MEDICARE PAYMENT ADVISORY COMMISSION

ONLINE MEETING
VIA GO-TO-MEETING

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12:36 p.m.

COMMISSIONERS PRESENT:

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AGENDA PAGE

P R O C E E D I N G S

[12:36 p.m.]

DR. CROSSON: Okay. Eric, you have the microphone.

MR. ROLLINS: Great. Thank you.

Good afternoon, or good morning, for some of you. For the first session today, we're going to talk about MedPAC's vision for payment and delivery reform in the Medicare program. The Commission has discussed this issue on a number of occasions over the last 12 to 18 months, using an outline that was developed by the Chairman. What we've tried to do here is synthesize the views that Commissioners expressed during those discussions and flesh them out some. The material from this session will form the basis for the opening chapter of the June report. Our goal today is to get your reactions to the draft chapter that was included in the mailing materials and your suggestions for any additional changes.

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All of you are well aware that the growth in Medicare spending poses a significant challenge for the federal government. We discussed this spending growth in

the context chapter in our March report, and the mailing materials highlighted some key points from that work. Between 2018 and 2027, Medicare spending as a share of GDP is expected to increase from 3.6 percent to 4.7 percent. About 70 percent of this growth is due to higher per capita spending, which is driven more by growth in payment rates than by growth in service use. At the same time, the aging of the population is making it more difficult to finance the program.

The Commission contends that policymakers will need to address this unsustainable trend by developing new payment and delivery models. Given the size of the financial challenge that Medicare faces, these models will need to produce substantial savings if they are going to have a meaningful effect on the program's financial situation. A common element for these new models should be the use of value-based payment, or VBP, which is a term used to describe methods of paying for health care services that provide stronger incentives to control costs than fee-for-service while maintaining or improving quality.

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Commissioners have expressed interest in a

multiyear effort to strengthen and expand the use of VBP in Medicare. Our work on this issue will be guided by the same fundamental principles that serve as the foundation for all of our policy development: ensuring that beneficiaries have access to high-quality care in an appropriate setting, paying providers equitably and giving them incentives to supply efficient and appropriate care, and assuring the best use of the taxpayer dollars that finance most of Medicare's spending. In particular, the Commission will seek to identify policy changes that encourage more providers to accept accountability for both the cost and overall health of a group of beneficiaries. This accountability would include attention to the quality of care, the provision of preventive services, the avoidance of waste, and the delivery of care at the most appropriate and cost-effective site of service.

Commissioners have indicated that the Medicare Advantage and ACO programs could provide a foundation for the broader use of VBP. These payment models currently cover almost two-thirds of beneficiaries who have both Part A and B, and they have stronger incentives to manage overall spending than traditional fee-for-service.

However, both programs need to be improved before they can realize their potential. For example, MA has always been more expensive than fee-for-service due to the way that Medicare sets plan payment rates, and the savings from ACOs have been fairly modest. If these programs are going to have a meaningful effect on Medicare's financial sustainability, they will need to produce much larger savings than they do now. The MA and ACO programs have already been a priority for the Commission and have been the focus of multiple presentations during this meeting cycle. Later today, you'll vote on draft recommendations that would create a new MA Value Incentive Program and modify how ACO benchmarks in the Medicare Shared Savings Program are calculated.

The Commission plans to conduct more work in the future to identify specific policy changes that improve the MA and ACO models. For example, in MA, we may examine issues such as the benchmarks that help determine plan payment rates and the risk adjustment system. For ACOs, Commissioners have discussed ways to make beneficiaries more engaged, whether there needs to be better integration between ACOs and other new models such as bundled payments

for episodes of care, and whether ACOs should have incentives to manage the use of outpatient prescription drugs.

This work may also include issues that are outside of the scope of the current ACO and MA programs. For example, we may consider whether Medicare should pay hospitals using global budgets that cover all of their inpatient and outpatient services.

Some Commissioners have said that the development of new payment and delivery models needs to accelerate. The traditional fee-for-service approach has an inherent incentive for providers to deliver more services and thus receive more payments; there is significant variation in quality and outcomes; and coverage for activities that are not directly related to a service, such as care coordination, has often been limited. However, fee-for-service has had some success at constraining spending growth through its use of administered prices, and efforts to broaden the use of VBP should be careful to avoid undermining this feature.

Medicare has taken numerous steps to reduce the basic fee-for-service incentive to provide more services

through initiatives such as the creation of bundled payment rates such as DRGs for hospitals, the use of capitated payments for health plans, and the development of ACOs. There have also been numerous efforts in recent years by the Congress, CMS (most notably through the Center for Medicare and Medicaid Innovation), and the private sector to develop new payment and delivery models, but these efforts have had relatively little impact on the average beneficiary. For example, we discussed last fall how evaluations for most of CMMI's models either have not been completed or have found that the model did not have a significant impact on cost or quality. So far, only two CMMI models have met the criteria for expansion.

Medicare has used a fee-for-service model to pay for services throughout its history, and it still plays a central role today, even in the MA and ACO programs. For example, MA benchmarks equal a percentage of fee-for-service spending and plans use fee-for-service rates to pay out-of-network providers. ACO benchmarks are also tied to fee-for-service spending and the vast majority of ACO providers are paid on a fee-for-service basis.

Nevertheless, based on your discussions, it's our

sense that the Commission contends that, to the degree feasible, Medicare should transition from paying providers using fee-for-service to paying providers through "accountable entities" that have incentives to control overall costs and improve quality while still providing appropriate care. The development of these entities could also facilitate other beneficial changes in the health care delivery system, such as better care coordination among providers, efforts to address the non-medical needs of beneficiaries, and the use of new technologies. Both beneficiaries and providers should have incentives to participate in these entities. These entities should also pay individual providers in ways that support value-based payment, such as the use of upside and downside financial risk.

That brings us to the discussion. In this presentation, we have tried to synthesize your views on the Commission's work on payment and delivery reform, building on the outline that the Chairman developed and that you have discussed multiple times. We'd now like to get your feedback on the draft chapter and your suggestions for any revisions to the text. In particular, we'd like to know if

there are any additional topics or areas that you think the Commission should consider in the future as it works to realize its strategic vision.

Thank you.

DR. CROSSON: Thank you so much, Eric, not just for the presentation but for all the work that you've done over the last number of months to get this draft chapter put together and, as you've mentioned, reflective in general of the comments, discussions, and in many cases desires of Commissioners as expressed over the last year or so.

Now we'll turn to one round of discussion. We're not going to have a Q&A discussion per se, but, of course, if you do have a question, you can incorporate that into your comments. And as Dana mentioned before, when you want to comment, send her a note in the chat box, and now, Dana, you can start from the top and we'll have a discussion.

DANA KELLEY: Okay. Kathy, you're up first.

MS. BUTO: Thank you. And, Eric, thank you so much for putting this chapter together. I think it's really important. I think it describes really well the work that the Commission has done to date and some

aspirations about further improvements.

I'd like to see or suggest that we look at, going forward, the bigger picture of are we aiming to make not just fee-for-service evolve more to an accountable system, but really put the existing payment systems -- fee-for-service, ACOs, and MA -- on a comparable footing so that we can -- beneficiaries even as we transition toward more accountable systems -- have a way to compare them within their area. So something that's a little more proactive about moving in that direction.

I think the Commission has already done a lot. For example, we have consistently worked on improving the population-based quality measures of value across all settings. We've also done some work -- it's been a number of years now -- comparing how fee-for-service, ACOs, and MA perform in different geographies around the country.

I think that it would be good to have a section that talks about what's next to how do we go beyond that to potentially getting away from a legislated MA rate-setting and benchmarking system to something that's more competitively bid or priced alongside fee-for-service and ACOs, maybe some opportunities for more beneficiary skin in

the game. There may be areas -- I think we've already identified home health, but there are other areas where beneficiary skin in the game is really important. And we've also touched on over the years the role of Medigap in fee-for-service.

So I think I'd just go the next step of suggesting some other areas that could sort of break this open a bit more. And then I would really love to see at least a challenge out there about continued innovation in Medicare. For example, service delivery differs so much from area to area. At times Medicare has sort of toyed with the idea of letting area health delivery systems get together and manage, whether it's all-payer or with Medicaid or employer-based, a broader set of sort of health system changes that would improve health across the board from the time somebody's employed or even childhood all the way through Medicare. So I think some notion of that next, you know, horizon of innovation.

The other thing I just want to mention is there are so many root cause conditions in Medicare like diabetes, mental health issues, that drive costs, and we've never done a good job in Medicare of developing models to

really focus more, target more, better management of those conditions, and they are longstanding in Medicare. So, again, some degree of innovation or experimentation that would advance that kind of work is something I think Medicare can do more aggressively, not just focus on payment but focus on the beneficiary and improving overall care.

And then the last thing I'll mention I was going to mention in executive session -- and I don't know that it belongs here, but it's something I hope people will discuss going forward -- is I think Medicare needs an investment fund. We need a fund that will fund research, whether it's on those kinds of conditions I just mentioned or whether it's to help contribute to a better system of developing flu vaccines going forward. Flu is obviously something that affects our population to a greater extent in many cases than the rest of the population. So something that's a little more proactive in the research area or in the area of service delivery would be really, I think, a breakthrough for Medicare, where Medicare takes some responsibility for whether it's partnering with NIH or CDC or even FDA to advance treatments in a way that really will

serve the population.

Thank you.

MS. KELLEY: Brian, you're up next.

Brian, you'll need to turn your mic on. There you go.

DR. DeBUSK: Can you hear me now?

MS. KELLEY: Yes, we can.

DR. DeBUSK: Okay, great. First of all, Kathy, thank you for your remarks. I categorically agree with what you said. So many of the things that you mentioned I wanted to touch on.

Eric, wonderful chapter. I was really, really excited to read the chapter, and I think you really touched on so many things that we can build on going forward.

Just a couple things that I do want to mention. Kathy, I really appreciate what you were talking about, trying to bring more of a competitive element into this, and I think that would be important as we try to decouple from fee-for-service, at least partially decouple, because I do think fee-for-service will be around as a way to measure productivity. But I'm really excited about the idea of moving away from fee-for-service as a way to

determine the aggregate level of payment.

So, again, really exciting, and one thing I would propose -- and I don't know that it's ready for this chapter, but there are elements that we may want to bring to ACOs. For example, would you want an ACO benchmark to be developed by some type of competitively bid mechanism? I know it sort of has the specter of premium support and some of the things we've talked about before, but there may be some technical things that we could do with ACOs to help them, for example, with their attribution. You know, maybe prospective attribution isn't the answer. Maybe we need to go straight to attestation and incorporate some of that -- whether they attest or not and which ACO they attest to, the Part B premium, or go back and revisit Medigap. I don't think there's a wrong answer there, but I think as long as we bring MA and ACOs -- as we harmonize them and build them out as vehicles to maintain health, not as vehicles to just deliver services, I think it's really, really exciting. Again, I love this chapter.

The other thing that I do want to mention, I really like the way we touched on engaging on how providers are paid. I really think that that's going to be an

important element of this, too. I think there are some more progressive methods out there for paying providers, and I also think there's some very regressive methods. And I think a lot of that's going to be tied back to how dependent they are on the fee schedule.

So wonderful chapter, wonderful vision. I cannot wait for the retreat at this point. Just a fantastic chapter. Eric, extremely well done. Thank you.

DR. CROSSON: Thank you, Brian, and thank you, Kathy.

Let me just pick up on this because I'm already detecting kind of two strains in the discussion here. One has to do with, you know, in this particular chapter I have a comment about -- and here a substitute comment about we ought to do it this way or a little differently. The second part, which is equally or perhaps more important, is as we continue to evolve this work, as both Kathy and Brian have mentioned, you know, here are issues that we need to take on that are perhaps not fully baked into this chapter yet, but definitely serve as priorities for future Commission work.

So to the extent that in your comments you can

try to distinguish between those two things, I think that would be helpful.

MS. KELLEY: Okay. I have Marge, Bruce, David, Dana, Amol, Jon Perlin, Larry, and Jaewon. Let me know if somebody else wants to jump in. Go ahead, Marge.

MS. MARJORIE GINSBURG: Okay. I just unmuted. So I'm in the category Jay was just referring to where I'm talking specifically about this chapter and the promise of value-based payment. So, anyway, like the others, I was very energized by reading this and very excited about it.

I have several different questions, and I think what I'm going to do -- questions or comments. I'm just going to -- there aren't that many -- lay them out and then maybe get some response afterwards.

So the first one is on page 3, the first paragraph. It says, "Our first step is to improve existing ACO models." So I want to really go out on a limb -- and I may be the only one to propose this, but I think our first step would actually be to fulfill the expectation of MA plans, that they deliver higher-quality care at lower cost to taxpayers and beneficiaries. So I just talking with we really haven't gone far enough. We've gotten great steps

moving forward to undo the wrongs that I think are currently baked into how MA is paid and evaluated. But I think we haven't gone far enough. And the future, in my mind, is with MA, and we need to get in front of that, get ahead of that. So that was my first comment.

The second one is really a question, a possible research. I know that was one of the areas of interest. So the essence of fee-for-service is that beneficiaries can go to any provider they want at any time. This is what sells people to original Medicare more than anything else. Do we know or can we find out how often beneficiaries actually use this privilege and the extent to which this increases costs to the program? I know with ACOs we're trying to corral that instinct to go outside, but just looking at the data we have or don't have, how big an issue is that? And does it represent a significant financial problem?

One other possible research area is to what extent does minimal beneficiary cost sharing affect overuse in services? So we all know that those with Medigap have virtually no cost sharing if they purchase, you know, the whole kettle of fish. Now, effective this year for people

who are new, who are 65 this year, Medigap will no longer cover Part B deductibles. But, you know, that's just one. But the fact is for most people they really can get anything they want.

Can we assess the use of services of beneficiaries, those with and without a gap plan? Because I think the extent to which we understand how much beneficiary cost sharing influences their decision to adhere to the highest-quality, most effective care could be meaningful.

And my last comment is on page 9, at the very end, and this may be too radical, but it's the bulleted list about the use of fee-for-service, just that it should be replaced over time and the degree feasible by systems that have incentives to, and then it lists all the bullets here. And I would add the bullet to reduce the financial burden on taxpayers and beneficiaries. For all the attention we give to the importance of corralling the cost of Medicare, I don't see we've done that much in focusing on the burden on individual beneficiaries. So that sort of sums up my major points on this. Very exciting start, and I look forward to moving ahead.

Thank you.

DR. CROSSON: Thank you, Marge. That is pretty radical, but I think we can incorporate it.

MS. KELLEY: Okay. Bruce.

DR. MATHEWS: Dana, can I get in here? Marge, on your second point, there's actually fairly extensive health services research literature on the relationship between cost sharing and service use, and we've done a good bit of that ourselves. I want to say back in 2013 or thereabouts we actually made a recommendation that there be an additional charge imposed on beneficiaries with high coverage Medigap plans because of the inductive effect of, you know, reduce cost sharing on service use.

MS. MARJORIE GINSBURG: So maybe we can dust that off and find a way to incorporate it into this plan as well. Thank you.

