Podcast episode transcript: Clark Cameron and Tom Scully

Clark Cameron: Hello again. My name is Clark Cameron, and this is “The road to value,” where we hear from interesting and influential voices on the health care industry's long and winding journey from fee for service to value-based care.

Today, I'm pleased to be joined by Tom Scully. Tom is a general partner with Welsh, Carson, Anderson, and Stowe, a private equity firm in New York, which is the most active U.S. private equity investor in health care. Tom joined the firm in 2004. Tom was the administrator of the Centers for Medicare and Medicaid Services, or CMS, from 2001 to 2004 under the George W. Bush administration. CMS administers Medicare, Medicaid, CHIP, and is the largest agency in the US government, controlling more than $1.4 trillion a year.

At CMS, Tom had an instrumental role in designing and passing Medicare Part D and Medicare Advantage legislation. He initiated the first public reporting and disclosure for comparative quality among hospitals, nursing homes, home health agencies, and dialysis centers. Before joining CMS, Tom served as president and CEO of the Federation of American Hospitals from 1995 to 2001. The FAH represents 1,500 privately owned hospitals. Tom also serves on a number of boards throughout different health care agencies, and we are pleased to have him with us today.

Today's episode of “The road to value” is brought to you by 3M Health Information Systems, who offers a comprehensive portfolio of value-based care, software solutions and services. For more information, Google the words, "3M, drive, value-based care." Now, please enjoy my conversation with Tom Scully.

Welcome, Tom. We're glad to have you with us. Where do we find you today?

Tom Scully: Oh, you don't want to know that. That's an unfair question. I'm looking out at Edgartown Harbor in Martha's Vineyard.

Clark Cameron: Oh, wow.

Tom Scully: Been up here for a few weeks, a few more days to go. So yeah, it's August recess as they say in Congress.

Clark Cameron: Enjoy the break and the vacation. We do appreciate the time today. And I guess just wanted to start, as we mentioned in the intro, you're the architect of Medicare

Advantage, and for listeners who only associate Medicare Advantage with the endless Joe Namath, Jimmy Walker, Bill Shatner commercials that occur at every football game break the last three months of the year. Give our listeners a succinct, high level overview of the program, if you will.

Tom Scully: Yeah, I'm not sure I was the architect. So basically Medicare Plus Choice or various levels of Medicare managed care have been around probably since the 90s. So when I came in to run, it was called HCFA at the time. It's now called CMS, I changed the name when I got there, or Tommy Thompson, I changed the name when we got there. In 2001, what was then called Medicare Plus Choice was probably, I guess four or 5 percent of the Medicare program. And most managed care plans couldn't stand it because due to some quirky accidental changes in the law in 1997, Medicare Plus Choice with private Medicare plans were relatively way underpaid and the managed care plans couldn't stand it and were getting out in flocks, and we were trying to keep them in.

So the main thing that my time working for George HW... I'm sorry, I worked for George Bush Senior but when I came back I was in the White House for Bush Senior. I came back to run Medicare and Medicaid for George W. My major goal and Tommy Thompson, the secretary, he's a good friend of mine still, was to fix the Medicare private managed care world, which was Medicare Plus Choice and add a drug benefit, which at the time there was no drug benefit in Medicare. So we spent most of my three years doing that. It was mostly legislative. We changed the name to Medicare Advantage when we sent our proposal up to the hill. We just proposed that as a new name, so that's where the name came from. It was really a rejiggering of the old Medicare Plus Choice program to essentially make it more attractive for plans to stay in, make it more attractive for beneficiaries. Adding a drug benefit was a big piece of it.

So it passed in December of 2003, didn't start until 2006. But the combination of the drug benefit, making the program more attractive, changing the way it was beneficiary paid. I'm shocked that it's almost 50 percent of the program, but it's worked out well and it's exactly as to be... Not exactly as I intended or Tommy Thompson or others invented. There were a lot of cooks in the kitchen, I guess Secretary Thompson and I were the two primary ones in the Bush administration. And I think it's worked out well. I mean, people pick on it still, but back then we passed, it was highly controversial. The drug benefit was incredibly controversial. Medicare Advantage was pretty controversial and now everybody seems to like it. And I would say my primary driver for doing it way back then and making it a primary focus of my time and that stint in government was that Medicare is a fabulous program but Medicare has huge deductibles and co-payments, and lower income people in particular really can't afford Medicare plans.

