

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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COMMISSIONERS PRESENT:

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P R O C E E D I N G S

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[9:21 a.m.]

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DR. CROSSON: Okay. Let's reconvene. Welcome, everyone, including our guests, to the opening session of MedPAC's April meeting.

We're going to begin with a presentation which is the beginning of an anticipated stream of work that the Commission is going to be doing over the next couple of years on expanding the use of value-based payment in the Medicare program, and Eric Rollins is going to take us through our initial discussion. Eric.

MR. ROLLINS: Good morning. Today I'm going to talk about expanding the use of value-based payment in Medicare. There has been widespread interest in this issue among Commissioners, CMS, and other health care experts, and your discussion today will help us develop our work plan for the next meeting cycle.

Before I begin, I'd like to note that many of my colleagues provided valuable contributions to this presentation. The number of people who helped is actually large enough that I'm not going to run through everyone's names, but I did want to recognize and thank them

1 collectively.

2 I'll start by giving an overview of the
3 presentation. I'll begin by explaining what we mean when
4 we use the term "value-based payment" or VBP. I'll then
5 talk about the Commission's previous work on Medicare
6 payment and how that informs our future work on VBP. After
7 that, I'll discuss Medicare Advantage and ACOs and how
8 those programs could provide a foundation for the broader
9 use of VBP. Finally, I'll examine what it would mean for
10 VBP to replace the traditional fee-for-service program.

11 During this meeting cycle, Commissioners have
12 expressed interest in expanding the use of value-based
13 payment. This term has been used in many contexts and does
14 not have a standard definition, so it's helpful to clarify
15 at the outset what we mean by it. For our purposes, VBP
16 refers to methods of paying for health care services that
17 provide stronger incentives to control overall costs than
18 traditional fee-for-service payment, while also maintaining
19 or improving quality. VBP is thus a broad concept rather
20 than a specific policy, and as we'll see later on, there
21 are many ways to expand its use in Medicare.

22 Reviewing our work over the past decade makes it

1 clear that the Commission has consistently been interested
2 in moving away from the traditional fee-for-service model
3 and giving providers, health plans, and beneficiaries
4 stronger incentives to control costs and improve quality.
5 For example, we have done work to reduce the incentives in
6 fee-for-service that encourage greater volume, to make MA
7 plans more efficient and improve our ability to assess
8 their effects on service use, and to develop better ways to
9 measure quality. Determining how to expand the use of VBP
10 will likely require us to consider a range of issues, but
11 the examples of our prior work in your mailing materials
12 show how this work can proceed on multiple tracks while
13 still being part of a larger overall effort.

14 Our future work on VBP will also be guided by the
15 same fundamental principles that serve as the foundation
16 for all of our policy development: ensuring that
17 beneficiaries have access to high-quality care, paying
18 providers equitably and giving them incentives to deliver
19 care efficiently, and assuring the best use of the taxpayer
20 and beneficiary dollars that finance the program.

21 Although the traditional fee-for-service program
22 has long been Medicare's primary delivery system, more than

1 half of all beneficiaries are now either enrolled in MA
2 plans or assigned to ACOs. These programs have stronger
3 incentives to control overall spending than traditional
4 fee-for-service because MA plans receive capitated payments
5 to provide the Part A and B benefit package and because
6 ACOs can qualify for shared savings payments. However, as
7 we'll see, the performance of both programs has been mixed,
8 and they need to be improved before they can realize the
9 potential benefits of value-based payment.

10 One of the biggest strengths of the MA program is
11 the ability of plans to provide the Medicare benefit
12 package at a lower cost than the fee-for-service program.
13 For example, the bids that plans submitted for 2019
14 averaged about 90 percent of fee-for-service costs, once
15 you account for differences in coding. Another positive
16 feature is that most plans offer additional benefits that
17 aren't available in traditional fee-for-service, like
18 reduced beneficiary cost sharing or dental coverage.

19 On the other hand, a major weakness of the
20 current MA program is that it actually increases overall
21 Medicare spending relative to fee-for-service. For 2019,
22 we estimate that Medicare pays 1 to 2 percent more for MA

1 than fee-for-service coverage due to rebates, quality
2 bonuses, benchmarks that exceed fee-for-service costs in
3 some areas, and coding differences. However, our work has
4 highlighted how plans can reduce their costs in response to
5 changes in the MA benchmarks, which suggests that changes
6 to the benchmarks and MA's quality bonus program can both
7 lower program spending.

8 Here are two examples of our work to improve the
9 MA program. Over the past couple of years, we have
10 examined the encounter data that MA plans submit to CMS.
11 This data should make it easier to understand how service
12 use differs between the MA and fee-for-service programs and
13 to calculate quality measures, but we have found that the
14 encounter data that has been collected so far is
15 incomplete. This work has led to a draft recommendation to
16 improve the quality of encounter data that you will vote on
17 later today.

18 Another issue that we will discuss at this
19 meeting is the MA quality bonus program. This program is
20 overly complex and differs from Medicare's other quality
21 incentives because it provides additional funding instead
22 of being revenue-neutral. We will explore ways to simplify

1 the program in a manner consistent with the Commission's
2 quality principles and to make it revenue-neutral.

3 As for accountable care organizations, the ACO
4 model is appealing because it creates incentives to control
5 overall spending and improve quality that are not present
6 in traditional fee-for-service. However, researchers have
7 found that Medicare's ACOs have generated modest savings of
8 roughly 1 to 2 percent after four years of operation, and
9 that does not include the cost of shared savings payments.
10 It's worth noting that those are overall figures, and some
11 ACOs have been more successful.

12 Whether ACOs will produce larger savings in the
13 future is unclear. CMS recently made significant changes
14 to the largest ACO program, the Medicare Shared Savings
15 Program. While those changes have some positive elements,
16 such as encouraging more ACOs to bear financial risk, on
17 balance they may result in lower savings. Policy changes
18 that incorporate features from a more advanced ACO program,
19 the Next Generation model, may be more effective at
20 improving ACO performance but may not appreciably change
21 the program's modest savings. Given these challenges, the
22 Commission may want to have a broader discussion about the

1 role that ACOs should play in Medicare. For example,
2 efforts to expand ACO participation may not reduce program
3 spending if they result in more ACOs that do not generate
4 savings.

5 Here are some examples of potential improvements
6 to ACOs. The first change would assign beneficiaries to
7 ACOs on a prospective basis instead of a retrospective
8 basis. We will discuss this issue in more detail in our
9 next session. The second change would waive some of
10 Medicare's regulatory requirements for ACOs that use
11 prospective assignment and accept two-sided risk. One
12 example would be to allow these ACOs to have gainsharing
13 arrangements with post-acute-care providers.

14 Since the MA and ACO models are viewed as
15 alternatives to traditional fee-for-service, it's worth
16 spending a minute to briefly review the strengths and
17 weakness of that model as well. The program does a good
18 job ensuring access to care because it operates throughout
19 the country and provider participation is high. Another
20 positive feature is the use of administered pricing, which
21 has helped constrain spending growth, especially in recent
22 years as providers have consolidated and increased their

1 market power. In addition, the program's fee schedules and
2 claims data play important roles in other parts of Medicare
3 and are often used by other payers. For example, CMS uses
4 fee-for-service spending data to calculate the MA
5 benchmarks that plans bid against and the ACO benchmarks
6 used to calculate shared savings.

7 The fee-for-service program also has its
8 weaknesses. The program has no entity that is responsible
9 for overall spending, and beneficiaries and providers both
10 have incentives to use or deliver more services. However,
11 policymakers have taken a variety of steps over the years
12 to address these weaknesses. For example, they have put
13 some limits on supplemental insurance, used bundled rates
14 to pay for multiple services, and developed quality
15 incentives like the Hospital Readmissions Reduction Program
16 that aim to improve the fee-for-service program's value.
17 Continued reforms along these lines could be considered.

18 Moving now to Slide 11, Medicare has relied on a
19 fee-for-service model to pay for services throughout its
20 history, but supporters of VBP often describe it as a way
21 to "replace" or "eliminate" the fee-for-service model.
22 However, it is not clear what this would mean for Medicare,

1 particularly since the current MA and ACO models, which are
2 the obvious successors to fee-for-service, are, in fact,
3 closely linked to the fee-for-service program. To provide
4 some clarity, we developed four illustrative scenarios to
5 inform our initial discussions on this complex topic. Each
6 scenario would expand the use of VBP in Medicare, but they
7 differ in how far they would go to replace the fee-for-
8 service program, and highlight some of the issues that
9 policymakers would need to consider.

10 The first scenario would be the closest to the
11 current Medicare program. Medicare would continue to
12 operate the traditional fee-for-service program, along with
13 MA plans and ACOs where they are available. Beneficiaries
14 could enroll in fee-for-service or an MA plan, just as they
15 do today, and provider participation in ACOs would still be
16 voluntary.

17 Under this scenario, the Commission would look
18 for ways to expand the use of value-based payment within
19 all three payment models. We believe that each one can be
20 improved to provide better value to beneficiaries and
21 taxpayers. I touched on some potential changes to the MA
22 and ACO models earlier in the presentation. With respect

1 to traditional fee-for-service, some possible areas for
2 future work are alternative payment models for clinicians,
3 expanding the use of bundled payments, and improving the
4 quality incentives that now exist in fee-for-service.

5 Under the second illustrative scenario, Medicare
6 would require all fee-for-service providers to participate
7 in ACOs. The traditional fee-for-service program would no
8 longer be an option. Providers would have to join ACOs to
9 receive fee-for-service payments. Medicare would assign
10 all beneficiaries to ACOs and would continue to pay claims
11 for ACOs using standard fee-for-service rates.
12 Beneficiaries could still enroll in MA plans.

13 This scenario could affect Medicare's
14 longstanding policy that allows any willing provider to
15 participate in fee-for-service and may have implications
16 for beneficiary choice. Policymakers would also need to
17 consider that MA plans and ACOs could be more challenging
18 to operate in some areas. For example, almost all
19 beneficiaries have access to an MA plan, but that is partly
20 due to the fact that MA benchmarks in rural areas are often
21 significantly higher than fee-for-service costs. Ensuring
22 universal access to ACOs might also require higher spending

1 in some areas -- for example, by using higher benchmarks or
2 not requiring the ACOs in those areas to bear as much risk.

3 Our third scenario is similar to the prior
4 scenario except that Medicare would also stop paying
5 providers directly. MA plans and ACOs would instead pay
6 for all Medicare-covered services. Even though CMS would
7 no longer make direct fee-for-service payments to
8 providers, the agency would continue to produce the fee-
9 for-service fee schedules so MA plans and ACOs could use
10 them as a reference when they develop their provider
11 payment rates.

12 Under this scenario, CMS would stop collecting
13 fee-for-service claims data since it would no longer pay
14 providers directly. ACOs could be required to submit
15 claims-like data as a substitute, but our work with MA
16 encounter data suggests this would be challenging, and
17 without adequate data CMS could have difficulty producing
18 the fee schedules. There would also be major challenges in
19 the MA and ACO programs because fee-for-service claims data
20 is used to develop their benchmarks and risk-adjustment
21 models. One potential alternative for setting benchmarks
22 would be to implement some form of premium support and use

1 competitive bidding.

2 This scenario would also effectively turn ACOs
3 into capitated health plans because they would become
4 responsible for functions like paying claims and would
5 receive some sort of overall budget for their
6 beneficiaries. This raises the question of whether
7 beneficiaries would need to actively enroll in ACOs instead
8 of being passively assigned as they are now.

9 Our fourth and final scenario is identical to the
10 third scenario, except policymakers would go one step
11 further and stop producing the fee schedules. Here
12 policymakers would need to address all of the issues that
13 we discussed for the second and third scenarios, but there
14 would be other challenges related to the elimination of the
15 fee schedules.

16 Perhaps the biggest challenge is that MA plans
17 and ACOs might have to pay providers using rates that are
18 much higher than fee-for-service rates. With the current
19 fee-for-service program, Medicare uses its purchasing power
20 to set payment rates that are often much lower than
21 commercial rates. These rates are also used in various
22 ways to limit MA and ACO spending. Without the fee

1 schedules, Medicare's purchasing power would be fragmented
2 and providers would likely be able to use their market
3 power to force MA plans and ACOs to pay higher rates.

4 Now that we've looked at each scenario
5 individually, we wanted to put them next to each other and
6 show you how their implications differ. You can see the
7 four scenarios listed on the left side; remember that as
8 you move down the rows, you're taking more extensive steps
9 to eliminate fee-for-service.

10 The first area where the scenarios differ is
11 whether beneficiaries could receive services from any
12 willing provider. They could under the first scenario if
13 they were in fee-for-service or an ACO. They might not be
14 able to under the second scenario and would not be able to
15 under the third and fourth scenarios. The number of
16 delivery models that Medicare uses would also differ. The
17 first scenario would have three models, while the second
18 scenario would use two models, and the third and fourth
19 scenarios would essentially use just one model, since ACOs
20 would effectively become capitated health plans.

21 With respect to implementation, the third and
22 fourth models would be much harder for CMS to implement

1 because they would go much farther in curtailing or
2 eliminating the fee-for-service program. Finally, the
3 effects on program spending would depend on the specific
4 changes made to each model, although it seems clear that
5 costs would rise significantly under the last scenario due
6 to the complete elimination of the fee-for-service fee
7 schedules.

8 That brings us to the discussion portion of our
9 session. The Commission is interested in expanding the use
10 of value-based payment in Medicare because of its potential
11 to reduce spending growth while maintaining or improving
12 quality, and we plan to make work on VBP a priority for the
13 next meeting cycle. For our discussion today, we would
14 like your guidance on how the use of VBP would affect each
15 of Medicare's delivery systems, but we are particularly
16 interested in your thoughts on the illustrative scenarios
17 and the extent to which value-based payment should replace
18 traditional fee-for-service coverage.

