situation in which the extended measurement period, three years, is not consistent with the period of utilization of the beneficiary. And so it's not necessarily predictive of the experience, good, bad, or otherwise, that a beneficiary might expect.

This point about public reporting I think is absolutely imperative, and I think some of the health

services research would strongly indicate that in the instance of relatively mild financial incentives, in fact, it is the public accountability that actually is the greater of the levers in terms of affecting performance. And it's in that regard that I would hope that one of the goals of this type of set of metrics is not just the financial reward but to allow providers, patients, consumers, advocates, et cetera, to help determine where the care is better or where it's not as good to make the most informed decisions.

So I just offer that not as a recommendation that we do anything other than move forward because the preceding program is so substantially flawed, but really to set our sights on how we move to the next level.

Now, David and others subsequently brought up the notion of patient function and patient experience. Dana rightly pointed out the complexity of experience in a situation where in many instances you need a proxy report, and we're all aware of the concerns about, you know, interpretability of functional assessment. And this is where I get to the notion of, okay, if this is a journey, what next?

Well, wouldn't you really want to have a balanced scorecard? Wouldn't you really want to have the numerator and denominator aspects of value, the quality, and I put safety up there, too, in relation not to the cost? Wouldn't you want measures of function and experience as part of that?

Which leads me to the question: Why are we having such difficulty getting to credible data? And it leads me to this observation: that I would hope part of the ongoing direction here is to telegraph the need for electronic data, electronic quality measures, where there is not interpretability but, in fact, a measure of production is actually a byproduct of the care process itself so they can gain insights into function, perhaps not experience but into potentially things that matter.

That leads me to my final point. I note that skilled nursing facilities have a panoply of patient types. Many of their patients are older. Full disclosure, I'm on the board of advisers of the Age-Friendly Health Systems, which parses into four M's: the issues of mobility, issues of mentation, medication, and what matters to the patient. I would hope that as we then create the construct, we can

extract greater data, that we also begin to think not only from the public accountability and the sort of referral perspectives, but from the perspective of the patient themselves in terms of what matters to them.

Final comment. You know, I happen to just think it's also important that these programs always support access for those beneficiaries who need it. Thanks.

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

DR. RYU: Thanks, Dana. You know, I'll pile on here. I like our direction here as well. I think it addresses many of the unintended consequences and incentives in the current, you know, VBP model. And I think it's a marked improvement for that reason.

I like the peer grouping approach. I like the illustrative metrics. I think the only thing that I would offer -- you know, I agree with many of the comments already stated, but I think the patient experience measure is something that I would love to see as part of what we're either going out with as a recommendation or soon thereafter to be incorporated.

The other is this notion of improvement. I would offer that, you know, maybe it makes sense to have an

actual separate improvement measure, a portion of the withhold that could actually reward improvement measured over a period of time. Maybe it's not just a single year but consistent demonstration of improvement.

I think alongside Larry's comment around public reporting, offering that extra incentive for folks to continue to improve across any of the peer groups, I think having a dedicated amount that's rewarding improvement will help to bolster that.

Thanks.

MS. KELLEY: Paul?

DR. CHERNEW: Paul, you are muted.

DR. PAUL GINSBURG: Yes, sorry about that. First, I'm very supportive of this approach. I like the direction it's going. A couple of comments.

I'm really intrigued that Amol brought up the issue that this is really a quality program, and maybe we should just call it that. And Brian's comment about, you know, being concerned about SNFs wanting to serve high-risk -- high social risk populations I think is very important. It really -- whereas, this started out as a quality or value program, the details are critical to whether it's an

access program. And I'm concerned both about institutions, you know, not being interested in duals and also concerned about the institutions that historically treat the duals not being unfavorably impacted.

I can't discuss this fully, but I have always been uneasy about having distinct rewards for improvement over good performance because the incentives in a sense -- and I'm really concerned about the equity of penalizing the organizations that are not terrible, so that's something I really need to think about, hear more discussion about going forward.

DR. CHERNEW: All right. I'm going to make a comment, and then a few folks haven't spoken, and so I'm going to do what I'll call a lightning Round 2, which is I'm going to call folks out just to get a general sense if you're on board with this basic approach. While you think about your answer to that question, I'll make a comment on improvement and more a broad comment.

A lot of this is about the nuances of the math, which we will work through and come back with you. In the particular improvement case, for example, you always get value for improvement because even in an absolute model,

you get more money if you go from a lower to a higher performance. The question is essentially by how much, and should we double-weight your improvement in the axis scale and then have a separate value for actual improvement? So we will think through the math of all of this, and, of course, in implementation there will be some options how to get the exact details right.

I think the most important thing that I've heard so far is the basic principles that Dana outlined very nicely, which is, first of all -- I'm going to expand on them. First of all, we want quality improved for everybody. Second of all, we want to make sure that we don't disadvantage the providers that are serving the most disadvantaged populations. We're very worried about disparities. And third was the point of universality. We don't want to appear or otherwise hold -- give organizations a pass because of the populations that they serve. And I think the challenge we will work on going forward is taking those basic ideas for which there seems to be broad agreement and converting it into math, which is never fun, and certainly never fun to do in a GoToMeeting.

So that said, I'm going to go down how you're

based on the screen, and please don't make a long comment because we don't have a lot of time, although certainly there's time for a short comment. So let me start with you, Karen, just to get a sense of where you are with our direction.

DR. DeSALVO: All right. Thank you. I like the general direction. You know, clearly this area needs improvement, and the team has done a great job of thinking about how to move forward in a principled fashion that aligns with other value work that we're doing as MedPAC. I very much think that we still in all areas, not just in the area of SNF, have to work through this challenge of not only people who are dually eligible, with dual eligible being a marker of lower socioeconomic status or other social challenge, but this is going to continue to be an increasingly complex area.

So I like the fact that we're asking these tough questions about whether peer grouping is enough or if we should be doing more or something different. I agree with Dana's principles around how to think to approach it.

I just want to make one comment, though, as we're thinking about social -- whether or not social drivers can

influence care or outcomes and/or there should be some additional rewards to the SNFs to support lower-income Medicare beneficiaries. One of the challenges, of course, for appropriate community discharge is that those beneficiaries need safe quality housing with running water and electricity and social support when they leave the SNF. So there's a problem on the other side even if we make investments in the SNF to help them with their quality improvement and other work. We should just remember that there are some other complexities as beneficiaries leave that safer environment of an institution, at least with respect to them having additional resources that would come through added payments and have a place for safe discharge. I'm not saying that we should solve all of that from here. I just want us to recognize that as we're thinking about performance, because there's a reality that that may cause some people to need to be readmitted or to be more difficult for them to be discharged.

Thank you.

DR. CHERNEW: Great. Thank you, Karen.

Next on my screen is Marge. You may have said what you needed to say in Round 1, but I just want to give

you a chance, Marge, to briefly signal or nod if you're on board.

MS. MARJORIE GINSBURG: This was a fabulous discussion, and as much as I completely appreciate Dana's views and perspective on this, the peer grouping to me was, in fact, number one when I looked at all of the recommendations. I was most excited, if that's the right word, for the concept of the peer grouping, and perhaps somewhere, we're going to find a way to compromise on whether we can do without it versus doing with it. But the fact is these SNFs are serving a different population, a much more difficult population, and there has to be a way to legitimately reward high-quality care. So that's my main comment.

The only other thing I wanted to mention about the peer grouping is the discussion at the hospital SNFs sort of shouted out to me maybe we ought to take them out. They really, to me, don't fit well into the rest of the community-based SNFs. So that was just an add-on but not critical.

Great discussion. Thank you.

DR. CHERNEW: Thanks, Marge.

Again, I apologize for moving quickly. Jonathan, if you have a general reaction?

DR. JAFFERY: Yeah. Thanks, Mike.

So like others, I'm generally very supportive of this. I think it's a great step in the right direction, a pretty big leap forward.

I'll just make two very brief comments to respond to what some others have said.

Amol, you brought up the issue of the word "value," and I think it's significant to acknowledge that the word "value" is being thrown out a lot now in health care and some combination of quality and cost or resource utilization. I just think it's something that we might want to think through because it does get used a lot now.

But maybe a more substantive comment is to think about what Dana has brought up. I really appreciate Dana bringing up these points. For many years, I've been concerned about quality measures creating different standards for different groups, and you've made me think a lot, start to think at least a lot deeper about this now.

The one comment I'll add about, though, is we've talked about how to help with resources for organizations

that are serving different, maybe more marginalized or higher-risk populations. And we've talked about technical assistance, and I always wonder exactly what we mean by that. And I wonder if there's some way that we should think about how we can support organizations up front with additional resources, perhaps through some sort of payment mechanisms since that's a lot of what our charge is as opposed to just on the back end as an adjustment after the fact for achieving certain goals.

So I'll leave it at that. Thank you.

DR. CHERNEW: Great. Thank you.

I think next, just on my screen, it looks like it's Sue Thompson. She just jumped around on my screen.

[No response.]

DR. CHERNEW: Sue, I can't see you. Let's go to Bruce, and then we'll go to Sue.

MS. THOMPSON: I'm sorry. I was messing with my camera. I'm sorry.

DR. CHERNEW: All right. We'll go to Sue, then Bruce.

MS. THOMPSON: Okay. Generally, I agree. I will be brief.

Again, I want to join the chorus of the Commissioners in terms of the good work done by the staff directionally. This is absolutely great work. I also want to call out the commentary by Dana. I think that was exceptional in terms of adding richness to the discussion along with other Commissioners as well.

I would put a note of caution about removing the hospital-based SNFs, as I'm hearing in some of the most recent commentary. I think in rural America, these critical access hospitals use the swing-bed concept. They're putting patients into swing beds, and they become SNF providers.

Also, in the narrative of the chapter, there was a comment about why hospital-based SNFs perform better, and likely, it's because of staffing levels and the availability of physicians. I think there's good information out there to support it's a nursing staff availability that drives the difference in terms of why the outcomes are better, and I think there's some lessons to be learned there.

I just want to caution us from thinking we should pull these hospital-based SNF information out of this work.

I think there's something to learn there.

So those would be my comments. Thanks, Mike.

DR. CHERNEW: Okay, great. Then I'm going to go to Bruce next and then Wayne and Pat.

MR. PYENSON: Well, thank you very much, Mike.

I am very supportive of the direction. I think the work is first rate and very insightful.

In the coming months, I'd like to see some consideration of the movement towards mandatory bundled payments after the BPCIA program and how we can craft this very good work into that future. That's not very many years ahead of us, but I'm supportive of the direction.

DR. CHERNEW: Great. Wayne?

DR. RILEY: Y es. Thank you, Chairman.

I want to thank Sue for raising the issues of nursing. As an internist having referred patients to SNFs throughout my practice and career and then having family members in SNF, the secret sauce is nursing, and when there's good nursing staff and good nursing training, it really does make a difference in terms of the quality, not only the objective measures of quality, but also the family satisfaction and I would argue probably the patient

satisfaction as well.

I think Marge's point was right to raise the issue, but I would still because of also the rural issue, as Sue mentioned, retain the hospital-based SNFs in the program.

But terrific work by the staff. I think we talked about making sure that we do not do anything that exacerbates the difficult terrain that dual eligible patients have to traverse to get care and also to get SNF care when they need it, if and when they need it. So I think this is superb work, and I endorse.

DR. CHERNEW: Wayne, thank you, and that leaves Pat. I'm going to go to you, and since Dana led off a lot of this conversation, I'm going to give Dana 20 seconds or so to give a final point because we're coming up to the end.

Pat?

MS. WANG: I am supportive of the direction in the chapter. I think it's really, really good work.

A couple of emphases that I would put, I really endorse what others have said about the importance of continuing work on developing measures of functional status

and patient satisfaction. So I think that's good for emphasis.

I actually really like Larry Casalino's comments about public reporting. I think whatever we're doing inside to try to level the playing field for facilities that are taking care of more vulnerable patients, it's very important still to unblind all this information and make it transparent to people so that they have sort of unweighted and unadjusted information to make their decisions.

And the final thing, though, which is sort of related is that -- and we've talked about this before. I know that we use dual eligible status to adjust for SES. I really, really want to encourage us to at least in or a chapter to encourage measure developers and others to make this more sophisticated. Dual eligible status is such a blunt instrument.

We know so much more about folks who are near dual, non-dual. I mean, it's much, much more than whether you are a dual eligible as to whether or not you should be recognized or a facility should be recognized as treating a lot of folks with complicating conditions.

And I really appreciate Karen DeSalvo's comments

about at a certain point, there's only so much that a facility can do. The environment of the community and the housing, et cetera, the neighborhoods into which people are returning is beyond the control of the facility, and I just think that we need to recognize that there are certain things that these components of the delivery system just really can't handle on their own.

Thank you.

DR. CHERNEW: Pat, thank you.

That point on using duals is, I think, spot on actually, and if we had another bunch of time, I'm sure we could go around and make a comment on that. But we don't.

So, Dana, you're going to get the last word. I can't see where you are now, but you're somewhere.

DR. SAFRAN: Just really quickly, I think this was a fantastic discussion. I only wanted to make one clarification based on something that Marge said.

I wanted to be very clear, I'm not at all arguing against having the peer grouping. I think peer grouping is a really important advance that the team has made. What I was trying to express was that we not use peer grouping as a basis for setting this performance standard, but rather

that we use it as a basis for setting how much of a reward or how much support providers get.

And I love Larry's additional point about using it for public reporting so that we can see how providers within peer groups compare with others in that peer group at the same time that we're showing how a provider performs relative to the country and relative to their region.

So I just wanted to be really clear. I was not at all saying we should dispense with this innovation of peer grouping, just that it not be used to set different performance standards. There should be universal standard of performance, and let's adjust rewards and support based on peer groups.

Thanks.

DR. CHERNEW: Dana, that was incredibly helpful, and I know I said I want to move on. But I want to make one other point.

I think the way this actually works -- and, again, I'm not going to have discussion on this now, but luckily, we get to meet other times. I think the way this actually works is you get points based on national standards, and the peer grouping is largely used to

determine how much money those points translate into.

But I think it's crucial that your original point about universality, not different standards, and getting the incentives right across the board is spot on.

So, again, we will in a later time or offline talk about the nuances of the math that this was designed. I think Carol is going to give me a thumbs-up on the screen or not, but I think this design to try and have national standards for the points you get and not have a standard influenced by the peer group you're in and the peer grouping, I think, is largely used to translate it into money, although literally there might be other ways to do that.

But now I've taken us too long, and I feel badly because the hospice stuff is most important and is another great job. So I'm going to skip any great intro except to thank you all and switch over now to the next item on our agenda, which is the hospice payment chapter. And I think that's going to be Kim.

So now I'm just -- there we go. We have the slides up. I just don't see Kim, but, Kim, just jump in whenever you're ready.

MS. NEUMAN: I'm here. Good morning.

So today we are going to talk about issues with the hospice payment system and potential new policy directions that could be explored in future research. I'd like to thank Evan Christman, Kathryn Linehan, and Jamila Torain for their contributions to this work.

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

We are going to talk about two primary issues with the hospice payment system. First, aggregate payments substantially exceed providers' costs, and margins vary widely by length of stay. We'll discuss a site-neutral payment policy for long hospice stays as a possible approach to address this.

Second, we will discuss concerns about outlier utilization patterns among some hospice providers and the potential to develop a compliance threshold policy to address this.

Both of these items are in response to issues raised by Commissioners at the October 2019 meeting. Before we discuss each, let's review some background on

hospice and the hospice payment system.

Hospice provides palliative and supportive services for beneficiaries with terminal illnesses who choose to enroll.

To be eligible, a beneficiary must have a life expectancy of six months of less if the disease runs its normal course. There is no limit on how long a beneficiary can be in hospice as long as a physician certifies that he or she continues to meet this criterion.

Beneficiaries who choose to enroll in hospice agree to forgo curative care for the terminal condition and related conditions.

The hospice benefit covers a range of services; for example, visits from nurses, social workers, aides, therapists; drug, durable medical equipment, and supplies; short-term inpatient or respite care and other palliative services in the patient's plan of care; and in addition, bereavement for the family.

Medicare spent $19.2 billion on hospice services in 2018. Medicare pays a daily rate for hospice, and this rate is paid regardless of whether the patient received services on a particular day.

There are four levels of care. Routine home care is the most common, accounting for 98 percent of days. The three other levels of care offer more intensive services to manage a crisis or offer respite care.

The hospice payment system also includes an aggregate cap that limits the total payments a provider can receive in a year. If a provider's payments during the year exceeds the number of beneficiaries treated multiplied by the cap amount, the hospice must repay the excess to the Medicare program. As we saw last year, the cap has the effect of reducing payments to providers with unusually long stays and high margins.

As we consider Medicare spending on hospice, it is important to note the role that long hospice stays play. Although a relatively small share of beneficiaries have long stays, long stays account for the majority of Medicare spending. Only about 14 percent of hospice enrollees who died in 2018 had stays exceeding 180 days, but nearly 60 percent of total Medicare hospice spending in 2018, or $11 billion, was on behalf of beneficiaries with stays exceeding 180 days. And of that $11 billion, about $7.3 billion was for additional hospice care for patients who

had already received at least 180 days of hospice.

As we have discussed before, long stays in hospice have been profitable due to the per diem nature of the payment system and hospices cost structure.

Prior to 2016, routine home care C was paid a uniform daily rate. Because hospices provide more services at the beginning and end of an episode and fewer in the middle, this has meant that longer stays have been more profitable.

In 2009, the Commission recommended the hospice payment system move from a flat payment per day to a U-shaped payment structure, and directionally consistent with that recommendation in 2016, CMS modified the payment structure for routine home care with a higher payment rate for Days 1 through 60 and a lower rate for Day 61 and beyond, and providers also receive additional payment for nurse and social worker visits in the last week of life.

More recently, in 2020, CMS rebalanced the payment rates for the three less frequent levels of care, increasing them substantially.

Although CMS estimated that the routine home care payment rates exceeded costs by 18 percent, CMS only

reduced the routine home care rates slightly because the statute requires changes be budget neutral. Although the changes made by CMS in 2016 and 2020 are improvements, the issues remain.

And findings from our March 2020 report illustrate this. In that report we found that the aggregate level of hospice payment substantially exceeded providers' costs.

We estimated an aggregate Medicare margin in 2017 of 12.6 percent, and as has historically been the case, profitability varied widely by length of stay.

Grouping providers into quintiles based on the share of the providers' patients with stays greater than 180 days, the aggregate margin ranged from about -5 percent for providers in the lowest length-of-stay quintile to about 22 percent in the second highest length-of-stay quintile. The slight dip in margins in the highest length-of-stay quintile reflects the effect of the hospice aggregate cap.

Based on our analysis of hospice financial performance and other payment adequacy indicators, in March 2020, the Commission concluded that the aggregate level of

payment could be reduced and would be sufficient to cover high-quality hospice care.

In March 2020, the Commission made a two-part recommendation, which has not been acted on by Congress. The first part was freezing the Fiscal Year 2021 payment rates at 2020 levels. The second part was wage adjusting and reducing the hospice aggregate cap by 20 percent as a way to focus payment reductions on hospice providers with unusually long stays and high margins.

The table here illustrates the effect of the hospice cap recommendation based on our simulation using 2017 data.

Next.

If you look at the last row in the table, it shows the effect of the cap policy on the 20 percent of providers with the most long stays. Payment to these providers would be reduced substantially, with their payment to cost ratio declining from 122 percent to 103 percent.

But payments would continue to substantially exceed costs for some providers, as also shown here in the chart if you look at the payment to cost ratio for the next

two highest length-of-stay quintiles.

So what this means is that if Congress were to adopt the cap policy in the future it would reduce payments to providers with the most lost days but it would not fully eliminate the distortions in the payment system where long stays can be quite profitable, particularly for providers who keep their utilization patterns near but below the cap. Given this, there could be merit in considering additional adjustments to the routine home care payment rates for long stays.

At the October 2019 meeting, Commissioners raised the idea that long hospice stays for some patients may be substituting for other types of care such as home health care, and raised the possibility of adjusting payments for hospice stays accordingly. Building on that discussion, we could explore developing a site-neutral payment adjustment for long hospice stays using home health as a starting point.

Although there are important differences between hospice and home health, home health could provide an appropriate payment benchmark for long hospice stays for several reasons. Both hospice and home health offer visits

from similar types of practitioners: nurses, aides, social workers, and therapists. With long stays in hospice, a larger portion of care is occurring earlier in the disease trajectory where patients are likely to be more stable, and as such may be more akin to home health care than shorter hospice stays where the patient is nearing the end of life and typically experiences increased needs for hospice nursing and psychosocial supports.

As hospice length of stay increases, aide minutes make up an increasingly larger portion of total visit minutes while nurse minutes decline. The greater share of hospice time devoted to aide visits among patients with the longest stays may suggest that hospice may be performing some of the same functions as custodial care. At the same time, any effort to develop a payment adjustment for long hospice stays based on home health would need to take into account the differences between the two benefits, with one of the biggest being that hospice covers a broader set of services than home health.

As an example, this next slide sketches out one approach to constructing a payment adjustment for long hospice stays based partly on home health rates, while

being mindful of the differences between hospice and home health. First, we could rely on the home health per-visit payment rates for each type of discipline -- nurses, aides, social workers, and therapists -- to estimate how much the visits received by hospice beneficiaries would have been paid if home health payment rates were used.

Using the home health per visit payment rates instead of the home health episode payment rates helps to address the differences in the mix and frequency of visits between home health and hospice patients. Since some items like drugs, DME, and certain other services are covered by hospice but not home health, we could develop estimates of the costs of these additional items and services using data from hospice cost reports.

Summing together the estimated visit costs, based on home health rates, and the other costs, based on hospice cost report data, we could develop a benchmark site-neutral payment amount for long hospice stays. This benchmark payment amount could be compared to the average amount hospices are paid for long stays under the current hospice payment system to develop an adjustment factor.

To develop a site-neutral payment adjustment for

long hospice stays, a number of design questions would have to be considered. For example, hat length of stay would trigger site-neutral payment? Would the payment adjustment apply to the entire stay or to only those hospice days beyond the threshold? Would there be a period near the end of life that is exempt from site-neutral payment? How would the policy be structured to best minimize the potential for providers to avoid site-neutral payment by discharging and readmitting patients to hospice, and how should the policy be structured to treat providers equitably in situations where patients switch hospices and receive care from multiple providers?

Next, we will turn to the issue of providers with outlier utilization patterns. This is an issue that also came up at the October meeting last year, where several Commissioners expressed interest in steps to address providers without unusual utilization patterns that raise program integrity concerns.

As shown in the chart, some providers have much longer stays than other providers. And as we've discussed before, length of stay varies by diagnosis and patient location so providers that wish to do so can focus on

patients likely to have long stays. OIG has also reported on cases of some providers enrolling patients not eligible for the benefit.

Some providers have unusually high live discharge rates, as can be seen from the distribution in the chart. Although hospices are expected to have some live discharges, an unusually high rate raises concerns. Very high live discharge rates may indicate that a hospice provider is not meeting the needs of patients and families or is admitting patients who do not meet the eligibility criteria. In addition, a study by Abt Associates for CMS found evidence suggesting that some hospice providers inappropriately encourage beneficiaries to revoke hospice or inappropriately discharge patients to avoid hospice aggregate cap liabilities.

The care provide by hospices with unusually long stays and high live discharge rates differs from the care provided by other hospice providers in some ways. Hospices treating a mix of patients with very long stays are providing more days of care earlier in the disease trajectory when patients tend to be more stable and have less-intense care needs. In addition, unusually high live

discharge rates seem inconsistent with the mission of hospice which is to support patients through the last days of life.

In other sectors, such as IRFs and LTCHs, Medicare has used compliance thresholds to counter incentives for patient selection and encourage providers to focus on patients most appropriate for that level of care. Compliance thresholds are blunt tools, but they are sometimes turned to when other approaches are not successful. With a compliance threshold, Medicare defines certain criteria that a provider must meet to qualify to be paid as that type of provider. Examples are the IRF 60 percent rule and LTCH 50 percent rule, as discussed in more detail in your paper.

We could explore this type of approach for hospice providers. For example, a policy could be developed where hospice providers whose length of stay or live discharge rates for its patient population exceeds a specified threshold would receive a reduced payment rate for all patients. Having this type of policy in place may help reduce the potential for patient selection under the hospice payment system and reduce the potential for hospice

business models focused on revenue generation strategies.

To develop a compliance threshold for hospice providers, a number of policy design question would have to be considered. For example, what would be the basis of the threshold -- length of stay, live discharge rates, or an alternative metric? If hospice length of stay, what is an appropriate metric -- share of stays exceeding 180 days, average length of stay, or an alternative? At what level should the threshold be set? What would be the consequences of not meeting the compliance threshold, for example, a lower payment rate or no longer qualifying to be a Medicare hospice provider? And finally, to what time period would that consequence apply, retrospectively or going forward for a specified period?

So in summary, to address issues with the hospice payment system, we could conduct future work to explore a site neutral payment adjustment for long hospice stays and a compliance threshold for hospice providers. It would be helpful to get Commissioner guidance on these research directions and issues to consider for future work.

DR. CHERNEW: Terrific. From what I've seen, the first person in the round one queue is Larry. So Larry,

you're up.

DR. CASALINO: Yeah. Very interesting and really kind of disturbing report.

Just a quick question. If we were to say that for certain long stay days that occur, you know, somewhere in the middle, let's say, of a person's care cycle in the weeks before they are dying, if we wanted to pay those at a lower rate I think you guys were suggesting let's base their lower rate off the home health rate plus some addition payment for special things that a hospice provides.

But if I understood correctly, at least, from what we discussed last meeting, is that maybe these long stay days, quote/unquote, in the middle of the cycle, are really home health days and that's what they should be. For example, for a patient with Alzheimer's who is living at home and don't need these specialized SNF resources. If that's the case, why would we pay an additional amount beyond a home health payment rate for hospice resources, I should say, that aren't really necessary during those days?

Because my understanding is, we wouldn't be paying, you know, fee-for-service depending on whether the

nurse shows up or not in those days. It would just be a different hospice per diem rate than an HHA rate for those days. And if the patients are just getting home health services, why not just pay at that rate and not make the hospice per diem higher for those days. That, to me, would be truly site neutral.

MS. NEUMAN: So there are some differences in the services covered by hospice and home health, and the two things that come to mind immediately are drugs and durable medical equipment. So if a beneficiary is in hospice and there are drugs that they have been previously using to address the symptoms of their chronic condition, those medicines would have been previously paid through Part D. But once a beneficiary goes into hospice those medicines are supposed to be paid by the hospice.

And so a difference between hospice and home health is the hospice will have been absorbing those medication costs whereas the home health agency would not have been. Those would have been paid through Part D. So that's an example of where you might want to think about, if you were going to pursue this approach, possibly adding on to the home health rate.

DR. CASALINO: Thanks.

MS. KELLEY: I have Brian next with a round one question.

DR. DeBUSK: Okay. Thank you. I have two questions. First of all, how many NPIs are in this space? I'm under the impression this is a really fragmented industry and that there are a lot of providers who even have multiple NPIs. Can you speak to that please?

MS. NEUMAN: Are you asking how many provider numbers there are?

DR. DeBUSK: Yeah. How many providers are in this space, and to what extent do they use multiple numbers? For example, the DME industry used to be marked by, you know, one operating have five or six or seven different numbers. Is that similar to hospice, in hospice?

MS. NEUMAN: So in hospice there are about 4,600 provider numbers, roughly, and there are companies that have multiple locations and can use different provider numbers for those different locations. So yes, there is some of that. We have never looked at that in detail, sort of trying to get at the corporate entity and then how many numbers per entity there are.

DR. DeBUSK: Okay. I was -- and this will be round two. I was just trying to unwind how effective a solution would be if they can just simply switch from one provider number to another. That's round two.

My second question was, how does the hospice revenue cycle work, in general? For example, if a provider gets the aggregate cap, how is that actually -- I mean, does Medicare quit paying for the year? I mean, these are daily bills, I would assume. How does that whole revenue cycle work?

MS. NEUMAN: So with the aggregate cap what happens is the cap year ends in the fall of a year, and then in the spring the hospice is required to do their own self cap calculation, and based on that in initial data if they're over the cap they're required to submit money to the MACs, or to come up with a payment arrangement with the MACs. And if they don't then Medicare can stop payment to the hospice.

DR. DeBUSK: So there's a mechanism in place now for if we do develop policy that has a claw-back or a bill-back, all that machinery is in place already.

MS. NEUMAN: Yes, there is a machinery sort of,

an infrastructure surrounding the cap.

DR. DeBUSK: Okay. Thank you. Those were my questions.

MS. KELLEY: Bruce, did you have one?

MR. PYENSON: I did. Thank you very much, Kim. This is terrific work. I've got two questions. One is in the reading material, on page 9, you identify that hospice has a focus on nursing homes, and I think ALFs tend to have patients with longer hospice lengths of stay, and they also have an efficiency because of very small travel time in a facility between patients. And my first question is whether the home health program recognizes a difference in reimbursement in such situations, and whether that could be applied to hospice. So that's one set of questions, perhaps a related question in the case of NORCs naturally occurring retirement communities.

The second question is, as I believe the data, we are examining includes patients receiving hospice services who are enrolled in Medicare Advantage. I believe all of that flows into the Part A data that we're looking at. And with the move towards MA taking risk for hospice, what all that would do to our thinking here. And part of that is do

we see actually different patterns of hospice use in patients who come from an MA plan versus others?

So two questions. Sorry. Very different questions.

MS. NEUMAN: So on the first one, you are asking about home health and assisted living facilities and if the payments are different. Evan, you should correct me if I'm wrong but I believe they are not.

The second thing is about the MA population in hospice, and the beneficiaries who are in MA plans that then get referred to hospice and are under effectively the same hospice system as fee-for-service beneficiaries currently, we've looked at their utilization patterns and, in general, they are pretty similar. Maybe the median length of stay is a tad longer and maybe the long stay tail is a tad shorter, but it's not that much. It's pretty similar. So that's what we know with the data that we have at this point.

MR. PYENSON: But for me, a policy recommendation standpoint, if MA absorbs the risk for hospice patients in the future, I think that means that the volumes we're looking at go down by about half.

MS. NEUMAN: The volumes would go down, yes. Yes.

MS. KELLEY: Karen, did you have a round one question?

DR. DeSALVO: Thanks, Dana. My question has a little bit to do with the other side of the equation, and just to ask, there's some clinical characteristics of the patients that are in longer stay and, as always, I really appreciate the staff trying to shed some more light here. And given that a lot of them have neurologic diagnoses I just wondered if there's more detail you could share about whether those individuals also, if we note they had other comorbidities as well. So were they potentially people who also had other significant conditions but were admitted to hospice purely for neurologic conditions but were more medically complex going in? There's a cost question behind that, I think. I'm just trying to understand what are the other factors driving the higher costs in addition to potentially length of stay.

MS. NEUMAN: So it's a good question. We have not looked at the sort of clinical profile of the neurologic patients and the sort of array of comorbidities.

It's something that is on the claims data so it would be possible to look at something like that.

DR. DeSALVO: Thanks.

MS. KELLEY: That's all I have for round one, Mike. Should we start with round two?

MS. MARJORIE GINSBURG: Actually I had a round one question, if you don't mind if I jump in.

MS. KELLEY: Go ahead.

MS. MARJORIE GINSBURG: Actually, I'm glad Bruce brought up the question about MA, because that was one of my questions. But the main one is this issue about the eligibility criteria to be in hospice. It was fuzzy. And yet there was a reference on one of the pages, page 5, where it talks about eligibility criteria but there was no additional information on what that meant besides diagnosis. Clearly this must be key to the differences we're seeing in the super-utilizers and those who are not.

So I wonder if staff could talk at all about what other eligibility criteria are part of the system here. Thank you.

MS. NEUMAN: The main criterion is that the patient have a life expectancy of six months or less if the

disease runs its normal course, as determined by a physician.

There are policy documents the MACs have that give some guidance on sort of where that line might fall for patients with a certain condition, but a lot of it is up to the judgment of the physician.

MS. KELLEY: All right. If we're done with Round 1, we can go to Round 2, Mike.

DR. CASALINO: If I could just follow up.

DR. CHERNEW: Yeah.

DR. CASALINO: Karen is it the patient's physician and the hospice physician has to certify the six months or just the patient's physician?

MS. NEUMAN: So when a beneficiary first enters hospice, it's both their attending physician and the hospice physician subsequent to the first benefit period, so each recertification, it's only the hospice physician that has to make that judgment.

