STRATEGIC HEALTH CARE

PROFESSOR MICHAEL CHERNEW DISCUSSES THE MEDICARE ADVANTAGE PROGRAM

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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 or ProMedica. I'm pleased to welcome you to this eight part series of healthcare reform discussions with nationally recognized health policy experts. These interviews will discuss Medicare policy including healthcare pricing, long term care and the social determinates of health.

This series is part of an ongoing two year effort by more than a dozen hospital CEO's from around the U.S. to urge Congress to take up significant healthcare policy reform legislation largely by calling for the creation of a national commission on healthcare 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 healthcare delivery and financing during the next congress.

Our motivation is straightforward. 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 American's 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.

DR. INTROCASO: Welcome to this series of eight interviews concerning federal healthcare policy reform. I'm the host, David Introcaso. With me to discuss the Medicare Advantage program is Michael Chernew, Leonard D. Schaeffer Professor of Health Care Policy at Harvard Medical School and Chairman of MedPAC, the Medicare Payment Advisory Commission. Michael, welcome.

DR. CHERNEW: Thank you, David it's great to be here.

DR. INTROCASO: Professor Chernew's bio is posted with this interview's audio file and transcript and Michael's comments, I should note, are his own.

On background, the rapidly growing Medicare

Advantage program currently provides care to 36 percent of Medicare beneficiaries or over 24 million at a current cost of approximately $275 billion.

Despite MA plan bids averaging 88 percent of Medicare fee for service spending in 2020, Medicare Advantage still does not, as initially intended in 1982, reduced Medicare spending. Per MedPAC, this year overall MA benchmarks will average 107 percent of fee for service spending. This is due in part to MA's quality performance program that pays bonuses to plans with a four star rating or higher. And risk adjustment upcoding, not fully offset by the program's coding intensity adjustment factor.

Even if MA equaled fee for service spending, no spending efficiency would be gained due in part to inherent fee for service over utilization. More problematic is a September CBO budget outlook that concluded Medicare's hospital insurance trust fund will be insolvent as soon as 2024. As MedPAC candidly recognized in its most recent congressional report, "Medicare is on a financially unsustainable trajectory". So, with that Michael as background or context, let me

ask you, let me begin by asking you rather, this general overall question. What's your impression in sum of the Medicare Advantage program currently?

DR. CHERNEW: Well, first David, again thank you for having me and to your listeners, thank you for listening. And again, I want to emphasize that these are my views and not the views of MedPAC or for that matter, any other organization that I'm apart of.

My general view of the Medicare Advantage program is I think there is decades of research that broadly makes the point that Medicare Advantage plans can provide better care for less money. That being said, there's a number of features of the Medicare Advantage program that impede the ability of the Medicare program itself to reap those savings. And I think the challenge is for policy going forward is how one structures the Medicare Advantage program to allow the gains that Medicare Advantage can provide to be captured by both the beneficiaries and the Medicare program itself. And I think that's the direction that policy should go in.

DR. INTROCASO: Okay, thank you. So, let's

get into the specifics here of MA. Primarily, MA's financing problem or challenge is as it's phrased, due to the fact it's built on a fee for service chassis. MedPAC is likely to recommend to the Congress a revised alternative MA benchmarking formula. But regardless of where MedPAC goes, what's your general sense or view of how MA benchmarking can be reformulated?

DR. CHERNEW: Yeah, so I think there's a number of issues. I won't run through all of them right now but I don't think the core problem is that there's a role for fee for service in how the Medicare benchmarks are set. I think the core problem relates to the way, the specifics of those numbers. I personally have two concerns.

One of them is there's this quartile system where in low fee for service spending areas, the benchmarks by design are set at 115 percent of the fee for service amount at a location. But at high spending fee for service areas, the rate shows 95 percent. Of course, 95 percent of a big number can still be higher than 115 percent of a small number.

But the point is the set of numbers, the way

they're constructed when combined with a quality program and combined with some issues related to how risk is coded have generated a Medicare program, Medicare Advantage program that probably spends a little bit south of 5 percent more than would have been spent on fee for service beneficiaries otherwise. That doesn't necessarily mean we need to reform the entire program. There's a number of places where efficiencies might be gained but one might have to change some of the specific parameters to try and make the program at least break even on a fee for service basis.

DR. INTROCASO: So, are you saying, are you suggesting with the quartiles structure should be abandoned?