19 That concludes my presentation. I will now be
20 happy to take your questions.

21 DR. CROSSON: Thank you, Eric. Excellent
22 analysis.

1 We're now open for clarifying questions. We'll
2 start with Brian.

3 DR. DeBUSK: First of all, thank you for an
4 excellent chapter. I know you discussed this in the
5 reading, but I'd like you to elaborate on it a little bit
6 more. How would this apply, say, to the most rural areas
7 or to, for example, extraordinarily high-cost cases, you
8 know, say high-cost outlier policies, rural areas, and even
9 potentially some of the short-stay issues that we may run
10 into?

11 MR. ROLLINS: Well, I think that's one of the
12 issues that sort of the rest of you around the table would
13 need to grapple with. If you want to replace the
14 traditional fee-for-service program, the lesson of MA
15 suggests that you may have to spend more money to make sure
16 that model is available in all areas, and that might hold
17 true for ACOs as well. So to the extent that one of your
18 goals is to sort of reduce program spending growth, that's
19 a little bit at odds with ensuring sort of universal access
20 to, say, MA plans or ACOs.

21 DR. CROSSON: And, you know, I think another --
22 this is a set of issues we're going to have to discuss.

1 Another option would be that there could be certain areas
2 of the country, you know, particularly really, really rural
3 where the population density is very, very small and the
4 number of providers is very small and some of the models
5 would be not feasible. There could be a continuation of
6 another model in that area.

7 Okay, Kathy and then...

8 MS. BUTO: So, Eric, thank you for this work. I
9 wondered whether you, in looking at the options and
10 scenarios, had looked at the work that you all did earlier
11 on the use of premium support. And the reason I bring that
12 up is, as I was reading the paper, I wondered how would the
13 areas do that have -- of the three, MA, ACO, fee-for-
14 service, where fee-for-service is the lowest-cost option,
15 what would the impact of these different scenarios be on
16 areas where fee-for-service is a pretty cost-effective
17 option now? And did you have a chance to think about that?
18 And I guess a related question would be: Which of these
19 scenarios would do the most to sort of bend the cost curve
20 in Medicare in your view?

21 MR. ROLLINS: We did very much think about the
22 work that we had done previously on premium support, and I

1 think we mentioned it in a couple of places in the mailing
2 materials.

3 In particular, the work that we did on premium
4 support, as you know, some of the premium support proposals
5 would eliminate the fee-for-service program, and I think
6 sort of where the Commission ended up after looking at it
7 over a number of years was that it was worth keeping. And
8 one of the reasons is what you said, that there are areas
9 where fee-for-service is actually the low-cost model.

10 So if your goal is to sort of control overall
11 program spending, you probably want to take advantage of
12 that in the areas where it is available.

13 Whether or not that gets used as part of this
14 shift of value-based payment is very much a policy
15 question.

16 I'm sorry. Kathy, could you repeat the end?

17 MS. BUTO: Yeah. The second question -- and,
18 actually, so that was sort of an analysis, sort of a static
19 analysis of what it looks like now. But, if we shifted to
20 a more coordinated care model, ACO, MA, potentially that
21 whole outlook could change.

22 So my second question was really whether you

1 thought about which of these scenarios produced the best
2 long-term savings potential for Medicare if we moved to one
3 or the other. My own take would be the capitated models,
4 but I don't know if that's what you concluded.

5 MR. ROLLINS: I think that is a far too complex
6 question for me to respond to knowledgeably.

7 [Laughter.]

8 MR. ROLLINS: Although I will say that of the
9 scenarios we fleshed out here, I think the last scenario is
10 the most problematic because of the upward pressure on
11 provider payment rates.

12 Leaving that aside, the rest of it would depend
13 very much on what exactly would be -- what changes would be
14 made.

15 DR. CROSSON: So some of these issues are in fact
16 the body of work that we are going to entertain.

17 But I did like the fact that you pointed out that
18 our work on premium support in the past was essentially
19 looking at the situation as it was then or a few years
20 previously.

21 I think part of this work, if it is going to end
22 up in a successful place, is going to include work to try

1 to improve the ability of the alternative models, both MA
2 and ACOs, to actually produce the kinds of savings that
3 they're capable of, at which point an analysis might show
4 something different, as you point out.

5 I've got David.

6 DR. GRABOWSKI: Great. Thanks, Eric. I really
7 enjoyed reading this chapter, and I think it is a great
8 piece of work.

9 I wanted to ask you about Slide 16. This was a
10 really nice way of laying out the different options, and I
11 think the step from Option 2 to Option 3 is a very big
12 step, as you note. I think the key distinction there is
13 having ACOs serve as these capitated health plans.

14 I guess my first question is, Are they up to that
15 task? I would like you to help us think about what is the
16 better risk-bearing entity or capitated health plan. Is it
17 a traditional kind of MA plan, or is it an ACO? Because I
18 think that is an important distinction.

19 MR. ROLLINS: Well, I think in terms of what's
20 the better risk-bearing entity, the work that we have done
21 on MA versus ACOs -- and this feeds back into the work we
22 did on premium support -- is there is no one right answer.

1 There is no model that is the best in all areas. So it is
2 hard to say that we should always use one particular
3 approach.

4 The MA model works in areas that have high-
5 service use. As you know, the plans incur nontrivial
6 administrative costs, and so the question is sort of are
7 the savings they are able to achieve in utilization enough
8 to offset that.

9 There are going to be areas of the country where
10 that tradeoff doesn't really work. Again, that was part of
11 the thinking for premium support was you may want to sort
12 of let the market kind of decide which model works best in
13 each area.

14 DR. GRABOWSKI: As a follow-up to that -- I think
15 I asked it, but I will ask it again -- do you think these
16 ACOs, especially those in rural areas, can manage this type
17 of risk and this function?

18 I think about the savings you documented, and we
19 will talk more about that in the second session this
20 morning. It has really been around the physician-led ACOs,
21 taking on one-sided risk. It is a very different model
22 than the one you are proposing here.

1

2 MR. ROLLINS: It would be a very substantial
3 change for them. I am not sure exactly how that would play
4 out. You could ask Jeff, Luis, and David the next session
5 what they think.

6 DR. GRABOWSKI: All right.

7 MR. ROLLINS: But the lesson of MA is that if you
8 pay plans enough, they will serve -- they will go serve an
9 area, so --

10 [Laughter.]

11 DR. GRABOWSKI: We should put that in Latin above
12 --

13 One other question on scenario four, and you
14 already touched on this, the cost to the higher provider
15 rates. That is not a given, right, that the provider rates
16 would necessarily be higher if we didn't have the fee-for-
17 service? I mean, those would be negotiated. You sort of
18 put it as just a higher cost here.

19 MR. ROLLINS: They would be negotiated. I think
20 given the market power that many providers enjoy, I have
21 difficulty seeing a scenario where they negotiate something
22 that is lower than what they pay now. I think in a lot of

1 cases, the pressure is going to be upward.

2 DR. CROSSON: Okay. I have Sue, Dana, Jonathan.
3 Let's do Sue, Dana, Jonathan, and then I will work my way
4 up here and back this way. Sue?

5 MS. THOMPSON: Thank you, Jay, and thank you,
6 Eric. I, too, enjoyed this chapter. I think this is great
7 foundational work for a lot of good discussion to come.

8 My question is very, very foundational and
9 clarifying, and that is just simply the definition we are
10 attaching to ACO. I infer by the discussion and by the
11 reading and the footnote in terms of we believe next-gen is
12 more likely to achieve savings that we are talking about an
13 ACO that will have both downside as well as upside risk.
14 That wasn't real clear to me in the reading, but that was
15 my impression. I wanted to confirm that.

16 MR. ROLLINS: I think that's fair. We didn't get
17 super-specific on sort of what exactly is the ACO because,
18 as you know, there's multiple models --

19 MS. THOMPSON: Exactly.

20 MR. ROLLINS: -- and they are all kind of
21 evolving.

22 MS. THOMPSON: Thank you.

1 DR. CROSSON: By the way, that is the current
2 Commission's position.

3 Dana.

4 DR. SAFRAN: Thank you.

5 I add my congrats on a really helpful and
6 informative chapter.

7 I had a couple of questions just about whether
8 some of the things I was thinking about are things that you
9 looked at and decided worthy of mention or haven't been
10 looked at.

11 One is we assume that the fee schedule, when it
12 exists, is what gets used for payment. In the private
13 sector, risk-taking organizations sometimes are doing their
14 own negotiating with other providers for the rates that
15 they are willing to pay them. I wonder if that is
16 contemplated at all as a mechanism or whether it is even
17 legally allowed in Medicare. If it were allowed, then the
18 savings those entities might get in their negotiated rates,
19 assuming there are savings, could be shared back with
20 Medicare program.

21 MR. ROLLINS: So, as you know for ACOs, at least
22 for Medicare ACOs, that is not a feature. They are paid at

1 standard fee-for-service rates.

2 MA plans do have the leeway to not use the fee-
3 for-service rates when they are negotiating with providers.

4 That being said, the research that has been done
5 suggests that in many areas, they will, nevertheless, end
6 up with something that is relatively close to fee-for-
7 service. Particularly for hospitals, it seems they are
8 paying very close to fee-for-service rates.

9 It might differ a little bit for certain other
10 sectors. I think our impression is that physicians might
11 get paid a little bit more than fee-for-service fee
12 schedule by some MA plans.

13 On the flip side, MA payment rates for SNF care
14 are often noticeably lower than what is on the fee
15 schedule.

16 So there is that flexibility now in MA. It is
17 very sector-specific sort of how much of a difference it
18 makes for sort of standard fee-for-service rates.

19 DR. SAFRAN: Yeah. That's helpful. Thank you.

20 Then the two others are these. As we think about
21 access and the ability to implement these models in certain
22 areas -- and rural has been mentioned a couple times today

1 -- it struck me that we are presuming very much the status
2 quo in terms of bricks and mortar is the way we deliver
3 health care, and I just wonder whether in this work, did
4 you model, did you contemplate how it might work in this
5 areas, rural areas in particular, if we relied much more
6 heavily on technology to create virtual care and enable
7 those organizations to be part of larger organizations that
8 were based elsewhere?

9 MR. ROLLINS: That's not a level of specificity
10 we got to for these scenarios. These were just sort of
11 very broad brush, high level. If that is something that
12 you all are interested in, that could certainly be an issue
13 that we explore in the future.

14 DR. SAFRAN: Great.

15 Then the last question has to do with data from
16 the EHR. As we think about the possibility of what happens
17 without fee-for-service, an underlying fee-for-service
18 system and the data that it generates, have you explored at
19 all the possibility for the rule that data coming out of
20 the EHR, especially as the regs start to liberate that data
21 in ways that we haven't seen before, might be used in place
22 of what we rely on from claims data today?

1 MR. ROLLINS: I think that would be another area
2 for future work that didn't really get to at this work for
3 this session.

4 DR. SAFRAN: Thanks.

5 DR. CROSSON: Jonathan.

6 DR. JAFFERY: Yeah. Thank you, Jay.

7 Eric, this was wonderful. It really gave, I
8 think, everybody clearly a lot to think about.

9 I am thinking about, as you know, the ACOs have a
10 minimum-size requirement of 5,000 members right now. I am
11 thinking about what it would take for an ACO to become a --
12 we think through the scenarios about becoming a capitated
13 health plan and all the capabilities that what in many
14 situations are relatively small organizations would have to
15 develop that they don't have now.

16 I guess thinking about even just in general full
17 risk to form my question, have you thought about or done
18 any -- is there any empiric data around what size an ACO
19 would really need to be if they are going to take on that
20 kind of full risk? I'm struggling with that. I don't know
21 that there are a lot of MA plans out there that would just
22 pop up and have 5- or 6,000 members and really be able to

1 manage that with all the administrative capabilities and
2 such.

3 MR. ROLLINS: In terms of empirical data, I don't
4 think we have that data.

5 But in terms of the MA program, there are some
6 plans that are very small, but they're very much sort of a
7 very small slice of what goes on in the MA program. Most
8 plans are serving a much larger number of enrollees than
9 5,000, and even if they're not -- even if their MA line of
10 business is fairly small, they have other lines of business
11 as well.

12 DR. CROSSON: One of the ideas that I think could
13 eventually be explored in this regard is the notion of
14 gradual assumption of risk through the application of risk-
15 mitigating corridors and reinsurance program.

16 If you remember how Part D was put together,
17 there was a concern at the time that there would be no
18 plans that would want to accept risk for pharmaceuticals,
19 and so there were belts and suspenders, three tiers of risk
20 sharing, some of which we now feel need to be removed.

21 But, at the time, I think there was a legitimate
22 concern, and that created this infrastructure, which was

1 notably helpful in getting plans to sign up and to be
2 engaged. Again, we're in a setting now where I think a lot
3 of that can be backed up.

4 So the notion of full risk, I think needs an
5 asterisk applied to it in this context, which means that
6 maybe some of these processes that were used in the past
7 for Part D could be at least thought of in terms of how
8 that full risk could be managed.

9 Now let's go with Pat and come back up this way.

10 MS. WANG: It was a great paper, and I really
11 like that you laid out a whole spectrum of alternatives.

12 In scenario two, there is a bullet that it might
13 affect beneficiary choice to require that every provider
14 participate in an ACO, et cetera. Can you say more about
15 why that would be the case? Because today somebody who is
16 in an ACO can use an out-of-network provider and that
17 service will be paid by fee-for-service. That is the first
18 question. Did you contemplate that that would change
19 somehow?

20 The second question is, in the third and fourth
21 scenarios which really talk about insurance risk -- and I
22 think I have a bias in that direction because it's really

1 expensive to set up those kinds of infrastructures, and
2 insurance risk is really big risk. But did you think about
3 and maybe discard -- I'm just curious like what other
4 alternatives you might have thought of, of different types
5 of bigger risk, like global budgets for certain kinds of
6 providers that may be dominant in a community and they are
7 really the main provider, so that they wouldn't be
8 processing claims, necessarily.