DR. CASALINO: I see. So there's all kinds of things that the hospice physician could do to select patients that would be favorable to the hospice one way or the other, other than just increasing the volume of

patients.

MS. NEUMAN: It's possible that you could, you know, enroll or seek out referral sources that have sort of a different mix of patients at different points in the disease trajectory. That's possible if an entity wanted to do it.

DR. CASALINO: And there's a tremendous amount of judgment and uncertainty involved in deciding how long you expect the patient to live, and your decisions along those lines could be favorable to the hospice you work for.

Okay. Thanks.

DR. CHERNEW: Great. So now we're going to switch to Round 2. I think we have Sue was first for Round 2, and then we're going to go to Marge. I think that's going to be the order.

MS. THOMPSON: Very good. Thank you.

Just to set context for my comments on this chapter, a reminder that in 2018, we're talking about $19 billion in total spent on hospice, and that's on the total Medicare spend in 2018 of $750 billion. So we're talking about the total hospice spend being 2 percent of our total Medicare spend. So just keep that in mind. We have a $750

billion issue, and I want to talk a little bit about thinking about hospice a little differently, because much like my sentiments after reviewing the context chapter last month, I felt less than satisfied with the progress we've made over the course of the past five MedPAC cycles, while I've had an opportunity, I think, every year to comment on hospice.

We're concerned with long hospice stays and the distortions in the payment system that quite likely are incentives to creating more long hospice stays. So do we believe that long-term hospice beneficiaries do not receive value? Do we believe that restructuring payments will lead to long-term modification of bad actor behavior? Is this a program integrity issue to deal with those that play games with a payment system, and are we thinking broadly enough about what hospice means to the overall Medicare program? And I wonder if we're asking a complete set of questions.

So to illustrate my very conflicted thinking here, I'm going to go out on a limb a bit to share my own personal experience with Medicare hospice services.

In 2013, my father left this good earth at the age of 83 following a fall on ice while getting out of his

car on an icy January day in Iowa, resulting in a traumatic head injury with cerebral head bleed, following a long history of cardiomyopathy with atrial fib that required an escalation. He spent his last week of life at our hometown nursing facility with the support of hospice, and we said goodbye to my mom just after midnight on Christmas Day in 2017. She was 85 years old. She enjoyed the support of hospice while residing in an independent living facility for 13 months after being diagnosed with pancreatic cancer.

At the time of each of their diagnoses, my parents were offered additional medical and procedural therapies. Dad was offered a trip by Life Flight from the local critical access hospital to the University of Nebraska Medical Center, where they proposed doing a craniotomy followed by vascular procedures to stop the head bleed followed by whatever rehab service would be needed following whatever his neural status might be following his stroke, with certainty of compromised quality of his life. For my mother, her choice is including stenting various ducts and vessels followed by aggressive chemotherapy.

Both of my parents chose to reject these aggressive therapies and opted to enjoy the best quality of

life possible with the support of hospice. My sister, also a nurse, and I did not have a crystal ball in either case. Dad lived less than a week. Mother lived an incredible 13 months.

Hospice services contributed immeasurably to the quality of both of my parents passing to their next life, and quite likely, as this story is completely told, their choice saved the Medicare program substantial dollars.

So I'm left to wonder. On behalf of the total Medicare beneficiary population and on behalf of the future of the Medicare program, are we asking a complete set of questions, and are we missing the forest for the trees?

According to a study by Kelley, Deb, and Morrison, included in the National Hospice and Palliative Care organization's 2019 annual report, the total Medicare savings between hospice and non-hospice patients with a 15-to-30-day length of stay was $6,430. These savings to Medicare declined as the length of stay increases. However, even with the length of stay up to 105 days, the savings are in excess of $2,500.

So instead of attempting to limit Medicare hospice participation and payments, should we not be

putting at least some of our focus on recommendations, encourage the timely enrollment of qualified patients into the hospice program?

As a reminder, Medicare beneficiaries make the selection. It is one with substantial consequence. What is the comparison of hospice cost and curative cost? What is the total cost avoidance by the Medicare population based upon the election of hospice compared to a craniotomy followed by an ICU stay, followed by long rehab services, or going down a long-term chemotherapy protocol?

This chapter focuses on unusual utilization patterns among some hospice providers, and if program integrity issues exist -- and they do -- then let's focus our recommendations on proving compliance and enforcement of rules that already exist.

I struggle with creating a new set of payment formulas that will only create a new game for the bad actors to manipulate and leave the good hospice providers with additional complexity and regulatory burden to sort through while they're doing the right thing, improving the experience of the Medicare beneficiary while reducing Medicare spend.

So I recommend we spend more time understanding and putting into context of this discussion, the cost avoidance opportunity the Medicare program experiences through its hospice programming.

However, the chapter calls for comment on the concept of using site neutral, and I struggle with this. I have a hard time comparing hospice and home care. It seems faulty, as the inputs of labor, the skill mix, the drugs, the equipment, and the outputs are substantially different.

The chapter does a nice job of listing these differences, and the narrative ultimately seems to imply that hospice is home care plus a few more benefits, to which I just don't agree. But nevertheless, my preference would be perhaps for a more episode-based approach to payment for hospice with payments rising for longer stays but at a decreasing rate.

But nevertheless, should we proceed down a path of site-neutral discussion, which I anticipate we will, I would offer these reactions. I would favor a length of stay greater than 365 days before triggering a site-neutral payment. For those stays that do meet the criteria, I would support the payment adjustment applied only to those

days beyond that threshold. I would support for very long stays where the patient is ultimately discharged deceased that the last seven days be exempt from the site-neutral payment. I would suggest that policy could be structured to lessen the potential for providers to avoid site-neutral payment by discharging patients and readmitting them to hospice by setting thresholds. Threshold for payment should be based on high percent of long length of stay and high percent of live discharges, using a national benchmark.

It would be important to note the reason for live discharges within these metrics, including patient and family choice, relocation, they found a new treatment, or perhaps the hospice determined the patient is no longer terminal.

The consequences of not meeting compliance thresholds should be similar in concept to the lower payment rate setting for not participating in required quality reporting, and yes, some recognition for small providers to address concerns about random variation in very small patient populations is relevant and important.

And for those patients that switch hospices,

which can only happen once during a certification period, they would stay in the same benefit period so their days would continue to accrue.

In summary, making recommendations regarding payment adjustments to the hospice program seems somewhat narrow in our thinking. Attempting to modify behavior through payment system restructuring without including the context of the cost avoidance opportunity, hospice provides to Medicare, seems to me to be a missed opportunity.

As a family member who was blessed to have experienced the hospice benefits afforded to my parents and as a MedPAC Commissioner concerns for the sustainability of this Medicare program, I encourage us to take a broader view concerning hospice to be an important puzzle piece towards solving our $750 billion problem.

Thank you.

DR. CHERNEW: Okay. Thanks, Sue. As always, eloquent.

Marge?

MS. MARJORIE GINSBURG: Well, I'm glad Sue went first. Sometimes I felt like we were reading entirely different chapters.

I actually started part of my career as a home care nurse. This was before hospice even came into being, but I also have very strong feelings about the benefit of hospice, having used it for a variety of family members.

But I look at the billions that we lose through it not as a tiny segment of this big pie that we spent but as money that taxpayers are paying that they shouldn't be paying, and no way do I think we should jeopardize the existence of hospice or discourage the new hospice programs coming into being.

But I am not happy with the billions we are wasting because there are hospice programs that are gaming the system, and those are words that are in this report. They use the word "gaming," and even though it's a small slice of the Medicare pie, it has consequence. And the fact that we might just leave it alone, to me, is definitely not what MedPAC should be doing.

Like Sue -- I think this was like Sue -- I don't support encouraging it to become part of the neutral setting, whatever that terminology is, because I think there is a tremendous difference between hospice services and home care services. There are too many differences in

those kinds of programs that make the idea of setting the neutral setting payment the same. So I don't support going there.

I do support compliance thresholds, and how we set this up, I'm not sure, but I have this vision that we give hospice program -- if they're outside the compliance threshold for one year, we give them a warning. If they're outside the compliance threshold two of three years altogether, then they go on probation. They're basically taken off the hospice rolls for those three years, and then they can get back in.

I was kind of surprised by the low thresholds of compliance thresholds that were given, the 60 percent and 50 percent. I can't understand how that can be so low, and I'm envisioning compliance thresholds more in the nature of 80 percent, that you have to make that cut at that level.

So those are basically where my thoughts are. I don't think we should give hospices as pass because they're wonderful and they do great things and we love them. I think we should hold them to the same kind of standard we hold every other Medicare provider in terms of integrity and the legitimate use of taxpayer dollars.

Thank you.

MS. KELLEY: Okay. I have Brian next.

DR. DeBUSK: Thank you, and thanks to the staff for an excellent chapter.

There was a lot of contrast between Sue's comments and Marge's comments. Actually, I do understand the important role that hospice plays to the program and to families.

In reading this chapter, the thing that jumped out at me, though, was that there is a group of pretty obvious offenders. I mean, I can fight some of the statistics, but that 95th or 90th percentile is really somewhat outrageous in some cases.

The one thing I'd like to recommend, I'm not sure the site-neutral payment to home health is necessarily relevant, but I do definitely think that these worst offenders need to be paid at a lower rate. So I strongly support paying them at a lower rate, and here's my thought. And this is a little bit against the tide.

I know we don't like payment discontinuities. We label them as "cliffs." This might be one of those rare situations where a cliff helps the program, and for

example, I think the 5 percent APM bonus in MACRA is a beneficial cliff. It's a payment discontinuity that rewards a particular type of behavior.

In this situation, we may want to look at where the cut points are, and for example, the worst offending hospices, we may only want to pay them at 60 percent or 80 percent of the fee schedule.

So I think if we could look at the cut points and find the worst group of offenders, find that next tranche of offenders, and use two or three payment discontinuities there. I think what you do is every year you keep bringing that average up, because the worst offenders obviously wouldn't want to fall off that edge. So we should see length-of-stay shortening.

That was why I had the question earlier about NPI numbers, Kim. I was just concerned that if every hospice or if a lot of these offenders had a number of NPI numbers they could use, they could just simply move between them. But here, I do think this is an example where a cliff could be beneficial.

Thank you.

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

DR. CHERNEW: Yeah. sure. We're going to go on in a second, but, Brian, I want to just push on this for a minute.

So, first of all, just to lay the groundwork for the people here who I think know but certainly for the folks listening at home, we're not moving now towards a recommendation this cycle. We're really getting direction for where to go forward. So hearing these comments are very useful, including, Brian, your comment about cliffs and how they might be useful, including the hesitancy to deal with the home health site neutral stuff and those types of questions.

The thing that I want to throw on the table earlier rather than later is there's another approach for our work going forward that might think about different types of episode models where there can be predictions and variation around predictions and try in getting the averages right. So as we go forward, I think we're doing the exact right thing, which is thinking through, broadly speaking, as much out of the box as we can, basic directions for accomplishing our goal.

There is the program integrity approach. There's

a sort of cliff-type approach, and then I want to throw on the table maybe an episode approach.

I'm not a hospice expert. I did have two grandparents in hospice, and the hospices were absolutely angels. But I'm interested in people's broad thinking about where our broad body of work could go to hopefully shape a recommendation in future cycles.

So with that, Dana, let's move on down the queue.

MS. KELLEY: All right. I have David.

DR. GRABOWSKI: Great. First, thanks to Kim for this incredible work.

So hospice length of stay has been increasing. The types of beneficiaries accessing this benefit have really been shifting. This largely started as a benefit for cancer patients. Today it's a much more heterogeneous group of beneficiaries using hospice, especially those with dementia. Based on MedPAC analyses it's pretty clear Medicare is overpaying for a lot of these long stays, and these long stays are grouped in particular agencies. That needs to be fixed.

However, it's also pretty clear that hospice is really filling an important coverage gap for our

beneficiaries with dementia and other conditions. These beneficiaries lack broader palliative care. They also, in many instances, lack long-term care. And hospice provides coverage for both, although I would argue imperfectly.

And so I think we sort of have these dual purposes. One is how do we eliminate wasteful hospice use while also filling a coverage gap for beneficiaries with dementia and other conditions? In my opinion we can and we should be doing both.

First, in terms of MedPAC's prior recommendations, tightening the agency-level cap and implementing a wage adjustment on that cap, I believe both of these are really smart and useful reforms. They really target that inappropriate, wasteful use of hospice in certain agencies. They, of course, don't fix the bigger issues around the clinical needs of beneficiaries with dementia.

I feel very similarly about the compliance thresholds, in that they are great at targeting the inappropriate use, that wasteful use, but they don't really get at kind of this coverage gap for our beneficiaries.

I generally like site-neutral payment models, but

similar to Sue and Marge I'm really worried about this site-neutral payment model in that I don't think hospice and Medicare home health are all that similar. I actually think the better sort of comparison with hospice here would actually be home care, which is financed, of course, by either Medicaid or privately out-of-pocket. I think hospice is maybe substituting for home care, not the skilled home health care that Medicare pays for. So I'm not very supportive of moving forward with site-neutral payment.

The chapter also raised kind of other ideas, and I just wanted to touch on two. One was episode-based payment. I like this approach. I think it could encourage some greater flexibility in service delivery if designed correctly. It could both eliminate some of the wasteful use but also fill some of the gaps for our beneficiaries. It would, of course, need to be, like any episode-based payment model, we'd need to think about low utilization. We'd need to think about quality measures. There's a lot to be built in. But I do like that approach.

My final comment. We're scheduled to have a discussion during this meeting on APMs, alternative payment

models, tomorrow. We never think about hospice in APMs. Indeed, they are often left out. I actually think there is a role for hospice in that discussion and I hope that, over time, we could think about building hospice into alternative payment models, because I actually think there is a real opportunity there, in terms of thinking about some of the tradeoffs that beneficiaries experience towards the end of life.

I'll stop there. Thanks.

MS. KELLEY: Amol, did you have something on one of David's points?

DR. NAVATHE: No. Just a general comment.

MS. KELLEY: Okay. I will add you to the queue then, if that's all right. Jon Perlin, you're next.

DR. PERLIN: Thanks for a terrific chapter. I really have a provocative couple of comments. I align very much with David on this. You know, philosophically we've got two issues on the table. One is bona fide need amongst beneficiaries. The second is misuse or inappropriate use of the hospice program itself. I think we need to address the first. My comments are really on the latter.

It leads me also to thinking about episode

payment, potentially a clip or a clawback, as well. I'm not a fan of the application of site-neutral payment for this reason. In this instance, we are conflating the issue of duration of services with intensity of services. And, you know, the arbitrage that's going on is a low-intensity need at a higher-intensity reimbursement.

And it really leads me to think that a better approach, is one that's alluded to, I believe our chair may have suggested many moons ago, which is really a U-shaped approach. Because if you think about clinically the intensity of service in a hospice episode, really orienting to the new patient, understanding that patient's needs is a high-intensity activity. There may be a more stable period, particularly in a more protracted length of stay. And then as the end comes and the patient succumbs there may be additional services that are required, that’s certainly what the literature would suggest.

So with that in mind it really maps the intensity of services with an episode-based approach. To be sure, I think we're probably never going to come up with a system that's perfect, and Brian's point about a cliff or outlier or even a retrospective clawback or disproportionate rate

of patients over six months or disproportionate rate of discharge and readmission to try to get around this, would seem to be a set of mechanisms that gets at the issue of intensity. Thanks.

MS. KELLEY: I have Bruce next.

MR. PYENSON: Thank you. I would like to agree with David and Jonathan on not seeing the value of a site-neutral approach, but also to point out my opinion that the work that MedPAC has done in the past, the recommendation for a U-shaped reimbursement and some of the other changes, I think should be reiterated. That work, I think, would go a long way to solving, on a payment basis, the dynamics.

I would like to point out that it seems as though the monitoring of hospices based on their length of stay and the outlier cases could be redirected to identify the performance of the certifying physicians, and I think that might be a better tool to understanding where the issues are coming from and to create the right kind of attention to get the issue fixed.

And finally I think the issue of integration with Medicare Advantage is another approach that will take care -- could potentially deal with a lot of the high portion of

the issue as Medicare Advantage is expected to cover 50 percent of beneficiaries in a few years.

Thank you. This has been a terrific work, terrific conversation.

DR. CHERNEW: Bruce, just to respond quickly, I was indeed on MedPAC when we made the U-shaped recommendation. In fact, I have a published peer review paper advocating for the U-shaped. What I understand, because I asked Jim about this a few days ago, is it's not clear we can have a huge effect by pushing just that, and what we're looking for going forward is sort of where to go beyond that. We're moving a bit toward the program integrity or episode approach, and I think we'll continue going there.

I say that now because at the end I'm going to want to summarize to give people a sense of where I think we're going, and then we won't have time to go around again but people could send messages about how they think my summary was.

But I think Amol is probably next.

MR. PYENSON: Thank you. I would ask Jim to share that analysis that says that won't fix the problem,

because I think that would be very helpful.

DR. CHERNEW: Yeah, and I see him writing that down.

MS. KELLEY: Mike, I have Karen next.

DR. CHERNEW: Oh, I'm sorry. Actually, Karen, then Amol. I'm sorry. Karen.

DR. DeSALVO: No problem, and I'll try to be quick, given the time. I just very much want to say thank you to the staff for the thoughtful iteration of this. You listened to a lot of our comments last time.

Like Sue I'm passionate about this area, not only as a clinician but from personal family experience, and I think that, you know, the flip side of the program integrity piece is the number of beneficiaries who should have access or should take advantage of this kind of service and don't. So I always want to balance trying to encourage uptake of this really important service with our interest in capping unnecessary spending or really looking for challenges and program integrity.

And what I would ask going forward, though, is, one, can we just make sure we are lifting up more than just the cost issue and thinking about the beneficiaries, the

impact on them with respect to experience, service quality. The OIG report from a little more than a year ago really, I think, highlighted some important issues that, you know, maybe as much as 80 percent of the programs have some kind of a complaint or problems.

So there's some underlying quality and experience opportunities here for improvement but also, I just want to make sure that we're thinking about the beneficiary's experience in the systems. And that's just one as we go forward, and thinking about it a little more commentary and understanding of who's in a hospice, who is not, what are our opportunities to make sure that their service and experience is of the highest quality and value to them, not just to the program.

But I want to raise something also which is a third way issue. I understand very much the drive for this site-neutral payment and to think about can home health, for example, be a way that we could couch or shape the payment. I still think that there's some other opportunity here for us to consider, which is that there is a new type of benefit, that we're not meeting a need of long-term debilitated Medicare beneficiaries who them or their

families need extra support, especially if they want to try to stay home.

So I hope we'll have a little bandwidth over time to think about whether there's a new kind of service benefit, something that meets the needs of these potentially high-risk and long-term hospice clients. I'm not sure if it's all just about the revenue or recoupment from the providers, but that there's some need for beneficiaries that may only grow as more age and live longer and acquire dementia and other neurologic conditions.

So if we can put that on the agenda somewhere in the future, I think that might do a lot of good. It might be just worth understanding, again, whether the program is meeting the epidemiologic and clinical changes that are happening to the beneficiaries. Thanks.

MS. KELLEY: I have Betty next.

DR. RAMBUR: Thank you so much. So I found this to be very disturbing as well. I've spent a lot of my life worrying about overtreatment at the end of life, and I can tell you that there's nothing that causes more moral distress to nurses and nursing students than what they see

in this cascade of treatment that happens, oftentimes which then ends with families having to decide to discontinue treatments that maybe weren't in the best interest to begin with. And I could go into a story about how my father was offered dialysis as he was dying. So, you know, we've seen this first-hand, so I very much support the earlier comments and what Sue said so eloquently about cost avoidance.

That said, I was stunned to see a 12.6 margin. I mean, that's astonishing. So we have, you know, the most vulnerable of people, of which we will all be someday. So I'm very interested in the ideas around Medicaid Advantage. I think David mentioned about alternative payment models and I think that's very interesting, episode-based payments, or something new, as just was said. Because I think this need to really create the opportunity for this sort of healing death that people can have, and cost avoidance, without having some of this gaming is really an opportunity if we can figure this out.

So I'm really excited to be thinking about all of this with you.

MS. KELLEY: I have Jonathan Jaffery next.

DR. JAFFERY: Thanks, Dana. Yeah, I'll try to be brief. I'm in agreement with many of the comments that have been made, including some of the ways that David and Jon framed this around these kind of dual purposes. We clearly are not meeting the need of a group of beneficiaries in some ways but there is a need to manage some of the compliance issues. So, like others, I don't think that a site-neutral payment adjustment really meets those dual needs, or even moves us necessarily in the optimal direction for that.

You know, to Brian's points about cliffs, and I think a compliance threshold may help us think about that a little bit. I sit on the board of a local hospice, one that has a pretty high number of beneficiaries in nursing homes and assisted living, and also with dementia, and yet still has an average length of stay and live discharge rate that's in the 25th percentile. So I think there is some need for us to address some of these, maybe they're outliers. Maybe it's even more common than that.

But my two last comments will be I think exploring more about episode-based payments I think is a really interesting idea. I don't have in my mind yet

exactly how that might work but I think that's something for us to think about. And then to get to one of the specific questions that had come up in the slides, talking about what are the consequences if we get to a threshold policy, I would not favor no longer qualifying as a hospice provider as an early step. I think that could be very disruptive. I think that's a pretty harsh penalty in some ways. So I think rather than that, a lower payment rate that might be prospective for the next year. Hospice is so reliant on Medicare as a payer that I think that would have a pretty strong message. Thank you.

MS. KELLEY: Pat?

MS. WANG: Thanks. So thanks to Sue for context, really impactful about the value of hospice and a bigger global picture. I am concerned, though, that the profit margins really do seem extraordinary, and so I think we do have to look further into the payment systems.

I am supportive about continuing the work around compliance, because there do seem to be some outliers and there seems to be ample reason to believe that compliance thresholds of some kind are necessary.

The one thing I wonder about, though, and David

Grabowski stimulates this thinking very, very much, the nature of patients in hospice has shifted tremendously. And as David says, you know, and Karen alluded to this, maybe there's a different benefit happening here. In addition to thinking about varying payment by day and episode, is it worthwhile to look at different conditions to essentially kind of case-mix adjust hospice patients? Because it does seem that the lower lengths of stay, for cancer patients in particular, do fit with the original payment model. Their lengths of stay are lower. They seem to be well within, you know, the boundaries of what's expected.

It does seem that the resource utilization for folks with dementia and Alzheimer's would be quite different from those with cancer. And I wonder, given the mix of patients, whether we could understand first more about who is in that neurological condition and whether it would be worthwhile to pursue a line of inquiry around different resource utilization, because that might be a way to address sort of right-sizing payment levels, regardless of length of stay. Thanks.

DR. CHERNEW: Thanks, Pat. In fact, I think a

case-mix adjustment and an episode model have some similarities to them, but I think, Amol, let's go to you and then I'll begin to think about a wrap-up comment.

DR. NAVATHE: Great. So I just want to say I thought a lot of the thoughts I -- I express support for the direction that we're going in exploring these. I, too, support exploring an episode-based model, perhaps here less excited about site neutral.

The one thing that struck me is given, you know, in Slide 5 we had 60 percent of hospice spending for the greater than 180-day length of stay is it seems to me that we want to be careful to have a program designed also to address program integrity issues. We don't want to hold the program design hostage to these small hospice outliers that are perhaps doing bad behaviors. And so as part of our work, I think it might be nice for us to actually carve out a piece and say this is where program integrity has a role to play. And so setting that aside, how do we design a program that works for the vast majority of hospices who are unlikely to be truly bad actors, if you will.

So that's just a point I wanted to add to what we've said thus far. Thanks.

DR. CHERNEW: Let's go to Paul. Paul, I think you're going to be the last comment before me.

DR. PAUL GINSBURG: Okay. Just keep this, you know, I think it's unfortunate that we use the term "site neutral" because I don't think that's really what we were talking about. I think we were talking about paying less for certain stays, and we don't have to link it to home health. We could just decide X percent less. But I think the issue is in dealing with program integrity, are we going to focus on the stays that seem to be outliers or the organizations which have a lot of those stays that seem to be outliers? It's probably a better direction to focus on the organizations.

DR. CHERNEW: Okay. Then let me try and wrap up quickly as we get to the bottom of the hour and towards lunch.

First, let me reiterate a point that I've made repeatedly. There's a difference between the level and form of payment. If we're worried that there's too much profitability in this sector, I'm not going to comment on it now. You've all done a lot of work in this part because there's going to be a payment update recommendation. We

can deal with that with the payment update recommendation.

This is really a discussion about the form of payment and the way to deal with things that aren't simply an up or down on the payment update rule. And I think what I'm hearing is linking it to site neutral seems to -- I agree with Paul, it has been a little distracting. But at the core we're going to have to come up with an approach that tries to balance this concern about program integrity and the concern about overall spending, recognizing -- and I think I want to emphasize particularly for people who are listening at home, there seems to be -- and I certainly share this -- universal appreciation for the job that is done in hospice and a recognition that we have to maintain and in some ways potentially even expand use of hospices in certain situations. We have to do that in a way that maintains reasonable fiscal stewardship. And what I'm hearing is that we should explore -- and we'll think about how to do this and come back to you -- two broad strategies. One I would put in the program integrity kind of bucket, and the other I would put in the payment reform kind of bucket, which could include certain types of case mix adjustments, certain types of episode models,

incorporating into A-APMs, thinking about how this is working in MA, a whole slew of things that fit into that broader getting the incentives right and deciding how to go about doing that.

So I think we will continue to work through those things, and I appreciate all of the ideas that have come up here today. It's actually very useful.

I may let Kim react, if she wants, to where we are. Kim, do you have any reactions, anything you want to say as we begin to wrap this up?

MS. NEUMAN: No, not [inaudible].

MS. KELLEY: Kim, we lost your audio there for a moment.

MS. NEUMAN: Oh, sorry. I was just saying that I think that's a good summary of, you know, directions that we can pursue going forward. So this has been very helpful.

DR. CHERNEW: Okay. So, Dana, is there anyone I'm missing? Anything I haven't seen? I'm sorry. Since we're not moving to a recommendation, I'm not forcing all of you to weigh in. But you obviously are free to weigh in whenever you want to. Besides, we're at the bottom of the

hour, which is our break time.

So, Dana, is there anything I'm missing?

MS. KELLEY: No, I don't think so. I just want to remind our viewers that public comments can be submitted using the link on the Public Meetings page at MedPAC.gov. And that's all I have, Mike.

DR. CHERNEW: Great. Yeah, so we're going to -- I'll go to lunch. I wish we could go to lunch together because Lord knows there's no food like Reagan Building food. And then we're going to come back, we're scheduled to come back at 2:15. It would be great if you could try, at least for the Commissioners, to get on somewhere between -- you know, around 2:10, maybe shortly after that so we're already to go at 2:15. I think we're going to have two really good topics after the break. Remember it's a different link, and, again, thank you all for the session this morning, and I look forward to our afternoon sessions, and thanks to everybody who is listening at home. Please reach out if you have comments.

Jim, do you have anything you want to add before I say "happy lunch"?

DR. MATHEWS: No. All good.

DR. CHERNEW: Okay. Happy lunch, everybody. See you around 2:10

[Whereupon, at 1:32 p.m., the meeting was recessed, to reconvene at 2:15 p.m. this same day.]

AFTERNOON SESSION

[2:18 p.m.]

DR. CHERNEW: Welcome back, everybody, to the afternoon of the October MedPAC meeting. I'm Mike Chernew. I'm thrilled to welcome you.

We have two good topics. The first one is on Medicare Advantage, the next one on indirect medical education. We're going to start with Medicare Advantage, and so without further ado, here's Andy.

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 the availability of extra benefits. Unlike our payment adequacy analyst in original or fee-for-service Medicare, where we consider the direct financial pressure necessary to constrain providers' costs, the MA payment system relies on passive financial pressure through reductions 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. We are presenting a new benchmark approach that builds on the Commission's public discussion in November 2019. This approach can be calibrated to improve equity and achieve an appropriate level of financial pressure on MA payments.

In today's presentation, I will provide some context about the level of financial pressure in MA and fee-for-service programs and highlight differences in the two programs' benefit structures.

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

Then Luis will present an alternative approach to setting benchmarks. Discussion about that approach will help shape our work for this cycle.

We start by looking at Medicare payments over time. Research on this topic learns that although private plans have generated savings in some high-spending regions of the country, no private plan program has ever yielded aggregate savings for Medicare. During the early period

with payment rates set at 95 percent of fee-for-service spending and continuing up to 2004, payments to private plans were biased due to favorably risk 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, a new benchmark policy introduced by the Medicare Modernization Act significantly increased payments to MA plans, reaching a peak in 2009 at 14 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 2 to 3 percent more than fee-for-service costs for similar beneficiaries.

Although some predicted that MA plan offerings and enrollment would have declined 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 2020, the share of Medicare beneficiaries enrolled in MA rose from 32 to 39 percent. The average number of plan

choices increased from 18 to 27 plans, and the availability of a zero-dollar premium plan rose from 81 to 93 percent of Medicare beneficiaries.

Extra benefits include reduced cost sharing, reduced Part B and Part D premiums, and health-related benefits such as vision and dental coverage or gym memberships. The annual value of all extra benefits increased by about 50 percent, reaching nearly $1,500 for 2020 and accounting for 13 percent of all MA plan payments. All of these metrics are near or at record levels in the MA program.

Comparing the MA benefit such to fee-for-service, one difference is that for most plan enrollees, the choice of providers is limited to their plan's provider network. Enrollees accept this limitation in exchange for reduced cost sharing and health-related benefits the 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 costs and excess limitations.

In today's discussion, the Commission should consider whether to expect Medicare savings from the MA program. If overall benchmarks are not reduced, the existing system is unlikely to translate plan efficiencies into savings for the Medicare program. The Commission should also consider whether the benefit structures are equitably balanced. Thirteen percent of MA plan payments fund extra benefits that are not available to fee-for-service enrollees and that are inequitably available among MA enrollees due to differing benchmark levels.

These inequities 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 the "rebate," ranges from 50 to 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 the 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 then 95 percent of local fee-for-service spending in the highest-spending quartile. 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.

The 2020 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 the paper.

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

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

Finally, despite plans' demonstrated efficiency relative to fee-for-service, with bids averaging 88 percent of fee-for-service spending, the current system of benchmarks results in payments to MA plans that are higher than fee-for-service 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 and benefits. Changes like this would likely entail a larger overhaul 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 apply fiscal pressure on MA plans and support wide availability of plans without paying excessive rates.

These attributes are consistent with general preferences that many Commissioners favored during our discussion of MA benchmark alternatives last November: eliminating benchmark cliffs, bringing benchmarks closer to fee-for-service spending in the 115 percent and the 107.5 percent quartiles, putting additional pressure on some benchmarks in the 95 percent quartile, and an immediate change in benchmarks that is not overly disruptive to basic supplemental coverage.

We have spent the intervening time thinking of an alternative that more uniformly achieves these preferences.

Thus, we present an alternative system for establishing benchmarks that conforms to Commissioners' preferences and immediately replaces the current quartile structure. The system removes the quartile base 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.

We compare our simulations with current base benchmarks which do not include quality bonuses and are an estimated 103 percent of fee-for-service. 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. As we alluded to earlier, an alternative structure for MA supplemental benefits will require a longer-term discussion in the future. More detail on the underlying assumptions used for our simulations can be found in your mailing material.

There are three parts of a blended benchmark alternative and which we will ask the Commission to focus on: one, how to weight local and national spending in the

blend; two, whether benchmarks should have a floor and ceiling relative to local fee-for-service spending; three, what level of savings should be incorporated into benchmarks through a discount rate? We will go through these aspects in the next few slides.

First, we turn to the weighting of local and national fee-for-service spending. We focus on comparing current base benchmarks, as seen in the row in italics, with blended benchmarks under 50/50 weighting. While we modeled three different local and national weights, the 50/50 blend is the most promising. We are happy to discuss the other options that are also detailed in your mailing material.

Overall, a 50/50 blend was the only option that moved benchmarks in the lowest-spending areas much closer to fee-for-service while also applying some additional pressure on the highest-spending areas. For example, looking at the 10th percentile with fee-for-service spending in the second column, benchmarks would be lowered to 106 percent of fee-for-service, which is down from 113 percent currently.

One related consideration is whether Medicare

should set benchmarks in the lowest-spending areas above fee-for-service spending in perpetuity or gradually decrease benchmarks closer to 100 percent local fee-for-service in these areas.