So generally, if you're in traditional Medicare and you go out and buy Medicare coverage, if you're a couple who's 70 years old, you probably pay 600 bucks a month for supplemental coverage, generally it's not part of Medicare, it's private insurance that has nothing to do with the Medicare program or the federal government. It's really expensive. So creating a program where people can get into more traditional managed care, like most of us. I'm now 65, about to turn 66, but most of us under 65 have was the goal. And to give patients a choice of either going to traditional Medicare plus, Medigap, which is generally what you see the ARP and others advertising for, which is supplemental coverage. Or going for a managed care plan

where they could get a PPO and maybe have some limitations on what docs and hospitals they could go to. In exchange for that, they have much lower costs and much greater benefits, and that's turned out to be extremely attractive.

And the number of people that choose Medicare Advantage is highly weighted towards lower income population. And that's exactly what we had in mind when we did it. Is that a quick summary?

Clark Cameron: Well, it is. That's perfect. Exactly what I was looking for. So if you think about Medicare Plus Choice, the precursor to Medicare Advantage, and you said it was in the mid to low single digits in terms of the Medicare enrollment that had selected that plan. Was it more the reimbursement increase or more the addition of the prescription drug benefit, which had not been part of Medicare prior to that? Or was it the combination of both that created the perfect storm and in less than 20 years took basically from 5 percent to 50 percent?

Tom Scully: It was a combination of both. If you went back to 1997, I won't give you too much tortured detail. But two of my favorite members of the Senate, Dave Durenberger, now passed away, and Pete Domenici from New Mexico, Durenberger was in Minnesota. In '97, they pushed through a provision essentially lower cost parts of the country like Albuquerque and Minneapolis that had lower costs got hurt in the Medicare Plus Choice calculation because it was basically paid a percentage of Medicare. So if you had relatively low cost, their view is they got penalized. So they basically rejiggered the formula in '97 to try to drive more people into rural areas and smaller towns and make the payment more equitable to rural, less populated states. And they were well-intentioned, but what it did is that nobody showed up in those areas and it crushed the urban areas. So in New York and Philadelphia and Pittsburgh and then where we are, the percentage, the payment for Medicare Plus Choice by 2000, when I came in, I can tell you in suburban Philadelphia where I grew up was 83 percent a fee for service.

So Aetna, Independence, Blue Cross, Oxford, I was on the board of Oxford Health Plans back then before I went in the government. They were trying to get out of the program because it was impossible to sell. It was a loser and it wasn't attractive to patients. So it was a combination of, I think, two things, and lots of people are still debating whether the reimbursement is right or wrong. A bunch of things, making the reimbursement much more attractive to the plans that they actually want to get in it. I can tell you in 2000, 2001 you called them, Jack Rowe was then running Aetna or Mccallister is running Humana. They basically were just irritated. The program was not a good business, they were trying to get out of it as fast as they could. And we basically wanted to turn those incentives around, and so we did that, that was part of it.

We also added risk adjustment, which is also still controversial. But I used to joke in the 90s that if you were running an HMO in Medicare, you try to put your enrollment office on the 60th floor of a walk-up because you wanted get only healthy people and you wanted to avoid sick people. Those were just the financial incentives that were there. So by adding risk adjustment, we tried to reverse that and basically say, "Look, we're going to figure out who the sick people are. We're going to pay you more for that and make it attractive for the Blue

Cross plans and the Humanas and the Aetnas and everybody else to basically want to get sick people because if you get sick people that are actually sick, you get paid more."

Now, people can argue forever about risk adjustment and whether it's appropriate or not or whether the payments are appropriate or not. But there's no question that changing risk adjustment changed the incentives. Health plans used to want to avoid sick people and now they want to find sick people, which is exactly what we intended. But obviously it's difficult to get all the parameters of risk adjustment and payment perfect. But I think the combination of risk adjustment, changing the payments to the plan and adding a drug benefit, probably all three of those.

Clark Cameron: Yeah, I want to come back to risk adjustment in just a minute, but I have long thought that Medicare Advantage is probably the most successful iteration of value-based care to date. I mean, if you think of all the various demonstration programs from CMS and all the other value-based care type models that are making their way through the industry. Medicare Advantage has really been successful because, in my opinion, it allows each of the stakeholders to do what they do best. It allows health plans to build networks, extract discounts, manage care with armies of care management nurses and other programs. And it allows the government to do what it does best, which is regulate and provide oversight and fund.