9 I have heard some large provider organizations
10 talk about the notion of global budgets. I just was
11 curious if there were other alternatives to insurance risk
12 that maybe you had considered for three and four.

13 MR. ROLLINS: So on your first question of the
14 choice of any willing provider, as we thought about it, for
15 the second scenario, in contrast to the current ACO model,
16 every provider that wants to get paid by fee-for-service
17 has to belong to an ACO. So if you are not willing to
18 participate in an ACO, you could not get Medicare payment
19 for your services. In that sense, it would be different
20 than what we have now where you can go see somebody who is
21 outside your ACO, and they are just in traditional fee-for-
22 service.

1 Under the scenario, at least as we sort of
2 thought about -- and, again, these are only for discussion
3 purposes -- you could still potentially go outside of your
4 ACO, but whoever provider you are seeing still has to
5 belong to some other ACO.

6 In terms of how entities would bear risk, these
7 are illustrative scenarios. There's other things you could
8 contemplate. Global budgets might be one of them, but
9 presumably, global budgets carry some element of risk as
10 well.

11 DR. CROSSON: Warner.

12 MR. THOMAS: I concur. A great chapter, a lot of
13 great information, and certainly applaud the staff's
14 direction in taking this one.

15 A couple of question on Slide 6 on the first
16 bullet. You mention MA plans provide care compared to fee-
17 for-service at a lower cost, yet Medicare then pays 1 to 2
18 percent more than overall MA. Can you just clarify that
19 and give me a little bit more color on those two bullets
20 together?

21 MR. ROLLINS: Sure. When the plans submit bids,
22 they are submitting bids to provide the standard Part A and

1 B benefit package, and that is the element where the data
2 from the bids that the plans submit suggest that the vast
3 majority of plans can beat the fee-for-service cost in
4 their area.

5 But then on top of that, given the way that we
6 pay MA plans, they receive part of the difference between
7 what they bid and what their benchmark is as a rebate, and
8 their rebate can be used to provide extra benefits to
9 beneficiaries. These are things like the reduced cost
10 sharing, dental coverage, hearing aids, things like that.

11 So when you factor in these other payments that
12 the plans get in addition to just providing the standard
13 Medicare benefit package, it actually, based on our latest
14 estimates, is about 1 to 2 percent more expensive than the
15 cost of providing fee-for-service.

16 MR. THOMAS: But that differential is essentially
17 additional benefits or additional cost reduction to the
18 beneficiary? It is either benefits or cost reduction?

19 MR. ROLLINS: Not all of it. Some of the rebates
20 can be used by the plans for administrative cost and
21 profits. There's also the effect of upcoding.

22 MR. THOMAS: Okay. The second question is on

1 Slide 8 on the ACO model. Obviously, I have information
2 about the next chapter that kind of plays into this
3 chapter.

4 The ACO savings have been modest. That is kind
5 of outlined there. I guess the question I have there, you
6 got kind of roughly 1 to 2 percent, but there is really not
7 an appreciable cost savings. I guess, what would be
8 considered appreciable? I mean, because 1 to 2 percent on
9 trend over time to me seems material. So I'm just trying
10 to figure out what would be appreciable.

11 MR. ROLLINS: Well, I think what is appreciable
12 is going to be, to some extent, in the eye of the beholder.
13 So I'm not sure I have a firm answer for that.

14 I think one thing I just want to make sure is
15 clear is -- you are talking about sort of saving 1 to 2
16 percent on trend -- these are not savings that you are
17 getting year-over-year. You are not getting another 1 to 2
18 percent a year, another 1 to 2 percent a year, and this is
19 sort of after 4 years of operation. Compared to what we
20 think you would have spent without the ACO, instead of
21 spending \$100, you are spending somewhere between \$98 or
22 "99. Whether or not that differential --

1 MR. THOMAS: And that is not annual? That is
2 over a 4-year period?

3 MR. ROLLINS: No. That's in the fourth year.
4 You're down roughly 1 to 2 percent from what we think you
5 would have spent otherwise.

6 Whether or not that differential continues,
7 whether it gets smaller or bigger, we don't know.

8 MR. THOMAS: Okay. Go ahead.

9 DR. CROSSON: Marge.

10 MS. MARJORIE GINSBURG: I have two questions.
11 The first is related to this and the savings accrued to
12 ACOs and MA plans.

13 So the assumption is, to make all this
14 worthwhile, the -- let's say MA plans, using that as an
15 example -- have to be showing continual rates lower than
16 what the fee-for-service benchmark was, because right now
17 we know they are getting more, sometimes much more, because
18 of either risk adjustment or the bonuses, and I know we are
19 going to be working on the bonuses.

20 But I just wanted to make the point that the
21 pressure really needs to be on to justify this by making
22 sure that what the government is paying for through these

1 other two models will, in fact, be lower than fee-for-
2 service. So that's kind of a question. Maybe it's a
3 statement.

4 Now I have a real question. Dumping the fee-for-
5 service model I suspect is going to get considerable
6 pushback from the public, and I wondered whether staff has
7 done any research on public perceptions about what it means
8 to not have fee-for-service anymore. Certainly, anybody
9 who is following the discussion around Medicare for All,
10 blah-blah-blah, tremendous division right there of people
11 who unwilling, ever, to be able, you know, to not be able
12 to go to their own doctor.

13 I love this report, and Dana said earlier about
14 it being great reading. It really was a page-turner, and
15 you all just did a fabulous job. But I feel like that's
16 one piece that might be missing, and that is the public's
17 views on doing away with fee-for-service. And I wonder
18 whether you had done any research about that, done focus
19 groups with the public about the fee-for-service model.

20 Thank you.

21 MR. ROLLINS: Off the top of my head I don't
22 know, but there may be other people here who can answer

1 that. But certainly the fee-for-service program is very
2 popular with many of the people who are enrolled in it, and
3 so these are scenarios meant to spur discussion amongst all
4 of you, and certainly some of the changes that we have
5 outlined would be fairly far-reaching, and, you know, there
6 would certainly be opposition.

7 DR. CROSSON: To be clear, Marge, this is an
8 issue that we are going to have to address, to say the
9 least.

10 Warner, did you want to comment again on this?

11 MR. THOMAS: I just remembered my other question.

12 DR. CROSSON: Okay. All right. Go ahead.

13 MR. THOMAS: It's on a different topic, so I
14 don't know if you want to continue to address this or if
15 you're done.

16 DR. CROSSON: Well, do we have further comments
17 on Marge's point? I couldn't quite tell from the hands.

18 So you want a mulligan?

19 MR. THOMAS: Yeah, I want a mulligan. Usually
20 when I play I need like four or five, but anyway, so back
21 on this slide. Just on the trend, I just want to make sure
22 I've got this right. So when we talk about the savings, 1

1 to 2 percent, is that an often-inflated trend or is that
2 off of the actual cost? So is that a true 1 to 2 percent
3 reduction from what the baseline cost was or is that a 1 to
4 2 percent reduction off an inflated cost that has some sort
5 of trend built in?

6 MR. ROLLINS: It's based off of our, or
7 researchers' estimate of what fee-for-service would have
8 spent on those beneficiaries if the ACO program did not
9 exist. It is the counterfactual.

10 DR. CROSSON: Okay.

11 MR. ROLLINS: Yeah. I'll be happy to talk about
12 it more.

13 DR. CROSSON: Okay. Jonathan?

14 DR. JAFFERY: Yeah. So this actually, I think,
15 goes back to what Pat was asking about. In Scenario 2 you
16 talk about the beneficiary choice being limited. So I get
17 what you're saying that providers would be forced to be in
18 ACOs but that it still would -- that still wouldn't limit
19 beneficiary choice in this model, is my understanding.

20 So the question is, did you contemplate something
21 where not only would providers have to be in ACOs, or in
22 MA, but something short of a capitated point, so maybe

1 something more like Scenario 2 but where beneficiaries also
2 need to choose one of either two or three options? And
3 maybe this starts to play into the premium support
4 conversation as well.

5 MR. ROLLINS: I think that's a -- I mean, there
6 are obviously a lot of variations of all of these scenarios
7 that you could entertain, and that would be one of them. I
8 think for Scenario 2 beneficiary choice could be implicated
9 if there are providers out there who simply decide they do
10 not want to participate in any ACO. So in that sense you
11 could have maybe fewer providers available than you have
12 now in certain areas. I don't want to overstate it because
13 I don't know how much that would be an effect.

14 But then in terms of sort of how tightly you want
15 to tie beneficiaries to ACOs and sort of really have them
16 see the providers who are participating in the ACO, those
17 are issues to discuss.

18 DR. CROSSON: Karen.

19 DR. DeSALVO: Just to follow on to that, I can
20 see a scenario, though, where that could exacerbate
21 inequity, so those who had a means to pay could go outside
22 of the system and pay, and those who didn't have a means to

1 pay would be locked into their provider network. So choice
2 might be differentially limited based upon your ability to
3 pay.

4 Eric, thank you for launching us into this
5 discussion. I am beyond excited about the chance to think
6 about a future world where there are entities accountable
7 for the total health and cost of the beneficiary, to have a
8 long-term relationship with them.

9 But I had some things I didn't particularly see
10 in the chapter and I wondered if they were relevant and if
11 you all had looked at them, and maybe they weren't
12 included. One of them had to do with the impact on what I
13 might call special groupings. Some were mentioned already,
14 but like rural providers who may be in cost-based
15 reimbursement models or federally qualified health centers
16 that aren't easily in the value-based payment world.

17 And then, in a related fashion, I wondered about
18 whether there is any consideration for the impact on
19 graduate medical education funding, if we move along the
20 continuum to Scenario 3 or 4. That's my first question.

21 MR. ROLLINS: Those are terrific issues that are
22 sort of not at the level, sort of -- it's just not at the

1 level of specificity that we got to for these scenarios,
2 but are absolutely fair game.

3 DR. DeSALVO: Okay. I had a question also about
4 being able to lift up the beneficiary's voice in some of
5 these scenarios. We won't get into a discussion about
6 quality, though that will be relevant over time, but
7 wondered about whether there is any way to compare their
8 experience using measures that we might be capturing, so
9 that we could get some sense about, you know, whether their
10 experience has improved. I was thinking about, you know,
11 the work that we did in the past, along with the
12 Administration, and weigh not only cost and quality but
13 also beneficiary experience. And in some of those models
14 that are better coordinated it's a better experience for
15 them.

16 So is there data that could allow us to use that
17 as a comparator?

18 MR. ROLLINS: I am not sure, off the top of my
19 head, but that's something -- we can look into that.

20 DR. DeSALVO: Like the CAHPS?

21 MR. ROLLINS: I mean, certainly CAHPS would be
22 sort of getting at things like patient experience. I don't

1 know what data we've got that would look specifically at
2 sort of the issue you are getting at.

3 DR. DeSALVO: Like so if I'm in a fee-for-service
4 -- we always say people in fee-for-service are very happy,
5 though I suspect that people are just happy if they can get
6 their services and see the doctor that they want to see.

7 So, anyway, it would be nice to have a little bit
8 more of a dimension that was about their voice. I like the
9 idea of focus groups also, but I think something
10 quantitative.

11 I just had one more question about whether
12 there's any lessons learned from what Medicaid MCOs do in
13 states, about setting payment rates. This gets to your
14 point about how does the commercial market do it, how does
15 Medicaid do it, and if we try to disarticulate from this
16 whole benchmark idea in the first place is there some other
17 lessons that we could learn that might free us from the
18 benchmark and allow us to create a future system that was
19 predicated on future needs?

20 MR. ROLLINS: Yes. Medicare managed care would
21 be an area that would be interesting to look at. For
22 example, a lot of times Medicaid managed care programs

1 would serve the entire state, which can, for a lot of
2 states, include highly rural areas. And a lot of times
3 what the tradeoff is there is they will say to the state
4 you are bidding to serve the entire state. You can't pick
5 and choose certain areas.

6 And the tradeoff is that, as you know, a lot of
7 the Medicaid managed care contracts are very long -- three,
8 four, five years, or something in that range. So that's
9 kind of the tradeoff, is we will make you maybe serve areas
10 that you aren't really sort of happy about or maybe aren't
11 the most profitable, but you'll have a long period of time
12 to sort of try and sort of recover costs.

13 Also, and this is an area we could look into
14 more, particularly for some of your traditional populations
15 like low-income children, pregnant women, things like that,
16 states are basically now at a point now where they don't
17 have a Medicaid fee-for-service program and so they are
18 finding new ways to sort of set the payment rates for their
19 plans, based on sort of their financial performance data,
20 encounter data, things like that.

21 DR. CROSSON: Jaewon.

22 DR. RYU: Yeah. I just wanted to revisit the

1 access and availability and the willing part of the any
2 willing provider dynamic. I don't know if there have been
3 any studies or survey data or maybe it's focus groups
4 around providers and specific pain points that might
5 precipitate them to depart and say, "You know what? I'm
6 just not going to participate at all." But I was just
7 going to tee up that as a question. Do we have any
8 information that might help us forecast that kind of
9 migration out of the program to say, you know, that might
10 impact this group of beneficiaries differently than this?
11 Any commentary on that?

12 MR. ROLLINS: It's not an area I could comment
13 on. I don't know. Other people might want to comment on
14 it.

15 MS. TABOR: I'll just say a little bit about our
16 position focus groups over the past couple of years, and
17 they don't think physicians generally know whether they are
18 in ACOs and why they're contracting with certain MA plans
19 versus taking fee-for-service. I think it's handled much
20 more at the practice management level. So I think it's a
21 harder question to answer, just because physicians seem to
22 be focused more on providing the care as opposed to who is

1 the payer.

