MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Via GoToWebinar

Thursday, January 13, 2022
1:00 p.m.

COMMISSIONERS PRESENT:

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AGENDA PAGE

P R O C E E D I N G S

[1:00 p.m.]

DR. CHERNEW: Hello, everybody, and welcome to our January 2022 MedPAC meeting. As is the norm in January, we have a set of abbreviated sessions followed by a vote on our update recommendations.

There's a few implications of that that I just want to lay out at the onset. The first one is because the sessions are abbreviated, we're not expecting all of the Commissioners to speak in every session. Speak if you have comments that you want to make, but don't feel the need to. Believe me, having heard you over the course of these debates in December and otherwise, I know you're engaged.

The second thing I want to emphasize is it is possible that one might infer from the abbreviated nature of the session that we don't think that these issues are important. That could not be further from the truth. We are very, very aware of the challenges and sympathetic to the challenges faced by all participants in the delivery system ranging from physicians to hospitals to nurses to a whole range of other people that provide the care that Medicare beneficiaries need.

These have been particularly trying times for a whole variety of reasons. Certainly, there's been a lot of financial challenges, but just the emotional hardships associated with what the country has been going through are really remarkable, and so before we get into what will inevitably be a somewhat dry set of discussions, I don't want people to take the tone as not understanding and not empathizing with the challenges that are being faced across the board.

So, with that very brief intro, I will jump in and turn it over to Alison to discuss the outpatient update recommendations and the mandated low-volume hospital payment adjustment report.

Okay. Alison.

MS. BINKOWSKI: Thank you, Mike, and good afternoon to our audience.

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.

This presentation will provide a very brief summary of our December presentation that assessed the adequacy of Medicare's payments for hospital services,

followed by a policy update since our December meeting, and the draft recommendation for updating hospital payments in 2023. The presentation will then conclude with a summary of the mandated report on changes to the low-volume hospital payment adjustment.

Additional details requested by Commissioners during the December meeting are noted in the updated mailing materials.

As a reminder, each year MedPAC assesses the adequacy of fee-for-service Medicare payments by looking at four categories of payment adequacy indicators: beneficiaries' access to care, the quality of that care, providers' access to capital, and Medicare payments and providers' costs.

The specific set of indicators used for acute care hospitals are enumerated on this slide.

To assess the adequacy of Medicare payments, we start with the most recent available and complete data, which this year is generally 2020, and include preliminary data for 2021 when possible. We also project a Medicare margin for fiscal year 2022 using current law.

Based on these indicators, we develop the draft

update recommendation for Medicare's base payment rates to acute care hospitals, which for this year will be 2023.

A key difference from most prior years, both for hospitals and all other sectors, is the coronavirus public health emergency, which has had tragic and disproportionate effects on Medicare beneficiaries and on the health care workforce, and regrettably, COVID-19 cases and hospitalizations have increased since our December presentation as the omicron variant spreads.

From the perspective of assessing the adequacy of Medicare payments, the public health emergency has also had material effects our payment adequacy indicators. Therefore, though analyzing 2020 data is important to understand what happened, it is more difficult to interpret these indicators than is typically the case. For example, mortality rates increased in 2020, but this reflects the tragic effects of the pandemic on the elderly rather than a change in the quality of care provided to Medicare beneficiaries or the adequacy of Medicare payments.

As the Commission stated last year, to the extent the coronavirus effects are temporary, even if over multiple years, or vary significantly across providers,

they are best addressed through targeted temporary funding policies rather than a permanent change to all providers' payment rates in 2023 and future years.

The considerations on this slide apply to all the upcoming payment adequacy presentations.

As we described in December, despite the coronavirus pandemic, our indicators of hospital payment adequacy are generally positive.

First, in terms of fee-for-service Medicare beneficiaries' access to care, while capacity was stressed at times and volume declined sharply in spring 2020, hospitals maintained the excess capacity in aggregate, fewer hospitals closed, and hospitals continued to have a positive Medicare marginal profit on IPPS and OPPS services.

Second, we cannot draw any conclusions about quality in 2020 as measure changes reflect the PHE rather than changes in quality or the adequacy of Medicare payments.

Third, hospitals maintained strong access to capital thanks to substantial federal support, including targeted federal relief funds to rural hospitals which

raised their all-payer total margin to a near-record high.

Fourth, while hospitals' aggregate Medicare margin remained negative in 2020, it remained steady when including Medicare's share of federal support, and the median Medicare margin among relatively efficient hospitals increased to positive 1 percent.

Since our December meeting, there have been two key policy changes relevant to our projection of the adequacy of Medicare payments in fiscal year 2022.

First, Congress extended the suspension of the 2 percent sequestration on Medicare payments through March 2022, followed by a 1 percent sequestration June 2022; and second, as expected, HHS began distributing $9 billion in Provider Relief Fund Phase 4 payments. The funds are being distributed to over 69,000 health care providers, including but not limited to hospitals, and consist of a graduated base payment as well as bonus payments based on the amount and type of services provided to Medicare, Medicaid, or CHIP patients.

While the extension of the sequestration on Medicare payments slightly increased our projected 2022 Medicare margins, our projected margins still round to

minus 10 percent for all IPPS hospitals and zero percent for relatively efficient hospitals, prior the inclusion of any relief funds, and 1 percentage point higher after the inclusion of relief funds.

With those policy changes in mind, we turn to considerations for the draft recommendation.

The draft recommendation seeks to balance several imperatives. These include to maintain payments high enough to ensure beneficiaries' access to care and close to hospitals' costs of efficiently providing high-quality care; to maintain fiscal pressure on hospitals to constrain costs; and to minimize differences in payment rates across sites of care, consistent with our site-neutral work.

Clearly, there are tensions between these objectives that require a careful balance in the draft recommendation.

Furthermore, as we mentioned previously, to the extent coronavirus public health emergency continues, any needed additional financial support should be separate from the annual update and targeted to affected hospitals that are necessary for access.

With that, the draft recommendation reads: For

fiscal year 2023, the Congress should update the 2022 Medicare base payment rates for acute care hospitals by the amount determined under current law.

CMS will publish its current law update for fiscal year 2023 in the summer of 2022 based on historical data through the prior quarter and its future projections on the growth in input prices and productivity. As of now, this estimate is 2 percent, including an estimated 3.1 percent growth in hospital wages and benefits, but may be higher or lower by the time it is finalized and more data is available. Inpatient rates will also be subject to an additional statutory 0.5 percent.

This draft update recommendation will not affect Medicare spending relative to current law and should not affect beneficiaries' access to care or hospitals' willingness and ability to furnish care. We expect that a current law update will maintain IPPS and OPPS payment rates close to hospitals' costs of efficiently delivering high-quality care.

Lastly, as discussed in December, the Bipartisan Budget Act 2018 required in that act to report on modifications for the low-volume hospital policy. The BBA

of 2018 modified the eligibility criteria for the LVH adjustment to be based on all-payer volume instead of Medicare volume and modified the statutorily set LVH adjustment. We found the modifications increased the number of LVHs in 2019 by 5 percent and also increased the average number of fee-for-service Medicare inpatient stays per LVH and the average LVH adjustment.

The requirement to base LVH eligibility on all-payer volume is consistent MedPAC's prior recommendation, and LVH policy will become more consistent with MedPAC's prior recommendation beginning in 2023 when CMS's authority to determine an empirically justified LVH adjustment is restored.

Still, concerns remain that the policy is not well-targeted to isolated hospitals and is duplicative for the subset of LVHs that already receive cost-based payments.

And now I turn it back to Mike.

DR. CHERNEW: Alison, thank you.

I am going to turn it to Dana Kelley to go through the queue. I know there is a list, and again, remember this is an abbreviated session, so keep that in

mind. We're not doing Round 1's and 2's, and please be brief.

Dana.

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

MS. BARR: Thank you very much, and thank you for your work on this chapter.

I have a concern. First of all, I do support the recommendation, and I want to make that clear, but I am concerned that we have one rate adjustment for all types of providers, and I think that needs to be considered going forward.

And I am also concerned about the low-volume hospital adjustment. I think that what Congress was facing in 2018 is still true today. Seventy-five percent of those hospitals are rural, and I'm not sure that I -- I do not agree with the recommendation.

Thank you.

MS. KELLEY: Brian?

DR. DeBUSK: First of all, I do support the recommendation as well, but as written, the recommendation places all of the emphasis on the market basket updates, which is going to be finalized later in September of this

year.

2023 marks our second year of a really profound shift in both labor and materials costs in hospitals, and I'm going to briefly speak on each of them, first with labor.

I think it's more than just the salary increases that these hospitals receive. There's an increase in contract nursing use, and there's even an increase in the cost of nursing education as we shift toward more BSN versus ASN degrees in hospitals. So I think there's a whole workforce readiness issue here that's really still unfolding this year, and it's going to conflate this market basket update with the hospital wage index calculation, with nursing workforce development in general, and it leaves us with a lot of policy to unpack beyond just this hospital update. And just as one example, I mean, do we want the hospital wage index calculation to reflect an MSA's nursing -- contract nursing policy?

Briefly, on supplies, there are clearly some core inflation issues. I think there's some inflation that's here to stay, but we're also seeing an unwinding of risk in the supply chain. We know the supply chain we had pre-

pandemic can't withstand the shock. I mean, it left us with nurses reusing respirators and wearing trash bags. So I don't know how all this settles out, but there's a lot that's going to have to go into this September market basket update, and I hope that hospitals and other authoritative sources will provide CMS with the information they need, because as provider relief funds recede, I think it's going to be more obvious that these fundamental input costs have shifted and shifted dramatically.

Thank you.

MS. KELLEY: Jon Perlin?

DR. PERLIN: Well, thanks. Let me thank staff first for really a very thoughtful chapter that has incorporated so much. I think the tone of the chapter is tremendously important. I think all of us owe a debt of gratitude to those individuals at the front line, those individuals who are keeping hospitals going across really odds that are unprecedented.

I want to agree with concerns about how it affects certain sectors. Lynn's terrific comments about low volume, I think that has some risk that she outlined, and Brian DeBusk is absolutely correct about the double

whammy of labor and supplies.

But let's look at the convergence, and this is really where I worry. I realize we're making recommendations now, January 13th of 2022, for fiscal '23. I realize there will be adjustments, but let's look at what happens between now and then.

We have the end of the bonus with 20 percent sur-payment associated with public health emergency. We have a productivity adjustment that will remain in place also as downward pressure. We have, in the end, the moratorium on the sequester. We have the beginning of the recoupment of the accelerated payments. So all of those things converge simultaneously in the context of what we know to be the inflationary environment that surrounds us focus particularly in the two areas of labor and supplies.

I do worry that the reality for hospitals and, frankly, all provider sites in terms of the cost of labor actually is not going to be captured in a timely fashion, by way of the wage index, and that's going to be something that we have to look at going forward. And so I think that needs to be noted in the chapter, that we're going to have to be somewhat dynamic in that.

But every aspect of operation is going to have a challenge, whether it's energy or reduction in revenues from non-operating sources, investments and the like. Those are going to have a challenge.

To the degree that hospitals or employers of physicians, we'll obviously have a conversation about the physician update. That also will converge on hospitals.

My point being is that it's a precarious environment, and even if you can get the labor, the labor is asymmetric. The attrition in the workforce has been substantially amongst the more experienced individuals. So, one for one, even at higher cost, is not one for one in terms of capacity, and that has to figure in as well.

I think we need to be a little bit cautious in terms of the two other areas that are our responsibilities beyond just talking about the cost side, and that is the access to services. There's obviously been artificial suppression of demand for services outside of COVID-related services because of COVID and because of concerns of Medicare beneficiaries seeking care in the care environment. At this point, we're all acutely aware of hospitals, in fact, markets and even states where pressure

has precluded the ability to get services for other not only elective but critical needs.

With that in mind, I think there are two things that we have to recognize. First, that as we try to make good decisions for those most vulnerable facilities, our instruments are not really sharp enough to know which facilities are uniquely vulnerable, and so while we may get it right in some cases, in many cases, we're not going to get it right in all cases, and I think we just have to be aware of that, that to try to target specific groups is going to have some intended benefit and some unintended consequence.

The second, though, in terms of beneficiary access and quality, we need to, I believe, improve our measures of access to care, whether it's not only the elective and critical services in the acute care environment but particularly in the outpatient environment as well. We've been struggling with having comparable quality measures for a while, let alone comparable quality measures that have the appropriate degree of risk adjustment to at least attempt to address vulnerability conferred by social issues.

So I do support the recommendation, but it is with the caveat that we have just a very frank discussion of these vulnerabilities and the reality that we're still trying to project in a very uncertain environment.

Thanks so much again to staff and fellow Commissioners.

MS. KELLEY: Betty.

DR. RAMBUR: Well, first of all, thank you for the chapter, and I support the recommendations and appreciate the comments from my fellow Commissioners and have, perhaps, one comment to add.

Certainly, we've all witnessed firsthand the devastating of the front line of care delivery and its toll on nurses and others, nursing students, nursing faculty, et cetera, but I'm not convinced that more revenue to hospitals in the long run will necessarily translate to more staff or better compensation for those actually doing the work. Documented in the past, it hasn't. So perhaps it could be different, but I think that it would be advisable to consider a policy of payment changes that more directly bolster the conditions or rewards for those who are actually doing the hard work at the bedside.

So, with that sort of extension rather than a caveat, I do support the recommendation.

MS. KELLEY: Bruce.

MR. PYENSON: I want to echo Betty's comments and point out that during this tragic time when literally hundreds of thousands of Medicare beneficiaries have died during the public health emergency due to COVID, that the record is that some of the largest hospital systems in the country have reported record profits in 2020, and some of the quarterly reports of 2021 suggest likewise.

So I agree with Jonathan, to look at this comprehensively, but that also needs to look at what we're getting for the money that we're spending. It's clear that the outcomes have to be looked at comprehensively and what we would really get if we paid the hospital industry more.

Of course, I've never seen organizations that have suggested that they get paid less by the federal government, but in this case I think the financial reporting facts are at odds with some of the other concerns that are being expressed.

MS. KELLEY: Amol.

DR. NAVATHE: Thank you. Thanks to the staff for

all the hard work here and responsiveness to the comments, and I echo the prior Commissioners who have noted the challenging circumstances during the public health emergency and the impact on the front lines and the organizations.

First, I do want to point out that I do support the recommendation. Second, I just want to voice some concern, to some extent, in making sure that we're interpreting it, perhaps aligning our intent of the relatively efficient hospital analysis with what we're seeking to gain from it, from an informational perspective. The additional work the staff has done has been illuminating, at least to me, in that it highlights the relatively efficient hospital group, and perhaps this applies outside of just the hospital sector, it is certainly not representative of all the hospitals, and I think that part we may have guessed.

That being said, it also varies in certain systematic ways. Part of this I think is unavoidable in the sense that we're defining this group in part based on outcomes, and to the extent that those outcomes are related to underlying factors of the populations or the communities

that these hospitals serve, we would expect that this might be true.

That being said, I think it was marked in the revised paper and the work that's been done that organizations that are either situated in communities that face disproportionate social determinants of health challenges or otherwise because of the circularity, to some extent, of the methodology, they are less likely to be represented in this relatively efficient group. That is an input. I would like to highlight that I understand that it's an input. There are multiple dimensions here. It is one dimension on which we assess how the impact of our payment updates will be on the financial health of the sector.

So the concrete point, I think, going forward, would be to take a look at whether there is some modification and/or maybe alternative specification or kind of like a gut check sensitivity analysis type of approach on the relatively efficient hospital analysis alone here, again recognizing that it's one dimension of many dimensions of financial indicators that we look at. Thank you.

DR. CHERNEW: Terrific. If I followed this right, Amol, you were the last commenter in the queue. Is that right, Dana?

MS. KELLEY: Yes, that's correct.

DR. CHERNEW: Okay then. I think we should probably then have a roll call vote. Last year we did it in alphabetical order, so this year we'll do it in reverse alphabetical order. Next year, hopefully, we'll be able to do it in the order in which people are seated. But in any case, Dana, can you run through the roll call?

MS. KELLEY: Yes. Okay. For the draft recommendation that reads, "For fiscal year 2023, the Congress should update the 2022 Medicare base payment rates for acute care hospitals by the amount determined under current law."

Voting yes or no. Pat?

MS. WANG: Yes.

MS. KELLEY: Dana?

DR. SAFRAN: Sorry. Yes.

MS. KELLEY: Jaewon?

DR. RYU: Yes.

MS. KELLEY: Wayne?

DR. RILEY: Yes.

MS. KELLEY: Betty?

DR. RAMBUR: Yes.

MS. KELLEY: Bruce?

MR. PYENSON: Yes.

MS. KELLEY: Jon Perlin?

DR. PERLIN: Yes.

MS. KELLEY: Amol?

DR. NAVATHE: Yes.

MS. KELLEY: Jonathan Jaffery?

DR. JAFFERY: Yes.

MS. KELLEY: David?

DR. GRABOWSKI: Yes.

MS. KELLEY: Marge?

MS. MARJORIE GINSBURG: Yes.

MS. KELLEY: Stacie?

DR. DUSETZINA: Yes.

MS. KELLEY: Brian?

DR. DeBUSK: Yes.

MS. KELLEY: Larry?

DR. CASALINO: Yes.

MS. KELLEY: Lynn?

MS. BARR: Yes.

MS. KELLEY: Paul?

DR. PAUL GINSBURG: Yes.

MS. KELLEY: Mike?

DR. CHERNEW: Yes.

Thank you all. And I will say I very much appreciate the discussion, the challenges, and for those listening, as we move forward understanding that we're going to come out of the public health emergency, there's been a lot of changes and a lot of challenges. We are not only going to continue to address those as we think about update recommendations moving forward.

Some of you may know that we have initiated an entire workstream on safety in hospitals. We have done a lot of work on rural hospitals as well, some of which has made its way into policy. And it is really a high priority for us to figure out how to deal with the heterogeneity of all of the providers and their circumstances in a world where we have a singular update recommendation.

So I want to make sure to go on the record as acknowledging that we are aware of that heterogeneity, we are concerned about the heterogeneity, and we are going to

continue to seek mechanisms to address it in a way that is efficient and allows beneficiaries access to high-quality, efficient care.

DR. CHERNEW: So I think, if I'm not mistaken, that brings this session to a close, and we will move on to the next in our sessions, which is going to be the physician fee schedule, I believe. Am I right about that, Dana?

MS. KELLEY: Yes, that's correct. Is the Commission staff ready?

MR. WINTER: Yes.

DR. CHERNEW: Great. And both by the slide and by the voice I am turning it over to Ariel.

MR. WINTER: Thank you. Good afternoon. In this session, I will recap our assessment of the adequacy of Medicare's payments for physician and other health professional services. I will present a draft recommendation for updating payment rates for 2023, and a draft recommendation to collect data on audio-only telehealth services.

My colleagues -- Geoff Gerhardt, Rachel Burton, and Ledia Tabor -- are also involved in this work and will

be on hand to help answer questions.

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

As a quick recap, the physician fee schedule is used to pay for about 8,000 different services that are provided in a variety of settings. In 2020, Medicare paid $64.8 billion to 1.3 million clinicians for fee schedule services. This is $8.7 billion less than was spent in 2019, before the pandemic.

To offset declines in revenue from Medicare and other payers during the pandemic, Congress has provided tens of billions of dollars in relief funds to clinicians. In addition, Congress and CMS gave clinicians much more flexibility to provide telehealth services.

Under current law, there is no update to the base payment rate for 2023, but clinicians can potentially receive a positive or negative performance-based adjustment if they are in the Merit-based Incentive Payment System, known as MIPS, or they can receive a 5 percent bonus if they are in an advanced alternative payment model.

Congress increased physician fee schedule payment

rates in 2020 and 2021. Since our last meeting in December, Congress also increased payments for 2022, and they are nearly 4 percent higher than they were scheduled to be under prior law. In January 2023, these temporary payment increases will expire, and clinicians' payment rates will return to pre-pandemic levels through 2025.

In 2026, differential payment updates will begin for clinicians in A-APMs and clinicians who are not in A-APMs.

Because there was interest at the December meeting in increasing payments for primary care services, the next three slides discuss this issue.

The Commission has done a lot of work in this area. In 2011, we recommended that CMS regularly collect data on service volume and/or time from practices to establish more accurate prices for clinician services.

In 2015, we recommended that Congress establish a per beneficiary payment for primary care clinicians, which would supplement their existing fee schedule payments.

In 2018, we explored an approach to rebalance the physician fee schedule by increasing payment rates for ambulatory E&M visits while reducing rates for other

services.

We modeled the impact of raising the rates for E&M visits by 10 percent, which could be offset by lowering rates for all other services by 3.8 percent to achieve budget neutrality.

In 2019, the AMA/Specialty Society Relative Value Scale Update Committee, or RUC, recommended that CMS substantially increase the work RVUs for E&M office and outpatient visits. Subsequently, CMS increased the RVUs for these visits in a budget-neutral manner in its final rule for 2021.

In our comment letter on the proposed rule, we strongly supported CMS's decision.

In the final rule, CMS estimated that total fee schedule payments would increase for primary care and some other specialties but decrease for many specialists. This is because the higher payment rates for E&M visits, as well as a new add-on code for E&M visits, would be offset by reducing rates for all fee schedule services.

Some of the impacts by specialty are shown on this slide.

However, Congress reduced the size of the cuts to

specialists by raising total fee schedule payments in 2021 and 2022, as well as delaying the new add-on code for E&M services by three years. As a result, the impacts by specialty that are shown here were actually smaller.

We have also explored ways to expand the supply of primary care physicians in Medicare. For example, in our June 2019 report, we discussed a potential federal student loan repayment program for primary care physicians who treat Medicare beneficiaries.

At a Commission meeting in November 2019, we described other approaches based on interviews we did with two dozen experts, such as requiring residents to rotate through community-based primary care practices.

Based on Commissioners' feedback at that meeting, we are now researching the role of geriatricians in Medicare, which we will discuss at a meeting this spring.

Now I will turn back to our payment adequacy analysis.

In summary, although COVID affected our indicators of payment adequacy, they remained generally positive. Most beneficiaries report access to care that is comparable to the privately insured and to prior years.

The number of clinicians billing Medicare is stable, and the number of clinician encounters per bene declined in 2020, due to the pandemic.

Turning to quality of care, we found wide geographic variation in the rates of ambulatory-care-sensitive hospital use, and CAHPS patient experience scores remain high. However, it is difficult to interpret quality measures in 2020, due to the effects of the pandemic.

In terms of clinicians' revenue and costs, Medicare payments to clinicians declined by $9 billion from 2019 to 2020, but clinicians received tens of billions of dollars in relief funds to offset financial losses due to the pandemic. Medicare payments per beneficiary decreased in the spring of 2020, but then rebounded and almost reached pre-pandemic levels by June. The MEI is projected to continue growing.

Commercial payment rates for clinician services continue to exceed Medicare rates, and physician compensation from all payers increased modestly between 2019 and 2020, despite the pandemic.

This leads us to the first draft recommendation, which reads: "For calendar year 2023, the Congress should

update the 2022 Medicare base payment rate for physician and other health professional services by the amount determined under current law."

In terms of implications, there would be no change in spending compared with current law, which calls for no update.

This should not affect beneficiaries' access to care or clinicians' willingness and ability to furnish care.

It is important to note that the payment update applies to all clinician services. If there are concerns about payment adequacy for primary care services, they should be addressed through a targeted approach, instead of the payment update mechanism.

In addition, we will continue to monitor our indicators of payment adequacy each year using the most current available data, and we will make recommendations accordingly in future years.

Our second draft recommendation concerns telehealth, and reads as follows: "The Secretary should require that clinicians use a claims modifier to identify audio-only telehealth services."

In terms of implications, there would be no change in spending compared with current law, and this should not affect beneficiaries' access to care or clinicians' willingness and ability to furnish care.

CMS already requires a claims modifier for audio-only services for mental health and substance use disorders, so this recommendation would extend this policy to all audio-only services. This policy would enable CMS, the Commission, and researchers to assess the impact of audio-only services on access, quality, and cost.

This concludes our presentation, and I will turn things back over to Mike.

DR. CHERNEW: Ariel, thank you, and as before I am going to turn it over to Dana to manage the queue.

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

DR. DeBUSK: First of all, thank you for an excellent report.

I support both recommendations as written, recognizing that confining the recommendation to changes in the conversion factor really limits our flexibility on policy.

I do want to point out that around 45 percent of

the physician fee schedule is practice expense, and we have to assume that those expenses are subject to at least the effects of inflation and maybe some of these other factors, such as nursing shortages and things like that. And the PFS doesn't have a market basket type update mechanism, so when we talk about a zero update, it is a zero update. And I do think this could lead to a substantially different update for physicians and for hospitals, again with hospitals enjoying the market basket update, which could, in turn, drive more physician employment.

And I just want to point out that physician employment, to Medicare, is largely a one-way function. We can incentivize physicians at the practice level when they are in private groups, but once they are employed to hospitals we do lose a lot of our financial leverage to influence physician practice patterns.

So I do want to mention, I note just that in 2021, Congress authorized a 3.17 percent adjustment to the PFS, 3 percent in 2022. I do want to mention that if the Congress were inclined to do something in 2023, I do hope they would consider an update that focuses solely on practice expenses, leaving the physician work and

professional liability portions alone.

And that is my comment on this session. Thank you.

MS. KELLEY: Lynn.

MS. BARR: So first of all I do support this, although it is very difficult because as we know there is no adjustment for inflation, and I do echo all of Brian's comments.

Very quickly, we are experiencing extraordinary amount of trauma in our physician workforce. It has gone beyond burnout. We are serving them and we are starting to see evidence of PTSD. So I worry a little bit about a slap in the face to the people that are really on the front lines, but it is what it is.

And I hope that Congress continues to intervene as necessary until we can fix the overall MACRA issue of not being able to adjust to inflation. And so I'm hoping that Congress will do the job until the program is fixed.

And I want to say I do appreciate the expanded loan forgiveness program for rural. This is huge. And all providers, rural providers, that applied for loan forgiveness in the last cycle got it. It used to be almost

nobody got it, so that is very, very positive, I think, and thank you for that.

MS. KELLEY: Jonathan Jaffery?

DR. JAFFERY: Thanks, Dana, and thanks to the staff for a great chapter. I am also supportive and, like Brian and Lynn, say that with some concerns about the longer-term approach that we have in place right now for physician updates or lack thereof, as the case may be, and how that can be adjusted. So I do want to have us think about that and address it a bit more going forward.

I just have two comments about some things in the chapters that I wanted to -- the chapter I wanted to bring out. On page 28, there's a comment about beneficiaries' report good access to care, and then it follows that 91 percent have a usual source of care that was not hospital or ED or urgent care center.

So I think in subsequent iterations of this, thinking about -- and this probably pertains to not just the physician sector, but thinking about our measures of access to care, we may want to spend a little more time thinking about how we assess that. If one in eleven beneficiaries are going to the hospital or the ED or urgent

care for their usual source of care, I think that might be something that actually is a concern of ours.

The second thing is on page 32, and there's a paragraph that discusses some factors that may be driving differences in some of the care experience among different races and ethnicities in the survey data, and there's some hypothesis around some things talking about income and some things like that, income and care experience.

While that may be a factor, I think that we're missing some pieces here that have really been brought out in some of the national discussions over the last couple years, and so I feel like we have an opportunity and maybe even obligation to acknowledge some of the systemic factors that also are likely and certainly possibly driving those differences, things like implicit bias, things like the lack of diversity in the workforce, and even things like the impact of some historical events like redlining and what that does to create neighborhoods and communities that are limited in their access to health care.

So I just wanted to throw those out there as things for us to consider as we go forward but again supportive of their recommendation and certainly very

supportive of the audio only, that a recommendation too for that data. So thank you.

MS. KELLEY: Larry.

DR. CASALINO: So I'm planning to support both recommendations. I'm enthusiastic about being able to identify audio visits on claims, and I have more mixed feelings about the first recommendation. So I would like to make a few comments.

One thing I think is important for people to understand is that MedPAC tends to give deference to current law when we're thinking about payment updates, and it tends to recommend changes in the update that current law prescribed only when the need for a change is clear. When we think that biologics MACRA should be modified, we address through means other than the annual payment update recommendation, and I think that's an important point to understand.

So I have to say that based on the staff report, it's not clear that a change from the current law is necessary in 2023, which is why I'm willing to support it.

But I do want to just mention that looking to the future, I'm very concerned about three things, all of which

have been mentioned to one degree or another. The physician fee update, fee schedule update is basically prescribed by MACRA, which is a multiyear prescription for the updates and which for quite a few years is zero, zero, zero. That's one thing during a period when inflation is stable and quite low. It's quite another thing when inflation is unpredictable and quite high. I am quite concerned that it be quite expensive for physicians to hire staff, to retain nurses, and also other kinds of staff, and with a zero update, that will make it even harder for them to do. So I think going forward, we need to think about the zero-update year after year that MACRA prescribes.

The second point is Brian's point, which is a subtle point but extremely important, I think, namely that the hospital payment update will give increased facility fees for services provided by physicians who are employed by hospitals. So there will be an update there that will be basically based on inflation, but there will be no practice expense. The practice expense part of the physician fee schedule is kind of the equivalent to the facility fee for independent physicians. They get practice expense. Hospital-employed physicians, hospitals get the

facility fee. So there will basically be an inflationary update for hospital-employed physicians for the practice expense part of what they do but not for independent physicians, and the difference could be quite substantial with inflation as high as it looks like it's going to be running.

So hospital employment of physicians may or may not be a good thing, but if it happens, it should happen for good reasons, not because it's driven by differential payment updates. So that is something I'm quite concerned about, and I think the Commission should pay attention to as soon as possible going forward.

And then just briefly to echo Lynn's comment about physician morale, physicians -- and not just physicians but to other health care workers obviously, it's been a tough time, and it's going on and on. So a current law update won't feel very good to clinicians, and so I think it may have some deleterious effects that won't be easily measurable by the types of access and quality measures that are available to MedPAC. So I'm hoping that we can consider these things during this coming year, and then in our upcoming work on alternative payment models,

we'll think about MACRA, which is closely tied to alternative payment models and whether there might be any changes to the MACRA.

Thanks a lot.

MS. KELLEY: Betty.

DR. RAMBUR: Thank you. Thank you for the excellent work on this chapter, and I appreciate the comments of my fellow Commissioners.

I have just a few comments. First of all, I should say I support the recommendation.

I really appreciate the teasing out of the role of nurse practitioners and PAs and the statement on page 41 that we're likely undercounting the number of encountered by APRN and PAs because of incident-to billing. I know MedPAC has made a recommendation to eliminate incident-to billing, but in addition to being able to track the cost and outcomes of people's care, we actually have no idea how much money this involves. I don't think we do. I don't know of anyone who's done this analysis with that extra 15 percent.

We've just heard Larry and others talk about -- Larry, Brian, and others about unmet needs and at places

that those resources really could be shifted too.

Nurse practitioner organizations have been strongly in support of eliminating incident-to billing, and I know many of my colleagues feel very troubled by it. But they're in a system where capturing revenue is important. So I know there's a recommendation on that, but I'm wondering if in the future, we could put some dollar parameters around that.

I was quite taken with the conversation about analysis of compensation adequacy, and it lists the average primary care physician salary as $250,000 and, of course, specialists much higher than that. In the future upcoming reports, next year, I wonder -- I do think it would be helpful to include the others that are delivering primary care, nurse practitioners and PAs. The salary right now is around 115 or 117, and we've seen a dramatic increase in those individuals working everywhere but in primary care. So, obviously, even at less than half the physician compensation, it's been adequate or attracting those individuals, with nurse practitioners being the most highly recruited, bypassing physicians for the first time ever last year.

So these are just thoughts I would like to sort of put out there for future reports, but I really do appreciate that inclusion and recognition of the role of PAs and nurse practitioners in primary care. Thank you.

MS. KELLEY: Paul.

DR. PAUL GINSBURG: Yes. I support both recommendations, and I can be very brief in my comments because my colleagues have made such excellent points before me. And I think Larry was particularly eloquent and thorough in his analysis.

So, to me, the bottom line is that in an era where inflation may be higher than it's been in recent years, that the current law approach is really not viable and really needs to be revisited. I hope the Commission in future cycles can spend time doing that.

MS. KELLEY: Amol?

DR. NAVATHE: Thank you for the great work on this. I think I also echo a lot of the comments that my colleagues have made prior to this comment.

I do want to just be very clear that I do support the recommendation, both recommendations here.

I think that the addition of the text box, I

think, starts on page 7 of the revised paper that talks about -- sort of explains the multiple different areas that the Commission has been doing work and making recommendations that touch on the physician fee schedule. The fee schedule was very helpful. I think it is important.

Larry started to do this, I think, to put where these payment updates sit in the context of the overall Commission's work and the overall Commission's view. Certainly, I can say my view in terms of how it fits in. There's many different dimensions at play here. There's many different factors that one would want to consider in the broader context and in the long run, and I think Paul and Larry have highlighted some of these along the way. Betty did as well.

If we take a look at Slide 3 where we look at the trajectory of the physician fee schedule payment rates, we can see obviously that there are responses to the current pandemic, and that we can see what's happening because of MACRA in terms of the APM divergence versus the non-advanced APM patient divergence, which we can debate.

I think the couple of points that I want to make

here are that, again, I support the recommendation, I think, in the context of the current policy environment. I will say in parallel to that -- and I think this is what Paul, Larry, Betty, and others are also saying -- is that we're also highly supportive of the idea that we continue the Commission's work on the fee schedule in terms of elements contained in the text box, such as the accuracy of the physician fee schedule, which certainly has migrated in accuracy from where it started.

I know the Commission has made recommendations, but to the extent that we could come back and reemphasize some of that work outside of the context of this payment update chapter, I think that is incredibly important for us to do.

There's other points that are made in the paper that obviously are not addressed by payment updates themselves regarding primary care versus other specialties, physicians versus -- or really professional clinicians versus the other sectors and the relative -- the way we're approaching it. Larry touched on this in the context of the OPPS adjustment to the kind of practice expense analog. There's a number of areas here that we cannot touch on as

part of the payment update, but I think the important point that I would like to leave is that that doesn't mean that we as a Commission shouldn't continue to pursue that work because the physician fee schedule, professional clinician fee schedule is so fundamentally important to the way that the Medicare program works.

I know we're also going to touch on this in part in the context of APMs, as the slide is in part highlighting, and I think that that also is important.

So I just wanted to kind of echo the comments of Larry, Paul, Betty, and others regarding the importance of this work while also in parallel supporting the recommendations. Thanks.

DR. CHERNEW: Amol, thank you.

Dana, I think that was the last person in the queue.

We're going to run through the votes in a moment, but let me just say a few things in response to these outstanding comments.

The first one is the point -- and I will credit Brian for bringing this to my attention about the practice expense portion of the physician fee schedule, the

asymmetry with other sectors is indeed important and something we will look into in a lot more detail and actually fits quite nicely with our longstanding interest and aspects of site neutrality. So for those of you that are wondering where that will go, I want to assure you that is not a comment that will just be made and fall by the wayside. It has already been dog-eared. I guess that's when people used to read books with actual pages, but anyway, it has been dog-eared.