Now that the program has achieved parity, 50 percent, as you said, roughly Medicare Advantage and 50 percent original fee for service Medicare, we do see, you read a lot of articles, you see in the news how the Biden administration and Congress are starting to tighten the screws a little bit, pump the brakes a little bit. And I'm wondering, to use a football analogy, if the NFL would love for every team in the league to go eight and eight every year just to create drama in the playoffs. Do you think the government is trying to leave it at parity between fee for service and Medicare Advantage or capitation? Or do you think that the genie's out of the bottle and because of the selections of newer seniors like yourself in the Medicare program, going three to one or whatever the case may be to Medicare Advantage, that they really won't be able to dial that back and in five years or 10 years, it'll be 70/30 the other way?

Tom Scully: 70/30 MA, inevitably.

Clark Cameron: Yeah, that's what I mean.

Tom Scully: Yeah. Look, when this thing got passed in 2004, the reason I'm not in the government anymore and I work in New York is I got creamed. This was incredibly unpopular when it passed, and I got, I think, a lot of hits for it, which is fine. And now people all seem to like it and I don't think it's particularly partisan. Democrats like it, Republicans like it. I think the current administration is maybe not quite as gung-ho on private managed care as I was, but I know Chiquita, the current administrator is great and I think they're very much behind making MA work. I think they totally understand that it's a better choice for low-income seniors, which in fairness, they're very focused on. I think they want to make sure that the payment is accurate and fair. And lots of my democratic friends argue me that all Medicare Advantage

plans are way overpaid and they get paid too much. It's costing the government. You can read lots of articles, and people I like and respect, like Don Berwick would say that.

I disagree. You can debate a thousand different ways whether the payment is the same between fee for service or Medicare. But the one thing that's clear is if you add fee for service and Medigap together, the cost of that, which is really comparable, is way higher. Now, I personally think that the payments are pretty close to parity. But we have a senior, if I could, fortunately I could probably afford it, if I went out and had to buy a Medicare plan and bought Medicare plus Medigap, I'm going to be paying 600 bucks a month for my wife and I to buy Medigap. And in some states you can't buy Medigap. I'm going on this with my in-laws because they don't want medical underwritten. If you want to switch into private Medicare at 90 years old, like my in-laws, you can't because Pennsylvania does not have any kind of community rating. So the plan's medically underwritten.

So my point is for a lot of people going into Medicare fee for service is not a viable economic choice. So making Medicare Advantage work better is, in my view, a goal. So do I think that there's things in Medicare Advantage that could work better? Yeah, I mean, CMS has been messing around with risk adjustment, which I think is fine. Yeah, I can get too off track here. My fundamental view after my 30 years of messing around with the government is that price fixing doesn't work. And the fundamental problem with Medicare fee for service is the government pays every surgeon the same amount, every primary care doc the same amount. And whether well-intentioned or not, Medicare fee for service is basically single payer price fixing and it drives huge volumes and drives a lot of inefficiency.

So my view over the years has become by the choice of taxpayer of paying Blue Cross of Florida 15,000 bucks in an MA plan, say call me next year, you run a good network, run a plan that's going to be way more efficient for the government than what they do in fee for service, which is by the way, run mostly by Blue Cross of Florida. So when you're in a traditional Medicare plan, you have Medicare coverage and Blue Cross of Florida, and I won't torture on how it works, but probably 60 percent of the country, Medicare payments are actually paid by Blue Cross of Florida and they get a fee and they write it on the government's fixed price checkbook. My view is just pure functioning markets. It's much better off to Blue Cross of Florida. It works at risk for the 15,000 bucks per person than to have them writing it out of government price fixed checkbook with no utilization thought at all.

So that's the difference between their two programs. I think Medicare Advantage is going to keep winning. I worry and I love all the MA plans, but it has to be well-regulated and risk adjustment has to be rationalized and the payments need to be equitable to fee for service. And I understand if you're in the MA business and I'm on the board of one little team in MA plan that you want to drive margins and get every nickel out of the program. But in the long run, if you really believe in Medicare Advantage like I do, the design of the program was intended to be, it's a 5 percent margin program. You have a 5 percent margin, 85 percent MLR and a 10 percent ALR. And around the margins, you can argue about that, but that's what's intended to be. High volume, relatively low margin, great business for MA plans.