DR. CHERNEW: Well, I'm not a fan of the quartiless. You can obviously abandon that structure. One of the problems of the quartiles is areas that are adjacent to each other in spending could have very different benchmarks. For that matter, places that are adjacent to each other geographically could have very different benchmarks and so there's issues of the market definition. But you could try and find a formula that

gets rid of the quartiles. I would probably personally be in favor of that.

Or and/or you could try to change the ratios within each quartiles. Instead of 115 percent, you could go to somewhat lower. Instead of 95 percent, you could go to somewhat lower. That's just a possibility of ways you might be able to create a fiscal equivalence between what people would be spending if they were in fee for service versus what they're spending if they're in Medicare Advantage from the point of view of the program.

DR. INTROCASO: So, let me just ask you. MedPAC has discussed, is discussing of course, and in fact in a recent meeting, had a specific discussion on alternative benchmark structure. But just let me ask you generically, in that conversation, MedPAC discusses moving all of Medicare in sum to a value incentive program. What's meant by a value incentive program?

DR. CHERNEW: There's a whole range of ways that MedPAC in general discusses different ways of structuring the quality portion of the Medicare program. So, without going into detail, there's a hospital

program, there's SNF program. Obviously, the Star part of the Medicare program fits into this. So, there's different versions of basically value based payment models floating around in the Medicare program. And the core question in all of them is some variant of what should the measures be and how should the measures be adjusted and how should providers or plans be awarded for their performance on those issues?

The Medicare Advantage program is slightly different for a number of reasons. But the Medicare Advantage plan themselves are not providers and they get rewarded according to the quality Stars program in Medicare Advantage which again, has some merits but I think there's also a lot of room for improvements in the way that the quality payment program is working.

DR. INTROCASO: I will get to -- we'll get to the so-called Stars program in a second. But before we do let me ask you about and I mentioned this issue of coding intensity. This issue has persisted in MA. Nearly all MA contracts have risk scores higher than comparative fee for service even with a nearly 6 percent coding intensity adjustment or deduction that remains.

A study said 2 to 3 percent spending in unaccounted upcoding. That adds up to real money per some CBO scores. How can this be corrected or how can this issue which has been extent for a long while and in fact MedPAC has made recommendations on this issue as early as 2016. How can this issue be resolved?

DR. CHERNEW: Yeah. So, I mean again, there's some easy fixes which involve basically the claw back provisions where they lower the benchmarks for coding. My personal view and again, partly I feel this because the coding issue arises differently in different plans. Is they need to begin to think through other quality metrics and other coding metrics, I'm sorry, other coding approaches, risk adjustment approaches to how to deal with coding issues. And I just think there's a lot of underlying research that has to be done to try and figure out different ways of more accurately capturing health status differences across the plans.

I would be remiss if I didn't note there's been really large improvements over time in terms of the risk adjustment systems in Medicare Advantage. And so, I think they, they CMS have been making progress and

there's obviously continued room for improvement. But you could think through a whole series of policies that one might use ranging from simple adjustments to capture coding more to other models that will not only capture the level of coding across plans but also the variation.

And again, the key thing is, it's important to recognize that we often talk about Medicare Advantage versus fee for service. Medicare Advantage is comprised of a wide range of heterogeneous health plans so it's important not to get things right on average. We want to try and get mechanisms in place that recognize that heterogeneity. And in particular provide incentives for enrollment and high quality care for people that are at higher risk suffering from more chronic conditions.

DR. INTROCASO: Right. So, you mentioned CMS and how it's improving its data collection. This is the encounter data effort they've been pursuing for several years to be more specific. Let's go to the quality question or the quality issue. And there have been several proposals to reform what's formally termed the Medicare Quality Bonus program, also terms Stars. And back to MedPAC, in June of '19, MedPAC introduced an

alternative model called MA-VIP or Value Incentive Program and in the past June report detailed the proposal. What generally does this try to accomplish?

DR. CHERNEW: Yeah. So, just to be clear for your audience, I was actually not a part of MedPAC in June 2019. But the VIP program does a few things. It has simpler methods, simpler measures, it has peer group adjustments for differences in sub-groups like low income beneficiaries. Those, I think, are the main things.

