STRATEGIC HEALTH CARE

DR. AMOL NAVATHE DISCUSSES TRADITIONAL MEDICARE OR MEDICARE FEE FOR SERVICE REFORMS

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P R O C E E D I N G S

MR. OOSTRA: Hello, my name is Randy Oostra, President and CEO of ProMedica. I'm pleased to welcome you to this eight-part series of health care reform discussions with nationally recognized health policy experts. These interviews will discuss Medicare policy, including health care pricing, long-term care, and the social determinants of health. This series is part of an ongoing two year effort by more than a dozen hospital CEOs from around the U.S. to urge Congress to take up significant health care policy reform legislation, largely by calling for the creation of a national commission on health care reform.

It is our intent that these policy reforms discussed during these interviews demonstrate our desire for substantive national reform. Moreover, that these interviews help to further inform congressional members and committee staff as they work to craft legislation to improve health care delivery and financing during the next Congress

Our motivation is straight forward. Well before the onset of the Covid-19 pandemic we were

adamant that race, age, and/or economic circumstances should not be defined as preexisting conditions, nor do we accept the premise that Americans should be resigned to live shorter lives in poorer health.

We invite you to listen to or to read the transcripts of all eight interviews. If you'd like to provide comment, you can do so via the contact information noted at the conclusion of these interviews.

MR. INTROCASO: Welcome to this series of eight interviews concerning federal health care policy reform. I'm the host, David Introcaso. With me to discuss traditional Medicare or Medicare fee for service is Dr. Amol Navathe, Assistant Professor of Health Policy and Medicine, Co-director of the Health Care Transformation Institute, and Associate Director of the Center for Health Incentives and Behavioral Economics, all at the University of Pennsylvania Perelman School of Medicine.

Dr. Navathe, welcome to the interview.

DR. NAVATHE: Thank you, David, for having me.

DR. INTROCASO: On background, the Medicare program is expected to grow from 62 to 80 million

Americans by the end of this decade. Approximately $400 billion of the $650 billion incurred Medicare costs are attributed to Medicare fee for service spending, the remainder to MA funding. Medicare spending in sum is projected to double to nearly $1.3 trillion by 2029. Among other current Medicare fee for service policy problems, the Part A Trust Fund is projected to be insolvent in three years. Part B policy intended under the 2015 MACRA legislation to move eligible fee for service clinicians into advance alternative payment models or financial at risk models remains unproven, largely due to the fact that less than one in five eligible clinicians participate. And the Part D and Part B drug spending growth continues to exacerbate Medicare program spending largely because HHS, unlike the VA, is prohibited from exercising its purchasing power.

Among other policy problems, Medicare fee for service, unlike Medicare Advantage, has no annual out of pocket spending cap. Fee for service does not provide long-term care, hearing, oral, or vision care or social service supports. The Center for Medicare and Medicaid

Innovation payment demonstrations have proven to be at best marginally successful and post-acute suffers numerous quality and reimbursement issues. For example, skilled nursing facilities continue to over-prescribe anti psychotics while 2018 marked the 19th consecutive year free standing skilled nursing facility profit margins were in the double digits.

With me again to discuss Medicare fee for service policy reform is Dr. Amol Navathe. Please note Dr. Navathe's comments are his own.

Dr. Navathe, let's start with my asking a general question. That is, what Medicare related policy conclusions do you draw from the pandemic's affect on the Medicare beneficiary population?

DR. NAVATHE: Well, the -- the pandemic -- the public health emergency here with Coronavirus and Covid has obviously had devastating impacts on elderly Americans in particular. The data is pretty clear that age is a major risk factor in the -- and older Americans have disproportionately bore the burden alongside the inequities that we see along racial and socioeconomic lines as well. And so I think there's a few things that

we see here. I think one, you know, just from a -- a basic humanity perspective, of course, we have a large population of vulnerable folks who -- who unfortunately have died and others who are at risk. Particularly we have heard a lot about those who live in the nursing homes.

So the Medicare program I think, one, has obviously to support vaccination efforts, public health efforts, as strongly as possible, as well as trying to get more support guidance, you know, PPE, sort of the full nine yards, if you will, in particular to nursing homes and assisted living facilities and other institutions that are caring for particularly vulnerable Medicare beneficiaries.