And if you get to the point where people are pushing the envelope and making too much or driving too much below those MLRs, I think if you're a true believer, a zealot about program

like I it is, I think, good solid regulation and keeping people between the lanes and doing the right thing in the long run is good for the program and good for all the plans. So I think CMS making sure this thing is run correctly on fair margins with equitable payments to fee for services is absolutely the right thing to do and I think Chiquita is trying to do that.

Clark Cameron: So do you think that people like Don Berwick and others who have been somewhat critical of the program to date, or at least MA plans, do you think that's more of an indictment on Congress and on the oversight or the lack of oversight and regulation to your point? Because if you do have those rules of the road in place and they're a little bit tighter, then it takes care of what you're describing, right?

Tom Scully: Yeah. I believe in the long run, whether you're United or Humana or a Blue Cross plan, if you have a growing MA market, very solid defined rules and you can make a fair margin, you'll be happy. It's uncertainty that makes them a little crazy, but if they're allowed to make a bigger margin, human nature tells you they will. So I think really good regulation is critical. I was involved in creating RBRVS in 1989, which was my first stint in the government when I was working for Bush Senior, which fixed prices were all docs and I was pretty involved in DRGs. And looking back on the 30, 40 years, it doesn't work. Having the government fixed prices flat out doesn't work, and Don and I just disagree on that. So no disrespect to Don, he's a great guy. His heart's in the right place. I hope he'd say something about me. He probably just thinks I'm a misguided capitalist. I think he's a wonderful misguided single payer guy.

Clark Cameron: Well, so it does sound like though that one of the interests from you and Tommy Thompson and the program and it drove your thinking was that this was a way for Medicare to fix its costs. Because if you do have those runaway costs and fee for service, essentially it's almost... You're an attorney, you've heard the phrase many times, anyone who has themselves for a client as a fool, if they represent themselves in court. With fee for service Medicare or fee for service health care, you've got essentially the least informed and probably worst person managing the care, which in the case of Medicare is the beneficiary. They're coordinating their care, they're managing their care. If they go to the doctor 10 times in a month, no one from CMS is going to call and say, "What's going on? Are you okay?"

And so part of the thinking was when you bring managed care into the mix, you've got plans with clinicians and nurses and nurse practitioners and others who are trying to help say, "Okay, Mr. Scully, we see that you have been to the doctor 10 times last month. Is there

something we can help with or a problem?" Was that part of the thinking as well? Both trying to bring some clinical expertise to the management of members but at the same time fix the costs for the government because the costs were just unsustainable under fee for service?

Tom Scully: Yeah, and let me be honest with you, I think this has become way less. I mean, if you look now at Senator Schumer or Senator Wide has to be an old friend of mine in Oregon, those guys like MA now because their states are overwhelmingly... Oregon and a lot of New York state are very dominant MAs. So now they like it, but they want to make sure it's regulated appropriately. Was the goal here a combination exactly said? Yes. My view when we were doing it was people under 65 that had the choice of PPOs and in some cases HMOs. And that's what most of the structure of the insurance business was, generally had better service options than people who just had single payer fee for service over 65, didn't make any sense to me. I thought as people turn 65, they want the same option they have when they're 64. And similarly, on a political basis, I had noticed over the previous 15, 20 years, in the 80s and 90s, the leading states that had figured that running a single payer Medicaid system didn't make any sense were generally big Democrat states like California.

So the biggest theoretical and most liberal states were the ones that had all gone to managed care. They'd seen great success in happier low-income patients and controlling their costs because they were capitating to a third party. And it wasn't the state treasury at risk, it was Molina or Centene or something like that. There's no question the models work better as far as I was concerned. So my goal was all what you mentioned above. Capitating and having somebody other than the federal taxpayer at risk for the cost because they weren't very good at understanding or managing it, having somebody who had an interest in making sure the patients had more clinical attention was clearly part of it. More than anything else for me, I just to become having been very involved in DRGs and RBRVS, both of which were well intended, and I was actually part of reading, unfortunately, I just came to the conclusion over the years that fixing prices doesn't work.

And I'll be honest, so they say this to Don and other people, lots of people think health care should not be a private entity. Well, you know what? The three things that the government really has to provide in the world are food, housing and health care, and nobody would argue we should get rid of all the safe ways and the acme's and have the federal government go out and fix prices for food and run distribution centers. And I think food is just as important as health care. And nobody would argue that public housing worked well when the government was building public housing. It's worked a hell of a lot better since the government said, "We're going to let some evil capitalists build public housing and we're going to get out of it." Because the government's just not very good at doing those direct services and I feel this is exactly the same way about health care.