MR. PYENSON: I also want to compliment the chapter and point out that I think the Chairman's piece is prevailing despite the criticism that I and others had for it last summer. So I think compliments to Jay that that piece was perhaps more going in the right direction than many of us had given him credit for last summer.

I have a couple of big-picture items and small-picture items. One is I think we have an opportunity to look at the profound structural changes in the health care system and recognize those in our work. So much of our inadequacy is focused on the system as it had existed 20 years ago or more with individual physician practices and community hospitals. Today we are far from that kind of structure, and consolidations are not reversing. So I think as we look down this road of a future of Medicare and accountability, a utilities model comes to mind, that we actually have a health care system in many regions that would best be thought about as a utility like the electric company. And what does that mean in terms of accountability and payment?

There's a variety of models in existence for treating utilities. Some are more successful than others. But I think that's really the kind of financial head that we ought to be looking at and kind of models as opposed to a fee-for-service approach or a system based on fee-for-service. So I think the utility model of payment and regulation is something we ought to look at because consolidation is not going to get reversed.

On a big-picture item, I think we should use the deflation word for health care spending. I think that's what we're all talking about, so I think we should get it out there and not mince words. We're talking about people getting -- organizations in the health care system in the future getting paid less than they're paid today, and that's our expectation. And I don't think there's a credible case to be made that we're going to be able to pay people more because they become so much more efficient. Hopefully that will happen, but I think we have to pay people less.

And, finally, I want to pick up on the large -- and Kathy had talked about Medigap, and I think looking forward a tax on Medigap is something that ought to be on the table, and that has to have an impact on how the benchmarks are set for MA plans, that the induced utilization of Medigap ought to be taken out of the benchmarks for MA plans to level the playing field. I think that gets to perhaps some of Marge's accountability for MA.

But, again, back to the beginning, I think Jay laid this out about not quite a year and a half ago, and I

think he was more prescient that I had given him credit for.

Thank you.

DR. CROSSON: All right. Well, thank you, Bruce. Appreciate it.

MS. KELLEY: David?

DR. GRABOWSKI: Great, thanks. I also want to echo the other Commissioners and pass along my thanks to Eric. This is an excellent chapter and I think really lays out a nice agenda.

Jay, I think these comments would probably be in the bucket of largely edits to this chapter, although I do think they could influence our larger agenda here. I really like the part of the chapter that we're very direct about the problems with fee-for-service, and I think we sort of put ACOs as being necessarily better. And ACOs can be many things to many people, and so I wondered if we might be a little bit more explicit in the chapter around what we think is an ideal ACO. And we even talk about some of the changes that ACOs might undergo in the future, the inclusion of Part D, better engagement of beneficiaries. That sounds great to me. I wondered if we could even go

further in sort of outlining what are some key principles. I know we probably have done that in a chapter in prior years. Jim will probably remind me of exactly the year and the report that we did that in. But I think we're turning to that and saying these are the sets of principles and what else might need to change, and just to flag a couple, how we're setting the benchmarks with historical and regional components is problematic. The risk adjustment that we're currently using is problematic. And so there's a series of changes that we might think about such that we're not just saying ACOs are better but, rather, this is the ACO type model and value-based model that we have in mind.

I think that's really important here, and as a final comment, I think the ACO program has obviously undergone a lot of changes. We're going to talk more about that later this afternoon, or late morning for some of you. But I think we need to think about kind of what is that core principle around an ACO?

So I'll stop there, and, once again, Eric, this was a great chapter, and I'm really happy we're going down this path. Thanks.

DR. CROSSON: Thanks, David.

MS. KELLEY: Dana?

DR. SAFRAN: Thank you. I'll be brief. I echo many of the comments that have been made by other Commissioners, including kudos to you, Eric, for really excellent work.

The only two things I would chime in on are one I chimed in on before, that I think would be good to incorporate here, and that is a reference in the future work section to the importance of models that encompass the hospital and that really transform payment and payment incentives for hospitals. We really haven't, I don't think, addressed that, and we've talked many times over the past two years within the Commission about how without that we've really got one foot nailed to the floor as we try to move away from fee-for-service. So I'd like to see us mention that.

The other thing is -- and maybe this is not possible given the late date on the calendar relative to when this gets published, but, you know, we did have an interesting set of comments about telehealth in the crisis and how long-lasting that might be. And it seems to me

that in the future work section it might be worth a mention of, you know, the -- I hate to call it this but exciting response in the industry to the crisis and making mobile care available to people and the importance with which that will compel payment reform requirements once we are on the other side of this.

And then, lastly, just to underscore the point -- now I'm trying to remember who raised it; it might have been Brian? Or somebody -- sorry, I'm forgetting who. But somebody raised the importance of getting to physician or front-line clinician level payments and that, you know, we have to address that piece, too, in order to hope for the success. We can't keep rewarding folks on an RVU basis and hoping that these models work. And, you know, I am mindful that CMS still has this framework -- I believe they do -- around sort of the different typology of payment reform with a kind of most evolved view in their model is, you know, where there's actually capitated payments. And, you know, I think the question is: How do you within the Stage 3 in their framework get to more effective programs? And I think part of that we might want to underscore that even when it's all sitting on top of the fee-for-service

infrastructure, if we address the issue of the incentives for individual clinicians in particular and to move away from RVU-based payments, maybe even as one of the measures of performance or criteria for participation at some level of having payment based on other things, that that can really strengthen our ability for success in that third level of the typology.

So those are my comments. Thanks very much.

DR. CROSSON: Thank you, Dana.

MS. KELLEY: Amol?

DR. NAVATHE: Hi, everyone. So, Eric, great job. I think I'll echo many of the comments that other Commissioners have made supporting the work, supporting the direction, supporting I think many of the ambitious types of goals around future work and future state that have been articulated here.

I wanted to pause on a couple of things. So one point I thought that was important is I like the fact -- I think David said this, and I would repeat it, which is I like the fact that there's an explicit statement about fee-for-service being a very problematic chassis to which everything seems to be connected. So I think, you know,

you made the point in the chapter about Medicare Advantage payments being calibrated effectively to fee-for-service. Obviously, the MSSP or ACO type programs are calibrated to or based on fee-for-service. And so I think the idea of shifting away from there is very powerful.

The one piece that I thought we need to probably explicitly acknowledge is that that's not -- one, that's not trivial, and right now we don't have a lot of great examples out there of how to do it another way. And I think if you kind of sync that up with one of Dana's points, one of the examples that was offered, perhaps the main example that was offered was the Maryland hospital capitated budget type of model. And the evidence for that model, at least to date, is not resoundingly positive, and there's perhaps an issue of centrality of the hospital and some other models.

And so I think that to me highlights kind of two things. One, we need to harken back to Kathy's point about, you know, we need more innovation, we need to think more carefully about how we could catalyze the type of change that we need. What is the core system that ends up replacing fee-for-service? I feel a strong tension

between, on the one hand, saying that we need to, you know, partner or, as Dana was saying, make a requirement that you don't pay through RVUs or don't pay through fee-for-service, but, on the one hand, that's sort of very heavy handed from a regulatory perspective. At the same time, the question is, well, then what's the alternative? How are we actually basing productivity, how are we basing our ability to actually collect data?

So another important aspect, this one probably more concretely I think we can include as either a bullet point or a sentence or something in this chapter to acknowledge that what the fee-for-service system has given us is an ability to actually record what happens in a very effective way, albeit not specifically for research or measurement purposes, still has been the way predominantly that we've been able to do things like measure cost, measure utilization, measure productivity, to this point at least measure value, however we're doing it. And so we need -- there are elements of fee-for-service that we also need to preserve that are not related to the financial incentives but that are related to the ancillary ways in which we're able to make our system function and the way in

which we're able to actually measure and then try to improve our system. And I think it's important that we don't lose that point. Otherwise, it feels like perhaps we're chasing an ideal without really recognizing what we have in place at this point that could be potentially very problematic if we were to lose it.

The second point that I wanted to make is related to Dana's point around the shift -- and others, you know, we made in executive session as well around the idea that in this COVID crisis we've seen this dramatic shift toward telehealth. And I think one of the things -- when I took a step back and reflected upon this, obviously this is not a positive situation in which we've had to do this, you know, we've seen CMMI and CMS and Congress try to put out, you know, guidance and legislation and models and, what have you, regulation, to try to get our system to perform differently. And, largely speaking, we've said, well, there's small, modest effects. And here I think what we have seen -- in the context of a crisis, mind you -- the ability for the system to shift in a very dramatic way. I mean, this is kind of shocking, in a positive way, how much the system has changed in the matter of a month.

And so I think we should -- I don't know that we need to bring up COVID specifically, but I think we should point out that there is evidence that the system can shift in a pretty dramatic way, and what we need to be thinking about as MedPAC and as a nation is: How do we create the right environment in which to shift the system in a way that now we have a sense that it can shift much more dramatically? It doesn't have to be 1 percent, 2 percent. You know, there are actually ways to shift the system in a more dramatic way. So those are the two points.

I had one question perhaps for Eric, but I'm happy, of course, for others to respond to it as well. There was a comment in the chapter that basically said we have to be careful -- I can actually read it because I think it might be easier than my trying to paraphrase it. It's on page 6, about middle of the page or maybe a third from the bottom: "Since Medicare is on a financial unsustainable trajectory, efforts to broaden the use of value-based payment, which focused largely on changing patterns in service use, should be careful to ensure they do not inadvertently undermine the program's control over prices." And so I wanted to cue this up. I think I maybe

understand exactly what we mean, but I'm not sure, and I thought it might be worth asking Eric perhaps to clarify what was intended there and then in the chapter making sure that we're clear about that, because in some sense that feels like it could be ambiguous and it could be misinterpreted.

MR. ROLLINS: So in terms of that passage, Amol, I think that what we were trying to communicate there is historically Medicare has had maybe not perfect but at least a decent degree of control over the price of the individual service and less control over the volume side of the equation. And value-based payment is really looking to sort of put more attention on sort of what does the volume side look like, but we just wanted to underscore that, you know, one reason that cost growth in Medicare has been a lot lower than the commercial sector is this control over prices. And so when you're designing new models, just sort of, you know, be cognizant that that is an element of one thing that Medicare has done relatively well compared to the commercial sector and don't sort of inadvertently weaken it. So I think that was sort of, you know, what we were trying to communicate.

DR. NAVATHE: Got it. Okay. So there wasn't any particular concrete example or particular scenario that we're concerned about here? It was more of a guiding principle?

MR. ROLLINS: Yes, that's right. I don't think we had a specific, you know, people are considering X and this would cause all sorts of problems. It was more sort of a general caution.

DR. NAVATHE: Okay. Got it. Thanks, Eric.

DR. CROSSON: Thank you, Amol.

MS. KELLEY: Jon Perlin?

DR. PERLIN: Let me add to the thanks for a terrific chapter, and let me also strongly associate with Amol's first two points. I think they're right on target in terms of understanding what the replacements are.

With respect to that, I'm just trying to think of the reality of this chapter, which I realize should be transcendent, transcending current events like COVID with the reality of COVID. To the best of my mind, everybody I've been speaking with -- I mean, I think we have a peak, you know, last eight weeks, we'll have simmering activity for eight months, rinse and repeat in the fall, hopefully

there's a vaccine, but we're talking about 18 months of dislocation. And I want to just give you a view from the front. I'm sorry Warner's not on because I think he could speak pretty eloquently to New Orleans. We operate Tulane University Medical Center there and a number of other hospitals. You know, health care providers of all stripes are going to come out severely wounded. You know, surgeons have got no revenue. And I'm not asking for sympathy for surgeons. What I'm noting is that their offices are not paying their staff. Their staff will not reconstitute, and things will not look like what they did. Practices of non-proceduralists are decidedly limited. I want to absolutely associate with the notion that many have brought up, that telehealth is a boon and it is quite remarkable, Amol, that the adaptation and the adoption of that has been so rapid. In fact, one of my predictions that it would sort of merge with electronic records is really being borne out. And, you know, that's terrific that we're able to make some of those adaptations. But the human infrastructure is not going to be quite as adapted, and, you know, I don't know how we should think about some of what our transcendent principles have been a la Kathy Buto's point about really

building some resiliency into the system. I mean, we're struggling across the country because the system is not resilient. It is sounding like just-in-time inventory as one example, bed capacity as one example. It's not resilient. And I realize that's directly antithetical to the notion of trying to pull out additional efficiencies. So it takes us back to things where we have adapted, like with telehealth and finding a need to actually recommend perhaps a more adaptive policy, legislation that permits that policy, et cetera.

Switching gears from, you know, painting a picture that things will look very different as we emerge from this in an economy that is also distressed, I want to associate with Dana's comments. Some colleagues engaged in this. How will ACOs weather this? Looking at Sue, head nodding, I'd be interested in your comments. What are the permutations in terms of the benchmark attribution? How does that play in terms of a year that's been disruptive, and for next year as well? And how will we account for current events in evaluation of ACOs?

You know, to Bruce's point on deflation, you know, fine, I get that we need to take money out, but you

can't do that absent the regulatory and legislative adaptations to make things like telehealth durable, make things like licensure reciprocity among states durable, that make scope of practice more durable.

I remember back to my VA days; life was a lot simpler. It was completely capitated, just -- it was a different country in our country. But at the same time, I can't tell you that we were totally devoid of fee-for-service because you had to have a mechanism to reward effort from non-effort. And, you know, I think we're going to have to sharpen in future iterations our thinking about even if populations are capitated, what are the mechanisms that simultaneously balance the need to differentiate between effort and non-effort in a way that also supports a coherent philosophy about the maximum utility of the dollar.

Thanks.

DR. CROSSON: Thank you, Jon.

MS. KELLEY: Larry?

DR. NAVATHE: Is it possible for me to respond to Jon's points really quickly? Apologies to Larry.

DR. CROSSON: On this point, Amol?

DR. NAVATHE: On this point. So, Jon, I think there's one thing that you -- well, there's several things that you said that I think were really important and resonated, but one in particular that I thought would be great to add onto rather than really respond to even, you pointed out that as part of this telemedicine/telehealth shift, this has been done in rapid form in a way that perhaps we never could have truly predicted or really realized how fast it could happen, but there's also this collateral impact on the human elements and the human capital of health care. And I think that's a really important point because one thing to recognize is I think there is a really positive story here around how fast the health care delivery system has shifted, but we do need to recognize that it hasn't really shifted in a systematic, reasoned, and well-thought-out way in terms of how to maximize the positive impacts while minimizing the negative impacts.

And so as we think about the sort of ideation of the future system, I think we do want to capture and harness and retain some of that really positive element of how much the delivery system has shifted. But we need to

also counterbalance that with a systematic approach so we're not chasing system change without really recognizing what the countervailing effects might be.

DR. CROSSON: Go ahead, Dana.

MS. KELLEY: Larry?

DR. CASALINO: So I share the enthusiasm about how good the work on the chapter is, and also I agree with the direction and with the emphasis on finding ways to make the ACO and make programs better.

I do have five questions or reservations that are geared to the report, I think, but also toward the retreat. And then I have a quick bonus comment on telehealth based on the discussion so far. I think I can be very brief.