The other point I'll note is that the other impact it's had on the Medicare program is of course financial, given the amount of cost associated with the type of care and the PPE that's been required along the way and that will be continued to be required over the next year at least. And we've seen, for example, the Medicare Trust Fund, or the Hospital Insurance Fund, the estimates of its insolvency have accelerated. Now I

think the Congressional Budget Office is estimating as soon as 2024.

DR. INTROCASO: Correct.

DR. NAVATHE: So -- so first, you know, we obviously have a lot of people who've been harmed by this and the Medicare program's first duty is to try to -- to help them as best as possible get the care that they need and to set up the appropriate public health measures and the like. And the second is we need to now address the financial implications of the Covid public health emergency on the program at large.

DR. INTROCASO: Okay. Thank you for that. And we'll get back to the solvency question or issue.

But before we go into specific program policies, let me ask you, what's your take on expanding the Medicare program or a Medicare buy in policy? As you're very well aware, this has been discussed for several decades actually and there was, not surprisingly, in this past Congress a bill introduced to allow seniors -- and it varies, beginning at 50 or older -- to buy into the Medicare program. What's -- what's your -- what's your policy perspective on a buy in?

DR. NAVATHE: Yes, it's a great question. You know, my -- my policy perspective here is the -- the Medicare program on one hand, for current Medicare beneficiaries, obviously has been very successful in general. And within it, you know, we've had a successful Medicare Advantage program that has also engaged the private insurance industry and the private sector within the Medicare program as well. So -- so I think from that perspective, starting from that as a foundation, looking forward and saying, okay, is there a way to expand the Medicare program to allow more people to buy in, if you will, makes a lot of sense.

That being said, unfortunately, with all things health care, the devil is in the details. And if you look at the concept of a public option or the concept of being able to buy into Medicare, one, we know that Medicare beneficiaries from an age perspective and an end of life perspective, virtually for those who eventually will pass on, bear a, you know, or a cost, if you will, expend a lot of dollars. And so if -- if we think about this at least in some sense as a traditional insurance concept of (inaudible) risk, having younger

individuals buy into Medicare is likely at least to start out to be rather expensive compared to an actuarily fair insurance product, if you will, that you could buy on the commercial market.

And so to make that pragmatically feasible would mean that we would have to mobilize very substantial subsidies. And so I think that's where the devil in the details becomes particularly important. Is this the mechanism that we really want to pursue as a society, you know, from a legislative perspective, from an executive perspective, to try to expand insurance or are there other ways to do it, kind of like the way the Affordable Care Act tried to do it.

So I think -- I think in principle -- put it this way I guess -- I would say my -- my policy opinion, as in principle, it sounds like a good idea, but to make it feasible and actually to make it affordable, such that you get considerable uptake as a way to solve some of the under insurance or uninsurance problem in this country, I think actually it's not as trivial or as simple as it might seem otherwise.

DR. INTROCASO: Right, thank you. I'll just

note there was an Uurban study just out this month, effects of a Medicare buy in for older adults, and you're right, it's a very complicated question as relates, as you note, how you flesh out the details.

Let's get into then more specifically the Medicare fee for service program. As I noted in my intro, Medicare's goal is to move physicians, or as their term, eligible clinicians, into what are termed advanced payment models. The flagship advanced payment model, you're well aware, is the Medicare shared savings program, or ACOs, with currently over 11 million fee for service beneficiaries assigned.

On balance, it's fair to say the program has not succeeded to the extent hoped. And I'll quote research recently published by Harvard's J. Michael McWilliams in which he concluded the program is "not headed in the right direction" in part because he argued estimated savings to date over stated largely because the program lacks -- and he listed a long list of concerns, including rigorous evaluation and problems with, as he details, financial benchmarking, benchmark rebasing, financial incentives, risk exposure, risk

adjustment, et cetera.

So, since this is the again flagship Medicare fee for service reform program, I wanted to start with this particular aspect by asking you what's your understanding of the ACO program's performance to date and what would you recommend -- say two or three policy reforms you think would help improve the program.