Next, we turned to whether it is appropriate to apply a benchmark ceiling and floor relative to fee-for-service spending. Under 50/50 blended benchmarks, 529 counties had benchmarks below the current 95 percent quartile factor.

We looked at the average bid within each of these areas and found that MA plans showed a propensity to bid far below fee-for-service spending in most of these areas. We also found that once blended benchmarks dropped below 90 percent of fee-for-service, they tended to affect rural areas with low shares of MA enrollment.

To balance plan availability and the impact on overall spending, we simulated a blended benchmark under two contrasting scenarios: one, a 95 percent floor with 115 percent ceiling; and, two, a 90 percent floor with 115 percent ceiling.

Now we turn to a level of savings that the program should target through a discount rate. Without

applying the discount rate, the program is unlikely to share in plan efficiencies and achieve savings. We simulated a discount rate of 2 percent. Under a 95 percent floor, lowering all blended benchmarks by 2 percent yields savings of 1 percent. Savings of 2 percent are yielded with a 90 percent floor.

While a blended benchmark structure would remove the payment quartiles, we examined payments by quartile with fee-for-service spending to compare with current policy. As seen in this cell on the right-hand side circled in yellow, a 90 percent floor helps ensure modest savings of 1 percent in the highest quartile areas.

With that, we pull together three policies: a 50/50 blend, a 90 percent floor, and a 2 percent discount rate. We use these assumptions to assess availability of basic supplemental coverage in the next slide.

Under a blended benchmark structure, nearly all beneficiaries would continue to have an MA plan available with enough rebate dollars to cover 2020 levels of cost sharing. Also, beneficiaries would have access to nearly the same number of plan sponsors that could cover cost sharing under current policy. Even beneficiaries in the

lowest-spending quartile areas, indicated by the second column, would have access to five different plan sponsors offering 12 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, the relative disruption to beneficiary access to MA basic supplemental coverage would likely be modest. These simulations do not assume any change in plan bids. If plans reduce their bids by half of the decrease in benchmarks, nearly all plans would be able to maintain current levels of both cost sharing and premium reductions.

Overall, blended benchmarks are one immediate way to help Medicare realize MA's potential. The Commission's June 2020 report contends that the growth in Medicare spending poses a significant challenge, and MA, along with ACOs, have the potential to serve as vehicles that address that challenge.

MA has not realized this potential in no small part because of its benchmark structure. Applying appropriate financial pressure to MA benchmarks through a

blended structure could help the program realize savings and broaden value-based payment in Medicare as plans become more efficient overall.

Over the long term, we may examine the potential for a more substantial overhaul of the MA payment system. As noted in MedPAC's earlier work, several other aspects of the Medicare program are worth considering in conjunction with such an overhaul, such as redesigning of the Medicare benefit and standardizing MA plan options.

The approach we discuss today would not preclude such longer-term changes to the MA program but would more immediately address current problems created by MA benchmarks and produce savings to Medicare. In the near term, we are seeking input on a blended benchmark alternative that could be implemented relatively quickly.

For Commissioner discussion, we have the following questions:

Does a blended benchmark of local area and national fee-for-service spending appropriately balance financial pressure with geographic equity?

Should additional financial pressure be phased in for areas where benchmarks would still be above fee-for-

service spending?

Is it appropriate to have a benchmark floor and ceiling relative to fee-for-service spending in each local area?

And, finally, is 2 percent the appropriate level of savings for the Medicare program to share in MA efficiencies?

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

DR. CHERNEW: Thanks so much, Andy and Luis. That was terrific.

There is so much here. I have not seen any Round 1 questions, which, by the way, is good. Don't feel obliged to have one, although, Pat, I am going to lead off with you for Round 2 anyway. So maybe I could just go to you, Pat, and you could ask your Round 1 question and jump into your Round 2 comments. If anyone else has -- oh, Jaewon does. Here we go. We're getting some.

All right. Pat, you go first with Round 1, and then we'll go to Round 2.

MS. WANG: Round 1, yeah, I think that makes sense. Okay. Yeah, there's a lot here, so my questions

may be relevant or not relevant.

So the blend takes the market area, in this case county area, fee-for-service per capita spending and blends it with the sort of median of all counties or market areas so treated, right?

MR. SERNA: That's correct, yes.

MS. WANG: Okay. Is the national average cost component of that adjusted for cost of living before blending, or is it just a straight dollar amount per capita?

MR. SERNA: It's a straight dollar amount per capita that's risk-adjusted to a beneficiary with average risk.

MS. WANG: Okay. In the paper on page 18, Footnote 12, it kind of goes through some of these components of blending. But I am not sure that I'm following it because the terms -- you know, I can interpret the terms to mean different things. So could you just clarify? It says that national spending, you know, assuming -- so you have local area spending and national spending being the median of the local area per capita amounts. It then says that beneficiary average fee-for-

service spending was 4 percent higher than county median fee-for-service spending in 2020. What does that mean?

MR. SERNA: The United States per capita cost was 4 percent higher than the median --

MS. WANG: Okay.

MR. SERNA: -- across all local areas.

MS. WANG: I got you. So if you just took a straight average of the fee-for-service per capita, per beneficiary spending would be 4 percent above the way that we've done it here --

MR. SERNA: Yeah.

MS. WANG: -- which is the median of the counties.

MR. SERNA: Yes.

MS. WANG: Do you know further what taking the median of the median of all of the counties further does?

MR. SERNA: We don't. So we use CMS' estimates at county level, and they report the average.

MS. WANG: Okay.

MR. SERNA: In each county.

MS. WANG: Are there other instances in Medicare payment policy where we have taken unadjusted national

average cost calculated this way, medians of county fee-for-service spending unadjusted to blend into things like hospital wage index or RBRVS or what have you, actual dollar amounts to drive payment levels?

MR. SERNA: I can't speak to that.

MS. WANG: Okay. It's just curiosity. And can I just ask you, on Slide 17 can you just say what -- there was the last bullet that applying this financial pressure through blended benchmark structure could help broaden the use of value-based payment. Can you explain what that means? How do you see that happening?

MR. SERNA: Sure. So the thought is that as a little bit more financial pressure is applied to plans, they'll have to use payment structures that use more value-based payment. Of course, half or more plans are still using fee-for-service payment.

MS. WANG: Okay. Thank you.

MS. KELLEY: Okay. I have Jaewon.

DR. RYU: Yeah. I have a quick follow-up question on one of Pat's question and then a separate question. The separate question is on Slide 13.

You had mentioned -- I think, Luis, you had

mentioned that you modeled 50-50, and then I think 70-30 and 90-10. And you made a quick mention of if you had weighted it the other way, where there would be more national versus local, it would not yield net savings? Or can you just walk through that again?

So, for example, if the mix was 30-70 instead of 70-30, what would this chart look like?

MR. SERNA: All right. So it would put less financial pressure on the local areas and put more on the -- I'm sorry -- on the low spending areas and put more on the high spending areas.

So the thought from what we gathered from the November discussion was that several Commissioners wanted to bring spending closer to fee-for-service, closer to 100 percent local fee-for-service. So that's basically what we found is if you go below a 50 percent local weight, you start deviating from that much more.

DR. RYU: Okay. Then the other question gets back to the wage index question that Pat asked. If you had adjusted for wage index differences, what would the spread look like across the different quartiles? Do we have a sense of that? In other words, how much of the spread is a

result of the wage index differences, I guess?

MR. SERNA: So I can't speak to that directly. I would assume that some of it is, but I can't speak to that directly.

The reason why CMS does it this way is because it's what the actual payments are. So if you get more into kind of cost-of-living adjustments, you get further away from what plans are actually paid, and you make this that much more complex.

DR. RYU: Thanks.

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

DR. CHERNEW: Paul had something on this point.

DR. PAUL GINSBURG: Yeah. Let me begin. I was perplexed about these questions about wage adjustments because this is all pegged to the fee-for-service experience, which already has all the wage input and other adjustments build into it. So as long as Medicare Advantage is being pegged to the fee-for-service spending, it's got all those adjustments built in.

DR. CASALINO: Yeah. Dana, I was going to say exactly that, except Paul said it more concisely.

DR. CHERNEW: Yeah. I think when we visit that, I don't want to get distracted here, but it's really the national part which has an overall thing. So if you were looking in Miami, you'd have the Miami local, which is all that built in, I understand, but the national portion of the blend wouldn't have the Miami-specific adjustment. So some of the amount has to stay consistent.

I don't think that's a big deal for the issues we have to resolve here. So we can sort through that when we get to where a recommendation might be. We're obviously not quite there yet, but I think, Pat, you raise a very good point. I think it is, in some sense, what I would call a technical fix to the -- or a technical adjustment to what's been proposed, but I don't think it's a fundamental change in the nature of what we're doing.

Luis and Andy, do you have any reaction to that?

MR. SERNA: That's exactly right. Yep.

MS. KELLEY: Okay. Bruce, I have you next with a Round 1 question.

MR. PYENSON: Yeah. Thank you very much. This is really terrific work and very provocative, which is a compliment.

I've got two questions. One is in the various simulations, you have described the assumption that plan bid behavior does not change, and in a couple places, you've said that plans might actually bid lower.

But I'm wondering if you've considered that some of these changes would cause plans to bid higher, and in particular, there's enormous pressure, as you mentioned, for plans to bid low to generate rebate because that's how you get members through the supplement benefits.

What I would ask, how do you think about that, the opposite happening, with some of the changes, that some of these changes could actually cause plans to bid higher than they're bidding now, and what effect would that have? That's one question.

The second question, which folks are used to hearing me ask about, is on page 22, you talk about a gradual phase-in of some of these changes, but I don't see any rationale for gradual change or a comparison to changes that had been done in previous years, some of which were pretty dramatic. And MA grew through those. So do you have any evidence that suggests a gradual change for these kinds of changes has any justification?

Thank you.

MR. SERNA: Yeah. Sure. So I'll take the first question. So on the first question, when we thought about this, what we reported in the past is that when plans lose their Star bonus status, they tend to lower bids to keep the same level of rebates to stay competitive at a rebate level because there is so much competition in a typical MA market. It seems likely that plans would want to maintain their rebate levels, and that's how they responded in the past.

And that's another reason why we also did the analysis that looked at the availability of plan sponsors, which was close to unchanged as far as the number of plan sponsors that could offer a plan with the same levels of both cost sharing and premium reductions.

MR. PYENSON: Just to follow, maybe I wasn't clear on my question. If the rebate and supplemental benefits are -- so a plan might decide to take a loss so that it would gain members to be able to spread its administrative costs and to gain scale, and without -- so that's part of what's driving lower bids.

Some of the changers we're talking about would

take away that incentive to reduce bids, and so I think plan behavior is just really important. And I'm wondering, trying to think of how to think of the different sides of that.

MR. SERNA: Sure.

DR. CHERNEW: If I can jump in, Andy and Luis?

MR. SERNA: Yeah. You can go ahead.

DR. CHERNEW: I've done some research on this. There is a literature on this. I think the general sense is I'm going to give you a number for my paper because I'm not egocentric, but others, Mike Geruso, for example, has done papers and finds a somewhat similar number.

A $1 change in the bid, a drop in the bid, has been shown to have a -- a drop in the benchmark has been shown to have roughly a 50 cents drop in the bid, which is consistent largely with what Luis and Andy were saying earlier.

I suppose the converse is true. If you raise the benchmark, you might expect bids to go up but not dollar for dollar. So that's a scoring issue that one could adjust, and I think there's this core question about whether we should in the formula have anyone end up with a

higher benchmark or whether we should pressure all around. That's a question I'll leave for Round 2.

But the sort of Round 1 version of your question is I think the academic literature is pretty clear that if the benchmarks go down, the bids go down, but not dollar for dollar.

MR. PYENSON: Yeah. I'm glad the academics are looking at this, the behavior of what actuaries are asked to do, like offer some insight from the real world. So I think the issue that we're asking is not the empirical behavior but the motives and what would happen in a change.

DR. CHERNEW: We'll continue that probably in a different round.

Luis, do you want to jump in?

MR. SERNA: Right. So from a behavioral perspective, we would see the same, roughly the same number of plan sponsors in each market, so that competitive incentive would still be there to offer high levels of rebate dollars, even as you put more financial pressure on plans.

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

MS. MARJORIE GINSBURG: Yes, I do. Thank you.

I'm interested in the research on the impact of patient cost sharing on the decisions about choosing original versus an MA plan.

Everybody knows that if you get a supplemental plan, you have almost no cost sharing whatsoever. With an MA plan, you have lower monthly premium costs to get in, but once you're in, you have higher cost sharing when you're seeing providers and such.

So the question then becomes are MA plans doing better because of their cost sharing is reducing demand, and once you're on original Medicare with a supplemental, with very little cost sharing, is that what is inducing a higher demand because there's so little stop there? So it's this balancing of the impact of cost sharing on beneficiaries' decisions.

So I hope this isn't too far afield, but I wonder if our staff can talk about that at all.

MR. SERNA: So we commissioned a study, I think, in 2009, and that's exactly what we found, and we also reported in 2012. And Bruce has done similar work seeing that there is an inducement of higher utilization when you

have first dollar coverage. So that's is at least partially where MA plans are getting some of their efficiencies from.

MS. MARJORIE GINSBURG: Maybe this is an add-on to that, and maybe this is a question for the future, and that is MA plans using their extra dollars to provide extra benefits but not necessarily lower cost sharing, and whether that at all is -- we just leave that alone or whether we as MedPAC have any comments that luring people in with gym memberships is not necessarily the best use of the taxpayers' dollars.

MS. KELLEY: Dana, did you have a Round 1 question? Oh, I'm sorry. Andy?

MS. MARJORIE GINSBURG: That was a question, I think.

DR. JOHNSON: I was going to say I think that's some of the commentary in the paper about the potential for that concern, and that there is some limit on the amount of cost sharing reductions that plans would be willing to offer, that they wouldn't want to go all the way to a first-dollar coverage situation like Medigap plans sell.

So there is some money going to other extra

benefits that the plans offer, and that share is growing. So we are highlighting that for discussion at the Commission.

MS. KELLEY: Dana?

DR. SAFRAN: Yeah. Just a couple of questions from me, and this slide that you have up is a good one for my questions.

So one is that I'm trying to understand your appreciation, let's call it, for 50-50 versus the 70-30, because I thought that based on some discussion that we had last time that one of our objectives was really trying to get everyone as close to 100 percent of Medicare as possible, which, of course, 70-30 does -- actually, 90-10 does even better, but so I was just curious about that.

And then I also wondered why do we not test some models, or did you, that weighed nationally more heavily than local?

MR. SERNA: So what you said is true that that was one of the preferences that Commissioners expressed, but also given the options that were presented in November, there was also a lot of discomfort expressed with raising benchmarks for some plans, plans that had a 95 percent

quartile factor now going to 100 percent.

There was also a little bit of concern for plans serving the lower spending areas and whether they would be able to have basic supplemental coverage available for beneficiaries if this change were to happen immediately.

So we were trying to balance those two things in tandem, and the 50-50 blend was the one that balanced those two things.

Of course, we did look at several different kinds of weighting factors, aside from these three, but once we got to a lower local weight, we started to get away from the other preference that you express, which is getting everyone closer to 100 percent of fee-for-service.

Now, whether you would rather go with a different weighting structure, that's up to the Commission.

DR. SAFRAN: I think it would be helpful to just see what that would look like because I think if we stand back and we understand that Medicare pays the same rates pretty much across the board and so the differences we're seeing by market are not about different prices for the most part, they're about different utilization patterns, it does make you want to lean toward a national benchmark

versus a local one that might perpetuate those differences.

So maybe that was a Round 2 comment, but since I have to sign off for a little bit in four minutes, I'll just squeeze that in there.

Another question I have is, do we have any information or evidence about how quality outcomes or experiences compare across the quartiles? In other words, we know we're giving people more benefits, but do we know if there's a difference in performance across the quartiles?

MR. SERNA: We don't really have a comparison across the quartiles, mostly because the quality measurement is done at the contract level, which can span wide geographic areas, sometimes non-contiguous states, and that those are going to cover, in a given contract, multiple counties in different quartiles. Aside from the other issues we have with the measurement of quality in MA, there's that reason we haven't done a quartile-by-quartile comparison.

DR. SAFRAN: Okay. And then my last question, kind of thinking about our ACO work, is there a reason that benchmarks can't be set relative to a plan's own historical

experience and then a blend of local and national?

MR. SERNA: That's certainly a possibility, though that would be for you all to discuss.

DR. SAFRAN: Okay. Thank you.

MS. KELLEY: Amol?

MR. SERNA: In some way --

MS. KELLEY: Oh, sorry.

MR. SERNA: The historical experience is included in the bid, and the basis of that has some -- the basis of the bid has some historical information, but that would be a different policy of basing benchmarks on some prior bid information.

DR. SAFRAN: Thank you.

MS. KELLEY: Amol?

DR. NAVATHE: I'm going to forego. I'll just comment in Round 2.

MS. KELLEY: Jim, did you have something you wanted to get in here?

DR. MATHEWS: Yes, I did. So to go back to the question that Pat asked early on in Round 1, Pat, you asked if there was precedent for Medicare using national and local blends in other payment areas. I don't have any

direct analog for you, but it would not surprise me if one exists.

But there was an indirect one in that currently MSSP benchmarks are set using a blend of the ACO-specific experience and the regional experience, and so there is a little bit of precedence that we could point to for proposing something like this.

DR. CHERNEW: Okay. I think we have 45 minutes. I imagine we're going to have a rich discussion. I'm going to go to Pat in a second. I just want to make an important framing point.

There are two distinct questions on the table and I want to be clear when you talk as to what you're relating to. One is what I will call, broadly speaking, the direction of the form of payment, essential a local blend, and the second is what I would call technical adjustments or preferences about how aggressive or not aggressive to be. So an example would be adjusting for geographic area, the national part, or moving from 50/50 or 90/10, or in the other direction, as Dana was talking about, or changing any other aspects of the discount factor or other things that are going on.

I'm really looking for a sense of how aggressive you think one might be in terms of setting the formula. But that is a different question than the type of formula that uses blend as opposed to the quartile cliff. And understand that we could take the formula and make it more flexible. So we could have a different blend even if you're above or below the national average or some version of that, if you wanted to do something differently.

For now, let's go on to you, Pat. Then we're going to go to Bruce and to Jaewon.

MS. WANG: Great. Thank you, and thank you for the work. I think attacking the failings of the quartile system is a really good idea, and I just appreciate, Michael, what you just said about, you know, tinkering with elements of it.

So there are a couple of comments. First, you know, I do want to reiterate the importance of the Commission's past work on encounter data submission, the risk score recommendations, particularly moving to two years, contract consolidation and Stars, because these are all things, especially the last two, that have driven up the bidding behavior and the cost of the MA program. So I

want to start with the importance of those.

I also, when it comes to, not the lower -- the higher fee-for-service quartiles, reiterate, as the paper notes, that those quartiles do save money for fee-for-service today, so the aggregate overall observation that their no savings is aggregated and it's not broken down by the quartiles.

On the tone of the paper I just want to kind of, for the future, I just want to make a comment that I think that there's a tone in the paper around supplemental benefits that needs to come down a little bit, you know, because on pages 9 and 10, for example, there is some suspicion that supplemental benefits are kind of being gamed because plans can load admin and profit into them, and I just don't think that's a correct assumption. I think supplemental benefits are real benefits to a lot of people. You know, actual experience is used for the supplemental benefits. You allocate what dollars you have, based on utilization.

So there is some kind of suggestion in the paper that I suggest we tone down a little, that somehow plans are loading up kind of phony supplemental benefits to

leverage this admin and profit thing.

I will also say that our experience is that the supplemental benefits, besides cost-sharing reductions and premium buy-downs, are very valuable to a lot of beneficiaries, particularly lower-income, not even down to dual status, but lower income. Oral care, falls prevention, medically tailored meals post-discharge, these are all very valuable, they are highly utilized, and I do think they have a relationship to reducing avoidable readmission and so forth.

In terms of work, you know, the blend which I appreciate this may be technical, but on Slide 13 this work I think succeeds in eliminating the cliffs, but my understanding from the subsequent recommendation to take an additional 2 percent discount factors, it doesn't actually save money.

And so I guess that my question is whether, you know, sort of why are we doing this, and it goes to Dana's question around if it's to get the benchmarks closer to 100 percent of fee-for-service, I think that the middle scenario is a little bit more attractive. It's harder on the low fee-for-service areas but it maintains some of the

status quo in the high fee-for-service areas. I don't think that you can go below 95 percent. Just my personal view.

I realize that in the high-level analyses that you did within the quartiles it might appear, from a percentage basis, that that's viable from a modeling perspective, but my great concern is that there's a huge amount of heterogeneity inside of each of those quartiles, and that those high-level sort of conclusions around you can bid at 90 percent, you can bid at 80 percent are a little bit too broad a generalization. That's what I fear, and I worry about that.

The question that I raised about the cost-of-living adjustment for the national spending, if I could just belabor that for a second. I understand, Paul, absolutely I agree with you that the local area spending obviously certainly reflects things like modification that we do have in the fee-for-service system, wage index, and RBRVS being two that I can think of. You know, Jim, I appreciate your comment about the ACOs and the blend regional and national, but I think that that has more to do with the trend factor that's applied to establish the

benchmark as opposed to the actual dollars.

And so I guess where I'm still struggling a little bit, and when you look at this chart on page 13 it kind of bears it out, the high fee-for-service areas sort of -- their benchmarks go up when the blend relies more on local spending, and the converse is true of the low fee-for-service areas. I guess that I sort of feel like there's a relationship between the high fee-for-service spending areas and cost of living that's reflected in wage index and some of those other modifications that we do make to the payment system. It's not all uniform. It just concerns me that the fee-for-service amount that we are blending is actually pulling down averages in different areas, or raising them maybe not appropriately. I may be wrong about that but it's kind of a question.

Again, the quartile analysis in Figure 2 is kind of the basis for testing the different scenarios. This is okay, it puts more pressure, people can still afford supplemental benefits. You know, there's an implicit sort of theme, like if I could overstate it -- it's not stated this way in the paper, of course -- but the only supplemental benefits worth really preserving are cost-

sharing reductions and premium buydowns, which I totally support, cautionary note about the value of other supplemental benefits, although I certainly understand the desire to rationalize them a little bit, and I think that's fine. But I would just be a little bit careful about that.

Again, I'm nervous that Figure 2 sort of starting point that is our benchmark to sort of say we can go deeper, we can go deeper. The 95th percentile, or the highest quartile in there, there's mention in the paper about very outlier characteristics of the Miami-Dade experience, and I just worry that outlier situations like that, high and low, may be distorting what is shown in that quartile analysis.

The other thing, and I asked to this when we saw a version of this earlier, in that Figure 2 quartile analysis it includes the Stars bonus, but the subsequent modeling assumes that there is no Stars bonus. I'm still a little bit worried that the distribution of the Stars bonus may also be skewing the way the quartiles look and what the bidding behavior looks like. So I wonder whether there is a possibility of taking that out and sort of doing an apples-to-apples comparison -- here's the quartiles today

and the bidding behavior with Stars included in the revenue available and here's what it looks like without the revenue. I also wonder whether it might be worthwhile, in looking at the quartile analysis, to take out the outliers, high and low, so that you -- whether that increases the reliability of it.

The reason that I asked about the value-based payment comment, Luis, which I really appreciate and I think it should be a goal of the MA program, absolutely, and it has to do with my worry about, you know, like Slide 13, lowering benchmarks in the high fee-for-service areas, even below where they are now, and then taking an additional 2 percent discount factor. At a certain point, providers will do better under fee-for-service, because fee-for-service will actually represent their sort of special adjustments for cost of living.

And I think that I actually have the opposite concern to your optimism that it would actually pull back on value-based arrangements, because providers, at a certain point, would feel like I'm better off just taking my fee-for-service payment fully loaded than having to deal with a plan whose benchmark is now 90, which is going to

squeeze the heck out of me, because the 90 percent is actually based on a blend that represents lower-cost providers. So I'm nervous about that.

The final comment, I guess, is, again, reiterating, I think we should not go below 95 percent, however we get there. I think that's really too aggressive. I would prefer to see us fiddle more with rebate percentages than benchmarks, the reason being if the desire is to get savings and to sort of smooth a little bit the availability of supplemental benefits, I'd rather that a community plan, which is not able to bid 90 percent, not able to bid the AB benefit for something that makes sense in a 90 percent benchmark, could have the opportunity still to bid their actual experience for providing the AB benefit and maybe provide less in supplemental benefits so that they don't get put out of business. I'm concerned about the heterogeneity and the substories that exist inside of the rolled-up analysis and observations about the quartiles.

The final thing that I would say is -- this is just a personal -- the term "geographic equity" is used in the paper, and I think that what is meant there is equity

of the availability of supplemental benefits, you know, people in one part of the country should have access to the same supplemental benefits as in other parts of the country, and so part of this blending proposal is to try to get there.

If it's possible to use a different word or a different term than that, I mean, especially these days, honestly, I think of geographic equity as being we're sending more money to the Bronx, not less money to the Bronx, and I have a personal reaction to the use of the word "equity" in that term. Just a personal thing.

The last thing, you know, let me just throw this in. A curiosity that I have always had in setting the benchmarks, whether it's today or under a future proposal like this, is the treatment of DSH and UCP that is paid to hospitals serving high proportions of low-income and uninsured patients. Unlike IME, which is pulled out on the benchmarks side as well on the payment side, mostly, DSH is not.

And so to the extent that -- and I'll use my example of Bronx County, overwhelmingly minority, overwhelmingly poor, highest COVID death rate in New York

State, multiple, multiple issues of social determinants of health and health inequities -- the rate of DSH payments and the concentration of high-DSH hospitals there drives the fee-for-service benchmark. And we could have an interesting conversation about how that translates to plans that are serving folks who live there.

But I just wonder whether that is also something in this blending approach that might be worth taking a look at, because the more you blend to national averages the more all of these distinctions, which were put in there for a reason, to target specific situations, gets sort of washed out in the blend. And so I guess that I would want to make sure that -- it might be an area of opportunity also to think about, not as an SES adjustment per se but to do something in benchmarks that represents the condition of a locality as opposed to trying to come up with SES adjustments for members, if that makes sense. I'm happy to pursue that further with you.

Those are my comments. I'm sorry. It's --

DR. CHERNEW: No, I was just thanking you, because we have a half an hour and we have about 16 people to talk.

MS. WANG: Thank you.

DR. CHERNEW: So I want to thank you, Pat. Luis, I think you want to say something, so remember, we have about a half an hour and about 16 people to talk.

MR. SERNA: Yeah. I just want to clarify that we died look at the distribution with any quartile by plan, which is what Figure 2, it's bids relative to fee-for-service spending, so that's apart from the actual benchmarks. And we also looked at it by county, where most counties within that highest spending quartiles bid far below fee-for-service spending. That's it. Thanks.

DR. CHERNEW: Okay. Bruce, if you can go with your comments, and then we'll go to Jaewon, and then I'm going to try and make sure we can move quickly through people, to make sure everyone gets to comment on our direction. Bruce.

MR. PYENSON: Thank you. Both Pat and I are from New York so we talk fast.

I share Pat's concerns, almost all of them, but I am supportive of the proposal and I think we can address the concerns that she has. And it's really important to address those concerns.

One thing, I've been very struck in my four years as a MedPAC Commissioner at the deep support for Medicare Advantage that the current crew of Commissioners and others I've interacted with, and I think that's because we recognize that there is something about Medicare Advantage that addresses population health, that addresses medical management, that addresses quality, socioeconomic determinants, other aspects of health care that's missing, that's largely missing from the fee-for-service world, and in the past we've characterized ACOs as sort of halfway to Medicare Advantage. So I think Medicare Advantage is something, there's broad consensus to support.

I think the framework that has been presented to us is a stepping stone in the right direction to have the Medicare program gain from the successes of Medicare Advantage. I'm going to suggest some other things, additional things that have to be done and things that I think should be done to address the disadvantage that plans that focus on local populations have, and some of the other gaming. Some of this are things that MedPAC has recommended in the past that are absolutely essential for the survival of the local plans and the various provider-

sponsored plans, and I'll get to that in a minute.

What I would say about the framework, I am not particularly concerned with the cliffs in and of themselves that the current benchmarks have. I think they're not elegant and there's better ways of doing things. What I would say is that a simple weighted average of national and local is better than the cliffs, but it's also too simple.

In actuarial science we often use a credibility formula -- it's a curve -- and that could provide a greater weight for national, for the highest-cost areas and a lower weight for national in the lowest-cost areas. It's way less complicated than anything we're doing now with benchmarks, so I think there's some real validity there from a policy and a flexibility standpoint. So I would urge us to --

DR. CHERNEW: I'm sorry to interrupt, and mostly because I want to emphasize a point. Pat said she wasn't comfortable going lower than 95 percent in the highest set of counties and you just made a comment that implies you are comfortable going below 95 percent in the highest fee-for-service counties. So sometimes it's really impactful if I just can call out a very specific modeling choice. I

know there's not a lot of time.

MR. PYENSON: Well, you know, that's a very specific modeling choice but I think the answer is different if you're in a high-cost area or if you're in a low-cost area. I think a reasonable goal for policy is that the low-cost areas are doing something right and they're doing it okay, and we don't want to encourage them to go higher cost. They should not be higher cost. I think my overall perspective is that we need to move the system to overall lower cost, so otherwise we are never going to meet the goals, the bold goals that, as we said, the Susan Thompson challenge. So I call that a credibility formula, and once we've created it, we can calibrate it in various ways.

I do want to emphasize that the current system is incredibly complex and it's really hard to take one thing at a time, or even a few things at a time. And in particular, the world we live in, in MA, is this endless cycle of bids where the bids are created at pretty much the beginning of the year when you don't even know what the results from the previous bid were. And the Medicare Advantage plans are chasing members through supplemental

benefits that often are much more marketing than anything of substance. And, frankly, you know, we all talk about evidence-based medicine, and there's probably zero or negative evidence for a bunch of the benefits I've seen.

I think we should move to standards for supplemental benefits to take away this chaos of redesigning supplement benefits every 12 months. And in particular, we've talked about value-based insurance design and value and how hard it is. The very basic value here is that we could consider that supplemental benefits have to go to reduce the Part B premium, have to go to reduce cost-sharing, and maybe a limited amount for supplemental benefits. If we do that, that could force the plans to compete on real value, meaning dollars saved by Medicare beneficiaries.

I think supplemental benefits are critical for dual eligibles, so we need to address the duals in a different way. And so I would separate the dual eligibles, including low-income subsidy folks, from the broader population of Medicare Advantage, because there are particular needs there that supplemental benefits, as we have them now, are addressing, and they're really

important.

But I want to end by saying that the previous MedPAC recommendations are really critical to fixing the benchmarks. So we have -- one of the recommendations was to use two years of history for risk score calculation. Why is that critical? Well, that takes away most of the value of risk score optimization. We have organizations that are investing hugely in optimizing risk scores, optimizing quality, the various metrics that are out there, which they can do because they're well-capitalized organizations, and the innovators have a rough time doing that, smaller regional plans. So some of those recommendations are absolutely critical to fixing benchmarks, fixing supplemental benefits, and getting a level playing field. Otherwise, what we risk doing is actually promoting the further consolidation of the industry, which is not a good thing in my mind.

So I'll hand over the virtual microphone to you, Mike.

DR. CHERNEW: Great. So, again, now we have 20 minutes and we have 15 people -- or 14 people. So, again, I'm going to -- I apologize in advance if I start making

noises while you're talking, but I really do need to get everybody in, and that's going to send us to Jaewon, and then we're going to go to Brian, Larry, Jonathan, David. But then I will do a slashed version where I'm going to look for very quick reactions to where we're going. Jaewon.

DR. RYU: Yeah, so thank you. Just a couple thoughts.

On the form of payment from a broad concept standpoint, I'm in favor of some sort of blended approach that gets us away from the cliffs and the quartiles. I think that makes sense.

That being said, I think -- and Bruce touched on this, as did Pat. I think the story differs depending on which of those quartiles or which end of the spectrum you're in. And at a very high level, I think about the Medicare Advantage program, the goal, if you're a plan, is to beat fee-for-service. And if you're in an environment or a county geography where the spending levels are already low, it becomes that much tougher to beat fee-for-service versus if you're in one of the higher-spending counties.

Now, that's all other things being equal, but I

think the concern is all other things aren't necessarily equal. So you might be in a higher spending county or area, and you may have more lower-income members. And, of course, that makes it tough or tougher to beat fee-for-service spend as well.