So the first point is on page 9 there's a sentence that says, "The entities" -- these are accountable provider organizations -- "would in turn be expected to pay individual providers using approaches that support value-based payment." Why would we want to reform micromanaging how accountable entities pay their individual providers? If their incentives are strong enough to improve the care they provide, quality and cost, then they'll find ways to compensate their providers that work best within their

organization. I think any attempt to tell entities how they're supposed to pay their physicians, for example, would be misguided at best. So I do have a reservation about that sentence.

Second point, should there be some mention of size somewhere in the chapter and also discussion of this at our retreat? Clearly, the current crisis is going to lead to more consolidation, both on the physician and on the hospital level. And the directions that will be proposed by the ACOs, for example, probably will lead to even more consolidation, which hurts the private sector, but even for Medicare, with administered prices, if competition is reduced in a geographic area, that can hurt beneficiaries. So this is obviously not the focus of the chapter, and I don't think it should be, but I hate to see the chapter not make any mention of the risk of consolidation and maybe possibly a comment or two about, you know, things that might be important in that respect, like antitrust enforcement.

Then the second thing I think about consolidation and size, I think we might want to mention -- we might want to think about this at the retreat more extensively -- that

the programs as they develop probably should include ways for smaller practices to participate in accountable entities without being owned by accountable entities necessarily. I know there have been efforts like that in ACO programs, for example, but this chapter makes no mention of that, and I think it would be good to call it out. There are still a lot of physicians in small and medium-size practices that are independent, although obviously the number is shrinking.

Third point, should the government be picking winners and losers in terms of categories of organizations? And what I mean by that, if you look at the statement on page 4, which, I think if you read it carefully, it's actually ambiguous what it means, the statement is: "As models improve, we would support Medicare increasing incentives for providers to participate in and improve delivery of care." So the ambiguity there to me is the meaning of "increasing incentives." It could mean, on the one hand, making very strong -- you know, very large potential rewards masked in some way, say large potential risks/penalties for providers that want to be accountable entities, making the incentives larger than they are now.

So increasing incentives could mean that. And/or it could mean just giving provider organizations or accountable entities money for participating as an advanced alternative payment model, even if they don't perform better. So that would be, for example, the 5 percent bonus that's been given for five years to advanced APMs.

To put it another way, one way to proceed is just to make increases of payment in a fee-for-service system very small or none, as has been done again in MACRA, and then make the rewards and risks much larger for organizations that want to take accountability, so you can choose to stay out of those accountable organizations, but you then get very little pay increases. Or you can join them, and you have potential big bonuses but potential big penalties. So that's one way to do it. Another way is to do that or maybe not do that as extensively, but then just give money to organizations just for being an A-APM, and that to me it is being done, it does smack a little bit of government picking winners and losers, maybe we want them to pick winners and losers. But I just raise this as a question. I don't mean it as a rhetorical question or take a position on it, but I think it's important to explicitly

consider it.

Fourth point, we've talked a lot about fee-for-service today. I think some mention that it's not likely to disappear completely and soon, and that it might be worth spending some energy on finding ways to make it work better insofar as it does exist, for instance, getting the prices better, and there have been various suggestions about how to do that.

Then the fifth point, Dana emphasized that it's important to give hospitals some significant incentives to reduce costs and increase quality. I agree with that. And I also agree that MedPAC studying global budgets for hospitals is worthwhile. It almost sounds too positive the way it comes down in the chapter as it's phrased now, at least to me. I mean, it would take some real convincing for me to think we should give hospitals control of the delivery system and just kind of hand it to them, which is what global budgets for hospitals that can include outpatient care does, I think. They haven't done very well as ACOs, and I wouldn't expect them to do much better with these global budgets necessarily. So I think we would really want to think before we come out to that.

And then just this thing about telehealth, I thought that telehealth was great before when there were only telephones, no video, and the more, the better. I'm delighted to see so much -- and Cornell has done outpatient care and NY Presbyterian pretty much to virtually 100 percent for all outpatient care. Very, very little is being done in person now, and that happened in just two weeks, as people have said. And I don't think -- well, that's going to retreat some after all this is over, but I agree that telehealth is going to be around, and I think that's great.

I think some thought needs to be given -- this doesn't have to be in the report, but I'll just flag the issue here. Obviously, what has made telehealth happen more is partly the contagious problem but partly the fact that now all of a sudden, it's going to be paid for pretty well. It is being paid for at fee-for-service, and I think we'll want to give some thought going forward, if not in the report, to think about probably in the short run it does have to happen that telehealth get paid at fee-for-service, but that could have all kinds of unintended consequences. In our ideal system, I think, the incentives

to be efficient would be so strong that you would do telehealth -- you in accountable care entities -- you would do telehealth because it's the best way to provide care, quality, and cost, not because you get paid every time you do a telehealth visit in fee-for-service. So that's it.

DR. CROSSON: Thank you, Larry. I'd just make one comment in terms of your third point, which is the issue of whether or not a 5 percent bonus should be paid or not. And I think our position, which we made a couple of years ago, anyway, after MACRA, was that that should not be the case, that the 5 percent bonus should be paid -- and it is paid through these entities, but it should be paid to entities for distribution who are, in fact, being successful as opposed to just being in existence.

DR. CASALINO: Is that the MedPAC position? I didn't realize that, actually. I think that's terrific.

DR. CROSSON: Yes, it is.

DR. CASALINO: Good.

DR. JAFFERY: Jay, on that point?

DR. CROSSON: Yes.

DR. JAFFERY: I'm aware that that's been the position, and I think that -- because that was a couple

years ago, so that discussion about that predated my time on the Commission. I think that it's worth at some point maybe thinking about why we think that, again, or clarifying what we think the purpose of the advanced APM is, because in some ways there is a sense of that being not quite a cash flow issue, but a way that systems that aren't able to necessarily be confident that they can weather certain losses as they're ramping up, know that they've got some sort of backstop, and that may or may not be the right thing, but I think that is a perspective that a lot of folks have as they're entering into some of these models, especially if it's a physician group that may not have the financial backing of a hospital system.

Again, I wasn't part of that conversation a couple years ago, but I do think that there is some perspective of that.

DR. CROSSON: It can certainly be re-thought. I was simply noting that that is our current position.

MS. KELLEY: I think Bruce has a question for Larry.

MR. PYENSON: Larry, you brought up, as you often do, some really important items and questions. I wanted to

support examination of whether MedPAC -- whether we should tell Medicare how providers pay their expenses. And I've been in favor of that, pointing to the vertical consolidation of organizations where what used to be distinct entities are now in effect self-dealing organizations.

There is, of course, another side to that, which is as long as the providers can get efficient, why do we care? But I think there's two sides to that, and I think that deserves to be on our agenda. We see that in some profound ways in the supply chain where organizations are getting paid by Medicare, own part of their own expense determinations, which is potentially a big distortion in the Medicare cost reports as well as probably being a bad thing. So, Larry, I think that issue is something we need to look at. I might have a different take on it than you do, but I'm glad you raised it.

DR. CROSSON: Thank you, Bruce.

MS. KELLEY: Jaewon?

DR. RYU: Can you all hear me? Hello? Yeah, okay. I have a couple comments. I also want to thank Eric for a great chapter. I like that it was short but sweet,

but I did have a couple comments, and I think this goes into both of your categories, Jay, as far as things that should be, I think, incorporated into the chapter but also could inform future work for the Commission.

The first was I like the mention of both Medigap and the Part D plans as really the way it's framed it seems like impediments to the advancement of the ACO work, and I think that sounds about right. But I think we may want to have a section in the chapter that looks at other big impediments. Think of them as oak trees that sort of need to be moved out of the path if we're to move out of fee-for-service and into more value-based payment. And I think Medigap is a great, almost a poster child illustration of one of them. But I imagine there are others as well, so I think it would be helpful from a contextual standpoint to lay out a little bit of what's the kind of work that would need to happen to take ground on this. And then, second, it would, I think, demonstrate the magnitude of tackling this because some of these things are big programs that would need to be addressed in order to make progress. So I think that was my first comment.

The second comment goes to the discussion we were

having around the downstream payments, so to speak, so MA plans and how they pay downstream providers, and if it's still on a fee-for-service chassis, I think that is an impediment itself. And how do we create incentives to have plans paying downstream providers or even systems in a way that's more conducive to value? I actually think from a payment standpoint maybe it doesn't make that much difference because, you know, the program has already paid the MA plan, what do we care what the plan does to the provider? But I think outside of payment, if you're really looking at how do you spark delivery system change and reform, I think that's really where that downstream payment becomes very relevant.

So I would suggest maybe incorporating some acknowledgment of that in the chapter as well, that that's why we would care about those downstream payments, is because this isn't just about payment reform and moving from fee-for-service to value, but it's also about taking that change and sparking or catalyzing change in the delivery system as well.

DR. CROSSON: Thank you, Jaewon.

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

DR. MATHEWS: Just for my benefit and Eric's benefit, as we come back and start to finalize the chapter in light of this discussion. So the back-and-forth that we've just had -- let's begin with Larry's commentary -- does highlight a certain difference of opinion that I want to make sure I can successfully adjudicate.

On the one hand, there seems to be a camp that says we should not care how one provider pays for its affiliates or acquires its requisite services if we set very strong performance targets with respect to cost and quality, and those are the things against which the entity that is receiving a payment from Medicare is judged. This was Larry's point. Why should we care? And to the extent we're saying you can't pay fee-for-service, what would we suggest?

The other camp seems to, you know, fall into the category of, no, as long as any fee-for-service exists in the payment stream, it is going to bring all of the adverse effects of that mechanism of payment, and so we do need to care about how things are paid throughout the system. And if an MA plan is paying its providers on a fee-for-service basis, that is of concern.

So could folks say a little bit more to try and help me, at least, figure out what to put --

DR. CROSSON: Let me jump in here because I'm not sure -- because I want to make sure everybody gets a chance to comment on the chapter, and we're closing in on 15 minutes to go here.

The difference of opinion that you just mentioned and that we heard has been present really for a long time. I think it was probably earlier in the fall when I brought up this question with respect to MA, which is kind of along the lines that Jaewon say: Should we care or should we not care? And, you know, a few people raised their hands on both sides, and just looking at the Commission, I got the sense that there was maybe some difference of opinion, but more than that, people needed to think about it, so I -- because I think they're god points. The first person to raise their hand when I brought that up said, well, why would we care? Because, you know, we're transferring the risk in this case to MA plans, and as Larry said, they have incentives to manage cost and quality. So why not? Or why get in the middle of that?

And I think another commenter said, yeah, but

they're not doing it. I mean, they seem to be agnostic to the value of trying to encourage some sort of value-based payment. Personally, I think the reason that they have not done it is it's just hard, it's difficult. As many people have said, it requires, you know, substantive change in mind-set and in mechanisms and the rest of those things.

On the other hand, I think the point that Jaewon made, I wouldn't say, you know, personally, now we should just say that we want to expunge fee-for-service payment as a matter of principle. But I do think that the point that Jaewon made that if we think, you know, with one half of our brain that movement towards value-based payment is valuable per se -- and we're talking about that, you know, in the context of ACOs and MA and even in fee-for-service -- then you know maybe -- and I think in the language you've got here, Eric, you just basically said some consideration should be given to thinking about whether or not CMS should encourage, not even incent but just encourage holders of risk MAs and ACOs, to think about how they pay. I think that's -- you know...

So my guess here, Jim, would be maybe we expand that a little bit to bring in both points of view here,

which is kind of a pro and con, well, here's the arguments for not interfering in that relationship, but then there are arguments for why it might be done, and I think we could get to a point -- and remembering we will have a chance to review this, the wording of this, one more time. But I think by framing it as pros and cons, which is just simply reflective of the discussion that we've had, we can get through that. At least that's my thought.

Is there disagreement with that approach?

MS. KELLEY: Larry, your mic?

DR. CASALINO: Yeah. So, no, Jay, I think it's always good to say pros and cons. I'd be happy with that. You know, I would just add -- and I won't take more than 30 seconds for this. In what other industry would government even think about telling the companies, say telling Delta Airlines how to pay its employees? If you just step back, it's a very radical suggestion and real kind of micromanagement. And I would say it's kind of an admission of failure that we don't have the incentives right. If we had the incentives right, we wouldn't be trying to tell people how to pay their employees. So I'll just end with that. But I think putting in pros and cons would be great.

MS. BUTO: Jay, it's Kathy.

DR. CROSSON: Yes, Kathy.

MS. BUTO: On the same point, I agree with Larry. I think I was one of the first to say I don't see why we'd do this. Actually, the main reason is we don't get fee-for-service right; I don't see how we're going to get payment from an MA plan to providers within the plan right. I think there is a danger of overreach by sort of the several levels, because it's easy one-stop shopping. We think we know best. But I'm not convinced that some of the approaches that we're talking about are better than fee-for-service. So I really -- until we have a better sense of that -- and I'd be interested to know what MA plans think of having the government come and suggest, well, we really need to move in this direction or that direction.

Back to my original point, I think that sometimes plans really do know best, and if we really want to hold them accountable, let's do it through quality measures and not try to tell them how to pay their providers.

DR. CROSSON: Okay, Kathy. Well, I think that thing would be one we would incorporate in the cons.

DR. DeSALVO: I actually agree with that,

although there is a situation where in MACRA there is an implicit expectation that providers are going to move to a different -- to a non-fee-for-service model over time. So there's some precedent for that bit of overreach. But I like the way that you all are shaping it. I do think that holding some kind of accountable entity accountable for outcomes and not for a certain type of payment would be the preferred direction that we should be recommending.

DR. DeBUSK: On that point, if I could make one comment. Maybe we don't go as far as to say this is how they're to be paid, but there may be some merit in saying these are the types of transactions we don't like. And, you know, I would go back to sort of the villain of the MA plan that just chose high and paid low. I mean, could we create incentives to at least not engage in certain behaviors and then let them decide what a global payment -- you know, what this new payment needs to look like, and maybe just discourage these very granular fee-for-service transactions. Is there a point -- is there a choice, I guess is what I'm asking?

DR. SAFRAN: Can I just add one comment? I think it's a new point here.

DR. CROSSON: Yes.

DR. SAFRAN: So I'm listening to this, and I think part of the disconnect here in some ways relates to this issue of hospitals and hospital participation. What I mean by that is if we think of an ACO that is strictly a large enough primary care group, then I totally think Larry's and others' point is correct, that we have created an accountability model, their population is their primary care base, that is their ACO, and they're accountable and everything lines up.

I think, Larry, what doesn't line up is where you have an institution that some of its population, they're accountable, and some they are seeing the population on a referral basis and still very much in fee-for-service mode. And I think in that situation our minds go to, gee, how do we stop such an organization from just churning, and so we think about the front-line incentives around volume versus outcome. So I think we have to give a little bit more thought to this issue because it's actually, I think, as I'm thinking it through in this conversation, it's not really the clinicians in service of the ACO patients that we're concerned about, because I think we're assuming or

striving at least to have the right incentives for the ACO that that all lines up. It's the fact that oftentimes the ACO is an organization that is caring for Medicare patients from somebody else's ACO and they have the wrong incentives. So I hope that is a helpful point, even if it doesn't give us a clear direction.

DR. CROSSON: Okay. Thank you, Dana.