But just like with food and just like with public housing, it needs to be regulated appropriately to make sure people don't screw around on the margins. So I feel strong that CMS should be regularly looking at reimbursement, regularly looking at things like risk adjustment, regularly looking at star ratings, and the more they can fine tune it in a way that appropriately is fair to the plans, I mean, as long as the plans have certainty and they can make a fair margin, they're going to love this business and that should be the goal.

Clark Cameron: So thinking a little bit more broadly, we've talked about Medicare Advantage a good bit, but pulling up a level and thinking about capitation more generally. You mentioned Medicaid managed care, even Obamacare to a degree has this element of capitation with subsidies and this hybrid approach between government and private health plans. The majority of health care in the country now between those three programs, I think is capitation. Do you think that capitation more generally is the future of all of U.S. health care? I mean, roughly, I guess 50 percent is commercial still, but that model's 80 years old. Is that on the way out as employers say, "These costs are unsustainable for me as a business." And et cetera?

Tom Scully: Well, we have company now with my firm, we invest in a lot of companies. We have this debate of our own all the time, whether ERISA makes more sense or whether somebody having money at risk makes sense. That's probably a debate you want to get into here. But do I think in the long run, believe it or not, I get insured through the DC Obamacare plan, which is... I was not a critic of Obamacare. I didn't like Obamacare, is just that the subsidies were too high. I don't think you should go subsidize 400 percent of poverty, which is 65 percent of the population in theory qualified for a subsidy for Obamacare. The structure, what Obamacare tried to do is to share exchanges and let people buy private insurance in large groups, I've been a fan of for 40 years. The issue is who gets subsidized and how much, and it's probably the reason I'm still theoretically Republican, a non-Trump Republican, is that I believe that you create these programs like the exchanges or the right thing to do.

The issue is not creating exchanges. The issue is who do you subsidize how much? And I think when you go too far up in the income stream in creating subsidies, you create a lot of distortions and that's my problem. Same thing with the drug benefit. We created the drug benefit in 2004 with significant deductibles and co-payments and for a reason to have people that were not poor feel some tension and when they buy drugs, you fill in the donut hole and give everybody full coverage, you remove all that. And I think that is really the debate, is who do you subsidize? Do you take the 50th percentile of America, the 60 percentile and collect taxes from them, turn around, subsidize them for benefits? I just don't think it makes a lot of sense. So for me, I have no problem with the structure. If it were up to me, and I've said this for years, one of the problems is Medicaid is one very large program that pays providers 60, 70 percent from the dollar depending where you are. Medicare is another massive program that pays a lot of provider bills.

And then you have ERISA and at risk programs in the commercial sector. So if you're a hospital or a doctor, you've got five or six different totally confusing payers coming at you. So if you can reinvent the world, which you couldn't, I would have everybody in the country in the federal employee health in an exchange like system, like the federal employee health benefits plan that I was in for years as a federal employee. Or if you're in Philadelphia, you have a choice of eight or 10 plans and whether you're on Medicaid or you're on Medicare or you're commercial, you pick from one of those 10 plans and your subsidy depends on who employees you or whether you're on Medicare, on your Medicaid. That to me would be the model system and I think eventually 50 years from now we'll be there. But we've got a very big, very complicated infrastructure of providers and plans and every local market's different. So getting to a model that looks like that may sound great academically, it's pretty hard to get there unless you do it incrementally. But I think we're incrementally moving in that direction.

Clark Cameron: And that speaks, I guess to the consolidation with roughly half of the Medicare Advantage membership being part of maybe one of half a dozen plans. Do you think that consolidation will continue or do you think there will always be a place for local plans or regional plans not-for-profit plans, or do you think that those over time wither on the volume? Because you did talk about volume with 5 percent being margin, 10 percent being MLR and it's a volume driven business. It's going to increasingly, I guess, be tougher as the goal rush, so to speak, starts to end and these 15 percent margins start to compress.