Larry's point on what I'll call long-run sustainability of the physician fee schedule is also very well taken. I actually think it was problematic in a world of low inflation, but to Larry's point, it is particularly problematic in a world of high inflation. We need to think through exactly how that will play out. The update recommendation turns out to be amongst the hardest places to do that, but again, for people listening, I'm not going to commit to anything because who knows how the world will change. But the current thinking is that we will have a workforce cycle. One of the chapter's next cycle will be on the workforce, which will include, I think, broader problems with both the physician fee schedule and, as Betty

pointed out and I think appropriately, issues with nonphysician workforce and people that are paid under then physician fee schedule.

I guess it should probably go without saying, but I will just say this from a personal point of view. This is a Michael position, although I'll bet many of you share it. The value of the health care system stems from the people that are actually delivering care, and that's what actually matters. We want the beneficiaries to get access, the high-quality care, and that requires people and the organizations they work for to be able to deliver that high-quality care.

The role that we play in MedPAC and I think the broader policy role of payment is to create the environment to enable that to be successful and do so while we meet the obvious fiscal challenges that we face.

So we will continue to do that. We will do that through work like our safety network, through work like our site-neutral work, through work that hopefully will kick off on the workforce because I think we need to have a healthy workforce and a healthy delivery system more broadly in order to meet our goals.

I sort of think that probably should have been implied by everything we do, but sometimes it's not. So I felt I should say it.

That being said, I do want to turn it over to Dana, and we will go through two separate roll call votes. Dana?

MS. KELLEY: Okay. Turning to the first draft recommendation which reads, "Per calendar year 2023, the Congress should update the 2022 Medicare payment rate for physician and other health professional services by the amount determined under current law." Voting yes or not.

Pat?

MS. WANG: Yes.

MS. KELLEY: Dana?

DR. SAFRAN: Yes.

MS. KELLEY: I'm sorry, Dana?

DR. SAFRAN: Yes.

MS. KELLEY: Jaewon.

DR. RYU: Yes.

MS. KELLEY: Wayne.

DR. RILEY: Yes.

MS. KELLEY: Betty.

DR. RAMBUR: Yes.

MS. KELLEY: Bruce.

MR. PYENSON: Yes.

MS. KELLEY: Jon Perlin.

DR. PERLIN: Yes.

MS. KELLEY: Amol.

DR. NAVATHE: Yes.

MS. KELLEY: Jonathan Jaffery.

DR. JAFFERY: Yes.

MS. KELLEY: David.

DR. GRABOWSKI: Yes.

MS. KELLEY: Marge.

MS. MARJORIE GINSBURG: Yes.

DR. CHERNEW: Stacie.

DR. DUSETZINA: Yes.

MS. KELLEY: Brian.

DR. DeBUSK: Yes.

MS. KELLEY: Larry.

DR. CASALINO: Yes.

MS. KELLEY: Lynn.

MS. BARR: Yes.

MS. KELLEY: Paul.

DR. PAUL GINSBURG: Yes.

MS. KELLEY: And Mike.

DR. CHERNEW: Yes.

MS. KELLEY: Turning to the next recommendation which reads, "The Secretary should require that clinicians use a claims modifier to identify audio-only telehealth services." Voting yes or no.

Pat?

MS. WANG: Yes.

MS. KELLEY: Dana?

DR. SAFRAN: Yes.

MS. KELLEY: Jaewon?

DR. RYU: Yes.

MS. KELLEY: Wayne.

DR. RILEY: Yes.

MS. KELLEY: Betty.

DR. RAMBUR: Yes.

MS. KELLEY: Bruce.

MR. PYENSON: Yes.

MS. KELLEY: Jon Perlin.

DR. PERLIN: Yes.

MS. KELLEY: Amol.

DR. NAVATHE: Yes.

MS. KELLEY: Jonathan Jaffery.

DR. JAFFERY: Yes.

MS. KELLEY: David.

DR. GRABOWSKI: Yes.

MS. KELLEY: Marge.

MS. MARJORIE GINSBURG: Yes.

DR. CHERNEW: Stacie.

DR. DUSETZINA: Yes.

MS. KELLEY: Brian.

DR. DeBUSK: Yes.

MS. KELLEY: Larry.

DR. CASALINO: Yes.

MS. KELLEY: Lynn.

MS. BARR: Yes.

MS. KELLEY: Paul.

DR. PAUL GINSBURG: Yes.

MS. KELLEY: And Mike.

DR. CHERNEW: Yes.

And so that brings us to the end of the physician chapter, and again, it is remarkable how thoughtful all these comments have been, given the limited time, and I

really very much appreciate it. I understand that several of you have said other comments that you haven't made here to the staff in response to the materials, and I very much appreciate that as well.

So I think now we're going to move on to a series of topics, and I think it's going to start with ASCs. is that right?

MS. KELLEY: That's correct.

DR. CHERNEW: Yes. Great. So I'm not sure who I'm turning this over to, but I am turning it over.

MS. KELLEY: Is Dan ready?

DR. ZABINSKI: All right. Good afternoon. The audience can download PDF versions of the slides for each of the three presentations in this session in the Handout section that is on the control panel on the right-hand side of your screen.

For ambulatory surgical centers, at the December 2021 meeting, we presented update information for ambulatory surgical centers, or ASCs, and provided draft recommendations, and at the meeting there was general consensus around the recommendations.

In your updated draft chapter, we have added text

in response to Commissioners' comments at the December meeting. For Bruce, we added text addressing three issues regarding on the performance of ASCs relative to hospital outpatient departments. For Brian and Paul, we added sentences explaining why it is plausible that MA plans are encouraging use of ASCs for their enrollees.

In today's presentation, we will provide an abbreviated version of the payment adequacy analysis for ambulatory surgical centers that we presented in December.

Important facts about ASCs in 2020 include that Medicare fee-for-service payments to ASCs were $4.9 billion; the number of fee-for-service beneficiaries served in ASCs was 3.0 million; and the number of Medicare-certified ASCs was a little more than 5,900. Also, CMS has updated the ASC payment rates by 2.0 percent for 2022.

Like other sectors, the public health emergency has had an adverse effect on some of the measures of payment adequacy for ASCs. Nevertheless, the measures remained generally positive.

Despite the public health emergency, the number of ASCs increased by 2.0 percent in 2020. But also due to the PHE, the ASC volume per fee-for-service beneficiary

declined by 13.6 percent. However, the 2020 decrease was largely due to a dramatic drop in the spring of 2020, and volume rebounded strongly by the end of the year.

The growth we saw in the number of ASCs also suggests that access to capital was at least adequate. Also, there's been many acquisitions and partnerships with ASCs by corporate entities, which also requires access to capital.

Measures of quality in ASCs were largely unchanged from 2019 to 2020. However, we believe CMS could improve on the ASC quality system by adding more claims-based outcomes measures.

Finally, aggregate Medicare payments decreased for 2020 by 3.9 percent after several years of strong increases. However, payments per user of ASC services rose substantially by 10.2 percent.

And then finally, there is a limitation in our analysis because we cannot assess margins or other cost-based measures because ASCs do not submit cost data, even though the Commission has frequently recommended that these data be submitted.

For the ASC update in 2023, we have two draft

recommendations. First, "For calendar year 2023, the Congress should eliminate the update to the 2022 conversion factor for ambulatory surgical centers."

Given our findings of payment adequacy and our stated goals, eliminating the update is warranted. This is consistent with our general position of recommending updates only when needed.

The implication of this recommendation for the Medicare program is that relative to current law spending it would be lower by $50 million to $250 million over one year and by less than $1 billion over five years. Also, this recommendation is not expected to affect beneficiaries' access to ASC services or providers' willingness or ability to furnish those services.

Also, the Commission has long argued that ASCs should submit cost data to help determine accurate payment rates for ASCs and guide future updates.

So, once again, we have this draft recommendation: "The Secretary should require ambulatory surgical centers to report cost data."

The importance of this recommendation is that the Commission has recommended this policy for over a decade,

but the Secretary has not acted on this issue. The Secretary could limit the burden on ASCs by using a streamlined system of cost submission.

Implementing this recommendation would not change Medicare program spending. We also anticipate no effect on beneficiaries. However, ASCs would incur some added administrative costs.

Now I turn back to the Chair for discussion and votes.

DR. CHERNEW: I know we have at least one person in the queue, so Dana, do you want to manage that, in case I'm missing some?

MS. KELLEY: All right. Brian.

DR. DeBUSK: Well, first of all thank you for the chapter. I really enjoyed the tone of the chapter, particularly how it discusses the role that ASCs can play in reducing beneficiary and taxpayer expense. So thank you.

And thank you for the additional pages 20 and 21 regarding MA plans and their accessing of ASCs. I do hope we could be a little bit more explicit on those pages on the effect of MA plans using ASCs over HOPDs. Since the MA

benchmark is derived from fee-for-service spending, the plan saves roughly 48 percent every time they shift a case from the HOPD to the ASC. And this becomes a sustained source of savings that can be used as plan profits, but it can also be used for incentives to enroll even more beneficiaries out of original Medicare and into MA.

So I do hope we could add maybe a sentence or two that really explicitly spells out this potential source of persistent savings between the two plans.

On page 21, we address the issue of physician ownership of ASCs and the incentives to do more cases. I think that is absolutely correct. I agree with every word in that paragraph. I do hope that we could also mention, though, that hospital-employed physicians often have compensation incentives to produce more RVUs as well. So the risk of volume induction at ASCs, while it is present it really isn't unique.

And then on page 22, we address services that overlap between physician offices and ASCs, and I hope we can mention there that for procedures that are performed the majority of time in doctors' offices there is already a site-neutral provision that sets the ASC facility rate, or

caps it, to the difference between the PFS non-facility and facility-based rates. So again, I hope we can mention that in the chapter.

And then finally, and this one is somewhat of an air drop, but I would like to propose, particularly to the fellow Commissioners, that we include a recommendation that directs the Secretary to modify the ASC claims infrastructure such that it can accommodate comprehensive APCs. Beyond the value, the well-established value of comprehensive APCs, my concern here is that it may limit our ability to do future site-neutral work. So if these ASCs can't process comprehensive APC claims, again, it might limit our ability to push forward with site-neutral work in future cycles.

Thank you. Those are my comments.

DR. CHERNEW: Dana, is there anyone else in the queue?

MS. KELLEY: No.

Oh, I'm sorry. Pat has a comment.

MS. WANG: I just wanted to pick up on, and we talked about this last time, Brian's observation about MA plans the use of ASCs and the request to note in the report

that this could be a source of savings to MA plans if they are substituting lower cost care for higher cost care.

I said this the last time. I think that there's a lot to be said about how MA plans spend the money that they have, and it's fair to have that discussion. I think it's very difficult to pick one sector, to say, you know, they are paying less for ASC services maybe and, therefore, they are generating this amount of profit, and we make an observation about that, because it fails to take into account that MA plans may be paying physicians above 100 percent of the fee schedule, for example, or certain hospitals above 100 percent.

There are lots of puts and takes and ups and downs, and so I just wanted to voice, you know, my rare disagreement with Brian on this particular point. Thank you.

DR. DeBUSK: Actually, Pat, on this point I completely agree with you. My comment wasn't to single out the MA plan and they're somehow making ill-gotten gain. My thought was that if fee-for-service beneficiaries are disproportionately using hospitals, and that disproportionate use gets swept up into the MA benchmark

calculation, what you've really done is created arbitrage. I mean, you've created a source of persistent savings, and while the result, while it's a little counterintuitive, the correct answer might be to figure out how to get original Medicare beneficiaries to use ASCs more. I think that's really the answer to the problem.

But thank you, Pat, and I hate disagreeing with you ever as well, so thank you.

DR. CHERNEW: Okay. So in a minute we're going to go to a vote. I was just going to say that APMs should do that. For those watching at home, Lynn added that in the chat.

So yeah, I think that is a good point, but more broadly, ASCs are, in some ways, ground zero for parts of our site-neutral work. It's very complicated because of all of the feedback work in hospitals. Just as an aside, getting prices right for firms that provide a wide range of different services, and there's complicated economies of scope and unobserved quality and unobserved case mix, the site-neutral work is actually really quite complicated because of a range of potential unintended consequences. It's not as simple as finding a similar service and setting

the prices the same, because there's all kinds of other cross-subsidies and things that have to be considered. That's why we have a separate work stream for site neutral.

But I very much appreciate that point, Brian. Your knowledge of the details is really appreciated.

Dana, do we want to run through the vote here, and then we will move on. I think after this we're going to move on to dialysis, to give the staff a heads up. I hope I got that right.

MS. KELLEY: Yes, that's correct.

All right, turning to this first draft recommendation for ASCs, the recommendation reads, "For calendar year 2023, the Congress should eliminate the update to the 2022 conversion factor for ambulatory surgical centers."

Voting yes or no. Pat?

MS. WANG: Yes.

MS. KELLEY: Dana?

DR. SAFRAN: Yes.

MS. KELLEY: Jaewon?

DR. RYU: Yes.

MS. KELLEY: Wayne?

DR. RILEY: Yes.

MS. KELLEY: Betty?

DR. RAMBUR: Yes.

MS. KELLEY: Bruce?

MR. PYENSON: Yes.

MS. KELLEY: Jon Perlin?

DR. PERLIN: Yes.

MS. KELLEY: Amol?

DR. NAVATHE: Yes.

MS. KELLEY: Jonathan Jaffery?

DR. JAFFERY: Yes.

MS. KELLEY: David?

DR. GRABOWSKI: Yes.

MS. KELLEY: Marge?

MS. MARJORIE GINSBURG: Yes.

MS. KELLEY: Stacie?

DR. DUSETZINA: Yes.

MS. KELLEY: Brian?

DR. DeBUSK: Yes.

MS. KELLEY: Larry?

DR. CASALINO: Yes.

MS. KELLEY: Lynn?

MS. BARR: Yes.

MS. KELLEY: Paul?

DR. PAUL GINSBURG: Yes.

MS. KELLEY: Mike?

DR. CHERNEW: Yes.

And so that will bring us to the second -- I'm sorry -- the second recommendation. I jumped the gun. Go ahead.

MS. KELLEY: That's okay. Turning to the second recommendation, which reads: "The Secretary should require ambulatory surgical centers to report data."

Voting yes or no. Pat?

MS. WANG: Very much yes.

MS. KELLEY: Dana?

DR. SAFRAN: Enthusiastic yes.

MS. KELLEY: Jaewon?

DR. RYU: Yes.

MS. KELLEY: Wayne?

DR. RILEY: Yes.

MS. KELLEY: Betty?

DR. RAMBUR: Yes.

MS. KELLEY: Bruce?

MR. PYENSON: Yes.

MS. KELLEY: Jon Perlin?

DR. PERLIN: Yes.

MS. KELLEY: Amol?

DR. NAVATHE: Yes.

MS. KELLEY: Jonathan Jaffery?

DR. JAFFERY: Yes.

MS. KELLEY: David?

DR. GRABOWSKI: Yes.

MS. KELLEY: Marge?

MS. MARJORIE GINSBURG: Yes.

MS. KELLEY: Stacie?

DR. DUSETZINA: Enthusiastic yes.

MS. KELLEY: Brian?

DR. DeBUSK: Enthusiastic yes.

MS. KELLEY: Larry?

DR. CASALINO: Yes.

MS. KELLEY: Lynn?

MS. BARR: Yes.

MS. KELLEY: Paul?

DR. PAUL GINSBURG: Enthusiastic yes.

MS. KELLEY: Mike?

DR. CHERNEW: Yes.

And now, if I'm not mistaken, we are going to move on to dialysis. Is that right, Dana?

MS. KELLEY: That is correct.

DR. CHERNEW: And so I think Nancy, you are up.

MS. RAY: Yes, I am. Good afternoon. Today's presentation on assessing the payment adequacy of outpatient dialysis services consists of two sections. First, I will summarize the indicators of payment adequacy that we reviewed in December. Then I will present the draft update recommendation for your consideration.

The update analysis and recommendation will be included as a chapter in our March 2022 report. This is an abbreviated version of what I presented at the December 2021 meeting. And at the December meeting there was a general consensus around the draft recommendation.

As background, in 2020, there were roughly 384,000 Medicare fee-for-service dialysis beneficiaries, treated at 7,800 facilities. Total Medicare fee-for-service spending was about $12.3 billion for dialysis services.

Now I will summarize the payment adequacy

analysis.

The indicators assessing adequacy are generally positive, and you have seen all of this material in December. Regarding access, there is a net increase of about 105 facilities between 2019 and 2020. Regarding capacity, the growth in dialysis treatment stations has exceeded the growth in the number of fee-for-service dialysis beneficiaries between 2019 and 2020.

Looking at volume changes, the decline in the number of dialysis fee-for-service beneficiaries and Medicare-covered treatments between 2019 and 2020, is related to the public health emergency. Dialysis patients are at increased risk of mortality from COVID-19. In addition, in 2020, there were fewer patients starting dialysis. The 20 percent marginal profit suggests that providers have a financial incentive to continue to serve Medicare beneficiaries.

Moving to quality, between 2019 and 2020, the percent of dialysis beneficiaries using home dialysis continues to increase, and this is a good trend and consistent with prior year trends. However, we see that monthly all-cause hospital admissions and ED visits

declined in 2020, and the rate of mortality increased. These changes are likely due to the public health emergency. By contrast, between 2018 and 2019, these three quality metrics held steady.

Regarding access to capital, indicators suggest it is robust. An increasing number of facilities are for profit and freestanding. Private capital appears to be available to the large and smaller-sized multi-facility organizations.

Moving to our analysis of payments and costs, in 2020, the aggregate Medicare margin is 2.7 percent, and the 2022 projected aggregate Medicare margin is 1.8 percent.

Based on our findings that suggest that outpatient dialysis payments are adequate, the draft recommendation reads: "For calendar year 2023, the Congress should update the 2022 Medicare end-stage renal disease prospective payment system base rate by the amount determined under current law."

This draft recommendation will have no impact relative to the statutory update. We expect beneficiaries to continue to have good access to outpatient dialysis care, and we also expect continued provider willingness and

ability to care for Medicare beneficiaries.

And with that I turn it back to the Chair.

DR. CHERNEW: Nancy, thank you, and if I have followed this correctly we actually don't have anyone in the queue. Oh, Bruce?

MS. KELLEY: Bruce.

MR. PYENSON: Thank you. I agree with the recommendation. However, this is an unusual sector because of the dominance of about 80 percent of two large players who are vertically integrated. So I could see our recommendation going to no update, given the circumstances. While this perhaps raises the question as we get into systems with very few players how we think about evaluating the updates and needs for updates, I think that's work for the future.

I just want to raise a cautionary note going into the future that as we see systems that dominate the market, and given the questions of transparency that we need to take a more cautious role.

MS. KELLEY: Alright. Mike, there's no one else in the queue.

DR. CHERNEW: Yeah. Thanks, Bruce. Okay.

So I think then we should move down to a vote.

MS. KELLEY: All right. Voting on the recommendation, "For calendar year 2023, the Congress should update the 2022 Medicare end-stage renal disease prospective payment system base rate by the amount determined under current law."

Voting yes or no. Pat?

MS. WANG: Yes.

MS. KELLEY: Dana?

DR. SAFRAN: Yes.

MS. KELLEY: Jaewon?

DR. RYU: Yes.

MS. KELLEY: Wayne?

DR. RILEY: Yes.

MS. KELLEY: Betty?

DR. RAMBUR: Yes.

MS. KELLEY: Bruce?

MR. PYENSON: Yes.

MS. KELLEY: Jon Perlin?

DR. PERLIN: Yes.

MS. KELLEY: Amol?

DR. NAVATHE: Yes.

MS. KELLEY: Jonathan Jaffery?

DR. JAFFERY: Yes.

MS. KELLEY: David?

DR. GRABOWSKI: Yes.

MS. KELLEY: Marge?

MS. MARJORIE GINSBURG: Yes.

MS. KELLEY: Stacie?

DR. DUSETZINA: Yes.

MS. KELLEY: Brian?

DR. DeBUSK: Yes.

MS. KELLEY: Larry?

DR. CASALINO: Yes.

MS. KELLEY: Lynn?

MS. BARR: Yes.

MS. KELLEY: Paul?

DR. PAUL GINSBURG: Yes.

MS. KELLEY: Mike?

DR. CHERNEW: Yes. And I believe now -- thank you, everybody -- and we are going to move on to hospice with Kim.

So, Kim, you're up.

MS. NEUMAN: Thanks, Mike.

Good afternoon. Today's hospice presentation has two parts. First, we'll discuss indicators of hospice payment adequacy, the hospice aggregate cap, and the draft update recommendation for 2023. Second, we'll discuss a draft recommendation on reporting hospice telehealth visits.

We discussed these issues at the December meeting and there's more detail in your mailing materials, which have been updated to reflect your December meeting discussion.

Before we begin, I'd like to spend a moment talking about one issue that came up in December.

Lynn asked about hospice use in frontier areas. Hospice use rates in frontier areas and other rural areas are lower than in urban areas. However, since 2010, hospice use rates in frontier areas and other rural areas have grown at similar rate or higher rate than urban areas.

Because frontier areas have low population density, the number of decedents in frontier areas is relatively small.

In 2020, about 23,000 frontier beneficiaries died. 7,700 of those beneficiaries, or about a third, received hospice

in 2020.

If frontier decedents had the same hospice use rates as urban decedents, we estimate an additional 3,600 frontier decedents would have used hospice in 2020.

Many factors influence hospice use such as patient preferences, disease type and progression, and provider preferences and referrals. So it's uncertain how much these types of factors versus access factors account for lower hospice use in frontier areas.

In the future, we plan to continue to monitor and gather information on hospice use in frontier areas and other rural areas.

So now moving to our payment adequacy analysis. As background, in 2020, over 1.7 million Medicare beneficiaries, including nearly half of decedents, received hospice care from over 5,000 hospice providers, and Medicare paid those hospices $22.4 billion.

This next chart summarizes our payment adequacy indicators which are generally positive; first, Indicators of access to care. The supply of providers continues to grow due to entry of for-profit hospices. With the pandemic, the number of decedents using hospice increased

substantially in 2020, but the share of decedents using hospice declined, as deaths grew faster than hospice enrollments. Average length of stay among decedents increased. In-person hospice visits declined in 2020, likely due to the pandemic. Medicare marginal profit in 2019 was 17 percent, a favorable indicator of access.

Next, quality. It is difficult to assess quality in 2020 due suspension of data reporting. Quality data for 2019 was stable or improving.

Next, access to capital. We observed continued entry of for-profit providers, and the sector viewed favorably by investors, which suggests that there's adequate access to capital. Also, provider-based hospices have access to capital through their parent providers.

In terms of margins, the 2019 aggregate Medicare margin was 13.4 percent, and the projected 2022 aggregate Medicare margin is 13 percent.

Now switching gears, let's talk about the hospice aggregate cap. The cap limits total payments a hospice provider can receive in a year. The cap is an aggregate limit, not a patient-level limit. Hospices that exceed the cap have long lengths of stay and high margins.

For the last two years, in March 2020 and 2021, instead of an across-the-board payment reduction, the Commission recommended the hospice cap be wage-adjusted and reduced by 20 percent. Changing the cap in this way would make it more equitable across providers and would reduce aggregate Medicare expenditures by focusing payment reductions on providers with long stays and high margins. The Congress has not acted on this cap recommendation.

So this brings us to the draft recommendation, which is the same as last year, and it reads "For fiscal year 2023, the Congress should eliminate the update to the 2022 Medicare base payment rates for hospice and wage-adjust and reduce the hospice aggregate cap by 20 percent."

This draft recommendation would keep payment rates unchanged in 2023 at their 2022 levels. It would also modify the aggregate cap to focus payment reductions on providers with long stays and high margins, while the majority of providers' payments would be unchanged by the cap policy.

In terms of implications, it would decrease spending relative to current law by between $250 million and $750 million over one year and between 5- and $10

billion over five years.

In terms of beneficiaries and providers, we expect that beneficiaries would continue to have good access to hospice care, and that providers would continue to be willing and able to provide appropriate care to Medicare beneficiaries.

Now turning to telehealth, CMS has permitted hospice telehealth visits during the public health emergency under certain circumstances. Different from in-person visits, hospices are not required to report telehealth visits on Medicare claims. A lack of data impairs our ability to understand the extent to which telehealth visits were furnished during public health emergency. Requiring hospices to report telehealth visits would increase the program's ability to monitor beneficiary access to care.

So the second draft recommendation reads "The Secretary should require that hospices report telehealth services on Medicare claims." In terms of implications, there would be no impact on Medicare program spending. In terms of beneficiaries and providers, there would be no direct impact on beneficiary access to care, but the draft

recommendation would improve the agency's ability to monitor access. Hospices may incur some additional administrative costs with claims data reporting.

So this concludes the presentation, and I turn it back to the chair.

DR. CHERNEW: Thanks, Kim.

I have one person in the queue, which is Lynn. Dana, is that it?

MS. KELLEY: Yes.

DR. CHERNEW: Okay. We'll go to Lynn next.

MS. BARR: Thank you.

I have concerns about hospice and the same concerns about home health that the payment rates are not adequate for home visits in rural areas. So I know that we have a peanut butter approach that we're going to make recommendations, and I do support the recommendations for the aggregate of hospice providers, but I do feel we have to look at the lack of access and consider that that's being caused by the fact that it is unprofitable for them to get to these remote areas, and that's why there's less access overall.

Thank you.

DR. CHERNEW: Thank you, Lynn.

Okay. I think now we will move to the first vote. Dana?

MS. KELLEY: Okay. Turning to the first draft recommendation which reads "For fiscal year 2023, the Congress should eliminate the update to the 2022 Medicare base rates for hospice and wage-adjust and reduce the hospice aggregate cap by 20 percent." Voting yes or no.

Pat?

MS. WANG: Yes.

MS. KELLEY: Dana.

DR. SAFRAN: Yes.

MS. KELLEY: Jaewon.

DR. RYU: Yes.

MS. KELLEY: Wayne.

DR. RILEY: Yes.

MS. KELLEY: Betty.

DR. RAMBUR: Yes.

MS. KELLEY: Bruce.

MR. PYENSON: Yes.

MS. KELLEY: Jon Perlin.

DR. PERLIN: Yes.

MS. KELLEY: Amol.

DR. NAVATHE: Yes.

MS. KELLEY: Jonathan Jaffery.

DR. JAFFERY: Yes.

MS. KELLEY: David.

DR. GRABOWSKI: Yes.

MS. KELLEY: Marge.

MS. MARJORIE GINSBURG: Yes.

DR. CHERNEW: Stacie.

DR. DUSETZINA: Yes.

MS. KELLEY: Brian.

DR. DeBUSK: Yes.

MS. KELLEY: Larry.

DR. CASALINO: Yes.

MS. KELLEY: Lynn.

MS. BARR: Yes.

MS. KELLEY: Paul.

DR. PAUL GINSBURG: Yes.

MS. KELLEY: Mike.

DR. CHERNEW: Yes.

MS. KELLEY: Turning to the second recommendation which reads "The Secretary should require that hospices

report telehealth services on Medicare claims." Voting yes or no.

Pat?

MS. WANG: Yes.

MS. KELLEY: Dana.

DR. SAFRAN: Yes.

MS. KELLEY: Jaewon.

DR. RYU: Yes.

MS. KELLEY: Wayne.

DR. RILEY: Yes.

MS. KELLEY: Betty.

DR. RAMBUR: Yes.

MS. KELLEY: Bruce.

MR. PYENSON: Yes.

MS. KELLEY: Jon Perlin.

DR. PERLIN: Yes.

MS. KELLEY: Amol.

DR. NAVATHE: Yes.

MS. KELLEY: Jonathan Jaffery.

DR. JAFFERY: Yes.

MS. KELLEY: David.

DR. GRABOWSKI: Yes.

MS. KELLEY: Marge.

MS. MARJORIE GINSBURG: Yes.

DR. CHERNEW: Stacie.

DR. DUSETZINA: Yes.

MS. KELLEY: Brian.

DR. DeBUSK: Yes.

MS. KELLEY: Larry.

DR. CASALINO: Yes.

MS. KELLEY: Lynn.

MS. BARR: Yes.

MS. KELLEY: Paul.

DR. PAUL GINSBURG: Yes.

MS. KELLEY: And Mike.

DR. CHERNEW: Yes.

And so now we are going to take a five-minute break. I assume that's okay with everybody, and then we're going to jump back, and we're going to start up with skilled nursing facilities. And I think Carol is probably going to be first.

We really do want to keep moving. So let's try and be back by 2:35, and we'll go from there with Carol. So see you back all in a second.

[Recess.]

DR. CHERNEW: I think we have most folks, and my guess is that other people are going to be joining us imminently. So I think, if you think it's okay, Dana, we should probably let Carol jump right in. What do you think?

MS. KELLEY: I think that sounds good.

DR. CHERNEW: Carol, you're up.

DR. CARTER: Okay. Hi, everybody. Before the PAC group starts its presentations I want to note the PDF versions of the slides can be found in the Handouts section of the control panel on the right-hand side of the screen.

In this session, each of us will present a high-level summary of the chapter that was discussed at length at the December meeting. The details of the analysis and findings can be found in the papers.

We will begin with the update, Medicare's payments to skilled nursing facilities. Here is an overview of the SNF industry in 2020. There were about 15,000 providers, most of which also provided long-term care services. About 1.2 million beneficiaries, or about 3 percent of fee-for-service beneficiaries, used SNF

services. Program spending totaled just over $28 billion.

Medicare makes up a small share of most nursing facilities' volume and revenue, about 10 percent of days and about 17 percent of revenues.

Our indicators of payment adequacy are generally positive, despite the impacts of COVID. The supply of providers is stable. Large volume declines reflect the pandemic, not the adequacy of Medicare's payment. The high positive Medicare marginal profit indicates that providers have a strong incentive to treat Medicare beneficiaries.

The unique circumstances of a public health emergency confound our measurement and assessments of quality of care. SNFs had adequate access to capital, and this is expected to continue. The all-payer total margin increased to 3 percent in 2020, and that was an increase from 0.6 percent in 2019.

The aggregate Medicare margin in 2020 was high, 16.5 percent, and the median Medicare margin for relatively efficient providers was even higher. The projected Medicare margin for 2022 is 14 percent.

This brings us to the draft recommendation. It reads, "For fiscal year 2023, the Congress should reduce

the 2022 Medicare base payment rates for skilled nursing facilities by percent."

While the effects of the pandemic on beneficiaries and nursing home staff have been devastating, the combination of federal policies and the implementation of the new case mix system resulted in improved financial performance. The high level of Medicare's payments indicate that a reduction to payments is needed to more closely align aggregate payments to aggregate costs.

In terms of the implications relative to current law, this recommendation would lower program spending by more than $2 billion for fiscal year 2023, and by more than $10 billion over five years.

Given the high level of Medicare's payments, we do not expect adverse impacts on beneficiaries. Providers should continue to be willing and able to treat beneficiaries.

Now I will turn things back to Mike.

DR. CHERNEW: Thank you, Carol. Again we will go through the queue. I see one person here, which is David. If that's right, David, go ahead, and then Dana will manage the rest of the queue.

DR. GRABOWSKI: Great. Thanks, Mike. I'll start by saying I'm definitely supportive of the recommendation. However, the chapter and Carol's presentation really highlight how broken nursing home payment is in this country. This was true before COVID, but COVID has most definitely magnified the problem.

Let me start with staffing. Staffing is at an all-time crisis right now. I had a medical director at a nursing home tell me just earlier this week that "crisis" is too tame a term. She used the term "apocalyptic." And maybe that's overstating it, but things are just really dire in terms of staffing.

I think the answer is probably putting more money into staff, yet we're talking about a decrease, and the challenge here is this disconnect. Nursing homes, as a whole, are probably underfunded publicly, yet Medicare is overpaying, and that disconnect across Medicare and Medicaid has really hamstrung this industry for a long time.

So I really think stepping back, you know, we'll continue to make recommendations around the Medicare part of this, but I think moving forward we need to think more

holistically about this sector, and I'm really excited we're talking about the dual eligible, special needs plans tomorrow. I think there's a lot of opportunities to think about integration of Medicare and Medicaid. This industry needs kind of to reimagine payment. It needs to reimagine delivery of care, staffing, and that's not going to happen just via Medicare. It's really going to need to be a joint Medicare and Medicaid solution.

Thank you.

DR. CHERNEW: Dana, I think we have another person in the queue. I'm not sure I followed it all, so I'm going to turn the queue over to you.

MS. KELLEY: Okay. Lynn, did you have a comment?

MS. BARR: No, I did not.

MS. KELLEY: Okay. Betty.

DR. RAMBUR: Thank you. I just want to underscore and pile onto David's comments. I've had similar conversations just this week with some directors who actually feel like everyone is so traumatized they're having post-traumatic stress disorder and can't function. And your comments were spot on.

And I would also refer to what I said earlier

that we have to think about policy payments that actually gets the resources to the people who are actually doing this very difficult work.

And one of the epiphanies I had earlier this week, I think I'm probably the only person who has worked as a nursing assistant at one time in a nursing home, many, many years ago. It was sort of expected when you were a young nursing student. It was so, so difficult, and that was in comparatively very good circumstances.

And so to the extent that we are helping shape the world we will eventually possibly be in, I think there is so much work to do. And I need to start reconceptualizing individuals as not being low skilled. They are very, very skilled. It's just that they haven't had particular kind of pathway, and it's skill that we haven't valued as a nation.

So sorry to go on and on, but it is absolutely heartbreaking circumstance. Thank you. And I support the recommendation.

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

DR. CHERNEW: Okay. So in a moment we will go to the vote, but I will say I also strongly concur with both

of those comments, and we are in many ways hamstrung by the payment fragmentation we have, which is particularly problematic here, although I might add in other sectors where we're not the high payer there are other deleterious consequences of the fragmentation of where we are.

So the more we can do to find ways to help address those issues I think the better, but here we have a very specific task. So being in agreement with both of the comments I think we should move to a vote.

MS. KELLEY: All right then. The recommendation reads, "For fiscal year 2023, the Congress should reduce the 2022 Medicare base payment rates for skilled nursing facilities by 5 percent."

Voting yes or no. Pat?

MS. WANG: Yes.

MS. KELLEY: Dana?

DR. SAFRAN: Yes.

MS. KELLEY: Jaewon?

DR. RYU: Yes.

MS. KELLEY: Wayne?

DR. RILEY: Yes.

MS. KELLEY: Betty?

DR. RAMBUR: Yes.

MS. KELLEY: Bruce?

MR. PYENSON: Yes.

MS. KELLEY: Jon Perlin?

DR. PERLIN: Yes.

MS. KELLEY: Amol?

DR. NAVATHE: Yes.

MS. KELLEY: Jonathan Jaffery?

DR. JAFFERY: Yes.

MS. KELLEY: David?

DR. GRABOWSKI: Yes.

MS. KELLEY: Marge?

MS. MARJORIE GINSBURG: Yes.

MS. KELLEY: Stacie?

DR. DUSETZINA: Yes.

MS. KELLEY: Brian?

DR. DeBUSK: Yes.

MS. KELLEY: Larry?

DR. CASALINO: Yes.

MS. KELLEY: Lynn?

MS. BARR: Yes.

MS. KELLEY: Paul?

DR. PAUL GINSBURG: Yes.

MS. KELLEY: Mike?

DR. CHERNEW: Yes.

MS. KELLEY: Okay. I believe we are turning now to home health.

DR. CHERNEW: Yes. Evan, go.

MR. CHRISTMAN: I am going to wait for the slides to come up.

MS. KELLEY: Hang on just one second.

MR. CHRISTMAN: Are you ready for me?

MS. KELLEY: Yes. Go right ahead.