So I just feel like if there's some way to recognize those differences, and it may need to be a slightly different formula or split between local and national, depending on where you are not only geographically with what the fee-for-service level of spending is, but also where you are relative to, you know, the mix of your population, I think a model that takes those things into account would be more desirable.

MS. KELLEY: Brian.

DR. CHERNEW: Thanks, Jaewon.

DR. DeBUSK: Thank you. First of all, I really enjoyed reading the chapter. I think the methodology is sound. I really like the 50/50 split. I think it creates the right balance between a drag on the high-spend areas as well as giving a little bit back or giving a little bit of room for the low-spend area. So I like the 50/50. I do like you taking the rebates straight up to 75 -- to a fixed

75 percent. Again, I think the methodology is good, and I support it.

Thank you.

DR. CHERNEW: Brian, that was brilliant in its brevity.

MS. KELLEY: Larry is next.

DR. CASALINO: I'll also be brief and won't get into detail, but I wondered reading this why it wasn't more aggressive. You know, we have several decades of Medicare Advantage now. It hasn't saved money ever. What has happened is some large health plans have become very large risk themselves with taxpayer money and begin buying up other components of the industry.

There is perhaps for some people a presumption that Medicare Advantage is important for advancing population health. However, as other Commission reports have shown, there really is no evidence that Medicare Advantage improves quality, never mind -- in narrow measures, never mind population health.

I think without going into the details, just in the interest of time, to me decision after decision in the report was very conservative and very unaggressive toward

plans. But I think the reason for that -- and I'll finish with this -- is not some kind of bias on anybody's part, but more kind of an attempt, which isn't too explicit in what's been written and presented so far, to deal t heterogeneity and particularly maybe heterogeneity in plan size and type. So there is a big difference between a small nonprofit local plan or even a regional plan and a big publicly traded national plan or international insurer, let's say. And there are other kinds of heterogeneity as well, including the geographic heterogeneity we've talked about and probably some others.

I think it might be better to try to think is there a way to address the heterogeneity directly without it making us, in my mind at least, too unaggressive in trying to get the Medicare Advantage plan program to actually save money for Medicare and demonstrably improve outcomes for patients.

DR. CHERNEW: So, Larry, I'm going to ask you but then future speakers as well about how you feel about aggressiveness in the higher fee-for-service spending areas. When you say that we're not being aggressive enough, what you just said, do you mean across the

quartiles or specific to any given type of quartile? I'm just thinking about the formula going forward.

DR. CASALINO: Yeah, yeah. So, I mean, that's one form of heterogeneity. I think there are people on the Commission better situated to speak to that than I am, Michael. So I'm not trying to dodge the question, but just not to use up any more time. It's an important question.

DR. CHERNEW: Perfect. Thank you.

DR. CASALINO: But I guess I would just say we shouldn't let an unspoken mental model that, oh, there's heterogeneity out there and we don't want to hurt plans of a certain type. We shouldn't let that tail wag the whole dog and let another decade go by where Medicare Advantage is still not saving money for Medicare and still not proving that it's improving care for patients.

MS. KELLEY: Jonathan Jaffery is next.

DR. JAFFERY: Thanks, Dana. So I'll also try to be brief. I also sort of endorse a number of the things that Larry just brought up and would favor being a bit more aggressive. I don't know, Mike, if this will get to your last comment, but I think Dana started to talk about this before she fell off the call, but I think there's an

overarching issue here about propagating some of the unjustified geographic variability in spending. We may hit on this tomorrow morning as well talking about advanced APMs and ACOs. But I think that to me that's a place that we need to start thinking about how do we get toward some sort of national benchmark overall. And, actually, Jaewon, you mentioned that there's, you know, higher-spending areas that may be easier to beat fee-for-service. That's the very similar issue with ACOs.

And so I would like to see us think about ways to be more aggressive and move towards that model, which then may suggest that we can be more aggressive in some of those higher fee-for-service spend areas to start with. So I'll leave it at that and probably talk about this more tomorrow.

MS. KELLEY: David?

DR. GRABOWSKI: Great, thanks. First, terrific work. I have about 25, 20 minutes of comments -- I'm kidding, Mike. I promise to be brief here.

I'm very supportive of this blended approach. I really think this is a nice kind of pathway. I in an earlier meeting was supportive of a competitive bidding

approach, and I appreciate why, and I think the chapter outlined that well, why we can't get there in the short term. But I believe this begins to correct issues with cliffs and geographic variation while also putting greater fiscal pressure on some of the plans.

I'm with Larry, Jonathan, and others in terms of being more aggressive in regards to weighting, use of the ceiling and floor, discount. I would favor a more aggressive approach. I believe the MA market is strong, and access to plans will be there under this blended approach, even with more aggressive rules.

A final point I'll make, and this is really to echo Bruce and Pat's remarks earlier. I, too, am worried about dually eligible beneficiaries in lower-income areas. I believe we can do what's proposed here and ensure sufficient payments to plans that serve these individuals. I think those goals aren't mutually exclusive, but they can be complementary, and so I would love to see that built in here. Let's not make those competing goals but, rather, ensure that we're also looking out for those lower-income dually eligible beneficiaries.

Thanks, Mike.

DR. CHERNEW: Terrific. Dana, was David the last in the official queue?

MS. KELLEY: Yes, he was.

DR. CHERNEW: Great. So now I'm going to go around starting with the people that haven't spoken, although if you want to jump in and you've spoken, you can. I think I saw Paul raising his hand. What I'm most interested to get us forward is to understand again sort of concisely, if you're supportive of the blend, several people have said they were, but remember I'm concerned if there's going to be a lot of opposition if a recommendation comes with that kind of approach, and then how aggressive you want us to be overall and particularly in various versions of the quartiles. You don't have to have an opinion on everything, but if there's something that's important to you, I'd like to hear that now, because you can imagine what's going through my mind in trying to think about where we can get the consensus, and that's best served by pointed comments about specific things.

So maybe we'll start with you, Paul.

DR. PAUL GINSBURG: Sure. I support the blended approach. I think it's a very effective way of getting at

a long festering problem. Striking that when Medicare paid too much in the 115 percent counties, what it got is a rush of MA, and it probably wasn't a very productive investment.

I would be more aggressive overall. I really like the point that has been made by a number that the previous MedPAC recommendations about coding and about quality bonuses are actually the most -- the first things that should come, but I'm not going to hold this, any approach to reduce the overspending we've had, hostage to if we can't get them through. So I'll just stop there.

DR. CHERNEW: Paul, thank you. Next on my list would be Karen, and then I'm going to go probably to Sue Thompson.

DR. DeSALVO: Well, I guess just on principle I think the more -- so the shaping principles for me as we move to first lower cost for the Medicare program, but not do that in a way that breaks a pathway of an accountable entity system, Medicare Advantage, that seems to be well liked or received by an increasing number of beneficiaries. So I respect and recognize we need to be aggressive in terms of savings, but also want to reflect that we need to be balancing that with quality, as we understand more about

the quality of the program and how to compare that to fee-for-service and other programs. I think that's going to help us get some better insights into what the Medicare program is actually buying here.

I do want to make the comment about the supplemental benefits which I know sometimes we think of as gym memberships, but there's a lot more that is done in the supplemental benefits that Bruce mentioned and maybe Pat about social determinants of health and ways that we're thinking more holistically about people's health and offering benefits, frankly, that even matter for physical health like dental. And so I just want to be cautious that we're being -- they have transparency about the quality and the value of what the beneficiaries are getting. Clearly, there's something in these programs they really like, but there's also a goal that's being met around having an accountable entity that's responsible for the total cost of health over time.

And then finally I just want to say, as always, we want to make sure we're not leaving anyone behind, so lower-income and dually eligible beneficiaries, I agree with David, I don't think we -- I don't think it's an

either/or. I don't think we have to make a choice, but I do think we need to pay a lot of attention to how aggressive we're being in terms of the benchmark and what that does to lower-income not only beneficiaries but some of the smaller regional plans that support them.

DR. CHERNEW: Thanks, Karen. Next on my screen is Susan Thompson and after that will be Amol.

MS. THOMPSON: Thank you, Michael. I'll attempt to be very succinct.

Broadly speaking, I do like the idea of blending national and regional cost. I think it's a fair way of encouraging MA plans in low-cost areas while providing some relief to the high-cost areas. But it's certainly a better methodology than the quartile scheme today.

On the technical side, I don't necessarily agree with adding the discount. That seems heavy-handed in a way to meet a goal that we might better meet in other ways, such as switching the Stars program to budget neutral or maybe getting after some of these rebates that we're paying. But, nevertheless, I just want to close my comments by saying we have 40 percent of our Medicare beneficiaries in an MA plan, so I really appreciate this

conversation and the fact we're getting after this.

I also just also want to jump on Jonathan Jaffery's comments about the connection of this conversation to that that we will have tomorrow around APMs and that I believe we're at a point we need to have a lot of conversation about harmonizing the benchmarks of MA to the work we've done in ACOs.

So I'll close with that. Thank you.

DR. CHERNEW: Thank you, Susan. Amol, and then after Amol is going to be Wayne.

DR. NAVATHE: Great. Thanks, Mike. So I think very elegant work, Luis and Andy, so thanks for putting it together.

I would like to voice my support, I think like many Commissioners, for the blended approach. While I think there's a lot of different things that we have work to do on, I think there's a practical approach here that accomplishes a lot of the goals. So I would say thumbs up on that.

I also, like David and others, would support a generally more aggressive tack here. For example, in the higher-spending areas, I think we could be comfortable

based on the bidding behavior that we're looking at right now, going below 95 percent.

I think broadly speaking I agree with Sue, though, it would be nice to see some symmetry across how we deal with MA and how we deal with A-APMs. Notably, on the APM side, we oftentimes in episode-based models and others feel comfortable doing discount rates to guarantee savings to Medicare. So it doesn't seem to me anathema to be able to do that on the MA side to drive a little bit more on the savings front.

I think in general I very much appreciate the idea that supplemental benefits have a lot of value in duals and low SES populations. I do think that we should also think about the value of how premium reductions are also extremely important. While we may not get there today, I think thinking about how we might reform that to guarantee more premium reductions as part of the bid below benchmark percentage or something like that should be an important piece of future work going forward, as well as some of the things that David outlined around competitive bidding and the like.

Thanks.

DR. CHERNEW: Amol, terrific. Wayne, we're going to go to you, then Jon Perlin is on my list, or at least on my screen.

DR. RILEY: Yes, I fully concur with the blended approach, as has been articulated by many of the Commissioners, and I really appreciate Pat bringing up the county-specific sort of dimensions, particularly in lower-income and the dual-eligible community, because as David said, you know, the goal is not mutually exclusive. So I am supportive, and I agree that an aggressive approach is probably prudent and warranted given the penetration of Medicare Advantage plans around the country, that we won't hopefully do too much harm by being aggressive, so fully supportive.

DR. CHERNEW: Thank you, Wayne. And then I think we have Jon Perlin.

DR. PERLIN: Thanks. Let me make three points on this. I appreciate the sense of the Commission that we want to see MedPAC succeed, and Bruce outlined some of the reasons. There's active management, there's quality, there's a population focus, and that active management is what the payers do.

I support a blend. I will diverge a little here from Bruce, I do think it's important to phase in both for the protection of the payers as well as the providers. I think Pat said it well. One immediate effect would be to sort of squeeze the providers, and not in the sense of active management of care, but in terms of other actions like denials, et cetera.

That said, I really like Bruce's notion of a two-year risk score to take some of the emphasis off of annual optimization.

Second, I would not be draconian in the high-spend areas, even with some of the area wage adjustments or readjustments, et cetera. The reasons for the high cost may not be under provider or payers' control, so I have some angst about that

And then, finally, with respect to the supplemental benefits, I think we need to specify the standard or essential benefits, but, you know, so there's more capacity to compare population outcomes, et cetera, in a reasonable way. But I wouldn't eliminate the supplemental benefits because I think if these are tools that the payer can use to actively manage and improve the

utilization, why would you strip them? I think those things become more self-limiting with the blended approach. And, by the way, one point that I forgot to make that in the phasing in, I would phase in over an increasing percent of national.

Thanks

DR. CHERNEW: Jon, thank you. I'm going to go to Betty, then Marge, and I think Dana is going to get the last word. I hope I've got everybody. If not, message me. Betty.

DR. RAMBUR: Thank you.

So in our materials, we had a question posed to us: Should Medicare Advantage have a greater role in Medicare solvency? And obviously, the answer is yes, and we're certainly hearing that. I support the blended benchmarks.

When I was first looking at this material and thinking about this comparison to fee-for-service, I was somewhat concerned, and of course, fee-for-service has a lot of inefficiency baked into the cake and a lot of small area variation that we know a lot about. So I would support a pretty aggressive approach in the high-spending

areas.

In terms of supplemental benefits, I need to ponder that a little bit. I had been more convinced by the data that hadn't found a lot of outcomes from it, but I'm also hearing and pondering the arguments for individuals from disadvantaged backgrounds benefitting from those. So I'm still pondering that piece, but I really appreciate the conversation and the effort.

Thank you.

DR. CHERNEW: Great. Marge?

MS. MARJORIE GINSBURG: Yes. Well, like, I think, the rest of you, I also support the blended approach.

I also support a really aggressive approach. It has been gnawing at me from day one that we pay MA plans so much and Medicare has not seen the financial advantage for the way this has been set up.

On the other hand, we also need to be realistic and pragmatic, and it worries me how often we make really fabulous recommendations that never get picked up by Congress or CMS. So it's let's do everything possible to make this work financially as well as good quality care,

but let's also get recommendations that we have some confidence are going to get passed.

Thank you.

DR. CHERNEW: And that brings us to Dana, and I think, Dana, you're going to have the last work. If I've forgot anybody again, Dana Kelley, let me know.

DR. SAFRAN: Thank you, Michael.

I will preface my remarks by saying I'm very sorry that I missed 30 minutes of the conversation, so really apologize if I'm repeating anything and really am sorry that I don't get to pick up and underscore things my colleagues have said.

I'll start by saying something that sounds like it has been mentioned, but the fact that this program has never had net savings was just so stunning to me and particularly in light of the conversation we'll have tomorrow and that, you know, the national conversation that's ongoing about the APM program and holding it to account, as we should, for achieving that savings. So that's just stunning and says to me we do need to get after this, as everyone has already emphasized.

I think I do like the blending approach. I

really support that, but as I indicated with my Round 1 questions, I'd like us to understand what the numbers would look like if we weighted more heavily toward national versus local and also explore the possibility of including a plan's own historic benchmark.

It sounds like I missed a great suggestion by Bruce around the possibility of two-year risk scores, which I think is a great idea, but I also wonder about using a provider's own historic benchmark or own historic spending as part of what gets into the benchmark as another way to help us reduce their kind of ever escalating impact of the risk scoring that we're seeing.

It strikes me that I don't think we fully understand what's driving the differences in spending across the quartiles, and I think that's critically important for us to do in order to really know how aggressively to go after this. So I would just say that if possible, doing some analysis to really understand the drivers of the differences in spending across the quartiles would be very valuable, but it could be that where that lands us is, yes, we should be really quite aggressive with our benchmark in the highest-spending quartile and strive

to get the lowest spending to something like 100 percent of fee-for-service, not so far above it.

Then finally, I would say that I would really encourage us. I heard Andy's explanation of all the complexity of trying to understand quality, patient experience, and outcomes across the quartiles, but that notwithstanding, I think we should do some work to really understand are we getting better performance from these different quartiles because I think that can further underscore the rationale for what we'll propose here because I suspect, as I imagine the rest of you do, that we're not going to find the areas where we're spending more, we're getting so much better patient experience, so much better quality or outcomes.

That's all. Thank you.

DR. CHERNEW: Dana, thank you.

I will say one thing in response to your comment, and then we need to move on to indirect medical education. There's obviously been decades since the work that Wennberg and the Dartmouth people did looking at geographic variation. I've even participated in some of that work with the National Academy of Sciences and other things.

My take is twofold, particularly in Medicare, where in Medicare, it's not prices. It's practice patterns. There's differences in how much of that is, for example, post-acute care versus not post-acute care, and there's literally, as I know you know, decades of research on geographic variation.

My take of the bottom line is we don't have a really good smoking gun for why the practice patterns vary so significantly across the country, and my general take is while I wish I knew the answer, mostly just like to publish more papers, I think we're going to have to act before we have full knowledge about what's going on. And we're going to have to decide how to do that.

So to wrap this up, I'm going to go back and brainstorm with Jim. What I took from this is, there's a lot of support for the blend. There's some heterogeneity for the level of aggressiveness. I probably heard slightly more speakers on the side of more aggressive than less. I think Pat's concerns are real, and, Pat, you and I can talk about some details of that. But that's sort of what I've taken away from where we are, and instead of belaboring that much more, I think we should jump right into the

indirect medical education session.

So I'm passing it over now to Alison and Jeff. I'm not sure which is speaking first. I guess I'll tell by the voice.

MS. BINKOWSKI: Thanks, Mike. This is Alison.

DR. CHERNEW: Hi, Alison. Thank you. Take it away.

MS. BINKOWSKI: I am excited to continue a discussion of Medicare's indirect medical education payments to acute care teaching hospitals. 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, with modifications and additional analyses in response to Commissioner comments and further research. This presentation will cover three topics: first, an overview of current Medicare IME policy; second, concerns with IME policy and potential principles for reform; and third, results from an illustrative revised IME policy consistent with these principles.

We anticipate that the information in this

presentation and your mailing materials will form the basis of the Commission's June 2021 report.

As a reminder, Medicare makes two types of additional payments to acute care teaching hospitals for the provision of graduate medical education. The first type is direct graduate medical education payments, which totaled $4 billion in Fiscal Year 2018. These payments support teaching hospitals' direct costs of sponsoring residency programs, such as resident stipends and physician salaries, and are made outside of the inpatient PPSs. The larger type is indirect medical education payments, which totaled $10 billion in Fiscal Year 2018.

These payments support teaching hospitals' higher costs of inpatient care that are not otherwise accounted for in the Medicare payment policy, such as unmeasured patient severity and additional costs associated with the teaching of residents. IME payments are calculated as a percentage add-on to inpatient PPS payments.

The treatment of teaching hospitals' IME costs varies across the three hospital PPSs and does not align with teaching hospitals' additional patient care costs.

When Congress created the inpatient operating

PPS, it specified an IME adjustment in statute, which it described as a proxy for factors which may increase teaching hospitals' costs that were not fully accounted for in the new PPS. The level of the IME adjustment was originally set at twice the estimated effect of teaching on hospitals' inpatient operating costs and remains well above the empirically justified level.

In contrast, Congress did not specify whether an IME adjustment should be included in the inpatient capital or outpatient PPSs.

HCFA decided to include an IME adjustment in the inpatient capital PPS but based it on its estimate of the effect of teaching on hospitals' total inpatient costs, not just capital costs.

CMS considered adding an IME adjustment to the outpatient PPS but stated it was not necessary to ensure equitable payments to teaching hospitals.

We note that because the inpatient operating IME adjustment is set in statute, if CMS had implemented an IME adjustment to outpatient PPS, aggregate IME payments would have only further increased above empirically justified levels.

The IME adjustment and resulting IME payments vary across the inpatient operating and capital PPSs but at a high level. For each teaching hospital, CMS calculates the hospital's teaching intensity, which is a measure of the hospital's residents relative to its inpatient size and subject to caps. The hospital's teaching intensity is converted to an IME percentage add-on, and this IME percentage add-on is multiplied by the base DRG payment for a Medicare beneficiary's inpatient stay. The result is Medicare's IME payment.

In Fiscal Year 2018, teaching hospitals received $9.5 billion in IME payments from the IME adjustment in the inpatient operating PPS, including $6.3 billion for facility beneficiaries' inpatient stays and $3.2 billion for MA beneficiaries' stays. Teaching hospitals also received a $0.4 billion in IME payments from the adjustment in the inpatient capital PPS.

The magnitude of the IME adjustments varied substantially across teaching hospitals. Specifically, in Fiscal Year 2018, the median IME percentage add-on to inpatient operating payments, as indicated by the middle line in the box, was approximately 6 percent. The middle

half of teaching hospitals, as indicated by the box, received an IME adjustment between 2 and 15 percent. However, some teaching hospitals received just lower or substantially higher IME adjustment, as indicated by the dashed whiskers, ranging from less than 0.1 percent to over 33 percent among the top 5 percent of teaching hospitals. The distribution of IME percentage add-ons to inpatient capital PPS payments was similar.

The Commission and others have raised two main concerns with Medicare's current IME policy, that it only applies to care provided in inpatient clinical settings and that it is not aligned with teaching hospitals' additional patient care costs in each setting.

These two concerns could be addressed in a revised IME policy. First, moving to an IME policy that applied to care provided in both inpatient and outpatient settings would help align IME payments with the contemporary spectrum of settings in which hospital care and resident training occurs and make IME payments more equitable for teaching hospitals that have shifted or will shift in the future to providing more care and resident training in outpatient settings. Second, keeping aggregate

IME payments initially budget neutral to current policy but distributing them across settings proportionally to the effect of teaching on costs would maintain Medicare's current level of support to teaching hospitals but better align IME payments with teaching hospitals' additional patient care costs in each setting.

Once empirically justified IME payments exceeded those under current law, IME payments would be set at their empirically justified levels. This revised policy would therefore maintain the higher than justified IME payments in the short term and increase IME payments relative to current law in the long term.

The updated IME policy could also be designed to address other concerns. Specifically, the IME policy could be made more consistent by having the Medicare program make IME payments for care provided to both fee-for-service and MA beneficiaries. This revision to a more consistent policy would ensure teaching hospitals receive equal IME support for their care of fee-for-service and MA beneficiaries.

To accurately calculate IME payments for hospital outpatient care provided to MA beneficiaries, Medicare

could start requiring hospitals to submit informational claims on MA beneficiaries' use of hospital outpatient services, as they currently do for inpatient services, a requirement that would not only support equitable IME payments, but also provide a valuable data source to validate MA plan-submitted encounter data.

Second, to increase the accuracy of IME adjustments and minimize adverse incentives, IME adjustments should only apply to payments for items, services, and locations when teaching hospitals have additional patient care costs that are not accounted for in current payment policy. Therefore, a new IME adjustment should not apply to separately payable drugs and devices nor to outpatient locations where residents do not train.

Lastly, to harmonize IME policy across settings and allow for adjustments over time, CMS could be given the flexibility to implement a revised IME policy consistent with these broad principles and to update it over time through rulemaking.

While the effect of a revised IME policy would depend on the specific design features chosen and related implementation decisions, to give the Commission a sense of

how IME payments might change and the effect on teaching hospitals' Medicare fee-for-service inpatient and outpatient revenue, we modeled one revised IME policy consistent with the principles described in the prior two slides.

These include making IME payments for both inpatient and outpatient care and maintaining aggregate IME payments budget neutral to current policy but distributing them proportionally to teaching hospitals' additional costs in each setting. More details on the illustrative policy are in Table 4 and the methodological text box in your mailing materials.

Our regressions showed that the effect of teaching on patient care costs varied across the hospital PPSs and differed substantially from current policy.

Specifically, under our illustrative policy, the median IME adjustment in 2018 would have been 2.5 percent for the inpatient operating PPS, which is less than half of the median adjustment under current policy and is consistent with prior MedPAC results; zero percent for the inpatient capital PPS, as there was no significant effect of teaching on capital costs, consistent with CMS's

conclusion in its 1991 proposed rule; and 4.7 percent for the outpatient PPS.

This larger estimate of the effect of teaching on patient care costs in outpatient settings could be driven by several factors, including the more limited policy adjustments in the outpatient PPS and that resident labor can substitute for nursing and other clinical care in inpatient settings.

Consistent with the empirical estimates of teaching hospitals' additional costs described in the prior slide, under our illustrative budget-neutral inpatient and outpatient policy, aggregate IME payments would be maintained but shift towards outpatient care.

In particular, as shown in the left-most bar, current policy IME payments totaled $10 billion in 2018, with 95 percent from adjustments to inpatient operating payments, split across the care of fee-for-service and MA beneficiaries, and the remaining 5 percent from adjustments to inpatient capital payments.

As shown in the middle bar, under an illustrative empirically justified but not budget-neutral policy, aggregate IME payments in 2018 would have decreased and

shifted towards outpatient settings, with the share of IME payments from adjustments to outpatient payments increasing from zero to 50 percent.

Finally, as shown in the right-most bar, payments could be proportionally scaled such that they are budget neutral to current policy.

While a budget-neutral inpatient and outpatient IME policy would not change aggregate IME payments, the redistribution of IME payments towards outpatient settings would redistribute IME payments towards more outpatient-centric hospitals.

For example, under our illustrative policy, IME payments to very inpatient-centric teaching hospitals would have decreased to 22 percent, while IME payments to very outpatient-centric hospitals would have increased 28 percent. While these are material shifts in IME payments, the change in IME FFS payments represent only a 1.5 percent decrease or increase in these hospitals' Medicare fee-for-service inpatient and outpatient payments.

Commensurate with the distribution of more inpatient- and outpatient-centric hospitals, there would also be shifts among other groups of hospitals, including

decreases in IME payments at for-profit hospitals with a high share of low-income patients and increases in IME payments at small and rural teaching hospitals.

The results on this slide are from a single year and assume no behavioral changes. To the extent that the revised policy facilitated more inpatient-centric hospitals to become more outpatient-centric, the redistributions would be attenuated.

In summary, current IME policy does not reflect or support the increasing shift towards outpatient care nor do IME payments align with teaching hospitals' additional costs in each setting.

During the upcoming discussion session, we look forward to answering any clarifying questions Commissioners may have.

In addition, we would like the Commission's feedback on the potential principles for IME reform summarized in this slide and any other comments on the information to include in a potential June 2021 chapter.

With that, I turn it back to Mike and look forward to the discussion.

DR. CHERNEW: Alison, that was terrific.

We are going to start Round 1. The gold star goes to Bruce for getting his name in the queue early. So, Bruce?

MR. PYENSON: Thank you. On, I think it's page 18, there's a discussion of the case -- inpatient cases versus outpatient cases. And I'm wondering if you could describe what's in the outpatient case. My guess is that's mostly emergency room and outpatient surgery. So I wonder if you could, like do you have handy the average dollars per case or what's in there?

MS. BINKOWSKI: Unfortunately I do not on my fingertips have that information, but I can follow up with you after the call. I suspect that it's mostly ER and outpatient surgery.

MR. PYENSON: So it's not like clinic visits and things like that. It's really the hospital facility-based services, and the facility component of that?

MS. BINKOWSKI: From a payment perspective, not a volume perspective. Jeff, did you have something to add?

DR. STENSLAND: I'm just going to say that there will be some additions to the clinic visits, the way we have it structured, but how large that will be as a share

of the total, we'll have to get back to you on.

MR. PYENSON: Okay. Thank you.

MS. KELLEY: I have Pat next.

MS. WANG: Thank you. On page 25 of the mailing materials I wanted to ask whether you could portray this or display this according to teaching intensity, unless I missed it. I mean, it's inpatient size and inpatient beds, but what about by teaching intensity and what the impact of the proposal or the thinking would be. I also wanted to ask why there is such a big negative impact on high-DSH hospitals of the new calculation. It looks a little alarming.

MS. BINKOWSKI: So taking those in turn, on page 24 we did look at it based on teaching intensity and we found it was relatively stable across those groups. And we didn't include it in the table but that's certainly something that we could. With regards to the highest share of DSH, the highest quartile, we found that those hospitals were more inpatient centric, that they received a higher share of their payments from inpatient, and therefore, that's the driver of why their payments would shift.

DR. STENSLAND: And we want to emphasize these

are averages for the group. So within any one of these groups there will be some distribution of some winners and some losers.

MS. KELLEY: I have Amol next.

DR. NAVATHE: So a similar question. I think it would be helpful to look at that table by teaching intensity. My question, which is highly related, was how does the inpatient centricity metric that we're using here correspond or relate? How is that associated with the resident-to-bed radio that we conventionally use for teaching intensity?

MS. BINKOWSKI: Yeah, I will need to follow up with you on the exact numbers there. There is a correlation but there are also hospitals with a lot of residents that are more outpatient centric and there are ones that are more inpatient. So I can get back to you with some specifics.

DR. NAVATHE: Great. Thanks.

MS. KELLEY: Larry?

DR. CASALINO: Yeah. If I were a leader at a teaching hospital, I think I would say, "Oh, my God, MedPAC is going to do something with IME." And then I would have

said, "Oh, look, they're changing their method, it's supposed to be budget neutral, I'm relieved. At least I'm relieved if I have a decent amount of outpatient care. But then I would see -- on the slide that's on now, for example, slide 12 -- over time transitions that empirically are just like IME payments."

So then I would, if I were that leader but also, actually if I'm me, I'd try to figure out -- I guess I don't really understand, technically, how empirically, justify IME payments increase over time, you know, relative to the budget now. So the proposal is budget neutral now, but in 10 years, or 5 years or whatever, would you still say it's budget neutral if the comparison is to what IME payments hospitals would be receiving if none of these recommendations were implemented?

MS. BINKOWSKI: Yeah. So the Commission can continue to, you know, discuss variations to this, but what was proposed in the paper is that it would only turn to empirically justified payments once those exceeded those that were in effect under current law. And the reason empirically justified payments we suspect will increase over time is because there's a higher IME adjustment

percentage to outpatient payments and they are faster growing.

DR. CASALINO: Okay. It might be helpful to just explain that a bit more in future reading materials. It might just be me having a hard time grasping it, but I what you said is actually very helpful.

MS. KELLEY: I have one last round one question from Jaewon.

DR. RYU: Yeah. I just had a question around what are the inputs for estimating the cost? I'm guessing it's the cost report, and I think this touches on Bruce's earlier question around if clinics are included as well, as those costs also derived out of that same cost report? I'm just trying to understand what are those data inputs that help us approximately what cost is?

MS. BINKOWSKI: So yes, we did use the cost reports specifically which will include everything that's designed a hospital outpatient. It won't include, for example, rural health clinics, but it would include off-campus departments and others. So it is a little bit of a gray area.

Do you have more to add, Jeff? We can't hear

you, Jeff.

DR. STENSLAND: Yeah, maybe this is obvious but it's just going to be the hospital costs. Like none of the actual physician salaries will be in there as a cost. It's going to be the facility costs.

DR. RYU: Got it. So to the extent there's clinic activity, it would only be hospital-based clinics then. Is that right?

DR. STENSLAND: And we had discussed hospital-based clinics that are on the main campus, or a clinic where they're actually doing teaching. So if you just acquired a practice and you didn't do any teaching at that practice you wouldn't get any IME in that practice.

DR. RYU: Okay. Thank you.

MS. KELLEY: It looks like there's a few more questions. Pat?

MS. WANG: Thanks. I'm sorry. This occurred to me afterwards. Is IME case-mix adjusted?

MS. BINKOWSKI: So yes, IME is applied to the wage and case-mix adjusted base rate.

MS. WANG: Okay. I don't know if it -- I mean, that's -- so that's a distributional issue too. There's

inpatient beds, there's the IRB. Is case-mix index, average case-mix, like if it's a big academic medical center, IME payments might be higher because case mix is currently higher, which would influence the impact, I guess, in this redistribution?

MS. BINKOWSKI: I will continue to think more about it, but the new IME policy that would apply to these base payments would have the same case mix before and after. So I think what you're talking is maybe certain hospitals teaching more severe patients on the inpatient side but less on the outpatient side, and there's a lot of heterogeneity in that.

MS. WANG: So on the outpatient side, how would you similarly adjust for patient acuity or intensity of the outpatient service? Is there a way to do that, or would it be a flat add-on, are you thinking?

MS. BINKOWSKI: So the way that we modeled it was just based on a percentage add-on to the APC. Certain APCs take into account levels of patient severity, but, you know, to a lesser extent than in the inpatient setting, because there's not an equivalent of like MS APCs. So there's some level of case mix adjustment.

MS. WANG: Okay. And the final question is -- I'm sorry?

DR. CHERNEW: No. It's just we've got to move on to round two at some point. Remember, this is round one questions. You know, I realize there's an intention to engage, so go on, Pat, but please very brief questions, and hopefully brief answers.

MS. WANG: I'll save it for round two and make an assumption on the answer. Thanks.

DR. CHERNEW: Okay. I think there was someone left, Dana, in round one?

MS. KELLEY: Yes. I think Jon Perlin had a question.