Dana Kelley, where are we in terms of the queue at the moment?

MS. KELLEY: I think Larry wanted to make a one-sentence clarification on this point, and then we have Sue, Pat, Paul, Kathy, and Warner.

MS. BUTO: I don't need to make my comment anymore.

DR. CROSSON: Okay. So I think that will be the queue. Larry, do you have another point?

DR. CASALINO: No, it's just a point of clarification. I think we have different -- I think we read the text differently, and we have different mental models in mind, and that would make you think that if it's published as is, there are other reasonable ones, too. So some of us seem to be thinking of MA plans and how they pay

provider entities, and others -- and I'm in the latter group -- had a mental model of, again, we were telling, you know, Geisinger how to pay its physicians. And it seems like some people only have one model and some people have others. So I'm just saying I think if we keep this in there at all, I think we need to be really clear about that, because those are quite different situations, I would say.

DR. RYU: Yeah, and I would comment on that point. I think that's the distinction because I would feel differently about those two scenarios. What I would be in favor of is MA plans and how they pay downstream providers. I do think there's a role for CMS to play there. But as far as systems and how they pay their employees, I think that feels like a bridge too far, and I don't know that that's as productive.

DR. CROSSON: I think that distinction could be made.

DR. NAVATHE: On that point, there are MA plans that also employ clinicians directly. So I think it does -- there's a little bit of ambiguity and potential gray area that could be problematic there. I think we should -- you

know, I'm generally in favor of your approach, Jay, of there's pros and cons, and clearly, I think there's a lot of complexity. We need to think more about this.

DR. CROSSON: That point could be included as well. Thank you.

Let's continue with the queue.

MS. KELLEY: Okay. Sue is up next.

MS. THOMPSON: Can you hear me?

MS. KELLEY: Yes, we can.

MS. THOMPSON: Good. Thank you. I will be as brief as I can be here. I agree with the conversation about payment to physicians and what was just said. I agree with Larry's point. I just want to go on record expressing support for Larry's position.

I do think the point made by David about a need to define ACOs is important, and I think that would help inform the discussion as well about how payment to physicians are made.

I also want to go on record in support of the comments that Brian made about the need for us to spend some time thinking more about blending some of the MA attributes to ACOs. But, again, it goes back then to us

having a clear definition of when we say ACO, what are we saying? Because ACOs mean very different things to those of us who are in different kinds of ACOs. And I think there's a need at some point -- and this may be in our work this summer, not necessarily for this chapter, but some acknowledgment that we are now having to reconcile to all kinds of new programming coming from CMMI around direct contracting and other alternative payment models or advanced alternative payment model participants like NextGen, which, again, contributes to, I think, a great deal of our internal confusion when we get into these discussions about the generic term of ACO.

Having said that about the comments made to date, in relation to the chapter, Eric, I think it's excellent. I enjoyed reading it. I found it to be very clear. But I had a hard time compartmentalizing my life today with imagining that we're ever going to be able to get back to something that looks like this world again without modifications from what we're learning in this COVID crisis.

I want to go on record: We're in Iowa. We are way behind the curve in terms of when the surge will hit.

But we have been entertaining all of these release and regulations that have been coming forward on nearly a daily basis, and the changes in regulations to our front-line workers are profound. And we are transforming health care as we speak in this crisis. Telemed is but one.

The three-day waiver, I mean, suddenly we had expansive three-day waiver going on across the state. The release of regulations around home care that just appeared on Monday this week, important for us as MedPAC to understand and know what those changes are going to mean to letting the horse out of the barn, if you will.

I mean, I am having a hard time imagining how we're ever going to go back to looking like anything that we looked like before. And I don't intend to suggest we do a lot in this chapter on what we're seeing in this short period of time, which feels like an eternity. But I think without some commentary in this chapter, recognizing there's such an opportunity to learn when we come out of this into whatever our new normal will be, and we do need to understand a lot of what we have been working on in MedPAC, we have seen regulations just evaporate.

I spoke with one of the front-line physicians

this morning who said, again, we've had the advantage in Iowa to have more weeks to prepare than those on the east coast. But our front-line physicians are saying, "I feel such freedom." And I think the impact on our workforce and their expectations going forward is profound. And whether that's some footnote to this chapter or certainly a comment for our summer work, we have a lot of great learning and a lot of transformation that's going to come forward from whatever this is and however long it will last that I just can't help but make comment on it as we're thinking about a world that we used to know that I think is going to be unrecognizable in the future.

DR. CROSSON: Thank you, Sue.

MS. KELLEY: Okay. Pat.

MS. WANG: Thank you. I will try to be brief. Just to pick up on that, Sue, it doesn't seem like an eternity. It really is an eternity.

You know, a comment on the conversation that was happening on the point that Larry brought up about how downstream providers get paid, Jaewon, too. My personal view is that it is very difficult to ask a federal agency in Washington to issue meaningful guidance on how

downstream providers should be paid, whether it's through an MA plan -- and I do agree with Jaewon's points on this and how we would like things to happen, but I'm a little bit more skeptical about the feasibility of CMS ever really coming up with anything that people could really implement.

Among other things, it takes two to tango. An MA plan could say, "I want to do all of this groovy stuff with all of this payment," and the provider could say, "Thank you very much, but I'm really not interested in that." So it's complex. It's complex by region, et cetera.

But there is an underlying point here which has to do with the flaws of the fee-for-service system, because a lot of the barrier to enter into value-based payment arrangements with providers is that there's something better on the other side. So as a comparison, could I do better with what fee-for-service would give me versus what you're giving me? Being at risk for something is a heck of a lot more work. Why don't I just bill, you know?

And so I think that the importance of the fee-for-service system is what Eric said. Medicare controls prices. It doesn't control utilization, but it controls prices such that the baseline of spending per beneficiary

is lower than it would be in a comparable commercial population. And I wouldn't want to kind of completely let go of that, but I think the important thing for fee-for-service reform is to shift fee-for-service to support models, whether they're ACOs or MA, to sort of make it more explicit that people get rewarded, not just that they're incentivized, the list on Slide 9, the bulleted list. I'd like to see that stated a little bit more forcefully, that not only should there be incentives to do the right thing kind of, but that there be actual -- the folks who will be rewarded in a future fee-for-service system that is migrating to an ACO/MA world, is that people who do the right thing about managing chronic conditions, keeping people out of the hospital, using telehealth, community-based organizations, and other things to achieve the outcomes that actually lower unnecessary utilization, inappropriate utilization, and thereby lower costs that we need to have a bigger emphasis on that.

On the point of telehealth, I agree with what everybody has said about how incredible it is. I mean, we have crossed the digital divide in this crisis, and there is no going back. My caution on this, though, is that if

what we have built with telehealth simply mimics what exists in the fee-for-service system, that's not so good.

For example, if somebody has built an entire telehealth system that makes open access to super-specialists available because that was the model that they used to practice, you know, in the face-to-face world, that to me is not progress. And so I think that we have to be mindful when hopefully this thing is over sooner than later and we see how people adjust the way that they get care, that we keep in mind that telehealth could simply just be additive to people having face-to-face care. And the only way -- my own experience with urgent care, which we put in place to try to divert people from the emergency room, what we have said is they're going to urgent care or they're going to the emergency room. So, you know, it's just a cautionary tale. I am hugely supportive of telehealth, but at least from my perspective, we're trying to be very intentional about the network that we are making available and building for our members, making sure that their community primary care providers are in it so that we don't sever those relationships as opposed to just kind of, God bless them, pushing everybody to the hospitals because

their telehealth capabilities are much more mature, much more stood up, et cetera.

So that would be my only point about whether it's telehealth or other modalities, it just underscores the importance of it being part of a budget so that you don't have, you know, just more modalities to do more fee-for-service specialty billing. And so that's really all I want to say. Thank you.

DR. CROSSON: Well, thank you, Pat, and I think you've underscored a point I heard Dana make a while ago, which is perhaps not surprising, but that I think we're beginning to realize looking forward that there's going to be a relationship between the expansion of telehealth and payment reform.

DR. DeSALVO: On this point, maybe some of the way we could message this in the chapter is that by moving to this vision of accountable entities having longitudinal responsibility for the cost and health outcomes in partnership with beneficiaries would allow more innovation not only in payment and we would hope better outcomes and cost savings, but also more innovation in modalities of delivery like telehealth. So, in other words, instead of

calling out -- we could call out telehealth, but I think the whole point of this is that let the beneficiaries and the delivery system and the financial accountable entity partner to achieve the outcomes that make the most sense based upon the tools and capabilities that are available in the environment and the health needs of the population that is being served.

MS. WANG: I think that's helpful. Let me, if I could, just mention one other thing. I will be perfectly honest with you. Whoever said it before, the hospitals are getting decimated financially by what's going on, emotionally, you know, in their souls and financially decimated. If I have any concern, it's that when people start to come out the other side, anything that they were doing in value-based payment, which is very much harder than the old fee-for-service tried and true, is going to get put to the side; and that, if anything, people are going to be more intense on the tried and true, you know, jacking up fee-for-service and really anything that's medically necessary, fighting every opinion about whether an admission could have been avoided, whether a readmission was really appropriate, things of that nature, it's much

harder to deliver health care that way than just, you know, like pay me for every service. I mean, I get it, but, you know, that's why this chapter's very important, and I realize that it's not COVID-specific, but I do think that it is a reality coming out the other end that all this will be good stuff that we've been discussing, is at least something that's very much on my radar screen, because I kind of see it happening with the anxiety.

DR. CASALINO: Jay, if I can, on the point that Karen and Pat just made, you know, I think the chapter does -- is very negative about fee-for-service, and that's fine. But I think it may miss -- if we're going to talk negatively about fee-for-service, I think the chapter may be missing an important opportunity. It's not news that fee-for-service leads to more service and, therefore, more costs, generally speaking. And certainly we want to say that, but that won't really surprise anyone. But equally bad about fee-for-service, and maybe really worse in the big picture, is that you have to decide what services to pay for, right? So you pay for telehealth fee-for-service or you don't pay for telehealth fee-for-service. You pay for getting someone an air conditioner, and you pay for

transportation, and there's endless things you could pay for. This really gets back to Karen's point. You really would like provider organizations to deliver the mix of services, the types of services and who provides them and where they're provided that they think is going to work best to take care of their patients at a reasonable cost. And fee-for-service inherently, you know, is opposed to that because you're saying we'll pay for this, this, this, and this, but these other things we won't pay for.

And so part of the reason for moving away from fee-for-service and for more global payment is individual organizations can figure out the best mix of services. And I think if we're going to criticize fee-for-service, we should give that equal billing with also that everybody knows that it increases costs because it increases the volume of services.

DR. CROSSON: Okay. Thanks, Larry.

Dana Kelley, could you give me a sense now of the queue? Because I think we're going to have to begin to end the discussion.

MS. KELLEY: Yes, just Paul and Warner left.

DR. CROSSON: Okay. Terrific. Paul and Warner,

go for it.

DR. PAUL GINSBURG: I'll be brief because it came up with this thought very early in the discussion and probably much of it is encouraged, but just the need in this chapter to perhaps add a paragraph just acknowledging how much change we're seeing because of many regulations that were put in place to protect us as payers in a fee-for-service system have been, temporarily at least, thrown away because of the need to respond to the epidemic and assure that a lot of medical care continues to be safe for patients and providers.

I would point to the fact that, you know, once we get some experience, we're going to have to proceed very cautiously in telemedicine, in the three-day hospitalization requirements, and now we're going to have to rethink some of these things, hopefully in the context of getting more value out of responsible changes. And it's just like putting a marker up there, that this is going to have to be part of our agenda as well as what we're describing so well in the chapter.

The other point I was going to make is that when we have this discussion particularly about MA plans that

use a lot of fee-for-service, my perspective is that over the last ten years MA plans have been doing a lot more to facilitate value. And I think a key reason for that is that their payment rates have been squeezed. Many of their payment rates are still very good, their margins are very high. But this relationship between how well you pay in the aggregate and how much organizations are willing to invest to get to a better payment structure in fee-for-service will always be with it. It's particularly complex in the ACO world because that's still volatile and, you know, ACOs are not doing that well. You know, we don't really have -- and, actually, ACOs are very restricted as to their role in payments. And this maybe brings up the notion of how I would like to see ACOs having more authority over how to pay the providers that are part of the ACO.

I'll stop now.

DR. CROSSON: Thank you, Paul.

Warner, I don't know how you ended up at the virtual end of the table again. This is your customary spot, but take us home.

MR. THOMAS: Here we go. Just a couple of

thoughts on the chapter. I think one thing that would be important here and I think it's going to be important as we move to global payment is the assignment of primary care physicians. I know it's a sensitive topic because people want choice, but the attribution model doesn't work. The idea that someone doesn't know who their primary care physician is or their personal care physician, I just think that's something that ought to be referenced or identified in the chapter.

The second thing is that I think it's important to indicate that even if we move to global payments, we still have to have fee-for-service as an interim reimbursement for essentially, you know, referral care that moves back and forth between global payment organizations, and that model will have to stay in place even if there's a global payment of an ACO or whatever you want, determine the name of it. So I just, you know, get the sense of, well, we're just going to do away with fee-for-service just doesn't work because how are you going to do interim reimbursement between entities?

The last thing would just be on global payments. You know, if there isn't alignment of incentives, then I

think the test point -- you know, hospital systems, physicians, physician-owned entities, whatever, they'll figure out ways to generate additional revenue. And so I think there has to be an upside to the global payment. It can't just be, well, you're going to be fee-for-service minus 3 percent or 5 percent. It has to be looked at as a long-term way to basically bend the curve. We're talking a lot about bending the curve on COVID-19. We need to bend the curve on Medicare costs that have been going up, you know, 3, 4 percent forever. You know, if we don't change the payment mechanism, maybe it doesn't show any benefit for multiple years. But the question is over a three- to five-year period, can you start to bend the curve by getting alignment of the economics? So I just think in the chapter, referencing that this may take time, that, you know, having alignment of economics from an incentive perspective is important. I think there are just pieces that need to be referenced a little more clearly.

Those are my comments.

DR. CROSSON: Okay. Thank you, Warner. And thank you, everyone. This has been a very valuable discussion, not just for the chapter but, as many of you

have noted, for the work that is to come.

We will now take about a ten-minute break. Let's say we'll reconvene at 25 minutes past the hour.

[Recess.]

DR. CROSSON: I see David now. Okay. We don't exactly have everybody back, but I think we should start the process here.

Just to remind everybody, we're going to have a brief presentation, which in many ways will be a summary of what was presented in March, and then there will be some changes as requested by Commissioners, in one case to the recommendation.

Then I'm going to ask Dana to call the roll and have everybody express their position, support for the recommendation, lack of support, if so, why not. That will not constitute the vote, but will give everybody an opportunity to express and record their point of view.

When that's completed, then we'll go back and have another roll call vote, which will be the official vote, and I'll ask for either support, no vote, or an abstention. That will be the process.

Okay. So I still see one. Someone is missing,

but why don't we proceed. I see Jeff and David. Who's going to begin the presentation? David?

MR. GLASS: Luis. Luis is.

DR. CROSSON: Luis. Oh, I don't see -- where is Luis? I can't find him. Oh, there you are. Sorry, Luis. Go ahead.