MR. CHRISTMAN: Okay. Thank you. Good afternoon. Now we will review the indicators for home health using the same framework you saw in the other sectors.

As an overview, Medicare spent $17.1 billion on home health services in 2020, and there were over 11,300 agencies. The program provided care to about 3.1 million beneficiaries.

In addition, in 2020, Medicare implemented two changes to the home health PPS required by the Bipartisan Budget Act, the 30-day unit of payment and the elimination

of therapy visits as a payment factor in the case mix system. The act required that MedPAC assess these changes. We presented this analysis at our September and December meetings, and the findings will be published in the March 2022 report.

Next slide, please.

As you may recall, our indicators for home health were positive. Beneficiaries' access to care were that 99 percent lived in a county with at least one home health agency. Volume decreased, but this was related mostly to the PHE, and agencies had positive Medicare marginal profits of almost 23 percent.

Quality of care was difficult to assess, as we noted, due to the circumstances of the PHE confounding our measures of quality. And access to capital, home health agencies had positive all-payer total profit margins of 8.1 percent, and the large publicly traded for-profit companies continue to have adequate access to capital.

In terms of payments and costs, Medicare agencies had an aggregate Medicare margin of 20.2 percent in 2020, and the efficient provider median margin was over 24 percent. And our projected Medicare margin for 2022 was 17

percent.

For our mandated report we concluded that the BBA 2018 change to home health care payments did not appear to have a negative effect on access or quality of home health care in 2020, though the PHE and lack of telehealth information confounded measuring the impact of these changes.

Now we turn to the recommendation. "For calendar year 2023, the Congress should reduce the 2022 Medicare base payment rate for home health agencies by 5 percent."

The implications are that this would decrease spending relative to current law by $750 million to $2 billion in 2023, with $5 to $10 billion over five years.

In terms of beneficiary and provider implications, we expect access to care will remain adequate. This should not affect the willingness of providers to serve beneficiaries but it may increase cost pressure for some providers.

At the December meeting we also discussed a recommendation for agencies to report when they provide services via telehealth. This recommendation was driven by the rapid rise in these services during the public health

emergency and the fact that HHAs are not currently required to report these services. The lack of information on telehealth confounded our efforts to assess utilization in 2020.

Bruce, you asked that we include some specific details about the information that HHAs should report, and that has been included in the chapter.

The recommendation reads, "The Secretary should require that home health agencies report the telehealth services provided during a 30-day period."

They should have no impact on spending, and in terms of beneficiary and provider impact beneficiary access to care should not be affected, and agencies may incur some costs to provide the additional administrative data.

This completes my presentation.

DR. CHERNEW: Thanks, Evan. Dana, I'm turning the queue over to you.

MS. KELLEY: Okay. I believe Lynn has a comment.

MS. BARR: Thank you, and thank you for a good chapter. Again we have this problem of peanut butter, where, you know, I agree with the recommendation for home health in general, but we have a serious crisis in rural

access. In our ACOs we have 60 percent of the average annual home health visits of the rest of all ACOs. And it is not because we don't want to use them. We can't get access because they get paid the same, no matter how far they have to drive.

And so I hope we can address this in a future comment around the safety net, but when we have in-home care it costs more if you have to drive an hour, and you have got to pay the nurse either way.

So I support the recommendation but I look forward to addressing some of the disparities and lack of health equity in hospice and home health. Thank you.

MS. KELLEY: Jon Perlin?

DR. PERLIN: Thanks. I will support this recommendation, but I really encourage us to begin thinking differently about home health. I know we think of it in this basket of post-acute care, but I think we really need to be thinking about Medicare beneficiaries of the future receiving home health as part of a continuum of care, especially with capacity for decentralization of lab testing and all of the other remote monitoring that could be put in place. The ability to augment what the

individual who is with the patient in their home or institutional environment can bring can be augmented by something at a distance. And not only can this be valuable post-acute but it can even be preventive.

So I will support this recommendation with some reluctance, because I think, you know, certainly during the pandemic the rationale for home health is self-evident, but more broadly I think we have something that we hope Medicare beneficiaries focus on. Thanks.

MS. KELLEY: Brian.

DR. DeBUSK: First of all, I do support the recommendation as written. I also agree, though, with Lynn's comments and Jon's comments, particularly about the continuum of care.

I did want to elaborate just a little bit. Lynn, I really agree with what you're saying particularly on some of these rural issues, because, for example, we're quick to do things like wage adjust home health care payments, based on hospital wage index factors, calculations. So we're quick to make those kinds of corrections because they're easily measured. They're easy to get your hands around.

Whereas to the point you made, Lynn, about the

driving. You know, it's very difficult. The driving distances and even simple things like getting equipment repaired and having to specialties, technicians and things.

So the rural setting has some costs that I sometimes worry we don't fully capture in the payment rates, whereas, again, we're really quick to correct those rural payment rates downward when we find something that's easily measured, like wages.

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

DR. CHERNEW: All right. I think this issue of heterogeneity broadly, and how challenging it is to provide care in rural areas, is something that we'll continue to look at. I might add, I'll channel a colleague of mine from MedPAC, the last time I was on, Mitra Behroozi, which would often, in these conversations, point out unique challenges with certain things in urban areas, but that's really neither here nor there for this part of the discussion.

I think we need to continue to understand how to deal with this and these types of issues broadly. So, Lynn, I appreciate you kicking this off with that comment,

and your follow-up, Jon, but now I think we'll move to the votes. Dana.

MS. KELLEY: Okay. The first draft recommendation, "For calendar year 2023, the Congress should reduce the 2022 Medicare base payment rate for home health agencies by 5 percent."

Voting yes or no. Pat?

MS. WANG: Yes.

MS. KELLEY: Dana?

DR. SAFRAN: Yes.

MS. KELLEY: Jaewon?

DR. RYU: Yes.

MS. KELLEY: Wayne?

DR. RILEY: Yes.

MS. KELLEY: Betty?

DR. RAMBUR: Yes.

MS. KELLEY: Bruce?

MR. PYENSON: Yes.

MS. KELLEY: Jon Perlin?

DR. PERLIN: Yes.

MS. KELLEY: Amol?

DR. NAVATHE: Yes.

MS. KELLEY: Jonathan Jaffery?

DR. JAFFERY: Yes.

MS. KELLEY: David?

DR. GRABOWSKI: Yes.

MS. KELLEY: Marge?

MS. MARJORIE GINSBURG: Yes.

MS. KELLEY: Stacie?

DR. DUSETZINA: Yes.

MS. KELLEY: Brian?

DR. DeBUSK: Yes.

MS. KELLEY: Larry?

DR. CASALINO: Yes.

MS. KELLEY: Lynn?

MS. BARR: Yes.

MS. KELLEY: Paul?

DR. PAUL GINSBURG: Yes.

MS. KELLEY: Mike?

DR. CHERNEW: Yes.

MS. KELLEY: Moving to the next recommendation, which reads, "The Secretary should require that home health agencies report the telehealth services provided during a 30-day period."

Voting yes or no. Pat?

MS. WANG: Yes.

MS. KELLEY: Dana?

DR. SAFRAN: Yes.

MS. KELLEY: Jaewon?

DR. RYU: Yes.

MS. KELLEY: Wayne?

DR. RILEY: Yes.

MS. KELLEY: Betty?

DR. RAMBUR: Yes.

MS. KELLEY: Bruce?

MR. PYENSON: Yes.

MS. KELLEY: Jon Perlin?

DR. PERLIN: Yes.

MS. KELLEY: Amol?

DR. NAVATHE: Yes.

MS. KELLEY: Jonathan Jaffery?

DR. JAFFERY: Yes.

MS. KELLEY: David?

DR. GRABOWSKI: Yes.

MS. KELLEY: Marge?

MS. MARJORIE GINSBURG: Yes.

MS. KELLEY: Stacie?

DR. DUSETZINA: Yes.

MS. KELLEY: Brian?

DR. DeBUSK: Yes.

MS. KELLEY: Larry?

DR. CASALINO: Yes.

MS. KELLEY: Lynn?

MS. BARR: Yes.

MS. KELLEY: Paul?

DR. PAUL GINSBURG: Yes.

MS. KELLEY: Mike?

DR. CHERNEW: Yes.

And I think that moves us to IRFs. Am I right there?

MS. KELLEY: That's correct.

Jamila, are you ready?

DR. TORAIN: Yes, I'm ready.

Good afternoon. We continue with the updates of Medicare's payments to inpatient rehabilitation facilities.

Pat, at the December meeting, you asked specific questions about the utilization of IRF waivers. To follow up, you asked whether we could determine, for example, how

many providers use a waiver that allowed acute care hospitals to relocate their patients to the IRF setting as a result of the public health emergency.

Overall, there were a number of waivers that applied to IRFs during the public health emergency, but unfortunately, the IRF Medicaid claim does not allow us to differentiate the types of waivers used by IRF providers at the claim level.

However, we do know that about 9 percent of IRF Medicare claims were reported using a modifier or condition code that distinguishes the use of a waiver in 2020.

Hospital-based IRFs share of IRF Medicare claims is about 43 percent and free-standing claims share is about 53 percent, but as you may expect, patients admitted under the waivers were more likely to be hospital-based than freestanding possibly due to the proximity of hospital-based IRFs to the acute care hospitals.

Additionally, you asked who paid for acute care hospital patients admitted to IRFs under a waiver. I confirmed that acute care hospitals bill for acute care patients treated in IRFs during the public health emergency.

Now we will review the indicators for IRF using the same framework you saw in the other sectors.

Here is a reminder of the IRF industry in 2020. In 2020, there were 1,113 IRFs and about 335,000 beneficiaries at 379,000 stays. Medicare spent about $8 billion on IRF care provided to fee-for-service beneficiaries, and Medicare accounted for about 54 percent of IRF discharges.

In summary of the materials we discussed in December, despite the coronavirus pandemic, we found that the IRF payment adequacy indicators were generally positive. First, in terms of fee-for-service, Medicare beneficiaries' access to care, while IRF supply declined in 2020 and volume declined sharply in the spring of 2020, steady occupancy rates and high-marginal profit for free-standing and hospital-based IRFs' providers suggest that IRFs continue have capacity that appears to be adequate to meet demand.

Second, we cannot draw any conclusions about quality in 2020 as measure changes reflect the public health emergency rather than changes in quality or payment adequacy.

Third, IRFs maintain good access to capital markets. The all-payer total margin for free-standing IRFs is a robust 10.2 percent.

Fourth, Medicare payments and IRF cost indicators were positive. In 2020, the aggregate Medicare margin was 13.5 percent. We project the margin of 14 percent in 2022.

So that brings us to the update of 2023. The draft recommendation reads "For 2023, the Congress should reduce the 2022 Medicare-based payment rate for inpatient rehabilitation facilities by 5 percent." To review the implications on spending relative to current law, spending would decrease by between $750 million and $2 billion in 2023 and by between $5 billion and $10 billion over five years. On beneficiaries and providers, we anticipate no adverse effect on Medicare beneficiaries' access to care. The recommendation may increase spending, financial pressure on some providers.

With that, I will close. I'm happy to take questions. Thank you.

DR. CHERNEW: Jamila, thank you.

Dana, I am turning over to you with the queue.

MS. KELLEY: I don't think we have anyone with

questions at this time. I'll just pause for a second to let someone raise their hand if they do, and not seeing any, I think we can move to the recommendation, if that's all right with you, Mike.

DR. CHERNEW: Perfect.

MS. KELLEY: All right. The recommendation is that "For fiscal year 2023, the Congress should reduce the 2022 Medicare-based payment rate for inpatient rehabilitation facilities by 5 percent." Voting yes or no.

Pat.

MS. WANG: Yes.

MS. KELLEY: Dana.

DR. SAFRAN: Yes.

MS. KELLEY: Jaewon.

DR. RYU: Yes.

MS. KELLEY: Wayne.

DR. RILEY: Yes.

MS. KELLEY: Betty.

DR. RAMBUR: Yes.

MS. KELLEY: Bruce.

MR. PYENSON: Yes.

MS. KELLEY: Jon Perlin.

DR. PERLIN: Yes.

MS. KELLEY: Amol.

DR. NAVATHE: Yes.

MS. KELLEY: Jonathan Jaffery.

DR. JAFFERY: Yes.

MS. KELLEY: David.

DR. GRABOWSKI: Yes.

MS. KELLEY: Marge.

MS. MARJORIE GINSBURG: Yes.

DR. CHERNEW: Stacie.

DR. DUSETZINA: Yes.

MS. KELLEY: Brian.

DR. DeBUSK: Yes.

MS. KELLEY: Larry.

DR. CASALINO: Yes.

MS. KELLEY: Lynn.

MS. BARR: Yes.

MS. KELLEY: Paul.

DR. PAUL GINSBURG: Yes.

MS. KELLEY: And Mike.

DR. CHERNEW: Yes.

MS. KELLEY: All right. And -- go ahead, Mike.

DR. CHERNEW: No, you go.

MS. KELLEY: I think we're ready to turn to LTCHs now.

DR. CHERNEW: Yes, and it's Kathryn.

MS. KELLEY: Yes.

DR. CHERNEW: Okay. Perfect.

MS. LINEHAN: Okay. Last, we turn to assessing payment adequacy and updating payments for long-term care hospital services. I'll summarize our analysis we presented in December and review the recommendation.

As we discussed in December, LTCH care is relatively expensive and infrequently used. In 2020, the average fee-for-service Medicare payment per LTCH case was about $45,000 across all cases and approximately $50,000 across the cases meeting the LTCH PPS criteria.

Fee-for-service Medicare beneficiaries had about 78,000 stays, and total Medicare spending was approximately $3.4 billion in 2020 for care furnished in 348 facilities.

In summary, as discussed in December and detailed in your mailing materials, our indicators of LTCH's payment adequacy showed effects of the pandemic and the temporary

waiver of policies that allowed LTCHs to provide expanded hospital capacity.

With respect to access, volume declined, but the largest monthly reductions in early fiscal year 2020 appeared to be related to the dual payment rate system. Occupancy rates were steady. Supply decreases were lower than in the pre-PHE period, and Medicare's marginal profits increased to 18 percent.

Quality of care is difficult to assess in 2020 due to the PHE.

LTCHs had access to capital in 2020. Their aggregate all-payer margins increased, and the largest provider of LTCH services acquired multiple facilities.

Finally, Medicare margins for LTCHs with a high share of cases qualifying for payment under the LTCH PPS increased to 6.9 percent in 2020 due to temporary PHE-related payment policies.

Assuming the resumption of the dual payment rate system policies, we project that aggregate Medicare margins in 2022 will be 3 percent.

That brings us to the draft recommendation. Medicare payments to LTCHs are not updated in law. So our

recommendations made to the Secretary, the draft recommendation reads "For fiscal year 2023, the Secretary should increase the 2022 Medicare-based payment rate for long-term care hospitals by the market basket minus the applicable productivity adjustment."

CMS typically makes the update based on market basket and productivity forecast. Therefore, this recommendation update is expected to have no effect on federal program spending relative to the expected regulatory update.

We anticipate that LTCHs can continue to provide Medicare beneficiaries and meet the LTCH PPS criteria with access to safe and effective care.

That concludes my presentation, and I'll turn it back to Mike.

DR. CHERNEW: Thank you, and I'm going to turn it over to Dana. We now have this working smoothly. Dana?

MS. KELLEY: All right. I don't have anyone in the queue, but I'll pause for a moment to let someone raise their hand if they'd like to.

All right. Seeing no one, we'll go to the recommendation: "For fiscal year 2023, the Secretary

should increase the 2022 Medicare-based payment rate for long-term care hospitals by the market basket minus the applicable productivity adjustment." Voting yes or no.

Pat.

MS. WANG: Yes.

MS. KELLEY: Dana.

DR. SAFRAN: Yes.

MS. KELLEY: Jaewon.

DR. RYU: Yes.

MS. KELLEY: Wayne.

DR. RILEY: Yes.

MS. KELLEY: Betty.

DR. RAMBUR: Yes.

MS. KELLEY: Bruce.

MR. PYENSON: Yes.

MS. KELLEY: Jon Perlin.

DR. PERLIN: Yes.

MS. KELLEY: Amol.

DR. NAVATHE: Yes.

MS. KELLEY: Jonathan Jaffery.

DR. JAFFERY: Yes.

MS. KELLEY: David.

DR. GRABOWSKI: Yes.

MS. KELLEY: Marge.

MS. MARJORIE GINSBURG: Yes.

DR. CHERNEW: Stacie.

DR. DUSETZINA: Yes.

MS. KELLEY: Brian.

DR. DeBUSK: Yes.

MS. KELLEY: Larry.

DR. CASALINO: Yes.

MS. KELLEY: Lynn.

MS. BARR: Yes.

MS. KELLEY: Paul.

DR. PAUL GINSBURG: Yes.

MS. KELLEY: And Mike.

DR. CHERNEW: Yes.

MS. KELLEY: All right.

DR. CHERNEW: Okay. I think that's the end of this session, if I followed everything right.

MS. KELLEY: That's correct. We've gone through all our update votes now.

DR. CHERNEW: Everybody take a big sigh. I know no one wants to join MedPAC for that discussion, but I must

say I was really impressed with a lot of the comments as one would generally have in the January session. So I actually really do appreciate that.

But, nevertheless, we are now going to move on. I think Carol is back up again with Ledia to talk about the post-acute VIP program. Are you ready, Carol?

DR. CARTER: Yes, I am.

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

This afternoon, Ledia and I will present the second of two presentations on the mandated report to design a value incentive program for post-acute care. In September, your discussion and questions led us to frame the chapter as a series of questions that policymakers will need to answer in designing a value incentive program.

As a reminder -- next slide, please -- the Consolidated Appropriations Act of 2021 requires MedPAC to report on a prototype value-based payment program that could be used in a unified payment system for post-acute care.

The report should consider design elements,

analyze the effects of implementing the program, and make recommendations as appropriate.

Our report is due March 15th of this year. Given this tight timeline, we are not making formal recommendations. However, the work we present here has a strong foundation in the Commission's past work and recommendations on value incentive programs.

Today I'll briefly review a unified payment system for post-acute care, or PAC, providers.

Next, Ledia will present the five elements of our proposed design for a value incentive program.

Then I will summarize our results of the illustrative modeling of this design and the steps to implement a PAC VIP program.

PAC providers, including skilled nursing facilities, home health agencies, inpatient rehabilitation facilities, and long-term care hospitals, offer Medicare beneficiaries recovery, rehabilitation services, and specialty services. For years, the Commission and CMS have documented the overlap of many of the types of patients treated in the four settings, yet Medicare uses separate prospective payment systems for each setting that result in

considerably different practice patterns and payments for similar patients.

To begin to align quality and payments across the four settings, the Congress passed the IMPACT Act in 2014. This called for uniform quality measures and patient assessment items and recommendations for the design of a unified payment system.

We were required to complete two reports. The first report in 2016 recommended design features. The second report is due in 2023. In the meanwhile, the Secretary is working on his mandated report, which is due at the end of this year.

Congress also mandated this report on a PAC VIP.

A unified payment system for all PAC providers would establish site-neutral payments based on patient characteristics, not setting.

Since its 2016 report on design features, the Commission has completed a series of reports on various aspects of a PAC PPS. This work estimated impacts on providers and more than 30 patient groups based on extensive analysis of cost reports, claims data, and risk scores.

Because a unified PPS would establish a common payment system, MedPAC noted that the unified payment system should be accompanied by aligned regulatory requirements. Otherwise, providers would face different costs to meet the current setting-specific requirements.

We also notes that a PAC VIP is an essential complement to the implementation of a PAC PPS because it would counter the fee-for-service system that provides little incentives for providers to furnish high-quality, efficient care.

MS. TABOR: Relying on the Commission's principles for quality measurement and consistent with our previous work on redesigning Medicare quality incentive programs, we discuss key design elements of a PAC VIP. The design elements include a small set of performance measures, strategies to ensure reliable measure results, a system to distribute rewards with minimal cliff effects, an approach to account for differences in patients' social risk factors using a peer-grouping mechanism if necessary, and a method to distribute the entire provider-funded pool of dollars.

For each element, I'll describe the decisions

that policymakers will need to make to develop and implement the PAC VIP. I will also describe how we incorporated the design elements in our illustrative modeling of a PAC VIP.

First, Medicare quality programs should include a small set of performance measures tied to outcomes, patient experience, and resource use.

Key decisions for policymakers in developing the PAC VIP are whether all providers should be scored on the same set of measures or also include measures that are specific to the patients a provider treats. Policymakers will also need to identify which measures should be scored.

The measure set should evolve over time, especially as the accuracy of patient function measures are improved and patient experience measures are developed. Work we did in 2019 raised serious questions about the reliability of the recording of functional information in patient assessments.

In our illustrative modeling, we used common measures across all providers. The three measures are hospitalizations during the stay, successful discharge to the community, and Medicare spending per beneficiary.

Second, the measure results used in the PAC VIP should be reliable, meaning that they should reflect the true differences in performance and not be attributable to random variation.

Key decisions for policymakers include defining the reliability standard for measure results and determining which strategies they should use to ensure reliable results for as many providers as possible.

In our illustrative modeling, we used a reliability standard of 0.7, meaning 70 percent of the variance in a measure's results was attributable to actual performance differences, not random variation. This standard translates to a minimum of 60 stays for each measure. We scored three years of performance to include as many providers as possible.

Third, the PAC VIP would establish a system for distributing rewards with minimal cliff effects.

A key decision for policymakers in developing the PAC VIP is whether a provider should meet some minimum performance standard before it earns performance points that translate into a reward.

In our illustrative model, we used a simple

scoring approach that awards points for every performance. It includes no minimum thresholds or cliffs. This way, every provider has an incentive to improve. Our design scores providers within their settings because practice patterns differ across settings due to the varying regulatory and payment policies. Eventually, under a uniform payment system and aligned regulatory requirements, we expect practice patterns to converge for like patients and then common performance targets can be set.

Fourth, providers that treat a large share of patients with social risk factors may be relatively disadvantaged in a quality payment program because it may be harder for them to achieve good outcomes for their patients. When this occurs, a quality payment program should account for differences in the providers' patient population through peer grouping.

A key decision for policymakers when implementing peer grouping is how to define and measure the social risk of patient populations. The measure should have a conceptual relationship with the outcome of interest; that is, there should be a reasonable hypothesis that the social risk factors could affect the outcomes. The measure should

also have an empirical association; that is, there is evidence of an association between the social risk factor and the outcome.

Policymakers will also need to determine how many peer groups would differentiate providers.

In our illustrative model, we used the share of fully dual-eligible beneficiaries a provider treats as the measure of social risk because there is a conceptual relationship between the social risk and the three performance measures in the literature. We used peer grouping in settings when the measure of social risk was inversely related to performance, meaning higher share of duals was related to poorer performance. We scaled the number of peer groups to the size of the setting.

Finally, Medicare quality programs should not attempt to achieve Medicare savings but rather should fully distribute provider-funded pools of dollars as rewards and penalties. A PAC VIP would distribute the entire provider-funded pool of dollars within each peer group based on providers' quality performance.

A key decision for policymakers is how large potential rewards and penalties need to be to motivate

providers to improve performance and avoid poor performance.

In our illustrative model, we used a pool of dollars funded by 5 percent of payments. All withheld funds were distributed back to providers.

Carol, do you want to jump in next?

DR. CARTER: Sorry. I didn't have my mic on. Sorry about that.

Before reviewing the findings, I wanted to summarize the data and analyses that underlie this work. First, in terms of data, we used the claims from almost 23,000 providers to calculate performance measures and to estimate the impacts on payments; that is, the net payment adjustments. We used the enrollment file to calculate the measures of social risk.

To assess whether peer groups were needed, we used correlation analysis to consider whether the measure of social risk was related to provider performance. Then we evaluated alternative peer groupings, different numbers of groups or whether there were natural breaks in the distribution of social risk measures. After modeling the performance points and calculating the net payment

adjustments, we confirmed the impacts by provider characteristics using regression analysis.

Although there is a conceptual relationship between the share of fully dual-eligible beneficiaries a provider treats and their outcomes, we did not find an empirical relationship in each of the four settings. I'll summarize our results, but there is more detail in the paper.

Using a provider's share of dual-eligible beneficiaries treated as the measure of social risk for IRFs and SNFs, we found that higher shares of fully dual-eligible beneficiaries were related to poorer performances. Peer groups helped counter the disadvantages IRFs and SNFs faced in achieving good performance.

Nonprofit providers and hospital-based providers received larger positive payment adjustments compared with other providers.

For home health agencies and LTCHs, higher social risk was associated with better performance. More work is needed to confirm this finding and to disentangle the various factors that shape provider performance.

Because high social risk was not related to

poorer performance, we did not use peer groupings for home health agencies or LTCHs.

We found that nonprofit providers and hospital-based home health agencies received larger positive payment adjustments compared with other providers.

The results for home health agencies and LTCHs highlight the complexities of measuring social risk and performance. More work is needed on both and is beyond the scope of this report. But we outline some factors that may complicate the relationship between the share of fully dual-eligible beneficiaries and provider performance.

First, the dual eligible status is considered a good proxy of social risk. It may be compromised by differing Medicaid eligibility rules and pathways across states.

Second, states also differ in how much their Medicaid spending is devoted to home and community-based services. These services can help beneficiaries remain in their homes, which is especially relevant for beneficiaries receiving home health care.

In addition, risk adjustments may not fully capture differences in case complexity. Accurate risk

adjustment is always challenging, but developing an accurate model across four settings is especially so, and there is a lot more discussion of this in the paper.

Finally, when beneficiaries are treated in their homes, the social risk factors of the communities where they live may be especially important in shaping the performance of home health agencies. Policymakers could design and test the accuracy and measures of social risk that incorporate community factors.

Implementing a PAC VIP would involve many steps and would be a multi-year endeavor. First, a PAC PPS would be implemented so that practice patterns begin to converge. Concurrently, regulatory requirements need to be aligned across PAC providers. Until this is completed, comparisons of performance across providers will need to be done within settings.

CMS needs to design a PAC value incentive program with the five elements listed on the slide. We have outline reasonable approaches to four the design elements that could be readily incorporated into a design: a starter set of performance measures, strategies to ensure reliable results, a system to distribute rewards with

minimal cliff effects, and the size of the incentive pool.

More work needs to be done on the measure of social risk and its relationship to performance before concluding whether adjusting performance results for social risk is always needed. We outlined the multiple measurement issues that will complicate the implementation of a PAC value incentive program, and while surmountable, they present challenges to implementing a program.

This brings us to your discussion. We look forward to your comments on this draft chapter, which will be included in this March report to the Congress.

DR. CHERNEW: Great. Thanks so much. I should have said at the beginning of this session we are reverting back to MedPAC Classic, which in this case means you will have Round 1 and Round 2 questions. And per the rules of MedPAC Classic, Round 1 questions should be clarifying. Don't make everybody that wants to make a comment have to wait. And then Round 2 will be our set of comments.

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

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

DR. SAFRAN: Thank you, and this is really exciting work. I'm very excited about it. I'll say a little bit more about that in Round 2.

But my question for Round 1 is, as we think about the challenges around data adequacy in terms of volumes, you make a comment in the chapter -- I think you do -- about the potential of using all-payer data, or maybe that was just a note I made to myself. But either way, my question was would it be possible to use all-payer data in this program, given small sample sizes? Is that something you've considered?

DR. CARTER: No, because we have all-payer claims data, and so that would be the main reason. Also, I guess there's a more conceptual question, which is do want to base a Medicare program on performance for potentially non-Medicare patients? But the short answer, narrowly, is we don't have the data to do what you suggest.

Ledia, did you want to say something?

MS. TABOR: That covers it. Thanks.

DR. CARTER: Okay.

MS. KELLEY: Okay. I have David next.

DR. GRABOWSKI: Great. Thanks, Dana, and thank

you, Carol and Ledia. This is great work, as always.

I had two questions. One is kind of a more minor data issue and the second is kind of a broader conceptual question. So the first, I appreciate these measures are illustrative. I think they're really good candidates. I just wondered, they're very similar in nature, and I just wondered how well correlated are, you know, hospitalizations during the stay, successful discharge, and then overall Medicare spending per beneficiary. They all seem to be getting at a very similar construct. So I wondered if you'd look at that. I can even imagine the first two running counter to one another, you're either hospitalized before, during the stay, but maybe not after, something like that.

So tell us a little bit about just how well correlated these measures are.

DR. CARTER: We haven't looked at that. I think they do capture different dimensions, but that doesn't mean they wouldn't be correlated, right. One is looking at hospitalizations that happen during a stay. The second is really looking at hospitalizations in a post period, after the stay. So providers might be good at one and not at the

other. We don't know.

In terms of spending, you know, if you have hospitalizations it is going to increase your Medicare spending, so that's probably more related to each of those two than the hospitalization and discharge to community measure.

DR. GRABOWSKI: Great. Thanks. I have some more thoughts on measures but I'll save those for Round 2, or Mike is going to zap me or something.

I did want to ask a larger conceptual question. You kind of touched on this at one point during your presentation. Everything is being done within settings, so SNFs being compared to SNFs, home health compared to home health. At some point, and you noted this, it should evolve, right, to a model that we can compare across settings, and I'm wondering what are the steps from here to there, at a high level? Like what do we need to do in order to, at some point, be able to compare across PAC settings?

DR. CARTER: I think until regulatory requirements begin to be aligned you're going to continue to see differences in practice patterns. Just as like the

simple example of the stay differences across settings is substantial, and some of that is in response to the payment incentives and the payment unit. And until we have a common unit of payment that is moving from a day to a stay for SNFs, and everyone having the same incentive regarding like the stay, I think you need to have aligned regulatory requirements, I think, before you can begin to compare providers across settings.

DR. GRABOWSKI: And so the regulatory piece is a part of it, and then are the quality data sort of, like do we need to wait on like functional assessments, quality there, patient experience? Or could we do this with the existing measure set?

DR. CARTER: Ledia, do you want to take this?

MS. TABOR: Yeah. I can jump in here. So we have claims data right now across the different settings. The functional data, our previous analysis has found, we question its accuracy, and that was true across all four PAC settings.

For patient experience there is a home health CAHPS that is currently be used in the home health BBP and publicly reported, but the other settings do not yet have

implemented CAHPS or other patient experience surveys. So we would definitely encourage especially the Commissioners' support for the Secretary to continue to improve the function measures and develop and implement patient experience surveys.

DR. GRABOWSKI: Great. Well, I'll say it now and I'll say it again in Round 2, we need those measures. So I'll hold off on saying more until it's my turn again. Thanks.

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

DR. NAVATHE: So I have a few questions. First, I have a question which actually might extend beyond the PAC question, but in the Medicare spending per beneficiary measure, I was curious how if, at all, how hospitals are currently being incentivized around MSPB or how it's being used with hospitals.

MS. TABOR: So currently in the hospital BBP, MSPB is scored. The measure is a bit different because it's spending during the stay and after the hospital stay, whereas this MSPB measure looks at spending during the PAC stay and 30 days after. So I would say they're aligned

conceptually but measuring different things.

DR. NAVATHE: Okay. That's a very helpful distinction. Thanks for that.

My second question is, when we're looking at the way the points are allocated at this part of the VIP, so Table 14-1 in our mailing materials, I was curious, the way that the points are assigned, are those assigned based on, sort of equally across the decile of the distribution, or is it assigned in a linear fashion, in a continuous way, saying here's the lowest, here's the highest, and then we're going to assign this in a linear fashion?

MS. TABOR: So we actually, with consultation with Dana Safran, used a beta distribution, which I can go into more detail kind of offline about. But we basically used the national set of data for each provider and then used this beta distribution, which is continuous, to assign points.

DR. NAVATHE: Great. Okay.

MS. TABOR: So I guess to part of your question, it is a continuous scale.

DR. NAVATHE: Right. So that's super helpful to the extent that we can follow up offline, that would be

great. I would love to see the additional points, and I think that could just be noted, even in a footnote in the material. I think that would be helpful for clarification sake.

The third and last Round 1 question that I have is, in looking at the social risk analysis for home health, did we consider, or did we try stratifying by whether this was a community referral or if it was a referral from an institution?

DR. CARTER: We did not do that. Are you thinking about the duals measure or the ADI measure?

DR. NAVATHE: The duals measure.

DR. CARTER: We didn't look at how that was related to performance, if that's your question. Is that your question, did we look at that?

DR. NAVATHE: Yeah. My question, I guess, is what is the relationship between duals and performance, depending on whether the referral to home health was made in the outpatient setting or whether it was effectively more of a post-acute care?

DR. CARTER: Yeah. So we did look at that relationship, and the share of a provider's patients that

were community admitted was inversely related to performance points. And we wondered whether the risk adjustment for home health, but maybe frailty was a more important factor in performance points. We weren't really sure. But the risk adjustment doesn't factor in the frailty of a patient. It does have lots of comorbidity measures but not a specific measure of frailty.

DR. NAVATHE: I see. So you see this inverse relationship but then we didn't stratify them and then run the analysis.

DR. CARTER: No, we didn't. Right. I see now your question. We did not do that.

DR. NAVATHE: Okay.

MS. TABOR: And we can talk about it internally, and this is something the Commissioners could weigh in on, but I think we wanted to treat, you know, a home health agency should kind of be responsible for the quality and care, regardless of where the patient comes from. So we were, I think, had some conversation about this and we were a little hesitant to divide them out.

DR. NAVATHE: Yeah. I guess it depends a little bit on what the intent of the analysis is, and sort of from

an informational perspective versus a design perspective, to some extent they're a little bit different in my mind. But I will come back to it in Round 2, for the sake of time. So thanks, Ledia and Carol.

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

DR. CASALINO: Yeah. Ledia and Carol, really a fantastic chapter. It's so interesting to read and so important. So thoughtful and well done.

There's lots of things I could ask about, but I'll just bring up one area. On page 10, you have a couple of paragraphs on discussing your supervisory score on the same set of measures, and you mention there's one possibility, for example, scoring everybody on the same set of common measures, and that would be part of the financial incentive program, VIP. And then publicly reporting other measures on patient population specific measures. So this would be, for example, in the examples you used on this page is for ventilator patients, for example.

So just two questions. One is, what would be a couple of other examples of population-specific measures?

MS. TABOR: Carol and I actually talked about

this yesterday. So we kind of played on this idea of right now there are some health care-associated infection measures that are applied to institutions, like the long-term care facilities. So perhaps institutions like SNFs or LTCHs could be scored on an infection-related measure.

There could be some measures on worsening or improving pressure ulcers, which could be more applicable to some patient populations than others, falls prevention, and number of falls could be also another measure that could be perhaps applicable for some providers and not others.

We also discussed that these are all great measure concepts, especially the pressure ulcers and the falls, but we do question the accuracy of the data since it is provider reported, so some improvement would need to be made there as well.

DR. CASALINO: Okay. Yeah, this is a tricky area. And the other question I have is, in terms of risk adjustment, so would the risk adjusters be the same for all patients across all settings, or would they differ by patient or by setting? I mean, I'm only in the kind of very early stages of thinking about this, but just for

example, would being on a ventilator, or not, be a covariate? Would that be a risk adjuster? Even though being on a ventilator, there could be measures just for patients on ventilators, as you suggest here. But then risk adjusting, would everybody in every setting have the same risk adjusters? And so one of them, for example, would be, be on a ventilator, yes or no.

But I don't mean to focus on the ventilator aspect. More do you think that the risk adjusters would be the same for all patients across all settings, or would they differ?