Tom Scully: Well, it depends on where you are. So I think it's tough to be a small regional plan. There's a lot of reasons why it is, including national networks. If you're in Minnesota or let's say you're in Michigan covering people that spend half their year in Arizona or Florida, as more inclusive seniors do was tough. It was a benefit to being in Humana and Aetna. So creating national backup plans is probably tougher for them to cover people nationally. But look at UPMC in Pittsburgh, very, very strong plan, does very well. There's a lot of the blues that are good at Medicare Advantage like Independence, Blue Cross, I mentioned Philadelphia do pretty well. So do I think there's a place for well-run nonprofit MA plans in the long run? Absolutely. I think they're going to be because if they can offer a good benefit and people are used to being in them, especially on the commercial side. But I think there'll be some consolidation. I mean, you've got come from Priority and Michigan is a very good plan.

Intermountain Health has a great plan called Select Care at Utah. So some of these guys do quite well. I think some of what you might see there, and it's hard because they're all big successful plans. Some of the bigger successful nonprofits like that, probably at some point like the Blues have we'll probably up doing some kind of affiliation agreements that when you're in Utah and you leave town and Select Care, you get covered in other places and if you're in Pittsburgh and you leave, you can covered in other places. I think that's their toughest part of their strategy. But UPMC is doing great, Select Care is doing great, Priority is doing great.

So I think there's a strong place for good well-run local nonprofit regional plans. Do I think that they may consolidate a bit more? Probably. I mean, look, Aetna, United, Humana, the big guys are great at marketing. Whatever, it's Joe Namath or whatever. And I think their growth has been a lot bigger. I don't think any of those guys can consolidate anymore because obviously Aetna and Humana's consolidation was blown up by the FTC injustice and they're so big in the MA market. I don't think any of those guys can really buy each other anymore on an antitrust basis. And I think that's unlikely to see any mergers with the big plans. So I think you're going to see much more consolidation of good solid local, regional plans. I just saw scan buck care arg, and that's a good example of it. I think you'll see more of that kind of stuff going on.

Clark Cameron: Okay. And certainly among the chronic care special needs plans as well where you've got disease specialty type programs that perhaps some of the larger Medicare Advantage companies might not be able to pull off quite as well. Let's talk about risk adjustment. You mentioned that. In terms of your thinking, obviously HCCs are the risk adjustment methodology for underlying Medicare advantage. You mentioned a few minutes ago, if you had it to go back and design again the U.S. health care system what you would do. If you had to go back and redesign risk adjustment for Medicare Advantage, would you make any changes? I mean, obviously HCCs are financially driven from a reimbursement

perspective. Would you include more clinical elements or non-regression models? Or talk a little bit about risk adjustment, if you will.

Tom Scully: No. And again, this is all very friendly. We were cooking up risk adjustment in 2002 and three in preparation for this and we're starting to do it. I remember the plans were coming in saying, "We hate risk adjustment." In fact, AHIP wanted three risk adjusters and my staff at the time wanted 175, I remember. I mean, they hated the idea of risk adjustment, which was crazy in hindsight. And the staff wanted to a zillion of them, and I think we sent, if I remember, originally it was 83. So I don't think the problem is the number of HCCs. You can always fine tune it. You can add and subtract and add for various levels of acuity. The issue to me is budget neutrality. The biggest problem I had with risk adjustments should probably cause some of the plans a have heart attack. If you go to every state that I'm aware of, and I was very involved in CareSource in Ohio, which is the dominant one in Ohio until recently. Or the exchanges, if you have... Let's just pick Ohio.

So if you're in Ohio and you have six Medicaid plans, they all provide very detailed risk adjustment scores to the state. State collects them all, puts in a mechanism and calls back and say, "Here's your score. Everybody that works out to 1.0. See you later. If you don't like it, tough." That was the idea of risk adjustment. If somebody's going to be at 1.1, somebody else has got to be at 0.9. Does that make sense?

Clark Cameron: Mm-hmm.

Tom Scully: Problem and exchanges in the Obamacare method is the same thing. If they're in the DC health exchange and there's five plans, they measure risk scores and people share them, but the plans have to pass it back and forth and it all comes out to 1.0. So in that, there's no extra payment on top. What happened in Medicare Advantage and it was an implementation, I was involved in designing the original framework and passing it through Congress. It was really in the implementation between 2004 and 2006 that it was designed like this, that the plan payments are based on fee for service, but in theory the MA plans are coding against fee for service. That make sense?

Clark Cameron: Yes.