MR. SERNA: That's okay.

Good afternoon. Today we are going to talk about challenges in maintaining and increasing savings from accountable care organizations.

I will provide a brief background on ACOs. Then I will present our concerns with patient selection and one method of addressing some of those concerns, using National Provider Identifier, NPI-based benchmarks. We will then present the draft recommendation on requiring NPI-based benchmarks.

During the discussion in March, you expressed interest in knowing more about ACOs' documented reasons for conducting annual wellness visits and which ACO NPIs would be used for assignment under NPI-based benchmarks.

We have provided that information in your reading material and can take any questions later during the

discussion.

The recommendation will be included in a June chapter. In addition to the topic presented today, the chapter will include other areas of Commissioner interest such as specialist involvement in ACOs, beneficiary engagement, ACO integration with Part D, and hospital incentives. The chapter will also include other ACO analyses presented in this cycle on PAC savings and the spending of beneficiaries who are switched out of and into ACOs. In future analytic cycles, we will continue to consider other aspects of MSSP such as regional benchmarking and risk adjustment.

For review, ACOs are collections of providers willing to take accountability for the spending and quality of care for an assigned patient population.

Actual spending is compared to a benchmark. If spending is under the benchmark, the difference or savings is shared between Medicare and the ACO. If spending is over the benchmark, there are two cases. If the ACO model is one-sided, then Medicare absorbs any spending above the benchmark. If the ACO model is shared risk also known as two-sided risk, the ACO may have to pay CMS for some of the

spending above the benchmark.

Today we are going to concentrate on the Medicare Shared Savings Program, MSSP, which is by far the largest ACO program in Medicare and the only one set in statute.

In 2020, there are 517 MSSP ACOs and 11.2 million beneficiaries assigned to those ACOs.

MSSP benchmarks are a blend of two types of spending. First, benchmarks include spending for beneficiaries who would have been assigned to the ACO in the baseline years; that is, the three years prior to an ACO's agreement period. And second, benchmarks include fee-for-service spending in the ACO's region, which includes spending on beneficiaries in ACOs.

To understand if an ACO model as a whole is saving money for Medicare, a counterfactual is necessary; that is, understanding what spending would have been in the absence of the ACO model.

Relative to a counterfactual for MSSP, we found slower spending growth for beneficiaries assigned to an ACO in 2013, about 1 or 2 percent savings through 2016. That estimate does not include shared savings payments, which would have decreased estimated savings.

The point is savings are relatively small but still more than most care coordination models, and they need to be protected. If shared savings payments are unwarranted, they could put Medicare savings at risk and shift MSSP from small savings to program losses.

The modest savings achieved in MSSP thus far could be vulnerable if ACOs can engage in patient selection that is not reflected in their benchmarks and leads to unwarranted shared savings payments.

Selection is problematic because it can inaccurately improve an ACOs performance year spending relative to its baseline years.

Selection can occur by adding clinicians that disproportionately have low-cost patients or by removing clinicians that disproportionately have high-cost patients.

Selection can also occur via beneficiary assignment to ACO clinicians by keeping low-cost patients and losing high-cost patients.

We do not believe selection in MSSP has been occurring on a widespread basis, but under current rules, Medicare is vulnerable to such manipulation.

We provide one way of addressing the

vulnerabilities of patient selection: the use of NPI-based assignment for benchmarks. I will go over how patient selection may be exacerbated through assignment to an ACO's Taxpayer Identification Numbers, or TIN, to create benchmarks. Recall that each clinician has a unique NPI, and an NPI can bill under one or more TINs. MSSP identifies an ACO as a collection of one or more TINs. This determines beneficiary assignment because beneficiaries are assigned to ACOs based on the TINs under which their claims are billed.

Spending for those assigned beneficiaries is then used to construct ACOs' benchmarks. However, the use of TINs to identify an ACO's clinicians weakens the utility of historical assignment and benchmarks, potentially creating unwarranted shared savings.

When individual clinicians leave or join a TIN, the beneficiaries historically assigned to that TIN do not change, and the ACO's benchmark is also unchanged. We have seen anomalies where this has occurred. The figure in this slide illustrates how changes in clinicians who make up a TIN could lead to unwarranted shared savings.

In the benchmark year, the TIN is comprised of

Clinician A and Clinician B. If Clinician A's beneficiaries are high-cost and Clinician A is removed from beneficiary assignment for the performance year, these high-cost beneficiaries remain in the ACO's benchmark.

Further, if the ACO adds Clinician C, who has historically low spending to its TIN, the ACO's benchmark would not reflect the low cost of this provider's beneficiaries, but performance year spending would. The mismatch between the benchmark and performance year clinicians raises potential concerns about the accuracy of baseline spending used for benchmarks.

CMS annually recalculates an ACO's benchmark based on its updated list of TINs. However, CMS does not recalculate benchmarks based on changes in the NPIs billing under the TINs. What this means is changes in how NPIs bill through TINs are not reflected in the benchmark calculation

As we discussed in January and March, rather than basing historical benchmarks on TIN, NPI-based benchmarks would most accurately capture the ACO's historical spending. Any changes in an ACO's performance year clinicians would correspond with changes in the clinicians

used for historical benchmarks. If an NPI bills under a TIN participating in an ACO, CMS could use all primary care visits from that NPI, regardless of what TIN they are billed under, to assign beneficiaries to that ACO.

Using NPIs to compute benchmarks and performance year spending would reduce selection from, first, removing high-cost clinicians from ACO TINs; second, adding low-cost clinicians to ACO TINs; and third, billing high-cost beneficiaries outside of ACO TINs.

It is important to understand that redefining ACO assignment on the basis of clinicians' NPIs would not require any changes to the structure of the ACO, its clinicians, or the specialists clinicians recommend for beneficiaries. The only difference is that the rather than the ACO's assignment being computed based on a collection of TINs, the ACO assignment is now computed based on a collection of clinician NPIs. The set of NPIs used to compute performance year assignment are now used to compute assignment in the base years. This means that all claims billed by the ACO's clinicians are now used for both benchmark and performance year assignment.

In summary, ACO savings have been modest.

Unwarranted shared savings payments to ACOs could result in costs that exceed MSSP savings.

To avoid putting MSSP at risk of being a net cost to Medicare, CMS needs to reduce vulnerabilities that can result from patient selection, even if the selection is not intentional.

To help limit program vulnerabilities, the Commission could recommend that MSSP baseline and performance year spending use NPIs rather than TINs.

The integrity of using historical benchmarks requires reliably matching the ACO's performance year clinicians with the ACO's historical primary care visits. Calculating benchmarks based on a collection of NPIs would better ensure that performance year clinicians are captured in benchmarks.

Allowing ACOs to benefit from changing NPI participation in TINs creates the potential for patient selection and unwarranted shared savings.

That brings us to the draft recommendation, which reads "The Secretary should use the same set of National Provider Identifiers to compute both performance year and baseline assignment for accountable care organizations in

the Medicare Shared Savings Program."

Three corollaries would need to be included when implementing this recommendation. First, if an NPI bills under a TIN participating in an ACO during the performance year assignment period, CMS should use all primary care visits in the ACO's market from that NPI, regardless of what TIN they are billed under. This would prevent the ACO from allocating high-spending patients to a TIN not in the ACO. Thus, it would partially address selection against high-spending patients.

Second, claims occurring outside the ACO's current market should be removed from assignment calculations. This would prevent claims from other areas from being considered in the case of clinicians who either join the ACO after moving from a different market or leave the ACO midway through the performance assignment period and move into a different market.

Third, clinicians' claims would only be used for assignment to a single ACO. This would be needed in the case of a clinician billing under multiple TINs to prevent selection among that clinician's patients.

This recommendation will result in a decrease in

spending of less than $50 million over one year and under $1 billion over 5 years compared with current policy.

The recommendation would not have any effect on beneficiary access to care.

The impact on providers would likely be small. Some providers may receive smaller shared savings.

With that, we look forward to your discussion, and I turn it back to Jay.

DR. CROSSON: Thank you, Luis. Could you put the recommendation back up? Thank you.

So Dana is going to ask for Commissioner positions on the recommendation. She will do this as well in the voting process and in the subsequent treaty presentations and discussions that we have, but she'll use a different order. So you don't have to always think that you're going to be at the beginning or the end or even in the middle.

Dana?

MS. KELLEY: Okay. Kathy?

MS. THOMPSON: I support the recommendation.

MS. KELLEY: Larry?

DR. CASALINO: I support.

MS. KELLEY: Brian?

DR. DeBUSK: I support the recommendation.

MS. KELLEY: Karen?

DR. DeSALVO: I support the recommendation.

MS. KELLEY: Marge?

MS. MARJORIE GINSBURG: Support.

MS. KELLEY: Paul?

DR. PAUL GINSBURG: Support.

MS. KELLEY: David?

DR. GRABOWSKI: Support.

MS. KELLEY: Jonathan Jaffery?

DR. JAFFERY: I support the recommendation.

MS. KELLEY: Amol?

DR. NAVATHE: I support.

MS. KELLEY: Jon Perlin?

DR. PERLIN: Support.

MS. KELLEY: Bruce?

[No response.]

MS. KELLEY: Microphone? Say again, Bruce?

MR. PYENSON: Support.

MS. KELLEY: Jaewon?

DR. RYU: Support.

MS. KELLEY: Dana?

DR. SAFRAN: Support.

MS. KELLEY: I don't think Warner is with us. I'll give him a second in case he is.

[No response.]

MS. KELLEY: Sue?

MS. THOMPSON: Support.

MS. KELLEY: And Pat?

MS. WANG: Support.

MS. KELLEY: Okay. Jay, that's everyone.

DR. CROSSON: Okay. Dana, now we'll take a vote, and we'd ask Commissioners to vote aye, no, or abstain.

MS. KELLEY: All right. Just to make sure the transcriptionist gets everything; I am going to use last names.

Casalino?

DR. CASALINO: Aye.

MS. KELLEY: DeBusk?

DR. DeBUSK: Aye. Yes.

MS. KELLEY: DeSalvo?

DR. DeSALVO: Aye.

MS. KELLEY: Ginsburg, Marjorie Ginsburg?

MS. MARJORIE GINSBURG: Aye.

MS. KELLEY: Paul Ginsburg?

DR. PAUL GINSBURG: Aye.

MS. KELLEY: Grabowski?

DR. GRABOWSKI: Aye.

MS. KELLEY: Jaffery?

DR. JAFFERY: Aye.

MS. KELLEY: Navathe?

DR. NAVATHE: Aye.

MS. KELLEY: Perlin?

DR. PERLIN: Aye.

MS. KELLEY: Pyenson?

MR. PYENSON: Aye.

MS. KELLEY: Ryu?

DR. RYU: Aye.

MS. KELLEY: Safran?

DR. SAFRAN: Aye.

MS. KELLEY: Thomas is not here.

Thompson?

MS. THOMPSON: Aye.

MS. KELLEY: Wang?

MS. WANG: Aye.

MS. KELLEY: Jay Crosson?

DR. CROSSON: Aye.

MS. KELLEY: And Buto?

MS. BUTO: Aye.

MS. KELLEY: That's everyone, Jay.

DR. CROSSON: I believe we heard 16 affirmatives, no negatives, no abstentions, and one Commissioner, Warner Thomas, not present.

MS. KELLEY: Correct.

DR. CROSSON: Okay. Thank you so much.

We'll now move on to the second presentation.

Okay. I see Shinobu, Rachel, and Eric. Shinobu, it looks like you're going to begin.

MS. SUZUKI: Yes.

DR. CROSSON: Go ahead.

MS. SUZUKI: Good afternoon. Today we're here to discuss draft recommendations to realign incentives in Medicare Part D. They reflect the Commission's work over the past year, including our June 2019 report to the Congress and the Commissioners' discussions during the four meetings we've had this cycle.

Next slide.

Trends in Medicare's payments to plans suggest that Part D needs to be restructured. Cost-based reimbursements for reinsurance and for low-income cost-sharing subsidies have grown, while risk-based capitated payments have declined. Those trends are counter to the original intent for the program, and cost-based payments undermine plans' incentives to manage benefits.

Part D's benefit design also results in misaligned incentives. Brand manufacturer discounts in the coverage gap lower brand prices artificially relative to generics. And because of the coverage gap and Medicare's generous reinsurance, plans do not bear much insurance risk. This structure may also affect manufacturers' pricing decisions because manufacturers may be able to gain market share by setting prices high and providing larger rebates. Those situations result in high cost sharing for some beneficiaries and higher program spending.

You've seen this slide several times, so I'll go through it quickly. The benefit for enrollees without the low-income subsidy is on the left and the benefit for LIS enrollees is on the right.

Here is the coverage gap. The figures show how

the coverage gap looks for brand-name drugs and biologics. The blue sections show plan liability, which is small for both types of beneficiaries in the coverage gap and in the catastrophic phase. By comparison, rebates for some brand-name products can exceed plans' liability in these parts of the benefit.

For non-LIS enrollees, in the coverage gap, there is 70 percent brand discount, which distorts prices, because plans and enrollees don't get this discount for generics. What this shows is that the current structure doesn't give plans strong incentives to push back on high drug prices or to manage spending.

This table summarizes the key elements of the current benefit on the left and compares it with the restructured benefit on the right. Under these changes, the annual out-of-pocket threshold would roughly equal the amount that beneficiaries now pay under current law.

At the top, under the restructured benefit, the coverage gap would be eliminated for all enrollees and the coverage-gap discount would be discontinued. Plans would become responsible for 75 percent of spending between the deductible and the out-of-pocket threshold.

At the bottom, you can see the changes to the catastrophic phase. Enrollee cost-sharing would be eliminated and Medicare's reinsurance would be lowered from 80 percent to 20 percent, as in our 2016 recommendations. There would be a new manufacturer discount of at least 30 percent for brands and high-priced generics. The remaining costs -- 50 percent for brands and high-priced generics, and 80 percent for all other drugs -- would be plan liability.

Next slide.

MR. ROLLINS: Here's how the restructured benefit would look. There's a single benefit structure for all enrollees. The coverage gap has been eliminated, discounts have been shifted from the coverage gap to the catastrophic phase, and plans have more liability than they do now. Medicare would still cover 74.5 percent of the costs of the basic Part D benefit, but more of its subsidies would be provided through capitated payments instead of cost-based reinsurance. Medicare's LIS would continue to cover most or all out-of-pocket costs for low-income enrollees.

Some related policy changes would help make the transition to a restructured benefit successful. One set

of changes relates to the implementation of the new benefit structure. We think that the increase in plan liability in the catastrophic portion of the benefit should be phased in gradually, that CMS should recalibrate the Part D risk-adjustment model to ensure that payments to plans are adequately adjusted for differences in enrollees' health status, and that policymakers should make Part D's risk corridors more generous during the transition period to protect plans against unexpected financial losses.

The second set of changes would help Part D plans control drug spending and manage the additional risk they would bear. We think that LIS enrollees should be required to pay somewhat higher cost-sharing for non-preferred and non-formulary drugs, that plans should be allowed to use separate preferred and non-preferred tiers for high-cost specialty drugs, and that plans should have greater flexibility to manage spending in the protected drug classes.