DR. CARTER: Well, we discussed that a little bit in the paper. There are kind of pros and cons to having uniform risk adjustment across the settings. It leads us more towards a unified approach, and so that's a thing to like about them.

But it does mean that, say home health and SNF make up -- this is ballpark -- 95 percent of PAC stays. So those stays and those patients' comorbidities swamp the model definition. Yet you can imagine, and your example of LTCH patients on vents, you might have different factors if you were looking at lots of patients in long-term care

hospitals, because the things that are relevant to that patient population might be a little different, or they could have the same components but the weights might be really different. So how important a particular comorbidity is might differ across settings.

So I think there is a tradeoff between having setting-specific models that might be more accurate for the providers in that setting, but it moves you away from the uniformity that we're trying to move towards.

DR. CASALINO: Yeah, no, that original tradeoff there, because if you go too far in that direction you wouldn't have the uniformity, but I know that if you don't do it at all it might be unfair. It's tricky.

DR. CARTER: Yeah.

DR. CASALINO: That's it. Thank you. Very nice work.

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

MS. WANG: Yeah. Thank you, and congratulations as well on the quality and thoughtfulness of the work. It's really great.

I had questions generally about the social risk

adjustment work that you've been doing, and, you know, you've been looking into so many different dimensions of it. And I may be mixing apples and oranges here, but I wonder whether you thought there was any utility in looking at -- you know, I'm thinking about the Medicare Advantage world actually, and the way that risk scores are generated, base their scores. And within the dual population, you know, it's very different for -- duals are duals by reason of disability versus are duals by reason of age or other non-disabled status.

You know, I just wonder whether there's more perhaps, just even within dual mix to explore in terms of correlation to some of these results.

And I also was just really would be interested in your point of view, because you have looked at this issue and it's so important-- it's swirling everywhere -- whether you have formed any kind of point of view on sort of the most promising indicators of social risk that are available from, you know, general databases. You've looked at ADI. You've looked at the social vulnerability index. I don't know whether people are doing work to correlate those with the association of dual status with certain outcomes.

But I wondered if you've developed a point of view on what is the most promising direction to further refine our understanding, because as you noted, dual status has got some imperfections, based on state-by-state different rules, things of that nature. And I was just curious if you had a point of view.

MS. TABOR: I do not have. I think we have found that duals, as a proxy for low income, is the best that we have available to us. And again the Commission has talked about, too, we need better data. Perhaps there is some ability in these geographic area-level indices to better represent social risk along with some patient-specific data. I know Brian and Jeff are kind of working on this same question for how do you define safety net providers.

So I don't really have a thought other than to say, you know, probably more work needs to be done, but I have enough faith in the duals status as a proxy for social risk in kind of what we're trying to do with our peer grouping.

DR. CARTER: Just a thought I would add, and I add this maybe because I know less about it so I can feel more free to talk about things than Ledia. I'm intrigued

by a composite measure, because the fact that we found, at least through the area-based measure and the duals measure to be inversely related, tells me that they're capturing different dimensions of social risk.

So I think somebody should be looking at some kind of -- and this is just me thinking -- some composite of something that's capturing important dimensions about the community plus dual, which is a very good measure of income, and maybe some combination might be a good direction for someone to look into.

MS. WANG: Thank you.

MS. KELLEY: Okay. I think that's the end of Round 1, unless I missed anyone.

Mike, did you want to get in here before we move to Round 2?

DR. CHERNEW: Well, I would like to move to Round 2, but I think Larry has a second Round 1 question.

DR. CASALINO: Yes. I just came up with it, just a second before you started talking.

So a quick question again for Ledia and Carol. I'm by no means an expert on this, but I have the impression that just in the last two or three years, there

are research groups that are doing quite a lot of work on trying to figure out what are good social risk adjustors that will be linked to -- or are linked to important outcomes.

So I wonder to what extent you guys have had a chance to look at that. Clearly, the work that you've already done in the specific settings we're talking about is important. But still, there might be something to be learned from what others are doing, possibly in other settings about ways to measure social risk.

Your findings are -- you know, it's disappointing that we're getting kind of opposite results. So I think there's a fair amount going on in this area. Have you had a chance to look at it? Are you planning to do that?

MS. TABOR: We have. So we've spoken with some experts in the field. Thanks to Pat and Dana for referring us to some of the colleagues on that, and it seems like a lot of people are doing interesting work. And we've also been tracking the research, and it kind of -- you know, one group of people could come up with one indicator for one purpose, and another group of people could come up with another indicator for another purpose. So I think there is

a lot of promise for people, researchers, and those in health care organizations to continue to kind of develop what is the best proxy for social risk, but I think that internally we felt that that's kind of a little bit outside of our scope, beyond kind of keeping track of what's going on in the environment.

DR. CASALINO: But there's nothing out there that you haven't tested yet in this context that you think could be valuable?

MS. TABOR: I don't think there's a gold standard is what we found, other than duals, but we did look into other publicly available indices. I think there's a text box in the paper about it; for example, the places indicator. There's a CDC social vulnerability index, and they're all kind of created using Census data for the most part. But they're created for different purposes, not necessarily for identifying providers that treat higher social risk patients. The social vulnerability index, for example, was used to identify communities that should be prioritized for vaccine distribution in 2021.

So, anyway, I guess I'm rambling a little bit, but I think there is a lot more work to be done, and we're

kind of keeping apprised of it. I don't know how much work there is for us to do in developing these indicators.

DR. CASALINO: Thank you.

DR. CHERNEW: Okay. Now I think we're done with Round 1.

So, Dana, I'm going to turn it over to you to run Round 2.

MS. KELLEY: Okay. Dana, I believe you're first.

DR. SAFRAN: Okay. Thank you.

So just this really is an exciting piece of work and really, really well thought out and well written. I particularly really do like the way you've incorporated some of the features that we've talked about and reflected in other sectors for the quality incentive model, the focus on ensuring a reliability standard of at least 0.7 and how that will be done, the absolute performance targets and the use of ongoing -- you know, not a single target so that we avoid cliffs is really a positive feature.

The beta binomial, as we talked about, I really think is going to be very, very helpful to this work and motivating to providers.

I have a different point of view from the one

that you express in the chapter around whether to have or not have a lower bound on performance targets. So I know you know that, but I thought I would once again just mention it and say two things about it.

One is one of the concerns you raised about a lower bound is that it could create the type of a cliff or at least vast disparities in reward for providers who are, you know, a couple decimal points below it versus those who just make it, and I would just mention that one of the ways that we've dealt with that in the past that I think is very successful is you can create a kind of a buffer zone that is -- you can think of it as a one-sided confidence interval, though. It's a little bit different in the math, but the upshot of it is that anybody who is within a certain zone below the lower bound that we set will have a kind of great inflation that gives them a bump up over the line so that you can see that there is a no more than 5 percent risk of misclassifying somebody as not being worthy of a reward, and that really addresses that part of your concern. I know you had other concerns.

One other comment I'll make and it's something that covered California -- has recently announced that

they're going to be doing is for contracted health plans -- and I know we're talking about providers here, but bear with me -- who fall below a certain level of quality. They're going to start using a penalty. So I know we might not really want to consider this, but it is a way to get around the concern that you were talking about of particularly punishing providers who care for those with higher social risk who might fall below that line. The way they're dealing with it is similar, you know, almost analogous to how we're dealing with better rewards for providers who have higher social risk for a given level of performance, and so what I think they may be doing is lower penalties for providers who care for a higher level of social risk.

So it's something to consider with respect to having a lower bound, but the upshot of that is I still think that's something worth considering.

And then two final things. One, just reflecting on something Pat said about social risk, I think the way you've now handled the illustration of duals versus the area deprivation index is much, much better. So I appreciate that. I think it could be improved further by

really making clear that with these other indices that are geographic that they differ in terms of some of them are using Census Tract, which is really different from Census Block Group, and I think you should take a stand and say if we're going to use geographic proxies, we should have proxies as proximate to the person as possible, and therefore, that's why you selected the area deprivation index to evaluate.

But I also would say I still find it concerning that you get an opposite answer, sometimes with duals versus the area deprivation index, and Pat's comment really gave a thought about that because if we can parse apart the duals who are eligible because of disability as opposed to socioeconomic vulnerability, maybe that starts to help those two indices agree more.

So I don't know if you have the indicator of why some of these are dual, but if you do, I think that is a very worthwhile test to do before we finalized this chapter.

Then my final comment is absolutely, as you might imagine, very much supportive of your desire and your support for including patient-reported measures. I do

think it's important in this chapter that we acknowledge the challenges of patient-reported measures with this population and the challenges of proxy respondents which is typically the alternative.

So I didn't see any mention of that, and I think our enthusiasm for patient-reported measures should be there, but I also think we have to show an awareness of the significant methodological challenges of responses, being able to get responses or not, and then using proxies as really a very, very dicey methodological challenge.

So those are my comments. Thank you again for a great chapter.

MS. KELLEY: Brian?

DR. DeBUSK: Yes. First of all, I was really excited to see Carol's PAC work and Ledia's VBP work. To both of you, please keep that going.

I did think it was important, the way you pointed out in the chapter that regulatory harmonization is going to be necessary to truly unify that. I hope we can turn that into a boldface recommendation fairly soon, just because that presumably will take years to make happen.

And then also, I wanted to put in a plug for a

reliable, functional status measure. Again, I know how elusive they are. I know how difficult they are, particularly when they're provider-reported and are tied to payment. I do feel your pain. I hope at some point that we do have a viable measure.

But what I want to focus on in my comments is that mixed results that you received from peer grouping. Based on the paper, in some cases, the peer grouping even produced counter-intuitive results, and I'd like to raise the order of operations issue yet again. And that is, when you're doing the risk adjustment and the point scale conversion on everyone first and then you're peer grouping them, you're tacitly assuming that the risk adjustments and the point scales work homogenously across the peer groups.

One of my favorite measures is successful discharge to community, and I'm just being illustrative here, but what if that measure actually works differently in low versus high socioeconomic groups? Perhaps for a fluent beneficiary, age doesn't really affect successful discharge rates, or maybe it even works in reverse because maybe it raises the chances they'll have dedicated in-home care. But then for the people that hide socioeconomic

risk, maybe age drastically decreases their chances of a successful discharge to community.

Again, I'm raising this for illustrative purposes, but would we consider or have we considered doing the peer grouping, say, based on SES or some composite measure? Have we considered doing the peer grouping first and then doing the risk adjustment and then doing the risk scale conversion?

And really, to be more specific, if you look at pages 31 and 32 of the reading material, basically, all I'm proposing is that we move steps four and five before steps one and two.

Then, again, I want to also echo some of the comments around the support for a composite measure. I think, ideally, we could titrate a measure based on available data, like area deprivation index and fully dual eligible status.

But, again, I guess this is almost a Round 1/Round 2 comment, but have you looked at or would you consider looking at changing the order of operations for the peer groups, particularly in light of the fact that it's giving some very counterintuitive results?

Those are my comments. Thank you.

MS. KELLEY: David.

DR. GRABOWSKI: I think, Brian, that was a real source of innovation. You snuck a Round 1 question into a Round 2 comments, kind of backwards there.

Let me just say I'm very excited we're doing this work. This is incredibly challenging. I thought the chapter was quite thoughtful and detailed in terms of addressing all the issues at hand.

I want to make two comments. The first really relates to what Dana and Brian already touched on around the quality measures. I like the three measures that are there. I do think they're all claims-based, which is similar to other MedPAC measures from other quality improvement systems.

I think moving forward, we do need to expand the measure set. Obviously, the problems aren't MedPAC's. They're kind of the quality of the data or just the availability of the data. So I don't know if those need to be recommendations that we build into a future version of this, but really pushing, I thought the chapter did a nice job of discussing kind of the patient experience measures

and the issues with functional experience measures. But, in both instances, I really think those need to be added.

I think the three measures we have right now don't really capture the post-acute experience completely. They're pretty narrow in a lot of ways, and if you ask most families or patients in our system what they value and what they want in terms of quality of care and outcomes, I think all of these would be in that set. But I don't think this would encompass the set, and so I really think we need to think about alternate measures.

The two that really jump out are what Dana mentioned around patient experience and then what Brian touched on with functional improvement.

Just to push on that latter, we've tried to use functional improvement in a lot of our studies. It's flawed for all the reasons MedPAC has noted over the years. It's provider-reported. It's tied to payment. It's biased. But are there ways to begin to audit that or otherwise encourage post-acute care providers to report more accurate information? That seems like maybe a discussion. It's just too important a measure to be kind of left on the sidelines. So that's one comment.

My second is more about the bigger picture, and I touched on this in my first round of questions. I think I'm as close to this work as any of the Commissioners, and I sometimes get lost as to where we are in the big picture because we have kind of regulatory harmony, we have payment harmony, and then we have now a PAC VIP harmony and just trying to get all those pieces together.

I wonder if there's not a broader framework or sort of figure -- and if I've missed that somewhere, I apologize, but something to kind of say here are the steps that we need to take.

I totally agree -- I think it was Carol that said in the first round about the first step being regulatory harmonization. I do think then you need to get kind of the payments kind of aligned across the settings, and this quality part might be the last part. But is there an exhibit or figure that kind of lays that out? I think that would be really helpful as a text box or an exhibit in the broader chapter such that we can sort of think about.

I know this is years in the making and probably years out in the future until all this happens, but I think some of that orientation could be really useful.

Thanks.

MS. KELLEY: Amol.

DR. NAVATHE: Carol and Ledia, thanks for the terrific work. I'm a big fan of pursuing this, and I think you're tackling an immensely complex issue here and doing a very nice schematic job of it. So thank you for the hard work, and I echo other Commissioners who highlighted its importance.

So I have a few different things that I want to hit upon in part because, Ledia and Carol, you both have mentioned also that it's something that we would want to do if Commissioners highlight support for it. So I have kind of a few tick marks, and then I have a broader comment.

The first thing is I just want to, like Dave and others, echo support for the idea -- and Dana as well -- for patient experience measures here. I think patient-reported and patient experience measures are incredibly important. I understand, as you have outlined, that functional measures are not easy, but I think that doesn't mean that we should stop pursuing them, given their potential incredible importance in this space specifically being the PAC world.

Second thing, this is a smaller point, but following up on the MSPB measure point, there is a part in the paper that you highlight, the importance of the overlap between having that measure in the hospital or in the PAC room, and I wanted to highlight that point because I think that's an incredibly important design issue. Otherwise, we have a heavily concentrated PAC market like we do particularly for IRFs, but in some markets, we do for SNFs and others as well. We can create an unfortunate situation where it actually may reverse, highly concentrated hospitals and not as concentrated on the PAC side. We can create a situation where the incentives are not aligned and effectively one organization, either hospital or PAC institution, is kind of at the mercy of the other, which we may not want from a certain quality perspective or even for the beneficiary's benefit.

Quickly, I just wanted to also echo support for the idea of using multiple years of data in the setting of low volume and weighting recent years more heavily, and that being said, trying to restrict that to low volume rather than apply that uniformly across high volume, which would mitigate responsiveness over time.

That's my punch list of things I wanted to echo support for.

The bigger issues, so like Brian, David, Dana, and others, I'm grappling a lot with the conflicting results on social risk and the other elements of trying to create something that's unified here. So I have two big points. I'll go less broad to more broad.

The less broad point is I think you highlighted this, but I think it's just worth noting that I think we need to do a lot more work on the social risk adjustment points. It strikes me that there's probably confounding factors. I think, conceptually, it doesn't make sense what we're finding and the sensitivity as what we're seeing in two different settings.

It suggests that the suggestions that people have made, such as Pat and others, around looking at duals and disability, looking at the referral source for HHA, looking at how this might vary by markets based on availability of PAC. I think Jon Perlin and Lynn and others have pointed out that a lot of the intensity of PAC actually depends on capacity in the market and availability and market dynamics.

So we need to try to start to disaggregate this, to look and see if we can find systematic patterns. I think these are important confounding factors, and we have to be systematic about it, as you are doing. So I just want to propose that we continue to dig deep as we can to continue to push on this.

The second, much broader point here -- and I'm standing on the shoulders of Brian and David and others, shamelessly -- I wonder, to some extent, if our pursuit of unified PAC is, I don't want to say misguided, because that's not the right word, but maybe we're too literally interpreting the concept of unified. And what I mean by that is if we rely on our risk adjustment system, for example, to do everything for us, including, say, what is the most appropriate setting where we know there is market-to-market geographic variation, we may be destined, to some extent, to create a system that can't be feasible, that just won't work.

And what I mean here, to some extent, is imagine conceptually that we could actually separate out this notion of what is the appropriate setting of care for an individual beneficiary. Should they be in an IRF? Should

they be in a SNF? Should they be home health? Should they have any of this, depending on what they need.

Then you could imagine that within those settings we could design a much more sensible risk adjustment model. We could design a much more sensible quality measurement model and incentive model.

I think part of the challenge here is that we're trying to say we want -- and this is my proposition. I don't know if this is exactly what's in our minds, but to some extent, conceptually what we're saying is, let's use a risk adjustment model to perfectly identify how we could be paying for this, paying for individuals, because we think there's a continuity of severity or intensity that should be tied to payment, and therefore that should be perfectly tied to where people should be placed, from a setting perspective.

I actually don't think that's very feasible, and the reason that I don't think it's feasible is because of the aforementioned reasons, around different market dynamics and other pieces, as well as dimensions that might vary, much in the same way that Brian was pointing out, that if we look at the relationship between age and

comorbidity and frailty and other factors, they may, in fact, have very different relationships in the different parts of the severity or intensity spectrum.

So to ask a risk adjustment model, including social risk, to answer all of those questions for us in this so-called unified system may be too much to ask of a single unified model, so to speak. And so maybe our approach here is one that kind of differentiates the situation of how do we best identify the optimal setting or most likely, best setting up here while allowing them to have flexibility to think about risk adjustment parameters and quality measure, performance measurement parameters within those subsets, almost like a P-slice model if you're a regression bot.

So I wanted to conceptually propose that, because as I thought more and more about this I was wondering why it felt so daunting and hard, and I think that that might be it, and I propose to you all to react to whether that might be it or it might be something else. Thank you.

MS. KELLEY: I have Lynn with a Round 2 comment.

MS. BARR: Thank you. This actually might be a Round 2 sinking into a Round 1 comment, so I'll go the

other way around. But why are swing beds not included in this model, is kind of the question. And, you know, that is the major source of skilled nursing care in rural facilities. And one of the issues we have, other than it being incredibly expensive on a per diem rate, but much shorter length of stay, you know, what is the value of swing bed services, and it's been something we've been struggling with, to try to understand. And because swing beds are exempt from the type of reporting, OASIS reporting, et cetera, that other post-acute care settings have, we have no data, other than the data we have, you know, to try to understand the value, and what should future policy by around swing beds.

So I'm not suggesting that we create an incentive program for swing beds, because they're in a totally different universe than everyone else, from a payment perspective. It's cost-based. But if these are claims-based measured, by including swing beds we could have a much better view of the relative value, particularly if they were their own cohort.

Any comments on that, Ledia?

MS. TABOR: Let me think about this some more. I

will say that, you know, in our modeling and our measure calculations we focused on providers since this is provider accountability program. So swing beds, as you have said before, are kind of a different type of provider, so we didn't include them in this modeling. But again, I can kind of take it back and think about it some more.

Carol, do you have anything to add?

DR. CARTER: They are cost-based so they wouldn't be, you know, on the PPS side. Because they're cost-based, they are paid on a different basis, like you mentioned. I guess for this, thinking about a value incentive program, I just want to think about that.

MS. BARR: Well again, I would just suggest we shadow them and measure them, because we have no way of measuring. There is no data that anyone, in CMS or elsewhere, has about the quality of swing beds, right? And it's really hard to fix what you don't measure. And so if we had any kind of data that we could compare them against each other, even if they're not used for payment policy, we could potentially help the beneficiaries.

MS. TABOR: I've never given this any thought, but it is something to think about, so I will do that after

the meeting.

DR. CHERNEW: Dana, am I correct that that was the end of Round 2, or at least the last person in the Round 2 queue?

MS. KELLEY: Yes, according to my notes.

DR. CHERNEW: All right. I'm going to quasi wrap up, and then I'm going to ask if people want to say some more things. So let me jump in on a few broad reactions to this very thoughtful discussion.

First, and I apologize to the extent to which this is frustrating, recall this is in response, as you know, to the congressional mandate, and it's going to appear in the March chapter. And so while there was an enormous amount of comments, much very well taken, there's going to be a limit as to how much we're going to deviate until we get to the March chapter. I think folks understand that.

The comments fit into a broad set of concerns. One, I would say, the measures. That honestly is one of my biggest concerns. Two is what I will call general statistics, a whole bunch of things you might do statistically that's a little bit different. And three,

I'll call it the peer-grouping approach, social risk adjustment, other risk adjustment approaches in how we do the peer grouping, some sort of very specific statistics around there.

All of those are really important, and I think people point out, in a number of ways, what seems clearly true, that while there is a lot of overlap in the sites that patients might go to, there's actually a lot of not overlap. In other words, there's a lot of uniqueness, and so the task at hand of putting everything into a single, unified model across all parameters is, in fact, in many ways, a herculean task, conceptually, statistically, and otherwise. And I hope I'm capturing the theme of discussions with that sort of broad-based comment.

The chapter will have to take that tone, in some ways, but I do want to point out that what the discussion here is, and I think it's pretty clear in the chapter, although you may differ, you can send messages if you do, is what we're describing is an illustrative approach. We are not going to build. We are not building this exactly in ourselves.

I can tell you, there have been discussions

between MedPAC staff and folks at CMS, more broadly, about how to address some of the thornier issues that arise here. But there is not a clear, direct path that if you do X you will find Y, and therefore we can adopt a program that looks like Z.

Many of you -- I'll look to you, Dana -- have given a lot of thought about quality measures, statistical things around quality measures, how to translate them into payment models, and I know in your current role you will be continuing to think about all those types of things. You're certainly not the only one of the Commissioners that fits that characterization, but we are going to have to draft behind what a lot of other people in the world are doing, just given the limitations of our resources and our time, quite frankly.

So this is, I think, universally considered by all of you and by me, both a great body of work and a really important topic, and something you were asked to do anyway, but it is not one where you could simply be asked to do it and we could come back with the answer. It's a quite challenging thing to do.

So we will do our best to capture a lot of the

tone of some of these comments, given the timing that we have and what we're doing, and certainly many of these comments transcend just this chapter. I think the idea of quality measurements in post-acute, broadly, is something that will continue to be looked at in MedPAC. But we are where we are for the March chapter, and I think your comments will help make that a better chapter.

But I feel that I want to emphasize to the people at home who read it, we are well aware that we do not have, we are not presenting on a silver platter a SNF VIP which could just then be adopted, and solve the problems. I think Ledia and Carol would agree, and I should probably let you respond in a minute. I certainly think you would agree. And so hopefully the insight and the comments that we make as a result of your comments are helpful, but there is a lot more work to go from where we are now, in this chapter, and actually where CMS is now in their thinking, to actually a program that we like and we think would work and we would be proud of.

So that's my broad summary of this discussion. Carol and Ledia, do you want to add anything to either what anybody said or correct me if you think my summary is off

in any way? I'm really just trying to make sure the Commissioners understand where we are in this process, which is closer to the end than the beginning, at least for our immediate workload.

MS. TABOR: No, nothing. Thanks for all the helpful comments. You know, I think there are some things that we can add to the March chapter but then a lot of things that we can kind of take back and think about over the coming projects.

DR. CHERNEW: Thanks. Jim, do you want to add anything?

DR. MATHEWS: No. You're good.

DR. CHERNEW: Okay. So I'm going to pause for a few minutes -- not a few minutes, a few seconds -- to see if anyone wants to add anything else. Otherwise, I am going to give a hearty thank you to the staff and all of you for your comments.

In the meantime, I will say to those of you that joined us online, we really do want to hear your comments. You can send an email to meetingcomments@medpac.gov, or you can go to the newly redesigned MedPAC website, and if you go to Public Meetings and Past Meetings there will be a

place where you can enter your comments.

There is obviously a lot of material here. We've heard from some of you in the past. But we really do want to meet the spirit of public meetings and taking public comments. So please don't hesitate to reach out to us.

Okay. Going once. Going twice. Thank you all very much. We will be reconvening tomorrow morning at 10 a.m. Eastern, discussing APMs and MA and Part D tomorrow. So very much looking forward to those topics. Thanks to those who joined us, and we look forward to seeing you tomorrow. Stay safe.

[Whereupon, at 4:16 p.m., the meeting was recessed, to reconvene at 10:00 a.m. on Friday, January 14, 2022.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Via GoToWebinar

Friday, January 14, 2022
10:02 a.m.

COMMISSIONERS PRESENT:

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PAUL B. GINSBURG, PhD, Vice Chair
LYNN BARR, MPH
LAWRENCE P. CASALINO, MD, PhD
BRIAN DeBUSK, PhD
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AGENDA PAGE

P R O C E E D I N G S

[10:02 a.m.]

DR. CHERNEW: Hi, everybody, and welcome to the Friday session of our January meeting. We have three topics today: alternative payment models, Medicare Advantage, and Part D. We're going to start with alternative payment models.

For those joining us on the livestream, I want to emphasize this material is going to be integrated with a session in March on episodes into a single alternative payment model chapter that will appear in June.

So with that I think I'm turning it over -- Rachel, are you starting?

MS. BURTON: Yes, that's right.

DR. CHERNEW: Go ahead, Rachel.

MS. BURTON: All right. Good morning. In this session, my colleagues and I seek Commissioner input on a hypothetical, multi-track, population-based payment model, with administratively updated spending benchmarks. Two of us will present but all four of us will be on hand to answer questions.

The audience can download a PDF of these slides

from the webinar's control panel, under the Handouts section, which is likely on the right side of their screen.

Today's presentation is meant to capture Commissioner preferences, articulated at the October and November meetings. At the October meeting there was broad Commissioner interest in centering CMS's alternative payment model strategy around a single, multi-track, population-based payment model.

Different tracks of this model would be geared toward different types and sizes of provider organizations and would involve different amounts of financial risk.

At the November meeting, Commissioners expressed interest, in moving away from the current practice of periodically "rebasing" ACO benchmarks to an approach that only uses annual administrative updates.

Today, we present a hypothetical payment model that incorporates the features Commissioners favored at these meetings and seek your feedback and further input on this model.

A multi-track, population-based payment model could have three tracks. Participating providers could be given benchmarks, that reflect their attributed

beneficiaries' total expected spending under Parts A and B. The actual spending generated by these patients could then be compared to their benchmark, to determine if shared savings or losses were generated.

Track 1 of this model could be geared toward groups of small provider organizations, such as independent physician practices, safety net providers, and rural providers that meet certain volume thresholds, and it could involve no financial risk, with providers keeping up to 50 percent of the savings they generate relative to their benchmark, after a minimum savings rate is exceeded.

Track 2 could be geared toward mid-sized organizations, such as multi-specialty physician practices with multiple locations and small community hospitals, and could allow providers to keep up to 75 percent of the savings they generate and make them pay back up to 75 percent of the losses they generate.

Track 3 could be geared toward large provider organizations, such as health systems with multiple hospital campuses, and could use a 100 percent shared savings and loss rate, meaning they would essentially be paid capitation. Smaller or mid-sized providers could

participate in higher tracks if they wanted.

Beyond these broad strokes, some further details of this model will need to be fleshed out, which will be the focus of the rest of this presentation.

First we present some options for incentivizing providers to participate in this model. Next we ask Commissioners how quickly providers should take on financial risk in this model. We then explore how to address the risk that random variation in spending could lead to unwarranted shared savings payments. And then we describe an approach that could be used to administratively update benchmarks while minimizing the need for periodic rebasing.

Our first implementation issue is how to incentivize providers to enroll in this model. It is usually important to incentivize model participation, because if a model is left voluntary it can attract only those providers who expect to receive more Medicare revenue by participating. This selection bias is likely a reason why many Medicare APMs have resulted in net increases to Medicare spending so far.

We focus on how to incentivize participation in

Tracks 2 and 3 of the model, since these tracks will involve financial risk and therefore may not appeal to some providers. But we also invite Commissioner input on whether incentives are even needed for this model. It could be that the elimination of the "rebasing" of benchmarks is enough to make this model attractive to many providers.

We assume there would be no need for incentivizes to participate in Track 1, because it's an upside-only track and will therefore be attractive to many on its own, but Commissioners should let us know if they think otherwise.

Before we talk about options for incentivizing providers to participate in this model we should talk about some existing incentives written into current law.

Under MACRA, starting in 2026, clinicians in A-APMs like the one contemplated in this presentation will receive annual updates to their Medicare physician fee schedule payment rates of 0.75 percent per year, shown by the dotted green line. Clinicians not in A-APMs will receive 0.25 percent updates, shown by the lower red line.

These differential payment rates will create an

incentive to participate in A-APMs that is weak in the early years of this policy but then will grow to become strong. For example, by 2040, payment rates will be 8 percentage points higher for clinicians in A-APMs compared to clinicians not in A-APMs.

Not shown in this graph is the MIPS program, which will adjust the payment rates of clinicians who are not in A-APMs by up to plus or minus 9 percent, and add further complexity and mixed signals to the system.

Now that we have level-set, there are a number of options for incentivizing mid to large providers to participate in Tracks 2 and 3 of the model. One option is to simply require that provider organizations of certain types or sizes participate in the model, if they want to continue in the Medicare program, as has been done in a few models in the past.

Another option is to pay lower rates to clinicians who do not enroll in the model, either through differential payment updates like the ones I just showed you, or a flat 5 percent reduction to payment rates.

The model could also employ the type of soft incentives that are currently used in some of CMS's

alternative payment models, such as waivers of certain Medicare requirements and free technical assistance.

We seek input from Commissioners on other incentives that should be considered.

Our next implementation issue is how quickly to incentivize providers to enroll in model tracks with financial risk. For example, Track 1 providers could be allowed to participate in that upside-only track indefinitely or they could eventually be encouraged to move to a track with financial risk.

Pushing smaller providers to take on financial risk before they are ready could increase provider consolidation, since small organizations may look to join larger organizations that are better able to cover the cost of any financial losses that might be owed once they are in a higher track.

Another decision point is whether to incentivize mid-to-large providers to participate in the model right away or to give them some number of years of notice first. Pushing larger organizations to quickly enroll in one of these tracks may lead to provider pushback.

I will now pass things over to Geoff.

MR. GERHARDT: The idea behind population-based payment models is to reward organizations that reduce spending by improving efficiency, but changes in spending can also be the result of random variation. This issue is of particular concern among small ACOs in upside-only risk arrangements because their spending is more susceptible to random variation and one-sided models may reward spending reductions due to random variation but not penalize them for spending increases.

Medicare has tried to address the issue by requiring ACOs to have at least 5,000 beneficiaries, but there is evidence that this threshold may not be high enough to guard against the phenomenon. The threshold could be increased, but that would make it more difficult for smaller organizations to participate.

Another approach would be to require ACOs to exceed a specified savings threshold before being eligible for shared savings payments. This approach reduces the likelihood that shared savings payments will result from random variation, but could discourage participation if providers think it will be too difficult to meet the minimum savings rate in addition to the applicable discount

factors.

This slide briefly describes a hypothetical approach to setting and administratively updating benchmarks in the model. The process starts by determining total Part A and Part B fee-for-service spending for beneficiaries that would have been assigned to each ACO during a historical period of time. For each performance year, each ACO's benchmark would be updated using the following growth rates.

First benchmarks would be updated to reflect locally weighted changes in Medicare prices. Next, a risk-adjusted allowance for growth in the volume and intensity of Medicare-covered services would be applied to the benchmarks. Finally, the proposed benchmarks would include some discount factors. A consistent national discount rate would be applied to the volume and intensity allowance as a means of encouraging more efficient care and savings to the program.

Regional adjustments would also be applied to each ACO’s benchmark. For example, a "within-region" adjustment could vary according to the level of spending in that ACO relative to other organizations in their region.

This table shows how some parts of the update method discussed on the previous slide could work in practice. The numbers in this table are illustrative and are not based on actual growth rates or policy recommendations.

Each row represents ACOs in a given region, grouped by spending compared to other ACOs in that region. ACOs with the lowest spending are in the top row and those with the highest spending at the bottom.

The second column shows how updates for all benchmarks would reflect the weighted change in Medicare prices within a given region, in this example 2 percent.

The next column over shows an allowance for projected growth in the volume and intensity of Medicare services. Notably, the 2.5 percent rate shown in this column includes a uniform national discount rate of 0.5 percent.

The second column from the right shows the regional discount factor for each quintile of ACOs. The regional discount factor the lowest spending quintile is 0, while the discount factor for the highest spending organizations is 1 percent.

Finally, the column on the far right shows the net growth rate for ACOs in each spending quintile.

Administratively determined growth rates address important concerns that have been raised about how the current methodology "rebases" benchmarks to reflect changes in each ACO's actual spending. Rebasing benchmarks in this way may reduce incentives to participate in the model and improve efficiency because any spending reductions make it increasingly difficult to get future spending below the rebased benchmarks.

This so-called "ratchet" effect is not a concern with administratively determined benchmarks because updates are disconnected from actual changes in ACO spending.

Another feature of the proposed methodology is that over time the regional discount rate is likely to cause spending to converge around a regional average, thus reducing spending variation within regions. Despite these potential benefits, a number of important issues remain to be worked out. For example, how would the update method account for large changes in beneficiary risk scores after the initial benchmark is established? Also, how would the update approach account for large and unexpected changes in

volume and intensity once that part of the growth rate has been set? And how should policymakers address potentially large differences between benchmarks and actual spending that may develop over time?

That concludes our presentation on a hypothetical population-based payment model and framework for updating benchmarks using administratively determined growth rates. We are interested in getting your general feedback about the features of the hypothetical model, as well as the benchmark methodology.

Throughout the mailing materials and today's presentation we also raise a number of more specific issues about how the model and benchmarks would be implemented, some of which are included on this slide.

We look forward to your discussion and are happy to answer any questions you have. With that, I will hand things back to Mike.

DR. CHERNEW: Okay. We are about to jump into Round 1. I just want to give one sort of level-setting comment going into the session. There is obviously a lot of material here. I think the staff has done outstanding work. There are different levels with being discussed,

from the idea of a multi-track, population-based model, where we seem to have some consensus, the idea getting rid of the "ratchet," and then there are some tactical things about how we do that and some of the specific things that are set and discussed.

All of those are fair game, but I do want to make sure that we step away from this session with some understanding of where we are in the bigger picture of things, and we can continue to discuss some of the other details as we move forward.

So I may ask later, depending on where the consensus is going, where people are thinking about those bigger things, but for now let's move through the Round 1 questions.

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

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

DR. JAFFERY: Thanks, Dana, and thanks to everyone who worked on this, the staff. This is a fantastic chapter, obviously a topic that's very important to me, as you know. But this has been such great work.

I have two questions for Round 1. The first one

is pretty quick. There is text box on page 23 that talks about shared savings that are included in the benchmarks, even as they're excluded from the ACO benchmarks, which I guess was not something I was totally aware of. But the question is, is that in statute or how is that determined?

MR. SERNA: So CMS generally, or OACT generally determines that based on how it affects the trust fund. So if those funds come out of there they generally include them in the benchmark. That's the general rule that they apply. So not just shared savings but other kinds of incentive-based payments will also be in the benchmark.