DR. NAVATHE: Sure. So I -- I follow Mike McWilliams' work quite carefully and he's obviously been one of the key leaders in helping us understand what the ACO program, you know, MSSP and others have done in terms of effects. So I would say you're going to find that I largely agree with him, but I -- I might differ in a couple of places.

You know, my general sense is that overall the ACO program has certainly not been a smashing success. You know, we would have loved for it to have truly had a very substantial amount of savings and quality improvements. I think what we have seen, however, still is that there's actually been quite a bit of practice pattern changes underneath the program in way that we may not necessarily think is driven by the financial

incentives, which are rather -- or, you know, rather not strong, if you will. And -- and so I actually think -- I walk away from that saying that's -- that's very good news from two respects. Number one, it means that the health care provider sector, hospitals, physical practices, clinicians, et cetera, they're signing up to change in a -- in a -- at a time and in a form where the financial incentives aren't overwhelmingly driving them to change. And it also likely means that there's enough change that is being catalyzed as part of the secular trend, if you will, you know, just the general -- the general direction of the Medicare program, that means it's worth it for them to start to invest and prepare in these types of practice changes.

I take that to be very good news. I don't think that's all attributable to the MSSP, but I do think some of the early moves that Medicare made in the previous decade by signaling that we're going to move towards value, we're going to move toward alternative payment models, we're going to even move fee for service to incentivize participation in alternative payment models, it started to create a cultural shift in the

practice patterns and in the expectations of providers. MSSP was a big part of that. As you note, it's one of the flagship initiatives. And so I think from that perspective we should be optimistic about the impact that MSSP has had in the direction we're going.

Now, the specific financial structure of the program and the way that is has evolved I think, you know, does have considerable challenges and perhaps corrections that are needed. You know, practices, hospitals, it takes time to actually improve quality and change the way that -- you know, redesign care, if you will, or transform practices -- pick your favorite buzzword. And -- and so the way that the model has been concurrently constructed around what some of us will call, you know, race to the bottom types of designs, I think that is not conducive to a lot of investment in infrastructure. And so I think a more stable longer-term type of a cycle to the financial incentives that is benchmarked to more of what the general health sector is doing within Medicare is likely to generate more participation and hopefully more results.

So I think that's one key thing, is let's

change the structure to be a longer-term model here and less about squeezing existing systems and then rebasing in a way that takes away the incentive to really participate at all.

The other struggle that others have written about, and I've written about as well, is the voluntary participation piece in confluence with these other challenges creates a big problem because it does create opportunities for preferential selection or preferential participation. And while I think on one hand we've seen more of a direction towards geographic models, including, for example, the direct contracting "Geo" model that was just announced within the last few weeks, I think sure, a lot of us think geographic based models make a lot of sense, right. Then you can actually create structures where the most efficient providers are not the ones who are penalized because they can generate savings against historical benchmarks and you don't get the situation where you're only incentivizing participation from "the most wasteful" providers, but then you rebase them and so then they're out, right. They're going to quit after they make their savings for

a couple of years.

The challenge is when you have non mandated participation, you have voluntary participation, then -- then practices and hospitals are going to join when it's favorable and not when it's not favorable, and that's going to deconstruct this whole regional system. The big challenge is we've seen bundle payment models as an alternative -- alternative payment model to ACOs. We've seen the successful implementation of a mandated design with a comprehensive care for joint placement program. I think it may be more challenging to mandate ACO participation. And so I think that actually brings a very challenging point that I actually haven't seen a lot folks write yet about, is how do we solve this problem. I think, you know, folks are generally quick to point out that there's weak incentives, they're generally quick to point out that we have this race to the bottom that we -- you know, we need stronger incentives, but do we really need downside incentives. That's another thing that I've seen written. I think we've heard about preferential selection and gaming, we've heard about the benefit of regional pricing, for

example, at regional market structures, but the what do we do about this voluntary mandatory problem?