This brings us to the three draft recommendations. The first restructures the Part D benefit and the other two make concurrent changes that give plans more tools and flexibility to manage spending and provide

greater financial protection during the transition to the new benefit. We've grouped the concurrent changes into two separate recommendations because some changes fall under the purview of the Congress while the Secretary of HHS would have responsibility for others.

The three recommendations should be viewed as an interrelated package of policy changes that balance the goals of ensuring Medicare's financial sustainability and providing beneficiaries with good access to prescription drugs.

The first draft recommendation reads:

The Congress should make the following changes to the Part D prescription drug benefit: Below the out-of-pocket threshold, eliminate the initial coverage limit; eliminate the coverage-gap discount program. Above the out-of-pocket threshold, eliminate enrollee cost sharing; transition Medicare's reinsurance subsidy from 80 percent to 20 percent; require pharmaceutical manufacturers to provide a discount equal to no less than 30 percent of the negotiated price for brand drugs, biologics, biosimilars, and high-cost generic drugs.

The second draft recommendation reads:

Concurrent with our recommended changes to the benefit design, the Congress should establish a higher copayment amount under the low-income subsidy for non-preferred and non-formulary drugs; give plan sponsors greater flexibility to manage the use of drugs in the protected classes; modify the program's risk corridors to reduce plans' aggregate risk during the transition to the new benefit structure.

The third draft recommendation reads: Concurrent with our recommended changes to the benefit design, the Secretary should allow plans to establish preferred and non-preferred tiers for specialty-tier drugs; recalibrate Part D's risk adjusters to reflect the higher benefit liability that plans bear under the new benefit structure.

The Congressional Budget Office estimates that the three draft recommendations, taken together, would reduce federal Medicare spending by more than $2 billion over one year and by more than $10 billion over five years. CBO's estimates do not break out the effects of each component of the draft recommendations.

DR. SCHMIDT: For beneficiaries, the key advantage of the package of recommendations is that it

would eliminate cost sharing in the catastrophic phase. Beneficiaries would gain more complete financial protection. As a result, beneficiaries would have increased access to drug therapies, some of which are appropriate but also some that may be less appropriate or inappropriate.

LIS enrollees who use preferred drugs would not be affected by setting a higher LIS copayment for drugs on non-preferred tiers. Likewise, beneficiaries who use drugs on a preferred specialty tier would either see no change or lower out-of-pocket spending.

However, LIS enrollees who fill prescriptions for drugs on non-preferred tiers or non-formulary drugs and beneficiaries who use non-preferred specialty-tier drugs would need to switch medications, pay higher cost sharing, or seek tiering exceptions.

The effects of restructuring on beneficiary premiums would depend on a number of factors. The manufacturer discount rate could increase over time if catastrophic spending increases rapidly, which could moderate changes in premiums. Other factors would affect premiums too, such as how effectively plans manage

benefits.

Under the restructured benefit, more of Medicare's payments to plan sponsors would be capitated, which would give plan sponsors stronger incentives to manage spending and lower the financial benefit of placing high-price, highly rebated drugs on plan formularies.

Because there would be no cost-sharing once an enrollee reaches the out-of-pocket threshold, plan sponsors may find it more challenging to manage catastrophic spending. However, other new tools would help plans better manage spending and give sponsors more leverage in negotiations for rebates on some drugs.

Plans with larger numbers of LIS enrollees will see larger increases in plan liability. However, CMS would recalibrate its risk adjusters and make Medicare payments that, on average, compensate sponsors for the higher plan liability. Modified risk corridors would provide greater financial protection to plan sponsors, particularly smaller ones that may have less capacity to absorb unexpected costs of new therapies.

Today, employer group waiver plans receive a disproportionate share of manufacturer discounts because

those plans provide richer coverage and, under Part D's true out-of-pocket provision, their enrollees don't tend to reach the catastrophic phase. After restructuring, EGWPs would receive fewer discounts, but they should have some lead time to modify their benefit packages.

The effects on manufacturers would vary by company. Eliminating the coverage-gap discount and replacing it with a discount in the catastrophic phase would shift much of the discount liability from manufacturers of brand products with lower prices to manufacturers of high-price products. We anticipate that the policy changes would affect manufacturers' pricing behavior, but exactly how depends on factors such as Medicare's market share for each product and how much competition a product faces within its therapeutic class.

Because plans would have stronger incentives to manage spending and new tools to do so, some manufacturers may see lower Part D revenues or have less ability to raise prices. At the same time, other manufacturers may launch at higher prices. Going forward, different outcomes across manufacturers may affect the mixture of future research and development projects.

Next slide.

This slide summarizes the draft recommendations. Together, they make up an interrelated package that's designed to strengthen plan incentives and tools under Part D's market-based approach. We think these changes would restore the risk-based capitated approach envisioned in Part D's original design, and eliminate program features that distort market incentives and create inflationary pricing pressure and higher program costs.

Thank you for your attention.

DR. CROSSON: Thank you, Shinobu and Rachel. I want to make just one suggestion here on how to proceed. I think we can take the discussion part, if we want to call it that, of support, et cetera, as one body. We will need to vote separately on each of the recommendations, however.

In terms of this phase, I would like to make slight change, particularly given the complexity of this, which would be to offer Commissioners to express either support, general support with following reservations, and then lack of support, because I think there may be some Commissioners who generally support this but have a particular perspective that they would like to add.

So Dana, with that, you can begin.

MS. KELLEY: Okay. Why don't we start with Paul Ginsburg?

DR. PAUL GINSBURG: Yeah. I fully support.

MS. KELLEY: Jon Perlin?

DR. PERLIN: Support. Thank you.

MS. KELLEY: Dana Safran?

DR. SAFRAN: Support.

MS. KELLEY: Brian DeBusk?

DR. DeBUSK: I fully support it.

MS. KELLEY: David?

DR. GRABOWSKI: Support.

MS. KELLEY: Bruce?

MR. PYENSON: I generally support. However, I strongly oppose the transition for the period for the catastrophic for three reasons. I am very strongly in support of the change, and especially given the discussion we just had about the dramatic transitions in the health care system today in response to COVID. It seems silly to extend, over multiple years, in an environment where we have exquisite data, foresight over new products coming in, and increased protection through risk corridors.

I think the paper and the staff has done an extraordinary job of identifying the pathology of the current structure, and I see no reason to prolong that. So the first objection is that a transition will be a hindrance to new market entrants because new market entrants will not be successful playing the pathological game that staff has identified.

I had mentioned the risk corridor protection, but let's recognize that part of the protection is that moving from a 20 percent to a 30 percent manufacturer recommendation also diminishes the plan liability from 60 percent to 50 percent in that period.

My third reason is that a transition would require separate risk adjustments for each year of transition, and it is hard enough to get risk adjustment right, and the transition requires that over a course of three years.

So I am enthusiastically supporting the new structure and the work behind it. I just think transition is the wrong way to go, and I see no evidence from anybody, including staff, that the financial risks are such that we should support it.

DR. CROSSON: Bruce, I think I will weigh in here. I do remember, and I think the rest of the Commissioners remember the points that you made in March, quite similar to this point of view. We did, at the time, entertain the possibility of doing some further analysis to support your position, for example, an analysis of the potential for a hybrid model where new entrants would have a different ability to come, and the second one was the notion of trying to understand the relative impact of existing plans on having no transition.

As I mentioned in the March meeting, and given the time frame that was required, to say nothing about what has happened subsequently, it has not been possible to do those analyses, unfortunately.

I do, however, recognize that the point you've made here, which is that the transition could potentially inhibit the entrance of as-yet to be described new entrants into the market, was not mentioned at all in the material, and I do believe, and I think I've taken a look at where that could be inserted, simply to say that the point has been made that this is a possibility. So I just wanted to let you know that.

Dana, you can proceed.

MS. KELLEY: Okay. Karen?

DR. DeSALVO: I support.

MS. KELLEY: Amol?

DR. NAVATHE: Support.

MS. KELLEY: Jaewon?

DR. RYU: Support.

MS. KELLEY: Sue?

MS. THOMPSON: Support.

MS. KELLEY: Larry?

DR. CASALINO: A quick question. Is this on draft recommendation 1 or all three?

DR. CROSSON: It's all three, Larry.

DR. CASALINO: Can I just see number 2 for a second? So I realize we don't want to count micro in the recommendations, but the first bullet point there, establish a higher copayment amount, blah-blah-blah, for low-income subsidy beneficiaries. Is there any reason for concern that Congress could say a higher copayment amount? We had in our materials, I think, looked at very low copayment increases, or copayments. Is there any concern that that's not the way Congress would see it, and is there

any reason to worry, you know, establish a slightly higher copayment amount, or something like that?

DR. CROSSON: So let me ask Jim or the staff to comment on whether -- because I don't have it in front of me right now -- whether the language in the text would make it clearer to what our intent is here.

MR. ROLLINS: There is additional detail in the text on this point. For example, we have a table in the chapter that sort of lays out here's the cost-sharing structure that LIS beneficiaries face now, here's what they would face under this higher co-payment that kind of lays out we're talking about these sets of drugs, about other sets of drugs and sort of we can be careful to make sure that we're talking -- you know, that the magnitude we have in mind is sort of, you know, relatively modest. We didn't want to get into obviously specific dollar amounts, but I think the surrounding text sort of makes all of those points.

DR. CASALINO: I know that the text is there, and I think it's great. My question is just: Will the text have that much influence compared to the recommendation? And should there just be an adjective in front of "higher"?

And I don't know, so I'll shut up, but that's my question. I support the recommendations. I'm just asking if we should have an adjective in front of "higher" there. That would perhaps make it less likely that someone in Congress would jump on this and say, oh, great, you know, let's make it $30.

DR. CROSSON: Okay. So in terms of altering the recommendation, Larry, do you have a specific word that you're suggesting?

DR. CASALINO: Again, I don't have the experience to know whether it matters or not, and I really would defer to Jim and the staff and others who are knowledgeable. But, you know, when I read this, I thought I'd feel more comfortable if it said "slightly," "modestly," something like that. But, again, I may be splitting hairs here that don't need to be split, so I'd defer to what others think.

DR. MATHEWS: So I would suggest leaving it as is. If we do get into the process of advising Congress on specific legislative language, we can convey this and point them to, you know, the surrounding text here. But including a term that says "modestly" or "slightly" or "nominally" or something like that, those are sufficiently

subjective that while they might convey we're talking about magnitudes of, you know, $10 and not $100, it still isn't specific enough to constrain, you know, the kind of reaction that you might be anticipating. My recommendation would be to leave the language as is.

DR. CASALINO: All right. And I would support it as is.

DR. CROSSON: Okay. Thank you, Larry.

Dana, proceed.

MS. KELLEY: Pat.

MS. WANG: So I think -- you know, my appreciation to Jim and the team for producing what I think is the most comprehensive and thoughtful and well-researched implementation, you know, sort of road map for the original proposal that had its roots I guess in the 2017-ish recommendation of MedPAC to shift the risk in reinsurance where it's magnificent. The chapter is incredibly comprehensive. I truly appreciate all of the extra work that has been done and the sensitivity to the LIS population, to regional plans.

My dilemma is that in the current environment, it has made me sort of sit back and sort of try to visualize

if this structure were in place today, what would that actually mean to my plan or to a plan that is like mine. Hopefully, God willing, it will be seen sooner than later. No idea how much it's going to cost. Forty million seniors are going to be running out to get it. There may be other treatment modalities. There may be treatment modalities that exist today that will spike in cost. It's just hard to know. And it's not specific to this crisis because this is extraordinary, what we're going through, but what it has made me kind of visualize is how do you do a bid when there are new drugs coming in, you have no idea what utilization and cost is going to be. And so I think, you know, Congress is going to go forward with this thing. This is the best possible road map they could have to do it.

I wasn't here in 2017 when the original MedPAC recommendation was made to shift the liability, and so I am going to abstain.

DR. CROSSON: Thank you, Pat. I would point out that it is our hope -- no guarantee at all -- that as this plays out, and it may well play out as you describe, there will be consideration in terms of the bidding process, because I think there's already recognition of the point

that you're making.

Go ahead, Dana.

MS. KELLEY: Kathy.

MS. BUTO: So I strongly support the recommendations. I really think the restructuring is a brilliant stroke. I'm excited to see the coverage gap go away. I think you're aligning the incentives in the right direction.

I agree with Bruce on one level, not so much his point of no transition, but I think the transition needs to be more clearly explained because saying four years, it wasn't clear to me in reading the chapter how it was going to work. I assumed the coverage gap would go away right away and manufacturers would shift to the catastrophic area with their discounts. And I assumed what you were talking about for transition were the risk corridors, percentages that plans and manufacturers and the federal government would have to bear -- in other words, above the cap. I assumed you're wanting to be sensitive to plans having to shift to a large chunk of risk. We might want to either keep manufacturers at 30 or go to 20 and then ramp up to 30 when you go to fully phase in. But you'd want the federal

government to absorb more of the risk during the transition, I assume. But I didn't see that clearly spelled out or I missed it if it was there.

So I would urge you to be clearer on that, and I would actually suggest we might want to consider a shorter transition. Four years just seems like a lot to me. I think PPS was only three years. Jim, maybe it was four. But the whole inpatient DRG system didn't take, I don't believe, four years.

DR. CROSSON: It actually was four years, Kathy.

MS. BUTO: It was? Okay. The whole DRG system, the whole hospital system. So all I'm saying is I think that's being super generous, and I'm not sure that we need the extra year.

Lastly, to Pat's point -- and I think she's pointed something out that's really important -- with MA plans, when a new technology comes along that hasn't been anticipated, there is the ability to provide an add-on payment, and I think there ought to be some acknowledgment that for extraordinary circumstances there ought to be some process for plans to come in and make their case, and maybe you use sort of the adjudication process that we talked

about earlier to really assess whether or not there ought to be an extra payment. In other words, it shouldn't be automatic. We don't want to create another TDAPA. But there should be a way, when there's extraordinary circumstances totally out plans' control and the timing is not right to anticipate it, for there to be some redress for those circumstances.

So I would suggest those points.

DR. CROSSON: Thank you, Kathy.

Dana, you can proceed.

MR. PYENSON: Just on that point, Jay.

DR. CROSSON: Yes.

MR. PYENSON: There's currently a process where PD plans don't have to put new drugs on their formulary right away. Now, there might be extraordinary issues like a new vaccine comes along and that gets required. But there's currently a delay process to allow for medical review and appropriateness and contracting and everything else. So that exists today. And it's not like plans don't know what's coming. There's PIPLA (phonetic). There's sources of pipeline information, expected dates of FDA approval indications that are readily available to the

plans.

MS. BUTO: But they don't know what the prices are going to be, Bruce, even while they're --

MR. PYENSON: Actually they do pretty well. I mean, there's sort of benchmarks for different prices depending on what the market has borne for other conditions. So what I've seen is that there's an expectation that, for example, any new MS drug is going to be around $100,000. A rare ultra-orphan gene therapy curative is going to be in the, you know, million-dollar range. Not that many of those are used for Medicare patients. CAR-T therapy was kind of known in advance.