Tom Scully: So you can have all the MA plans, it can be a 1.2 or 1.3 or 1.4 because they're coding against a pot that includes the 50 percent versus it's all part of the plan. So in my view, in risk adjustment, if you're in a market, all the plans, you have to sit down a pot and say, "We're all going to put our risk scores in, but it all comes out to 1.0 period." That is the biggest problem. Does that make sense?

Clark Cameron: It does.

Tom Scully: Can you do that overnight? No, but I think if I said from the beginning had it been clear to the plans that you're all sitting down a market and you're all going to come out and that was the original design, by the way. And look, I hate to torture you with this too, but if you went back and looked at the original Bush proposal we set up to Bill, that's how risk adjustment worked. If you were in a market, everybody put their codes in and the regional MA

oversight came out and said, "Great, here's your risk score. Fine. But everybody's got to up to 1.0." One of the problems here, it's just human nature, it's nobody's fault, is when you have an unfettered risk scoring and everybody can pedal faster and put more codes in. I wouldn't even consider it upcoding, it's just more and more accurate coding. But your incentive as a plan is to accurately code everything you possibly can and stick it in there and you get paid more. And it's not a zero-sum game. It should be a zero-sum game. Does that make sense?

Clark Cameron: It does. So if you take chronic conditions, for example, we think about that. That's a big part of this with regard to coding and HCCs, was it an intentional decision not to include chronic conditions that will never go away once they're documented once or to require plans to capture those each and every year? Was that an intentional decision or just an unintended consequence?

Tom Scully: Well, in my case, when we start is an intentional decision, because if you put it in the basis forever, again, it would be fine to do that if it's a zero-sum game. If you let a plan collect a code for somebody that's got diabetes and they don't have to capture you, you put it in there forever, they're just going to keep piling on the risk scores. I mean, look, I see how it works. The plans, the consultants are doing exactly what they should do. My point is if you look at Medicaid again, like in Ohio, because I know CareSource, they have a big staff that does risk adjustment. They do a great job, their codes are incredibly accurate, they're very good at doing it. But they have to put it into the system with every other plan in the state and it comes out as a 1.0.

You can be really good at risk adjustment, and maybe I'll just give an example, CareSource may be way better than... I'm trying to think of one of the other plans, Aetna in Ohio, including their patients, and they have every indication to do it, but it's not an unlimited incentive to do it. In other words, it's not like the more you risk adjust, you keep getting more and more and more and nobody else loses. You follow me?

Clark Cameron: Right, right. You push inside of the balloon, it's going to come out on the other side.

Tom Scully: I think that's problem. So the incentive was you have to make the plans go back and encode the patients every year because otherwise you're just going to have this piling on of unending codes. I don't consider it upcoding, it's accurate coding, but the incentives that created are not in the long run good for the program. So I think at some point over many years because I think the program is doing very well. If you went out tomorrow and said, "We're going to have everybody get back to a rebased one and risk adjustment." You'd blow off the program. It's like anything else, it's got to be solved gradually.

Clark Cameron: I see. So shifting gears a little bit, you've got history with obviously naviHealth, which is around post-acute care bundles, bundles being a very close kissing cousin, so to speak, of capitation. Talk a little bit about that. Bundles have not taken off quite as much as capitation has. Do you see a greater future there and more opportunity there in some of the post-acute spaces or other spaces in health care?

Tom Scully: Well, look, my general view is, I don't know, is again, price fixing doesn't work. So every bundle, if you look at Medicare fee for service, every bundle is a good bundle and the ultimate bundle is Medicare advantage and pure capitation. So I'll give you an example, dialysis, the providers in dialysis used to get paid separately and then you paid for EPO on the side, which was crazy. They spent five or six years in a big fight folding in drugs and the dialysis payments, which was a bundle. All of a sudden, wow, cost went down by a significant percent, your outcomes were better. I mean, any place you look at bundling, I consider ACOs to be a half a loaf. I mean, I think it's great. If you want to go get doc's risk and pay them for patients and give them an incentive to do some bundling, that's better than fee for service.

In the ultimate world, I would say do a pre acute bundle, do a post-acute bundle, do an acute bundle, put them all together, call it Medicare Advantage or whatever other payment and get the hell out of the way as the government. That works the best. But every sub bundle is a good bundle. Does that make sense?

Clark Cameron: It does.