DR. JAFFERY: Okay. And then on page 29 of the chapter you talk about the differences in plan bids and Medicare price growth as a potential empirical way to get at volume and intensity. Can you say a bit more about that? I'm just have a little hard time, a little difficulty, thinking about how these different things might line up and inform the ACO benchmarks.

DR. STENSLAND: Well, the general idea here is we were putting a lot of weight on this OACT estimate of how much value and intensity is going to grow over a certain period of time, if that's where we're getting the number,

or where else we're getting that fixed number.

So a way to try to get a better idea of empirically how much is the industry being forced to increase their payments due to volume and intensity would be to look at the MA bids, and MA bids are going to reflect changes in Medicare prices, in the prices they pay, and they're going to reflect changes in the volume and intensity of care.

So if prices are going up by 2 percent and MA plans are able to limit their volume and intensity growth to 1 percent, then we could say we would expect the ACOs to also limit their value and intensity growth to 1 percent. Both those are growth factors so we're not saying the volume has to be as low as MA volume is. It's just that the growth would be expected to be similar.

DR. JAFFERY: Okay. That's helpful. Thanks. And then just to flesh out the timing a little bit more, so as the MA plan bids come in, when -- in the fall?

MR. SERNA: So they come in in the summer, so they would be finalized by the fall. So it would be similar, if you want to think of it in terms of ACOs that have prospective assignment now, right. So they use those

claims-based experiences through the third quarter of the calendar year. So if you want to think of it in the same way, they would still have that prospective rate if this method was done.

DR. JAFFERY: So for a January performance period, start period, you would know it by the fall.

MR. SERNA: Correct.

DR. JAFFERY: Okay. All right. Thanks. That's all I have for Round 1. Thank you.

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

MR. PYENSON: Thank you, and I want to echo Jonathan's compliments to the staff.

I've got a couple questions that I think are big picture and some that are pretty granular. I'll start with the big picture question.

The multitier or multiclass approach is evident here with sharp distinctions between different classes of providers. I'm wondering if you had considered a continuum approach or a unified approach since that's what's widely adopted in the insurance industry; for example, risk-based capital when it comes to assessing risk. So the question is why the model of setting up, in effect, cliffs as

opposed to a continuum of risk assessment, which would be, from my standpoint, more consistent or more in harmony with the way the Medicare Advantage plans operate?

DR. CHERNEW: Do you want me to say something about that, or do you want to go, Luis, Jeff, Rachel, or Geoff?

DR. STENSLAND: Well, you can say something too, but just to clarify, these are the three categories that we were talking about of different ACOs, which supposedly would have three different sets of regulations to govern them. So I think it would be hard to do it on a continuous basis if you're having different sets of regulations, but maybe I missed something in the question.

MR. PYENSON: Well, the issue is how much risk does an organization take, which is connected to a number of things, not just shared savings. It's connected to the winsorization of costs or stop-loss issues and a number of other factors in the formula, and those are continuous variables.

So I'm puzzled at this, why you felt the need to set up separate tiers.

DR. CHERNEW: Can I try and jump in? First of

all, we should have a discussion of this point, Bruce, if you'd like, in Round 2 because this is a complicated point.

The answer to the clarifying question is because there's a number of program parameters, the minimum saving percentages, a range of other aspects of things, as Jeff was laying out, it's difficult to make all of those things continuous as a function of whatever variable you want, and the variable that you might want itself could fluctuate from year to year, meaning the parameters an organization is under would fluctuate form year to year.

So the Round 1 answer is the reason the decision was made is because it's difficult to see how to make all the different parameters continuous around the fluctuating variable. That's just a Round 1 answer.

There's a Round 2 point where you might respond, well, you could do that in the following ways. I'd encourage you, if you're okay with everything, that that's your view, that's sort of a Round 2 point, and I'm perfectly willing that you should say that.

The answer is basically in the spirit of exactly what Jeff said.

MR. PYENSON: That it's too hard.

DR. CHERNEW: Again, you can certainly explain how it could work, but I will say I -- and I won't blame the staff -- I didn't see how that could work, and it became much more transparent to have it discrete, and three tracks versus four tracks versus two tracks versus whatever, that's a slightly different issue and the continuous version of what you picked some variable that someone could manipulate with their TINs or some other way to game to change other types of program parameters.

But, again, that discussion is a Round 2 discussion.

MR. PYENSON: Okay. I'll have something in Round 2 to say on that.

The granulate question, there's a statement, I think, Jeff made that there's evidence that 5,000 is not a good number for taking risk. I didn't see what I consider evidence in the report. Maybe I missed it, but there were some simulations done on 15-year-old data.

Maybe this gets to my first question, but I think there's more sophisticated ways of picking thresholds than to say 5,000 isn't the right number.

Let me phrase that as a question: What was the

basis for that statement?

DR. STENSLAND: I think what we need to do is come up with a -- what we had talked about is doing some sort of simulation, creating some simulated ACOs and seeing how much their spending would vary, even though they weren't in an ACO, moving back and forth, using their three years of baseline spending and seeing how much, then, their fourth year changes versus their three years of baseline. I think you probably want to look at the simulated ones rather than the actual ones because the actual ones might actually be adjusted because of their actual incentives.

But we haven't done that, and we haven't had time to do all that. So we tried to come up with what is out there that has some sort of flavor for how variable these things are. So I don't think it's something that you want to actually base policy on, but we wanted to raise the question of is 5,000 enough, and we should be seriously thinking about how much random variation there is with 5,000 and more importantly how that affects your incentives. Is there an incentive to stay small so that you can get one-sided shared savings? Is that going to be a profit-maximizing strategy, or once you have a whole lot

of random variation, does actually doing things to try to improve the efficiency of care become less incented because there's so much potential and random variation?

Those are the kind of questions we need to get at, but it's clearly going to take more empirical work than we've done to date, but we need to, I think, raise those as serious questions.

MR. PYENSON: Did you consider the impact of risk adjustment and stop-loss-type programs in the variability?

DR. STENSLAND: We haven't done it. We could add those on there. We could do any sort of stop loss and trimming to see how much variability there is in there. That's a good point, but I think that's all for future work.

MR. PYENSON: Just a question, is it the intent that MedPAC would do that work as we did with the VIP SNF program, do some work and say here's the issues to be considered?

DR. CHERNEW: Let me address that, if I can, Jeff.

I think for a lot of those types of questions, particularly in this area where there's risk, we will try

and do some of the work. I'm not going to speak for Jim or Jeff or the rest of the team as to how far we'll go down, but I will emphasize we are not CMMI. So our highest value-add is to say you need to worry about the statistical issues associated with operating the model. Analysts at CMMI, as they move to the actual regs, will be the ones that will have to do that analysis. We are not going to pick a number with CMMI, what it is. If they were to pick five people, we would probably say that's too small. If they were to pick a million people, we'd probably say you probably don't need that.

But, as long as they're working within region or maybe pooling things in different ways, I think we shouldn't -- my personal view is we shouldn't spend our time now debating whether it should be 5,000 or 7,000 or 3,000 or whatever thousand you think it is. I think what we have to say is there's statistical problems of running a population-based payment model, and you need to think about them. And one of them is just a random variation, both in baseline and frankly also in performance, like the variation of performance year.

So, unlike MA plans, ACOs are smaller, and so the

statistical issues are bigger, and if we make a clear statement that that must be addressed, I think we've accomplished at least 80 percent of our goal. At least I'm speaking for me.

Staff? Every time I say something, I want to make sure that I'm not saying something that's violating where the staff is.

DR. STENSLAND: Sounds reasonable.

DR. CHERNEW: Okay.

MR. PYENSON: Thank you.

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

[No response.]

MS. KELLEY: Dana?

DR. SAFRAN: Sorry. I was having a hard time finding my unmute button.

So I did have something on this point. I just wanted to make the point that I do think that there is some statistical testing that we could do on the data that we have.

In my time at Blue Cross Mass, as we were playing around with whether we could relax the 10,000 number that

had been what we started with because of it being an actuarial standard, at least in that organization at that time, my actuarial colleagues kind of took a page from the book that we were using on the quality measurement side around testing for what sample size do you need to get to 0.7 reliability, which was something we talked about yesterday with the VIP program, and developed a methodology that's analogous to that to see how much reliability essentially in our actuarial estimates do we lose as we move from 10,000 down to 8, 7, 6, 5.

So I just wanted to offer that if that methodology is something that would be of interested, I'd be glad to connect the staff to the team at Blue Cross Mass that did that from the actuarial side. So I think it could be practiced here.

DR. CHERNEW: Bruce, I want to push past this. This is no longer clarifying anymore. We've had some discussion of where it came from. If this is where people want to go in Round 2 and discuss how to deal with it, I would put it in Round 2, but I want to have a lengthy discussion now about a number, which I view is not our primary responsibility. So let's move on.

MR. PYENSON: I would agree with that.

Just on the issue of variability, if I could just make a comment on that, that the variability in Medicare, variability of cost is actually a lot less than in the commercial world, and part of that is because of the Medicare fee schedule. And let's keep that in mind.

There's other factors in that, but let's -- I'll shut up.

DR. CHERNEW: Well, when we get to the summary, one of the key points will be there are statistical issues that need to be addressed in any of these types of models, and a clear statement of that, I think, is more important than the actual details of the statistics, although as far as we could push on that the better.

Dana, let's move along in Round 1.

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

MS. BARR: All right. Thank you so much and a great chapter. I really, really enjoyed it.

My Round 1 question goes to the proposals around estimating annual trends, and I'm curious as to why the recommendation is to get away from the national trend. So, initially, the program -- and for many of us, we live with

national trend in our benchmarks as our adjustment, and things were great. I mean, it seemed quite resilient, and it worked well. And then we added regional adjustments, and then the regional adjustments started creating TIN selection and all sorts of nasty things.

Now we're talking about creating a new national estimate, and I'm curious as to what is the thinking of the staff on why that estimate would be better than using the national trend and the data that we already have and we know, and what would be the benefit of using some estimates versus what we actually know is the trend, which has been working kind of brilliantly for eight years?

DR. MATHEWS: Mike, do you want to take this?

DR. CHERNEW: Sure.

So that is also -- I'm going to give you an answer, and then we can debate it to the extent we want to debate it in Round 2, but the problem is if the ACO program grew broadly and you used the national trend and the ACO program was very successful, you would find if it's working, the national trend is going to get slower and slower and slower. Eventually, you're going to have a situation where ACOs inherently must lose because it turns

out that people must have -- if the national trend averages 2 percent, that means some are going to be under 2 percent and some are going to be over 2 percent. There's wide geographic variation in that and a bunch of other factors.

So, by having what I would call an "endogenous trend factor," it works fine when the programs are small and not nearly as well when the programs are big, and this is what's been a problem in our MA work, for example. It worked fine when the program was small, but as it grows, it becomes more problematic to tie everything together.

So I would love to hear people's thinking on this point. Again, I don't want to debate it now. I want to debate it in Round 2, but the Round 1 answer is that an endogenous national trend number, if the ACO program is successful, will inevitably lead the losers -- and I'm worried those will be the losers serving the disadvantaged populations whose spending is hard to control, and that it is actually advantageous to have a program which lowers spending relative to where we think it would otherwise go. But, if everybody is successful, everybody can actually succeed, as opposed to a model with imposes by definition losers.

MS. BARR: Well, but just to be clear, we don't have any evidence of that happening today. We've been in the program for eight years, right? And I just want to make sure because there's lots of issues around other possibilities, and I'm wondering, are we fixing a problem? Is there any data that shows that we have a problem that we're trying to fix with other things that are going to have other problems, and that's what I'm asking in this Round 1 question. Is there any data to suggest we are at this tipping point or anywhere near it?

DR. CHERNEW: I'm not sure where the tipping point is, so I won't respond to that. But Amol, I think, wanted to get in on this point. So, before I say more, Amol, why don't you talk.

DR. NAVATHE: Yeah. So I think there's a couple points that are important here to make.

One thing is, Lynn, to some extent, what Mike is referencing is endogenous basically generated by impact of the ACO program itself, right? In the very long term, the OACT projections are going to be influenced by that, and so that's, in some sense, good for the program from a savings perspective. But, in the short run, as Mike said, if the

program grows relatively rapidly, which would be important -- and I think this is another really important piece is that for the benchmark model to work as well as we want it to, it has to be big enough for it to work.

So that's where you're getting to circularity, Lynn, that I think is creating potentially some challenges to think through.

MS. BARR: I'm concerned about adding new error to the program. It's not that having OACT estimate that estimate trend next year is perfect, right? So I'm looking for the data that says we're -- you know, there's other evidence in other parts of this presentation, that there's clear evidence that we have problems to fix. This is a theoretical problem that we're going to apply error to. So, I mean, I'm like why are we predicting trends when we have trends, you know, is my question. So I'm just looking for that clarification to clarify.

DR. CHERNEW: Yeah. I would say the answer now is that the program is sufficiently small that -- and there's so much going on, it's hard to attribute what is driving things, but we clearly see concerns now in participation. So we could debate what is happening, but

one of the reasons why I would argue participation is low now is because people understand that they're chasing a model in which ultimately the benchmark is going to grow slower and slower and slower. If other people get into it, that discourages participation.

Can you attribute that econometrically to what's going on? I'm not sure, but let's save that debate for the second round where we discuss the merits of it because that's not a clarifying point. That's a point of debate, which is a totally legit point of debate, but the answer to your question is it's too hard to disentangle why we see the many problems we see in the program now.

Some people would attribute it to things like this. I'm sure you will comment that you wouldn't, but it's going to very much depend on where you are by region.

DR. NAVATHE: I think to most directly answer Lynn's question, to some extent, Lynn, the idea of putting this in a prospective growth world. So, if we're relying on what's actually happening for national trend in short run when the program is small and maybe it's less problematic, then you're always trailing when you can actually grow that benchmark. So you end up in a --

MS. BARR: Amol, I totally get that, and I know we want to move on to other questions, but that ignores the fact that you're introducing all kinds of error in this other -- you know, you're going from a fact to an estimate, and it's sort of like, okay, I've got facts, and there's no problem with them, and now I'm going to start creating estimates to solve a problem we don't have. But that's, you know, again, for Round 2. I'm looking for evidence that says we should do something that's black box that turns this over to another agency.

DR. CHERNEW: Okay. We will have a very robust Round 2 discussion. Let's move on to the next Round 1 question.

MS. KELLEY: Larry is next.

[Pause.]

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

DR. CASALINO: Sorry about that. It's just as well. I'll start again. Yeah, I just had one question, which could be a Round 2 debate or not, but I mean it simply as a simple Round 1 question.

Has the staff given any idea to what type of organization could be an ACOs? Can a health insurer be an

ACO? Can an organization, a corporation that's not a provider organization be an ACO? Can a private equity firm be an ACO? Has there been any thought about that, and if not, what is your thinking about why it's not needed?

DR. STENSLAND: We haven't thought about that yet. All we've thought about at this point is you need some primary care clinicians. Who else you allow to be aligned with them; we haven't specified.

DR. CASALINO: Okay. Thanks.

MS. KELLEY: I think that is the end of Round 1, Mike. Did you want to say something before we move to Round 2?

DR. CHERNEW: No. I think we should just jump right in.

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

DR. JAFFERY: Great. Thanks. So again, I just want to reiterate, this is a great chapter, and I do think we are moving in a great direction around giving some direction to CMS and CMMI.

And so I'm going to focus on a couple of the bigger picture direction items, I think, maybe make a

couple of comments that are a little more granular, but mostly on a few of the bigger picture things. And like Mike alluded to before, I want to make sure that we don't get too hung up on this idea of three tracks. I know that was an illustrative model but, you know, I think we would agree it shouldn't be 35 tracks, but maybe it's 4 or 5 or 2 or something like that.

So first of all, in terms of the benchmarks, I really like this work. The notion of the constant rationing is clearly sort of a fatal flaw of the program, and it makes people very reluctant to jump in, and it makes people willing to jump out. And even places that have sort of been in the program, there's often a lot of people at the health systems who are eyeing it with a view of, well, this isn't going to really work. So I think that is a huge sticking point, and so moving away from that is just -- I can't emphasize how important I think that is.

And furthermore, I really like the idea about convergence over time at both regional and national levels. I think that is where we need to get to, and clearly the degree of regional variation across the country -- we've known this for decades, that it could be extreme, and, you

know, there's just a lot of saving opportunities over time that just make sense.

In terms of the tracks and how we think about where organizations might land, there's one really important point that I don't think has been addressed, and there's this sense, through a lot of our conversations and through the illustrative example that as organizations get bigger they should be ready for more risk. And I wonder if we know that that's actually accurate. To me size doesn't automatically equal readiness for risk. So it doesn't account for different challenges in achieving shared savings when the baseline total cost of care is low.

For example, it also doesn't really speak to the notion that smaller organizations, maybe even physician groups, they may be more nimble in some ways, and we've seen some of that maybe play out in that physician organizations have tended to do a little bit better in the ACO model. There are lots of reasons that we can think about for that.

So really, I think it comes down to how do we define ready to take more risk? Is it size? Is it resources? Is it the existing care coordination

capabilities? Is it baseline spending? And I think there's something in the chapter that references to how quickly systems adapted telehealth during the PHE as evidence that systems can change quickly if they need to. And I think it's an important concept but I don't think that's a great analogy, really.

Telehealth, to me, is really we took some tools that existed that at this point we're all very used to using in our work life and in our personal lives, like we are right now, and took work that we've been doing for decades and kind of are just doing it using this tool. What we're talking about, I'd just like to come back and make us all remember that we're talking about fundamentally redesigning the care model, the way we deliver care, to achieve the ACO goals, the accountable care goals. So anyway, that is an important point that I really want to emphasize for thinking about those tracks.

And then in terms of some of the incentives, other incentives to participate, just a couple of points. I agree with some of the comments that we've had over the last couple of cycles really, and yesterday, that this differential of 0.25 and 0.75 is maybe not the strongest

incentives and is problematic in other ways. Thinking about the 5 percent as a defined difference could get around some of the issues that we talked about yesterday, where there's zero updates and they don't account for things like inflation. And if you think that the 5 percent maybe isn't enough, maybe over time that becomes bigger. Maybe after three years it's 7 percent. I think the important thing, one important thing is to signal this for providers in advance.

And then my last comment is, you talked about some of the technical assistance that might be necessary to help providers participate in some of the more advanced models, and one of the things that gets talked about a lot is these learning collaborations. I think that it's important to think about things way beyond that. There are a lot of those out there. I think they're helpful. But in many ways the what that needs to be done is clear already. A lot of it is the how, and I'm not sure these learning collaborations quite get there.

And there are some other things that could be barriers. This sort of builds on Larry's question a little bit about thinking about who might participate in this.

But as we get into more advanced models and organizations are going to be responsible for things like maybe claims processing and payments and contracting and even aggregation, there may be some opportunities to provide some technical assistance around those things.

So anyway, thank you so much for this work, and I'm looking forward to continuing to see how it evolves.

MS. KELLEY: Brian?

DR. DeBUSK: First of all, I'd like to thank the staff for the chapter. There are some really great ideas here, and I want to dive into specifics in a moment.

I do want to say I'm a very strong supporter of ACOs and I want to see them be wildly successful. I am, however, concerned about the timeliness and track record of their implementation. We have MA gaining share on original Medicare 3 to 4 percent per year. We've got numerous counties now at 60 and 70 percent MA penetration levels.

And my concern here is that many of the delivery network features and competencies that make ACOs successful are also the same features and competencies of MA plans, and presumably these plans are enrolling the beneficiaries that are the most attractive to their topology, and it is

leaves ACOs with a shrinking pool of beneficiaries. And the whole point here is that time is not on our side. You know, we're used to looking at actuarial assessments and when does the Part A thing go insolvent. I don't think those are our limitations now. I think we're on a burning platform.

So my first comments are really going to be around simplification and how to achieve speed and timeliness for simplification, and the first being has the idea of separate tracks ran its course? I mean, could we -- - and I think Bruce mentioned this earlier -- could we look at the size and the capital and the characteristics of each ACO and just give them a continuous risk rating that would set their shared savings and their shared losses?

And I ask the question, are tracks something that we just simply rolled forward over the years? Have we just inherited those tracks from model to model? Because I would think that there are plenty of hybrid physician, hospital, maybe even plan examples that we could draw from.

The second aspect of simplification would be the use of a single administratively set regional benchmark. I know it's controversial, but we spend so much time and

treasure calculating and managing these ACO-specific benchmarks, and it triggers an entire set of side discussions around, well, what are the counterfactuals? What are the selection of things, wellness visits? And then we have to discuss trend factors and ratcheting and some of the things that Lynn and Mike alluded to earlier. That's a lot of complexity for a program that is on a pretty short fuse.

I think there are a lot of reasons to support a single administratively established benchmark per region, and if no other reason it is because they are inevitable. I mean, again, these high MA penetration rates are certainly going to buy us the average fee-for-service calculations that we're going to have to rely on. And I'm also concerned that not moving to an administrative benchmark may put rural and smaller providers at a disadvantage, because it introduces all this volatility into their specific benchmark targets.

So I do want to emphasize my very enthusiastic support for the materials distributed in this meeting. It's full of good ideas. But my concern is really around timeliness and simplicity. And again, I just don't foresee

time as something that's on our side.

And the final thing I want to touch on is mandatory versus voluntary, and my concern here is that mandatory ACOs send us down a path that we may not want to go. First of all, it could drive physician and provider consolidation, but second, it really challenges physicians and providers, because I have to assume that mandatory means they either join an ACO or somehow can't participate or are limited in their participation in Medicare. And with that said, I think the voluntary approach has a lot of merit, but I like the approach of breaking down our spending in terms of the price component and the volume intensity component. I think that's an excellent way of addressing it. And as Geoff mentioned earlier, I think there are a lot of novel approaches on how to estimate the volume intensity, particularly basing it on the MA bids.

So I do support the drive-a-wedge approach very much, but my approach would be to include the price component and a small portion of the volume intensity component, incorporate that into the fee schedules, but don't incorporate the full volume intensity component. And then as physicians and providers voluntary join these ACOs

and assume risk they earn, or have the opportunity to earn that additional volume component back.

And again, that's my rationale for moving toward a voluntary program, because you would have the savings already incorporated into the fee schedules, and then as providers participate and expose themselves to risk then they have this opportunity to do better or worse, based on their performance.

And those are my comments. Thank you.

MS. KELLEY: Bruce.

MR. PYENSON: Well, thank you, and again I want to compliment the staff on identifying a lot of information and a lot of key factors.

I am a big supporter of ACOs. I want them to be very successful. What I see us heading into with the interaction with non-ACO, non-attributed lives, attributed lives, and Medicare Advantage is a nightmare of adverse selection that's going to work against the Medicare system as a whole. And part of that is the nature of attribution and leaving some people out of the calculation, and that's one reason why I've advocated holding Medicare Advantage as well as ACOs accountable for regional outcomes. That's a

harmonization of MA and accountable care, and I think the benchmarks is a way to get that harmonization.

If you consider how the insurance industry is regulated, a lot of it has to do with risk-based capital and formulas that were developed starting in the 1980s, 1990s, and consider factors for health insurance such as what's the nature of the reimbursement of the organization. Is it fee-for-service? Is it capitation? There is less risk for an insurance entity if they're paying by capitation.

That's a formulaic model that I think would work for ACOs broadly and would enable the recognition of things like episode-based payments as a risk reduction feature or sometimes for providers perhaps a risk-enhancing procedure.

So the issue I think has to be put in a uniform way to avoid introducing a whole series of cliffs and classes of business that are really unnecessary. The issue of shared savings has to be seen, in my view, in the context of things like the limits on losses and gains or the exclusion, stop loss features, risk adjustments, whether the organization is focused on duals or not. All of that needs to be considered in how an ACO, what sort of

risks it should be taking, what sort of populations should be taking. And if we do that we don't need the different tiers.

So I think that would be the conceptual framework to move ahead, and it brings ACOs in line with Medicare Advantage in a lot of different ways, so we can address that harmonization as well.

So I'll stop my comments there.

DR. CHERNEW: Bruce, I just wanted to, because you said a lot of things, I want to just make sure I've got them a distilled version of your comments. Because if this is what you said I agree, and if it's not I want make sure I didn't misunderstand.

If you had a version of an admin benchmark you could use that going forward to get around this circularity between MA being based on fee-for-service and fee-for-service being based on MA. You could just get to where Brian was saying, sort of a regional benchmark, and you wouldn't have to worry about some regions winning or losing, because if you set it at a reasonable rate and all the regions were successful they could all be okay.

That's my summary of what you said, and if I'm

wrong now is the time to say it, for everyone to hear.

MR. PYENSON: I said something else in addition to that. You captured it right. What I said in addition to that is if you get that, then you can use it instead of setting up tiers. You could use that as the tool to smooth out the jumps.

DR. CHERNEW: Sure, over a long run. I think Jon Perlin wants to say something on this point.

DR. PERLIN: Just a question for you, Mike. Would that imply that you'd use that same figure then across both MA as well as these APM models?

DR. CHERNEW: So no. One of the great challenges that I face, and I think MedPAC faces, is this is a big, systemic kind of question that we have to bite off in pieces. My hope was to figure out how to think about MA in this context in perhaps a future cycle. So I don't want to commit one way or another. So now I am speaking as me and something that I think is going to be well beyond what would be in this chapter.

But I will just way, while people are listening, the Michael view, which is not necessarily the MedPAC view, but the Michael view is -- and I think it's very consistent

with what Bruce said -- you could get a point where that was the case. It is easier to solve another problem that MedPAC will address when we talk about MA, what to do when MA shares grow and you're basing off fee-for-service is not typical, you could harmonize it a lot better and have the same type of benchmark between MA and ACOs. I'm not saying that we've done any analysis or any evidence or are supporting that as a policy option or goal. That is not my intent. But I do, just in interpreting Bruce's comment, believe that if you go down this path -- and I don't know what the right word is, I'll take a soccer analogy -- you're setting yourself up for a good shot later, although I'm not sure what it's really going to look like.

I will hate reading that in the transcript. But maybe that's the answer to your question, Jon.

I do think -- the last point before we go to the next person -- I do think it's really, really important we try and build this model to be successful in the long run and not build the model to be successful in a year or two, because we've had the tendency to do that, and when we do that we then get to a conundrum and then have to change it. I think some foreshadowing of where we're going, in the

long run, itself will be of huge value.

Anyway, Dana, who's next?

MS. KELLEY: Lynn.

MS. BARR: All right. Thank you so much for this chapter and for the thoughts of how to work through these difficult issues.

One guiding principle, I think, we need to think about as we think about it, we want people in the program. I think we're all in agreement on that, and so things that destabilize the program or drive people out of the program are things that we should be concerned about.

The problem is back in 2013 or 2012, when this all started, it was all upside only. People could screw around with the benchmarks all they wanted, and people could make lots of choices.

But now we have lots of providers that are way out on a limb on risk, and we must be very careful on any changes we make to that program because, as participants in the program, if we can't predict what's going to happen -- and we'll all spend lots of money on Milliman trying to predict what's going to happen -- we're going to have to back out because we can't take the risk of writing that

check.

So whatever we decide to do, we need to be able to provide our providers with a couple years of data looking back saying this is what would happen, and we should have as much certainly as possible, which is why I'm very much supportive of most of these recommendations. But having some sort of black-box trend thing is really concerning to me and I think will destabilize the system. I think it will make the reinsurance market go away again and make what's left very, very expensive. So that's just my overarching principles of my concerns about the trend, specifically about the trend.

Does the three-track model make sense? Absolutely. And also going into, you know, should ACOs and the upside-only track be required to move into risk? I think if you have a 25 percent no-risk model and then risk is at 75 or 100, people will move into risk as soon as they're comfortable with the program. You will not need to make it mandatory because they will be in that 25 percent track until they realize, okay, I've got this, I understand it, now I'm ready to take downside risk.

Remember we're not insurance companies as

providers. We can't take this, you know, "Oh, I won," "I lost," "I won," "I lost." And one of the things that we could do to really help providers is when we give them data, we should give them confidence intervals on the data, because how many times have I had this 5,000 life ACO tell me how great they are and not understanding that they're actually in the noise? They might have savings; they might have losses. They have no idea. But we don't communicate those confidence intervals to them, and I think that's going to be a very important principle going forward.

So I do think that we should allow any provider to stay in a 25 percent risk track because, frankly, they'll lose money at that, just at the cost of participating in the program, but they could stay in there as long as they want to. But then the difference between 25 and 75 will be enough to move everyone into risk without having to force them into risk. So that would be my opinion on that.

In terms of the framework for updating benchmarks, I think that I agree with everything, except for the update of trend, and I think that we should approach that with extreme caution and look to find

alternatives.

Again, you could parallel play that for a few years until we get to the point where we have some sort of tipping point, but you enter black-box projections like this, and they will not be able to predict a flu season. They will not be able to predict a pandemic, and then providers are going to be writing checks.

MA plans, if they have a bad flu season, they write a check. Next year, they'll have a good flu season. They're fine. That does not work in a provider world.

Thank you.

DR. CHERNEW: Okay. We're going to go on in a minute. There's just a few things I want to say that I want to react to.

The first one is I think there's reasonable evidence that the way the program is currently structured is really problematic related to selection. So I do think that some change is going to be absolutely needed.

Second of all, I agree 100 percent that no one is doing anything without the right set of simulations so people understand what's happening. Just so people understand, this session is not going to go into a -- we

are not CMMI. We're not about to promulgate a model. CMMI does not do anything with a lot of thinking about what will happen and what will be simulated out or we will simulate as much as we could.

Third, the issues of how much risk different organizations bear is really, really, really important. My personal belief is the current system, by making everybody chase other successes, makes that risk much, much, much worse than we would and much, much, much less predictable than we would if we had an exogenously set regional or national benchmark for that matter. But, again, we will continue to discuss.

What it sounds like you're saying, Lynn, again, if I can repeat, is you're supportive of the multitrack ACO model. You're really worried that something will be put in place that will cause organizations to have to lose and write checks, and they really need to know what that is up front and make sure that we understand how it would play out which, by the way, I agree.

I personally think that, in the long run, that will be much more successful if we can just tell somebody you get a 2.5 percent, 3 percent, whatever it is, volume

and intensity growth number and meet that over time and manage the risk with a bunch of other risk protection mechanisms, but again, that's me.

I'm going to turn --

MS. BARR: I think I disagree.

DR. CHERNEW: So we'll --

MS. BARR: You're not able to capture what's really happening in the country, right? It's all based on projections as opposed to truth, and I don't know why we would go away from truth and go to projections when we --

DR. CASALINO: Mike, may I raise a process point?

DR. CHERNEW: Yeah.

DR. CASALINO: We have 23 minutes left and probably about 10 people who want to speak. This is a very important area to all of us. Clearly, we're not going to have nearly enough time for very many people to say even a fraction of what they want to say. How are we going to deal with that both today and going forward?

DR. CHERNEW: Yeah. So right now we might end up having to go a little long, but it is important that we get through some of these particular types of things. So I'm just going to say one thing, and then we're going to move

on to Amol.

I guess I will say to everybody -- we actually don't have that many more people, I think, that need to speak. I've been keeping track, but nevertheless, I actually think, Lynn, if you're all successful that the other approach would actually be better for you, but, Amol, why don't you go ahead and talk? And I will check again where we are in the queue, Larry. I think there's five more people left or maybe six.

Amol.

DR. NAVATHE: Great. Thank you.

So, first, I'm very thankful to the staff. I know this is a big effort, and I appreciate everything that we've done, and I am supportive of this direction of work as well.

First, I'm very supportive of the multitrack population-based payment model. I'm supportive of the administrative benchmarks.

I have a couple, three big points and a couple minor points, which I'll try to step through efficiently.

Number one, I think it's very important conceptually that we keep in mind the benchmark or the

baseline that we're talking about and then the trend factor. So as I understand from what we is proposed in the paper here is that the benchmark itself where we start from is something that is beneficiary population-specific and, therefore, ACO-specific. That is not regionalized or market-based. That's very important from a selection perspective, and I think that's very important to understand and to differentiate from the trend factor, which is how that ACO-specific or bene-specific benchmark is then growing over time. They're two very different things. I think we should just be very careful to understand that they're very different because they have very different implications for selection as well, meaning by not having a market or regional component to the benchmark itself, we're making some of the selection affect concerns that we might have.

Number two, I agree very strongly that it's very fundamentally important for the long-term success of the program to have an exogenous benchmark. If it is, indeed, meaning it's pulled from GDP, it's pulled from OACT, pulled from some external construct not from within national spending or the ACO programs itself, because of this issue

that we then, as the program scales, get into a problem that is probably, in fact, very hard to separate out and pull back from that structure. So I think that that is incredibly important to get right up front.

My personal sense is there is a whole science and long history to OACT projections, in fact. So I don't think we're starting this for the first time. In fact, I've written a piece about how APM evaluations look relative to OACT projections. OACT actually surprisingly is very good at this, and so is the CBO. So I think there's a track record to look back on and to understand what those perturbations would look like, which I think will mitigate some of the concerns paired with the idea that you're actually creating certainty in the future in how that is developing which, in my view, should mitigate some of the issues.

Third, a big point, and I want to really emphasize this. While the exogenous trend factor does help with selection, to some extent, certainly relative to market-based benchmarks or something like that, our participation incentives and selection are fundamentally important to the success of the program structured in this

way. We need enough participation.

My personal view is right now in the paper where we are, we have not dedicated enough importance, enough specification, enough options around the participation incentives piece, because unless we get those pieces right along with some design dimensions around longer-term commitments and ability to opt in and opt out rapid, in rapid-cycle form, as well as, I think, to Lynn's and some other folks' points around protections for ACOs that they're not going to go bankrupt, those pieces are really important so that the administrative benchmark in the system works in a way that, in fact, will eventually generated savings for the Medicare program and not lead us in a way that would actually stop momentum from the APM movement and from what we're trying to accomplish here. I think, in that sense, the stakes are high around participation incentives and selection. So I wanted to highlight that.

Those are my three big points. I have smaller points that I'll quickly run through.

I think, personally, my view is that the notion of paying the earlier track or even small practices in a

capitated form for primary care for some other portion is a very positive thing. I would say, in fact, if we could include that in the governing population model, I think that would be a win. So that is something that truly becomes scalable to the country, and again, it's not some people are in, some people are out and what have you here.

I think there should, in fact, be some sort of reward or incentive or bonus associated with taking prospective dollars, and then there's administrative reasons for that. There's psychological reasons for that for why the program could actually work better if we structure the program in that way.

That being said, side by side, minimum savings rate, critically important to have and get right because we do want to ensure upside-only models for small practices, et cetera, so the Medicare program is not hemorrhaging money from random variation.

Last two points. One is -- actually last point, I think that the way we're structuring this does eventually lead to a way that we could see harmonization with the MA program. For example, on one of the slides that we talked about regional discount factors as a trend, I think that

concept could actually over very nicely with the way the whole health benchmark process, although it needs to be formed for MA. You can see how this could converge in a harmonized way, although I think that's not a huge problem to be thinking about or solving at this time.

Thank you. I'll stop here.

MS. KELLEY: Betty.

DR. RAMBUR: Thank you very much. Thank you for a great chapter and a very interesting conversation.

I'm just going to briefly go through areas that I'm very enthusiastic about and more tepid about so the Commissioners and staff can know at least where this Commissioner stands.

I strongly support population-based payment model as a condition for participation in Medicare, so maybe stronger than some of you. It seems some of the challenges we have as mandatory fee-for-service, which is, of course, what makes this alternative.