But the bigger issue for Part D isn't the new drugs. It's the existing drugs, right? If you look at the driver of trend -- and MedPAC has reported on this -- it's not the new technology. It's the price rise in existing specialty drugs. I'd ask staff to confirm that or not.

DR. CROSSON: Okay. I'm going to interrupt because I think we're getting a little far afield. I appreciate the discussion, but I'd like to proceed with positioning, and then we have three votes to go through.

MS. KELLEY: Okay. Marge?

MS. MARJORIE GINSBURG: Support.

MS. KELLEY: Jonathan?

DR. JAFFERY: Support.

MS. KELLEY: And Warner is not present, so I think we're done. Oh, wait, I'm sorry, he is here.

MR. THOMAS: Support.

MS. KELLEY: Okay. That's all, Jay.

DR. CROSSON: And I support as well. Okay. So I suppose we could do them all together, but I think to be consistent with how we've done work in the past on the Commission, we'll take each recommendation in turn, starting with Recommendation Number 1.

MS. KELLEY: Okay. The recommendation is up there on the screen, and I'll run through and ask for a yes, no, or abstain. Kathy?

MS. BUTO: Support, yes.

MS. KELLEY: Larry?

DR. CASALINO: Support.

MS. KELLEY: Brian?

DR. DeBUSK: Yes.

MS. KELLEY: Karen?

DR. DeSALVO: Yes.

MS. KELLEY: Marge?

MS. MARJORIE GINSBURG: Yes.

MS. KELLEY: Paul?

DR. PAUL GINSBURG: Yes.

MS. KELLEY: David?

DR. GRABOWSKI: Yes.

MS. KELLEY: Jonathan Jaffery?

DR. JAFFERY: Yes.

MS. KELLEY: Amol?

DR. NAVANTHE: Yes

MS. KELLEY: Jon Perlin?

DR. PERLIN: Yes.

MS. KELLEY: Bruce?

MR. PYENSON: Yes.

MS. KELLEY: Jaewon?

DR. RYU: Yes.

MS. KELLEY: Dana?

DR. SAFRAN: Yes.

MS. KELLEY: Warner?

MR. THOMAS: Yes.

MS. KELLEY: Sue?

MS. THOMPSON: Yes.

MS. KELLEY: And Pat?

MS. WANG: I abstain.

DR. CROSSON: And Jay says yes.

MS. KELLEY: And Jay.

DR. CROSSON: I believe we have 16 votes yes and one abstention. Is that correct?

MS. KELLEY: Correct.

Now to Recommendation 2. The recommendation is up on the screen. Pat?

MS. WANG: Abstain.

MS. KELLEY: Sue?

MS. THOMPSON: Yes.

MS. KELLEY: Warner?

MR. THOMAS: Yes.

MS. KELLEY: Dana?

DR. SAFRAN: Sorry, I was muted. Yes.

MS. KELLEY: Jaewon?

DR. RYU: Yes.

MS. KELLEY: Bruce?

MR. PYENSON: Yes.

MS. KELLEY: Jon Perlin?

DR. PERLIN: Yes.

MS. KELLEY: Amol?

DR. NAVANTHE: Yes.

MS. KELLEY: Jonathan Jaffery?

DR. JAFFERY: Yes.

MS. KELLEY: David?

DR. GRABOWSKI: Yes.

MS. KELLEY: Paul?

DR. PAUL GINSBURG: Yes?

MS. KELLEY: Marge?

MS. MARJORIE GINSBURG: Yes.

MS. KELLEY: Karen?

DR. DeSALVO: Yes.

MS. KELLEY: Brian?

DR. DeBUSK: Yes.

MS. KELLEY: Larry?

DR. CASALINO: Yes.

MS. KELLEY: Kathy?

MS. BUTO: Yes.

MS. KELLEY: Jay?

DR. CROSSON: Yes. I believe we have 16 yes and 1 abstention.

MS. KELLEY: Yes. And now Recommendation 3. The

recommendation is up on the screen. Paul?

DR. PAUL GINSBURG: Yes.

MS. KELLEY: Karen?

DR. DeSALVO: Yes.

MS. KELLEY: Jonathan Jaffery?

DR. JAFFERY: Yes.

MS. KELLEY: Larry?

DR. CASALINO: Yes.

MS. KELLEY: Jon Perlin?

DR. PERLIN: Yes.

MS. KELLEY: Kathy?

MS. BUTO: Yes.

MS. KELLEY: Dana?

DR. SAFRAN: Yes.

MS. KELLEY: Brian?

DR. DeBUSK: Yes.

MS. KELLEY: Jaewon?

DR. RYU: Yes.

MS. KELLEY: Marge?

MS. MARJORIE GINSBURG: Yes.

MS. KELLEY: Pat?

MS. WANG: I abstain.

MS. KELLEY: Amol?

DR. NAVANTHE: Yes.

MS. KELLEY: Warner?

MR. THOMAS: Yes.

MS. KELLEY: David?

DR. GRABOWSKI: Yes.

MS. KELLEY: Bruce?

MR. PYENSON: Yes.

MS. KELLEY: Sue?

MS. THOMPSON: Yes.

MS. KELLEY: And Jay

DR. CROSSON: Yes. I believe we have 16 yes and 1 abstention.

MS. KELLEY: Yes, that's correct.

DR. PAUL GINSBURG: Is it possible to give Warner a chance to vote on the ACO recommendation now that he's here?

DR. CROSSON: You know, there is precedent for that. As much as I would like to do that, the Commission precedent is we do not go back and revisit votes.

Okay. Let's proceed to the third of the recommendations.

MS. KELLEY: Jay, I think we've gone through all the Part D recommendations, and we're ready to move to the next --

DR. CROSSON: I'm sorry. I meant the next item of business.

MS. KELLEY: Okay.

DR. CROSSON: Okay. Ready to begin. We've got Andy, Carlos, and Sam on as well? I see Carlos.

MS. TABOR: And Ledia.

DR. CROSSON: Oh, and Ledia? Okay.

So it looks like, Andy, you've got your microphone on you. It looks like you're going to be it. Go ahead.

DR. JOHNSON: Good afternoon. I'll be presenting on behalf of our team, including Ledia, Carlos, and Sam.

We are here to discuss the draft recommendation to implement a redesigned value incentive program for MA. The design of the value incentive program was initially published in our June 2019 report to the Congress and discussed at several Commission meetings over the past year.

During the discussion at the March meeting, the

Commission made clear that although today's recommendation would produce savings for the Medicare program and its beneficiaries, the Commission is not rendering a judgement on the appropriate level of payments to MA plans overall.

Reforming the quality bonus program is a matter of urgency. One-third of Medicare beneficiaries are now enrolled in Medicare Advantage, and that number is growing. MA plans have the potential to be more efficient than fee-for-service Medicare while providing high-quality care. However, the Medicare program does not have the tools to judge the quality of care MA plans provide, and beneficiaries do not receive accurate information about plan options.

The current QBP uses broad contract-level quality results that have spurred contract consolidation and led to unwarranted bonus payments.

The QBP ineffectively accounts for social risk factors of plan populations, and plans that serve high-needs population are less likely to be classified as high-quality plans.

Also, the QBP adds $6 billion per year in program costs, unlike nearly all fee-for-service quality incentive

programs, which are budget-neutral or produce program savings.

Over the course of the quality bonus program, many companies consolidated contracts to boost star ratings and obtain unwarranted bonuses.

As of 2020, the majority of MA enrollees are in plans that have some level of consolidation.

Although recent legislation has limited plans' ability to use the consolidation strategy to obtain unwarranted bonuses, the legacy of past consolidation continues to result in increased program expenditures, inaccurate consumer information on quality, and quality data that is not representative of performance in a local area.

In addition, past consolidations have given some companies an unfair competitive advantage in certain markets.

Over the next several slides, I will walk through the key design features of the MA value incentive program.

First, the value incentive program scores a small set of population-based measures that focus on patient outcomes and experience.

This table displays an illustrative measure set that incorporates the Commission's discussion. It is not a definitive list of measures. CMS should develop a complete measure set through a public review and input process that could evolve as better data, including encounter data, become available.

In our illustrative modeling, we scored the six measures noted with an asterisk, which are the only measures with sufficient beneficiary-level encounter or survey data.

The value incentive program evaluates quality at the local market level, meaning it scores a plan's performance for the enrollees in each local market area as opposed to the contract.

Using market-level measure results provides a more accurate picture of quality, both for beneficiaries to select a plan in their market and for the Medicare program to understand plan performance.

In our illustrative modeling, we used a parent organization within a local area as the reporting unit and limited our analysis to markets with sufficient enrollment to reliably calculate measure results.

Medicare should take into account, as necessary, differences in enrollee populations, including social risk factors.

One way to do this is to stratify plan enrollment into groups of beneficiaries with similar social risk factors to determine payment adjustments. Comparing beneficiary groups with similar compositions accounts for social risk factors without masking disparities in plan performance, which occurs when measure results are adjusted directly.

In our illustrative modeling, we stratified each parent organization's enrollment into two peer groups and then calculated measure results for each of the groups. We used eligibility for full Medicaid benefits because it is readily available in our data sources and capture the characteristic that may affect a plan's ability to serve its enrollees. Policymakers could explore other factors for potential peer grouping.

The value incentive program uses a performance-to-points scale for each measure to convert a plan's performance to a score which determines the rewards and penalties the plan receives. There are two key features of

this scoring mechanism.

First, plans know that performance improvements can impact their rewards, which can drive quality improvement.

Second, the scale is continuous, meaning that every change in performance will affect the number of points achieved and the size of any reward or penalty. Unlike the current QBP, there are no performance cliffs in the scoring.

In our illustrative modeling, we set each measure's scale based on a beta distribution of current national performance.

Rewards in the value incentive program would be financed through a pool of dollars that is funded by a share of plan payments.

A key change from the current quality bonus program is that quality bonuses would not increase plan benchmarks. Instead, the value incentive program would redistribute plan payments based on quality performance.

Reward pools would be distributed within each local market based on local performance, resulting in some parent organizations receiving rewards and others receiving

penalties. Local distribution controls for varying market conditions, including differences in safety net programs, like Medicaid and food assistance, that could cause a plan applying the same quality strategy to have different results across markets.

Based on the Commission's discussion during the March meeting, we revised the chapter to reflect the Commission's support for distributing rewards and penalties at a local market level as opposed to a national or blended approach.

Your mailing materials contain information about our illustrative modeling of the MA value incentive program, but here are the main points.

First, local distribution of reward pools guaranteed that some parent organizations received rewards and other received penalties and controlled for varying market level conditions. We think that the market-specific conditions contributed to differences in average market performance, which varied from 3.5 to 7.5 points out of 10.

Second, fully dual-eligible enrollee peer groups tended to have lower quality scores than the all-other enrollee peer group. This result highlights the need for

stratifying enrollees into peer groups to account for differences in social risk factors through the distribution of rewards and penalties within those populations.

Finally, payment adjustments tended to be small in our modeling. When implemented, payment adjustments could be scaled appropriately by adjusting the performance to points scale or the share of plan payments used to finance the program.

Finally, I will note that there are differences in how plans fare in the value incentive program as compared to the current QBP. The three most important differences are, first, plans enrolling large shares of fully dual eligible beneficiaries are treated more fairly under the value incentive program. Second, large organizations that had an undue advantage in the QBP system have less of an advantage in the value incentive program, and third, the value incentive program would better target positive financial results. Some plans that are not in bonus status would perform better under the value incentive program. These plans tend to be smaller and operate in single markets or limited geographic areas.

That brings us to the draft recommendation, which

reads "The Congress should replace the current Medicare Advantage quality bonus program with a new value incentive program that scores a small set of population-based measures, evaluates quality at the local market level, uses a peer grouping mechanism to account for differences in enrollees' social risk factors, establishes a system for distributing rewards with no cliff effects, and distributes plan-financed rewards and penalties at a local market level."

Next slide, please. We should be on Slide 12.

MS. KELLEY: Is that it?

DR. JOHNSON: Thank you.

We seem to have a slightly different slide than we have in our deck. That looks like the Part B slide.

MS. KELLEY: Hang on. Let me make a switch. Just one second.

DR. JOHNSON: That's the one. All right. Back on Slide 12.

The rationale for the draft recommendation is that the QBP is flawed and does not provide a basis for evaluating MA quality in meaningful way. Plans have also received unwarranted bonus under the QBP system.

The QBP increases Medicare program spending. A plan-financed value incentive program that does not involve additional dollars would put the MA quality incentive program on par with nearly all fee-for-service quality incentive programs, which are budget-neutral or produce program savings.

Compared to the QBP, the value incentive program will provide the Medicare program and its beneficiaries with more accurate information on MA quality and will produce a fairer distribution of incentive payments across market areas and across MA enrollees.

The implication on spending is that the draft recommendation would reduce program spending relative to current law by more than $2 billion over one year and by more than $10 billion over five years. The chapter clearly states that in making the recommendation, the Commission is not rendering a judgement on the appropriate level of overall payments to MA plans.

The recommendation is not expected to affect beneficiaries' access to plans or plan participation in MA.

Depending on how plans respond to the lower benchmarks that some plans would face, extra benefits may

be reduced, plans may choose to reduce profits, or plans may lower their cost of providing the Medicare benefit.

Plans serving high-needs populations would be treated more equitably, putting those plans on more even footing in competing with other plans in their area and possibly improving the level of extra benefits for their enrollees.

Finally, beneficiaries will have better information on the quality of plans in their area, but some plans will have higher administrative costs due to the additional surveys required to produce quality information in each local market area.

That concludes the presentation, and now we'll turn back to the draft recommendation for your discussion.

DR. CROSSON: Okay. Thank you, Andy.

So we will proceed, and again, I would suggest that Commissioners either respond by support, generally support with a comment, or do not support.

Dana, you can begin.

MS. KELLEY: Okay. Amol?

DR. NAVATHE: Support.

MS. KELLEY: Bruce?

MR. PYENSON: Support.

MS. KELLEY: Dana?

DR. SAFRAN: Support.

MS. KELLEY: Sue?

MS. THOMPSON: Support.

MS. KELLEY: Pat?

MS. WANG: I support, and I think you guys did a fabulous job.

I just would note I still think that like nothing on Part D -- somebody is going to have to do like part two of this to figure out what should happen with the Part D quality measures. But I support.

MS. KELLEY: Warner?

MR. THOMAS: Support.

MS. KELLEY: Kathy?

MS. BUTO: Support.

MS. KELLEY: Paul?

DR. PAUL GINSBURG: Support.

MS. KELLEY: Jonathan Jaffery?

DR. JAFFERY: Support.

MS. KELLEY: Jaewon?

DR. RYU: Support.

MS. KELLEY: Jon Perlin?

DR. PERLIN: Generally support with two comments. First, I'm worried about the effects of unintended consequences of -- even though I totally agree that this should be -- operate just like all of the other value-incentive programs, where it's out of the corpus, as opposed to an add-on. I do worry that it will have some downstream effect on providers, particularly coming out of COVID.

Second, while I totally agree in principle with the notion of redistributing the dollars to the local market, it strikes me that as a practical matter, those national organizations that operate in different markets will essentially redistribute on the basis of fungible dollars, not these dollars. So I think the intent is correct, but I'm somewhat skeptical of the operation it takes in a multimarket interest. Thanks.