DR. PERLIN: Thanks. Quick question. How are the number of outpatient clinics measured? Behind my question is that fungible? What’s one clinic today is that now five tomorrow?

MS. BINKOWSKI: So I'm not -- I'd need to look at more about the way outpatients, the count of them is measured, but the count of clinics wouldn't affect this. It's about what counts as a hospital outpatient department. And as Jeff said before, because we're saying the new

outpatient adjustment would only apply where resident training occurred, if they acquired more or split, you know, provider practices that would not affect payment. Do you have more to add, Jeff?

DR. DeSALVO: Could you say that one more time, Alison?

MS. BINKOWSKI: The short version was nothing is based on the count of outpatient clinics, and it also would only apply to the locations where residents actually trained.

MS. KELLEY: Bruce, did you have one more question?

MR. PYENSON: Yeah, just very quick on semantics. This slide talks about principles, and I think of MedPAC principles as being something else, like, you know, Medicare should know the quality of the outcomes for what it's spending money on. Are these really principles in that sense or are they maybe modeling principles as opposed to policy principles? Because this kind of really locks us into some pretty specific approaches.

MS. BINKOWSKI: Yeah, I'll defer to -- yeah, there are a lot of different implementation decisions that

could be done within these, what we were calling principles. We're open to other language.

DR. MATHEWS: We could call them --

DR. CHERNEW: I'm sorry. Bruce, these are just the traits of the proposal that's sort of on the table and what's trying to happen, the characteristics of the of what we're proposing, which is going to lead me to my next point. I'm sorry for pushing us along. I know you all want to get to the happy hour.

I'm going to go to Wayne in a moment, but the key thing here is I think Alison and Jeff laid out a direction to go in, and I know you all may have many broad thoughts on IME and various issues, but understand what really matters in this context is how you feel about that correction concretely, and if you have concerns, what concrete things you might think we should think about.

So with that I'm going to you, Wayne. Wayne, I think you're muted.

DR. RILEY: Thank you, Mike. Quick observations because I don't think you need too many reactions from me on this topic. But this is obviously something that MedPAC has taken a long look at over the years. And given Alison

and Jeff did a great job on the paper, you know, from where I sit, having been in academic medical centers all of my professional life as a physician and teaching, I'm a little bit battle-scarred, bruised, and battered like Karen and maybe others who have been in teaching situations, trying to get more teaching into the, quote/unquote, "outpatient setting." And that's been a battle even within the specialties, and I wonder how robust is the data to suggest that there's been that much migration into teaching in the outpatient setting. Because at least anecdotally it doesn't feel like it's been a big sea change. It may be there. I may just be oblivious to the data. So I wonder about that.

Second comment is I worry that we have to be careful that whatever modification to IME policy doesn't panelize inpatient teaching, or teaching in the inpatient center. And obviously this is sort of somewhat related to what we're going through now. We could not manage this pandemic as an outpatient national enterprise, and so you don't want to overly penalize inpatient teaching.

The other thought I had is where Pat mentioned the DSH. I happen to lead an organization that is a DSH

hospital. And I checked to see what our IME apportion is today and just as the paper reflects in respect we get more direct Medicare GME than we get indirect, which again underscores what I would refer to as the heterogeneity among teaching hospitals, that from where I sit, serving in a safety net hospital community, you know, any major shift in IME may not inure to our benefit and the benefit of the patients that my particular teaching hospital, and several others, particularly in inner cities, will experience. So I'm worried about that as well.

You know, when this was all set up, the regression models, back, I guess, in the '90s or so, you know, how good were the regression models to factor in something we had talked about earlier in terms of social determinants of health and social, quote/unquote, "factors." I suspect maybe a little bit but probably not as much as a model should do in 2020 and 2021 and beyond. So I wonder about sort of the modeling assumptions that undergird some of the way that this is played out over the years.

Those of us, again, who have been in academic medicine, we know that even in the outpatient setting we

see very, very challenging patients that would not necessarily be the same in other parts of the community and other practitioners. So there is a level of complexity in outpatient teaching hospital care that is not to be sort of sublimated.

Again, you know, this is a tough topic for the teaching hospital community, but I hope that in arriving at whatever reforms that we try to take a balanced approach, that we keep in mind that the heterogeneity among teaching hospitals is real, the balance sheets of these hospitals are very different. You know, and again, I guess I have PTSD from my own experience here in Brooklyn and having worked pretty much in predominantly safety net teaching hospital environments throughout my career. So I'm very sensitive to that, particularly at this time.

So I'll turn it back to you, Mike.

DR. CHERNEW: Thanks. I think Jonathan -- do I have that right, Dana? -- and then Brian.

MS. KELLEY: Yes, Jonathan is next.

DR. JAFFERY: Great. Thanks, Mike. This is a great discussion, a great discussion, a great chapter and presentation. It is very complex of an issue.

So just to address the notion of how we react to where we want to go directionally, I'll say that in general, I'm very much in support of trying to modernize the funding to align with kind of current and future -- current practice and future goals of where training does occur and where we want teaching of patient care, where we see patient care occurring.

But I think others have brought up -- and, Wayne, you spoke of it eloquently just a minute ago around the significant heterogeneity that exists, and so I think the question is how do we do this. If we're going to make a transition, how does it happen fairly and smoothly?

I think it's Slide 11, the one before this, where you show some of the impact on different, currently very inpatient-centric for outpatient. I get the point that on overall, fee-for-service payments, it's not a huge amount, but those are pretty significant swings in the IME payments, 22 and 28 percent and other things, and the DSH payment comments that Pat brought up and Wayne commented.

So I think trying to find how we do we phase this in, you speak of this in the chapter, and I think to me, a phased-in approach is the right way to go, starting with

like you proposed, a budget-neutral approach, so that we're not just taking money away from teaching hospitals right now.

In the chapter on, I think, page 26, you described a couple of approaches and one to have annual decreases to other updates. That seemed like a clever way to try and sort of smoothly adjust payments and remove some of the unpredictability.

Just two more quick things. I like the idea of giving Congress -- sort of having Congress outline principles and allowing CMS to adjust the policy over time and give some flexibility, not just for this policy. I think that we could see some advantage to that in some other areas as well.

And I guess the one thing that has already come up a little bit here and I still think needs some fleshing out there, when we're talking about where residents -- where outpatient resident teaching occurs. You spoke a little bit about hospital outpatient departments. I don't fully understand yet how we're going to measure that and what the optimal way to do that is over time.

There may be a lot more fluid movement of where

residents spend their time in the outpatient center, an outpatient setting. We've got this pretty straightforward in some ways, resident-to-bed ratio, which I think some of us may argue that it's flawed, but we can understand some of those flaws. So I guess that would be another place that I'd like to see a little bit more discussion on this in future parts of this overall discussion.

Thank you.

MS. KELLEY: I have Brian next.

DR. DeBUSK: Thank you.

I was really, really excited to see this chapter come up again. GME in general has needed an overall for decades. I've been dealing with residency development since 2007 when we first started setting up medical schools, and I knew we were in trouble the moment I saw a payment formula that had it to the exponentiation of 0.45, I think, is the number they used. I mean, the formula is just -- it's ridiculous.

So I'm really, really excited to see us take this on. I think this chapter outlines really the very first steps, though, the bare minimum. Just getting the payment distributed more equally between inpatient and outpatient

is a great first step, walking those levels down to their empirical levels.

I actually spoke with Ray Stowers, a former MedPAC Commissioner, former president of the American Osteopathic Association. He was part of the discussions with Congress back in the mid-'80s when they cut the original deal on IME payments, and they literally took the cost estimate for IME and just doubled it. And that's how they built it in the package.

And I think the assumption at least was that those levels would be brought down over time, and I think largely they have, simply because the IME payments are just bolted straight onto the fee-for-service schedule. So as fee-for-service inflates, so did the payments.

The other thing that I want to talk about, though, MedPAC got it right. They got it right back in June of 2010. There is a wonderful report, for those of you who haven't read it, entitled "Graduate Medical Education Financing: Focusing on Educational Priorities," great report, and it makes observations -- again, this is 10 years ago -- looking at do we have the graduate medical education program that produces the right mix of physicians

by specialty. Are they producing the right geographic mix? Are we getting value for the money? I mean, these were questions that MedPAC was asking 10 years ago, and they're all very valid questions today.

So, again, I want to applaud this chapter. I think it's wonderful. I think a half a loaf is better than nothing. So, again, I'm a huge advocate for the things that are being proposed here.

What I would ask us to do is, as we revisit this topic, just consider this, thinking big picture. Do we really want to take payments tied directly to volume? I mean, we're supposed to be moving from volume to value, but we're basically financing graduate medical education with no regard to geographic mix, to the quality of the programs, to the mix of specialties. But we're financing the program with basically add-on payments to the inpatient fee schedule, and I can't think of -- you know, it's one of the more regressive things that we do.

So I know I'm on a little bit of a soapbox here, but wonderful chapter, wonderful topic, and I hope that this is the first step toward broader GME and particularly IME, but GME, in general, reform. Thank you.

MS. KELLEY: I have Pat next.

MS. WANG: Thank you.

It's great work. I think it's incredibly important to encourage more investment in ambulatory care, and so I really applaud the findings and the general direction and where this would lead.

What I was going to ask in the Round 1 was related to the fact that IME is inpatient only now and the only places that provide inpatient care are hospitals, when IME moves to ambulatory, you have a diversity of ambulatory care settings that I think you would want to encourage, we would want to encourage residency training in, like FQHCs.

I'd just ask you to think about the unintended consequence of restricting outpatient IME to the hospital-based outpatient recognized clinic because it could cause folks to pull people back so that they can get IME, where what we should be doing, especially in the primary care area, is sending people out to the community. I don't know if there's a way to get at that. That's one.

The second thing is I am concerned about the finding on high DSH hospitals and the inpatient-ness, Alison, that you mentioned. I don't know. I'm just

saying, is it time to have a companion recommendation that DHS similarly be unbundled between inpatient and outpatient to kind of make those work in sync? To Wayne's point, outpatient care for underserved populations can be very, very complicated. So maybe DSH should also be distributed to match this, so there's not as big an impact.

To Brian's point, IME is still based on the per-click claim for each unit of service, and I don't know whether you guys have thought about ways of stimulating IME payments for population health training because that's what Jonathan works on in his day job and what many, many people are trying to push towards. And I think that still, there's a counterincentive in there about training people to practice better population health that may result in fewer clicks or units of service or being filled with other kinds of units of service, like care managers reaching out or social workers reaching out, that there's this counterincentive because you're not getting your full IME payment in.

I just wanted to ask you. You probably have thought about this, but to encourage you to think more about whether there is a way to do some sort of bundled IME

payment or something that would recognize population health training and not penalize people for reducing the clicks and units of service.

And the final thing that I will say is I think that this is very, very important work. I will voice a little bit of a worry for the most inpatient-centric teaching settings, like academic medical centers who -- I get that the empirical level doesn't support the level of payment anymore. We all know that it's baked into their infrastructure. Their all-payer margins are low. Their Medicare margins are high because of programs like this, but their total margins are low compared to non-major teaching hospitals, AMCs. So I just want to voice a concern about sort of going -- just figuring out how to address that in a transition or otherwise.

Thank you.

MS. KELLEY: Betty, I have you next.

DR. RAMBUR: Thank you.

I think my comments, hopefully, build well on that. As I think some of you know, I've spent a lot of my career as an academic administrator, including in an academic medical center but on the nursing and health

sciences sides. And it's actually from that perspective, a very curious and interesting thing to ponder, the magnitude of the subsidy that we'd have a graduate medical education that really comes from Medicare.

Residents certainly -- you know, there's a discussion of cost, but they also provide a great deal of labor, particularly over time. So who benefits from that labor, and how is that factored in?

I do think starting to think about outpatient is a good thing; however, we're still talking about very facility-centric. And as Pat mentioned in terms of FQHCs and other kinds of places, how do we start to really align payment policy so that it addresses evolving societal need? How do we think about workforce development? Because what we catalyze with these funds will be created.

And then, finally, I know that this is not on the docket for this conversation, but I can't resist by commenting. What's the accountability of residents whose education was, thus, subsidized to accept Medicare patients down the line?

Thank you.

MS. KELLEY: Karen, I have you next.

DR. DeSALVO: Great. Thank you, guys.

So I'll just start by saying, generally, I support the direction of the chapter, and I think it's a really great first step. It seems like I share some of the thinking of some other folks, so just a few comments here.

First, I'd like to see the principles either renamed or to go up a layer, just so that it's clear what we're trying to get to is more upstream, preventive care and services and being able to meet beneficiaries where they are. It's embedded in the chapter, and, Alison, you described it well in your remarks. But it doesn't come out crisply. If we're going to present these to Congress, it feels more financially oriented and like we're being reactive to what's happening in the field. Whereas, I think to Wayne's point, we want to be more proactive because the field is not able to move in this direction because of the financial constraints and maybe some other issues. So I would just request that we think about shaping the principles in that way.

I guess from a power standpoint, it feels like we are moving to more outpatient, but I agree that this is still -- sorry for my hospital friends -- feels like the

power and the money still rests with the hospital, and that there are some ways that we might really want to push that envelope as you go forward, so just to the point, for example, of hospital outpatient departments are being physically on-site. Even if you started to stretch it, you can see a context where this would encourage the acquisition of provider practices instead of partnering with community-based health centers or private practices. So, again, thinking about how the money flow really encourages a partnership with the outpatient environment and not that what is now a power structure where the hospital manages the money and residents and decides on essentially the curriculum.

But I agree with trying to pull it off the fee-for-service chassis and get on to some kind of a population payment chassis. That would be really great if we could think about how to do it.

I just want to make a final general comment, having done a lot of teaching and management in the academic environment. I think the further you could push this to really -- again, I'm going to use the word "power" -- to put the power in an outpatient environment, defined

very generously, not just a clinic, not just an ER, but really an environment that's ambulatory or home-based or virtual, you start to create bandwidth for the faculty in that environment to become better role models, to do more quality improvement work, to do more outpatient research. And that creates a pathway next for our pipeline, the next generation of physicians and others who are exposed to those kinds of role models in the outpatient environment that we just don't really have access to right now.

Most of the academic role models for trainees are in the inpatient environment. That's where they see the cool quality improvement and research and the leadership happening. So they see that as a pathway to how they want to focus their attention, and I just think it would be fantastic, the more we can create that kind of bandwidth and leadership opportunity for outpatient leaders and in the academic environment to really spend the time with trainees, to spend the time with the patients, but also doing that, the sort of population health work or the systems improvement work that is so much better role model than the inpatient environment because there are more resources there, not only GME but all the other kinds of

resources that we described.

So I love the direction. I think we need to keep going because we need to help pull the system along, not just react to where it's saying it wants to go, and I think it will do a lot of good, not just for today but for the next generation of trainees and beneficiaries.

Thanks.

MS. KELLEY: Jaewon?

DR. RYU: Yeah. A lot of similar comments, but I'll summarize a couple things that I'd like to throw in.

So, one, totally supportive of budget neutrality and the redistribution towards the outpatient setting for all the reasons that folks stated.

I think, two, I think to Karen's point, this really should go ideally beyond hospital-based clinics, per se. I think I can't help but go back to our primary care chapter from last year that illustrated that -- I think one of the things correlated with driving more people into primary care to have an interest in that area was exposing them to other models and other environments, whether it's FQHC, traditional clinics, models in the home, and so forth. And I think we probably want the program to have

some recognition that those are valuable settings to have resident education happen in. So I think ideally it would be great if there was a way to push into those settings and not limit it to simply hospital-based clinics.

But that leads to number three, and I think it's a hesitation and concern around how do you estimate cost in that environment, in those other environments. I don't think it's as straightforward as the inpatient setting, and so if you have a model like what's being proposed where you're trying to keep track of what is an empirically justifiable cost structure, I think it's a lot more nuanced and complicated when you take into account the outpatient settings.

Just as a quick example and maybe a simplest example, having an additional resident in inpatient rounds doesn't slow down rounds. Having an additional resident in an outpatient clinic, it does slow down that clinic, but exactly to what extent and how do you quantify that, I think those are tougher to get at. And so if there was some thought into how that could be done, I think that would really help as you fast-forward this model into the future.

MS. KELLEY: Bruce.

MR. PYENSON: I agree with a lot of the comments that others have made. I would just point out that we've spent hours and hours talking about the need for more primary care and hours and hours about the problems with fee-for-service, but as presented, this program doesn't address primary care even though it's about training, and it's all coupled onto fee-for-service.

I do support the proposal as a first step, which is why I think we should not call what we're doing as principles. It's a first step. And I'd like to suggest a next step which is to move residency -- on a pilot basis, move some residency into Medicare Advantage to actually give Medicare Advantage plans on a pilot basis the responsibility for residency training. I think Kaiser does that now, along with their medical school. But I think the large payers have huge training operations that they currently do for their own employees. They fund huge amounts of academic training as well for their employees, probably on a vaster scale than for the big plans than any academic medical center.

So I think there's some real value there on a

primary care basis, and let them come up with a way to move residents into primary care organizations. A lot of details to work out, a lot of challenges coming up with the right dollars. But there's an opportunity there that I think after we get through the fixes that we're proposing has some promise.

Thank you.

DR. CHERNEW: Thanks, Bruce. We're going to move on in a second. I just want to give people a time check. We have about 20 minutes, a little bit less, and about 10 people. We can all do the math. So, okay, who's next, Dana?

MS. KELLEY: Paul.

DR. PAUL GINSBURG: Thanks. A lot of what I was going to say has been covered by others probably better than I could have done. I just want to reinforce the fact that, over time, there's so many specialties that have very little involvement in the inpatient setting and actually very little involvement with the hospital outpatient setting. So I think we not only need to support this approach of moving some of the money to outpatient, but it's really worth looking into how we can get some of it

moved beyond the hospital setting to where the training can most effectively be done.

So others have said, probably more articulately than I have, I think that is a real priority.

MS. KELLEY: Jon Perlin.

DR. PERLIN: Thanks. You know, like many of you, I started my career helping to lead a large residency program, I grew up around academic health systems, et cetera. And, you know, I've strongly supported the notion of moving the dollars into the outpatient environment, those environments where the new health staff are training and should be trained. But I do have some concerns about the context.

In a perfect world, you know, the funds would be appropriate to the additional cost, but it's not a perfect world. It's a world in which we know that risk is concentrated in certain sorts of medical centers. It's a world in which we know that there's, you know, on average losses on Medicare patients. And so I think one has to figure this imperfect issue into the imperfect context.

And so I worry, when Jeff said there will be winners and losers, that the averages don't tell the story

of detail, and some of those losers, particularly when the average shows that high DSH hospitals lose 6 percent, becomes particularly concerning. So I think we need to do another level of homework which is really to determine what the impact would be on individual institutions. I worry about this as well for two additional reasons. One, the unintended consequences, could it suppress the training of specialties that are desperately needed? I don't know if any of my other colleagues have tried to hire general surgeons. They're extremely rare, and, you know, that's not typically an outpatient-based specialty.

And, finally, I just did a little vetting of this with a colleague who came from a large for-profit system who had run residency programs there, and I asked what would happen if in my old life we made plans to eliminate X number of residency spots. And so as we're looking to a period of time where we would certainly see more engagement of all members of the care team, we're also looking to a period of time where we know there will be physician shortages. And, you know, something where the reaction could actually be cutting slots would seem to be counterproductive.

So I favor strongly support for the new training environments, but really concerned about unintended consequences around redistribution. The system is on its face absolutely imperfect.

Thanks.

MS. KELLEY: Larry.

DR. CASALINO: Yeah, just two quick points. One, we haven't talked about this too much, but I think we could probably agree without too much trouble that if we were going to go -- if we could start with a clean slate and just go back to the drawing board and think about, well, what's -- just worry about what's the most rational way to support academic medical centers or teaching hospitals, we probably would come up with a way that's completely different. And so a lot of reasons why we're not going to do that today, but this just goes along with the people that have already suggested that we might not want to use the word "principles" for what we're doing because this is really more on a superficial level.

The other point I'd like to make, you know, I read this and I thought this is very good. I agree with attaching some support to outpatient as well as inpatient

activities. But the comments that Pat and Betty made, and then especially Karen, have really made me reconsider, especially Karen's comment. There has been one Medicare policy after another that has had the unintended consequence of giving hospitals financial incentives to acquire physician practices, and, you know, it has distorted -- in a very short time, it has greatly distorted the demography of the delivery system, and we don't know if that's a good thing or a bad thing insofar as there's evidence so far -- and I think Laurence Baker just came out with a review of this. I just got it sent to me. I haven't read it yet. But insofar as there's evidence, it looks like it's bad for costs and doesn't do anything for quality.

So, you know, any policy -- I hate to see one more policy that would have the unintended consequence of essentially subsidizing hospitals to acquire more practices. And I guess for me that would actually -- that consideration would actually outweigh the attractiveness of tying IME to some extent to outpatient care as opposed to just inpatient care.

So I guess to support this recommendation as is,

I'd have to be persuaded that it wouldn't subsidize hospitals to go out and buy more practices, and so far, it looks to me like it does or would.

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

DR. CHERNEW: Great. So because we're trying to move forward hopefully to get to a recommendation, I do want to be sure to hear from everybody. So I'm going to do another lightning round. To give you a little sense of the order, again, some of the faces bounce around on my screen. I'm going to do David and if you could quit moving around, then I'll do Amol, and then we'll go from there. But I think the key thing here is two-fold. One is Brian said the original model started with a basically doubling of what people thought would be empirically justified for cost. We can decide how aggressive to be. That's a somewhat separate question than this sort of move to outpatient. And I take both the support for that for the delivery system and, Larry, obviously, your concern about consolidation and those types of things is one that I share.

So let's go to David and then Amol, and then we'll move through it. Please, what I'm mostly looking for

is a view about how you feel about the direction that we're going as we try and get to some form of recommendation on IME. David.

DR. GRABOWSKI: Great. Thanks, Mike. I'm very supportive of this direction. I do share the same concern that you, Larry, and others have about consolidation, but I really like the way this is going. And similar to what Brian suggested earlier, this has been long overdue for some reform, so I'm glad we're focusing on it.

Thanks.

DR. CHERNEW: Thanks, David. We'll do Amol, and then just to give you heads up, we're going to go to Dana.

DR. NAVATHE: Thanks, Mike. So pretty similar comments. I think -- I'm broadly supportive of the general direction. I think the questions around DSH hospitals, consolidation, amongst other things, do give me a little bit of pause. So I think in some sense the general direction feels okay. I don't know that we want to make huge rapid changes or propose huge rapid changes. I think as people have pointed out what we call "principles" here probably shouldn't be called "principles." I think they're directional in nature, and it would be good and helpful, as

others have suggested to take a deeper look, just as Jon Perlin suggested, for example, just to make sure that we're not doing more harm than good.

But, again, just to recap, I do support the general direction that we're going in.

[Pause.]

MS. KELLEY: Have we lost Mike?

[No response.]

MS. KELLEY: Mike, do you want to --

DR. SAFRAN: I think Mike wanted me to chime in.

DR. CHERNEW: Yes, I did. I'm having an earpiece problem, so why don't you go ahead, Dana, and then just in case I lose you all again, we're going to go to Betty, Marge, and Sue will round out the session.

DR. SAFRAN: Great. Yeah, I really have very little to add to the excellent comments and discussion. I'm supportive of this work. Larry's concern about possible further acquisitions by hospitals of primary care is an important one that I hope we'll pay to, as well as just, you know, really thoughtful attention to unintended consequences. But I really appreciate the start to this work and support moving forward.

Thanks.

DR. CHERNEW: Great. Thank you, Dana. Betty.

DR. RAMBUR: I've previously spoken. I have nothing to add except to share I concur that we have to make sure that we do not incent additional acquisitions, mergers, et cetera.

DR. CHERNEW: Sorry. My recordkeeping's not so good. Marge.

MS. MARJORIE GINSBURG: Yeah, I'm on board with everyone else with the similar caveat about making sure we don't have unintended consequences. Whenever given an opportunity for large health care systems to make their systems larger, they will all take advantage of it. So we need to be particularly attentive to that.

DR. CHERNEW: Thank you, Marge. Sue.

MS. THOMPSON: Yes, and I'll close quickly. Generally, I'm quite supportive. I was happy to see the chapter appear in the bundle of material this time. I would just close out that I really do like the opportunity of connecting this work to other challenges we have, including addressing primary care shortages and overall transforming the health care system from fee-for-service to

value by thinking about incenting opportunities for training and environments where population health is the centerpiece of the work.

So thank you. That would conclude my comments.

DR. CHERNEW: Sue, thank you.

So I will wrap up in a minute, but, Alison and Jeff, do you have any reactions to this? I think the most important one would be the concern about consolidation, thinking through that. We can talk about that now or offline. Why don't I give you a chance to talk before I wrap up?

Alison, I think you're muted.

MS. BINKOWSKI: I think we can continue this offline. It was a really helpful discussion. I think we did try to address minimizing adverse incentives, including acquisitions in the future, and we did include some information on not just the aggregate support on different groups of hospitals, but how it would apply in the 70th percentile, but those are both things we can get into.

DR. RILEY: Yeah, Mike, this is Wayne. Don't forget the DSH hospital impact as well.

DR. CHERNEW: Yes. Thanks, Wayne. I should have

let you have the first and the last word. Jeff.

DR. STENSLAND: I think it's -- we're going to work through the details later. The natural tension is going to be there's some concern about DSH hospitals and some of the more inpatient-centric hospitals losing something and a desire to make it budget neutral and a desire to give some more money to some things outside of the hospital, so that process of -- that will be a difficult math to work out. I think the acquisition to physician practices, there might be some more creative solutions we can do on that.

DR. CHERNEW: Yes, I think that's right. And, Wayne, thank you for the point about DSH hospitals. I think the challenge we're going to face in all of our work as we try and implement the Thompson principle of being bold and concerned about what we spend is it turns out when you spend less, someone gets less. And most of the actors are doing good things in a whole variety of ways. That's true in hospice. It's true in graduate medical education.

I think we're going to continue to struggle with those types of tensions. I am struck by the discrepancy between what I would call the empirically justified amount

and the way that we're paying right now. And I think that if we face a problem in particular types of organizations or particular things, sometimes my instinct is to try and correct the formula, and then find ways if we think more money belongs in DSH hospitals to give more money to DSH hospitals, not to have an IME payment system that is not particularly efficient, for example. There's a whole range of other things in which that would be true for me.

So just to give you an idea of where we're going to go, we will regroup. We're going to move this forward. I did hear a lot of support for moving it forward. I heard a lot of general support for the principle of expanding this to be a little bit less inpatient-centric, and as this becomes closer to a recommendation and more concrete, I continue to look forward to your feedback about how we can make sure that it's an improvement over the existing system. And I do believe that medical education is sort of the foundation for the entire American health care system. So we do have to give a lot of thought to the incentives and the consequences of how we train our physicians of the future and do that in a way that supports the delivery system as we make that transition.

So I'll give a lot of thought to it. It's honestly not my area compared to something like MA or APMs, but I have learned a ton, and I really appreciate the comments. So many of you have had so much time in organizations and, frankly, being trained, that makes this helpful for me.

So I think I've got -- did anyone not get a chance to talk?

[No response.]

DR. CHERNEW: All right. Then we are going to, with three minutes under budget, adjourn. There will be -- I think there's a happy hour invitation so we can get together and just catch up and relax. But, again, I really want to thank the staff across the board, not just Jeff and Alison for this presentation, but all the staff that presented today. They always do a terrific job, and, again, I want to thank you for your comments. I think we had four important sessions, and I think we really had some really good discussions and got to where I hope we're moving in the right direction in all those places.

So, again, we start tomorrow morning at 9:30. Please try and come at 9:25 so we can actually really start

at 9:30. And thank you very much to the audience. I'll reiterate there's ways on the website and others ways to reach us.

Dana or Jim, do you want to add any thank you's, comments, or just a sigh of relief that the day's over? Whatever it is that works for you.

DR. MATHEWS: All good.

MS. KELLEY: All set, Mike.

DR. CHERNEW: Okay. Then with that, a hearty good-bye for today, and we'll catch up tonight or tomorrow.

[Whereupon, at 4:59 p.m., the meeting was recessed, to reconvene at 9:30 a.m. on Friday, October 2, 2020.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Via GoToWebinar

Friday, October 2, 2020
9:30 a.m.

COMMISSIONERS PRESENT:

MICHAEL CHERNEW, PhD, Chair
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
JONATHAN B. JAFFERY, MD, MS, MMM
AMOL S. NAVATHE, MD, PhD
JONATHAN PERLIN, MD, PhD, MSHA
BRUCE PYENSON, FSA, MAAA
BETTY RAMBUR, PhD, RN, FAAN
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AGENDA PAGE

P R O C E E D I N G S

[9:30 a.m.]

DR. CHERNEW: Hello, everybody, and welcome to our Friday morning session of the October MedPAC meeting. I thought we had a great day yesterday. I'm looking forward to a good day today.

We have two important topics. The one we're doing now is one of my favorites, alternative payment models, and then we're going to have a session on vertical integration. Because I happen to have some inside information that a lot of people want to talk today, I'm going to say nothing else except hand it right over to Geoff. So, Geoff, you're up.

* MR. GERHARDT: Thank you. Good morning. Today Rachel Burton and I are going to talk about the evolution of Medicare's advanced alternative payment models.

Several other analysts contributed to this presentation, so you might hear from David Glass, Luis Serna, Jeff Stensland, Nancy Ray, or others answering your questions in the Q&A section.

As a reminder to the audience, a PDF version of these slides can be downloaded from the handout section of

the control panel on the right hand of the screen.

We begin today's presentation by highlighting the major legislative actions on alternative payment models that have occurred over the last ten years.

Then we will provide an overview of each of the three types of Medicare's advanced alternative payment models and highlight some of the changes made to these models over the last decade.

Based on our review of past and current models, we identify some additional changes that might further improve the models going forward. We would like to get your input on these ideas, as well as any others you might have.

We'll start today by providing some history about the development of advanced alternative payment models, also known as A-APMs.

Medicare has designed and tested alternative payment models for decades. In 2010, the Affordable Care Act made several important changes. The law mandated that CMS create a permanent accountable care organization program, called the Medicare Shared Savings Program.

The ACA also created the Center for Medicare and

Medicaid Innovation, which is charged with creating A-APMs that show promise in improving quality of care while slowing growth in program costs. CMMI is allocated $10 billion every ten years, and models may be expanded in scope and duration if doing so would reduce spending without decreasing quality or improve quality without increasing spending.

MACRA, which was enacted in 2015, introduced the concept of advanced alternative payment models.

Advanced APMs are models which meet criteria for use of electronic health records, quality measurement, and level of financial risk on providers beyond what non-Advanced APMs require. MACRA encourages qualifying providers to participate in Advanced APMs by offering an annual 5 percent bonus for professional services above what they would be paid if they weren't in an A-APM.

The creation of CMMI, combined with the MACRA incentive, have led to growth in the number of providers participating in A-APMs and beneficiaries who receive care from them. CMS reports that during 2018, 183,000 clinicians participated in an Advanced APM and collected an A-APM bonus, compared to 99,000 the year before.

Next, I'll turn to an overview of current and forthcoming A-APMs.

Advanced alternative payment models generally fall into three categories.

The first category is population-based models. These types of models are also sometimes referred to as shared savings models or accountable care organizations.

The second category is episode-based payment models, also known as bundled payment models.

The third category is advanced primary care models.

One of the reasons we're exploring this topic is that based on evaluations of A-APMs tested to date, these models have not produced the results stakeholders and policymakers are hoping for.

Generally speaking, evaluation reports and other studies of these models find that the quality of care is maintained, and oftentimes some measures improved.

Some models also have shown changes in utilization patterns, such as decreases in emergency department visits, hospitalizations, and use of institutional post-acute care.

These utilization changes have sometimes resulted in gross reductions in Medicare spending per beneficiary compared to beneficiaries cared for by comparison providers.

However, the reduction in gross spending is often outweighed by shared savings or performance payments made to participating providers, resulting in statistically insignificant changes or increases in net Medicare spending.

The type of APMs that the most clinicians participate in are population-based payment models, also known as ACO models. About a quarter of original Medicare beneficiaries are in this type of model.

This slide gives some high-level information about four current population-based models. More detailed fact sheets for these models -- as well as the other Advanced APMs we will review today -- are available in Commissioners' mailing materials.

ACOs are groups of providers who agree to be held accountable for the cost and quality of care delivered to a defined population of patients over a one-year period.

For each organization, CMS sets a spending target

for assigned beneficiaries, called a "benchmark."