On the small upside-only, that's actually, of course, bonus-only, and having worked in a very small practice as a nurse practitioner with two physicians and two registered nurses, I know well that one financial

outlier can be disastrous.

At the same time, echoing Jonathan, the opportunity for being nimble is really, really valuable and also to know your patients in a way that could be much more difficult in a larger organization.

I also just want to comment on the importance, in my view, of thinking about these groups that are wanting to address really challenging populations. For example, I know nurse practitioners who have very, very small numbers of patients, certainly well below the 5,000, but they're trying to figure out ways to work together to address a very challenging population conditions and things that you can't do well in fee-for-service because it's not the kind of care these individuals need, more care than cure-based.

I did think as a clinician that the three tracks, whether it's two or three or five, whatever, seem logical because I can sort of sense where I would be or others would be in this small, medium, large sort of trajectory.

I know we're going to talk about episodes next time, and just briefly to comment, I absolutely think episodes could be nascent with in this model, and I doubt there's more sophistication in this area than I have,

certainly while in others, but it seems like that could be within the ACOs' choice of areas they need to work on to reach their overall goals. But there also might be areas of such national importance that they're ones that stand alone or that are required to avoid the use of the word "mandatory." So I look forward to that conversation in April, I guess.

The issue of selection bias is huge. I don't have the chops to know if the TIN NPI is enough, but I think that that's a very important area.

The minimum shared savings, I'm assuming that means in a small organization, minimum shared saving and quality benchmarks before payment. I would strongly support that sort of a gate-and-ladder model.

Benchmarks, I'm really taking all of this in. This has been very edifying. When I was in Vermont and we worked on the all-payer model there, I was a big supporter of rebasing because of the magnitude of the inefficiencies that are built not particularly in their case, but in all cases. We would know that certainly before COVID. That was an issue. So I was very concerned about starting the base from a relatively inflated place as an issue of

policy.

I will look forward to hearing more from all of you about all of this. So I'm really in the mode of being a listener.

On page 20, you start -- you describe a bit more, a tepid approach with differential payments. I'm less enthusiastic about that.

Capping on the coding and use risk scores, this is actually really important to me because we know that revenue capture is a huge portion of what goes on in organizations, and as it's a razor's edge to really get risk without having sort of coding-induced inflation.

The new tech adjustment that was mentioned, my initial instinct was, of course, and then as I pondered it more, I didn't know if there's a lot of gaming that can happen with that.

Then, finally, the converges over time nationwide, Jonathan mentioned, and I also strongly support.

So thank you for the excellent work.

MS. KELLEY: Larry.

DR. CASALINO: Thanks, Dana.

So, first of all, we started on this work over this past year. It's an incredibly complicated, diffused area, and I really wondered how we would focus. And I just think you can't say enough for the staff and for Mike to have to come up with a relatively simple, straightforward proposal that makes clear the key issues that have to be addressed and I think present some useful ideas for addressing them along with a lot of pros and cons of the ideas. So I really can't praise you guys highly enough.

Just very briefly, I strongly support administrative/exogenously determined benchmarks. Eliminate the "ratchet" effect is absolutely critical. The ACO program can't work as long as the ratchet is a problem.

I like the three categories of population-based models. They're simple to understand. They make sense. I'm certainly open to hearing more along the lines that Bruce as advocating, but for now at least I'm very supportive of these.

I've changed my mind since the last meeting. I would be okay with upside-only track permanently for small organizations.

What Jonathan said about relationship between

size and the ability to take risk, I just want to say if we're talking about actuarial ability to take risk, then obviously bigger is better, but I think if they find their way to leave it open for small organizations to take more risk if they wanted to is probably not a bad idea. They are more nimble. If they're physician-based, they can deal with hospitals and specialists as cross-centers, if necessary, and can generate real savings that way.

I just want to bring up the example of the California medical groups in the '80s and '90s, which has largely been forgotten. These groups when they were only about 50 physicians in a group, 50 primary care physicians, were able to generate huge savings in what we now call Medicare Advantage, and grew into things like HealthCare Partners, you know, the $4 billion medical group. That's how it made its money as a small independent medical group taking a lot of risk. So to try to find a way for small groups to take risk if they want to is probably not a bad idea. I think more attention should be given to who can be an ACO.

I want to talk a little bit about incentivizing provider participation, which I think is key, and as I

think Jonathan mentioned, we haven't given much attention to. Basically, we can do it with a mandate. We can do it with making a potential savings/bonus more attractive. One could have a very slow and possibly differential APM versus non-APM increase in fee-for-service payment rates. Those are the possibilities. I want to say a little bit more about them.

I think ACOs should be viewed as tools that over time can do better and better things. So supporting the creation of high-functioning ACOs is the goal, and I think it's a more important goal than generating short-term savings for Medicare. So I would make the rewards to successful ACOs as large as possible, and then over time, they'll generate larger and larger savings and higher quality, I think.

I think one thing that hasn't been mention is the reward for improving quality should play a bigger role as opposed to just generating savings. Improving quality is much more attractive to providers, and it's kind of important to patients as well. So I'd like a little bit more thought to that.

I think a key thing is how to deal with the

problem that hospitals and specialists make more from another admission or another procedure than they can make from savings from avoiding an admission or doing a procedure, and I think that's a critical problem for every ACO, so how to deal with that. One way would be to raise fee-for-service payments very slowly, but I would say not just for physicians but for hospitals. As long as hospitals have strong incentives to have more admissions, it's going to be very difficult for ACOs.

I think that -- well, let me not go down that rabbit hole.

In terms of mandatory participation, I think that for at least for type two and three and the three categories we have, setting the date in the future for mandatory participation might help a lot and might generate participation in the short run. So one could say mandate participation beginning five years from now for type two and three organizations or maybe in certain geographic areas in, say, three years, participation could become mandatory, and then if it works, be mandatory for everybody in six years.

I will leave it at that, given the time conflict.

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

DR. GRABOWSKI: Great. Thanks, Dana, and I just wanted to say to the staff great work to all involved. I'm super pleased we're pursuing this agenda. I'm quite supportive of the direction this is taking.

I was just going to go through the five questions that are laid out here on the slide in order, starting with the first one. I really like this three-track framework. There's no reason that one size needs to fit all. In particular, I'm very supportive of the upside-only for smaller organizations. I don't believe this has to be time limited.

I've always wanted to write a piece -- Mike and colleagues have probably already written this -- but Much Ado About Two-Sided Risk. I don't think we always have to have downside risk. We have a lot of tools and incentives available to build these models, and I think we've been overly obsessed with downside risk as one of those tools. I think the real key is encouraging broad participation.

Shifting then to the second issue, what are ways to encourage participation, here I very much think we should be old. One idea is to allow ACOs to keep a

substantial share of the savings. This may mean less short-term savings for Medicare, but I believe it will benefit the program through both spillovers to Medicare Advantage and also helping to slow the national fee-for-service spending growth rate.

And in terms of question 3 I already answered this, but let me be clear. The answer is no there. I don't think we need two-sided risk.

On question 4 and ways of kind of minimizing shared savings payments arising from random variation, here I think it's really essential we invest in risk adjustment. As benchmarks converge to a common basis the program is going to need to rely more heavily on risk adjustment to ensure a fair allocation of resources to providers serving relatively high- or low-risk patients. And, Mike, I know I don't set the agenda but I believe this might be an area we want to focus on in a future session, to think about risk adjustment, across the spectrum but especially in the ACO context.

The final issue around how to think about updating benchmarks, I absolutely agree with what was laid out in the chapter. The administrative benchmarks should

most definitely be exogenous. For the non-economists in the group, and I know others have defined it, exogenous just means preset or predetermined by policy here. There are different ways to do this, but I like having OACT set the rates.

Most importantly, the benchmarks should not be based on realized spending experience of the participating ACOs, on recent trends based on realized spending of the different participating groups.

Lynn, you asked about selection in Round 1. Mike and colleagues have written on this, but there's definitely selection. And the simplest way to frame this problem of an empirical benchmark based on average spending is that that means, by definition, about half the population will always have spending above the benchmarks. That's basically what an average means. So benchmarks have to be grown, such that they do not fall as ACOs lower spending.

So I'm going to stop there and thank the staff once again for this great work.

MS. KELLEY: Jaewon.

DR. RYU: Yeah. I'd also like to thank the staff. A lot of complexity, like many of the topics that

we tackle. But going through some of the questions and a couple of other thoughts, I too am a big fan of what's laid out here, both in terms of the tracks -- and I think it does a pretty good balancing of taking what used to be many, many tracks and proposing something that feels like we're closer to the right number, if not already there. I don't know if that's two, three, or four, kind of to Jonathan's point earlier, but I think the categories as they are laid out here make sense to me.

I'm also in favor of the administratively set benchmarks, for all the reasons that have been discussed. I think the current state with the ratcheting is a problem that needs solving if we are to try to encourage others to want to participate in this model.

I also think that upside-only seems reasonable, especially given that there's optionality within several different tracks. And if one of them tries to meet providers where they are and has an upside-only component for longer than just a short-term duration I do think that's reasonable.

I want to talk a little bit about some of the adjustments that were proposed, the discounts. I think, by

and large, they make sense, sort of the convergence concept that was discussed in the materials. I think the national discount makes sense, the within-the-region convergence makes.

The one that gives me a little bit of pause is the between-the-regions convergence. I think that one I just have a tougher time wrapping my mind around, because I think when we get between regions there's just an awful lot of heterogeneity across the country, some of which may be very justified in terms of how something like that could be set up to really drive longer-term convergence. Maybe it's just a longer road to get there with that particular aspect, but that was one that just made me pause a little bit.

As far as the random variation and how to mitigate that, I think I gravitate towards trying to have a higher life threshold versus having a cliff of needing to hit a minimum level of savings. I get the need to distinguish between, you know, are you lucky or are you good, or are you unlucky or are you bad, but I think the better way to do it is to encourage larger thresholds of lives rather than to say, you know, you've got to hit a

minimum level of performance to trigger any shared savings. That seems like a cliff effect that we'd be introducing there. And maybe there's a way to smooth it. I don't know, but those are some of my thoughts.

And then lastly, and this gets to the point Jonathan made earlier, the relationship between size and the ability to perform, I agree. I don't think it's necessarily purely size, but there do need to be investments for organizations to be successful in this model. And the investments might be things like data or analytics or investments in care management programs, care coordination staff. There are investments.

And I think there a little bit of tension here, and I'm not sure we could have it both ways, where we want people to make these kinds of investments in the delivery system, but at the same time consolidation is something we don't want to encourage. But I think there's a balance there to strike. I'm not sure we're going to be able to get these kinds of investments while completely having a system that avoids consolidation.

And so I don't know exactly where the tradeoffs are, but that seems like a tradeoff we might want to spend

some more time thinking about. Thank you.

MS. KELLEY: Dana.

DR. SAFRAN: Thank you. So just continue piling on the compliments to the staff for this work and to the Commissioners for really robust and excellent conversation. You know, I think this is far and away one of the most important pieces of work that we're doing, and a really valuable add-on to our recommendation last year around simplifying. Really pointing some specific ways that that can be accomplished I think is very valuable.

So a lot of the ideas that I had and observations I had have been said in various ways and so I'll be brief but just punctuate them.

I too like the idea of the tracks, though I would offer that I think we should consider the possibility that we make them an interim solution and that ultimately maybe this does converge to one track. In order to do that I know we do have to deal with the smaller organizations. I like an idea that would have CMS kind of accrediting certain aggregator organizations, and you named some of them in the chapter, companies like Aledade, that really have built a business model to support smaller

organizations' ability to participate in risk.

So I like the idea of formalizing that and enabling smaller practices to participate and to do so in a robust way, which relates to a point of view I have, I know somewhat different from what I hear being expressed, that two-sided risk actually really does matter. I'll share one thing, just from a conversation this week with a colleague who works in an organization that supports systems that participate in Medicare risk programs. And what he said to me was, it is a whole different world all of a sudden because of direct contacting. Really with two-sided and significant risk, providers have better their customers anyway, are no longer wanting to just tinker at the margins. They really are looking, in a very serious and robust way, at how to find where there is opportunity for savings and be serious about generating those.

That really resonated with me from my experience at Blue Cross Mass, which, you know, folks know the alternative quality of contact was from the beginning and remains two-sided risk only, symmetrical, and was highly successful and continues to be in that space.

One other thing, and then I'll comment on the

administrative benchmarks, I really liked Larry's idea about possibly setting a future date for the program becoming mandatory. One of the things that I heard a lot when payment reform was my job was how important it was for there to be a clear signal about where things are going. And, you know, that would certainly be a veery clear signal.

So that idea that came up this morning is one that I think we should look at as a possibility, while not moving away from voluntary at this point in time.

So let me just finally talk briefly about administrative benchmarks. I fully, fully, enthusiastically support a move to administrative benchmarks, and that too is based on the experiences I had when I was leading work around payment reform. Some of you know, but for those who don't, the AQC did start as a model where we used administrative benchmarks, and we did that for a number of reasons. One, you know, folks have made the point about not wanting to perpetuate a model with ratcheting, and administrative benchmarks do allow us to get out of that very problematic feature that I think we've seen play out in the existing ACO programs.

But maybe as importantly as that it was intended to be, and I think was, a very transparent way to set expectations around growth. So not at all a black box. It sets out a number that then those who are participating can plan around and really know what they have to do to succeed.

I also has the additional benefit, and somebody, I think, pointed to this, of because it's an absolute performance target it actually doesn't inhibit collaboration, because, you know, we're not being graded on a curve where your success impinges upon mine. And very much what we've done on the quality side in our recommendations for having absolute benchmarks, my experience with that in my time at Blue Cross Mass was on the quality side with absolute benchmarks it did promote collaboration around best practices because your success did not impinge on my ability to succeed as well. So I think that's an additional benefit I'd highlight.

And the final benefit I'd highlight is that the opportunity for an absolutely benchmark to begin to have provider systems, thinking really judiciously about how new technologies and therapies get in, and at what costs I

think is tremendously, tremendously valuable and something we should probably add to this chapter as one of the points of value.

That said, the reason that Blue Cross Mass ultimately moved away from absolutely performance targets, or one of those reasons, was we felt that to be fair we had to hold providers harmless for things in the environment that would happen that could impinge on their ability to meet the benchmark. For us that included, you know, if we negotiated some absurd rate increase for somebody else in the network their patients still get to use that part of the network. We had to hold them harmless. But it also included, you know, things like Aduhelm coming along, and pandemics.

And so Medicare can have other ways to adjust its benchmarks if we have an absolute benchmark and then things happen in the environment that impinge on the ability to succeed, so I don't think that should be an inhibitor, and I do think that the absolute benchmark can really enable us to have the providers who are participating rowing in the same direction that the Medicare program is trying to row, to really be judicious about what new treatments and

1 therapies get in and at what costs.
2 So the final thing I'll say just has to do with
3 the endogeneity and exogeneity. That was one of my biggest
4 concerns, honestly, in reading the chapter, and I may be
5 misunderstanding. But I really was concerned that the
6 proposed way of dealing with volume and intensity could
7 actually have an endogeneity problem in that some systems,
8 by making choices about how to spin off some providers from
9 their system to go participate and then gaining by, you
10 know, driving up fee-for-service utilization could really
11 undercut our desire for that exogenous benchmark to truly
12 be exogenous.
13 So I may misunderstand that and I'm open to being
14 told that I do, but I was really favoring something like
15 GDP+1 or, in Massachusetts, by policy, the state actually
16 used state GDP as a benchmark for both providers and
17 payers, with penalties if the provider or payer exceeded
18 that growth rate in a given year. So I just wanted to
19 underscore a point that at this point has been made but
20 also raise the point that I wasn't clear that provider
21 behaviors and decisions to participate are not so long as
22 this is voluntary, might actually take what we're saying as

exogenous and turn it into something that is not, because it might be gameable. So if that's the case I would argue for using something like GDP.

Oh, one final comment, and that's this, a very small point but it's, I think, a useful one. The way that chapter opens, not the executive summary but the background, there's a comment that I think -- take a look at the tone, but it kind of makes it sound like the Commission asserts -- that's the language used, basically, that payment reform works but the evidence suggests otherwise. So it was a little bit of a strange start to a chapter that is enthusiastic about at least one category of payment models, the global category. So I would just take another look at that opener.

Thanks very much.

MS. KELLEY: Paul.

DR. PAUL GINSBURG: Right. Thanks. Even though others have said it, I need to say that the staff has done marvelous work, and Mike has done a great job in leading us in this topic.

I think our goal, certainly my goal, is that a large part of fee-for-service Medicare, you know, that

alternative payment, it becomes the way that they are paid. I want to mention that we should assume that legislation will be needed, because this is so important, we don't want to lock ourselves into the 2010 statutes, where there was much less experience with these approaches to payments, and we've learned a lot. So we ought to be focusing on speaking to Congress, advising them on legislation, as well as providing a lot to CMS, the detailed limitation decisions.

I agree with pretty much everyone that said the exogeneity in benchmarks is really important, and again, there are two aspects to it. We don't want the individual ACO to have their benchmark ratcheted based on their performance, but as many have said we also want to have a whole group of ACOs, or the whole system, not be a zero-sum game where half of them are losers. We want to have the conditions where if all improve their care and reduce their costs they all win and the program wins as well.

I think participation incentives are really key. I don't think we could ever -- well, not ever, but I don't think in the near term or the medium term we could really contemplate as politically realistic a mandatory program.

But I think we can get almost there by having strong consensus for participation, which means, you know, having the benchmarks for ACOs reflect higher fees than the payment rates for those who stay out. And by having strong incentives for participation you avoid a lot of selection, and I think it's critical to getting the systems to move off the posits in that as far as relatively low participation.

One thing we haven't talked about, which I wanted to bring up for us to think about in the future, is that primary care physicians have always been a core of ACOs, and that makes sense. But we need to think about the relationship between specialists and the ACOs, particularly because they are the ones that spend most of the money. So these issues of attribution of patients to ACOs, based on their contact with specialists, maybe we ought to write something about what the program would perceive as a specialist being part of an ACO. I think that would clarify a lot of things.

Integration of benchmarks with MA, to me this is a very long-term goal but definitely worth thinking about, and anything that we can do to push us closer to that would

be great.

In a sense, in coming up with a longer-term, better approach to population-based health, it may actually be a blessing that population health hasn't progressed as much so far, as people had hoped 10-plus years ago, because, you know, it's always so many organizations who are comfortable with something are going to fight change. And I think this is why it's important to come up with a much better model now, before a lot of people get comfortable with what we have.

Thanks.

DR. CHERNEW: Okay. I think that was the last person. Is that right, Dana?

MS. KELLEY: Yes, that's right.

DR. CHERNEW: So I'm going to very, very quickly summarize. I know we're behind. We're going to jump quickly to Medicare Advantage, which has some conceptual similarities, although this is really for a March chapter, where now we're discussing for June.

But, in any case, here's what I heard. There's a lot of support for population-based payment. There's a lot of support for a harmonized multitrack model, be it the one

model with multiple tracks or multiple models that serve that way.

There's a lot of support -- Lynn, you may be an exception, but there's a lot of support for exogenous benchmarks and varying ways. There's a lot of concern about a number of selection issues, and that relates to how we incent participation. We have to certainly be aware of them and model them and make sure CMS is aware of them. I'm sure they are, and there's a lot of concern about gaming issues. That includes coding, but it also includes how you pick your TINs that are in your ACOs and what you might do for patients in a range of ways, which is another concern we have to both say more about and make sure CMS is aware of, and again, I'm sure they are.

So that's my sense of where we are. That was a high-value discussion of value-based payments, and I won't say more. We should move on to Medicare Advantage, and we will come back to the episode version of this, if people are listening and wondering where were episodes. The answer is where they are is March because we have to figure out how to integrate that as well.

So we're going to move on to Medicare Advantage

now, and I think we're turning it over to Luis.

MR. SERNA: Good afternoon. The presentation updates are findings on the status of the Medicare Advantage, or MA program. This cycle of work also includes a mandated report on dual-eligible special needs plans, or D-SNPs.

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.

I am going to present our analysis of the MA enrollment, plan availability and payment for 2022. Then Andy will give you an update on MA risk coding intensity, MA quality, and the general impact of the coronavirus pandemic on MA plans. Finally, Eric will present findings from a mandated report on the performance of D-SNPs.

Forty-six percent of Medicare beneficiaries with both Part A and Part B coverage are now enrolled in MA plans, a substantial and growing difference from 26 percent in 2011. In 15 states, the majority of eligible Medicare beneficiaries are now enrolled in an MA plan.

At current trends, the majority of all eligible

beneficiaries will be in an MA plan by 2023.

The Affordable Care Act of 2010 established changes to MA payment rates, essentially phasing in a reduction of MA payment rates by 10 percentage points between 2011 and 2017.

Despite some initial projections that the decrease in MA payment rates would result in enrollment declines, MA enrollment has continued to grow rapidly. In 2021, MA enrollment grew 10 percent to nearly 27 million enrollees. This is the third consecutive year of 10 percent growth in MA enrollment. The proliferation of MA enrollees has coincided with an increase in the number of plans bidding.

Medicare beneficiaries have a large number of plans from which to choose, and MA plans are available to almost all beneficiaries.

For 2022, 99 percent of Medicare beneficiaries have at least one plan available. Ninety-eight percent have a zero-premium option that includes the Part D drug benefit, up from 96 percent in 2021.

The average Medicare beneficiary can choose from 36 plans sponsored by eight organizations in 2022. Both

are increases relative to 2021.

I'll now briefly go over the MA payment system. More detailed information is available in your mailing material.

The key concepts are that plans submit bids each year for the amount they think it will cost them to provide Part A and B benefits.

Each plan's bid is compared to a benchmark, which differs by geography and plan quality rating.

For nearly all plans, Medicare pays the bid plus a rebate, typically 65 percent, calculated as a percentage of the difference between the bid and the benchmark.

Plan rebates may go toward lower beneficiary cost sharing for A and B services, supplemental benefits, or enhanced Part D benefits. Plan rebates may include plan administrative expenses and profit.

The average rebate that plans have available for extra benefits in 2022 has increased to $164 per member per month, a record high and a 17 percent increase relative to 2021, which was previously a record high. This rapid growth in rebates leaves plans with payments that are far beyond what is needed to cover supplemental Medicare

services. Consequently, the value of the high level of rebates is unknown to the Medicare program.

MA rebate dollars can be used to provide cost-sharing reductions as a means of competing with Medigap coverage. However, as MA rebate levels have increased, plans have allocated smaller shares of rebate dollars toward reducing beneficiary cost sharing, indicating that many MA plans do not want additional rebate dollars for this benefit much beyond medical inflation.

As rebates have increased, MA plans have allocated the largest share of additional rebate dollars toward other supplemental benefits. The most common supplemental benefits include international travel, gym memberships, annual physical exams but can often include discounts for vision, hearing, or dental services. Coverage for these supplemental benefits varies widely by plan and data on their use is unavailable, making it unclear whether these benefits are being administered efficiently for both beneficiaries and the Medicare program.

The level of rebates, now at 15 percent of total payment, reflects MA plans' ability to reduce their bids

relative to payment benchmarks.

However, because benchmarks have been much higher than fee-for-service spending, lower plan bids have not translated to Medicare savings. In 2022, before accounting for coding differences between MA and fee-for-service, we estimate that benchmarks, represented by the blue line, will average 108 percent of fee-for-service spending. Payments, represented by the green line, will average 100 percent of fee-for-service spending. Quality bonuses account for about 4 to 5 percentage points of MA benchmarks and about 3 percentage points of payments.

As Andy will discuss later, overall payments to MA plans will be about 4 percent higher than fee-for-service after accounting for our most recent estimate of coding practices by MA plans that result in higher risk scores. This is represented by the dotted line in red.

When we look at overall bids relative to fee-for-service, represented by the white line, we see a decline from 87 percent in 2021 to 85 percent in 2022.

Overall, while plan bids continue to decline, the Medicare program has not shared in these efficiencies through savings.

Next, we show how the level of fee-for-service spending in a plan's service area impacts its bid.

As expected, plans bid lower relative to fee-for-service where in areas where fee-for-service spending is high. However, even in the lowest spending areas, most MA plans bid below their local fee-for-service spending.

Looking at the left-most column, circled in yellow, which shows the bids for plans concentrated in the lowest spending quartile, we see that the median bid is 92 percent of fee-for-service. This is the fourth consecutive year where most plans concentrated in high benchmark counties are bidding below fee-for-service.

However, the relative reduction of plan bids in these areas has not produced Medicare savings. For 2022, Medicare is still paying an average of 109 percent of fee-for-service spending in these areas. This is due to the benchmarks in those areas averaging 118 percent of fee-for-service spending with quality bonuses.

Now I turn it over to Andy.

DR. JOHNSON: We are now going to turn to risk adjustment and coding intensity in Medicare Advantage. Your mailing materials explain how risk scores adjust

payments to MA plans to account for the health status of plan enrollees. Today we are going to focus on risk adjustment's biggest flaw: differences in diagnosis coding.

MA plans have a financial incentive to document more diagnoses than providers in fee-for-service Medicare, leading to larger MA risk scores and greater Medicare spending when a beneficiary enrolls in MA.

For 2020, we find that MA risk scores were about 9.5 percent higher than fee-for-service beneficiaries with comparable health status. The Secretary is mandated by law to reduce MA risk scores to account for the impact of coding differences.

This adjustment of 5.9 percent only partially offsets the full 9.5 percent impact. The remaining difference caused MA risk scores to be 3.6 percent higher, generating about $12 billion in payments to MA plans in excess of what Medicare would have spent for the same beneficiaries in fee-for-service Medicare.

This figure shows coding intensity and the adjustment for coding intensity over time. We have presented this chart for the past few years, and it is

explained more fully in your mailing materials. This version has been updated for 2020.

The main point is that MA coding intensity continues to grow over time, and the adjustment does not fully account for coding intensity's full effect.

The $12 billion in excess payments in 2020 will continue to grow, not only because the share of unaddressed coding intensity continues to grow, as represented by the green portion of the bars, but also because the share of Medicare beneficiaries enrolled in MA is increasing faster than ever.

These excess payments are one consequence of MA coding intensity.

Now we are doing to discuss a second important consequence that we have spent less time on in the past.

MA coding intensity undermines plan incentives to improve quality and reduce health care costs. These incentives are established by the rebate policy. Rebates are one of the primary ways that MA plans compete because they fund extra benefits that attract more enrollees.

As Luis explained, a plan's rebate is calculated as the difference between a plan's benchmark and bid,

multiplied by a rebate percentage. Looking at the diagram, lowering health care costs reduces plan bids, and improving quality can both increase a plan's rebate percentage and its benchmark. Both strategies result in larger rebate and more extra benefits offered to enrollees. However, coding intensity also increases a plan's benchmark, leading to higher rebate and more extra benefits. When using extra benefits to compete for additional enrollees, higher coding intensity generates a competitive advantage and can substitute for improving quality or lowering health care costs.

This illustrative example shows how the three strategies play out. Starting with the reference plan outlined in yellow, the plan has an annual bid of $9,000, a benchmark of $11,400, and a rebate percentage of 65 percent. The resulting annual rebate is $1,560.

The three plans on the right start with the same bid, benchmark, and rebate percentage, but each one uses one of the strategies from the previous slide to increase its rebate. The high coding intensity plan increases its benchmark by increasing risk scores by 5 percent. The quality improving plan increases its star rating and

receives a 5 percent increase to its benchmark, and the cost-reducing plan is able to lower its bid by 6.3 percent.

Each of these strategies generates the same increase to the plan's rebate, which is now $1,930. It is also noteworthy to compare the reference plan and the high coding intensity plan. Where all other plan attributes are the same, the coding intensity provides a competitive advantage in attracting enrollees.

This figure shows the amount of variation in coding intensity across MA plans by looking at MA contracts, which are groups of plans from the same company. Each gray column shows one MA contract's coding intensity relative to fee-for-service. The 2020 coding adjustment, shown in red, reduced all MA risk scores by 5.9 percent.

The figure illustrates two problems. First, the 5.9 percent adjustment for all plans generates payment inequity, penalizing contracts to the left of the dashed line, and failing to account for overpayments to contracts right of the dashed line. And second, it highlights the variation in coding intensity across MA contracts showing the potential for coding intensity to influence rebates and plan competition for enrollees.

In this figure, there is a 9-percentage point difference in coding intensity between the 25th percentile and the 75th percentile on an enrollment-weighted basis.

On the last slide, for reference, we considered a 5-percentage point increase to coding intensity.

In 2016, the Commission recommended a change to the coding intensity adjustment that would address both excess payments and the undermining of plan incentives. The Commission's strategy first focuses on addressing underlying causes of coding intensity by removing health risk assessments from risk adjustment and improving diagnostic documentation by using two years of data and then applying a flat adjustment to account for the full effect of coding intensity.

Since making our recommendation, the Office of Inspector General has highlighted the use of chart reviews and health risk assessments as significant underlying causes of coding intensity. Using the OIG's results, we calculate that nearly two-thirds of excess payments to MA plans are due to chart reviews and health risk assessments.

Furthermore, the use of health risk assessments and chart reviews varies substantially within MA,

contributing to the variation in coding intensity across plans.

Addressing these underlying causes of coding intensity would reduce excess payments and reduce the extent to which coding intensity undermines plan incentives to improve quality and lower health care costs.

Now we'll move on to a summary of quality in Medicare Advantage. Clearly the enrollment trend as showing large year-over-year growth in the share of Medicare beneficiaries choosing Medicare Advantage plans demonstrates that some baseline level of quality is being met.

However, through work over several years, the Commission has concluded that MA quality cannot be meaningfully assessed through the current system, and it should not be used as the basis for distributing bonus payments.

Your mailing material cite prior Commission reports explaining the many flaws of the quality bonus program, which include assessing quality for large contracts with dispersed enrollment, using too many measures, and not providing beneficiaries information about

plan quality in their local market.

Despite these issues, the MA quality bonus program now accounts for about between 11- and $12 billion in annual bonus payments to MA plans. Due to the relaxed quality reporting requirements under the public health emergency, plans were able to choose to report results for 2019 or 2020, leading to an unprecedented 90 percent of MA enrollees in a plan receiving a quality bonus. These extra bonus payments will generate a payment windfall for plans in 2023.

In our June 2020 report, the Commission recommended replacing the quality bonus program with an improved value incentive program that would focus on local markets, using a smaller number of measures, and distributing plan-financed rewards.

Before we conclude our summary of the MA program status, we considered the impact of the COVID-19 public health emergency. The pandemic has had tragic effects on beneficiaries and the health care workforce and material effects on providers.

As payers of medical services, the impact on MA plans continues to be very different from providers in fee-

for-service Medicare.

Reduced utilization in 2020 resulted in record-low medical expenses, yet plans' revenues remained above normal levels. For 2021, prospectively set plant rates assumed utilization would be higher than has turned out to be the case, likely boosting profits for a second year. It is important to note that these effects have varied across the country and over time.

Plans remain concerned about delayed care rebounding when the pandemic ebbs. We have not seen above-normal utilization yet. We will continue to track the impact of the pandemic on MA plans and enrollees.

To summarize, the MA program is extremely robust. If the current enrollment trend continues, the majority of Medicare beneficiaries with Part A and Part B will be enrolled in Medicare Advantage by 2023.

Plan offerings and extra benefits continue to increase, such that the average Medicare beneficiary now has the choice of 36 plans, and the average MA enrollee has access to nearly $2,000 in annual extra benefits, which now account for 15 percent of all payments to MA plans.

However, Medicare continues to pay MA plans 4

percent more than fee-for-service Medicare for similar beneficiaries. These overpayments worsen Medicare's fiscal sustainability and demonstrate significant flaws in the payment system.

Over the past few years, the Commission has made recommendations addressing flaws in the coding intensity adjustment, the quality system, and the way benchmarks are set. One topic not discussed today is MA encounter data, where the Commission has recommended ways to improve data completeness.

Reforms to these policies are urgently need.

This concludes the MA status report portion of today's presentation, but now I'll turn it over to Eric to discuss a mandated report on dual-eligible special needs plans.

MR. ROLLINS: Thanks, Andy. D-SNPs are specialized MA plans that limit their enrollment to beneficiaries who receive both Medicare and Medicaid, a group commonly known as dual eligibles. As of July 2021, about 3.3 million people were enrolled in D-SNPs, and that figure has grown steadily in recent years.

The Bipartisan Budget Act of 2018, or BBA, made

three important changes to D-SNPs. First, it made D-SNPs a permanent part of the MA program. Before that, the authorization for plan sponsors to offer D-SNPs had always been temporary. Second, the BBA required D-SNPs to meet new standards for integrating Medicare and Medicaid services, starting in 2021. I'll say more about that in a second.

Finally, the BBA also required some D-SNPs to use a unified process for handling grievances and appeals, instead of separate processes for Medicare-covered and Medicaid-covered services. That requirement also took effect in 2021.

D-SNPs have to meet certain requirements for integrating the delivery of Medicare and Medicaid services, and your mailing materials discuss how those requirements have grown over time. The BBA took another step towards greater integration by requiring all D-SNPs to meet one of three standards for integration.

Under the first standard, plans must notify the state about inpatient and SNF admissions for at least one group of "high risk" beneficiaries. These plans are known as "coordination-only" plans and account for 57 percent of

all D-SNP enrollment. They have the lowest level of integration because they do not have to provide any Medicaid services themselves.

Under the second and third standards, plans must provide Medicaid-covered long-term services and supports, behavioral health, or both. The key difference between the standards is whether the D-SNP has what is known as exclusively aligned enrollment, which is when enrollment is limited to dual eligibles who also receive their Medicaid services from the same parent company. The plans that do not have aligned enrollment meet the second standard and account for 35 percent of all D-SNP enrollment. The plans that do have aligned enrollment meet the third standard and account for 8 percent of enrollment.

The BBA also requires the Commission to periodically assess the performance of D-SNPs. Under the mandate, we should make this assessment using HEDIS, which is a set of quality measures developed for health plans by the National Committee for Quality Assurance. CMS requires MA plans to collect and report data annually for a subset of HEDIS measures. We can also use other data sources, like the CAHPS beneficiary survey or plan encounter data,

if feasible.

The mandate says that we should compare the performance of five types of plans that serve dual eligibles: the three types of D-SNPs that are defined in the BBA, the Medicare-Medicaid Plans, or MMPs, that operate under CMS's financial alignment demonstration, and other MA plans. For the other MA plans, we are looking only at the dual eligibles enrolled in those plans.

Finally, we must provide a report every two years, from 2022 to 2032, and then every five years starting in 2033. This is our first report under the mandate.

For this report, we analyzed person-level HEDIS data for measurement year 2020, the most recent available. We did not use CAHPS because the most recent data did not become available until late 2021 and we did not have enough time to analyze it, and we did not use encounter data due to our concerns about its completeness and accuracy. However, we could potentially use those data sources in future reports.

One issue we wanted to highlight is that HEDIS has some measures that are known as "hybrid" measures

because sponsors calculate them using a mix of administrative data and information collected from a sample of enrollee medical records. This sample is chosen at the contract level and is thus too small to generate reliable plan-level estimates. As a result, we excluded all hybrid measures, such as measures related to controlling high blood pressure and diabetes care, from our analysis.

The results of our analysis were mixed. We found that each plan type performed relatively well on some measures and relatively poorly on others. There is a table in your mailing materials that shows how each plan type performed on each measure.