DR. CROSSON: Dana, you can proceed.

MS. KELLEY: Okay. Marge?

MS. MARJORIE GINSBURG: Support.

MS. KELLEY: David?

DR. GRABOWSKI: Support.

MS. KELLEY: Brian?

DR. DeBUSK: Support and appreciative that we teased apart the level of payment from the mechanics of the QBP.

MS. KELLEY: Larry?

DR. CASALINO: I think this is excellent work, and I support it.

The only comment I would make -- and I think I made it before -- is that although I totally support providing incentives and presumably public reporting of quality at the local level, I think there also ought to be public reporting of quality at the national level so that a local plan can be rewarded for doing well compared to other local plans. But I still think that beneficiaries, business leaders, you name it, in a local area should see how their plans compare on a national level and not just to each other locally, even though the payments are all going to be the -- the rewards are only going to be distributed on the local level. I think that ought to be important. But I support things as they are.

MS. KELLEY: Okay. Karen?

DR. DeSALVO: Support.

MS. KELLEY: And Jay?

DR. CROSSON: Well, it's my recommendation. I kind of support it. Okay. You can proceed to the vote.

DR. SAFRAN: You're getting snarky towards the end of your term.

[Laughter.]

MS. KELLEY: All right. The draft recommendation is up on the screen. Yes, no, or abstain.

Kathy?

MS. BUTO: Yes.

MS. KELLEY: Karen?

DR. DeSALVO: Yes.

MS. KELLEY: Amol?

DR. NAVATHE: Yes.

MS. KELLEY: Jon Perlin?

DR. PERLIN: Yes.

MS. KELLEY: Brian?

DR. DeBUSK: Yes.

MS. KELLEY: David?

DR. GRABOWSKI: Yes.

MS. KELLEY: Dana?

DR. SAFRAN: Yes.

MS. KELLEY: Warner?

MR. THOMAS: Yes.

MS. KELLEY: Pat?

MS. WANG: Yes.

MS. KELLEY: Larry?

DR. CASALINO: Yes.

MS. KELLEY: Sue?

MS. THOMPSON: Yes.

MS. KELLEY: Marge?

MS. MARJORIE GINSBURG: Yes.

MS. KELLEY: Jonathan Jaffery?

DR. JAFFERY: Yes.

MS. KELLEY: Paul?

DR. PAUL GINSBURG: Yes.

MS. KELLEY: Bruce?

MR. PYENSON: Yes.

MS. KELLEY: Jaewon?

DR. RYU: Yes.

MS. KELLEY: And Jay?

DR. CROSSON: Yes.

I believe I heard 17 affirmative votes; is that correct?

MS. KELLEY: That is correct.

DR. CROSSON: Okay. Thank you. So we'll move on to the last item of business.

MS. RAY: Are we ready?

DR. CROSSON: Nancy, you're still there, and Andy is still there? Yeah, I see Andy. I don't see Nancy, but you must be somewhere off to the side here.

MS. KELLEY: Nancy, can you turn your -- there you are.

MS. RAY: Here I am.

DR. CROSSON: Okay. So Nancy, are you going to begin?

MS. RAY: Yes.

DR. CROSSON: Go right ahead.

MS. RAY: Thank you. Good afternoon. Andy and I will walk you through two draft recommendations aimed at improving Medicare's payments for dialysis services. We have discussed these issues for a couple of cycles and have developed the draft recommendations over the last several Commission meetings.

I will take you through the first policy option, eliminating the transitional drug add-on payment

adjustment, the TDAPA, for new drugs in an existing ESRD functional category. Andy will take you through the second option, to replace the low volume payment adjustment and rural adjustment with a single payment adjuster, what we call the low-volume and isolated adjustment.

Before beginning, a few housekeeping issues. The draft chapter has been revised to reflect your questions and comments from the March meeting. For example, Bruce, we have added text on dialysis organizations having long-term contracts with drug manufacturers. Warner, we have added a table that addresses your question, facilities receiving the low-volume payment adjustment are less likely to be associated with the two large dialysis organizations. And Brian, we have added a table showing that the adjusted cost per treatment for urban versus rural dialysis facilities is similar after adjusting for total treatment volume.

Recall that there are two TDAPA policies for new dialysis drugs. In the first, highlighted in the center column, the TDAPA applies to new drugs that are not in one of the 11 existing ESRD functional categories. Our draft recommendation does not change this policy. In the second, highlighted in the right column, the TDAPA applies to ESRD

drugs that are in an existing ESRD functional category. This is the focus of our draft recommendation.

As of 2020, no ESRD drug has qualified for either policy.

Our policy option addresses two concerns associated with the current policy. First, current policy reduces the competition that would occur if all drugs with the same function were paid under a single rate, and it fails to provide an incentive for drug manufacturers to constrain drug prices. Second, the TDAPA payment is duplicative of the payment for drugs already included in the bundle. For patients prescribed the TDAPA drug, Medicare will pay the facility the full base rate plus the TDAPA payment.

Not only is the TDAPA duplicative, it creates a financial incentive to provide TDAPA-covered drugs over drugs in the bundle, and potentially promotes the overuse of TDAPA-covered drugs.

The policy option eliminates the TDAPA for new drugs in a functional category. Its goals are to maintain the structure of the ESRD prospective payment systems, and; and create pressure on drug manufacturers to constrain the

prices of new and existing ESRD drugs. Drugs entering the market would immediately be included in the ESRD bundle with no changes the base rate.

It will be important to monitor how Medicare's payments align with providers' costs and the need for future rebasing. The Commission's annual analysis on payment adequacy, ESRD drug use, and changes in patients' outcomes can help inform policymakers.

As I said up front, this policy option would not change the TDAPA for new drugs that do not fit into an ESRD functional category.

So that brings us to the draft recommendation that reads:

The Congress should direct the Secretary to eliminate the end-stage renal disease prospective payment system's transitional drug add-on payment adjustment for new drugs and an existing ESRD functional category.

This draft recommendation is estimated to decrease program spending by $250 million to $750 million over one year and by $1 billion to $5 billion over five years, relative to current policy.

In terms of beneficiary implications, we do not

anticipate any negative effects on access to care. This draft recommendation would generate savings for beneficiaries through lower cost-sharing. In terms of provider implications, this draft recommendation would reduce future payments to dialysis facilities. This draft recommendation is not expected to impact providers' willingness and ability to care for dialysis beneficiaries.

DR. JOHNSON: We are now going to discuss a replacement for the current low volume and rural payment adjustments.

The current low-volume payment adjustment, or LVPA, increases the base payment rate for all treatments in eligible dialysis facilities by 23.9 percent. To be eligible, facilities must furnish fewer than 4,000 treatments in each of the three years prior to the payment year in question. The LVPA only considers facilities that are owned by the same parent organization if within five miles from one another. In 2017, about 5 percent of dialysis facilities received the LVPA.

We have three main concerns with the LVPA's design. First, the single volume threshold of 4,000 treatments may encourage some facilities to limit services

or report inaccurate data to maintain eligibility. Second, the LVPA does not address the higher cost of facilities with volumes of between 4,000 and 6,000 treatments per year. Finally, the LVPA does not target isolated facilities. In 2017, 40 percent of LVPA facilities were located within five miles of another facility.

Now we turn to the rural payment adjustment. The rural adjustment increases the base payment rate by 0.8 percent for all facilities located in rural areas, regardless of their treatment volume or proximity to another facility. In 2017, 18 percent of dialysis facilities received the rural adjustment.

Our main concern is the targeting of the rural adjuster. In 2017, about 30 percent of rural facilities were located within five miles of another facility, and about half of rural facilities had higher treatment volumes, furnishing more than 6,000 treatments per year.

Finally, I will note that an adjustment for low treatment volume is mandated by law, but a rural adjustment is not mandated. CMS introduced the rural adjustment in 2016.

Now we are going to review the low-volume and

isolated, or LVI, policy option. The LVI is a single adjustment that would replace the current low-volume and rural payment adjustments and would be targeted to facilities that are both low-volume and isolated.

In modeling the LVI adjustment, we used illustrative distance and treatment volume parameters. We required facilities to be farther than five miles from any other facility, and to furnish fewer than 6,000 treatments during each of the preceding three years.

The low-volume criteria could be implemented with a continuous adjustment or set of categorical adjustments. Either approach would help mitigate the cliff effect of the current low volume adjustment, and would better account for the higher costs in relatively low volume facilities.

Your mailing material contains more information about both approaches and also includes the results of our LVI modeling.

That brings us to the second draft recommendation, which reads:

The Secretary should replace the current low-volume and rural payment adjustments in the end-stage renal disease prospective payment system with a single adjustment

for dialysis facilities that are isolated and consistently have low volume, where low volume criteria are empirically derived.

The draft recommendation has the following implications. For spending, the draft recommendation is estimated to be budget neutral with current policy. Beneficiaries' access to care would be enhanced at facilities that are critical for access to dialysis treatment. Providers' willingness and ability to serve Medicare beneficiaries would not be affected.

Our analysis shows that payments would increase or remain the same for low-volume, isolated providers that are necessary for maintaining access to dialysis treatment. Payments would decrease for low-volume and rural providers that are in close proximity to another provider and would decrease for high-volume rural providers.

That concludes our discussion of the TDAPA and low volume payment policies. The material covered in today's presentation will be included in a June 2020 chapter on ESRD prospective payment system design issues. Both draft recommendations are listed on this slide.

Thank you, and we look forward to your

discussion.

DR. CROSSON: Okay. Thank you so much, Andy. Once again, we will proceed forward by roll call, asking Commissioners for support of both recommendations, general support with a comment or lack of support.

And Dana, you can start calling the roll.

MS. KELLEY: All right. Bruce?

MR. PYENSON: Support.

MS. KELLEY: Jaewon?

DR. RYU: Support.

MS. KELLEY: Dana?

DR. SAFRAN: Support.

MS. KELLEY: Warner?

MR. THOMAS: Support.

MS. KELLEY: Sue?

MS. THOMPSON: Support.

MS. KELLEY: Pat?

MS. WANG: Support.

MS. KELLEY: Kathy?

MS. BUTO: Support, but I just wanted to point out I noticed for the first time in this material that a large percentage of hospital-based are not close to other

facilities, but I wondered -- I just raised the question in the report itself that we address whether there is any rationale for hospitals to have dialysis facilities if they are low volume but they are actually close to a freestanding facility. You don't have to answer it now. I just think it's important to know whether we think that is of any value beyond the report.

DR. CROSSON: Thank you, Kathy. Dana?

MS. KELLEY: Larry?

DR. CASALINO: Support.

MS. KELLEY: Brian?

DR. DeBUSK: Support.

MS. KELLEY: Karen?

DR. DeSALVO: Support.

MS. KELLEY: Marge?

MS. MARJORIE GINSBURG: Support.

MS. KELLEY: Paul?

DR. PAUL GINSBURG: Support.

MS. KELLEY: David?

DR. GRABOWSKI: Support.

MS. KELLEY: Jonathan Jaffery?

DR. JAFFERY: Support.

MS. KELLEY: Amol?

DR. NAVATHE: Generally support. I think my one comment on the LVI work was it may have been -- I guess I would have preferred, it would have been even more convincing if we had seen some sort of match between supply and the population of beneficiaries, ESRD beneficiaries needing dialysis. And right now the way we approach it is proximity to other facilities, for example, whereas I think from an access perspective what we really care about is matching the, quote, "supply and demand." But I generally support.

MS. KELLEY: Okay. And Jon Perlin?

DR. PERLIN: Support.

MS. KELLEY: Jay?

DR. CROSSON: I support. Okay. So we are going to vote on -- I know they're on one slide here -- we're going to vote on each of the recommendations separately. We will take the first recommendation. Dana?

MS. KELLEY: Okay. Pat?

DR. CROSSON: Either yes, no, or abstain. Pat?

MS. WANG: Sorry. Yes.

MS. KELLEY: I should have set this up better.

Molly, can you put Recommendation 1 up? There we go. The draft recommendation is on the screen, and I'm sorry, go ahead Pat.

MS. WANG: Yes.

MS. KELLEY: Okay. Sue?

MS. THOMPSON: Yes.

MS. KELLEY: Warner?

MR. THOMAS: Yes.

MS. KELLEY: Dana?

DR. SAFRAN: Yes.

MS. KELLEY: Jaewon?

DR. RYU: Yes.

MS. KELLEY: Bruce?

MR. PYENSON: Yes.

MS. KELLEY: Jon Perlin?

DR. PERLIN: Yes.

MS. KELLEY: Amol?

DR. NAVATHE: Yes. Did you hear me that time?

MS. KELLEY: Yes. Thank you. Jonathan Jaffery?

DR. JAFFERY: Yes.

MS. KELLEY: David?

DR. GRABOWSKI: Yes.

MS. KELLEY: Paul?

DR. PAUL GINSBURG: Yes.

MS. KELLEY: Marjorie?

MS. MARJORIE GINSBURG: Yes.

MS. KELLEY: Karen?

DR. DeSALVO: Yes.

MS. KELLEY: Brian?

DR. DeBUSK: Yes.

MS. KELLEY: Larry?

DR. CASALINO: Yes.

MS. KELLEY: Kathy?

MS. BUTO: Yes.

MS. KELLEY: Jay?

DR. CROSSON: Yes.

MS. KELLEY: Okay. And could we go to Draft Recommendation number 2? The recommendation is on the screen.

Pat?

MS. WANG: Yes.

MS. KELLEY: Sue?

MS. THOMPSON: Yes.

MS. KELLEY: Warner?

MR. THOMAS: Yes.

MS. KELLEY: Dana?

DR. SAFRAN: Yes.

MS. KELLEY: Jaewon?

DR. RYU: 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: Paul?

DR. PAUL GINSBURG: Yes.

MS. KELLEY: Marge?

MS. MARJORIE GINSBURG: Yes.

MS. KELLEY: Karen?

DR. DeSALVO: Yes.

MS. KELLEY: Brian?

DR. DeBUSK: Yes.

MS. KELLEY: Larry?

DR. CASALINO: Yes.

MS. KELLEY: Kathy?

MS. BUTO: Yes.

MS. KELLEY: And Jay?

DR. CROSSON: Yes. I heard unanimous support for both recommendations.

MS. KELLEY: Correct.

DR. CROSSON: Okay. So that ends this order of business. I just have a couple of comments I would like to make for the record. The first is to acknowledge the hard work of Jim Mathews, Dana Kelley, Stephanie Cameron, and the rest of the staff during this year, to get us to the point where we have arrived at the end of our cycle here. It has been extraordinary all year. It has been unbelievably extraordinary during the last month or so, I think as everybody understands.

Secondly, for the record, I would like to make it clear that the staff will make available time for public input, which we normally have at our in-person meetings. That will be approximately in the week or so after the

publication on the MedPAC website of the transcript of this meeting, so people will have had a chance to read it and provide public comments.

That, I believe, if there are no comments from anyone, would be the end of this meeting. So we will adjourn the meeting and the recording will cease at this point.

[Whereupon, at 3:57 p.m., the meeting concluded.]