If actual spending for an ACO's beneficiaries is below the benchmark, the organization can receive a share of the savings it generates.

On the other hand, if an organization's spending exceeds its benchmark, it may owe a share of the cost overruns if it has opted for a "two-sided" risk arrangement.

Performance on quality measures is used to adjust the size of organization's shared savings and losses.

I'll note that in addition to broad-based models like MSSP and NextGen ACOs, CMS has also tested an ACO-style model for beneficiaries with end-stage renal disease.

The population-based payment model with the most participants is the Medicare Shared Savings Program.

During the eight years of MSSP's existence, CMS has made several updates, many of which were finalized in a 2018 redesign that CMS termed "Pathways to Success."

These updates were partly intended to encourage more ACO participation and included requiring participating ACOs to assume greater financial risk more quickly.

Pathways to Success also employs longer five-year

contracts and offers ACOs annual flexibility in determining whether beneficiaries are assigned retrospectively or prospectively.

Pathways to Success also made several changes to the way benchmarks are calculated, including basing benchmarks on an ACO's historical spending blended with their region and allowing ACOs' beneficiaries' risk scores to increase their benchmarks by up to 3 percent.

Next year CMS plans to launch a new ACO-style model, called "Direct Contracting," which can be thought of as a successor to the NextGen model.

Both are two-sided models, but Direct Contracting will allow providers to take on less risk sharing, if they want.

Direct Contracting also requires that providers receive some form of prospective payments; whereas, this was optional in NextGen.

Direct Contracting will also allow beneficiary assignment to happen as often as quarterly, instead of the usual annual determination. And it will allow smaller ACOs to participate and not require prior experience with risk sharing.

The agency also plans to launch a version of this model for beneficiaries with chronic kidney disease.

CMS has tested many versions of bundled payment models over the years, going back to the Heart Bypass Center Demonstration in the 1990s.

On this slide we provide some basic information about the three episode-based payment models that are currently underway and another that is scheduled to begin in January. More detail about each of these models is in your mailing material.

All episode-based payment models share a basic premise: hold providers accountable for the cost of services furnished over a specified period of time (commonly 90 days) during and following a triggering clinical event (such as knee replacement surgery).

On the next slide, I will talk about some of the trends we have seen as different approaches to these models have been tested.

The vast majority of Medicare's episode-based models have paid providers on a fee-for-service basis, then reconciled actual spending to the episode's target price.

There have been calls for more prospective

payment models that would make a single payment for each episode of care. But CMS has found providers face challenges in implementing prospective payments, especially when multiple providers are involved in a patient's care. The upcoming Radiation Oncology model will use prospective payments, although the range of costs covered by that model are narrower than other episode-based models, so it should be easier to implement.

The agency has also faced challenges when trying to implement mandatory models, and most have been voluntary. The CJR model was originally mandatory in 67 metro areas, but was later reduced to mandatory in just 34. And three proposed mandatory models were canceled in 2017 before being implemented.

Another notable trend has been movement away from episodes triggered only by hospital stays. Episodes in most current models can be triggered either by inpatient or outpatient events.

Finally, target prices in newer models tend to be adjusted for more factors, such as case mix and peer group characteristics. This has the effect of making target prices more specific to each provider, which is seen as

more likely to attract participation in voluntary models.

I'll now turn things over to Rachel to talk about advanced primary care models.

MS. BURTON: Over the past ten years, Medicare has experimented with several advanced primary care payment models, which are summarized as fact sheets in your mailing.

The current iteration is called "Comprehensive Primary Care Plus," or CPC+, and has 2,700 practices in it.

Advanced primary care models ask practices to engage in care processes associated with the patient-centered medical home model of care and offer technical assistance with this.

They in turn offer risk-adjusted payments per beneficiary per month layered on top of existing fee-for-service payments, and they tie a portion of model payments to performance on quality measures. These models are also usually multi-payer efforts.

In the forthcoming Primary Care First, the agency has made some changes that depart from CPC+.

CMS will offer much larger performance bonuses than before and base them primarily on performance on one

measure -- acute hospital utilization.

CMS has offered increasingly large monthly payments per beneficiary in its models, and Primary Care First continues this trend.

It will also shift some of participants' fee-for-service payments into capitated payments, which is an approach CMS experimented with in CPC+ but on a smaller scale, with only half that model's practices.

And, finally, the geographic reach of these models has been gradually expanding: primary care practices in 14 states and five cities can currently participate in CPC+, and Primary Care First will include those areas plus eight additional states.

I'll also note that CMS is planning to launch a model called Kidney Care First, which is based on Primary Care First but tailored to beneficiaries with chronic kidney disease.

In reviewing the various models we've talked about in this presentation, some issues emerged to us. These could be addressed through some model changes that we hope you will discuss and give us feedback on.

Before I get into these, I want to make an

overarching point, which is that in designing models, CMS has to navigate a tension between making models effective and attracting broad provider participation.

Models that have stringent spending or quality targets might generate net savings for Medicare, but they may not attract very many participants.

On the other hand, if you make models easier to succeed in, a lot of providers may be attracted to the models, but they might not generate savings for Medicare.

More specifically, ways that models could be improved include strengthening providers' incentives to deliver care more efficiently, such as by increasing the percent of shared savings and losses used in models, setting benchmarks lower, limiting the degree to which beneficiaries' risk score growth can inflate benchmarks, and lowering episode-based payment models' target prices through deeper discounts or quality withholds.

Of course, the things I just mentioned are hard to do in a voluntary model, since providers can exit such models if they think they are not financially advantageous enough for them.

But if CMS were to make greater use of mandatory

participation in models, it could do all of the things I just mentioned and, thus, increase the likelihood of generating net savings for Medicare.

Models could also experiment with more actively engaging beneficiaries in choosing where they get their care, such as by distributing information on who the high-value providers are in their area.

There are also some changes that might increase the likelihood of evaluators detecting impacts of payment models.

CMS could pare down the number of models it tests and instead focus on those models that hold the most promise, which could reduce provider confusion. If CMS enrolled larger numbers of providers in these models, it could also detect smaller-sized impacts with statistical significance.

CMS could also randomly assign providers into a treatment group that participates in a new payment model and a control group that does not.

CMS could test models over longer periods of time, because some studies have found that models take more than five years to generate net savings.

And, finally, CMS could freeze a model's features over its testing period rather than making annual adjustments, so providers can spend more time refining care processes and less time learning new rules every year.

We also note that new types of models could be tested, such as models focused on managing specific high-cost chronic conditions, simplified models geared towards independent practices, and, finally, models that test utilization management tools successfully used by private insurers, such as prior authorization or preferred provider networks.

As you consider how A-APMs could be improved, we're particularly interested in your thoughts on: testing fewer models; prioritizing or deprioritizing certain types of models; changing or expanding certain features of existing models; randomizing providers that are interested in a model into a treatment and control group; lengthening models' test periods, with fewer adjustments made during those testing periods; making greater use of mandatory participation in models; and developing condition-specific models.

Now that we've given you some food for thought,

we'll turn things back over to Mike.

DR. CHERNEW: Thank you. Sorry. One second to realize I'm on my headphones.

Usually I don't make comments before we jump in. We're going to do Round 1 questions. But I do on this particular topic want to say a few things. So first some reactions, and then some guidance on where I think we're going.

The first reaction is my overwhelming personal belief is that we have too many models that overlap, and there's no clear sense of how they all fit together, and that we're not going to be able to test a bunch of things or so a bunch of things until we get to some coherent set of models.

I want to point out that if you test five -- if you're running 40 models, which is roughly what are being run, and you test all of them supposedly against doing none of the models, and then you put a bunch of models together, the result you get is not just the sum of the results of all the individual tests because the models interact with each other. So I think basically CMS is a portfolio problem. They have to come up with a set of models that

will work well together.

A few other basic points. Obviously, I agree that many of these models don't save, but I want to emphasize some of these models do save, not a ton but they do save, not just in utilization but for Medicare overall. And I feel that very strongly. So I think what we're going to need to think through is that these models, even if they don't save a lot, they provide some flexibility for providers. We use them all the time when we think about how to deal, for example, with telehealth and a whole bunch of other things. So my motivation isn't simply saving money. I think it's a conceptually important way to pay. We have to sort through how to set all of this up.

The last point and the reason why I jumped in before Round 1 is I want to emphasize this to my fellow Commissioners. This is a big, big area, and this is a multi-cycle commitment that we're going to have to make as a Commission. And I want to do that in a somewhat systematic way instead of taking scattershot actions on very specific recommendations. So I really want you to think through the number and the coordination of models and sort of focus on the portfolio as we go through this, and

we will through many discussions, hopefully in person, be able to talk about a whole slew of some of the specific design features.

So that's for the Commissioners and for the folks on the line. Otherwise, that's where my head is. And now I'm looking forward to hearing everybody else's comments.

So, Dana, I'm going to go to you. We'll do Round 1, and then we'll jump into Round 2.

MS. KELLEY: So far, I think we have just one Round 1 question from Dana Safran.

DR. SAFRAN: Thank you. Yeah, one question. I didn't see in the chapter any information about some of the programs and whether they have gross savings. You were pretty consistent about reporting net savings, and then sometimes you said there were gross, but other times you were just silent. So, in particular, do you have information on whether NextGen had gross savings and whether PCMH had gross savings?

MS. BURTON: I can speak to the PCMH question. I believe CPC+ did not really affect gross spending, but I can check that and get back to you. And I'm going to defer to our ACO team on your next-gen question.

DR. CHERNEW: I don't think CPC+ made gross savings, if I recall the evidence correctly.

MR. SERNA: So on the next-gen evaluation, after year two, the comparison group changed from beneficiaries who are not assigned to an ACO to all beneficiaries. So the comparison group included beneficiaries who are assigned to an MSSP ACO, and in that instance, there were no net savings.

DR. SAFRAN: I was asking about gross savings, not savings.

MR. SERNA: There were gross savings. Yes, there were gross savings.

DR. SAFRAN: Thank you.

DR. CHERNEW: And again, that's compared to other ACOs that were running or at least in the control group, just to emphasize my point.

MR. SERNA: Yes.

DR. CHERNEW: I'm going to shut up now.

Actually, I'm not because I think we're going to Round 2. I think we've already done Round 1.

MS. KELLEY: I think we are done.

DR. CHERNEW: Okay. So we're going to kick it

off with Amol, and just for people to know, it's going to be Amol, Karen, and then Dana. Then we have a few people that have said already they want to go after that, and then we'll go through. But, Amol, to you

DR. NAVATHE: Great. Thanks, Mike.

So I apologize to the extent that some of my remarks are going to overlap with Mike's and perhaps other Commissioners but hopefully will offer a structured view here.

So I'm going to cover kind of five different areas that I think we can push forward in terms of sort of advancing the work that we're doing and advancing the chapter, perhaps, so one covering context and goals of A-APMs; second, vision strategy; third, key issues and design principles; fourth, other things that were just outright, we being the broader health policy community outright missing; and then five, some sort of minor points around how we're describing models.

So before I launch in, Geoff, Rachel, team, this is a huge topic, as Mike just noted. I think you guys did an amazing job of synthesizing and covering an overview that is an expansive topic into something that's very

digestible, so commend the great work and recognize how much hard work it has taken to get here.

I'm extremely excited that we're taking on this work, given that I think we've had a fairly focused view in the past, we being the Commission here. That predates me, certainly, around ACOs, and it's nice to see the aperture here widening and thinking about the whole suite of A-APM types, if you will.

Okay. So diving into the context and goals, I think one thing that would be helpful here is to set out immediately and say what is the goal from A-APMs. I think we talk a little bit about costs, controlling cost growth, which I think makes sense, but there are areas of trying to improve quality and patient experience that are also important.

And I think probably the biggest thing that I think we need to say is something around stimulating practice transformation. So without the A-APMs, we probably wouldn't catalyze the type of changes that could actually lead to cost growth reductions or savings, and while we may not get there in V1.0, the fact that we might stimulate those kinds of practice transformations that will

also potentially spill over more broadly into the community, changing people's expectations of what's going to happen in the future, people here being clinicians and health care delivery organizations, that's really fundamentally important as part of the A-APM strategy for CMS. So I think we should try to be forthcoming about articulating those pieces.

I think our synthesis of the evidence is good in the sense that we're quite comprehensive, and I think the tables are very nice. I wonder if we can't put those types of tables in an appendix, in fact, and focus more on some of the questions that we've already heard from Dana and others, maybe a summary table of here are the models, here are the ones that have achieved gross savings, here are the ones that have achieved net savings. I think that might be a more rapid way to get a sense of what's working and what's maybe not working as well.

And I think it will also highlight this point that today it seems like we have a potpourri of different A-APMs, even within the three big model types that you guys have outlined, and to me, it feels like one really major piece of value that the Commission can add here is to

articulate a vision and a strategy for how all of these models, all the testing that we have done historically and perhaps the testing that will happen next in the next decade, how can this all fit together? And how can we actually move toward a common strategy or a common approach that will, one, select the best models, the winners, if you will, and double down on them, perhaps expanding them, and a second piece, which is how do these different models actually fit together in the first place?

I could imagine that we could do some great work that talks about how each of these different types -- population-based models like ACO, the advanced primary care models, and episodes -- all actually fit together, where it's not necessarily picking the best one of the three, if you will, but picking the best ones within the three in a way that actually stitch together and actually coordinate.

so that, I think, also will support Mike's call, in some sense, to trim the models because I think that will give us a more unified approach of how we might actually do that in the first place, so definitely wanted to articulate that it would be great if we could take on some sort of vision and strategy work as part of this broader

workstream.

So moving on to the next bucket, key issues and design principles, I think there's a number of areas that we can also push forward the broader thinking here. I think there was actually a place very early in the chapter on the first page, the third sentence or something that talked about how A-APMs are a way for providers to capture savings, decrease spending, without incurring any loss of revenue. And I think that's true in some models, like the bundled payment models, the BPCI and CJR-type models, not necessarily true, for example, a hospital-based ACO.

So I think we should be clear about where we're aligned on these principles and not, and I think I would also make the point strongly that I think if we do look at the evidence, when participants are expected to cut their own revenue or their own reimbursement, those models on average tend not to do as well, and that may be a design principle in general that we want to veer away from as we think about a strategy and A-APM choice going down the road.

Other points around design principles. So I think there was a discussion, which I was appreciative of,

around the voluntary and mandatory. You guys teed up questions around voluntary and mandatory. I think the discussion of mandatory can probably be refined a little bit. There are aspects around selection between voluntary and mandatory that I think also can be refined. In particular, there are some bad types of selection for sure, but there are also some good types of selection. If you have participants that have the most opportunity for savings as the ones who select into voluntary models, we might actually get disproportionate impact from them.

That being said, there's also potentially pernicious types of selection that mandatory models address. So I think there's some more that we can do probably to refine our exposition on that piece.

And I think connecting back to the goals, one thing that I feel is a prevailing undercurrent of the way we have written the current chapter is that we have to see savings in the short term to feel like an A-APM model is successful.

And I was wondering that myself because if we're able to catalyze practice transformation for these models that accrue savings to Medicare hypothetically for

perpetuity or catalyzes a very broad shift that spills over from the A-APM group to providers nationally, then maybe we actually have a longer-term horizon, and getting gross savings but not net savings in the short run actually might be considered a win.

So I think, again, in the spirit of broadening our aperture, I think there's also sort of a breadth, but then there's also a longitudinal horizon that could be good if we have sort of a vision or a strategy for how CMS and CMI and legislators might think about that.

Number four, what do I think we might be missing? So I think the number one thing that strikes me is the focus on disparities in particular and populations who are living with disparities and disadvantaged vulnerable populations. There's evidence that A-APMs aren't available to communities that have a disproportionate share of duals, for example, and if we're expecting these A-APMs to be one of the key mechanisms to improve quality and patient experience as well as change practice and save cost, in particular, in this case, out-of-pocket expenditures, it feels like this is a huge miss for us not to be addressing directly, us directly as well as A-APMs directly. And I

would put a huge call on us to see if we can incorporate some piece of this agenda directly into our work. How can A-APMs more effectively help close the disparities gap?

A couple of minor points here at the end. So I think as I read through the paper in general, I thought fairly objective. I did feel that sometimes that we were almost a little bit too negative on A-APMs. The ACO chapter, for example, I think, didn't recognize some of the places where there were modest savings, even if they're just gross savings, connected to the idea that it's hard to change practice. I think that could be a way to actually identify something positive there.

Similarly, on bundles, which are, of course, near and dear to my heart based on the work that I do, I felt like there's on the mandatory side, the fact that we actually could mandate a mandatory bundle and that it did as well as it did is something quite remarkable, actually. And now, of course, we have the radiation oncology model that's going to be a mandatory model, and Brad Smith from CMMI recently sent out a letter saying that successful to the BPCI advanced model is going to be mandatory.

So I think articulating more around the success

there and why we think it might be successful and important would be perhaps a fair representation there in general.

So overall, if I were to recap, I think this is great work. I'm super excited that we're taking this on, broadening our view, both in terms of breadth and in terms of longitudinally. I would love to see us take on more in terms of the vision and strategy. I actually don't even feel the necessity in some sense to make specific recommendations as part of this chapter, given that we're starting out pretty early, but more can be articulated in a way that all this can work together in a more systematic and strategic way than I think perhaps has happened over the last decade.

Thank you.

DR. CHERNEW: Amol, that's great.

I think we're going to you now, Karen.

DR. DeSALVO: Great. Thank you.

I agree with so much of what Amol just shared and including commending the staff for putting together this tome, which is a gift to the policy and the health care world. It gives us a really great sense of where we are and how we got here, so thank you for this deep work that's

going to guide the Commission's work but I think guide a lot of people outside of the Commission.

I want to see that what we're learning from all this A-APM work is that we're moving towards a world where beneficiaries are partnered with accountable entities and have a known primary care physician or provider, that system inclusive of the beneficiaries accountable for the total cost and total health outcomes, and that kind of a model where it's a global budget that allows the kind of simplicity and flexibility that I know patients are hungry for. At least that's what I understand from them, and I can tell you that doctors want that level of simplicity that comes with that kind of global budgeting, particularly in the primary care sphere. So that's a lot of the lens that I'll bring to the rest of my comments.

I think that the counter-rate simplicity of moving these learnings on these various types of alternative payment models to a broader accountable entity model is one that allows us to have some more flexibility.

I'll just share a quick story about a patient I think about a lot. He's somebody that started falling under my care. He had been in and out of the hospital,

basically spending more time in the hospital than out. He had significant chronic conditions of his liver, his kidneys, his heart, his lungs, his blood system. He had diabetes. He had hypertension. He had heart failure. He had an artificial valve. I mean, this person had a hit in every organ but also had a great desire for quality of life and to spend time with is grandkids and wanted to be out of the hospital more than in.

The journey that we went on included an episode where I had just discharged him from the hospital for heart failure, and he came back shortly thereafter in heart failure, again, despite having been well optimized, as we say in medicine.

So I went to his home and did a visit and learned in that visit that he had been told to take his medication with pickle juice. So he had this green jar sitting next to him on the table next to his easy chair, and the thing was loaded with salt. And it became clear to me that one of the reasons he was coming back in heart failure was that he was drinking salt as soon as he got home -- and began to talk with he and his wife and learn more about their diet and what was happening in their lives, and through that and

a series of other strategies, we were able to get him to that place of quality of life where he was home more than in the hospital. And that took a level of human connection but also flexibility.

The way that I was paid as a primary care provider was to be able to do that kind of work, to spend extra time with that person who was extra sick but also understand his context, not just the medical conditions that he had and not just see him when he came into the health system.

And it sticks with me because that's exactly the kind of relationship and experience that I think all doctors and patients want to have when they're really sick. They want to have that kind of flexibility to know that they can do the right thing and do it in a way that allows them to meet people where they are.

And I think, honestly, that's where CMMI started year ago was with this idea that we could achieve the triple aim, that we would make the experience of care better, including the quality of care and satisfaction with care, that we would improve the health of individuals and populations, and that we would do that at a lower cost

overall, and began and did a lot of good work in partnership with the private sector.

But I think over the course of time, it got so noisy that we can't find the signal in what we're doing in all these alternative payment models. We could pull out a thesaurus and print a lot of words, "cacophony," et cetera. But I think the point that we're all feeling is we're not sure which of the models is making difference to achieve the triple aim or to give the kind of simplicity or flexibility that people on the front lines desperately want, just to focus on health, and then also how can we understand how much overlap there is. What does the Venn diagram look like for one patient or one clinician that's operating in a number of alternative payment models? So I strongly encourage this idea of simplicity.

I do also think that we need to give the strategy a refresh. It's not uncommon for kind of an innovation arm to get a lot of ideas rolling, but I think it's time to hit the reset button and really get back to the roots of what CMMI was laid out to do and think about a strategy that I hope we can inform as the Commission but also want to remember that there's been work done in some of these areas

about how to transition the health system across the continuum to -- of these four types of alternative payment models. So, for example, the Health Care Transformation Task Force or Learning in Action network have thought a lot with the private sector about how to create an all-payer approach that would move off of the fee-for-service chassis and onto a global budgeting chassis.

I want to just make a comment about creating models that are focused on specific high-cost conditions. It may come as no surprise, having shared that story of my patient, that that's not what happens in people's bodies. Unfortunately or fortunately, they don't have just one high-cost condition. They have multiple medical conditions, especially individuals that are high cost and high need.

So I would err rather for us to really understand better how cognitive specialties, how primary care can be appropriately rewarded and have the resources necessary to focus on high-cost, chronic individuals that are both complex medically and socially and do the best for not just repairing them when they're sick but actually moving upstream to improve their health.

I think we are on a journey to understand how to better fund primary care in this country, but we've made a lot of progress. And I would like to see us really double down in understanding that and not just thinking about people as a disease but really as a person in the context in which they live, which is the last comment I want to make.

And that's about opening the aperture. I had the same word that you had, Amol, but my aperture is inclusive of equity. I think that's exactly right, but it also includes the social determinants of health.

We talk a lot about social determinants in this Commission, and I think we've made some good progress in trying to incorporate that into our thinking, but as we've articulated, it's not just about the kind of insurance product that you have or it's not just about your finances. The social determinants are where we live, learn, work, and play in the context they're in, and it's a complex ecosystem.

But there's also proportions of addressing social determinants. There's a social care infrastructure that can partner with health care. Health care does not and I

don't think should not do at all on its own, and so whether CMMI can think about not just a passthrough set of models where it gives money to health care and passes that there the social care sector. But if it has the statutory authority to do innovation models that invest in the social care infrastructure in a way that we use CMMI to invest and modernize in the health care infrastructure, I believe that would go a long way to helping beneficiaries. And if CMMI does not have the statutory authority, I would love to see us think about asking Congress to consider creating an innovation arm that would be a partner to this health care innovation, given that social determinants can drive as much as 80 percent health outcomes and that there's a social care infrastructure that's woefully unprepared to partner with the health care system because it's so under-resourced and hasn't had the kind of attention that health care has.

And I do believe that that accrues benefits to the Medicare program. I think we're still learning what that means, but I think we all know from our personal experience that if you're food insecure or have housing insecurity or no housing, that that drives medical cost in

a whole variety of direct and indirect ways. So I think the aperture for me would be also expanding the opportunity for CMMI to directly work with social care systems and/or to create a separate avenue.

Thank you.

DR. CHERNEW: Karen, thank you. Dana.

DR. SAFRAN: Thank you. Echoing the praise that Amol and Karen have shared for the staff, really, there is an enormous amount of information here and it's really very valuable for all of us. I want to focus my remarks on sort of four main things and then a couple of small final comments related to some of the questions you have up on the screen.

The first thing that strikes me is that, you know, it seems to me that this chapter, in some ways, and the public policy rhetoric are kind of creating a dividing and holding APMs to a different standard from the standard to which we hold the Medicare Advantage program, and I think we need to address that and highlight that in this chapter.

You know, we spoke yesterday in our session about Medicare Advantage, about a program that's decades old and

has never achieved net savings, and now we have a program that is, you know, still learning. And some of the models have, in fact, achieved net savings. I feel like we should be celebrating that. And I also go back to the point that you had in one of the early slides that the objective and the benchmark for expansion of models was either lot save money without hurting quality or improve quality without increasing spending.

And so I just would flag, you know, that as we think about the overall framing. And I loved Amol's point about the value of these programs catalyzing change, and the kinds of changes that we believe will lead to the more holistic care of patients, people, that Karen is talking about. And I'm quite confident we are seeing that in some of these models, so I'd like to see us shining a light on that to the importance of type of care transformation that's being motivated by these models.

The second thing I would say is on the issue of voluntary versus mandatory, I personally fall quite strongly in the place of thinking that program should be voluntary, but it should be a very strong signal to providers that choosing to remain outside of these models

is going to be an increasingly unprosperous way to engage with the Medicare program. And I think some public policy has done that, but the other problem that we've pointed to along the way, in this discussion and in the chapter, is the cacophony of programs.

And I do think that in addition to having programs be voluntary but a strong signal that it will not be financially lucrative to remain outside of these programs, I think that we need to have fewer programs and we need longer tenure to study them, but also longer tenure for those who are in the programs. So, you know, I know that some of the more recent programs are testing five-year periods. I think nothing short of a three-year period for a program and five-year periods are good because the ability to give providers certainty about what their incentives from Medicare will look like over a long stretch of time will really help catalyze the kind of change that we're talking about.

I for sure saw that in my experience at Blue Cross Mass, both because we made the program voluntary and because the contracts were quite long, especially in the early years they were all five years. We heard provider

after provider system tell us that that enabled them to know that we weren't going to come back at them next year with a change in the way the model worked, and they could actually plan for how to be successful in the model.

And so I think having longer tenure for the contracts but then also longer tenure for the programs will really allow us to establish an evidence base that is more robust than what we have.

I also think that we need to have some standardization about the evaluation frameworks, because, you know, that's part of the confusion. Even, you know, the response to my question about what we know around gross savings for Next Gen and for PCMH pointed out that there was a change in the population against which we were measuring midstream. We really have to highlight the importance of standardizing the way these programs get evaluated and having them have a long enough stability that we can measure what impact they are accomplish, and improve them along the way.

I see no problem with having a provider cohort, you know, if say cohort number two or three, coming into a model, having that model have improved the way it does

benchmarking, but for those who were in cohort number one the model stays the same until they renew their contract. I think that gives us the best of both words.

I did toy a little bit -- I'll just share this -- with the idea that if we make any of this mandatory should we have Medicare make it mandatory that providers who exceed a certain size or scale need to be in a model that has accountability for total cost of care? I toyed around with that in part because of the conversation that will follow this one, about the consolidation and integration that we're seeing. So I throw that out as an idea, but mostly I feel pretty strongly about voluntary models and them creating a pretty ugly scenario for those who stay outside of them.

The fourth theme I would sound is that we really still have not addressed hospital payment reform, and that, by the way, this chapter doesn't draw out any of the evidence, as far as I recall -- and I apologize if I'm misremembering -- distinctions in performance that we've talked about previously between organizations that are physician-based ACOs versus hospital-based. But I think that's an important part of the evidence, and I do think --

I know I sound this almost every time we talk about ACOs -- that we need to keep working at a model that will change the fundamental set of incentives for hospitals around hospital-based care. I know it's very challenging but I fear that without it, with hospitals now owning so much of the physician workforce that we're really fighting upstream with these models.

And then a few final comments and thoughts. One is, you know, we haven't addressed an issue that I think, I forget if it was Amol or Karen started to point to, and I'll just flag it as something that may be worth mentioning in the chapter, that the issue of how physicians are paid by their organizations really has an important impact on all of this as well, and I don't know that we can ignore that.

And also, we don't address, in this chapter, that the quality measures, the performance measures really continue to need to move toward outcomes-oriented measures. And we're kind of stalled out on that and still stuck with a model that's trying to be global in its focus but it's still process-oriented like fee-for-service in its measurement, and we really need to address that.

Finally, just closing, I think that for sure we have to address, as you say in the chapter, the gaming that's happening with moving high-cost beneficiaries to non-ACO TINs. That seems like a no-brainer. The capping of risk scoring on benchmarking, I did there too want to harmonize a little bit of thinking between Medicare Advantage and ACOs, and also entertain the possibility of cohorting here, where we might allow -- you know, you talk about the challenges, and you're right, of getting providers who are higher spending motivated by the benchmark to come into a voluntary program while not making the benchmark such that those who are more efficient are struggling to meet the benchmark.

I don't know why we can't borrow from the Medicare Advantage book and create different cohorts and then set benchmarks differently, at least in the early stage, so that all providers can see in the program a way that they can succeed, a way that they can help their program generate savings, and then those benchmark strategies can converge over time.

So I know that was a lot. I will stop there. Thanks for the opportunity to share these thoughts.

DR. CHERNEW: Thanks, Dana. In a second, we're going to go to Betty. Just a time check. We have 40 minutes about 14 Commissioners, so please be conscious of the time. This is an expansive, expansive chapter, so I know everybody has a lot to say, but I do want to make sure we get the thoughts of everybody.

So Betty.

DR. RAMBUR: Great. I will try to be succinct. First of all, I want to again thank the staff and also the three opening comments. I'll focus on areas that amplify or perhaps disagree with some of the statements.

First of all, I differ a bit and I really support mandatory bundles in particular. And I don't know if it's still correct that 17 conditions are responsible for 50 percent of the spend, but I can't see how we cannot systematically roll those in to episode-based payments, particularly in specialty care.

I will say that I'm probably shaped in part by this, and I'm dating myself, but I was in my first year as a nurse practitioner when DRGs were introduced and I was stunned by the neck-snapping alacrity by which the system shifted. So I'm still imprinted by that.

I just want to mention a bit about my experience in helping develop Vermont's statewide all-payer ACO. It is still a work in progress. They are still trying to onboard enough people. But I just want to underscore that changing behavior really takes time, and so I strongly support longer increments.

And this year is year three of the model. The first year was zero. And long-term services and support Medicaid, which I know is not our authority, but Medicaid long-term services and support are to be rolled in. And it's really starting to look at that, that we begin to really see some behavior change in terms of providers.

A previous study found that it takes a high degree of capitation to catalyze non-visit care, and when we think about so many of the examples we have, Karen's example of the person who is drinking the salt water, you know, the limits of medical care versus something broader really starts to happen, I think, when you have accountability for the costs and outcomes for a population.

And just briefly, even though I know it's not a total success, some of the things we saw when the hospitals couldn't so easily shift the uncompensated care for, for

example, people who were homeless, they are really forced to start to think about how do we reach out to that population. So we can't rely on altruism. We have to create the financial incentives.

Dana mentioned the issue of how physicians are paid. I just wanted to briefly mention a study that was just in Health Affairs that found, I believe it was over four years, the increase of nurse practitioners and physician assistants practicing in ACOs went from 18 percent to 38 percent. We talked a bit about workforce development yesterday. I don't know if there is anything in here for us to think about. But workforce development, and also, I know you've previously taken a stance on incidental-to billing, and I just want to underscore I think that is an important stance that you took that it needs to stop.

And then finally, in our experience in Vermont, we were not able to consider Part D in the development of the all-payer model, and that was for technical reasons, was my understanding. It wasn't really a policy decision. But to the extent that models that are looking at all-inclusive total cost of care with full risk-bearing, it

would be really important and wonderful if we could roll that in.

So I do think there needs to be fewer, it needs to be clearer, and it has to be a strong message that there's no stopping the train that's pulling away from fee-for-service. Thank you.

DR. CHERNEW: Thank you. Jonathan, you're next.

DR. JAFFERY: Thanks, Mike, and thanks, everyone, for the comments. This has been an amazing discussion. As others have said, this chapter is really fantastic. I really appreciate this classification of the population-based episode and advanced primary care and also this distinction between population-based and advanced primary care. So I learned a little bit and I think it's a really great framework for us to keep this conversation going. I'll try to stick to comments that push us towards this idea of setting a vision, and like Mike said, this is a multi-cycle process.

So first of all, in thinking about the discussion questions on the slide that's up, absolutely, I'm concerned that there are too many models and that they keep changing. It's very, very difficult to operate under some of these

circumstances. Next Gen is a five-year plan. I think it's now on six years, because it got extended a year through COVID. But as a six-year model it's really more than just one model. It keeps changing, and it's very challenging to keep up.

There were some comments about direct contracting being an extension of that, and that's a great concept and I think that there are some aspects of that that make sense, in terms of an evolution such as more frequent reconciliation. But I can tell you, as an operator, it does not feel like it's just an extension. It feels like we're starting over and trying to figure out what are the rules of this new model. So I think simplifying them and having multi-year performance periods would really be helpful.