I think it's a real challenge. And, you know, one of the -- the policy like solutions I would -- or policy directions at least I would like to see is -- is to see the fee for service -- Medicare fee for service alternative payment model market look at the other side of the Medicare program, in Medicare Advantage and see how Medicare Advantage is addressing this, because Medicare Advantage does have voluntary participation intrinsically, by deciding to bid. And it has, you know, generated positive results, although I will be -- I think I will note -- important to note that the Medicare Advantage has not yet generated savings for the Medicare program overall. But I think moving to a model where you have -- you're able to effectively take the entire fee for service population and divide it up amongst a set of voluntary groups, whether they're actually providers or they need the convener like organizations that are used heavily in -- in the context of bundle payments or a lot -- many organizations now kind of function as enablers in the context of Medicare

shared savings programs or whether they can actually also help to bear some of the risk. I think we need some sort of mechanism there, otherwise we're headed toward a policy crisis where we can't really institute a model that is rational without moving to a market or regional based approach. But then we can't move to a regional or market based approach because we're stuck in a voluntary model. And I think that's a very important policy consideration, one I think that we need to start to take heed on, which largely -- especially in the last several years, I think we've seen this shift toward the voluntary side -- to the regional side, maintain the voluntary side, but kind of turned a blind eye, if you will, towards the -- the crisis that we're headed towards when we do that.

DR. INTROCASO: Okay, thank you.

You -- you foreshadowed my next question by using the phrase "race to the bottom", noting weak incentives and the mandatory versus voluntary problem. And that is your recent work titled "Medicare Payment Reform's Next Decade: A Strategic Plan for the Center for Medicare and Medicate Innovation", or CMMI.

But before I -- I ask you about that recent piece you co-authored with some colleagues at Penn, let me -- let me offer the question, would you like to comment about the -- the problem -- intrinsic problem with fee for service or pay for volume, or would you like to cover that or address that issue relative to unpacking what you recommend in this recent essay? Because in the essay you argue for, amongst other things, fewer demonstration models, here's the fee for service comment. That is you argue for population based payments. You also note a path to mandatory participation. I'm interested in that. You mentioned developing synergies and you emphasized health care equity, or trying to work towards improving health care equity.

So feel free to make comment again specifically on the problem -- inherent problem with the so called fee for service chassis upon which of course the ACO model is built. Or if you'd like to start by unpacking again your recent essay entitled "Medicare Payment Reform's Next Decade".

So take your choice.

DR. NAVATHE: So why don't -- why don't we start with the fee for service, because I think it's a building block on which --

DR. INTROCASO: Sure.

DR. NAVATHE: -- I can then step into other -- other topics, including that essay.

So the way that Medicare is pursued, fee for service reform, if you will, right, through the -- through the Congress, has been -- as part of the SGR fix that started the merit incentive payment system, MIPS program.

DR. INTROCASO: Right.

DR. NAVATHE: And Medicare fee for service, which instituted, you know, MACRA, MIPS, and the quality payment program.

DR. INTROCASO: Correct.

DR. NAVATHE: And -- and I would say I have two main comments about that program. You know, one is it's been successful in one regard and it's been not successful in another regard. And this area I would say it's been at least somewhat successful is making participating in regular old traditional Medicare fee

for service a little bit more unpalatable, or -- especially for specialists but also for primary care physicians and the like. And what that has done is created more of an interest in participating in advanced APMs, alternative payment models, as a way to get your bonus, if you will, 5 percent bonus on your Medicare fee for service rates, rather than having to participate in what is rather administratively onerous and somewhat, you know, not very well designed incentive programs from the perspective of behavioral economics and kind of traditional economics. And -- and so I think making fee for service a little bit less palatable, I think it's a success because at the end of the day, if we're really going to have alternative payment models and value based payments as a mechanism for financial sustainability, you know, a la the trust fund solvency problem and such, then we're going to have to drive a lot more spending into these programs, you know, much -- much greater than we currently have even as part of MMSP.

DR. INTROCASO: Mm-hmm.

DR. NAVATHE: And -- and as long as the alternative to alternative payment models is I'm in a

fee for service system where I can still kind of, you know, thrive and under the current practice patterns and current systems --

DR. INTROCASO: Mm-hmm.

DR. NAVATHE: -- without investing in change and, you know, sort of have my cake and eat it too sort of thing, then we're not going to get that -- that uptick in participation, we're not going to be able to solve Medicare financial solvency issues and to address the sustainability trajectory issues with our alternative payment models.

So that's the silver lining I think that -- that may exist, or that's a small win that exists under how MIPS has worked. Now, that wasn't the intention of MIPS straight up, to just make fee for service less palatable I think.