We think it is difficult to draw larger conclusions from this analysis about the relative performance of the various plan types, for a couple of reasons. First, there are numerous differences among the plan types that could affect their scores, such as the geographic regions where they operate, the types of dual eligibles that they serve, and the different quality incentives for MMPs and MA plans.

Second, the available measures are largely process measures, and we view measures tied to clinical

outcomes and patient experience as more meaningful. The limited insight from this analysis is consistent with some of the broader challenges we have highlighted in recent years in measuring quality in MA.

That brings us to the end of the presentation. We are happy to answer any questions you might about our MA status report or the mandated report on D-SNPs. Just as a reminder, the material from this presentation will appear in the Commission's March report. With that, I will turn it back to Mike.

DR. CHERNEW: Terrific. Thanks.

The last session went a little long so keep that in mind, please. But I think we'll just go right to the queue, and again, please keep the Round 1 questions for the questions and save the discussion related to the questions until Round 2. But go ahead, Dana.

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

DR. DeBUSK: Thank you. Two quick question. First of all, can you walk us through the timing of a RADV audit? If one was kicked off this year, what years would it look at? How long would the audit take? Is there a protest period? When would money be recovered? Help me

understand the timing of a RADV audit, and then please compare that to these GAO audits of high-risk codes that I see out there. If you could just walk me through those timelines, that is my only question.

DR. JOHNSON: I don't think we know that there is a standard timeline for the RADV audits yet. It happens sporadically, and I think the timelines vary, depending on the year. It says in the report the exact years, but I think there are a couple of years that are complete, but the results are not yet public. But I think the general process is that CMS would identify the contracts under audit, they would engage the audit process which would involve identifying the beneficiaries whose medical records need to be presented in order to support the diagnoses that were submitted for risk adjustment, and then results are sent to the plan. And there is sort of a -- I don't know if it's a protest period or a back-and-forth, where the plans have a chance to challenge the outcomes. But I don't know that there has been a specific timeline.

The OIG audits are carried out separately, and they use a little bit different process. And my recollection is that there was a number of them early on

and then they sort of stopped for a number of years, but in the past year or so there has been a number of them concluded. And they are operating, as I understand it, under different authority, but they use a general [inaudible.]

MS. KELLEY: Okay. I have Paul next.

DR. PAUL GINSBURG: Sure. This is an awesome chapter and I really enjoyed reading it, but let me get right to the question. You mentioned that encounter data is more reliable as far as coding than I guess claims. Could you explain why, say, an encounter for visits would have more reliable coding than a claim for visits?

DR. JOHNSON: I'm not sure the intention was to say that encounter data is more reliable than the claims. I know there is a section that compares the differences in using encounter data versus RAPS data. Is that the section you're referring to?

DR. PAUL GINSBURG: It might be.

DR. JOHNSON: I can say, I guess, the two things to say are that the RAPS data are collected in a summary format, which is just the minimum pieces of information that are necessary to produce risk adjustment, and that

we've done some analysis comparing the counters to the RAPS data and found that a few, the provider type category, in particular, was one that was maybe not as accurate on the RAPS data.

And we've also compared the risk scores based on encounter data versus RAPS data over time and found that they've generally converged so that the encounter data is at least capturing the same or similar sets of diagnoses that RAPS data are.

The one difference that we have found in using encounter data for risk adjustment compared to some of the analysis we've done that are looking at encounter data to characterize utilization overall is that the, I think as you know the risk adjustment is based on physician encounters, hospital inpatient and outpatient encounters, and diagnosis only needs to be submitted once per calendar year, whereas if you wanted a count of all hospital visits that occurred during the year you would need every single encounter from all plans and all beneficiaries to be present to get an accurate count. That's some of the distinctions we've talked about.

DR. PAUL GINSBURG: Okay. Thanks.

MS. KELLEY: Pat.

MS. WANG: Thank you. Great report. So I just want to clarify the different stacking of the components that lead to the conclusion that payment is 104 percent above fee-for-service. If payment is 100 percent, is the quality money that amounts to 3.6 percent of payment included in the 100 percent or is it on top of the 104 percent? Would you clarify that?

DR. JOHNSON: Quality is included in the 100 percent.

MS. WANG: Gotcha. Okay. Thank you.

So I have a question on Slide 13, and it was Figure 7 in the chapter, and I'm really happy that you updated that which shows the sort of progression, I guess, of coding intensity. I was curious whether it is feasible whether you have the data to overlay maybe the volume or the frequency of in-home assessments on top of that coding slope, just to see if it would produce -- you know, it could be nothing but it could reveal another dimension to the story. It would be interesting to know whether what seems to be at the far right of this, it coincides with a much higher frequency than home assessments. That's the

question I guess.

DR. JOHNSON: I think that is technically feasible but involves a lot of work and effort to do that. So far we think it is true that the contracts on the right end of the screen, with the higher coding intensity, are almost certainly the ones that use more health risk assessments and chart reviews. I think there is some more granular analysis in the two OIG reports about the use of health risk assessments and chart reviews that show the variation for particular parent companies and if they are highly concentrated along a certain number of parent companies in particular.

You know, we can look into providing some more detail there, but I think their reports have provided a good amount of evidence there.

MS. WANG: Okay. And the final question is sort of like, we've never discussed this before and so it's not a suggestion. It's just a question. At some point, does it make sense when comparing MA to fee-for-service spending to understand how much IME and GME is being paid for MA beneficiaries? Because that's carved out of MA but it is part of the Medicare payment system, and, you know, there

are very special reasons that it's kind of protected.

But I just was curious, especially now given the volume or the penetration of MA in the country, whether there might be anything to see there that could be revealing of changes in sites of service. I mean, this got triggered yesterday when Brian was talking about MA plan use in surg centers, which, if it's true that if any significant volume MA plans are diverting folks who would have had inpatient surgeries, you know, services, to something that is freestanding, it could reveal a shift. The shift could be revealed in the stream of payments. I don't know if that makes any sense or not, but we've never discussed it, and given the importance of MA right now in the country it's just a component that is still out there.

You don't have to answer. It's just a question to think about. It's not the most exciting thing to worry about. Okay for me for Round 1. Thank you.

MS. KELLEY: David.

DR. GRABOWSKI: Thanks, Dana, and thanks to the staff. Great work here.

So I had a question -- I think this is an Eric question -- for Slide 19. Eric, this is the first year, I

guess, that we're applying these new kind of standards for integration. I'm kind of looking at these categories and I just wanted to push you a little bit to get your thoughts. The first category sounds really weak to me in terms of like what we would typically think of aligned. That bottom category sounds like what I think about as kind of the idea. And I'm having trouble thinking about that middle category. Is that over the bar? Add some additional detail there. Would you categorize that as integrated -- it's obviously not aligned, but is the goal to push as many of the plans and enrollees down into that bottom category? Help me think a little bit. Is my thinking here right or wrong, or how are you thinking about these? Thanks.

MR. ROLLINS: So the BBA -- you know, and this is, as you know, a longstanding issue of sort of trying to promote more integration for the duals -- is there's a lot of variation among the states in terms of their use of Medicaid managed care, their attitude towards it, who they cover, what services are in, what services are out. And so you've got a tremendous amount of variation out there and you're trying to sort of use these three standards to kind of reflect a whole range of things that go on.

So I would agree that the third category is getting close to kind of what would sort of be kind of an everyday understanding of a fairly high level of integration. I would actually say that both of the other two categories, it gets a little fuzzy. And I say that because the first group, the coordination-only plans, the minimum requirement is low. You know, like I said, they just have to provide this notification of hospital and SNF admissions.

On the other hand, sort of the next step up in the ladder, if you will, but that middle category on the slide is really tied to long-term service and supports and behavioral health, and that varies a lot across states, as you know. So you could have a plan that is providing some Medicaid services through capitation -- acute care, primary care, you know, the cost sharing that Medicaid covers for some Medicare services, dental, transportation. There are other services that you could provide that provide some level of integration but you're still going to be in that coordination-only category because moving into the other two categories is really focused on behavioral health and long-term services and supports. So there's some fuzziness

there.

I would agree with you that the middle category is a bit of an in-between of where they are clearly getting capitated Medicaid payments to provide certain services but, you know, maybe it's LTSS or maybe it's behavioral health. In some cases it could be both. And sometimes the distinction between the second and third standards gets into like the contracting arrangements that the plans have with the states. So there is some fuzziness there, but I think just to go back to what I said earlier, it's more than just that middle category. It's also, to some extent, I think, the first one as well.

DR. GRABOWSKI: Great. Thanks.

MS. KELLEY: Larry.

DR. CASALINO: Yeah. Eric, thanks for an excellent chapter. You know, probably appropriately, it didn't come across much in the slide discussion today but the tone of the urgency in the chapter is very strong, I think, pretty much as strong as I've seen in MedPAC chapters. And I think that's appropriate. I was sort of glad to see it, because Congress and Medicare continue to overpay MA plans, which means giving money to some of the

biggest health care companies in the world. A very small number of those companies have very high shares of Medicare Advantage market. They're basically taking the extra payment that they're getting above fee-for-service payments and using it to buy lots of parts of health care system, including medical groups. So I think the urgency in the chapter is very appropriate.

Okay, that editorial aside, I have three quick questions. On I think it's page 2 of the chapter, yeah, there is a statement that Medicare Advantage plans continue to capitalize on their administrative flexibility and reduce health care costs year over year. So I think I understand what "reduce health care costs year over year" means. I think you're stating that they are reducing health care costs year over year because they submit lower bids year after year.

But I think if that's the case it would help for that to be clearer, because I think the kind of average person reading the chapter might way, "Well, wait a second. We're paying them 104 percent of fee-for-service but they're reducing costs year over year." And again, I think I understand the distinction but I'm not sure that some

people would. So maybe a little elaboration on that statement on page 2, and the basis for saying they are reducing costs year over year, and how that's different from them being paid, you know, more than fee-for-service year over year. I think that explicit attention to that might be a good.

Am I correct that the basis for the statement that they're reducing costs year over year is the lower bids year over year?

DR. JOHNSON: Yeah, that's right.

DR. CASALINO: Okay.

So then the second point, in terms of coding, I'd like the proposal to not allow HRA or chart review to raise risk scores, but wouldn't plans use other means? For example, I've heard anecdotally that some Medicare Advantage plans pay medical groups for coding more diagnoses. Is that permitted, or should it be permitted?

DR. JOHNSON: I think it is permitted and especially for relationships where there is a capitated agreement between the plan and provider, where a share of the payment that goes to the plan is passed directly on to the medical group. The medical group assumes the same

sorts of incentives that the plan has to document more diagnoses.

I'm not sure how we would prevent that from being the case.

DR. CASALINO: Yes. Okay.

And then just following up on David, on Slide 19, what's the timing of the plan having to notify the state of an admission, and what's the point of that? I mean, is it supposed to be something this data is supposed to be able to intervene in, in a timely way, or is this -- could you help us understand what the point of notifying the state is and when they have to do it by?

MR. ROLLINS: So, in terms of the timing, I don't think there's any explicit guidance or requirements in terms of how timely those notifications have to be, and I haven't seen anything yet that really digs into sort of each state's requirements and sort of what that time frame is. I don't know if it's fairly timely or if we're talking about something like it's sort of a monthly report.

But, in terms of the larger rationale, the focus was on beneficiaries who are using long-term services and supports or behavioral health on the Medicaid side, and I

think the idea is that by notifying the Medicaid program that a particular beneficiary is in the hospital or in the nursing home, you would pass that information along to perhaps their behavioral health counselor, or if they're getting long-term services and supports, like their personal care attendant, something like that, and they would -- you know, it would lead to better coordination of care. I think that's sort of the underlying rationale.

DR. CASALINO: Got it. So, in that case, it should be done in a timely way.

MR. ROLLINS: Yes.

DR. CASALINO: It would be much more valuable if it was done the day when the patient is admitted rather than a month from now.

Okay. Thanks. That's helpful. That's all the questions I had.

MS. KELLEY: Marge.

MS. MARJORIE GINSBURG: Thank you. Fabulous chapter. This was very exciting work, and I'm delighted to see us continuing.

Just a couple of questions for Round 1. On page 9 on the middle paragraph, it says the allocation of MA

plan efficiency is not uniform across the country. In some parts of the country, the MA program produces savings for the program, offers a higher level of blah-blah-blah.

Can you give us just a little bit more information about how many plans are we talking about and what is it that they seem to be doing right?

My second question -- and I'll just go ahead and give them both -- is on page 11, Table 1, where we summarized the major efforts we've been making to try to right the ship, and we include the percentage points that we think this would represent in terms of savings.

I think, like other Commissioners maybe, I'm frustrated that Congress or CMS have not taken us up on any of the wisdom of our thoughts here. I wonder if that chart can also include what the total dollar amount would have represented if these recommendations had been included.

That sounded a little Round 2-ish. It's really Round 1. Can we convert this into dollar savings for taxpayers? Those are my two questions. Thank you.

MR. SERNA: Yes. I'll take the first question. So the first one goes back to plans that are in higher fee-for-service spending areas have been able to take advantage

of those from a competitive standpoint relative to fee-for-service, and that's nothing new. That's something that's happened historically.

Our benchmark work last year pointed out that plans, even in those areas where the benchmark is 95 percent of fee-for-service spending, they've historically tended to have their bids lower relative to their benchmark still. So they can take advantage of that fee-for-service geographic variation in spending. So I think that's the main answer to the first part of your question.

MS. MARJORIE GINSBURG: So it has nothing to do with them being more efficient plans, looking at their risk adjustments more accurately? Is there anything about them that's laudable that in some way could be transferred to others?

MR. SERNA: I don't think we can particularly say. I mean, what's laudable, I think, could be interpreted as that they're relatively efficient compared to fee-for-service in those areas.

DR. JOHNSON: On your second question, we've often tried to characterize how much of payments is currently flowing through a particular aspect of payment,

like how much coding intensity is high or how much money is flowing through the current quality bonus program, but I think we've tried to stay away from putting a specific dollar on it because the way that the proposal might be enacted in law is a little bit different. And it should take into account some of the provider behaviors, and that's sort of the job of the CBOs. We try and help them stick to that side of it, and we restrain ourselves to talking about just how much money is going through some of the current aspects of policies so far.

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

DR. NAVATHE: Yes, I do. So it's a little bit building off of Pat's or maybe on the same comment, which is basically I was curious if we had to disaggregate, we have this point on page 8 in the paper that the Part A and Part B beneficiary spending is provided basically at 15 percent less than fee-for-service Medicare and for the average MA plan, but then Medicare spending 4 percent more. I was wondering if you can give us some sense of how you would decompose that into the various buckets that we've been talking about here, quality payments, coding

intensity, inflation, some related to the statutory requirements on the benchmarks and how that works.

If we had to disaggregate and even if we could try to rank it, I'm just curious. What would be your best estimates on that?

MR. SERNA: So I think, as we pointed out, quality bonus payments are about 3 percentage point relative to fee-for-service, and Andy can talk about more of his estimate. But the estimate of coding is about 3.6 percent. Those are kind of two ways that you can start thinking about it.

DR. JOHNSON: And the other major factor there is that the benchmarks are well above the fee-for-service, and that part of that is due to the quality. So part of what Luis said speaks to that, but there are other reasons of benchmarks are just higher as well, higher than fee-for-service.

DR. NAVATHE: So, I mean, by a process of elimination or a residual, are we ending up with -- if you have 104 percent, call coding, 4 percent, that's 100 percent, quality, 97 percent, so we're ending up at the benchmarks and reflecting something like 12 percent, the

way this statute on inflating the benchmarks by quartile of regional area, that that represents 12 percent, in fact?

DR. JAFFERY: Just to back up, I think you're asking about the difference between the benchmarks and the bids. Am I right, or did I get it wrong?

DR. NAVATHE: Yeah, yeah. Well, I guess I'm trying to understand to reconcile that 85 percent of fee-for-service -- it can provide the -- for the average bene that can provide this for or they are providing for and the 104 percent is what the Medicare program is paying for it. So there's a 19 percent gap there, and I'm just trying to understand how can we best decompose that gap, understanding that some of it is going to be, you know, regulation or estimates.

DR. CHERNEW: Maybe with time, we can sort this out offline.

DR. NAVATHE: Okay. Yeah. I'm not trying to hold us up, but I think it would be great to have some relative sense of that.

DR. CHERNEW: Yeah. No, I don't disagree. It's just we have about -- I think we have one more Round 1 and about nine Round 2 and about, you know, 30 minutes-ish.

So, anyway, sorry, Amol.

DR. NAVATHE: Sounds good.

MS. KELLEY: Okay. I have one last person in Round 1, unless I've missed someone, and that is Bruce.

MR. PYENSON: Well, thank you very much.

A question on Slide 13. I think this is directed to Andy, and I loved this slide, as others do.

My question is about tying this to the information about the two different kinds of audits that you describe in the material. The audits are recouping risk scores that are not valid, and it's not clear to me how that might interact with this slide. So it could be that even the organizations on the left, I guess, could have invalid codes as do the ones on the right.

So the broader question, is 4 percent the maximum number of over-coding, or is 4 percent what comes out of this analysis and there could be other kinds of over-coding, maybe including selection? So that's my question.

DR. JOHNSON: So the first distinction is that there are valid codes that are often submitted by MA plans that are submitted in MA that would not have been submitted in fee-for-service, but there's not anything in error about

that. It's just that the incentives are different, and it produces different risk scores for that difference.

Turning to the RADV audits or the OIG audits, but of them are checking for that the plans are meeting the program rules, that when a plan submits a diagnosis for risk adjustment that it is also supported by the medical record. So those are the types of invalid codes. It may not be that the diagnosis is entirely inaccurate, but it does not meet the program rules, that in order to be valid for risk adjustment, the diagnosis must be supported in the medical record.

So there could be -- that influence could be reflected here in the overall coding intensity estimates. Really, I think it would be difficult, and we've not been able to separate out what portion of all of the coding intensity estimates is due to valid and the appropriately supported codes versus those that would be found to be invalid under a RADV audit or inappropriate based on a RADV audit.

Your second question, I think when it comes to the estimate of coding intensity, I think the intent of our analysis reflects the effort that MA plans are putting into

documenting more diagnosis codes, and so if there are other selection issues between MA and fee-for-service, they may not be reflected here. But that is also a much more challenging question to answer.

MS. KELLEY: Jon Perlin, did you want to get in on this point, or did you want to wait for your Round 2?

DR. PERLIN: Exactly on this point, and I'm pleased to remove my Round 2.

MS. KELLEY: Okay.

DR. PERLIN: And it's right at the intersection of Bruce and Andy's interchange on what appears to be the discrepancy between those things that are found in the medical record and those things that are coded in terms of risk. Really two points.

One, just parenthetically, sort of apropos nothing, it's always shocked me that given the amount of money in the Medicare Advantage program and entities that have a direct interest in either lower or higher codes, why, you know, there isn't some neutral party who is doing the coding and risk stratification. Putting that side, it strikes me that in the program as it operates now, the real opportunity is in reconciliation of those things that are

served in the medical record and those things that are coded as risk, because if they're coded as risk and, you know, it's a broad fishing expedition, then that's a problem.

On the other hand, if there are a number of things that are served and they're not paid for, that's a problem, and so it strikes me that that intersection is actually to see to both the appropriate level of case, the appropriate reimbursement for services that are rendered, but also an appropriate internal mechanism for reconciliation of risk and service and program integrity.

Andy, I would just wonder if you have any comments on that. Thanks.

DR. JOHNSON: I think that is a good point, and I think the intention of the program roles that say that medical record -- that diagnoses submitted for risk adjustment need to be supported in the medical record is trying to enforce that and trying to make sure that the two sources of data are aligned and there isn't this difference.

One of the seeming issue with this is that the audits were set up initially, and they moved a little bit

slowly. There's currently an effort to put the method of conducting the RADV audits into regulation that has been delayed a little bit. So I think the fact that there has been perhaps a lack of enforcement or just a slow uptick of enforcement on that means that the connection between those two data sources, based on the audit results, has been a little bit more out of sync than it should be.

DR. PERLIN: Yeah. Because you've got the risk -- the claims data, and, you know, that if it's on the claims data, then it would seem to be that appropriate check on it.

DR. JOHNSON: Right.

DR. CHERNEW: Yeah. So let's move on. I'm sorry, Jon, to cut you off, but I want to move on to Round 2, recognizing we have 20 minutes. We may go -- for those of you planning your afternoon activities at home, you may have to allot an extra 10 minutes, but see if we can be efficient with both our comments and our answers in Round 2.

Brian, I think you're first.

DR. DeBUSK: First of all, I'd like to thank the staff for an excellent chapter, and I do agree with the

tone of the chapter completely. I'm an enthusiastic supporter of MA, primarily because I believe they have the tools they need to succeed.

My concern here is that leaving coding and selection issues unaddressed really creates an attractive nuisance that can distract these MA plans from their core mission of delivering health care to Medicare beneficiaries more efficiently. So I think we definitely need to plug those holes, if you will.

I'd like to focus on coding and selection. We have a good standing recommendation around removing health risk assessments from coding. I think we should add chart reviews because I'm not sure if chart reviews made it into the original recommendation. Hopefully, we could do that this cycle, if it isn't in there.

I would also propose at least a text box in the chapter that highlights the current consequences of upcoding because right now I don't -- it does not appear that there are any dire consequences to upcoding, and the process seems to take the better part of the decade. So what it feels like is free working capital.

I also think that there are a lot of analytic

tools that we could appeal to, and I hope we can speak to that in the chapter. One of my favorite examples is if someone is coded with the HCC for major depressive disorder, can we find prescriptions, or can we find office visits that relate to that condition? Because I would think the data is out there.

I want to go back to page 13 of the presentation materials as well and address the coding adjustment. There's an obvious problem with raising the 5.9 percent adjustment in that it penalizes the entities that don't code to at least that level. So we may inadvertently turn good actors into bad ones.

The chapter discusses a three-tiered approach, which I remember reading in 2017, which introduces three different compartments with their own separate adjustments, but I'd like to recommend this may be a great place for a cliff. And I'll do the Cliffs Notes version of this. But imagine if we leave the 5.9 percent adjustment in place and then we look at the residual amount of over-coding that's present, and again, on Chart 13, you can see that.

Why don't we take the top 20 percent of the code growth offenders and just simply distribute that residual

across that top 20 percent? So, basically, the game here, if you will, or the strategy is to not be in the 20 percent, the top quartile or top quintile of the aggressive coders.

I think from a behavioral perspective -- I won't get into it in my Round 2 comments, but I think from a behavioral perspective, you'll get precisely what you want in terms of coding response because no one wants to get stuck in that top quintile.

Page 21 of the reading materials, I was really encouraged to see this mentioning about biasing the MA benchmark through selection, particularly as it pertains to high penetration areas. We have a lot of MA counties now that have 60 and 70 percent penetration. I see the next big opportunity for MA plans to be around selection and avoidance, and the fundamental problem here is the MA benchmarks are derived from the fee-for-service spending. So, when the plan selects the beneficiary out of the population, not only do they gain the primary benefit of that persistently underspending beneficiary, but it also removes them from the fee-for-service average.

So what you can see, it has a very nonlinear

effect because what happens, as MA rates approach 50 percent or above in any given county, this secondary effect of biasing the benchmark begins to take over.

And I just want to do one example. In a 1 percent penetrated county, finding beneficiaries with a $20 per member per month selection has an obvious benefit, $20 per member per month, but in an 80 percent penetrate county, that same $20 a month benefit, because all those people are removed from the fee-for-service average, actually translates into a $100 per member per month benefit. There's an amplification of five times simply because you've moved the fee-for-service spending benchmark.

And with that, those are my comments. Big fan of MA. I just hope we can fix some of these gaps in the regs.

MS. KELLEY: Stacie.

DR. DUSETZINA: I'll echo what Brian and others have said already on this great chapter. I found it to be really an excellent read, and the tone, I agree, is excellent, especially given how many beneficiaries now are in MA and how that's growing.

I'm going to limit my comments to maybe a little

bit of a wish list of what I'd love to see moving forward for a chapter like this, and especially around access questions that I have around Medicare beneficiaries and their access to specialty care when they're in MA plans.

So I think a couple of things that would be really helpful to know are thinking about how are beneficiaries accessing specialty care when they need it. Is that really good? It seems very attractive to be in MA, but if your providers that you need are carved out of your network then it becomes less attractive. So I wonder about looking at how often people switch out of MA eventually, especially if they become ill.

The other thing I wondered is if it would be possible to do a breakdown of plan out-of-pocket maximums and the extent to which they apply to in- versus out-of-network services and how that has looked, especially in more recent years, trying to get a handle, I think, on this adequacy of coverage when you need additional care outside of your MA network.

And then I think the other glaring thing is really how do we improve the encounter data. You know, I think that's sort of where we leave the chapter, is that

they're not great. We know that about half of people are going to be in MA soon, so being able to have better records of the type of care they're receiving, even just from a research standpoint, would be really important.

So again, echoing others on this really incredible work and just a wish list for the future.

MS. KELLEY: Paul.

DR. PAUL GINSBURG: Yes. Well, first I really support the conclusion of the chapter that was put up on the slides about the urgency of reforming Medicare Advantage payments. As the participation rate grows, and it's growing very rapidly, as the chapter shows, you know, the magnitude of the overpayments and it feeding on itself, generating even more penetration is really a concern.

I'm very glad that Brian brought up the point about how higher penetration makes some of the problems like selection more serious. And I think for next year you might really want to devote some of the chapter to the various ways that the 60, 70 percent counties magnify the problems that we all know about.

I was very intrigued how the chapter brought up the Medigap issues, which I hadn't thought about for a long

time. I know the Commission has done work in the past on the degree to which having Medigap raises spending by those who purchase it in the Medicare program. The Commission did a lot of work on revamping the Medicare benefit structure, partly influenced by this.

And I was wondering, again with this growing penetration, whether the notion that the Medicare benchmark is influenced by the proportion of enrollees who have Medigap, whether that could actually be exacerbating things. And I don't know if we know about the percentage of the people remaining in fee-for-service that have Medigap -- I guess we do know, because they are the only people that have Medigap -- and whether this is a factor that is driving the benchmarks up, as well as perhaps doing new estimates. I know it's been a long time since the Commission estimated the magnitude of higher spending under Medigap, new estimates based on recent data.

Thank you.

MS. KELLEY: Dana.

DR. SAFRAN: Thanks. Just a couple of very quick things. One, I should have asked this in Round 1 so apologize that I forgot. I was curious whether is some way

that we could do some quantification of what the impact of the trust fund has been from having MA versus if we didn't have MA. And, you know, pick your starting point for that impact. But we've made this point over and over again, I think every year, about the fact that MA is costing the program money, and I just wonder if there's some other way that might be high impact to display that.

Second point around risk scores, I think it was Brian who called out the idea of having a text box, but adding to that, or maybe it's a separate text box, something around the coding practices that I think are well-known among many of the Commissioners, but maybe not that well-documented, that are contributing to this risk score escalation might be a really valuable contribution.

I like Jon Perlin's idea about potentially a neutral party who is doing the coding. I don't think I've ever heard us talk about that. I'll share that the idea I was thinking about, which admittedly is going to be operationally complex but has some interesting benefits to it, is if we used beneficiaries' self-reported social status information and changes in that year by year. So we already have seniors survey that is part of MA. It doesn't

get fielded to every beneficiary who is enrolled, and it doesn't get fielded, I think though I'm not now certain, in fee-for-service Medicare. But what if it did? What if annually, as part of your Medicare benefits, you, as a beneficiary, were asked by Medicare, not by your doctor, not by your health plan, to complete an SF-12 survey.

Part of what causes me to suggest this was the observation, in my years working at a health plan, about how risk scores were escalating at rates that were completely different from what we see in longitudinal data on functional status. Longitudinal data on functional status among people aged 65 and over, last time I was seeing them on a regular basis, arose by under a point a year. And so I understand there are some conditions, like hypertension, that aren't going to show up as impeding functional status, but I just throw out that idea as something that would have value in and of itself but could help us with risk scoring.

And then finally I just want to make the point, I was really glad to see the part of this chapter that was about the quality program. I think our chapter on this last year was a really, really strong one.

The thing that I wasn't so aware of last year as I am now is the real challenges around the way the stars program is applied to D-SNPs, both sample size issues that are problematic but also, as the team presented to us, HEDIS measures are what's used. Those are mostly appropriate but far from sufficient to measure quality for the significantly vulnerable populations that are in D-SNPs.

So I think some further thought, and in this chapter just at least underscoring the fact that current approach to quality are not only poor across the board in MA but particularly doing a disservice to D-SNP enrollees.

Those are my comments. Thank you.

MS. KELLEY: Pat.

MS. WANG: Thank you, and thanks for the comprehensive chapter.

I made this comment before but I would sort of request again whether it's possible to consider putting a little bit more sort of flesh on the bones of who is enrolled in the MA program, especially as it has grown in size. So, you know, historically MA enrollment has been disproportionally among lower-income people, below 200

percent of poverty, disproportionately among underrepresented minorities. Is that still true as enrollment grows? It would just be good to know who is attracted to MA, and so I would encourage us to think about that.

As far as the questions in the discussion that we've been having around this 104 percent is concerned, and I know that you will help people to disaggregate, one of the things that has been confusing to me is that I think the 104 percent is sort of the aggregation of what goes on in the low benchmark counties and the high benchmark counties. I think it represents the average, I think, because we went through this when we were doing the benchmark reform, that in the low benchmark counties, the 95 percent and 100 percent benchmark counties, there are savings in actual payments that are generated to the Medicare program. There are higher than fee-for-service payments -- you know, if you think about it, if your benchmark is 115 percent of fee-for-service it is going to wind up costing more than fee-for-service, and the 104 is a combination of all of that.

I just think it might be worth calling out, I

think it was in Text Box 36 on this point, that in at least half the counties, if that's the right number, there are savings that have gotten generated to the Medicare program as a result of the reforms from the ACA, and at least take a little credit for that. I think it's true but I ask you to take a look at it.

The question of profitability, this was on page 12 in the text box. You know, based on the information available to you from I think publicly traded earnings reports and forecasts, you know, there is an optimistic view about how 2021 is going to look for plans. That may be true for the plans that you're considering, but I would ask you to, particularly because the MA world is not yet as consolidated as the Part B world or the dialysis world, for example, there's a tremendous amount of heterogeneity among plans, and I would just ask you to be a little less strong in your conclusion that 2021 is going to turn out to be a good year for plans, because there are plans that are deeply underwater as a result of 2021.

The flip side of sort of social distancing in 2020, as you pointed out, and lower health care costs is lower risk scores based on those encounters. Those

encounters are the basis of risk scores in 2021. Risk scores were very depressed as a result of that. Conditions didn't go away but risk scores disappeared because of the lack of encounters, so risk-adjusted revenue was lower. There is a 20 percent inpatient surcharge on any inpatient code at admission for a Medicare beneficiary that is still in effect as part of the PHE. That is self-funded from MA plans' premiums, that there is no extra money coming for that.

And with testing costs and everything else, I just want to make the point that there are plans that enter 2022 very much financially underwater as a result of their 2021 experience. So I think it would be important to at least say someplace in the text box that plans are very different from one another and the generality might not apply.

On risk scores, you know, the recommendations that the Commission has made over the years are very consistent, and they are consistently repeated here. The fundamental problem with risk scores, so backing up -- risk adjustment, this is an insurance program. It's premiums per person that is supposed to pay for the whole health of

that person, obviously, as well as all of the care, the non-medical care, the durable medical equipment, the transportation, those other things, the home health agencies, just the arrangement of whatever care the person needs.

It's very important to have accurate risk adjustment, to ensure that the servicing plan has the resources to take care of that person, based on the complexity of their health condition, and it's also very important to avoid cherry-picking of healthier beneficiaries for whom you're getting an average premium. Right? We all know that. Risk adjustment is really important.

The fundamental problem with risk adjustment in the MA program is that there is this idea that it should be equivalent to fee-for-service, where, as you've noted in the chapter, there is absolutely nothing in the fee-for-service system that incentivizes or requires providers to capture the diagnosis codes that are the basis of risk adjustment in MA. And the fundament disconnect between the fee-for-service system that is supposed to drive risk scores, because of the diagnosis codes that are or are not,

or are correctly or incorrectly put on a claim, and are or are not reflected in the medical record, is kind of the fundamental issue here, which is why this excess that is being pointed out -- so I'm not quibbling with that.

But that is why health plans do things like chart reviews, because, you know, Mrs. Jones who has these five chronic conditions in 2020, or 2021, has no claims with any of those diagnoses in 2022, and the rules are you have to code it at least once a year. That's why plans do chart reviews. It's like I think she still has, you know, various conditions, and since we're spending money on it, we need to get adequate premium for it and make it accurate.

And so this issue that is always a disconnect, and as fee-for-service gets smaller, I just struggle to think about what the ultimate solution is here. I just want to make sure that the other Commissioners understand that that is the fundamental problem. Providers do not get paid by putting diagnosis codes on the claims accurately. Providers do not get paid fee-for-service for documenting in the medical record a condition that matches the diagnosis that they put on a claim. And that's why, as

Andy pointed out, when you look at that chart there are some diagnosis codes that are correct and supported by the medical record, according to the rule. Sometimes the diagnosis code is correct but is not supported by the medical record, because the provider has no incentive to do that, and it gets thrown out.

So there's a lot of noise in the risk adjustment system. You know, pre-pandemic CMS had announced a program, a pilot program that they were going to do -- I don't know if you remember this -- where they were going to try to sort of contemporaneously validate diagnosis codes that drive risk scores through APIs into the electronic medical record. I don't know, Andy and Luis, if you recall that. You know, the pandemic happened. I don't know whether or not that's going to be picked up again, but I think that there were some people who felt like that would be a really good solution, ultimately, to get to that point where you could sort of see diagnosis codes, validate in the medical record that it was real, and have that produce your accurate risk scoring.

That is really the ideal situation, in my view, and if you recall it, it might be something to call out in

the report.

And so, you know, statements -- anyway, I'll leave it alone -- on quality, it was painful for me to see the statement that because of the PHE accommodations on the stars program that plans got a windfall. That really hurt, okay, because I think that notwithstanding the flaws in the stars program, which the Commission has pointed out, it really does a disservice to the incredible work that many plans do for their members to improve their quality and make their lives better, with real outcomes.

And so maybe the answer is finally get to the point where some of those quality reforms are actually implemented, particularly measurement on a local level. But I just want to say that really hurt me, that statement.

The final thing, because I was not able to get my comment in but I withdrew during the ACO discussion, I just wanted to say that ACOs and MA plans do not compete with each other. I have no worries at all that we have to race forward with ACO because MA may take all the members. It's a beneficiary choice whether they stay in fee-for-service or in an MA plan. It has nothing to do with the existence of an ACO or what have you.

The goal, I think, long term, is to make these program a little bit more harmonized, because ultimately an ACO should serve the folks who choose to stay in fee-for-service, and there will be many -- there is a need for ACOs going forward -- and to be risk-bearing providers for MA plans, because they have developed the capability to do that. So I think that the ACO work is really important. Thank you.

MS. KELLEY: David.

DR. GRABOWSKI: Great. Thanks, Dana.

Two brief points related to the D-SNPs. Point number one, I would like to see us really push moving forward for true integration and alignment. Most of the D-SNP enrollees are still in those coordination-only plans.

I agree with Eric's point from Round 1 that there's definitely blurriness with the three categories, but the coordination-only plans strike me as really falling short of what we'd all like to see for the dual-eligible enrollees.