The proposal in 2019 was budget neutral and that I think was the main goal. There are some other issues that I think matter a lot. The way in which contracts, MA plans are judged based on their contracts and their contracts can be spread out across the country in a range of ways. So, there's some issues related to how the plans are aggregated.

I guess I'm sorry for not being particularly eloquent but we think about a health plan in the way that we commonly consider a health plan. But the way the MA program is often run is around contracts and different organizations, carriers if you will. So, that

would be the sponsors of the MA plans, can put different plans together if they want in California, one in Omaha whatever into the same contract and get judged on that.

And there's a whole slew of other things that I think personally are concerning about the Stars program related to how good the measures are, for example, and how the measures, how plans might be able to strategize to get better scores than they otherwise might. So, I think those are the key objectives of the MA-VIP program.

DR. INTROCASO: Okay thank you. I'll just add to that, per your point about plans and how they aggregate. So, it is the case that currently you could have the same quality rating under an MA plan in Iowa that also has a contract in Hawaii. And obviously, these are two totally different MA populations. So, the goal here is that Stars or the scores for plans be just on a local basis or within a local market. The other criticism again as you're well aware is that there are 45 measures meaning there are too many, too many of them are process or administrative measures and there are other issues.

Let me ask you, so the recommendation is, I think, across the board whether it's Medicare Advantage or the Medicare program fee for service generally is that there should be fewer measures in sum. And there is reference made to trying to increase a number of patient reported outcome measures. CMS has very, very slowly started down that road. What's your sense of how soon can we incorporate more patient reported outcome measures?

DR. CHERNEW: I would say that the more we can build patient reported outcome measures the better. The reason it has taken a long time is because it's technically very hard to do. There are issues with response rates, there's issues with the breadth of those measures. They obviously have some patient reported measures through CAHPS, for example. Which is the survey that they use for health plans and others to measure experience and, of course, some of the existing measures do come from that.

So, I think we have a ways to go. I don't think we will have a quality program in Medicare Advantage that's fundamentally based on new patient

reported outcome measures for some time. I don't know what some time is. I'd frankly be surprised to see it in the next five years. That doesn't mean it's impossible, I would just be surprised. Maybe I surprise easy. I suspect it's going to be a longer, slower journey than some may want.

DR. INTROCASO: Let me ask you a follow up question or two here. And just to be more here, the criticism is per the number of contracts. Reporting does not represent a specific market area. The other issue is that, and I know MedPAC has encouraged this and that is to address differences in social risk factors. MedPAC phrased this as peer groups.

And the reason I ask a follow up is because you may be aware that a few months ago, ASPE, the Assistant Secretary for Planning and Evaluation, at HHS drew the conclusion in a report to the Congress that quality measures used in value based payment programs should not be adjusted for social risk of patient populations. That runs counter to a good deal of research. Where do you fall out on this?

DR. CHERNEW: So, I haven't read the ASPE

report so I won't comment on it. There are some nuances about what changes mean by being adjusted, for example. Many of the MedPAC things keeps the quality measures the same they just adjust the way those quality measures are translated into dollars based on the peer grouping. So, they're not adjusting per se, the measure is what the measure is.

But when they pay, translate that score to payment, it is reflective of the groups of patients that are served by each of the organizations. And that's a point that they recommend as part of the MA program. It's common across a whole slew of other types of payment models that MedPAC has looked at.

My personal view is that we have to be very careful in the payment to organizations not to disadvantage the organizations that serve the most disadvantaged populations. And many of the measures, certainly many of the process measures, for example, are related to the traits of the patients that are served. Not just their clinical traits but, for example, the amount of social support that they have.

And so, I think there's some merit in trying

to find mechanisms that avoid shifting money away from the plans that serve the most vulnerable to the plans who have an easier time performing well on some of the quality measures, particularly some of the process quality measures. So, I'm not sure if that was a particularly coherent answer, but I am supportive of taking accounts of the SES type variables in the way in which plans are paid.

That is somewhat different than saying the measures themselves should be statistically adjusted but either way, it is important -- what matters at the end of the day is how your performance translates to dollars. I think that there's other uses for the measures like informing the population in which case it makes more sense to report the raw performance without adjusting it. But when you're translating performance to dollars, I think it's important to take into account socioeconomic status and other related variables.