DR. INTROCASO: Right.

DR. NAVATHE: And so -- but I do think that's one general theme that we do need to think about.

Now, in -- in making fee for service unpalatable, the other thing that I will note is -- this kind of links into the essay you were noting -- the goal

should not be -- I'm not at all trying to advocate, although I'm being a little glib about it, that we make fee for service literally so unpalatable that people quit taking Medicare fee for service patients, because that would also be an unfettered catastrophe. But what we do want to do is we do want to change fee for service to be aligned with the value in two ways. One, a transitional path where people see -- "people" being clinicians and healthcare organizations -- that even fee for service is either going away or changing fundamentally in a way that it's more advantageous to participate in advanced APMs, or that the way that we're altering fee for service, a la the fee schedule. For example, the professional fee schedule is changing in a way that actually reinforces the types of practice patters that we're trying to generate as part of alternative payment models in the first place.

DR. INTROCASO: Mm-hmm.

DR. NAVATHE: So can we turn fee for service "Medicare" as a glide path to APMs anyway? That's really what MIPS should be doing. And I think philosophically that may have been part of the intent,

but I think pragmatically the way that has been implemented unfortunately falls short of that.

DR. INTROCASO: Right. And as a member of MedPAC, the commission has recommended that the MIPS program of course be reinvented. MedPAC has said similar things about the MA quality bonus program as well.

Let's -- let's go to specifically again this essay published in Health Affairs last week, "Medicare Payment Reform's Next Decade: A Strategic Plan for CMMI." Again, if you could tell us where you -- where you -- where you and your colleagues want to go generally. I did clearly get the sense of course -- and this has been argued frequently that we have way too many -- as Don Berwick would have phrased -- canoes in the water -- far too many demonstration models. But I found it particularly interesting that you make note of and we're hearing increasing discussion about this, particularly with what the pandemic has done relative to utilization, and that is moving toward again to redress the problems with fee for service, that is population based payments. And then you do emphasize on trying to

work regionally.

So could you describe again how CMMI would do this?

DR. NAVATHE: Yeah. So I -- I think, you know, one -- one piece that -- that is fundamentally important -- and there's been some MedPAC discussion, although of course we wrote -- I wrote that article not as a MedPAC commissioner.

DR. INTROCASO: Right.

DR. NAVATHE: Not in my capacity as MedPAC commissioner. But I think the -- the point is that there have been a lot of canoes placed in the water, but the canoes have not really been placed in a way of saying, hey, you know what, downstream as some of them sink and some of them float or thrive, you know, are we going to end up in a place where they kind of all fit together and can become greater than the sum of their parts. That -- that doesn't seem to be what the priority was. I think the priority 10 years ago was to try to shift towards innovation. And I think -- I think of the -- the Medicare generally speaking, you know, MSSP was legislated as part of the Affordable Care Act,

so not really a CMMI program in some sense, but nonetheless I think they were successful at starting several programs. Now the question is we have a lot of evidence, so can we consolidate those learnings and actually put forth a much more cohesive and coordinated strategy.

DR. INTROCASO: Mm-hmm.

DR. NAVATHE: Yes, we need to reduce the number of models, but what we don't want to do is reduce the number of models without a great amount of thought and coordination such that we end up with a big gap in a particular sector, like post-acute care, or something like that, right.

DR. INTROCASO: Mm-hmm.

DR. NAVATHE: So -- so I think that's probably the simplest but the most important thing that we -- we have said in that, is yes we want to reduce, but we -- we need to layout a strategic plan and we need to convey and articulate that, much like Sylvia Burwell did, you know, relatively early in the Obama days, of pointing out, hey, we're moving -- we're moving to alternative payment models, we're moving to value. And this is --

and these are what our targets are. And, you know, everybody can see these targets, including the provider sector, and so you know where we're headed.

So, similarly, if we can do the same thing saying here's what the health care market of the future looks like, even in the context of Medicare, and although prices are regulated, we are going to institute some sort of competition based markets within the regional setting and we're going to use value based payments as the mechanism to drive that.

But I think those are the types of articulations that we really want to get out there, because those -- that will drive greater participation, that will drive greater change much in the way -- you know, alongside the idea of trying to prioritize and simplify.