2 DR. CROSSON: Thank you, Ledia. Sue, are you up?

3 No. Bruce.

4 MR. PYENSON: Eric, thank you very much for the
5 chapter. You make the point in some of the, I think,
6 Scenarios 3 and 4, that there might be an issue if fee-for-
7 service goes away with how do you create fee schedules, and
8 fee schedules are incredibly useful throughout the health
9 care system.

10 But I don't see the -- I wonder if you could
11 explain the connection between the reimbursement model and
12 the fee schedule, because I don't see them as necessarily
13 linked at all. I see a fee schedule as an accounting
14 exercise that's essential for accounting and the data
15 collection on that and the reimbursement as a different
16 issue. For example, in bundled payments there is bundles
17 that are defined and there is a background accounting
18 that's done on a fee-for-service issue.

19 So do you see the question I'm asking, that I
20 guess I don't see the -- even if fee-for-service Medicare
21 goes away entirely, I could see the fee schedule and the
22 collection of data maintaining itself very well.

1 MR. ROLLINS: Well, I think the question would be
2 what data are you using to come up with the fee schedules,
3 if, quote/unquote, fee-for-service goes away. So, for
4 example, we rely on data on inpatient hospital claims to
5 help set the weights for each DRG, and so sort of where are
6 you going to get that information if Medicare is no longer
7 paying those claims and getting those claims from the
8 providers directly?

9 One thing we talked about in the paper is maybe
10 you could get ACOs to submit data that looks kind of like
11 that, but that would certainly be a challenging endeavor.

12 So I think that's one example of sort of how
13 there is, I think, a link between sort of the reimbursement
14 you are using, where sort of, you know, if ACOs are in
15 charge of paying claims, so what data are you going to use
16 to help come up with some of your rates?

17 MR. PYENSON: If you could elaborate, like in the
18 case of hospitals, hospitals have costs and they allocate
19 costs, and how they do that, you know, is presumably
20 following accounting rules, so the cost basis gets reflect
21 ultimately in financial results and gets aggregated and
22 compiled.

1 It's not clear to me that any of that has to go
2 away in the context of different reimbursement systems,
3 because money is fungible, and how you pay revenue can get
4 allocated as well to that level of detail. So I don't see
5 the connection.

6 MR. ROLLINS: Maybe I'm not following entirely.
7 I mean, I think you would probably still need a scenario
8 where facilities like hospitals are submitting their cost
9 reports. But in terms of coming up with the payment rates
10 for an individual service, under our system you need to
11 essentially know what is the average cost of providing that
12 service. And so you would have the cost reports that give
13 you sort of the overall cost picture for the facility but
14 you need something like claims, charges, and cost-to-charge
15 ratios to figure out sort of roughly what is the average
16 for each individual service that the hospital provides.
17 And it's that second piece of data that would need to be
18 worked out.

19 MR. PYENSON: Why would it have to change
20 compared to what's happening now?

21 MR. ROLLINS: Well, that's a policy question for
22 you to consider. I mean, we were talking about situations

1 where, for example, if ACOs take over the responsibility
2 for paying all claims CMS would no longer be getting that
3 data stream that it now uses, and so you would need to find
4 another replacement for it. If CMS continues to pay all
5 the claims they would collect all the data that they do now
6 and they could, you know, continue to operate more or less
7 in the manner that they.

8 MR. PYENSON: But just on that point, there's all
9 sorts of mechanisms to have, you know, virtual payments
10 made and claims submitted and trued up retrospectively or
11 possibly prospectively. So that's the financing mechanism.

12 Anyway, I'm puzzled.

13 DR. CROSSON: Maybe we could take this offline
14 and you and Eric could talk about it.

15 Okay. That's a pen up? Pen up? Okay.

16 DR. PERLIN: Let me add to the chorus of
17 appreciation for this work.

18 When you think of this as a continuum of
19 evolution, perhaps, I appreciate the point that was made
20 earlier about a need to consider not only an end state but
21 a trajectory toward getting to that end state, I think a
22 point that Jay made.

1 It also brings to mind, you know, what are the
2 problems that you are seeking to solve, and in this sort of
3 hierarchy from 1 to 4 you have an end state that embraces a
4 world where a plan would have incentives to solve some of
5 the problems that we consider at every meeting.

6 One, of course, is the ability to really
7 coordinate the care across all circumstances and even
8 address some of the social determinants types of issues,
9 and that's there. On the other, you know, one of the
10 things that is so much a part of our continuing
11 conversation are the elements within the cost of care that
12 are really the most challenging cost drivers. They have
13 their upsides -- new technologies and curative drugs. On
14 the other hand, the cost of these new technologies and
15 drugs is rather daunting.

16 As the team considered this hierarchy of perhaps
17 even of evolution, did you consider whether individual
18 plans would be equipped to really grapple with those cost
19 drivers like drugs and devices independently or is there,
20 with this sort of hierarchy conceptualization of some
21 capacity to work together perhaps in ways that aren't
22 currently acceptable to be able to manage drug costs, for

1 example, not independently as a single plan but in the
2 aggregate of multiple plans?

3 MR. ROLLINS: That's not a level of detail we got
4 to for these scenarios but that's something that -- I think
5 something for you all to discuss.

6 DR. CROSSON: Okay. Paul and then Amy and then I
7 think we're going to move on.

8 DR. PAUL GINSBURG: This is clearly a Round 2
9 question but it's been relevant to at least half a dozen
10 questions in Round 1. If we're going to get to Round 2
11 soon I'll wait. If we're going to get to round two soon
12 I'll wait.

13 DR. CROSSON: We're going to get to Round 2
14 questions, or Round 2 definitive statements. We'll get to
15 Round 2 in, I think, in a minute.

16 Amy and then -- go ahead. Yeah, Amy.

17 MS. BRICKER: Yeah. So, Jon, I think just to
18 start with going there, I was curious as to our appetite to
19 take on potentially value-based design, if not in D,
20 realizing this is an MA chapter, but in B, and the ability
21 to allow plans to, either independently or in collaboration
22 with others, to negotiate with manufacturers for, you know,

1 value-associated contracts. So I realize the focus here is
2 in physician and in provider risk, but why not it also
3 include manufacturer risk?

4 So have we contemplated that or, if not, I can
5 elaborate in Round 2.

6 MR. ROLLINS: That's not something that at least
7 I am going to speak on knowledgeably, but I think that's a
8 good Round 2 item.

9 DR. CROSSON: Yeah, so feel free to make your
10 point and bring your idea forward.

11 Okay. We're going to move on now to the
12 discussion period, and I think it's useful to point out
13 that the questions have been excellent and point the way to
14 future work. You know, today's presentation and today's
15 discussion is kind of laying the groundwork for one area,
16 which has to do with the issue of how far the Commission
17 thinks we should go in this transition away from fee-for-
18 service, right? So I'm going to look for that. You've got
19 options from nothing to everything, so to the extent that
20 you have a sense of that based on the discussion so far,
21 that would be helpful.

22 The recognition here is that, you know, as we saw

1 from the first round of questions, there are a lot of
2 issues that would need to be resolved, such things as where
3 would exceptions need to be made, you know, what about the
4 rural aspects of this, you know, as well as trying to find
5 ways to really improve these alternative models so that
6 they represent, you know, not a loss to beneficiaries but
7 an obvious gain in terms of the levels of service, such
8 things as care coordination, obvious improvements in
9 quality, and reductions in costs both to beneficiaries and
10 to the Medicare program, and the ability, I think, to
11 discern how we might do that over time, make
12 recommendations in that area, I think is critical to the
13 notion -- to the idea that this notion would be something
14 that people would want to accept, and that's a good portion
15 of the work that we need to do over the next cycle or
16 beyond that.

17 So let's have a discussion period here. We're
18 going to run a little over time, but I think we need to on
19 this important topic, and we're going to start the
20 discussion with Warner.

21 MR. THOMAS: Great. Thanks, Jay, and once again,
22 thanks for the chapter.

1 First of all, I applaud the work, and I think
2 that we have to think a little bit about the philosophy of
3 how we approach this. And I think Karen actually mentioned
4 this, that it's positive to see a chapter where we're
5 talking about entities actually taking responsibility for
6 the cost of providing care and taking responsibility for
7 the quality as well. And I think that that's really, you
8 know, an important philosophical change in how we think
9 about moving to this model versus fee-for-service. And I
10 think moving to that model, you also find, I believe,
11 physicians, hospital systems, building capability to do
12 that and to do it better because they'll be forced to
13 essentially be held accountable for it.

14 But I think the other two things that are
15 philosophical that we need to ask ourselves is: Is
16 coordinated care better than fragmented care? Because
17 coordinated care and accountable care organizations or in
18 organizations that work closely with MA plans, it appears,
19 you know, looking at some of the information, does yield
20 better results. And I think philosophically we have to ask
21 ourselves if we think coordinated care is better than
22 fragmented care where people go all over, then this

1 direction for reimbursement seems to make a lot of sense.

2 I think the second is, Do we want to be reactive
3 or proactive about how we take care of people? Because
4 fee-for-service is all about being reactive. People have
5 an issue, they come to us, we take care of them; versus
6 being proactive where an organization is accountable and
7 kind of focuses on taking care of somebody in a more cost-
8 effective fashion and with better outcomes.

9 So I think those philosophical pieces are
10 important as to how we think about approaching this issue
11 and changing -- obviously, these would be major changes in
12 the model, but once again, I think this philosophy of
13 coordinated and proactive is important how we think about
14 care going forward.

15 I'll comment just briefly on the four scenarios
16 and then, you know, just give kind of my view of how I
17 think organizations may look at them.

18 First of all, if you think about Scenario 1,
19 continuing fee-for-service, and maybe moving to bundles or
20 those sorts of things, to me the challenge you see in that
21 is that bundles do not deal with the issue of duplicative
22 care or chapters we've had previously of unnecessary care.

1 And I think if you have a situation where providers take
2 financial responsibility, they're much more likely to move
3 to a model where they are trying to reduce unnecessary care
4 and try to reduce duplicative care.

5 Also, you know, at least in our system, we find
6 coordinated care, we definitely see a reduction in
7 duplication of testing for people that are coordinated and
8 have all their medical information in one location.

9 Some people would argue that bundles does that,
10 but the issue with bundles, you still in many cases have
11 unnecessary care in bundles or care that just doesn't need
12 to be provided. I mean, we see this in many of the
13 commercial or private studies for Centers of Excellence
14 that many patients that are referred, you see 30 or 40
15 percent of the referrals do not yield an actual procedure.
16 They actually go to a different type of care, a less
17 invasive type of care, and there is no surgery. I think
18 I've seen many articles on Walmart on this, for example.

19 The third and fourth scenarios, you know, where
20 you're actually either eliminating the fee-for-service
21 system or moving payment to the providers, as indicated in
22 the chapter, just seemed to be very, very complicated and

1 fraught with a lot of issues of -- I think that Pat said,
2 you know, when entities take risk, there's a reason risk is
3 a four-letter word. There are a lot of challenges that can
4 go with that, and I think moving to a model where you move
5 all the risk and all the payments to the provider system, I
6 think that can be really challenging, and it is, frankly, a
7 core competency that most physicians or hospitals or
8 integrated organizations do not necessarily have. Some
9 have it, so maybe you could make it an option if people can
10 demonstrate competency, but I would encourage us to steer
11 away from 3 and 4 just given the complexity and some of the
12 risk.

13 So that kind of comes back to Scenario 2, which I
14 personally think is the right direction, to move to a model
15 of evolving the ACO and MA models. I think that they're
16 the right models just because, once again, it's coordinated
17 and it's proactive. If you think about it, for physicians
18 they're rewarded for creating value. If it's a physician-
19 based ACO, to the extent that they reduce utilization or to
20 the extent that they do a better job creating value, both
21 cost and quality, they're paid more for that, and that
22 seems appropriate.

1 For hospitals, they'll be forced to work with
2 physicians or to integrate with physicians, and essentially
3 they get more focused on reduction of utilization, they get
4 more focused on post-acute, as I think Jay mentioned. If
5 you look at the ACOs, there has been a pretty significant
6 reduction in post-acute care, and to me it just puts the
7 incentive in the right place. And I think all of these
8 models forces coordination and collaboration. I mean, we
9 find in post-acute care, post-acute providers then want to
10 start working with hospitals and physicians because they
11 realize if they're not good utilizers of service, if they
12 can't show quality, then essentially they will not get
13 referrals going forward out of these types of models. And
14 I think we've seen post-acute providers get much more
15 sophisticated on quality and much more integrated with
16 systems.

17 So I believe that really exploring a lot of
18 detail, Scenario 2 makes a lot of sense. There are
19 challenges with that, and I understand that, but I think it
20 does have the right philosophy.

21 I would actually go to Jonathan's comment and the
22 questions about cost drivers, and I would encourage us to

1 think about still, even with these scenarios, making sure
2 that we can take on the largest cost driver and the
3 fastest-growing cost driver, which is drug cost. I think
4 in these models you certainly can see an improved
5 utilization from a drug perspective, but that's not going
6 to take on the pricing issue if we don't take that on as a
7 Commission.

8 And, lastly, I would say it would be nice to see
9 if there's a way to go -- I know some comments Pat has made
10 in the past, Part D, have Part D folded into this in some
11 way to create the right incentives for the delivery system
12 to work on the Part D cost. It would be interesting to see
13 that happen.

14 So I applaud the work. I would encourage us to
15 be expeditious and to move this forward, not to do it in a
16 fashion that's not careful, but I do think this will be an
17 evolution. It's not like we're going to solve it all on
18 day one. Whatever would be a recommendation, more than
19 likely we will continue to evolve it and build on top of
20 that. But we have to change the incentives, and we have to
21 put the providers in a position where they've got to be
22 held responsible for the quality and the cost of care that

1 they deliver.