So, moving forward, I'd like to see MedPAC either make recommendations or otherwise push to get more enrollees into more aligned and coordinated plans.

Point number two -- and Dana already made this point. So I'm going to be really brief here, but I also find the reliance on HEDIS measures to evaluate the D-SNPs unsatisfactory. I did a paper 10 years ago with some colleagues where we looked at HEDIS measures as applied to the D-SNPs. The results were all over the map then, and even today, the data Eric presented today, it's really kind of mixed.

It's a start, and I get why we're relying on it right now, but I hope in these two-year increments that MedPAC is kind of reporting on the D-SNPs that there's an evolution towards the CAHPS and the encounter data. I think we really need kind of a broader set of measures to evaluate these plans. I think if we continue to rely on the HEDIS measures, it's just going to tell the same story -- mixed story over and over again.

There are good reasons right now that Eric discussed about why CAHPS and encounter data weren't included in this round, but I hope going forward, they are incorporated.

I'll stop there. Once again, great work by the team and look forward to seeing the final chapter. Thanks.

MS. KELLEY: Larry.

DR. CASALINO: Yeah. Two quick points about coding going back to earlier discussions. One is I'll just reiterate that I think it's fine to talk about health risk assessments and chart reviews, but to ignore the fact that health plans actually -- Medicare Advantage plans actually pay physicians and in some cases pay a specific amount, like $20, to a physician for each diagnosis they can add, I think health risk assessments and chart reviews which is kind of a little bit esoteric to the average person on the street, but if you tell them their health plan is paying their doctor $20 for every diagnosis they can record for them, that would kind of shock them. So I think a little bit more attention to that issue in the chapter might be warranted.

The second point is quite different. Mike has made this point in the past, but I think it's an important one. It's important to distinguish between getting the diagnosis codes, the risk adjustment accurate, and what that means for payment of Medicare Advantage plans.

Ideally, Medicare Advantage plans should have as complete a list of accurate codes as possible because they

can use that at least in theory -- and some actually do -- to improve care for their beneficiaries, for their members. So there's nothing wrong with trying to get an accurate list of codes. Obviously, there's something wrong with doing that if it's got any for involved, but leaving that side, if we had a third party, say, to get an accurate list of codes for Medicare Advantage plans, that would be great.

But it wouldn't solve the problem of risk adjustment for MA plans based on the diagnosis codes in the fee-for-service world. There would still be this big gap between the diagnoses recorded in the fee-for-service world and the accurate diagnoses recorded in the MA plans, which would lead to MA plans being paid relatively more because of the way the payment is set. Any measures to try to make the MA plans recorded of codes as accurate as possible will still not solve the fundamental problem that there will be higher coding, as legitimate as it may be, in MA compared to fee-for-service, and that will lead to higher payments. That will lead to MA plans never saving money for Medicare.

So I think it's important to distinguish trying to restrict the plans to making the diagnoses accurate. That's not the same problem, as there will still be a gap

between fee-for-service and MA.

That's it.

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

DR. NAVATHE: Great. Thank you.

I'd like to make five, hopefully, relatively brief points.

The first point, thank you so much for this great report and the work. I'm very supportive of it, and I think it runs right into my second point, which is the Commission has already done a lot of great work on this, which I'm highly, highly supportive of and thankful for. Hopefully, we can continue to reiterate and reiterate and emphasize many of the points, where the Commission already has made great recommendations, and maybe we can drive some of those into practice.

The third point, kind of referencing, to some extent, my Round 1 question, I think it actually would be very helpful and effective if we could take some sort of estimation strategy to identify what are the core factors that are accounting for the discrepancy, if you will, between the performance of plans in terms of how much they're spending relative to average beneficiary and how

much the Medicare program or the federal government is paying.

I think it would help us to focus our efforts. I think there's understandably a lot of attention on coding. There's a lot of attention on risk adjustment. It strikes me, just from the back-of-the-envelope math that the benchmark piece and the statutory elements also have a huge role to play here. They're obviously over a decade old at this point, and I think while we've done some work on benchmarks on the bidding process perhaps, I think there may be some more work to be done on the fundamental structure of the ACA benchmark rates from the quartiles and such. So I think a top-down approach in some sense would be very helpful to help us focus our efforts.

Fourth point, I agree with Paul and others. I think a quick check would suggest that some of the higher counties with MA penetration now are exceeding 70 percent around the New York Metropolitan Area and Western Pennsylvania and other places. I think, in fact, we should really push hard on this point because it is identifying a core vulnerability of the way that we structure MA payments based on fee-for-service and that relationship.

Luis, Andy, and others, I think if we can actually do maybe some, for example, case studies of those countries to show the selection effects perhaps, the characteristics, spending patterns of the beneficiaries and how that's translating into what's happening in the MA world, that's basically a harbinger of what's to come, given the current trajectory. That's going to happen in more and more places. Those are real distortions. We have some case studies that we can do to actually illustrate what's happening there. So I think that would be well worth our time to put some effort in that domain.

A number five point, I think we've heard a lot about some concerns -- Larry articulated them -- around how coding is actually happening. I think there is some language in this in the paper, in the report around what the Medicare program does, the government does around auditing, for example, or other interventions. I would say if there is a way for us to be even more forceful on that piece, to do more effective auditing, as well as potentially tying some real penalties there, I think others have proposed ideas. I think the idea here is to make it very visible and create a strong behavioral response and

complement to some of the other ideas.

Thank you.

MS. KELLEY: Marge.

MS. MARJORIE GINSBURG: I'm not sure I'm asking for a response, but given the dominance of MA and the growing dominance of MA, isn't it time that we separate fee-for-service from MA price determinations or cost determinations? It's no longer feeling like this is as relevant as it obviously was at the beginning, and I have no idea whether MedPAC or anyone else has ever stopped to say it's time that we determine what the MA payments are going to be, but that has nothing to do with fee-for-service.

I know we can't -- I don't think we can ask MA plans to compete with each other and dump the high-price ones. I don't think we're allowed to dump them, but perhaps it's time we rethink or think about a new way to create what the payment mechanisms need to be that has nothing to do with fee-for-service.

Thank you.

DR. CHERNEW: So let me just say something quickly in response to that. A, Marge, yes, we were

continuing to think through that for both some sort of mathematical reasons but also policy reasons. In terms of doing that, the bidding, I'm not going to talk about them now. There's other ways of doing it through administrative benchmarks. We talked a little bit last session.

But because we're sort of overtime, I will stop there, and we'll move on. I think we have one more comment, and I think it's Bruce.

MS. KELLEY: That's right.

MR. PYENSON: Thank you very much. I'll talk as fast as I can.

I want to add my voice to some of the particular issues that others have raised, in particular, as Amol mentioned, a focus on the audit process, and it's described briefly in the chapter. If we can get into this chapter something about how obsolete the current RADV is by modern standards of audits, which of course could be done in a computerized format and perhaps some of the other audit techniques.

I want to compliment Brian on his idea that if there's a high portion of people who are coded with a condition but not treated, that's suspect and probably

identifies problems with in quality or coding; for example, lots of people coded with depression but hardly any treated.

Brian also had the idea of a velocity adjustment in addition to the risk score adjustment, where the velocity would be the increase in risk scores and to redistribute that among the plans, which would be more equitable.

Perhaps some of the current Commissioners will recall that several years ago, I had suggested that we move bidding to a two-year basis, and I think that there might be more evidence that that would make sense in the context of the findings of this chapter and the more than adequate growth of MA, that locking in beneficiaries, locking in bids, and risk scores and other phenomena like that for a two-year period would ease the administration and the chaos of the annual cycle but also do things to bring stability and less gaming.

Also, I want to lend my support to Paul's statement that it's time to revisit the impact of Medigap. It's been a number of years since the Commission has looked at that, and that impact of Medigap on benchmarks, I think,

is quite significant and is a part of what's funding the supplemental benefits.

Thank you. To the extent we can get all of that or some of that into this chapter, I'd appreciate it.

DR. CHERNEW: Thanks, Bruce.

We're going to break in a second. Let me summarize quickly, and before I do, in case I forget --

DR. PAUL GINSBURG: I have one comment, if you have a second.

DR. CHERNEW: Okay. We are, in fact, 20 minutes over, Paul, but --

DR. PAUL GINSBURG: Okay. Well, let me go quickly. You know, the point that Marge made about breaking the link between MA benchmarks and fee-for-service is very important. There have been proposals about how to do competitive bidding for MA only, and I'm an author of one of them. But I do think that there is so much more that we could accomplish in the near term by doing the administrative things that we've been doing that we really shouldn't lose our focus because there's a lot of potential here.

Thanks.

DR. CHERNEW: Thanks, Paul.

So I was going to say to those listening, please -- I imagine they have comments on the APM in this chapter. They can be sent to MeetingComments@MedPAC.com. So please do that. We really do want to hear your general comments or your specific comments for that matter.

My very quick summary in five bullet points are, first, there is strong Commission support for MA, and I hope that didn't get lost in a lot of the tone of this conversation. Two, I think there is a belief that Medicare Advantage plans can be more efficient that fee-for-service, and there's an understanding that those efficiencies can lead to added benefits, particularly for disadvantaged populations. We're quite aware of that, and we understand and believe that, in fact, it is important.

All of that being said, it remains problematic if the payment system, MA system overall, for whatever reasons, be it coding or other things, increases overall Medicare program spending, and so we have from last year an existing recommendation intended to help policymakers calibrate sort of what I will call the "benchmark benefit tradeoff," and just for people who are listening, we are

going to continue to do work to try and understand the value from those added benefits because it's really important that when we have added benefits that they actually provide value. And I think there's some concern that they're not providing as much value as the added benefits otherwise might.

So that's my summary. We are going to come back after what is now an abbreviated lunch and I would say a very rewarding morning set of sessions. We will be back at 2:00 to talk about Part D.

Jim, do you want to add anything?

[No response.]

DR. CHERNEW: All right. Then thanks, everybody. We will see you at two o'clock.

[Whereupon, at 1:22 p.m., the meeting was recessed, to reconvene at 2:00 p.m., this same day.]

AFTERNOON SESSION

[2:01 p.m.]

DR. CHERNEW: Welcome back, everybody. This is the last session of our January 2022 meeting. It is on the Medicare Part D program, for our status report, and I am going to, without further ado, turn it over to Rachel and Shinobu. Rachel.

DR. SCHMIDT: Good afternoon. Shinobu and I are here to present our annual status report on Part D, Medicare's outpatient drug benefit. This material will be a chapter in the Commission's upcoming March report. We would like to thank our colleague, Eric Rollins, for his help with this work. As a reminder to the audience, a PDF of these slides is available at the right-hand side of your screen.

In the interest of time, I'm going to touch on just a couple of points on this background slide. Part D provides Medicare beneficiaries with access to prescription drug coverage by using private plans that compete to deliver pharmacy benefits. Medicare subsidizes about 75 percent of premiums for basic benefits for all enrollees. The program was intended to have plan sponsors bear

financial risk for enrollee spending so sponsors would have incentive to manage benefits through formularies and through cost sharing.

Plan sponsors must be licensed to bear insurance risk, and most large sponsors are vertically integrated and own their own pharmacy benefit manager. Plan sponsors and their PBMs take part in a couple of sets of negotiations. One is with pharmacies, to set up networks and agree on payment rates for prescriptions and post-sale fees. The other negotiation is with manufacturers of brand-name drugs over formulary placement and post-sale rebates. Under current law, the Secretary is prohibited from interfering in these negotiations.

Today, the structure of Part D's benefit has plan sponsors bearing relatively financial risk in certain phases of the benefit. Part D now actually has two standard benefits, one for enrollees without low-income subsidies, on the left, and another for those with the LIS, on the right.

Focus if you will on the blue parts of the bars. Those are the portions where plan sponsors bear financial risk for enrollee benefits. You can see that for either

case, plans don't bear much risk in the coverage gap or in the catastrophic phase above the out-of-pocket threshold where Medicare pays 80 percent of costs.

There are other problems with this benefit structure, but relatively low plan liability for benefits undermines plans' incentives to manage spending. At the same time, plan sponsors and their PBMs collect rebates from drug manufacturers that can be larger than their benefit liability.

The total amount of rebates and post-sale fees that plan sponsors and PBMs negotiate from manufacturers and pharmacies has grown rapidly. You can see that in 2007, it made up less than 10 percent of the aggregate amount of Part D prescription spending, but by 2020, it was about 28 percent. Plan sponsors use rebates and pharmacy fees primarily to offset drug spending that they would otherwise be paid with premiums, so enrollees benefit because it keeps their premiums lower. However, enrollees who pay coinsurance are paying a percentage of the higher gross price at the pharmacy. For Part D, when we looked at the average price of all brand prescriptions over time before and after rebates, rebates haven't restrained growth

in that average price by very much.

Over the next few slides, I want to point out some notable trends. First, in 2021, Part D's enrollment of about 48 million and was split pretty evenly between stand-alone prescription drug plans and Medicare Advantage drug plans, which is a dramatic shift from the start of the program. You can see in the orange line how over time Medicare Advantage drug plan enrollment has grown steadily, consistent with more rapid growth in Medicare Advantage enrollment than in fee-for-service Medicare.

This movement is also true for low-income subsidy enrollees, who used to be predominantly in fee-for-service Medicare and in standalone PDPs. The blue line shows the share of LIS enrollees in Medicare Advantage drug plans. LIS enrollment has increased dramatically as MA-PD plan sponsors have offered more generous drug coverage and introduced special needs plans geared toward dually eligible beneficiaries.

In 2021, the overall Part D mean monthly premium declined by 3 percent to $26. That is an average across all types of plans including both PDPs and MA-PDs. Part D premiums have stayed within a few dollars of $30 per month

since about 2010, but the overall average hides a lot of variation.

An important thing to remember is that Medicare Advantage drug plans can use part of their Part C payments to reduce Part D drug premiums. So in 2021, MA-PD enrollees paid an average Part D premium of about $15 per month, but got an additional $40 worth of pharmacy benefits monthly beyond their Part D premium. Meanwhile, PDP enrollees paid an average of $38 per month.

For 2022, plan sponsors are offering 7 percent more MA-PDs and a whopping 19 percent more special needs plans over the previous year. Those new plans more than offset a 23 percent drop in the number of stand-alone PDPs. The sharp decline in PDPs and in PDPs that are premium-free to low-income subsidy enrollees is due primarily to mergers that have taken place among plan sponsors, along with CMS's rule that a plan sponsor can only offer 3 PDPs per region. Nevertheless, each region still has at least four benchmark PDPs available to LIS enrollees.

Another notable trend is that the small share of enrollees who reach Part D's catastrophic phase has been accounting for a growing share of overall prescription

spending. The blue line at the bottom shows that over time, about 8-9 percent of enrollees has reached the catastrophic phase. The orange line shows all drug spending for those individuals as a share of gross Part D spending. You can see that over time, that share has grown, making up over 60 percent by 2020, so overall Part D spending has gotten more concentrated among high-cost enrollees.

From the perspective of plan sponsors, this affects how they bid. Remember that Medicare covers 80 percent of costs in the catastrophic phase, so as high-cost enrollees account for more of the spending, sponsors expect more and more of their payments to come from Medicare's reinsurance instead of enrollee premiums and capitated direct subsidy payments.

In the chart on the right, the orange parts of the bars show how much plans thought they would get in cost-based reinsurance payments when they bid, while the blue and gray parts reflect premiums and capitated payments. You can see how reinsurance has grown and the direct subsidy in gray has declined. In fact, in 2022, the national average bid suggests that Medicare's average

capitated payment to plan sponsors is just $5 per member per month, compared with about $93 per member per month in expected reinsurance.

And now Shinobu will describe in more detail how this catastrophic phase changed for 2020.

MS. SUZUKI: In 2020, the statutory increase in the annual out-of-pocket threshold increased spending in the coverage gap. The out-of-pocket threshold increased by $1,250.

From beneficiaries' perspective, the higher out-of-pocket threshold does two things. First, it delays the point at which an individual reaches the catastrophic phase. You can see this in the line at the top. This shows the estimated average gross spending at the out-of-pocket threshold. In 2019, an enrollee with an average mix of brand and generic drugs would have reached the catastrophic phase at about $8,100 in gross spending. That amount rose to over $9,700 in 2020.

Second, it increases spending in the coverage gap where those without the low-income subsidy pay 25 percent coinsurance. For an average non-LIS enrollee, total gross spending in the coverage gap increased from about $4,300 in

2019, to nearly $5,700 in 2020.

The higher out-of-pocket threshold and the longer coverage gap phase does not appear to have affected the overall prescription drug use among beneficiaries without the low-income subsidy. For example, preliminary data for 2020 shows that per capita prescription drug use grew at a rate comparable to those observed during the previous five years. It also appears that many non-LIS enrollees continued to fill brand-name drugs in the coverage gap, with total payments by manufacturers for coverage gap discounts rising by 25 percent.

As expected, fewer enrollees reached the catastrophic phase compared with 2019. But the number of high-cost, non-LIS enrollees was higher than in all years prior to 2019.

Finally, based on the higher threshold, about 443,000 enrollees filled at least one prescription for a high-priced drug that was sufficient to reach the catastrophic phase with a single claim. That was fewer than in 2019, but still a substantial increase compared with just 37,000 in 2010.

The steep rise in the out-of-pocket threshold

changed Medicare's aggregate program spending in notable ways. Focusing first on the rows highlighted in red, reinsurance grew more slowly in 2020, 3.7 percent compared with an average growth of nearly 16 percent in prior years. This is because higher out-of-pocket threshold delays the point at which beneficiaries reach the catastrophic phase. It also means higher spending in the coverage gap.

As you saw earlier, spending in the coverage gap is paid primarily by Medicare, manufacturers, and non-LIS enrollees. For low-income subsidy enrollees, Medicare's cost-sharing subsidy pays for nearly all of the costs in the coverage gap. As a result, in 2020, low-income subsidy payments grew by more than 11 percent.

Finally, direct subsidy payments, which are the capitated payments to plans, have been decreasing for a number of years. In 2020, those payments decreased by 13.6 percent. There are multiple factors that have contributed to this decline, including features of Part D law and regulations.

Medicare's subsidies help Part D enrollees afford their medications. In the most recent survey, over 80 percent said they were satisfied with their plans and

reported having reasonable cost sharing. However, for individuals without the low-income subsidy, percentage coinsurance on high-priced drugs and biologics may make them unaffordable.

In 2021, CMS's Center for Medicare & Medicaid Innovation began testing a model to cap cost sharing for select insulins at $35. The $35 cap could improve access to insulins. However, it does not address the structural issues that have contributed to high insulin prices.

In addition, as prices continue to rise for many existing and newly launched products, more individuals will likely face affordability issues.

Finally, we need to balance access with giving plans tools to effectively manage drug use and spending.

In 2020, average drug prices continued to grow more slowly than in prior years, growing by 2.6 percent, compared to a growth of nearly 5 percent annually before 2019. The moderate price growth is largely due to the decline in prices of generic drugs, with a consistent and negative trend through 2020, and because Part D enrollees have embraced their use.

However, generics' share of prescriptions has

plateaued at about 90 percent since 2017, and low generic prices may be less effective at restraining future price growth. Prices of brand-name drugs are much higher today. It averaged 38 times that of generics in 2020, up from about 6 times in 2007.

In addition, generic or biosimilar alternatives may not be available because a significant portion of brand prescriptions are protected from competition through longer periods of market exclusivity, extensive patent protection, or both. As a result, inflation in prices for brand-name drugs and biologics will likely continue to drive spending upward.

Going forward, use of biosimilars, in addition to generics, will be key to controlling spending growth. However, Part D faces multiple challenges in creating effective biosimilar competition.

One major challenge relates to formulary incentives as post-sale rebates may distort plans' formulary incentives to prefer reference biologics with higher prices. For example, Part D plans have been slower to cover follow-on versions of insulins, lagging Medicaid in their uptake by more than 30 percentage points in 2019.

Another challenge relates to the extensive patent protection that continues to delay entry of biosimilars in retail pharmaceutical sector. For example, under the agreement reached between biosimilar manufacturers and AbbVie, the manufacturer of Humira, seven FDA-approved Humira biosimilars will not launch until at least 2023.

Finally, manufacturer tactics may reduce market for biosimilars even before they launch. For example, a new formulation of Humira was launched in July 2018. The product has rapidly gained market share, and by 2020, accounted for 61 percent of all Humira products sold under Part D.

As Rachel discussed, there has been a rapid growth in post-sale rebates and pharmacy fees. This focus on rebates and discounts contributes to misaligned formulary incentives. This happens because Part D's structure allows plans to benefit from high-priced drugs with rebates.

Part D is unlike other insurance in that, for such drugs, costs are mostly borne by Medicare, brand manufacturers and enrollees, while rebates disproportionately accrue to plans. That means post-sale

rebates and fees contributes to the decline in plans' share of benefit liability, for which they are at risk.

Plan's benefit liability was less than 37 percent in 2020, down from 75 percent in 2007. At the same time, in 2020, two-thirds of the wholesale rebates was used to offset plan liability, which can contribute to profits above and beyond those reflected in their bids.

The trends in program cost and access highlight two main issues in Part D: the decline in plan's insurance risk and the increasing role of drugs with very high prices. In 2020, the Commission recommended changes to restructure Part D. To address distortions in plan incentives the recommended changes would eliminating the coverage gap discount and increase plan liability.

To address issues of high prices and access, the recommendations would create a new manufacturer discount and providing a complete insurance protection in the catastrophic phase. Those changes would also reduce plans' reliance on cost-based reinsurance and improve incentives to manage benefits.

We are interested in your feedback regarding the mailing materials and would be happy to answer any

questions you have.

In April, we have two sessions related to Part D. In one session, building from his presentation last fall, Eric will be back in the spring to discuss PDP market segmentation. In another session, we plan to report initial findings from our analysis of the DIR data and other pricing data we gained access to last year.

With that we'll turn it back over to Mike.

MS. KELLEY: Yes. I have just one person in the Round 1 queue, so do let me know if you want to be added to the list. The one person I have is Amol.

DR. NAVATHE: Yes. Thank you.

In the paper on page 26, I had a question about a performance metrics between the plan sponsors and the pharmacies, and specifically, the paper reads: In Part B, plan sponsors use additional contract provisions that require post-sale recoupments from or payments to a pharmacy or group of pharmacies for meeting certain performance metrics. I was curious. Do we have a sense of what those performance metrics are, what examples might be?

DR. SCHMIDT: They have to do, we think, with things like rates of generic dispensing and so forth.

However, it's not entirely clear, and this is actually the start of the first year in which CMS has required plan sponsors to start reporting to them what those metrics are that they're using. This has been an area of a lot of contention between pharmacies and participating plans with some types of pharmacies in particular, independents and specialty -- smaller independent specialty pharmacies, very concerned about the metrics that are being used and the dollar amount of recoupment.

DR. NAVATHE: So, given that they're requiring them to be reported, does that mean that they're going to be publicly available?

DR. SCHMIDT: It's not entirely clear yet. I know that PQA is working to develop some consensus measures within all of the stakeholders, I believe, as much as they can do so, to try and get some consensus on what to measure, what's suitable for everyone's purposes.

We certainly hope that CMS will publish what those measures are, and we're happy to talk to them about it.

DR. NAVATHE: Great. Thank you, Rachel.

MS. KELLEY: Okay. Are we ready to move to Round

2, Mike?

DR. CHERNEW: It looks like it.

MS. KELLEY: Great. Then we can start with Stacie.

DR. DUSETZINA: Thank you, and thank you for such a great chapter. It's always my favorite and even more so this year.

So I had a couple of comments that I wanted to make about specifically where we start in the chapter talking about prices and being really cognizant about whose price, who the payer is, and I think, in general, you've all done a really good job. But there are a couple of places where I think we'll need to emphasize list price when we mean list price, just to make sure that we don't face a lot of criticism about not acknowledging the rebates in some of the contexts. But, in general, I think it's very well done.

I think in the case of biosimilars, there are a couple of papers that I plan to send. One that I just saw that really walks through how the dynamics work really differently in that market, the authors look at Part B-covered drugs, but I think the dynamics are going to be

working pretty similarly where some products -- the reference produce is actually being very aggressive at lowering their price, their net price and/or their list price, and others where they're not. So I think that adding a little bit of context about how complicated this area is and how it's really maybe not going to function the same way as traditional genetics is going to be great, and I think you have a lot of that already there. So I'll just kind of send a reference along on that piece.

You know, I think in that case, there is some more nuance that's probably needed around this issue of Medicare and payers and what they should be doing, picking drugs that have higher list prices, but potentially and most likely lower net prices, especially given the dynamics of the Part D benefit and the coverage gap discount.

We've done some work showing that rebates could be very, very low and would actually make the higher list price drug more attractive and more financially viable for Part D for the plans and for the Medicare program, not for the beneficiaries. So I think that there is kind of this who is penalized versus who is not penalized.

And I think encouraging us to move into a space

where Medicare and the plans are paying as low as they can but not disadvantaging the beneficiary at that point -- so, you know, we want the plans and Medicare to get the lowest price. We want the patient to not have a financial burden associated with that.

Just a couple more things. I think in the insulin example in the biosimilars piece, I really love the comparison to Medicaid, but I also think that we might want to add a note about the interchangeable status of biosimilars and how that might make a big difference because we have an interchangeable insulin that's now coming into the market.

And I think it would complement so nicely the product-hopping example you give for Humira, when we could talk a little bit about the automatic substitution laws and how they typically help so much with generic adoption.

Okay. Final thing, I think that throughout the whole chapter, it's very clear why the reform is so needed both from the beneficiary standpoint but also from the whole system's standpoint. You all do such a lovely job of showing how the plans have so little responsibility over time relative to what Medicare is spending.

And one more last thing. That wasn't my last thing. My last thing is also really excellent job of emphasizing this issue around the catastrophic phase. That huge amount of additional spending required to get people there, I think you did a nice job of highlighting how many fewer beneficiaries reached it, but that that was more because of the mechanisms of the spending required and not because we don't have a problem with high spending.

Again, loved the chapter. Thank you very much, and thanks to the Commissioners who jokingly ceded their time to me for this session.

MS. KELLEY: Okay. Lynn, I have you next.

MS. BARR: Thank you. Excellent chapter and fascinating.

I'm very upset, obviously, about the cost burden to the Medicare beneficiaries in Part D and have been working with our rural communities to create -- to begin passing through the 340B discounts to their Medicare beneficiaries so that we can ensure that they can afford their drugs and are up against all kinds of regulatory hurdles to do so.

So my comment is we do have the 340B program that

can help a lot of low-income people. It would be wonderful to have regulatory guidance that says if you do the program like this, you're good, because we're spending a lot of money on lawyers. And the risks of providers actually providing these drugs for free versus the rewards for them and the potential penalties from CMS are making this very, very difficult to pull off.

So that's my comment is it would be very helpful. There is something we can do outside of fixing the program that might actually be something we could do quickly, which is to clarify the rules where 340B providers can pass on the discounts to beneficiaries without penalty.

Thank you.

MS. KELLEY: Bruce.

MR. PYENSON: Thank you again for a terrific chapter.

I appreciate Stacie's comment about biosimilars but want to caution against looking at the status quo in Part D is inevitable. Biosimilars have played an impressive role in other countries where wholesale shift to biosimilars has occurred and actually expanded access in the context of restricted budgets.

Likewise, certain biosimilars in the commercial space have grown dramatically in certain circumstances. So I know there's been some prominent voices of skepticism about biosimilars saying that they would have limited impact. However, I want to make sure that that's not reinforcing the status quo.

Many of the changes that MedPAC has proposed, I think, would break the value of rebate compared to lower net price. So I would urge some recognition of the different dynamics in the commercial world and the explosion of biosimilars in other countries.

MS. KELLEY: Brian.

DR. DeBUSK: First of all, thanks to the staff on the chapter, and, Stacie, I really enjoyed your and Bruce's comments.

In reading the chapter, I was doing a little envelope math along the way. When my comments are finished, any from the staff are welcome to correct me, but it looks like 2020 had around $200 billion in gross spending, and assuming about a 26.5 percent rebate overall means there's about $53 billion in rebates. But 80 percent of the spending is on branded drugs, and on page 27, it

said about one-third of the brands were the only ones that had more than nominal rebates. So, again, envelope math here, it looks like there's about $50 billion worth of rebates trying to chase around $50 billion worth of branded drugs.

So, when we look at the actual impact or the power of rebates, as best I can tell, it's about a one-to-one ratio of these rebates that are offset, that are artificially distorting the process of these drugs, and with that, I would say I really hope that we can glean some insight from this rebate information that we've recently gotten. I wish Jim and the staff nothing but the best of luck with that data.

When it comes to trying to address rebates, because I do think -- I mean, considering how they're growing and considering how they do disrupt price signals, I think they have to be addressed. I think there's really two tactics. The first one is creating mechanisms that provide drag on the rebates, and I really want to compliment the staff and the Commission. The 2020 recommendation that included restructuring the catastrophic phase, those cap payments that were funded by the

manufacturers, tying them to the counter price, I think, was absolutely brilliant. And I hope that we can connect those dots a little bit more clearly in the chapter because by using the counter price instead of the net rebated price to calculate those cap payments, we're basically taxing, if you will, the rebates along the way.

I think also, at some point, MedPAC will have to address the safe harbor around fees, discounts, and rebates. I mean, up until this point, there's been this false dichotomy that rebates were either good or bad or we were going to have almost all of them or almost none of them. And I think that this Commission is very well suited to dig in and try to help the Congress and help policymakers differentiate good rebates from bad rebates because, again, I see a rebate in exchange for a brand placement on a preferred branded tier. That sounds appropriate, but the same discount on a brand in exchange for not even including a competitive brand on the formulary, to me, that doesn't seem like an appropriate use of a discount. So I do think we're going to have to get into calling balls and strikes here and try to provide some insight into particularly stipulated rebates, rebates with

strings attached, and I think there's a lot of opportunity for this Commission to really set the record straight and help policymakers going forward.

Thank you.

DR. CHERNEW: Dana, that was the end of the queue that I saw.

MS. KELLEY: Yeah, that is the end. We can just pause to see if anyone else --

DR. CHERNEW: I will say a few things while I pause to give some people some time to jump in.

The first one is that really is an outstanding chapter, and I'm moderately familiar with it. Every time I read it, it still amazes me, the complexity and all the things going on.

To summarize, I think Stacie said a lot of this. High list prices are problematic but largely because they increase patient out-of-pocket spending, and they move people quickly to the catastrophic phase, which is problematic or program spending. But as a measure of overall spending, net may in fact be better in varying ways, and understanding if the plans are rational, I think there are incentives. I think, Stacie, you said this or a

little bit perverse, that the ideal thing from a plan point of view potentially could be a high list price but a low net price. And that makes -- whether that's true or not is beside the point. It makes how we show list prices and how we interpret them in the chapter complicated, and I think it's important to understand.

The second thing I think it illustrates to me is the reinsurance part becomes problematic because the incentive to get through the reinsurance part is part motivated by the generosity of the catastrophic phase, and so that, in my mind, speaks to one of the values of the recommendation in 2020, which by the way was before my time as chair but was outstanding work.

The other thing that struck me about the chapter was really -- I think it was Slide 6 -- I'm not sure; I don't remember -- which is that the program is increasingly becoming a Medicare Advantage program, and there's some unique things going on in Medicare Advantage, some different incentives in Medicare Advantage, both in terms of how they manage the interplay of formulary, how there's a VBID demo in Medicare Advantage that allows them to do some really interesting things for product care

medications, for example. So I think going forward, I think that's just a useful thing to keep our eye on, which for those listening at home, just so you know, we are.

The last thing I'll say and I just think it's important to say, we spend a lot of time -- I think the policy folks a lot of time are worrying about high pharmaceutical prices. I certainly a lot of time worry about high pharmaceutical prices, and in fact, we have a separate workstream on high prices in Part B. So I don't want anything I'm about to say to distract from the concern about efficient pricing. That said, I do think we have to acknowledge the real value of many of the type of these new medications that are being developed, and I think there is this tension that we are, in some ways, both blessed and cursed with the innovation that we have been blessed with and cursed with, I guess. If we didn't want access to these medications, we wouldn't agonize so much about making sure that they could be afforded, and that tension makes this a particularly challenging area.

So there's a lot of places I call sometimes in nooks and crannies that we have to work in, but big picture, I think our goal is to make sure that

beneficiaries have access to the ever-growing array of high-value medications, may they be in Part D or Part B.

That was basically meant to take time so Stacie could chime back in if she had one more comments, and so, Stacie, to do that, good job, Stacie. You're back up.

DR. DUSETZINA: I just had to have the last word, I guess.

I had one other note that I decided I would table originally, and it was just on the part of the chapter that talks a little bit about the insulin demonstration project, the senior savings model. It strikes me that in absence of Medicare Part D reform, which I do think we need desperately for many reasons, it is a nice opportunity to think about opportunities where we have high rebates. We know this. There's a lot of head-to-head competition, and where we want to disconnect what the beneficiary pays from what the list price of the drug is, I think that type of model, if it works well to improve adherence for beneficiaries, is maybe a good one for thinking about other chronic disease areas where we have head-to-head competition, where we may want to do the same thing. So plans still want to get those large rebates, but we want to

make the beneficiaries' cost lower and more stable.

I do think there are lots of unanswered questions there. What happens to the list price for uninsured people in the country when we've effectively made it not really matter to a large group of people? Also, what happens to the role of competition? If everything is a $35 co-pay and all the plans offer the same, you know, every insulin, the biosimilars, the interchangeable biosimilar and other brands at $35, then we don't have a way to steer people to a most cost-effective option. So I think we've got a lot to learn there, but I really appreciated that being in the chapter. It just kind of -- it's one of those things.

I will say the other thing, the comment that Michael made about the MA plans, it also made me wonder with these types of models, you know, the senior savings model is running under enhanced MA plans, and MA plans are likely to be enhanced. PDPs are less likely to be enhanced. There are a lot of people who are in non-enhanced PDPs. So they wouldn't necessarily have access to this model.

One of the things I wonder is when we create models like this, are we pushing more people towards MA

plans because that's the way you get into the $35 insulin plan? So I think it's just something we'll have to keep an eye on.

That's my last word.

DR. CHERNEW: Okay. We are now going to see if that is, in fact, the last word.

Do you want to add anything, Rachel or Shinobu?

[No response.]

DR. CHERNEW: The little square with your little head is saying, "No, you don't."

Again, I will take a second to say to the audience that we really do want to hear your comments. You can go to MeetingComments@MedPAC.gov, or through the website, go to the public meetings, past meetings, and you'll see how to send a message. We would very much like to hear your feedback on this and the topics this morning.

I think Brian alluded this. We do have access to rebate data now, and we're in the process of processing that data. I will try not to read that sentence in the transcript. In any case, it will undoubtedly be important for us to get a better insight as to what's going on in the rebate system. It is actually a really big deal, and I

think it's quite exciting that we'll be able to look at that. So I am very much looking forward to that.

Other than that, I actually have nothing to add. I do encourage our audience to read the June 2020 Part D recommendation. I think it's outstanding, and we'll go from there.

So going once, going twice?

[No response.]

DR. CHERNEW: Everybody have a safe and happy weekend, and we will see you again in March. Thank you all, the staff and the Commissioners, for what was a very productive set of discussions today and yesterday.

So I'm signing off. Jim, anything to add?

DR. MATHEWS: No. We are good.

DR. CHERNEW: All right. Thanks, everybody.

[Whereupon, at 2:41 p.m., the meeting was adjourned.]