DR. INTROCASO: So, one other follow up question on MA quality. And that is as you know, this is just one example of how the MA program regulatorily is different than Medicare fee for service and that

again, Medicare advantage pays a bonus to plans with a four star rating or higher. And that bonus can be 5 to 10 percent of the plan's benchmark.

There has been discussion to make MA Star or the quality program budget neutral as it is, for example, in the Medicare Shared Savings or ACO program and that would mean the Medicare Advantage benchmarks would have a withhold of a certain percent. And that withhold and the payment of that withhold down the road would be based on quality performance. What's your sense of that?

DR. CHERNEW: That's a pretty broad question so I guess I'll just answer with a primary premise. By paying above the benchmarks, this is one of the reasons why the MA program overall doesn't save Medicare the program money. Because the benchmarks loosely are set towards fee for service, not exactly because of the reasons I mentioned earlier. And then the quality bonuses are in fact above that. And that is problematic for people that are looking for the Medicare program to actually save money relative to fee for service because you don't get the same above the line bonuses in the fee

for service program in general.

So, I think there is some merit in trying to find ways to both incent higher quality but maintain some fiscal equivalence between Medicare Advantage and Medicare fee for service. And I think that's what this issue is really about. The mechanisms do that is obviously debatable in a whole range of ways but I think the objective is a reasonable objective.

DR. INTROCASO: Okay, thank you. Since I mentioned it in that MA and fee for service regulatorily are different, let's drill down on this a bit. As you're well aware, the program is infamously siloed. In fact, you could largely argue that there are two Medicare programs, fee for service again and MA, for example which is increasingly becoming most of fee for service and that are ACO beneficiaries who number 13 million or 23 percent of all Medicare beneficiaries.

The Medicare Shared Savings again or ACO program is distinctly different than MA as it relates to in MA beneficiaries enroll, in ACO's they're assigned. There are also different regulatory rules as it relates to financial benchmarking, quality performance. Again,

in ACO it's penalty only, in MA there's a bonus. There are marketing differences and, of course, there's a cap in MA and MA plans can offer, of course, supplemental benefits.

So, there's an uneven playing field between MA and fee for service and this is becoming increasingly discussed. This too is a broad question, Michael, and that is how can we get to the point or can we get to the point where the Medicare program develops some synergy or proves to be greater than the sum of its parts. Meaning, can we get to the point where let's just start with quality measures that Medicare Advantage quality measures are the same as ACO quality measures.

DR. CHERNEW: Yeah. So, actually I think the quality measures are probably the least of the concerns. One could debate how they play out. There's a lot of other issues that differentiate Medicare Advantage plans from, for example, ACO's. The scale of Medicare Advantage plans, for example, allows you to do certain things statistically that would be harder to do with in an ACO world.

The Medicare Advantage plans have a number of

other differences. They're fundamentally insurers so there's usually a reserve requirement for example. The Medicare Advantage plans have more power to design their own benefits. The ACO's typically can't design their own benefits. So, there's a lot of different designs. I'm not sure equivalence is necessarily the ultimate goal. Although I do think some harmonization is valuable.

You mentioned the benchmarks are set in different ways. One is basically set at the county level. The MA plans are basically set at a county level whereas the ACO's are historically based on historic performance. Although there's some transition to regionally based benchmarks. There's a whole slew of challenges about how the system will work together going forward.

The other thing that I think is important to understand which is a core distinction and it really is inexcusable that we've talking so long and I haven't mentioned this. Medicare Advantage serves another very important role which is it's a vehicle for organizations to provide supplemental benefits to individuals which,

of course, does not exist in ACO's but is a very important aspect of the Medicare Advantage program.

And a lot of the challenges with Medicare Advantage revolve broadly around the realization that if Medicare Advantage plans can provide care, I'll just pick a number, 5 percent less expensive, 10 percent less expensive, you pick your number. I think you're going to be in that range for what the Medicare Advantage plans can do. How would those savings get distributed?

To some extent now, they get shared in part with the program although the sharing with the program gets offset by other payments that go to the plan. So, net the program is actually not capturing any of that efficiency. Beneficiaries capture a lot of that efficiency through added benefits, added supplemental benefits. And then, of course, the plans themselves benefit which is why you see such interest in health plans in participating in a Medicare Advantage program.

And I think there's some sense in Medicare Advantage of trying to rebalance that. But that entire discussion about beneficiaries gaining because they're getting their supplemental benefits to the MA plan

doesn't really pertain to the accountable care organization world.