2 So, once again, I applaud the work, so thank you.

3 DR. CROSSON: Thank you, Warner.

4 So I think we'll move this way this time, so
5 we'll start with David.

6 DR. GRABOWSKI: Great. Eric, once again, a great
7 chapter. I think I fall pretty much in the same place as
8 Warner, that I think Scenario 1 isn't far enough and
9 Scenario 3 and 4 are a little too far, and I just don't
10 have a lot of confidence right now that the majority of
11 providers really manage risk in the way you've outlined in
12 the chapter.

13 So I like this idea of further pushing providers
14 towards ACOs. I want to pump the brakes a little bit,
15 however, and you noted this earlier, Eric. The savings to
16 date, 1 to 2 percent, Warner pushed you earlier about
17 whether that's small or big. Warner, I think we get so few
18 victories at MedPAC, let's take a small victory and
19 celebrate it. I think 1 to 2 percent is great. However,
20 let's think a little bit more about that 1 to 2 percent.
21 That's based on ACOs that were physician-led. It was
22 largely in one-sided risk models from the Medicare Shared

1 Savings Program. And perhaps most importantly, and Warner
2 touched on this, it's really come on the backs of post-
3 acute-care providers.

4 And so as we push providers into these
5 arrangements, we're going to push post-acute-care
6 providers, too, into these kind of systems or ACOs. It's
7 great for a physician-led ACO to push down on post-acute-
8 care spending outside the ACO. It's a little bit harder
9 when that post-acute-care provider is part of that ACO. So
10 it's a very different arrangement. It could lead to better
11 care coordination. It could lead to more appropriate care.
12 But the idea that we can take that 1 to 2 percent savings
13 that we saw in the MSSP program and apply it here, we need
14 to think a little bit more about what are going to be the
15 true savings here and the true implications for
16 beneficiaries of going to these mandated kind of more
17 global ACO models.

18 Thanks.

19 DR. CROSSON: Amy.

20 MS. BRICKER: So building off of the questions
21 around how do you address and begin to truly manage drugs
22 within the Part A and B space, the struggle that has

1 remained generally in the regulated market with respect to
2 D and B is our inability to negotiate with manufacturers in
3 the same way that you do in the commercial market for fear
4 of kind of running up against, you know, safe harbors and
5 also anti-kickback statutes. Specifically, if a drug does
6 not work in the commercial market, you're free to negotiate
7 with a manufacturer for refund. We have done this time and
8 time and time and time again with tremendous success in the
9 commercial market. I would love for us to take a position
10 that those tools and having the manufacturer truly put
11 value on the table in response to, you know, the prices
12 that they're setting and the utilization of their products,
13 truly put value on the table. You know, we've evolved to a
14 place where we have wonderful data and the ability to track
15 patients throughout the continuum, regardless of if they,
16 you know, are jumping from plan to plan or, you know, fee-
17 for-service or not, patients, the progression of their
18 disease, these things can be managed. And while I would --
19 the most successful contracts are those that have a finite,
20 specific outcome, not things like, you know, if you have a
21 heart attack, because, you know, who knows what really
22 contributed to the heart attack, but did they stay on

1 therapy? Did they have to add additional therapies? In
2 the case of hepatitis C, when the patients had to be
3 retreated, all of that was funded by the manufacturer in
4 large part.

5 So there absolutely is a mechanism in the
6 commercial market that I think we should take on in the
7 regulated market such that plans, ACOs, health systems who
8 have done a very good job of managing formularies,
9 especially within hospital settings, could take on that
10 additional -- the conversations, negotiations, either
11 singularly or in collaboration with other health systems.

12 I realize that this is already a big chapter, but
13 the title value-based, it just reminded me that there's a
14 segment here that we haven't addressed that I think
15 everyone's collective point, it's not managed and there's a
16 real opportunity.

17 DR. CROSSON: Thank you, Amy. Paul.

18 DR. PAUL GINSBURG: Yes, again, I thought the
19 materials were terrific. I enjoyed reading them. I have a
20 concern, though, that discussing scenarios at this point is
21 really premature, because I found myself saying, well,
22 current ACO models look like they have slight savings.

1 That's not the context to talk about Scenario 2, you know,
2 having all providers being in ACOs. We should be talking
3 about significant changes in the models. We should be
4 talking about better ACOs. We should be talking about
5 doing something more aggressive on prescription drugs, as
6 Amy was talking about, because then we can have the
7 discussion of scenarios and it would not be so hollow. I
8 think it's very hollow today.

9 You know, the point that Marge brought up about
10 concerns about there being a fee-for-service alternative,
11 to me that issue is going to look very different if, in
12 fact, we have much more compelling alternatives to fee-for-
13 service than we have today.

14 So my advice is let's not burn a lot of time and
15 energy talking about scenarios now, with one exception,
16 which I will get to in a second. Let's go right into --
17 not today, but right into bolder options than we've
18 discussed before about how to move this value direction
19 more quickly. I agree with Warner as far as having
20 coordinated care, managed care, is the way to go. But we
21 haven't really talked much about how to go faster.

22 Now, the one exception as far as talking about

1 scenarios is that we have a situation now, which hopefully
2 we'll get to in a lot of other areas, in MA, in areas where
3 the MA penetration is very high, because the whole system
4 of, you know, setting a benchmark based on the fee-for-
5 service experience when MA is, you know, 60, 70 percent of
6 the enrollment doesn't make sense. That's something we
7 should be talking about because it's here now.

8 I think in the other areas, maybe it's going to
9 be many years before we're really confronting these issues
10 about what should we do with what's left of fee-for-
11 service.

12 So, anyway, that was my thought.

13 DR. CROSSON: Thank you, Paul. And, indeed, any
14 recommendation to come out of this Commission to change the
15 balance between value-based payment models and fee-for-
16 service would indeed be hollow unless and until we had
17 built the case, as I said a little earlier, that not only
18 is this a good policy idea, but it's essentially good for
19 the Medicare program, but also good for beneficiaries. And
20 that has to be patently obvious at the time.

21 Dana.

22 DR. SAFRAN: Thanks. Great material and great

1 discussion. I really appreciated how Warner teed this up
2 and Karen's comments earlier where we say accountability
3 from the providers to Medicare beneficiaries for the total
4 cost of care, for quality, and for outcomes really has to
5 be our guiding light. And for that reason, I actually do
6 favor Scenario 2 as a place for us to be driving.

7 I would offer a couple of points. One is the
8 fact that, you know, we talk about 1 or 2 percent savings
9 in the chapter. It does, after we factor in the shared
10 savings distribution, drop that down to, you know,
11 somewhere between 0 and 1. But I'm not intimidated by that
12 because I think that there was a lot of variability, and so
13 we can point to the configurations where we're seeing
14 bigger savings. But we also, I think -- I haven't heard
15 any mention today of one of the really important anchors on
16 ACOs' both ability and willingness to drive to higher
17 savings, which is that fee-for-service still sits there.
18 And, you know, in the market where I'm most familiar with
19 this in Massachusetts and my own work previously leading
20 payment reform, we could see very clearly providers who
21 were riding both horses -- right? -- riding the population-
22 based payment horse, but the fee-for-service horse is still

1 there. So I think that we can't ignore that as a
2 constraint on the kinds of savings that we're seeing, and
3 so I would just offer that.

4 A couple other thoughts. One is it was a
5 surprise to me in reading this to really come to grips with
6 the fact that the Medicare Advantage program is actually
7 costing more. And I think there are some structural fixes
8 that we're going to talk about with some of the other
9 chapters, but I think we have to think quite seriously
10 about that. One of the things I wondered about -- and
11 there was some mention to spillover effects, but I did
12 wonder whether, even though it's costing more, does its
13 presence actually act as a constraint on the fee-for-
14 service system and its rate of inflation? I don't know the
15 answer to that. I think that's an important issue for us
16 to try to analyze if we can.

17 But I guess the last thing I'd say is that, you
18 know, like others have said, I think contemplating -- the
19 material and this discussion really helped for me to
20 recognize that right at the moment contemplating a Medicare
21 program that doesn't have the fee-for-service fee schedule
22 as its underpinning is kind of too vulnerable a place to be

1 right now in terms of the potential for us to see, you
2 know, cost increases the way they were occurring before
3 there was administered pricing. You know, the chapter
4 discusses that.

5 So, I, you know, regrettably sort of got
6 comfortable that we're not at a place where we can
7 contemplate that yet, but I'll end by saying the four
8 things -- and I foreshadowed a couple of these -- that I
9 think we need to think about, if not in this chapter then
10 in our upcoming work -- are these four things in terms of
11 how they could support continued really evolution and
12 strengthening of accountability models. One is we have to
13 come up with a model to change the way hospitals are paid.
14 They are for sure a rate limiter on ACO success.

15 We have to contemplate the role of clinical data
16 sources, data coming out of the EHR as potentially our path
17 forward where we can get comfortable in a world that
18 doesn't have the claims data that today we cannot possibly
19 be without for purposes of measurement, risk adjustment,
20 and everything that comes with it.

21 We have to start to think about health care in a
22 way that isn't so in our own minds tied to bricks and

1 mortar, and that can help us with our challenges, thinking
2 about our rural providers.

3 And then, finally, I agree with the points that
4 have been made about pharmacy, and, you know, ACOs that are
5 not also taking accountability for pharmacy are missing a
6 big lever for managing cost, quality, and outcomes. And
7 we're missing their alignment with the Medicare program and
8 concern about pharmaceutical costs. So there's a lot of
9 good reasons to bring that into the picture.

10 Thanks.

11 DR. CROSSON: Thank you, Dana.

12 I have one comment on your metaphor. The
13 previous metaphor I've heard for the situation you describe
14 as "a foot in two canoes."

15 DR. SAFRAN: Yeah.

16 DR. CROSSON: I can visualize that. Riding two
17 horses, I can't. I'm not sure how to do that.

18 [Laughter.]

19 DR. CROSSON: Brian.

20 DR. DeBUSK: First of all, thank you again for an
21 excellent chapter. You could really argue that this is the
22 most important issue in front of the Commission today. I'm

1 really excited to see us spend time on it.

2 I want to start off just by talking a little bit
3 about fee-for-service. I do think in the most rural areas
4 and for certain low low-volume providers, we will need to
5 keep some type of fee-for-service option.

6 I do think that maintaining the fee schedules is
7 important because I think we need those reference and
8 transfer prices, and I do think Medicare has an excellent
9 history of using fee schedules to contain costs. I mean, I
10 think it is a living testament to the power of administered
11 prices as opposed to a purely market-driven price.

12 Now, having said that, I do think we need to send
13 a message, we the Commission, that fee-for-service is an
14 inherently uncoordinated care method, and it is the method
15 last resort for delivering health care. I also think we
16 need to send a message that it is not a mainstream option
17 in the long term.

18 As far as the scenarios that were discussed
19 today, I really see scenario two and scenario three as
20 bookends. I think two is the least we should do. I think
21 three is the backstop. And I think a lot of what we see in
22 the next-gen ACO is an excellent blueprint for balancing,

1 for this option two and three.

2 For example, in next-gen ACOs, I mean, they have
3 a lot of the things we like, like prospective attribution,
4 but if you notice -- and I am not sure if they can do them
5 today or if this is a 2020 feature, but they can move to
6 that per-member-per-month payment, and they can take on a
7 TPA and actually adjudicate claims themselves. I think
8 there's a lot of power in being able to use, again, almost
9 the next-gen as bookends here because I think ultimately
10 the most sophisticated ACOs are going to want to take over
11 the payment of claims and to be able to build more
12 sophisticated networks and basically be able to build more
13 sophisticated payment methods with their participants.

14 So, again, just to reiterate, I do think options
15 two and three are bookends. I would love to see next-gens,
16 for example, explore more with specialist integration
17 through programs like sub-capitation, where if you're in a
18 per-member-per-month model, you could take a portion of
19 your benchmark, say, for orthopedic services or
20 cardiothoracic services and sub-capitate that. Again, I
21 think that comes back to it being critical that they do
22 have the ability to take on per-member-per-month payments

1 and handle their own claims.

2 The final comment that I want to make here is
3 that I do think we need to be ready to experience a slight
4 increase in spending, if necessary, to get our hands around
5 these alternative payment models and value-based payments.
6 I look at this as a new product launch, basically.

7 In the commercial sector, you wouldn't launch a
8 new product without expecting to incur at least some losses
9 or some initial setbacks and increases in spending. I
10 don't think ACOs are going to be any different.

11 So I think the idea of being afraid to invest
12 more money in this model initially I think is something we
13 shouldn't be afraid of it.

14 Thank you.

15 DR. CROSSON: Kathy.

16 Thank you, Brian.

17 MS. BUTO: So, Eric, this is a great paper. You
18 can tell by the discussion that we're all pretty excited
19 about looking at these scenarios.

20 I have to say that as I look at this, I think
21 there's a lot of agreement that we're already in number one
22 scenario, which is all three programs trying to continue to

1 improve, fee-for-service and even ACOs, and that really the
2 question is, Should we try to push more aggressively toward
3 any of the others?

4 I would, like many people, favor scenario two,
5 but I would also say I think we can think of all these
6 scenarios as potentially transitional; in other words,
7 scenario two. And if it turns out it makes sense to evolve
8 down the road to scenario three, then I would say let's be
9 open to that. These are not mutually exclusive for all
10 time.

11 I'll also say that I think scenario two could be
12 a coster; in other words, you're going to pay more for
13 quality and accountability. It could cost the program
14 money, not necessarily save even 1 or 2 percent, especially
15 the way MA is currently structured.

16
17 So I really feel that if we continue this
18 discussion, we need a stronger connection between these
19 ideas and premium support, which is the earlier work that
20 you all have done to look at ways to constrain overall
21 spending over time. I don't think we can keep going down
22 the road, even with better, more accountable models, and

1 not think we are going to spend more money. We are. So I
2 think we really need to look at that alongside this.