A couple other thoughts to try and build on what some others have said, in terms of vision for Advanced APMs. I think moving beyond this idea of technical assistance and dissemination of best practices towards trying to incorporate some of the successful elements that we've learned about might be helpful, and I think this speaks to what Amol was talking about in terms of practice

transformation.

There are some things. We have talked about shifting to home-based care and where the advantages are there. There are things that we know work that might be embedded into some of these models, and I think that's probably more in terms of maybe that's a next cycle discussion, but I think it's something we should keep in mind.

I'd really like to flesh out how to integrate episodic payments with the population-based payments with the ACOs. That, I think, is an important idea and concept, and I think there's some work we could do to model that and figure out how the fortunes for both ACOs and the specialists could rise and fall together, based on success or failure of some of those episodes.

Related to that, this issue of should we develop models to manage high-cost conditions, I am going to strongly echo what Karen put forth. I am not in favor of that. First of all, I think it's going to create more silos and goes against the idea of fewer models. But, I mean, Karen, your example was a great one and it's really the pickle juice idea that struck home for me.

But, you know, that's not a rare situation. My practice as a specialist, of course, is a little different than Karen's, but I have very few patients that have just one condition, and the management for one often -- optimal management for one sometimes, not infrequently, conflicts with the optimal management for another. And so I'd much rather see that we focus on these high-cost populations, and specialists can fit in with episodes. The episodes don't have to be 90 days after a procedure. They can be a year. They can harmonize with the ACO payment period.

A couple other quick comments. In terms of mandatory, I don't feel as strongly, like Dana does, against mandatory. I'm a little bit more in keeping with what Betty was thinking about. I recall Paul making a comment a few meetings ago about DRGs going mandatory and how if we hadn't done that, we probably wouldn't have them still, and that really struck me.

I think Dana's points about thinking through, are there some characteristics or criteria for an organization to be put into a mandatory model that maybe moves more towards some of the bigger systems, especially as we're getting more and more consolidation, I think is an

important one to think about as opposed to mandatory models based simply on geography. But those are some things that I think we should think through.

And then, finally, I think the biggest issue perhaps is really still around the benchmarks, and here, like people have said before, we really, really need to harmonize this with how we're thinking about MA, and this really connects nicely with yesterday's conversation. But to just have a model that keeps continuously lowering the benchmark doesn't make sense. It doesn't seem sustainable. I'm not sure it's a desirable thing in terms of overall levels of spending.

So, ultimately, trying to find benchmarking for ACO models and MA that sets a target based on some national goals, takes into account the tremendous geographic variability that we see, and then set a growth rate and work towards that. There may be some opportunities for us to model what that could look like in terms of overall savings. So what if per-beneficiary per-year spending for all Medicare beneficiaries occurred at, say, the 50th percentile or 25th percentile, where we are seeing ACOs, what would that look like in terms of overall spending?

What would that do to the hospital trust fund solvency?

In September we heard about what would be needed to maintain solvency in terms of a $1,000 decrease per year, but that sort of implies to me a shift down of everybody, and I'm not sure that everybody needs to shift the same amount. We've got very high-spend areas and we've got some areas that aren't as high spending. So there is some additional modeling that we might think about there in terms of how would we think about benchmarks setting for that, target setting.

So I will stop there and thank you for the opportunity to comment.

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

DR. DeBUSK: Thank you, and I share the other Commissioners' enthusiasm over this chapter. I think it's very relevant work.

Going straight to the discussion slide, I see us consolidating to one population health model. We can call it an "ACO," we can call it "direct contracting," but one pop health model, I think we consolidate around one episodic model. I think the episodic model is sort of your classic BPCI-A version. But I also think that we create

some chronic disease management episodes that can go in there as well. So we may have acute episodes like lower joint replacements, but then we may also have chronic episodes, like a 90- or a 120-day COPD management episode or a diabetes management episode. I think that could all comfortably fit under this one episodic framework.

Then I think we should have one primary care model, and I think the paper alluded to that. But I think the primary care model should be compatible, and I'm going to talk a little bit about what I think compatibility really means, compatible with the episodic models, because I think that is -- it is inevitable that you're going to have people in, say, a Primary Care First model that are going to need a joint replacement, or you're going to have someone who maybe is in the Primary Care First model but who needs more specialized care for their diabetes or for their heart disease.

The other thing I want to mention is I think the primary care model that we do needs to conveniently walk. We need to be able to take the primary care model, scale it into a physician-led ACO or whatever we're going to call our people health model, and then scale that into a full-

blown hospital and physician consolidated population health model. So I think there needs to be basically crosswalks between those three basic frameworks: pop health, episodes, and primary care. But, again, there needs to be convection between those models and compatibility.

I am comfortable making these mandatory for providers. I think CJR proved that you can do that. And I also think we're going to have to create some beneficiary incentives or maybe even disincentives for not participating in these models. Medigap basically means that only 11 percent of our beneficiaries are exposed to any cost sharing at all. The only lever that we have left -- and it's an uncomfortable lever -- is the Part B premium. But I do think we need to revisit -- for people who actively refuse to participate in any of these models, who truly want the old fee-for-service chassis, it just doesn't seem right that they don't pay some surcharge or some incremental amount on the Part B premium; or, conversely, the people who do participate in these models should maybe enjoy a reduced Part B premium.

I think locking these models in for three to five years is great. I think we should codify some of the

waivers in statute. I don't think people should wait each year to see what their waivers look like or which waivers are going to be included with which model. I think those all need to be set in law.

I do think we need to adopt some common features. Other Commissioners mentioned this, so I won't belabor them, but I think we need to have a common benchmark development mechanism. I think we need to adopt a philosophy on risk scoring and how much or how little of the HCC model we're going to use. And then I think we need to stick to that throughout all the models, particularly so that you can have this flow from one model to the next.

I think we need to have shared quality metrics. Others have mentioned -- I think we need to be compatible with MA. I really liked the MA benchmarks being 50 national, 50 local, because in theory we could set our population health benchmarks the same way.

The last piece of this first round is compatibility. You know, when we talk about models being compatible, to me 85 percent of compatibility is really just setting precedents for how shared savings or how shared losses are distributed. Compatibility to me is just

being able to say if someone in a population health model enters into an episode and comes out, this is how we're going to distribute those savings or losses. And to me, I think it would be tedious, but to Michael's point earlier, if we consolidate these platforms down to a limited number of models, it shouldn't be hard to develop crosswalks for how to share and split those savings.

The last thing I want to touch on -- and it's the windmill I've tilted for a few years now -- MSSP is ten years old, and we've had basically mediocre, tepid results so far. And I just want to take a brief moment -- I know we're tight on time -- and reflect. For ten years, very talented, very passionate people have done really high-quality work trying to make these models work, and we don't have the profound results -- I think ten years ago when the ACA was passed, if someone had said this is where we're going to be ten years later, I don't think anyone would have believed it. And I've really narrowed it down to two hypotheses: either care coordination and focusing on high-value services is just a failed idea and it doesn't work and we need to focus on prices; or we've built these models on the wrong foundation.

So I do want to -- and I don't believe, by the way, Hypothesis 1. I do believe in care coordination. I do believe it's not just about prices. But I think we're going to have to get away -- and several Commissioners have mentioned this. We've got to get away from the fee-for-service chassis. And getting away means really three things: number one, it's not building your models directly on top of fee-for-service; number two, it's incorporating some type of global payment into these models. For example, CPC+ track 2 uses a global payment. Primary Care First uses a portion of the revenue from global payments.

But then the third element is I think we need to send a message that fee-for-service isn't going to be business as usual. We've seen the acceleration of the Medicare Trust Fund's depletion, Part A Trust Fund's depletion. Providers need to understand that it isn't going to be business as usual in fee-for-service no matter what. And I think that's one of the big things that we've missed in the last ten years in all of these alternative payment models, is the null hypothesis, the failed experiment is everybody gets to do what they've done the entire time, their entire career. And I think that one of

the messages that we need to send as we do this next round of A-APMs, we need to create a vision for what fee-for-service is going to look like as the trust fund depletes; beyond the depletion of the trust fund -- for example, maybe at 2027 maybe we cap all fee-for-service rates. Maybe we don't do updates to fee-for-service after a certain date, and people make their incremental revenue and their bonuses through A-APMs.

So, again, that was just my one plug to please let's consider not discarding fee-for-service, but at least decoupling it through the use of some global payments or a blend of global payments and fee-for-service.

Thank you. Those are my comments.

DR. CHERNEW: Brian, just an update --

DR. RAMBUR: Michael, at least for me, I can't hear you. Michael, it's all watery for me. I don't know if the others are able to hear him.

DR. CHERNEW: Maybe this will be better.

PARTICIPANT: It's better.

DR. CHERNEW: We have 20 minutes and ten people, and do the math, but I look forward to going ahead. Dana, go to the next person.

MS. KELLEY: Bruce, your turn.

MR. PYENSON: Thank you very much. I'll be very brief. It strikes me that one of the advantages of Medicare fee-for-service historically, although the rates were low, it was simple. And what we're seeing with ACOs might be very unattractive and very unappealing because of its complexity. So I am supporting fewer models.

I would decouple lengthening models, testing periods with fewer changes. We need fewer changes. I've called for multi-year bids for Medicare Advantage. It's the annual zoo of responding to changes that's simply not worth it, so we need stability there.

I would point out in this group of MedPAC Commissioners I'm one of the few people who's neither a clinician nor an academic, and I would caution folks to keep in mind that what may be some of the things that are being suggested and recommended would seem very odd to people not from your background. I can say as an actuary nobody paid the actuarial profession to transform our practice from paper to electronic. I don't think anyone paid the attorneys to do that. I don't think any government paid the CPAs to do that or the engineers. So

let's focus on what the outcomes are; otherwise, we're going to sound very self-centered to a bunch of people.

I like Betty support mandatory models, and I think the direction is already going there with the bundled payment program. So let's keep things simple, stable, and not micromanage the poor clinicians. Let's not blame the clinicians and let's not blame the patients.

MS. KELLEY: All right. David, you're next.

DR. GRABOWSKI: Great, thanks. Like other Commissioners, I'm very excited that we're embarking on this work. Lots of good comments already, so I'll be very focused in my remarks.

First, I'm very much in favor of moving to fewer models. Medicare's approach to date has been to put up a lot of shots on goal by implementing lots of different models. The idea is if you take enough shots, something's bound to go in. Unfortunately, as we've been discussing, lots of unintended consequences to this approach. Too many models provides conflicting incentives to participants and makes it difficult for the Medicare program to understand what works and what doesn't.

Most importantly, all these different conflicting

models don't serve our beneficiaries very well. We often use the phrase "less is more" in our meetings, and we hear it a lot in health care. But when it comes to A-APMs, once again less is more.

I also want to emphasize beyond shrinking the number of models that we also need to think a lot not just how the different models align with one another, but also how the different elements within a model align with one another. And one of the examples we've talked about before during our meetings was the voluntary pathways to success, the combination, of course, of two-sided risk and this blending of historical benchmarks with average regional spending introduced even stronger incentives for ACOs with high spending for their patients to exit the program and providers with already low spending to remain or join the program.

These kinds of selection effects happen when we don't align the different program elements, and I really think it's important going forward that we think about not just aligning different models, but aligning those elements within models.

I don't want to get into the weeds today, but I

hope discussions about benchmarks will be a big part of our agenda going forward. I think there's a lot of work to be done here. So I'm very supportive of kind of making that a major focus.

Similar to others, I am supportive of mandatory programs. One of my colleagues likes to say, "Mandatory solves everything, or at least a lot of things when it comes to selection." Amol mentioned the CJR earlier. We did research on that, as did others, and found savings with a mandatory program. Of course, it was very challenging politically to keep that model in place, and so I really like Dana's suggestion. If we can't do this in a mandatory fashion, providing strong financial incentives to get individual -- get participants even under a voluntary model to join the program.

I'll say quickly, as a researcher, I loved randomization in the chapter. I'm not going to hold my breath on that one, but it would be great in terms of evaluation. But I'm not holding out for that one.

The final point I'll make: I very much agree with the eloquent remarks Karen and Jonathan made around focusing on those high-cost, high-need patients. And I

would go even a little bit further to say are there high-cost settings that we might focus on? For example, most of the ACOs to date have been hospital- or physician-led. There's only one nursing home-led ACO that I'm aware of, but it's a really intriguing model, and other ways of taking these kind of base set of models and applying them, not just to high-cost beneficiaries but also in high-cost settings.

I'll stop there and say thanks and look forward to our continued work on this issue.

MS. KELLEY: Paul, you're next.

DR. PAUL GINSBURG: Yeah, thanks. I'm really glad we're doing this. I thought the staff work was excellent, and my colleagues have made really valuable comments.

I think the key thing is that we've been doing demonstrations aggressively for over ten years. We have learned a fair amount. We could have learned more if, you know, we had followed some of the advice we talked about.

I think that the Commission needs to come up with a proposed strategy for how we can get from where we are now to a system that is not a demonstration system, that is

a permanent policy, subject to change, of course, like the DRG system was. And I think we need to say, you know, are there any more demonstrations that are needed, one that could go on along with a permanent system? But I think we really need to come up with a plan to get there and to recommend that to Congress.

You know, some of the issues that are very important for us to figure out are how the models can fit together, the mandatory-voluntary, and I think that mandatory works very well, particularly with episodes. I think for population-based, it may be more important to follow Dana's approach of strong incentives to be in, but not insisting that everyone be in there.

I think we should pay some attention to the potential for commercial insurers to pursue parallel models and are some models easier if they are enthusiastic for them to do? I know our primary care models have deliberately recruited commercial insurer participants in the areas, but I think we should factor that into our thinking.

So I'll stop there.

MS. KELLEY: Jon Perlin.

DR. PERLIN: Thanks. Let me agree emphatically with many of my colleagues' appreciation for this chapter and this important work.

You know, in 2015, I had the privilege of serving as the Chair of the American Hospital Association, and my big epiphany that year is that in terms of transformation, two things are needed, not one: a clear vision of the destination as well as a clear mechanism for transformation. The absence of either one is insufficient. I think that transformation path that Amol alluded to really begs the question in the context that we have now: Which path? Which destination? So this potpourri makes defining the destination journey far less clear.

So with respect to the discussion questions, I'm emphatically in favor of fewer models, clearer, and as others have said, a lot less complex, and I think with strong incentives coupled with mechanisms to delineate the transformation process as well as the ultimate destination.

Second, this really leverages my experience in the VA. I think we need to emphasize the role of the primary care provider more as an organizing principle, whether like Jonathan Jaffery it's a nephrologist or,

Betty, whether it's a nurse practitioner, whether it a heart failure doctor, Karen, or an HIV expert. Someone needs to be the quarterback. What would be the problem? We're asking a system, a football team, just organize the play while you're out there. No. Someone needs to call the play, and I think this lack of focus on the primary care provider, whoever that might be, I think it's what's leading to some of the diffusion and lack of capacity to really sort of simultaneously advocate, understand professionally what matters, and then sort of make the system more effective in delivering to those needs.

In VA, just on this point, when we moved to essentially medical home type of concept, not only did functional longevity and quality metrics go up, the cost per patient went down.

Third, I agree with the points that were made about bringing MA and A-APMs closer together, and I think a lot has been said on that, so I won't reiterate.

I think we can gain a lot by looking to other countries like the Netherlands and Israel where there are uniform benefits packages that could be consistent across A-APMs and MA and essentially the payers could deliver

effectively on those packages, and I included the A-APMs in that, while the providers could deliver value to those commissioners of care.

And then, finally, putting it all together then, I would agree with Brian with consolidation to population health and episode and primary care plan, that those be integrated, and that the articulation of such be a mechanism that creates that clear understanding of what both the transformation process is and what the destination would be.

Thanks.

MS. KELLEY: Larry.

DR. CASALINO: Yeah. In the interest of time, I'm going to avoid trying to comment on each issue, but I just want to make two broad points.

One is I think that this -- however this winds up finally being published, I think we want to avoid being too critical. Actually, I think what's happened to date is pretty good. A great deal has been learned, and probably more importantly, I think what's gone on the last 10 years with CMMI has kind of begun the organizing of an atmosphere, I would call it. So it's becoming the case

where providers are gradually getting the idea that it isn't going to be business as usual forever.

Now, I think if progress doesn't speed up a bit, the reverse may start to happen. People may think, okay, this has been going on for 12, 13 years now, and people keep saying the train is going to leave the station. Well, it hasn't left the station yet. We're still doing mostly fee-for-service. That would be bad.

But I think a goal is to make it so that the taken-for-granted thing to do is to try to improve the health of your population of patients and not by being paid for fee-for-service.

I agree. I think with the pandemic, we've seen how quickly the health care system can change, at least for a short time and about certain things. The DRG example is a good one in some ways but not in others, I think. Much easier for hospitals to adapt the DRGs than for the whole delivery system to adapt to trying to create a population health.

But I agree with those who have said we need to move as quickly as we can from things that are heavily based still on a fee-for-service chassis to thinks that are

based on capitation of prepayment.

The trouble with this is -- and this gets into the idea of people have called -- I think Jon just said this, Jonathan -- you know, what's our strategy for change, where do we see the process as being. I think the problem is that -- and Jay wrote about this, Jay Crosson, years ago. We really have a chicken-and-egg problem. If we had certain kinds of -- or delivery system organizations, we could just give full risk capitation and get away from fee-for-service completely, have some quality patient experience measures, and we'd be done. But we don't have that. We're not even close to having that.

So I think Jay portrayed it, and it's frustrating and messy. And it takes time, but I think he's probably right that we make some payment changes, the provider organizations change a bit. This enables a bit stronger payment incentive changes to be given and the provider organizations change more and so on, so kind of a ratcheting up. So that's my first comment.

Second comment, I'll be briefer, and it's about episode-based payment. I think the concept that -- for example, if episode-based payment for joint replacement

works well, then let's get episodes for as many things as we can. And in particular, let's get episodes for chronic diseases, and so we'll be paying some providers for taking care of patients with diabetes and other providers are taking care of their COPD and other providers are taking care of their heart failure. And I think from what Karen and others have said, it kind of hints that that may not be a good idea.

Also, the more episode-based payments we have, the more this kind of gets in the way, evaluation-wise and in other ways, of having accountable organizations that are really accountable for the health of -- all the health of all their patients.

So without getting into more detail on this, I think we -- this isn't discussed often enough, I don't think. I think we want to think very carefully before we start to encourage a plethora of episodes as opposed to trying to get accountable organizations that would take care of patients, all patients' health care needs.

MS. KELLEY: I have Marge next.

MS. MARJORIE GINSBURG: Thank you.

I just wanted to briefly respond. Brian, I

think, so far is the only one that raised a comment of the involvement of participants, and I think one thing that was missing from the chapter, but perhaps it was me that missed it, is what happened to the whole process where the programs were supposed to notify participants that they are now in an A-APM. And I've never heard anything more about it.

The fact that people with Medigap insurance have almost no cost sharing, but it occurred to me -- and this may be that I read somewhere -- that Medigap plans could offer a discount for those who are willing to, in fact, be participants in this program.

So it just seems to me the one thing that's missing here -- and it may not have a gigantic impact on the success of these programs -- is where are the beneficiaries in this, and do we need to at least start testing programs that actively engage participants in the A-APM that they're a part of?

Thank you.

MS. KELLEY: Sue?

MS. THOMPSON: Thank you, Dana.

And I'll be quick as well because I think there's

still a few more to go. In terms of a context of this conversation -- and it was referenced. I think Larry commented, but between COVID, dealing with this entire pandemic, managing the complexity of the Next Gen contract and the constant changes while evaluating direct contracting looking forward, the bandwidth of interest around staying enthusiastic in this work is waning across the folks that I work with and across other organizations that we're in contact with in this ACO work. So I just call that out as a bit of the in-the-field context for kind of continuing at this pace.

And so with that, I just would strongly agree that we have way too many models, and we've got to bring some conclusion to all this voluntary activity.

The ongoing commentary about organizations that are hospital-based ACOs, first and foremost, patients are attributed to ACOs by their primary care provider. If there are hospitals in the ACO, they are increasingly frustrated that the ACO remains on a fee-for-service chassis. So the conflicts and the inherent -- the counter-incentives that go on are very difficult, but rather than being critical of their less than great performance, I

think we need to be thinking about how do we build an opportunity for hospitals to be incented to reduce expenses. So I would offer that as a suggestion.

I'm strongly in agreement with harmonizing the benchmarking between ACOs and MA.

And finally, we haven't spent a great deal of time talking about the role of the beneficiary and how we might do more work either in educating beneficiaries about their role or building incentives to help reduce utilization and improve health.

Thank you.

MS. KELLEY: The last person I have in the queue is Pat.

MS. WANG: Thanks.

Just really quickly, I won't repeat the really thoughtful comments of the other Commissioners.

I want to suggest that we not use the word "mandatory" because it sounds a bit harsh. I prefer to think of it as once there seems to be promise in some of these pilots that they become the new methodology for paying for certain things. I don't think it's a mandatory issue. I think it's just we decided that this is a better

way to pay.

I also want to -- I understand the interest in episodes and bundles, but I actually don't -- I have a lot of caution about going there. If it's a step along the way, it's fine, but to me, it's still a unit of surface. It's an expanded fee-for-service payment, and you can drive -- you know, I think that you can create different incentives by creating those kinds of things because then the more of them that you do, the more revenue you generate. So it drives towards the point of having some sort of global budget in the background against which all of these little bundles are held, because maybe you don't need to deliver as many bundles, even though they seem really neat in and of themselves. So that would be my caution there.

And that's all I want to say. Thanks.

DR. CHERNEW: So, hopefully -- can you hear me? I think, Dana, that was the entire queue, showing you once again the miracle of MedPAC Commissioners staying broadly on time.

I will reach out to some of you that may not have spoken, but I think in the interest of time, we should

probably move on to the next topic which is vertical integration.

I will say for those on the line that there's a lot of issues here. I've written down some, mandatory versus voluntary episodes versus population-based, the principles of benchmarks, downside risk. I have a few other things. We are not going to be able to address all of those things this cycle.

So I am hoping we will move -- there seems to be some agreement around harmonizing and trimming the models and stabilizing them. I think we will move toward a recommendation in that vein. I hope we can lay out a little bit of principles around certain things going forward in the chapter, but some of these issues are very analytically complex. And so we're going to have to take them in a targeted and thorough way as opposed to going around and just getting everybody's views on each particular one-off design principle.

But I really appreciate that discussion, and so I'm now going to turn it over to Rachel. Thanks so much.

* DR. SCHMIDT: Good morning.

Before we begin, I'd like to thank Jeff, Carol,

Eric, and Shinobu for their help. And as a reminder to the audience, you can download a PDF version of the slides in the handout section of the control panel on the right-hand side of the screen.

In this last session of the October meeting, we're going to have a big-picture discussion about vertical integration in health care.

Last March, we published a chapter about health care provider consolidation, with most of the focus on hospital consolidation and hospital purchases of physician practices. At the time you discussed that material, some of you said you'd like to see information about vertical integration in other sectors. So this morning, we'll talk briefly about health systems but then look at what health plans have been up to, because both have implications for the Medicare program.

This material is meant solely as food for thought as you deliberate policy issues during this cycle.

Because Medicare is such a large program, Medicare policies can influence how providers and health plans organize themselves as well as the degree of competition and rivalry among them. Of course, Medicare is

not the only factor when health care companies are considering mergers and acquisitions because we have a variety of payers in the United States, and market conditions vary geographically.

Nevertheless, here are a few examples of what I mean. In our March chapter, we noted that higher payments for physician services at hospitals played a role in hospital purchases of physician practices. Similarly, policies aimed at promoting care coordination such as accountable care organizations and bundled payments may lead groups of providers to decide that it's easier to align incentives by purchasing other providers.

Medicare has been making changes to how it pays for post-acute care, and a unified PAC payment system could have large redistributive effects among types of providers. Some PAC companies have begun reorganizing themselves in response.

Finally, Medicare's launch of a drug benefit and the expansion of Medicare Advantage enrollment, we've observed, have both contributed to changes in the structure of health plans.

Let's look briefly at the state of vertical

integration with respect to health systems. This information comes from the Agency for Healthcare Research and Quality's Compendium of U.S. health systems. Here, to be included, a health system had to have at least one non-federal general acute-care hospital and one physician group with at least 50 physicians connected through common ownership or joint management. In 2018, there were 637 health systems that had about 3,400 hospitals affiliated with just over half a million physicians.

Hospitals have been consolidating for decades, and in 2016, about 70 percent of hospitals and 88 percent of beds were already in health systems. Those percentages increased a little bit between 2016 and 2018, but not by that much. What's surprising is how quickly physicians have become a part of health systems over those two years.

By 2018, about half of physicians were a part of health systems, including primary care physicians. This quick increase may reflect steps to align incentives between hospitals and physicians, measures to help maintain referral patterns to hospitals, the incentives provided by higher physician payments at hospital-affiliated offices, or a combination of all of those factors.

Our March chapter has a review of the literature on the effects of hospital-physician vertical integration. To summarize, we found that while in theory, integration could lead to a lower overall volume of services through greater coordination of care, the empirical literature suggests that while there may be some substitutions in types of care, integration does not have a substantial effect on volume in the aggregate, nor does hospital-physician integration seem to improve quality. Most studies show ambiguous or no effects.

However, studies have consistently found that physician-hospital integration leads to higher commercial payment rates. One reason is that hospitals charge facility fees for physician services in addition to professional fees. Another reason is that large hospital-based practices gain market power and negotiate higher rates.

Medicare and its beneficiaries are insulated from these effects initially because Medicare sets fee-for-service prices administratively. However, higher commercial payment rates could lead providers to pressure Medicare to increase its rates. Meanwhile, vertical

integration is associated with higher payments for both commercial and Medicare patients because of higher payment rates for hospital-based care and because physician referrals patterns may be altered towards hospital facilities.

As hospitals have acquired physician practices, health plans have responded in kind. But physician practices are just one way in which health plans have become vertically integrated.

As this slide shows, the major U.S.-managed health care companies all own their own pharmacy benefit managers, typically with their own large mail and specialty pharmacies. In addition to physician practices, major health plans have purchased other types of settings for outpatient care and invested in data analytic and consulting firms. What health plans have not purchased, by and large, are hospitals, health systems, and other types of institutional providers.

Meanwhile, in the Medicare Advantage and Part D programs, enrollment is pretty concentrated in plans offered by vertically integrated managed care companies. This is an overall look at enrollment, not market by

market, but it can still give you a sense of the degree of concentration. The top three companies in the MA and stand-alone prescription drug plan sectors account for over half to nearly two-thirds of all enrollment, and the top 10 plans sponsors account for three-quarters of MA enrollment to nearly all PDP enrollment.

Empirical literature suggests that when insurers merge with each other and gain market power to negotiate lower commercial prices with providers, it doesn't necessarily lead to lower enrollee premiums. Premiums are lower when there is more competition among insurers in a market. For the same reason, it is important to promote competition among MA and Part D plan sponsors.

Over the next few slides, we'll consider the potential implications for Medicare of three categories of vertical mergers that health plans have engaged in, with outpatient providers, PBMs, and PAC services.

In your mailing materials, there are examples of vertical mergers that have taken place recently, making some health plans among the organizations with the largest number of physician employees or affiliates in the country. In addition, health plans have acquired chains of retail

clinics for lower-acuity services, ambulatory surgical centers, and multispecialty medical centers that focus on chronic disease management and senior care.

Presumably, a main advantage of this type of acquisition is that the health plan can include in its network providers that it believes provide higher quality or lower cost care and align providers' incentives with those of the plan through risk-based payments.

In turn, by encouraging enrollees to see those providers or go to lower cost sites of care, the plan could improve quality and lower costs. Health plans may have more resources to invest in decision support or quality-measurement tools for physician groups that they acquire. Health plans may also vertically integrate with outpatient providers to assert their own market power, to defensively counter the market power of health systems, or to remain competitive with other insurers.

Do these forms of vertical integration benefit the Medicare program and its beneficiaries? There's not a lot of evidence, but there are reasons to be cautious and not generalized.

For one, acquired practices and providers may not

overlap geographically with larger concentrations of a health plan's MA enrollees. There's overlap in some cases and not in others. Some of the vertical mergers lead to direct employment of providers, while others do not. In situations where a provider is not exclusively employed by a health plan and they see patients from a variety of payers, other payment arrangements can undermine incentive arrangements with the plan.

When health plans purchase a number of different provider groups, the providers may be using a variety of electronic platforms, and harmonizing those tools can take time.

For health plans that are providing more convenient access to care through retail clinics and centers, it is not clear that these care options will necessarily substitute for care at higher-cost settings and lead to lower spending. It could lead to more use of services.

Next, let's look at vertical integration with PBMs, which also own large mail and specialty pharmacies. Health plans have integrated with and built up large PBMs that may have market power to negotiate rebates with drug

manufacturers and achieve scale in mail dispensing. Those are important functions as medicines have become a larger component of health spending.

But why doesn't a health plan just write a contract with an independent PBM? Because of the complexity of drug pricing, the highly proprietary nature of rebates, and imperfect competition among PBMs, PBMs have an information advantage, so it can be difficult to monitor a PBM contract and costly to enforce it.

Health plans may have decided that it's easier to just buy the PBM. By doing so, the health plan gains access to information about drug prices net of rebates and discounts, which can allow it look at tradeoffs between medical and drug expenses. If instead the health plan had an arm's-length contract with a separate PBM, the PBM might have incentive to keep drug spending low even when a medicine might forestall other kinds of medical expenses. A vertical merger may align those incentives.

Acquiring or building your own PBM and mail and specialty pharmacies also gives the health plan access to an important source of data, claims that are typically adjudicated at the pharmacy. That data can be used in a

lot of ways such as monitoring adherence or predicting future use of services.

Does vertical integration between health plans and PBMs benefit Medicare and beneficiaries? There are ways it's beneficial, for example, by allowing a health plan to internalize tradeoffs between drug and medical treatment options. However, there are also reasons for caution. There are a number of smaller MA plans that have contracts with large PBMs owned by competing health plans. Those smaller plans may still find that because of the PBM's information advantage about drug prices, it can be difficult to monitor and costly to enforce their PBM contract. And because the PBM is owned by a competing health plan, it might be possible to raise the rival plan's costs, not obtain the best discounts or rebates on behalf of the smaller plan.

A second reason for caution goes back to the degree of concentration of MA and Part D enrollment among relatively few large health plans. If large plan sponsors are able to achieve efficiencies by acquiring a PBM, that doesn't mean it will necessarily lead to lower Medicare payments or enrollee premiums to MA or Part D plans. It's

the degree of market competition among health plans that affects whether they feel pressure to bid lower.

And the last point here is just that vertical integration won't overcome poor incentives in a payment system. Currently, Part D's benefit structure and subsidy payments provide incentives for plan sponsors to include high-cost, high-rebate drugs on their formularies. Those incentives remain whether a plan sponsor writes a contract with its PBM or vertically integrates with the PBM.

The mailing materials give examples of how health plans have vertically integrated with companies that provide PAC services. One strategy has been to directly acquire PAC providers such as home health agencies. In that situation, from the health plan's perspective, the advantages may be similar to those of acquiring physician practices. The plan can include what it views as higher-quality, lower-cost providers in its network, align incentives between the plan and provider through risk-based contracts, and then encourage enrollees to use those providers.

Under a second strategy, health plans have not acquired PAC providers, but they have acquired firms that

manage PAC services. Such a company would, for example, track enrollees with inpatient stays, use patient information to predict whether the individual needs PAC services, and then help clarify which PAC setting might be appropriate for functional improvement. In both approaches, a goal seems to be to encourage enrollees to use non-institutional PAC or to reduce lengths of stay at institutional providers if that type of care is needed.

Whether vertical integration with PAC companies benefits Medicare and beneficiaries depends on a number of things. As was the case with physician practices, PAC providers that are directly acquired by a health plan may or may not overlap with the geographic markets where MA enrollees live. If the PAC provider does not exclusively serve the health plans' enrollees and there are multiple payers, the provider may have mixed incentives rather than being aligned with the health plan.

Importantly, there is still some uncertainty as to whether substituting home-based care for institutional PAC will improve quality and lower costs. My colleagues have found that in fee-for-service Medicare, risk-adjusted rates of with-in stay hospitalization are higher for home

health than for other institutional PAC settings, so it is very important that the decision to use home care be appropriate to the circumstances of the patient. And again, even if the vertical integration of PAC companies does reduce costs, the degree of market competition among health plans is what is relevant for determining whether the Medicare program and beneficiaries benefit from any savings.