And I think the challenges therefore are slightly different and we won't end up in a world where we basically make the ACO's little MA plans. I think they work on a very different scale, they have very different tools. I do think areas like quality measurement to the extent possible could be harmonized. I think we could think about harmonizing the benchmark perhaps more than we do now.

But this is a problem across the entire Medicare program where there are also issues. We could have the exact same discussion about how to harmonize the ACO programs with the FFS programs or with the advanced primary care program or a slew of other activities that are going on in the Medicare program. And it's just it's a very complicated program. I don't know if anyone appreciates that quite as much as I do and I'm not sure my appreciation 8 months ago was nearly as deep as my appreciation now.

But all of that said, it's a journey to make incremental progress, some of which will involve making

sure that the Medicare program's parts work together. That may involve some convergence of certain types of programs but it certainly doesn't mean that all aspects of the programs have to be identical for a range of reasons.

You can't have, for example, a small physician led ACO program and independent physician led ACO's tend to perform better than say the big hospital system ACO's. You can't regulate a physician practice and you can't think of a physician practice as exactly the same way as you think of a MA plan in terms of, for example, the amount of risk they can bear. So, the statistical issues around the quality measurements.

So, there will remain, I think, some differences across the programs. We can only hope that they don't bump into each other so much that they make each of the programs less effective than they otherwise would be.

DR. INTROCASO: Thank you. Let me ask a follow up here. You're probably well aware that MA plans in theory can participate under MACRA's APM pathway. To my knowledge, there's been little if no

interest amongst MA plans to participate. And, of course, the APM pathway under the 2015 MACRA law of course, physicians could qualify for a 5 percent Part B bonus. What's your sense of the appropriateness and interest of MA plans to participate as an alternative payment model?

DR. CHERNEW: I honestly have no thoughts on the matter. I wish I had more thoughts on the matter. I fear listeners will think that I don't care. It's not that I don't care. There's an enormous number of features of both the MA program and the APM programs that are complex.

In fact, one of my concerns is rolling out too many APM programs with too many pathways with slight regulatory differences that will allow organizations to try and exploit them. So, I think in the grand schemes of problems to tackle, that's low on the list for me.

DR. INTROCASO: I would personally agree. Just one other quick question as an aside. Have you been following the MA, speaking of so many programs and demo's have you been following the MA VBID demonstration?

DR. CHERNEW: Yes. So, I'm not 100 percent sure what following means but I'm going to answer yes. There are parts of it that I know a lot about and they've expanded it so like happens so often in healthcare, we say the but in fact there's different incarnations of what's going on. The new program, I think, is about to launch in a month roughly.

The old program was really designed to meet a very specific goal which was to try and give plans flexibility in their benefit design. And in general, I'm quite supportive of that level of flexibility. I think particularly in that case, there was some chronic conditions that were very important and plans wanted to be able to address and there was some rigidity in their flexibility to do that.

In the MA VBID program, the original version which is a demo, allowed them to do that by, for example, lowering cost sharing on important medications in certain disease classes which is something I'm supportive of, personally. The new MA demo is going to be expanded in a range of ways. For example, they'll be able to incorporate hospice in ways that they haven't

been in the past, my understanding.

DR. INTROCASO: Yes.

DR. CHERNEW: And so, we will see how that plays out. But the core issue I think of the MA VBID program and frankly, more broadly the MA program, is to allow some flexibility of organizations that can adapt to local conditions and contract with specific providers. Design benefit design, packages and patient outreach packages and a whole series of other things to improve the care of Medicare beneficiaries.

And I actually think the evidence is pretty clear that not only have MA plans done that for the beneficiaries that they have enrolled but in fact there's been spillovers that has led to improvements in care outside of the Medicare Advantage program. The core evidence and I think I said this at the beginning of our conversation, the core evidence about Medicare Advantage is actually very, very positive. The complaint about Medicare Advantage is how the distribution of that positive experience has been allocated particularly between plan beneficiaries and the program.

And so, you've touched on the quality measurement issue which is one reason why there's more money flowing into the Medicare Advantage program than there otherwise might be. You touched on the coding issue which is another reason why more money might be flowing into a Medicare Advantage program that otherwise might be.