Tom Scully: It's all incrementally move in the right direction. I think ACOs are a move the right direction. I think all the stuff that CMI is doing is a great move in the right direction. Post-acute bundling, naviHealth is still the only significant player out there doing it that I'm aware of. I've been out of it for 10 years, but I started 12 years ago with Clay Richards. I think every move in that direction is a good move. The ultimate move in my opinion is to have a well-regulated third party, get the entire amount for the insurance for the year and call me next year. But you got to have a margin that's defensible and you got to provide the right level of services, and especially when the government is paying for it. And hopefully well-regulated, fully capitated model to me is the best.

Clark Cameron: We'll close with this. We're almost at time, but put on your prognostication carnet hat. Where do you see this heading? Not the ideal. Obviously, the ideal would be capitation across the board in your mind, but where do you likely see value heading? Because we've been talking about value as an industry for nearly two decades now, and there's still that very human part of this, which is it's difficult to make someone understand something when their salary is based on them not understanding it. And we're talking in many ways about stakeholders receiving less payment and less income over time, things like that. How far away are we from achieving a greater level of value, or will it always just be the ideal that's just out of reach?

Tom Scully: Value-based care is a real catchall concept thing. To me, the issue is government price fixing versus private at risk capitation. So value-based care is ultimately not having the government price fix. So if you're going to say instead of the government set prices for every dock through RBRVS and DRGs, you're going to give it to some non-government entity, have them take risk. They're going to be incited to create value, and they got to be regulated to make sure that the value they create is not excessive for the taxpayers and the public to handle. I think we're moving to that direction, but health care change is, in my opinion, slowly. I mean, I'm glad that MA's gone from 4 percent or 5 percent to 50, but health care is a very

local market. Things change really, really slowly for a lot of different reasons, and they change differently in every market.

So I just don't think it's going to happen. Anything happens quickly in health care. In the long run, if I asked 25 years from now, what do you think it'd be? I think you'll probably still have 15 or 20 percent of the wealthiest people that want to go to any doc they want, who will buy Medicare and buy a wraparound program. I think Medicare Advantage will continue to grow unabated. I think there'll be more and more people in programs like that. I also think the more you have the exchanges and fully capitated Medicaid and dual eligibles and Medicare, more and more, you're going to find in regions these programs are going to be more and more gradually combined and interactive, which is leading you inevitably, someday towards the federal employee health benefits model I was talking about. But I think that's a long way off. I mean, there's a lot of interactions here.

I mean, one of the things that I think is driving a lot of the doc and provider changes is... And this is really off the wall here, but if you went back 15 years ago, probably 30 percent of the docs in the country worked for hospitals. And then over a fairly short period, it went to 60 percent. And the reason was Medicare was paying provider base rates to docs. So they all sold their practice to the hospitals and they went and worked in hospitals. A few years ago that was reversed. And all of a sudden, these docs, they're all working from hospitals. Wow, I'm not getting paid anymore to have my office in the Sentara Health system anymore. They spun out and they started their own practice groups. They started taking risks in ACOs. They started sub capping with main plans. That's driving a lot of this change too, and I don't think you'll about that much. I don't know if that makes any sense.

Clark Cameron: It does.

Tom Scully: There was a big move towards doctors working for hospitals and hospitals becoming the local dominant providers and hospitals buying up more and more stuff. And number one, it's been a tough three or four years for nonprofit hospitals, but it's also been a huge trend towards doctors because of the change in the provider based rules, not wanting to work for a hospital anymore and spinning out. So a lot of these moves that people are going crazy about, about independent provider practice groups and individual groups, a lot of that has been driven by the reversal provider based payments. But when you're a doctor of a sudden you're not working for a big hospital anymore and you're not with your own 50 colleagues who are in your own practice group and you're taking risk and you're sick in sub cap, all of a sudden all these programs become a hell of lot more important to you.

Clark Cameron: It makes sense. Well, Tom, we are at time. We do appreciate your thoughts and your perspective. It's very valuable and we thank you for the time on the road to value. If people want to get in touch with you or just follow you, find out what you're involved in, where can they find you on Twitter or I guess X now or-

Tom Scully: I'm on LinkedIn. They can just message me on LinkedIn. It's Thomas Scully, I think on LinkedIn. Well, I'm a partner at Welsh, Carson, Anderson & Stowe, and they can go on our website and get my email from that too.

Clark Cameron: Well, we are so grateful for the time today.

Tom Scully: Absolutely. Take care. Thanks a lot.