3 I like Pat's idea that another way to think about
4 this is beyond these models to things like global budgets.
5 There may be areas where that makes sense. I've heard of
6 people considering regional models, so a metropolitan area
7 where there can be a fixed budget, where Medicare can, in a
8 sense, decentralize control of the program.

9 I'll say that to the extent that we move toward
10 more decentralized models, it strikes me that there may
11 need to be more centralized functions; for example,
12 advisory bodies on drugs, devices, medical education, other
13 things where there needs to be coverage policy, there needs
14 to be uniformity. So even though the payment is
15 decentralized, the program offers basically the same
16 benefits and equitable access and so on and so forth.

17 Like Bruce, I don't get why you couldn't keep
18 cost reports and other things, even in some of these
19 scenarios; in particular, scenario two, which pretty much
20 looks like today only with more emphasis. ACOs currently
21 don't operate without fee schedules. So you clearly need
22 those.

1 If we need to, I think as Dana mentioned, reform
2 hospital payment or, as Paul mentioned, do a better job of
3 looking at the ACO model, that has to happen. But I don't
4 get why you wouldn't continue to be able to have fee
5 schedules as long as fees are being paid.

6 Until you move to a pure premium support, where
7 it's really a capitated amount, I don't get why you
8 wouldn't have fee schedules because everybody wants them.
9 Providers like to have them for some assurance. Payers
10 like to have them so they have a least a benchmark, and
11 beneficiary need them so they can anticipate things like
12 cost sharing and so on.

13 Anyway, we can talk about that some more, but I
14 think that there isn't a good reason to just do away with
15 those.

16 DR. CROSSON: Thank you, Kathy.

17 Okay. I just want to make one of my usual
18 comments about time. We are over 20 minutes, and I
19 anticipated that would be the case. But I think if we go
20 too much more than another 20 minutes or so, then we are
21 going to run into scheduling difficulty. So all I would
22 ask is to be succinct.

1 Jon.

2 DR. CHRISTIANSON: So I think one of the things
3 that the discussion illustrates is how audacious this move
4 actually is because we talk about value-based payment, and
5 the examples we use are MA plans and ACOs. And yet we know
6 that there is not strong evidence that either one of these
7 kinds of organizations have or can reduce costs for the
8 Medicare program or improve quality.

9 We have had over 30 years of MA plans, and we're
10 still paying them more than the cost of fee-for-service
11 Medicare. But somehow we are assuming that whatever we do
12 going forward, that will change. We have sort of mixed
13 evidence on whether ACOs can serve Medicare in terms of
14 reducing costs. It's going to be research study of the
15 week in terms of what the evidence looks like, and we have
16 struggled for years trying to figure out how to measure
17 quality, particularly in MA plans. But somehow we are
18 going to be able to do that, and we are going to be able to
19 prove that quality increases as the same time that we can
20 reduce Medicare cost.

21 This is a really audacious move on the part of
22 the Commission, and I'm with Paul. I think we have to, at

1 the same time, really try to accumulate an evidence base
2 that suggests things will be different in the future, we
3 will be seeing better quality and lower costs, or a very
4 compelling story about why we are going to make changes or
5 that Medicare is going to make changes that will result in
6 moving things in that direction.

7 At the same time, I think the challenge to the
8 Commission is the fact that the delivery system is changing
9 very rapidly, and we have to be very certain and very clear
10 that whatever we are suggesting is not based on what the
11 delivery system looked like one year ago or five years ago,
12 and the assumptions about the delivery -- I don't think
13 many of us would have anticipated the sort of sort of
14 Aetna-CVS kind of vertical merger, much less all of the
15 horizontal mergers that we've seen in the hospital
16 industry.

17 Going back to Kathy's comment about premium
18 support, that was based on an assumption about the delivery
19 system, which is that the health care plans would compete,
20 and the competitive bids will drive down the payments for
21 health plans, and they would then turn around and negotiate
22 very aggressively with hospitals to keep down hospital

1 cost, which is a scenario that made a lot more sense when
2 they were multiple hospitals in the community and they all
3 had excess capacity. It doesn't make much sense now when
4 we have one or two large systems in a community that are
5 trying to manage their capacity so they don't have excess
6 capacity.

7 So I think that's an example of a policy solution
8 that needs to continually be rethought, and I think this
9 solution, the challenge to the Commission, will be to
10 continue to rethink what we think these systems can do in a
11 context of a changing configuration of a delivery system,
12 which will be very hard to stay ahead of.

13 DR. CROSSON: Thank you, Jon.

14 Bruce.

15 DR. PYENSON: I wanted to pick up on a couple of
16 points that Paul and Jon have both made and propose that in
17 the absence of scenarios, we have a fifth scenario, and
18 that is if we just have a much, much more aggressive fee-
19 for-service program, this could be the counter-factual.

20 We have seen some real successes in the fee-for-
21 service program, such as readmission reduction, and I think
22 optimizing what fee-for-service can do, such as lower the

1 price, which Brian mentioned, or bring back RAC audits to
2 make payment denials for medically unnecessary services,
3 that as a counter-factual would set a level for what is
4 possible and what an alternative to integrated care could
5 be, not that we'd want to endorse that.

6 The other point I wanted to make is that I think
7 for the Medicare program to be successful, it has to have
8 more influence over the private commercial market and for
9 reasons that we all understand. Looking at the traditional
10 fee-for-service Medicare Advantage and ACOs, I think it
11 would be worth our while to explore ways that that can
12 happen, perhaps through insurance law or perhaps through
13 terms of participation or other means, perhaps through some
14 ACO rules. I think there's historical precedent for those
15 kinds of influences.

16 But I think we've going to be very frustrated in
17 the ability of the Medicare program to transform for the
18 system if we don't also have some bigger influence on the
19 commercial world.

20 DR. CROSSON: Bruce, thank you.

21 Sue.

22 MS. THOMPSON: Thank you, Jay.

1 I just think it's worthy of a call-out, and it's
2 in our reading. But the acknowledgment that 55 percent of
3 Medicare beneficiaries now are either in ACOs or in MA and
4 despite -- I don't know when we hit a tipping point there,
5 but despite our lack of evidence, as Jon just pointed out,
6 that we don't have evidence that's just screaming at us
7 that we're saving a lot for the Medicare program, we're
8 here with this enthusiastic conversation. So there is
9 something else going on that I just think it's really
10 important for us to pay attention to in terms of
11 understanding the real benefit of value-based programs in
12 this arena.

13 In the category around rural, I just want to say
14 thank you to all my fellow Commissioners for your
15 acknowledgment of the concerns for taking this sort of work
16 on in our rural states and our rural communities, and I
17 think it's a great opportunity.

18 On page 16 of our reading, you referenced the
19 challenge of incorporating services such as telehealth into
20 this analysis, and that we continue to debate whether or
21 not telehealth actually increases volumes and increases
22 expense.

1 In a value-based environment, where the partial
2 or full cap, that incentive goes away, and it becomes just
3 an enabler to provide better care to the right patient at
4 the right time and the right place, and it improves our
5 access issues in all of our primary care discussions we've
6 had. So I encourage us to elaborate on that concept as we
7 continue to build out this chapter.

8 In our discussion about improving ACOs, page 9 of
9 the reading, there was discussion about the ACOs,
10 opportunity to generate more savings. If you've been in
11 ACO work, this business of shared savings is a whole
12 discussion about some of the flaws of the ACO. After a
13 while, there isn't any more savings to share.

14 So, in that structure, I think the rebasing of
15 the formulas and more recently the impact of the growth of
16 the thresholds to continue to quality and as an advanced
17 APM, we need to be paying close attention to them in terms
18 of the pacing of our work and the pacing of the calendar as
19 it moves forward as we hit those thresholds, so that we
20 don't create counter-incentives, particularly for
21 physicians, encouraging them to participate in ACOs.

22 Just finally, I think there was a statement in

1 our reading that began to explore the question of, Are ACOs
2 stepping stones into Medicare Advantage? I think so, but I
3 think that's a conversation and a whole lot of work that we
4 have yet before us.

5 DR. CROSSON: Jaewon.

6 Thank you, Sue.

7 DR. RYU: Yeah. Thank you, Eric.

8 Within the scenario paradigm, I think I also
9 gravitate somewhere between scenario two and three, but as
10 we explore this further, I think what I'd like to see is
11 just more of a focus on the design features, rather than
12 the scenarios, per se. And to me, the design features that
13 make sense are -- and I think this gets to Sue's point
14 earlier, but it's downside accountability. And maybe we're
15 just assuming that, but I do think we need to call that
16 out, getting more people into the model, whether it's
17 beneficiaries or providers.

18 I still have concerns around the engagement of
19 the provider, and I know Ledia mentioned earlier some of
20 the focus group results where they're not even aware. But
21 I think a lot of the success of this work hinges on whether
22 the providers and the beneficiaries will be engaged and how

1 we can create a program that's going to foster that kind of
2 engagement. So those would be some of the design features
3 I was thinking about.

4 DR. CROSSON: Thank you, Jaewon.
5 Karen.

6 DR. DeSALVO: That is a perfect segue because
7 that's part of my comment also.

8 Just stepping back, I think that I would be
9 inclined to move pretty far towards a more capitated model,
10 mostly because I think the dynamism in the marketplace
11 about how to deliver services and care and meet members
12 where they are geographically, socially, medically is just
13 so evolving. It's very hard to keep very specific payments
14 for services up to date with that, and what you see in
15 models that are capitated, there's more flexibility about
16 the who and the where and the when provision happens. And
17 so my inclination is that that's part of the added benefit.

18 As we're thinking about this, though, scenarios
19 aside, the dynamism in the market is that there are more
20 integrated delivery models, where it's not only that I have
21 an insurance risk as an entity but also providers.

22 And that kind of gets to the design issue, is

1 that this word "value-based payment" or this term "value-
2 based payment," I want us to get more clarity as we go
3 forward because when I think about this future state, what
4 I would love to see is that -- back to this an entity
5 accountable for the total health and total cost of
6 beneficiary and partnership with them, and that that kind
7 of a system means all the incentives are aligned for the
8 beneficiary, for the front-line providers, the clinical
9 team, and for the system that's managing the risk and the
10 population.

11 That's not a quality bonus kind of value-based
12 payment. That's, to me, more on that end of capitation,
13 and that's where new delivery design has to fit in because
14 you have to have a system that is not just paying providers
15 by the piece but really on those front-line docs and
16 clinical teams also have aligned incentives.

17 And just the last thing, Eric, because I
18 mentioned it earlier, but I think it's going to be so
19 important that we have a really balanced scorecard about
20 this because it may be a coster. It may save money, but we
21 also want to make sure paying attention to the impact on
22 not only quality, but the experience and the beneficiary

1 because those things all matter to health outcomes. And
2 that's just as to me -- not just. I think it's just as
3 important as making sure that we're saving money.

4 Thanks.

5 DR. CROSSON: Thank you, Karen.

6 Jonathan.

7 DR. JAFFERY: Yeah, thanks, Jay. So I do agree
8 that I think we want to focus on something that ultimately
9 gets us to align incentives so that all the players are
10 working towards this accountability for total cost and
11 quality and affordability for everybody.

12 As I think through the scenarios and some of the
13 discussion about ACOs moving towards being like capitated
14 health plans or being, you know, stepping stones to MA, I
15 do hear a lot about that from other people in the ACO world
16 and think about that.

17 It also makes me a little bit scared when I think
18 through some of the things we've talked about, that we
19 would have to start to do in terms of claims processing or
20 negotiating fees. And I guess I'm struggling to think that
21 there are a lot of ACOs out there that have -- could get to
22 those capabilities very quickly right now.

1 And I guess I also don't want to lose this idea
2 of, you know, why do we have these two different things?
3 Do we think that there is something different about ACOs
4 from MA plans that maybe each have positive attributes,
5 each are bring different expertise to the table?

6 You know, we've been talking about things like
7 care coordination and care management. I think that is an
8 important piece that we definitely feel like the fee-for-
9 service system has not encouraged, and we want to see that
10 happen, whether it's in ACOs or MA plans or whatnot.

11 But I do think there's something beyond just care
12 coordination, and I'm thinking about things that are going
13 to take time and are taking time, that some ACOs, at least,
14 are doing, which is really trying to build a different care
15 model, which is different than care coordination. I mean,
16 you're thinking about what does it look like to have a
17 primary care practice where there's behavioral health, and
18 that you're connecting to community-based organizations.
19 That's a different thing and it takes time and investment.

20 And the other thing that ACOs do that, you know,
21 maybe different from MA plans is that they are contracting
22 with multiple plans. They are working in different

1 populations. They're working in the commercial population
2 space and in Medicaid.

3 So I think, to sum up my thoughts in terms of the
4 recommendations, I do lean towards Scenario 2 as well here.
5 I think that we can think through the design elements so
6 that we can give more providers maybe some more nudges
7 towards that accountability, or maybe more than a nudge.
8 Maybe a loving shove.

9 But at the same time I think maybe there is a
10 two-tiered approach. So maybe we can do that for the bulk
11 of providers and at the same time go back to the fact that
12 we've got folks in an advanced model right now, in the
13 next-gen ACO, who are taking two-sided risk, who have
14 prospective attribution, and are in a demonstration model
15 that's going to end in 21 months. And we've got 50 or so
16 organizations covering I'm not sure how many beneficiaries,
17 but those folks are engaged and are going to need to do
18 something January of 2021, and maybe we can think through
19 how we could have a track for them that would be getting us
20 maybe more towards Scenario 3.

21 DR. CROSSON: Okay. Marge, and then Warner and
22 Pat, and we'll finish.

1 MS. MARJORIE GINSBURG: I'll try to make this
2 brief. I also support Option 2, and, I mean, right now,
3 under Option 2 we actually still have fee-for-service, so
4 as long as beneficiaries can go outside their ACO still,
5 and see anybody they want. So that hasn't been closed off.