But the solution, in my opinion, is really to work around the edges to make the program perhaps a little bit less generous. I want to emphasize a little bit less generous. Deal with some of the inefficiencies in the way it's structured. A good example would be the way things are paid by contracts as opposed to local markets. I personally think the quartile system in related things is a bit of a problem as opposed to an asset in how the program is structured.

But I think the important thing is to not throw the baby out with the bath water. And we can, I believe, build a Medicare Advantage program that maintains a lot of the value of Medicare Advantage but doesn't cost more than the fee for service system. In fact, if you start with the premise that Medicare

Advantage can provide the same or better care with less funding, we should be able to design a program that provides better care with less funding. We just haven't quite done that yet.

DR. INTROCASO: Yes, and that's my reference to the intention in 1982 was to have MA approximately at 95 percent as what was anticipated. I appreciate your point on VBID, right. There were major disease conditions that were emphasized, CHF, COPD, diabetes, et cetera.

Let me just ask you one quick question to conclude. I did note in the opening that the solvency of the Medicare program is becoming increasingly of concern. Certainly, in part because of this year and the pandemic. So generally, what's your sense that there's sufficient urgency to put the Medicare program, MA and fee for service on a solid financial footing?

DR. CHERNEW: Well, obviously the Part A trust fund is a big deal and I think we will solve that in any one of a number of ways. Although I will point out that the core problems, the core problem has to do with demographics in Medicare. And so, we face a

philosophical challenge about how we finance high quality healthcare for our Medicare beneficiaries. And that is obviously harder to do if you have fewer workers. There's just no way around that, fewer workers for beneficiaries.

DR. INTROCASO: Right, we go from 3 to 2.5 this decade.

DR. CHERNEW: Right. And that's a problem that is not related to inefficiency in Medicare, it's not related to problems with, you know, the payment models. That's just a core philosophical problem you're seeing around the world as the globe ages. How do you finance care?

And, of course, we don't want to just finance care that is of the style that people are getting now in 2020, we want to finance care that allows innovation so that there can be advances brought to the care of our Medicare beneficiaries. So, we face the fundamental challenge of demographics and being able to support innovation. Now some innovation may save money although many types of innovation really don't.

The other issue with the solvency of the

Medicare trust fund, of course, has to do with the COVID pandemic and issues on the revenue side. Because as the economy contracted, there was just less payroll money flowing into the system. My general view is we shouldn't reform the Medicare program because we suffered from a COVID pandemic. It is important for us to maintain payment adequacy across the board for providers and that we will have to find a way as a country to finance adequate access to care. In fact, adequate access to high quality care for Medicare beneficiaries.

And although I said at the beginning it was this call that I'm speaking for Michael and that remains true, I now say just personally that I believe that should be the goal of the Medicare program and I certainly think that will be the goal of what MedPAC is trying to do. To make sure that we have adequate payment so that providers can provide high quality care to Medicare beneficiaries.

The fiscal challenges are quite real and it is increasingly important that we find areas of Medicare where we might be able to reduce spending and maintain

high quality care. I think Medicare Advantage as we've been talking about is one of those areas where we can continue to provide access to Medicare Advantage plans that have the flexibility to provide more efficient care, higher quality care for less money. And they will be a part, although by no means the work horse in helping meet the fiscal challenges that the Medicare program faces.

But there's a slew of other areas that we don't have time to go into now which is good because I'd have to read up on all of them. But ranging from prescription drugs to post acute care payments to just an entire plethora of areas where I think the Medicare program might be able to become more efficient.

I don't think there's enormous amounts of waste that will allow us to solve all of Medicare's problems, but I certainly think there's room for improvement. And in each one of the areas, the prescription drug program, the Medicare Advantage program, the Part B drug program, all the fee schedules ranging from long term care hospitals to, you know, the physician fee schedule, there's room for improvement.

In some areas, the fees are set to rise very slowly and I think that's going to be a concern going forward. I think we're probably okay if I followed the evidence on access now. But we're going to have to think about all of those things going forward. And I believe that if we can get the promise of alternative payment models working in fee for service and the promise of MA working in the Part C program, we will at least be able to provide the care that we do provide more efficiently then we do now which is a good thing. But it's real people's lives and so we have to be careful in the actions that we take.

DR. INTROCASO: Okay, Michael we're at our time. So, thank you for this overview of MA, I'm very appreciative.

DR. CHERNEW: Thank you, David it's been wonderful talking to you.

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