The second key point that I want to make sure doesn't get lost -- because it's -- you know, we call it the twin goal alongside value, meaning that it's not second, it's not number two, it's -- it's, you know, number one right alongside value -- is the goal of trying to improve health care equity. And -- and that

is fundamentally important. What we need to also -- what we need to do kind of as we prioritize going forward is not have equity be an afterthought or a sense of well, we need to monitor for an unintended effect on equity, which has tended to be the -- the way that we've approached health care payment programs in the past, but rather, you know, elevate it to be a twin goal and say how do we actually create mechanisms such that value based programs are a mechanism for equity and equity is a pathway to value as part of value based programs.

And I think that's another really important piece that -- that I would like to underscore here.

DR. INTROCASO: Right. You do say early on in your essay that we can risk -- or that in fact value based payment forms are actually hindering access to care, worsening disparities for lower socioeconomic and minority populations.

Let me -- let me push you on this mandatory. Again you say that CMMI reforms should include a path to mandatory participation. How does that play out? Does that play out when we have enough experience to -- to prove that these models can drive value, improve

outcomes relative spending? Or when does mandatory kick in?

DR. NAVATHE: Yeah, great -- great question.

So I think there's -- I think part of what we're trying to articulate there is it really depends on the type of care, the type of health care organization that you're targeting a model to. I don't think we want to say out of the box every model should be tested in a mandatory fashion, because fundamentally I honestly don't believe that that's feasible in many cases. There are cases where it could be more feasible than others, so we also don't want to exclude the possible. That's why we, you know, wrote it as a somewhat ambiguously or kind of flexibly worded path to mandatory.

DR. INTROCASO: Mm-hmm.

DR. NAVATHE: The point, however, is that regardless of how you start a program, whether it's voluntary or mandatory -- obviously if it's mandatory, you're done, but if you're voluntary there has to be an articulated path for how you get to a mandatory program because if we live in the world of voluntary programs, as we talked about earlier --

DR. INTROCASO: Right.

DR. NAVATHE: -- the -- the -- the mechanics of program implementation, right -- and I -- and I have seen this in my work not only as part of MedPAC but, you know, my -- my group works a lot with -- with private health plans extensively across the country --in fact, also provider systems -- to set up new incentive programs, new payment models. And we see this over and over again. You know, if you -- if you don't have market based type approach it's very challenging to actually get participation from the -- the groups that you really want participation from for as long as you want them to participate.

And so that's why the mandatory piece becomes important. Yes, we might need to use voluntary as a proof of concept, we might need to do randomized designs where we -- you know, we pick some markets or we stagger the offering of programs. You know, even though they may be voluntary, we stagger in some -- in some structure or fashion so we can get real estimates of how impactful these programs are. But when we understand that something can work and -- and -- and provider

groups and hospitals and organizations have had some experience and we can get some understanding of what type of technical assistance other systems might need, at that point we -- we do need a plan to look forward and say, hey, this is how this could actually function in a mandatory way or -- or really I think -- and another way of saying it is, you know, could these be programmatic permanent changes that Medicare could make. You know, take mandatory out of it. Could -- could Medicare actually take the evidence from the -- from the -- what we've learned and make changes such that it can increase value, put beneficiaries in a better situation, and help the Medicare program overall.

And -- and I think sometimes we get tripped up in this context of scaling or mandatory thinking that, again, we're only living in the world of testing. You know, are we going to test mandatory programs? Sure, mandatory is a great way to test programs to get valid results to understand what the impact is, but at some point, if we're ever going to really capture value from the types of testing that CMI and CMS has done more broadly, then we have to be able to shift towards

permanent changes, otherwise all we're doing is experimenting for experimentation's sake, which is not the point. This is not the point of value based payment models. The point -- the whole goal of CMMI and all of the testing and the Affordable Care Act statutes around this for -- for Medicare have been to actually design models that improve quality of care and/or save money for the program.

DR. INTROCASO: Okay, thank you.

With -- with the time we have remaining I do what to spend a few minutes if I could on post-acute and fee for service. Crudely phrased, this is considered the Wild West in Medicare payments. We do know that, as you noted at the top, lessons learned from the pandemic relative to the effects on the long-term care setting, particularly amongst skilled nursing facilities. You're probably well aware that SNFs simultaneously suffer from -- let's just say quality performance that could be substantially improved while, as MedPAC has shown, 2018 represents something like the 20th year of free standing SNFs seeing double digit margins.