6 But I think as we move forward, in order to make
7 the ACO effective we are eventually going to have to find a
8 way to close off that option, and it may be that you can
9 still go outside your ACO but you have a higher co-pay,
10 something to discourage it before we completely shut it
11 off, which I think eventually that's what's going to
12 happen.

13 But I think the issue I raised earlier about
14 public perception is just a really hot-button issue and we
15 have to be extremely careful in how we present this going
16 forward or we're going to get hammered.

17 Thank you.

18 DR. CROSSON: Thank you, Marge. Warner?

19 MR. THOMAS: I'll be brief because I made most of
20 my comments before. But just on Scenario 2, the reason I
21 went in that direction is because even though -- and I will
22 just use our system, for example -- we would be willing to

1 take full risk for many folks, we're still going to have
2 fee-for-service business always because we're going to have
3 referrals. So I think this idea that you are going to have
4 all global payments is just not feasible.

5 I think you're always going to have some fee-for-
6 service and global payments, and so that's why I lean
7 towards you need to keep the fee-for-service system in
8 place, just because there's going to be referrals that go
9 between ACOs that -- and you could call it a transfer price
10 or whatever, but it's probably paid on a per-unit or a
11 bundle or whatever, but it's going to have to be on some
12 sort of fee-for-service to go between the ACOs. So just
13 another comment.

14 DR. CROSSON: Thank you. And Pat.

15 DR. WANG: Just a couple of points. I don't like
16 thinking about the discussion as move away from fee-for-
17 service and towards something else. I don't think that
18 there's inherently anything wrong with a fee-for-service
19 system that is formed to promote the goals of what we
20 describe as VBP, which is more efficiency, better quality
21 outcomes. And I just want to say that.

22 The second thing is that the discussion sort of

1 starts to blur ACO and MA plans, and I think that they are
2 two very, very different things. So put MA aside for a
3 second. I think that the discussion around ACO and sort of
4 the concepts in what's described as Options 3 and 4, you
5 know, maybe things go that way, but I think that we should
6 not get distracted by the shiny toys of paying claims, and
7 it seems like you're more like a risk-bearing organization
8 or something.

9 Because the fundamental truth is that ACOs, to
10 me, are how the delivery system reforms itself. MA plans
11 cannot reform the delivery system. There are a lot of
12 different ways to get there but I just want to -- you know,
13 before people rush into sort of like take on the attributes
14 of an insurance company, which, as you know, I think that
15 that's not a good idea and that's not necessary, that it's
16 missing the point of the goal of any work on ACOs should be
17 how providers start developing different care models in a
18 heterogeneous environment, given the various patient
19 populations and modes of payment that they deal with.

20 In that regard, I think that there is an
21 importance to focus on real-time data feedback to provider
22 systems that are reorganizing. Some people, I think, get

1 fascinated with the idea of paying claims. Let me tell
2 you, I don't know why anybody would want to pay claims,
3 honestly. There are a lot of people out there who really
4 would be eager to do it for you.

5 But I think that the real things that providers
6 at risk want is real-time feedback on what's going on. You
7 know, they may imagine that they control utilization by
8 denying claims -- that's not the way that it works. It's
9 the data. So I think that as we continue this work we
10 should talk about ways that future ACO models can give that
11 feedback on a more real-time, more digital way.

12 Similarly, for Part D, I would not encourage
13 provider organizations to take on risk for Part D. But
14 again, getting visibility into how your prescribers are
15 behaving is really important. You know, you want to know
16 what your doctors are prescribing, and you want to talk to
17 them if there are more cost-effective or clinically
18 effective approaches. It's amazing what that information
19 can do.

20 In any scenario that we discuss, I hope that we
21 will -- and, you know, I'm a broken record on this but I'm
22 going to keep saying it -- I hope that we will continue to

1 look at ways to improve the fee-for-service system to
2 remove disincentives to move towards risk. And I have
3 raised before the topic of IME, direct GME, DSH, any
4 payment system that is reliant on an inpatient statistic.
5 And I'm not saying let's get in there and change all of the
6 payment, you know, sort of like the amounts, but I think
7 that we should at least identify, in this work, whether
8 there are things in the fee-for-service system, which
9 everybody reviles, it seems, that are keeping people locked
10 into that system, and then once they're out there decide
11 whether there's something that we want to say about them,
12 or further work that we want to do.

13 And the final thing that I would say is I think
14 that we need to keep in mind like beneficiary engagement,
15 because, you know, we keep talking about the Medicare
16 program and making it more effective and lower costs and
17 all the rest and we never talk about the role of the
18 beneficiary.

19 Marge, you know, is a great voice, and I really
20 appreciate all your comments. I hope that we can continue
21 that, because people have responsibility for their own
22 health care choices and maybe there are things that we can

1 do in the design that help folks make better guided
2 choices.

3 DR. CROSSON: Okay. Thank you, Pat, and thank
4 you to all the Commissioners. Thank you, Eric. This is
5 very much a prologue, and I really appreciate the input.
6 It's going to help shape our work over the next two years,
7 at least.

8 Thanks very much and we will move on to the next
9 presentation.

10 Okay. We do need to move forward. So we are
11 going to continue the theme this morning, at least part of
12 the theme with respect to ACOs, and we're going to take a
13 look again at the issue of the performance of Medicare
14 shared savings programs, that David, Luis, and Jeff -- and,
15 David, it looks like you are going to begin.

16 MR. GLASS: Yes. Good morning. Today we
17 continue our review of the performance of the Medicare
18 shared savings program that we last spoke about in January.
19 As Eric just discussed, ACOs may be a way forward toward
20 value-based care and we need to understand how well the
21 various ACO models are working and how they might be
22 improved. But I would like to thank Emma Achola for her

1 help on this project.

2 I will briefly give some background on the MSSP
3 and review where we stood in January. Then Luis will walk
4 you through our new analysis and estimates of savings from
5 the MSSP, Jeff will look at some of the policy implications
6 of our findings, and we will end with your discussion.

7 The Medicare shared savings program, or MSSP, was
8 established in 2010, and the first cohort of MSSP ACOs
9 entered the program in 2012. The program has grown rapidly
10 and there were 432 ACOs in 2016. It has continued to grow
11 but our analysis looks at 2012 through 2016, so I will
12 reference 2016 data.

13 Almost all of the ACOs in the program through
14 2016 were in one-sided risk models. That means they could
15 share in savings but had no liability for any losses. They
16 also had retrospective assignment of beneficiaries meaning
17 that ACOs only knew which beneficiaries were definitely
18 assigned to them after the end of the year.

19 Bonuses for ACOs are called shared savings and
20 savings are calculated as the benchmark CMS had set for the
21 ACO minus actual spending on the beneficiaries assigned to
22 the ACO. Precise definitions of all these terms are in

1 your mailing materials.

2 With that as background we turn to the question
3 of the day. Did the MSSP save money for the Medicare
4 program or not?

5 To answer this question we examined the changes
6 in spending for beneficiaries who were alive and eligible
7 for assignment to ACOs from 2012 through 2016. As Dana had
8 suggested the last time we spoke, we have excluded
9 beneficiaries who moved during this period and we describe
10 the exact specifications of the population in some detail
11 in your mailing materials. I will mention that we have
12 also excluded decedents and we can address the implications
13 of that on question.

14 We define savings as the difference between
15 growth in spending for beneficiaries assigned to ACOs
16 compared to what would have been spent on those
17 beneficiaries in the absence of the MSSP. that is it is a
18 counterfactual analysis.

19 As the other David pointed out, we do not compare
20 spending to benchmarks, because benchmarks are set in
21 advance to create incentives for individual ACOs. They are
22 not designed to look back and assess the performance of the

1 MSSP as a whole.

2 We then find the difference in spending growth
3 between a "treatment" group, that is, the beneficiaries who
4 were in ACOs, and a "comparison" group that is made up of
5 beneficiaries who were not. Luis will show shortly that
6 how exactly those groups are defined is critical for
7 estimating savings.

8 And like they always say on your stock
9 prospectus, past performance is not an indicator of future
10 performance. We looked at what happened from 2012 to 2016,
11 under the MSSP rules of that time. The rules have just
12 changed in 2019, and future performance could be very
13 different.

14 So to start out let me review what we discussed
15 with you in January. We observed that beneficiaries
16 commonly switch in and out and between ACOs. More
17 precisely, CMS assigns beneficiaries to ACOs or removes
18 them from assignment to ACOs based on the beneficiaries'
19 claims history. But we will call those beneficiaries
20 "switchers" throughout this briefing for simplicity.

21 We also observed that beneficiaries who switched
22 tended to have higher growth in spending from 2012 through

1 2016 than those who did not, and that was true for those
2 who switched into ACOs and for those who switched out of
3 ACOs.

4 We speculated that a change in health status
5 could make beneficiaries switch. Getting sick could make a
6 beneficiary start to use different physicians and lead to a
7 change in assignment and getting sick could change
8 spending, which is the outcome of interest. You asked us
9 to look at what some of the changes in health status might
10 be, and we have looked into that, and Luis will review
11 those results.

12 The conclusion in January was that this
13 interaction between assignment change and spending
14 complicates estimates of savings. In this presentation we
15 will enlarge on that and show how because of that
16 interaction, different estimates of savings can arise.

17

18 Luis will now walk you through our results.

19 MR. SERNA: First, we looked at the churn in MSSP
20 assignment over time. We examined a cohort of
21 beneficiaries who, from 2012 to 2016, were alive, resided
22 in the same county, and were eligible for assignment.

1 This table shows the percent of beneficiaries who
2 remained continually assigned. For example, among
3 beneficiaries assigned to ACOs who entered the MSSP in
4 2013, only 59 percent remained assigned in 2016, despite
5 being eligible for assignment.

6 In addition, continual assignment was slightly
7 lower for beneficiaries assigned to ACOs that entered MSSP
8 in 2014 and 2015. For example, let's look at the continual
9 assignment rate in Year 3. For 2013 ACO entrants, 72
10 percent of beneficiaries were continually assigned by Year
11 3. Compare this with only 66 percent continued assignment
12 for 2014 ACO entrants by Year 3.

13 With an understanding that MSSP assignment is
14 dynamic, we now look at how assignment switching affects
15 spending growth. We used descriptive statistics to look at
16 the effect of moving in or out of an ACO. First, we show
17 beneficiaries who had no change in ACO assignment.

18 This table shows the percentage point change in
19 spending from 2012 to 2016, a negative number implying
20 savings. The first row is those who stayed in the same ACO
21 from 2013 to 2016. They have lower spending growth than
22 their market average by 10 percentage points. These may

1 disproportionately be beneficiaries without a change in
2 health status.

3 The second row shows beneficiaries never in an
4 ACO. We see that their spending growth was 1.3 percentage
5 points slower than the average for their market.

6 Overall, beneficiaries without an assignment
7 change have spending growth slower than their market
8 average. This implies that assignment switchers must have
9 higher relative spending growth.

10 An examination of switchers does indeed show
11 spending that is larger than the market average. The first
12 row looks at any switching prior to 2016, including
13 beneficiaries who were assigned to a newly formed. These
14 beneficiaries had spending growth 1.2 percentage points
15 higher than their market average.

16 In comparison, we see a large jump in spending
17 for beneficiaries that lost assignment in 2016. As shown
18 in the second row, even switchers with three prior years of
19 ACO assignment had spending growth 13.8 percentage points
20 higher than their market average.

21 In row 3, we see that switchers who were first
22 assigned to a newly formed ACO in 2016 had spending growth

1 2.1 percentage points higher than their market average. In
2 contrast, those first assigned to an existing ACO in 2016
3 had spending that was 16 percentage points higher than the
4 average in their market. The assignment switchers in
5 yellow show that there is an association between changes in
6 assignment and changes in spending. One possibility is
7 that a change in health care use triggered a change in
8 physicians.

9 We examined whether ACO assignment switching in
10 2016 coincided with a change in health care use. We looked
11 at ACOs that were in MSSP in 2015 and 2016. We tracked
12 whether beneficiaries were continually assigned, joined one
13 of the ACOs in 2016, or left an ACOs in 2016.

14 We measured change in health care use as having
15 one or more of the following in 2016 but not 2015:
16 inpatient hospital use, home health use, specialist
17 assignment, or plurality of E&M visits in a skilled nursing
18 facility. This table shows the percent of beneficiaries
19 that had at least one of these changes in health care use.

20 We found that switchers, especially those losing
21 ACO assignment, were more likely to have had at least one
22 of these changes in health care use. Among those with

1 continual assignment, 16 percent had one or more selected
2 changes.

3 In comparison, for those joining an ACO and those
4 leaving an ACO, 22 percent and 28 percent and one or more
5 changes in health care use, respectively. We also see that
6 switchers are particularly more likely to have had a new
7 specialist assignment in 2016. We can discuss this further
8 on question.

9 Given the association of switches with spending
10 growth and health care use, we used this to inform our
11 estimates of MSSP savings from 2012 to 2016. When
12 estimating MSSP savings, researchers compare spending
13 growth for the treatment group to its comparison group to
14 develop a counterfactual. The comparison group is a proxy
15 for how much spending would have grown if beneficiaries had
16 not been assigned to an MSSP ACO.

17 To test how sensitive estimates of savings were
18 to assignment switching, we created three different
19 definitions of an ACO treatment and comparison group.
20 First, we examined the effect of any exposure to an ACO.
21 That is, we compared beneficiaries who were ever assigned
22 to an ACO with those who were never assigned to an ACO.

1 Second, we examined the effect of being originally assigned
2 to the MSSP in its first full year. In other words, we
3 compared beneficiaries who were assigned to an ACO in 2013
4 with those not assigned to an ACO in 2013. Finally, we
5 compared spending growth for those assigned to an ACO in
6 2016 with those not assigned to an ACO in 2016.