To summarize, Medicare policies, among other factors, can influence how providers and health plans choose to organize themselves, including whether they integrate vertically. We have seen that hospitals have been organized into health systems and, increasingly, health systems have acquired physician practices. Health plans too have become more vertically integrated with physician and other outpatient providers, PBMs, and some PAC companies.

However, analysts have pointed to a tension between more coordinated care and the degree of market competition that remains once health care firms have reorganized themselves. Some vertical integration may work to improve quality and efficiency, but we have also

discussed some reasons why we shouldn't expect that all such deals will benefit Medicare and beneficiaries.

When policymakers introduce changes to Medicare, they are generally focused on the program's goals, making sure beneficiaries have good access to quality care that is provided in an efficient manner. But as we consider policy changes, it is also important to think about how they might affect market competition among providers and health plans. Many policies that would directly affect competition, like antitrust enforcement and state licensing requirements, are outside of our purview.

However, there are some policies within Medicare that can help promote competition. Carrying out site-neutral payments and focusing on fewer quality metrics that measure care outcomes are a couple of examples. As an increasing share of Medicare beneficiaries obtains their care through private plans, policies that promote rivalry and strong competition among MA and Part D plans are important for ensuring that any efficiencies associated with vertical integration get passed on to beneficiaries and the Medicare program.

At this point I am happy to answer questions

about the material. I would also like to know whether there are other aspects of vertical integration that you want us to pursue, or if there are implications for Medicare that we have missed and that you'd like us to address.

MS. KELLEY: Mike, shall we start with the round one questions?

DR. CHERNEW: Absolutely, and I think David is the first in the queue. I'm not sure.

MS. KELLEY: I think that's right.

DR. CHERNEW: Hopefully you can hear me.

DR. GRABOWSKI: Yeah, great. Thanks, Rachel. This is great work. I had a question on the post-acute care integration. Do you have any sense of why now? You know, MA plans have been, you know, using post-acute care and contracting with post-acute care providers for a long time. What is stimulating this?

And then I think the other part of my question would be, are these just two deals? I realize these are two major companies with Humana and United Health, but is there a sense that this is the way the world is going, or is this a couple of one-offs? So two questions.

DR. SCHMIDT: So I'd say it seems like there's

less of this than the other types of examples that we provided of vertical integration. I'm not sure that it's just one-off, however. I do see a few other things in the precedents. Of course, this is not a full inventory of everything that's going on. This was meant as a thought piece. So I think there are a few other examples out there that weren't in your paper.

And as for why now, that's a good question. I think Bruce has communicated ahead of time he has a hypothesis as to why that is, and I think I'll let him speak to that. But I think part of it is just that maybe the fact that you've seen so much growth in Medicare Advantage enrollment, and there are a few demonstrations on the horizon, for example, including broadening what Medicare Advantage plans cover to include hospice, and maybe it's a realization that they are going to be responsible for the full variety of care. But maybe I should also let Bruce have his say too.

DR. GRABOWSKI: We can all wait on pins and needles for Bruce's round two comments here, I guess. Thanks, Rachel.

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

DR. NAVATHE: Yeah, I had a quick question. So on page six of the readings, at the top there is a comment about horizontal consideration raising private payer prices, which makes sense, and then there's a comment that says, "However, higher payment rates could lead providers to pressure Medicare to increase its rates."

And so I just wanted to see if we have any thoughts around the mechanism would be there, because otherwise Medicare is collecting cost reports for many of the different provider types. Medicare is using its monopsony power, presumably. So it didn't seem clear to me that there was a mechanism there or what the pathway was, and I was curious if you guys have more evidence there than I might be aware of.

DR. SCHMIDT: I might invite my hospital colleague, Jeff, to join in on the answer to this one. But it may be partly a political sort of argument that, you know, if there's a wide disparity between commercial and Medicare rates it just becomes more difficult politically to hold down, tamp down administrative prices. As to whether there is evidence of that, this actually taking place or not, I would ask Jeff if he wants to comment on

that.

DR. CHERNEW: Can I jump in for a second before Jeff says something? So first, I watch Twitter to see how many people looked at the Stensland article in Health Affairs, which will be fun to discuss. I think the theory, from some previous work that MedPAC did, is if commercial rates are high the hospital cost structure inflates, and once the hospital cost structure inflates to compete for commercial payments or whatever you believe, that then the higher hospital -- or it doesn't have to be a hospital -- the higher provider cost structure tends to put pressure on Medicare rates.

Again, we can discuss the evidence of this broadly, but the question you asked, Amol, was what the theory was, and that actual work was done, I think, the last time I was on the Commission, and again, Jeff Stensland is the co-author on a related paper in Health Affairs.

So now that I got to plug Jeff's paper, we'll let Jeff say something.

DR. STENSLAND: I don't have much to add but I would say on the hospital side the concern is higher rates,

the provider has it, they spend the rates. Once they spend that money and Medicare rates don't go up initially, it looks like they're losing money on Medicare, and the lower the Medicare margins the bigger the losses on Medicare, the more pressure there will be to increase Medicare rates.

The other is simply, on the other sectors, even the physician sector, to the extent that the private rates become so much higher than Medicare, eventually there is this concern that will people stop taking Medicare and then eventually will there be an access problem. And we haven't seen that yet but that is a big concern, that the differential can't get bigger and bigger forever.

DR. NAVATHE: Thanks.

DR. CHERNEW: So if I followed correctly, we are now ready for round two. Paul Ginsburg is going to lead us off. We have a list, I think, of five, and Bruce, I think, is going to eventually be on that list. But we're going to now start with Paul.

DR. PAUL GINSBURG: Oh, thanks, Mike. I thought this draft that we read was outstanding, and it fascinated me with the comprehensiveness of different types of vertical integration, and the insights in the paper,

especially about what different types of vertical integration mean for Medicare and its beneficiaries.

As stated, many of the issues raised were outside the scope of Medicare policy, but a surprising number of these issues can be influenced by Medicare policy. So many of the approaches to vertical integration discussed appear to have the potential to create value, but the value may not go to Medicare or its beneficiaries, either because of poorly designed payment systems, the lack of competition in areas such as Medicare Advantage, or because of the combinations likely will reduce competition, either because of the horizontal integration that's often embedded with vertical integration, such as when hospitals acquire physician practices that used to compete with them, or its impact on discouraging entry into some markets.

So if we give the example of insurers and PBMs, my sense is if the potential data flows between the insurers and PBMs are creating value, but if only the largest insurers can create PBMs, the additional advantage of large insurers over small ones is likely to reduce competition in insurance.

The paper indicated that it was prepared because

Commissioners wanted to know more about vertical integration. We should use it to think about how the potential for vertical integration should be factored into our work, and the most obvious policy opportunity for Medicare is further reducing site differentials in payments, and MedPAC has done valuable work in this area, but perhaps it is time to revisit and do more.

Another opportunity is to make the Medicare Advantage market more competitive. Without that, insurer integration with PBMs or post-acute care may not benefit the program or its beneficiaries. And even without competitive bidding steps like standardizing Medicare Advantage benefits and bringing down benchmarks would likely help Medicare capture more of the value crated by integration.

An area that CMS plays a role in, which we haven't discussed, is data interoperability. To the degree that we can proceed quickly to make data interoperability a reality makes virtual integration a more viable alternative to mergers and employment, and that would be very much a positive thing.

So hopefully what we are learning about the

implications of vertical integration on Medicare and its beneficiaries can shape our agenda on other policy areas. Thanks.

MS. KELLEY: I have Jon Perlin next.

DR. PERLIN: Okay. Thanks, Mike, for asking me to comment on this area. Rachel, thank you for a terrific, provocative, and important chapter and discussion. I can't help but consider this chapter, this conversation, without referencing the thinking about our last discussion, and, you know, the late great John Eisenberg always asked "what would [inaudible] think?" And we are where we are by virtue of many of the incentives that exist. And I think Paul just challenged us to think about how our policy recommendations actually influence that set of incentives that yields these occurrences.

I want to just take as a test case, but I know it best of all, the area of hospital and physician vertical integration, and really unpack why hospitals and physicians do end up in mergers or essentially practices being acquired. You know, I think that the simplistic view is that the hospitals do that just to gain referrals, but Rachel's data actually shows that those alignments don't

make all that much of a difference.

I think we've not actually looked tightly enough, closely enough at the physician end, but the chapter, appropriately, alludes to the impact of regulatory complexity. There are hundreds of thousands of Medicare regulations that both hospitals, but in this instance, physicians need to comport with, and the capacity for a small practice to do that is very challenging. Capacity to engage in programs, understand the structure, the reporting requirement, the information transmission requirements of value-based purchasing, et cetera, is itself not extremely complex.

I also want to acknowledge, from a physician perspective, the asymmetry between a small practice and a highly consolidated market of both commercial as well as, as was pointed out in the chapter, MA players, and beyond that, trying to work one's way, as a clinician, though not just highly consolidated payers but then a myriad of products underneath, each with their own requirements in terms of how practice occurs is just an extraordinarily complex issue.

So I posit that actually from the hospital lens

that the most compelling reasons for consolidation are around clinical alignment and efficiency. Obviously, hospitals are paid under a DRG system, but the care is driven by the doctor under, who is paid under Part B. The old saw about the most expensive instrument in a hospital is a physician's pen. Perhaps today it's a mouse. But that remains true, and the arbitrage between the DRG and some say it's really based on efficient practice.

So aligning for clinical excellence, whether it's not meandering through diagnosis, not meandering through treatment, promoting timely discharge, preventing readmission, all of that are, I'd say, driving features.

I think that we also have to contend with the fact that there are challenges or circumstances that were simply not contemplated at the time Medicare was set up in the '60s. Being on a rotating call schedule is part of being a doctor. You didn't get paid extra for it. That was part of being on a voluntary medical staff. Today, physicians expect payment for that, particularly so at expensive subspecialties and areas where there's been attrition or a few new providers, general surgery as an example. There are thousands of dollars per night, per

specialty, that hospitals maintain in terms of providing and probably required on-call coverage.

The clinical alignment itself, third point, is very complex. I happen to thinking using a preferred formulary, but here's interesting because the same incentives apply, like health plans, on higher quality and lower-cost providers. It was pointed out that the quality measures may not be better but managing to the quality measures in an integrated environment is simply easier. And just to be very blunt about this, a portfolio of providers in a hospital health system gets winnowed based on performance efficiency and quality outcomes.

So when you step back and you ask why is it as it is, you need to know the facts and the first principles. You've got hospitals being paid over here and physicians being paid over here, and this is where it really takes me back to the last discussion. Imagine the power when payments combined performance measurement is symmetric, integrated, and consistent.

So let me stop there and I look forward to continuing the discussion. Again, thanks for the chapter.

DR. CHERNEW: Thanks, Jon. I think we have Larry

next. Is that right, Dana?

MS. KELLEY: That's right.

DR. CASALINO: Okay. I'm not exactly sure how I got into the queue, but I have two things I can say, very high level. I'll stay away from the details at least for right now.

One is I really -- first of all, thanks for this presentation and for the information about vertical integration between health plans and organizations other than medical groups. Very interesting to hear and so little is known about it, so thanks for doing that.

So the two points are, one, I really liked your point, which is not made very much, at least publicly, that there have been a lot of unintended consequences in terms of consolidation and vertical integration of Medicare policies that are aimed at one thing, like 340B or site-specific payments, that are aimed at one thing but wind up promoting a consolidation in general and vertical integration specifically.

And it probably would be good to enunciate very prominently the thought, although I think this is probably pretty idealistic, that policymakers may want to consider

the potential effects on consolidation and vertical integration in any policy that they're thinking about.

Then the second point is that the antitrust agencies, I guess it wasn't really stressed in the presentation very much. The antitrust agencies are very, very, very reluctant to bring vertical integration cases and especially so in health care.

There are Chicago School economists who are quite sure that vertical integration, for example, between a hospital and a physician group cannot lead to higher prices paid by the health plan. This is fairly amusing because in, I would say, hundreds of interviews of the last 10 years with health plan executives and hospital executives and medical group leaders, I have yet to find one who doesn't think that that kind of integration leads to higher prices from the health plan.

So I think the agencies are reluctant to bring these antitrust cases in any kind of vertical integration in part because I think a lot of the economists in the agencies don't believe that vertical integration is a problem, but also because they're hard cases to win. And the agencies are very risk averse and hate to lose cases.

We talked a little bit that the presentation does -- it's been mentioned this morning that a lot of things are beyond the scope of what MedPAC and do, and certainly antitrust enforcement is beyond the scope of what MedPAC can do, but it may not be beyond the scope of MedPAC to point out, if we come to believe this, that consolidation in general and vertical integration specifically are problems, and that the antitrust agencies might want to take a closer look at this in health care.

MS. KELLEY: Okay. I have Brian next.

DR. DeBUSK: Thank you. With some of the other Commissioners' comments, I'm really glad that we're looking into this area. I think this is a very important area.

First, I do want to mention I think that A-APMs sources are an overarching theme. I think A-APMs really are a solution to a lot of these vertical integration challenges. So I'm hoping that we see that as the long-term solution, A-APMs and market-driven programs.

As far as hospital to hospital and hospital to physician integration, I am really glad that we're now, for example, in the other sessions, looking at policies that could inadvertently drive that because I do think it leads

to higher prices.

Jeff, I really do agree with the sentiment that higher commercial rates drive hospital cost structure, which then drives cost reports, which then drives Medicare rates, and I do think there's a connection there.

And I just want to take a moment, though, and speak up for hospitals because imagine the position that they're in. Consider how difficult it is for us to measure equality. We're doing peer grouping. We're trying to look at the standardizing sets of measures. I mean, we as a Commission wrestle with measuring quality. Imagine how the public has to deal with that. They don't really have good transparent quality measures that they can use. So facility do become a proxy for quality, and it does -- I mean, there's a lot of brass and glass lobbies out there that are used to attract those commercial payments.

So, again, it makes total sense to me that commercial rates drive cost structure, drive cost reports, drive Medicare rates. That connection seems pretty easy.

The other thing that I want to talk about, though, is this insurer-provider-PBM-pharmacy consolidation. You know, it's much newer. It's not like

the hospital consolidations that have gone on for decades. It's much newer, and I think it could be very problematic.

I mean, imagine when we have the same people who issue Medigap plans are issuing MA plans, are doing PBP plans, are running the PBM, are running the specialty pharmacy. There's already a lot of money flowing in every direction there. Unwinding this when these were stand-alone entities was virtually impossible, and I think having these as fully integrated, vertically integrated entities really presents a challenge for us in transparency and really in just trying to figure out what's going on behind the scenes.

We can have this debate over does this vertical integration increase the coordination between, say, the plan and the physician practice and the PBM, but right now, that's really just a philosophical question. Does it reduce cost, or does it ultimately increase prices?

The frustrating thing there, by the time the economists have the data, it's going to be too late. So I do think there's a little bit of a paradoxical situation here because what we have is a philosophical issue, that by the time it becomes a concrete issue, the door will be

closed on being able to do anything about it.

The one last thing that I want to mention about this whole thing, imagine all the underpinnings of what we do with administered rates in Medicare. I mean, think of the mechanisms that we rely on. We rely on things like risk corridors, medical expense ratios, margins.

Here's just an interesting statistic that I did preparing for this chapter. In the June 2020 report, we used the word "corridor" 30 times. We used the word "ratio" 133 times. But here's my favorite part. In the March report if this year, 2020, we used the word "margin" 836 times in that publication. What happens in a vertically integrated environment, the concept of margin goes away? It's all internal transfer pricing.

So really the last thing I want to leave us with is, short of not doing anything here, just mechanically, how would we even publish? What does the next March report look like? Are we going to say relatively efficient providers reported an internal transfer price margin of 3 percent? I mean, what would that even mean?

So I do just want to challenge everyone here. I do think we need to pay close attention to this because I

do think this could interrupt the entire -- disrupt the entire foundation for administered rates.

Thank you.

DR. CHERNEW: And now Bruce.

MR. PYENSON: Thank you.

I wanted to thank Larry for mentioning the potential role of antitrust in this and some of the issues around that and also Brian for using the word "transfer pricing" because I think that's quite relevant.

Paul, I agree with -- I'm glad Paul said what he did, and one of the terms he used was "virtual integration" as a potential alternative to the corporate integration that we're seeing as perhaps a solution in the future and certainly potential competition to the vast enterprises that we're seeing.

I think one of the additional elements of vertical integration that I'd like the staff to pursue is to look at the accounting and financial issues that I believe are driving some of the integration that we're seeing, especially on the insurance side and the corporate side.

Let's keep in mind that just like provider

organizations are complex and have internal conflicts and people going in different directions, the same is certainly true of insurance companies, whether they're large or small. In fact, many insurance entities make sure to have a diversity of things going on. It's a way of managing risk. It's a way of encouraging new ideas and potential solutions.

In the reading material, there's certainly elements of here's some things that could be beneficial in vertical integration. I don't think I'm in a position to say, "No. That's not true." For sure, there's people working very hard on all of those things.

But I think there's another side on the corporate issues. You've got very large organizations that have huge capital resources. They are active investors in ventures. In today's low-interest environment, that makes sense to invest in buying entities. Not all those are going to work out, but for sure, there's differences in the accounting practices between insurance entities and other kinds of entities that I think play a role here and perhaps not so relevant to Medicare but more to the self-insured accounts that are much bigger than Medicare in lives and generate

potentially large margins for some of the non-insurance entities involved.

So I think an area for staff to pursue is to understand the differences in accounting perhaps between for an insurance entity that administers self-insured lives versus the margins involved in a PBM that seemingly does something similar, but it perhaps accounts for it differently -- or a specialty pharmacy.

I think the other aspect of this is the deployment of capital and resources that's an inevitable part of scale. Brian mentioned some of this in different lines of business, but a very large organization can move into a market and sustain losses there if it wants to gain market share and make life difficult for smaller competitors, as certainly large organizations can deploy the resources that we've seen deployed for administrative roles like risk adjustment.

And I think staff put together a remarkable chart looking at different entities and how risk scores evolved over time between fee-for-service and the different entities, and I think the information there suggests that some large organizations are very effective at optimizing

risk scores, but others are not. And it tends to be a problem when policymakers and even MedPAC look at this and say, "Well, we're paying too much." Well, when you bring down the average, you're hurting the start-ups, perhaps the innovators and the smaller organizations, and if that's the dynamic we're in, we should think about perhaps other policies that the future may not have those small entities and what sort of regulations and policies does Medicare need for a world where there's only a few large organizations. So I see that as an implication that I think staff could address.

So I think, overall, the work is very provocative and really terrific information, but I think a focus on some of the finance and accounting issues and the implications, what are we going to be needing to do if we follow this to its logical conclusion in a few years?

Thank you.

DR. CHERNEW: Bruce, thank you.

In a second, I'm going to let Paul jump in, who I think has something to say in response to one of Larry's comments. You're too small on my screen, Paul, to know if that's exactly true. But then we'll continue with the

queue.

But I do want to point out the theme from this is, for all the Commissioners and anyone listening, given all of these interrelationships and multiple businesses and organizations are part of and the different accounting things that I'll rely on Bruce and the staff to educate me on, it becomes extremely difficult to think about the weight we put on margins and the cost reports and a whole slew of other things that we traditionally look at, because the information we get from them may be capturing only a part of what is going on. And I think that's a theme of what some of these comments have been, but that we'll have to wait for further meetings.

For now, I'm going to turn it to Paul.

MR. PYENSON: Thanks.

I wanted to focus on -- I agree with Larry's disappointments in the Federal Trade Commission for not pursuing vertical integration cases involving hospitals and physicians. I think there are two reasons for that. One is that the type of the qualitative research that Larry has done long term and that I until recently did a fair amount of, that often comes to conclusions about market

organization and forces years before quantitative research does. And unfortunately, I don't think the Federal Trade Commission thinks it can win a case based on that, but the bright news is that the quantitative literature on vertical integration has developed a lot in recent years and has brought consistent results showing the higher prices that come from hospital physician integration. So maybe we're actually ready to bring a case.

The other concern, which is a big-picture one, is that the FTC has long been very underfunded, and when you're underfunded and have a big job to do, sometimes it's easier to block a few more horizontal mergers, which are relatively easy and may have had success, than take on your challenging first vertical integration case. Hopefully, that can change.

MS. KELLEY: I have Pat next.

MS. WANG: Thanks.

I love that this is the last session of the day, and I think it's such an important chapter. And it's great work because what it does is it links a lot of the discussions that we've been having, and I think it provides a broader context that Bruce was talking about towards the

end of his comments that we need to keep in mind.

I guess a question that I would have for some of the hospital systems in MedPAC in particular -- we talked about private equity and the role of private equity. I actually think private equity has a role in stimulating some of the system-ness that is happening on the provider consolidation side. Private equity is essentially taking advantage of the disorganization of the system and picking stuff out that they can make money on, and I've always wondered whether the response of the provider system has been to try to get more as a system to response to that. I was curious about that. I would throw that into the mix.

Important discussion. I think to the extent that we are talking about convergence of payer and provider, however that happens, there's some very positive aspects of that. I think that there are examples, for example, of organizations that have skipped the ACO step and gone straight to full risk when they have found an MA plan partner that they can really align with and pool resources like huge information analytics, care management, and that that's where they're going. And I think you see examples of provider organizations that are trying to start MA plans

around the country for that reason, to try to integrate better. The examples in the paper were more on the health plan side, acquisition of providers, and, you know, people have talked about some of the reasons that that has happened, and, you know, to the extent that there is better integration of EMR data, et cetera, I think it can be a good thing for beneficiaries.

On the down side and the danger side, you know, everybody has been mentioning what happens to competition, especially when you look at the MA market and how consolidated it is today, I think that this is a really big deal. I also think that some of the acquisitions of physician practices by health plans can actually lead to predatory behavior, in local markets in particular, where you can really affect your local competitor if you dominate their physician network by, you know, jacking prices up, and it's a bit of a danger.

As far as the -- both Brian and Bruce talked about transfer pricing, and I want to bring it home to implications for Medicare Advantage. Whatever we decide to do with benchmarks for payment to MA plans, there is just something to keep a big watch out about is that plans that

are vertically integrated, along the lines of the slide that we were shown earlier, have such a greater ability, through transfer pricing, to get in there, be it however they want, make their bids look a certain way, that will be very hard to discern.

It is a big disadvantage for regional plans, a big disadvantage for regional plans who do not have the means at their disposal to engage in that sort of financial flexibility, if you will. And so if it is a priority to maintain competition in MA, as well as heterogeneity of the type of plans that are available, I think it's a big watch out and I really -- I think it's an important thing to keep on the radar screen. There may be other things we want to think about. Thanks.

MS. KELLEY: David.

DR. GRABOWSKI: Great. Thanks. I'm, like others, very excited that we are doing this work. I just wanted to speak briefly about vertical integration between health plans and post-acute care providers.

I think it's really important here that we consider the context regarding Medicare Advantage and post-acute care. Three quick observations from the literature.

The first, and Rachel did a great job of reviewing this, we have really strong evidence that MA plans use less post-acute care, especially skilled nursing facility care. Some of that, as Rachel noted, may be favorable selection. But even after conditioning on particular health events like stroke or hip fracture, and controlling for lots of patient covariates, it does seem like MA plans are just better at limiting utilization, and especially utilization of institutional PAC. So that's kind of the first part about this.

The second is there's some really strong research suggesting MA plans use lower-quality skilled nursing facilities and home health agencies, even within markets, based on the CMS star rating. MA plans are directing to lower-quality SNFs and HHAs. And then the final results or thread from the research literature won't surprise anyone, at least when it comes to skilled nursing facilities and home health agencies, MA pays below traditional Medicare.

And so they pay less, they get less, in the sense that they're working with lower-quality places, but then they're also, kind of at least on individual beneficiary basis, using less services and using different services.

And so I want to sort of put that on the table as we think about vertical integration, these MA plans that are acquiring post-acute care providers can now do in-network management of these services. How does that impact the incentives that were already in place in terms of utilization and quality? I thought Rachel did a really nice job in the draft of outlining the possible implications here. In some regards it may not have any impact. In other ways it's definitely worth monitoring.

I just wanted to make certain we keep our eyes on the idea that beneficiaries in these plans may have obviously fewer options, but what is this going to do to their utilization and ultimate quality? I think this is something we want to pay attention to. It may be a good thing that they're using less institutional post-acute care. That may be consistent with their preferences and it may not have any implications for their health. But this idea that plans are often contracting with lower-quality providers is definitely something we want to keep our eyes on.

There's obviously some upside to this integration. Brian mentioned that it's largely been

philosophical or theoretical to date, the idea that you could better manage care within a network as these plans have their own post-acute providers. That could actually improve outcomes, of course. On the other side, we have to really examine what's going to happen to car at the margins.

So I really hope this is something we will continue to monitor as we think about implications of vertical integration. Thank you.

MS. KELLEY: Jaewon?

DR. RYU: Yeah. Thanks, Dana. Just a few thoughts to add to the mix. I think a lot of different actors and a lot of different combinations. It dawns on me that there are probably different motivations for each of those. I think Jon Perlin illustrated some good considerations that we see as well on the provider side that I do think comes into play, in addition to all the things that folks mentioned around what might motivate hospitals, what might motivate health plans. But I do think there are a lot of combinations out there.

I also think, in the reading there was payer actions and provider actions. It seems to me like there's

a chicken-and-egg kind of dynamic there. It's unclear to me, at least, is it the provider actions in this space that are motivating the payer actions, or vice versa? In reality it's probably both feeding off each other. But I think that is something I wanted to call up.

The other is I think there is a dynamic, and perhaps this is more pronounced on the payer action side, around easier channels for growth. If you have a fairly competitive market, I think there's a growth channel here that might be easier for them to tap into by vertically getting into other lines of business. I think there is a diversification component, which I think either Bruce or somebody else had also mentioned, but I think if you can't grow, or maybe it's easier to grow share of wallet, I guess you could say, when it becomes really tough to grow more wallets. So I think that may also be feeding into this.

The last is, and this I would have liked to see a little more of in the chapter, but I think there is a consumer expectation dynamic that's feeding this as well. It's this notion of end-to-end integrated, easy experience, know what I want, anticipate what I need, when I go here I want it to be this way and then when I go somewhere else, I

want that information to follow me. I think it's not unlike what we see with whether it's cellphones or streaming services. I do think there's a consumer expectation component that may be feeding into some of this, in terms of stickiness and a longstanding longitudinal relationship with patient members, and having that ability to end-to-end integrate, whether it's your payer, how you interact with the pharmacy and the PBM, how you even get your care. I think there is something to that.

There was mention in the readings about data, and I think that's also a very powerful driver, data and analytics, and understanding that consumer becomes tremendously more powerful when you have a full end-to-end experience.

MS. KELLEY: The last person I have in the queue is Betty.

DR. RAMBUR: Thank you so much. I'll be very brief. First of all I just wanted to underscore and share my support for the comments that Larry and others had about antitrust and the FTC. As a private citizen, I've been very concerned that the reach of the FTC has not really

included vertical integration in the same way it has horizontal, and I understand why now better than I did.

But at least from my perspective the data are increasingly clear, and to the extent that however it might be appropriate for us to make some statement about that, I would feel very comfortable, even though I know it's not in our wheelhouse.

Second, I was very intrigued by what Paul said about virtual integration. I would like us to think about that more and think about that tangibly, what that might mean. And finally, I just want to underscore that although site-neutral payments have been unpopular with hospital providers, I think that -- I just want to voice my support for that as an approach to this particular issue as well as others. Thank you.

DR. CHERNEW: Great. So I am going to make a comment now on this chapter, simply because there's time, and then I'll see if anyone else wants to add something. But the first thing I'll say is I think it's important, through Medicare policy, to avoid exacerbating our problem with vertical integration, and I think it's something we need to be aware of. Betty, you raised site neutral. I

agree with that. This has been an issue that MedPAC has addressed for a long time.

The other thing I'd like to emphasize is that this affects a lot of what we do. One of my personal concerns, for example, is we've built alternative payment models off of tax identification numbers, TIN. The TINs are related in organizations in complex ways. There is a MedPAC recommendation on that aspect to this point, but we need to think through how the integration affects a lot of what we do, particularly in the A-APM space, because we often think of the TINs as the actual organizations, but as has been pointed out it's really not.

Several folks have spoken eloquently about the impact in relationship between Medicare Advantage plans and providers. David spoke about the impacts of SNFs and different plans and providers.

So the direction we go in terms of recommendations is really unclear to me. I will be interested in what people's thoughts are. But I think more importantly, and I think the value of this chapter is to point out that increasingly we, MedPAC, work in a set of siloed payment models overlaid to a very, very complex and

very integrated delivery system with a plethora of interconnections between the types of organizations. And while I don't have any particular insight about how we address that -- in fact, I think Paul started us off by saying some of that is beyond MedPAC -- it is important for us to track it and monitor it and take the information we learn in chapters like this into our deliberations, I think, across the board.

So that's sort of where my head is on the vertical integration chapter, and I really did appreciate all of the work and the insight there.

I'm looking to see if anyone else is getting in the queue. It jumps by quickly so I don't see that easily enough.

MS. KELLEY: I think Larry has a quick comment.

DR. CHERNEW: Oh, great. Larry, you're on.

DR. CASALINO: Yep, just one quick point, based on what you just said. You know, I think that Paul gave some reasons, and then there are more, I think, why antitrust agencies have been reluctant to bring these vertical integration cases. I do think that if MedPAC draws some attention to this phenomenon and also to the

failure of antitrust to address it that that might have some influence on the agencies. At the margins, I'll say, probably a useful activity.

DR. PAUL GINSBURG: I agree.

DR. CHERNEW: Okay. Larry, thank you. Bruce, I see you have a comment you want to get in.

MR. PYENSON: Thank you. Several of us noted Paul's introduction of the vertical integration opportunity. In the previous MedPAC season someone used the term that we can't unscramble the eggs. I think that was referring to integrated delivery systems and physician and hospital organizations, but it could apply to a lot of things.

But innovation and new technology tends to, you know, replace the scrambled eggs sometimes. And I think one of the things that we could think about is making sure that virtual integration is open-sourced and that it doesn't need the vertically integrated organizations that it opens up for everyone, and I think that's something that Medicare can play a role in and make sure that that's truly public.

So just a thought there to add to the list of

things for staff to do, the virtual integration concept.

DR. CHERNEW: Thanks, Bruce. Karen, I see you have a comment.

DR. DeSALVO: I do. It's more of a comment about the ways that CMS policy drives physicians to perhaps become acquired. And so there are the payment models and some of the other strategies, but I think it's worth at least a little more mention and consideration of how policies like meaningful use or MACRA, that have this expectation of data infrastructure, not only the first investment acquisition of the EHR but then the ongoing need to renew that technology and the costs therein, and how some of that had been not only a financial challenge for front-line clinicians but a source of great frustration, to have to deal with the technology and selectives.

So it's not immaterial for the way physicians are thinking about how to simplify their back office, basically, and some of the business decisions they have to make. And that won't stop.

So I think there are some other ways that Medicare policy drives this integration and creates kind of this push for physicians to want to step out of having to

manage their own practice. I just don't want us to lose sight of that.

DR. CHERNEW: Great, Karen. Thanks a lot. I'm pausing for a second intentionally.

[Pause.]

DR. CHERNEW: Okay. Well, that was a tremendous discussion, in fact, I will say I think overall this was a tremendous meeting. We have had a lot of good discussions, and I think we have a lot of good directions to go. I will try to be open to all of your comments, and I will say to the folks listening I am aware of [inaudible] so I do appreciate that. Many of these are broader than Twitter exchanges, but I do appreciate the interest.

So to the public, you know there's ways to reach out to us. We look forward to your comments. To the Commissioners, I want to thank you again for a really educational and thoughtful meeting, and as always my greatest thanks goes to the staff who put a ton of time, and has continued to put a ton of time into the materials and the work that they do to prepare for these meetings, and you will have a lot to do going forward.

So I'm going to give everyone a bit of their day

back. Thank you all, to the Commissioners. Jim, do you want to add anything before I say my final thanks?

DR. MATHEWS: No. I appreciate everyone's engagement. You've helped make our latest virtual meeting a success, and we will do this again in early November.

DR. CHERNEW: Great. So, everybody, stay safe out there and I look forward to seeing you in November. Thanks all.

[Whereupon, at 12:10 p.m., the meeting was adjourned.]