So with the time remaining I'm -- I'm curious

to know your top of line policy reform recs in post-acute, maybe particularly moreover in SNFs. And let's just note that of course we are well aware that the Congress and CMS is working towards developing a uniform post-acute perspective payment system.

DR. NAVATHE: Right. So I -- I think, you know, you -- you noted several important factors and -- and points here, right.

So the -- the post-acute care sector has been particularly had hit by Covid, certainly nursing homes in particular and beneficiaries in those facilities also have been -- have been disproportionately harmed. So, you know, I think that this very current juncture is probably not the right time to be deploying major changes to how we finance care to try to -- to spawn either more efficiencies or other types of changes in that sector.

That being said, if we -- if we look at what we knew from before the public health emergency, and therefore what is likely to be the situation afterwards, you know, for one thing MedPAC, the commission, has recommended either zero or negative payment updates for

much of the payment -- of the post-acute sector for certainly as long as I've been on the commission, but years kind of going back multiple years now before that. And -- and so I think relative to how the Medicare program reimburses and pays across the different provider sectors within the provider sector, I think there is not parity. And, in fact, the post-acute care sector has continued to enjoy, you know, pandemic aside, relatively generous rates. And we know that there is a tremendous amount of variation in the practice patterns that is likely unwarranted from a clinical perspective.

So -- so I think from a Medicare perspective, there -- there is a tremendous opportunity and there's -- there should be a lot of focus on trying to make that sector more efficient, such that the Medicare programs, the tax payer are getting greater value.

The unified post-acute care system is something that MedPAC has been working on, has certainly argued for. That -- you know, I will say as an individual, again not on behalf of MedPAC, as an individual, it's still a daunting task given that there's a lot of unobserved heterogeneity that we don't

see in Medicare claims around individual patients and their needs. And so we have a ways to go there I think. However, in the shorter-term what we have seen is that even you know, the programs -- let's tie it back to Medicare shared savings programs or bundle payment programs -- they've actually generated pretty substantial gains.

DR. INTROCASO: Mm-hmm.

DR. NAVATHE: And most of those gains -- or many of those gains, I should say, have come from reductions in post-acute care that seem to be largely preference based or discretionary, or perhaps even, you know, outright unwarranted.

And -- and so I think to the extent that we can turn our attention to it, really in a multi-pronged way, right, one, can we make -- can we create and -- and institute greater parity in the generosity of payments between post-acute care and other areas of the provider sector, number one. That's just sort of rates on fee for service. Number two, can we actually pursue greater rationalization of post-acute care in the context of existing alternative payment model structures -- bundle

payments, Medicare shared savings, direct contracting, et cetera. And number three, is there an opportunity over time as the -- particularly as the data infrastructure improves to then get to a system that is truly rationalized post-acute care across the entire sector, including home health, you know, from the continuum, from within the home, all the way through more intensive rehab in the inpatient setting.

DR. INTROCASO: Mm-hmm.

DR. NAVATHE: And if we can get there, certainly I think that's the direction of the future. But I don't think that's impendingly upon us. And so I think we should have Medicare program and -- and Congress take on all three of these and -- and the Medicare Program Innovation Center sort of participate in taking on all three of these.

DR. INTROCASO: Okay, thank you. We're at our time. So I appreciate your comments on a very complicated program in sum. And I'm glad we got to touch on -- on as many of these as we have.

So, Amol, thank you very much for you time and I appreciate it.

DR. NAVATHE: Sure. Thank you so much for having me.

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CERTIFICATE OF NOTARY PUBLIC

I, Carleton J. Anderson, III do hereby certify that the forgoing electronic file when originally transmitted was reduced to text at my direction; that said transcript is a true record of the proceedings therein referenced; that I am neither counsel for, related to, nor employed by any of the parties to the action in which these proceedings were taken; and, furthermore, that I am neither a relative or employee of any attorney or counsel employed by the parties hereto, nor financially or otherwise interested in the outcome of this action.

Carleton J. Anderson, III

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