7 We found that savings was highly dependent on the
8 balance of ACO switchers in the treatment and comparison
9 groups. As more switchers were removed from the ACO
10 treatment group and placed in the comparison group, MSSP
11 savings estimates increased. For example, when comparing
12 beneficiaries ever in an ACO with those never in an ACO,
13 all switchers are in the treatment group. In this case, we
14 find no savings. Spending growth in the treatment group is
15 at least 2 percent higher than the comparison group.

16 However, when comparing beneficiaries assigned to
17 an ACO in 2013 with those who were not, we place switchers
18 in both groups. In this case, we find some modest savings
19 of 1 to 2 percent. Further, when comparing beneficiaries
20 assigned to an ACO in 2016 with those who were not, the
21 comparison group includes beneficiaries who were assigned
22 to high-cost-growth physicians that dropped out of MSSP.

1 This creates a survivor bias and results in the most
2 estimated savings.

3 Our finding that the balance of switchers affects
4 savings estimates likely explains the variation in MSSP
5 savings found in the research literature. Our three
6 treatment group definitions are analogous to those used by
7 researchers, and our savings estimates were similar. The
8 treatment definition in white font based on 2013 assignment
9 provides the most balance of how switchers are used and
10 reflects our closest estimate of MSSP savings.

11 In addition to estimating MSSP savings based on
12 different treatment group definitions, we investigated
13 whether changing our statistical method affected the
14 estimate of MSSP savings. Our first method was descriptive
15 statistics of changes in spending for the ACO group versus
16 other assignment-eligible beneficiaries in the market. Our
17 second method was descriptive statistics after using
18 market-level propensity weighting based on ACO-assigned
19 beneficiary characteristics. For our third method, we used
20 a propensity-weighted difference-in-difference regression
21 model controlling for changes in beneficiary
22 characteristics over time. More detailed specifications on

1 our models can be found in Appendix D of the paper.

2 While the definition of who is in the treatment
3 and comparison groups affected whether we found savings or
4 not, the three methods of statistical testing did not
5 affect the direction of our findings.

6 For example, our treatment definition of
7 assignment to an ACO in 2013 calculated savings of 2
8 percent using the descriptive method, 1.3 percent using the
9 propensity-weighted average, and 1.7 percent using the
10 propensity-weighted regression. As previously mentioned,
11 this reflects our most likely estimate of MSSP savings over
12 the period.

13 We note that these estimates are a national
14 average and do not account for shared savings. Savings
15 will vary by market and ACO. However, counterfactual
16 estimates are difficult to discern for individual ACOs
17 because smaller sample sizes increase statistical
18 variation.

19 Taken together, the modest savings in MSSP and
20 the degree of assignment switching pose potential future
21 risk for the program. Savings have likely been small,
22 signaling that asymmetric shared savings should be

1 carefully monitored as the program matures. In addition,
2 the higher relative spending of assignment switchers could
3 result in favorable or unfavorable selection for an ACO.
4 For example, high-spending joiners could be unfavorable
5 while high-spending leavers could be favorable. This could
6 result in unwarranted shared savings or losses for
7 individual ACOs.

8 Further, retrospective assignment used in MSSP
9 may exacerbate the program's vulnerability to favorable and
10 unfavorable patient selection. Next, Jeff will discuss one
11 potential vulnerability: annual wellness visits.

12 DR. STENSLAND: Okay. Annual wellness visits can
13 serve two purposes. They may be used for patient
14 assessment and to better do care planning. They can also
15 be used to try to assure beneficiaries remain assigned to
16 the ACO. In particular, wellness visits could be used to
17 retain attribution of beneficiaries with relatively low
18 spending during the current year. For example, if a past
19 patient had little health care spending during the first
20 half of the year, the ACO could invite them in for a
21 wellness visit. The beneficiary would not have to pay a
22 co-pay for the wellness visit, and under new rules the ACO

1 could also give the beneficiary a cash bonus for coming in.

2 So a couple of questions are:

3 First, are the ACOs actually providing more
4 wellness visits? And, in particular, are they providing
5 more wellness visits at the end of the year when partial-
6 year spending data may be known?

7 And, second, would this result in favorable
8 selection? Is it material?

9 With respect to the first question, we find that
10 ACO beneficiaries are almost twice as likely to receive a
11 wellness visit. This could be an effort to better assess
12 patient needs and improve their care planning, or it could
13 be an effort to try to maintain assignment of low-cost
14 beneficiaries; and, of course, it could be both.

15 As we said, the most potential for creating
16 favorable selection is to bring in patients with low
17 spending for a wellness visit at the end of the year. We
18 do see slightly higher share of ACO wellness visits
19 occurring in the fourth quarter.

20 So it looks like wellness visits could be used
21 for patient selection in ACOs with retrospective
22 assignment. For beneficiaries with a wellness visit in the

1 last quarter of 2015, we found they had 19 percent lower
2 spending in 2015. They also had relatively high spending
3 growth from 2015 to 2016, meaning after their wellness
4 visit, but they still had 8 percent lower spending than was
5 expected in 2016 due to starting at a low level of spending
6 in 2015. This combination of low spending in 2015 and high
7 spending growth after the wellness visit suggests that the
8 wellness visits have a stronger association with past
9 health than with future health or changes in spending.

10 What this tells us is that the wellness visits
11 may be used to gain assignment for relatively healthy
12 people. The risk is greater in a retrospective assignment
13 world. This is because the ACO can see a partial year of
14 spending data before it decides whether to ask the
15 beneficiary to come in for a wellness visit. A smaller
16 degree of favorable selection is possible in a prospective
17 assignment world, but that is a lower risk. This is a
18 lower risk because projecting future spending is just more
19 difficult than projecting current year spending.

20 So, in conclusion, as Luis explained, our current
21 model with the least potential for bias suggests ACO
22 savings in about somewhere in 1 to 2 percent range before

1 shared savings payments. Our work should be seen as one of
2 several studies, each of which has limitations and have a
3 different methodology. What is reassuring is that work by
4 other researchers at Harvard of the MSSP program yielded
5 similar results, as did past work by the Office of the
6 Actuary, and, finally, looking at a whole different group
7 of ACOs, the next-generation model ACOs, that evaluation,
8 which Jon Christianson actually participated in, also found
9 savings in the 1 to 2 percent range for the first year of
10 the next-gen model. The bottom line is that in the early
11 years of the Medicare ACO programs, there appears to be a
12 small but positive level of savings.

13 For the Medicare program to generate net savings,
14 these shared savings payments to providers will have to be
15 less than the small reductions in service use generated by
16 ACOs. Any opportunities for ACOs to increase their shared
17 savings payments through favorable selection could put the
18 net program savings at risk.

19 There is also a risk of unfavorable selection for
20 some ACOs. Under retrospective assignment, if an ACO
21 physician tends to attract patients when they develop new
22 serious conditions, those ACOs could have a unfavorable

1 selection of patients. Under retrospective assignment, the
2 ACO physicians would be responsible for that patient
3 spending during the year, and that is even for the portion
4 of spending that occurred prior to that patient ever seeing
5 an ACO physician. In contrast, under prospective
6 assignment, the ACO physicians are only responsible for
7 spending that occurs after the ACO physician has seen the
8 patient.

9 Prospective assignment, therefore, may help
10 mitigate some of the risks of both favorable and
11 unfavorable selection while still encouraging care planning
12 that could occur during the wellness visits.

13 So now we invite your discussion and how
14 different definitions of treatment and comparison groups
15 can affect the analysis, our estimates of shared savings,
16 and the policy option of moving toward prospective
17 assignment and other issues. I turn it back to Jay.

18 DR. CROSSON: Thank you, Jeff, Luis, David.

19 We're now open for clarifying questions. I saw
20 Brian, Dana.

21 DR. DeBUSK: First of all, thank you for an
22 excellent report. It was a very, very interesting read. I

1 had two questions.

2 First of all, the switchers, you know, it seems
3 to me like a lot of the action, a lot of the activity
4 around the switchers, do we have a way to determine how
5 much of that is due to gaming? I have run into an ACO that
6 was fairly proud of their ability to "punt," I think was
7 the term they used, certain beneficiaries that were
8 undesirable and for retrospective attribution. Do we have
9 a feel for that, I mean, either through interviews with
10 ACOs, or is there any way to potentially measure the effect
11 of gaming creating the switching behavior?

12 MR. GLASS: Well, I don't think there's any way
13 to quantify it, but, I mean, yeah, you can hear anecdotally
14 about --

15 DR. DeBUSK: Well, to be more specific, if, say,
16 50 percent of everyone who gets diagnosed with cancer in a
17 particular ACO happens to be referred to a group that just
18 so happens to not be affiliated with the ACO, would that be
19 a sign of systemic --

20 MR. GLASS: Or improper treatment, I guess,
21 depending on where you were. But I think, Luis, you had
22 one article, one study showing that, not only beneficiaries

1 with high spending but physicians with beneficiaries with
2 high spending who tended to be shifted out of the ACO.

3 MR. SERNA: Yeah, that's right. That was a study
4 by researchers from the University of Michigan that showed
5 that beneficiaries with higher risk scores tended to leave
6 the program, and physicians who had beneficiaries with
7 higher levels of risk scores also tended to leave MSSP.

8 DR. DeBUSK: Okay. And also, to Chart 11, I had
9 one other question. The area highlighted in white you were
10 saying was sort of the nominal way of estimating the
11 savings of the program. I think you found 1 to 2 percent
12 growth. What are the error bars on that in terms of
13 geographic variation? Is it 1 to 2 percent plus or minus 5
14 percent? Or is it 1 or 2 percent plus or minus a half a
15 percent?

16 MR. SERNA: So it's definitely going to vary
17 geographically, and I can get you the confidence interval,
18 if you'd like.

19 DR. DeBUSK: Okay. Well, just a swag would be
20 fine. I do not want to create --

21 MR. SERNA: Yeah, yeah.

22 DR. DeBUSK: Okay.

1 DR. CROSSON: Dana.

2 DR. STENSLAND: Just to clarify, I don't want
3 people to be too pessimistic about the savings and the
4 gaming, because one of the studies that we said that kind
5 of looked at it found somewhat similar savings was the
6 Office of the Actuary, which just looked at the market and
7 said this market that has more ACOs, did they have lower
8 spending? And they found, in general, the whole market on
9 average has some lower spending. So it doesn't -- you
10 know, I'm not saying there's not gaming, but it doesn't
11 look like it's all gaming that's causing all the savings.

12 DR. CROSSON: Okay. On that?

13 MS. THOMPSON: On the whole discussion about
14 switchers, I just think the whole business of who the
15 switcher is -- I mean, somehow in the reading it felt like
16 the switcher was the beneficiary, when the switching
17 implication is really a product of the attribution model.
18 And I think we've had some discussion about the pros and
19 cons of prospective versus retrospective attribution. So
20 it's really in that attribution the switching occurs. So
21 in the narrative of the paper, I just think that's really
22 an important point, because the beneficiary is either

1 choosing to seek another opinion, see another doctor, or
2 has been referred perhaps for better care to a provider
3 outside the ACO. So there's an important distinction there
4 that's broader than just called a beneficiary a switcher.

5 MR. GLASS: That was our shorthand for CMS
6 assigning someone to a different ACO.

7 DR. CROSSON: Important clarification. Dana.

8 DR. SAFRAN: Thanks, and really important work
9 that you're doing and methodologically so complex, so
10 you've done a really nice job.

11 I have kind of two and a half questions, and the
12 first one goes to where Sue's point just went. Can you
13 remind us whether assignment is based solely on touch
14 points with primary care physicians or whether it also is
15 made based on touch points with specialists when there is
16 or isn't primary care involve -- I can't remember that, and
17 it's really important to this issue of whether -- when a
18 "switch" occurs.

19 MR. GLASS: Yes, it's in Appendix C of the paper.
20 So the beneficiary has to have a qualifying time to visit
21 with a physician, specifically a physician from the ACO to
22 start with. Once that happens, then they count up visits

1 with primary care, and then there's finally visits with a
2 specialist as well. So assignment can work several ways.
3 But it's mostly, you know, the primary care-ish sort of
4 visits.

5 DR. STENSLAND: So if you have one primary care
6 visit and five specialty visits, the primary care visit
7 rules. But if you have zero primary care visit, then they
8 switch to look at your specialist.

9 DR. SAFRAN: Yeah, so I think that is really
10 important with respect to how we think about switching,
11 because there's a lot of research from, you know, a decade
12 before we were even thinking of the word ACO about
13 switching in and out of Medicare Advantage plans and the
14 traditional fee-for-service system. And we do know that
15 when -- that the people who switch between systems tend to
16 have a precipitating event that result in their switching,
17 and typically it's because they got sick. So I just think
18 that we have to be clear about what we can see in the
19 claims data about what precipitates a switch and, you know,
20 it appears that a patient got a diagnosis that led them to
21 seek care, and did they seek care outside of the network of
22 where their PCP was? Was the original attribution because

1 of a PCP relationship and then they needed specialty care
2 that they hadn't needed before? You know, there's a clear
3 scenario there as opposed to something that might look more
4 like gaming.

5 So I think we have to get even clearer about what
6 happened before and after a switch so that we can really
7 understand this phenomenon, because you've proven to us
8 that it matters greatly in terms of how we end up
9 evaluating the program.

10 My other question is a much simpler one, which is
11 about the annual wellness visit. There's a hypothesis that
12 I didn't see you address there that I know I saw quite a
13 lot in practice, which is ACOs bringing patients in later
14 in the year because they need to close gaps in care in
15 order to improve their quality scores. So that's less
16 about sort of gaming, I would say, and more about
17 population management and recognizing this patient is mine
18 and there are gaps and I need to close them.

19 So I just wonder, is that something that you
20 looked at? And if not, would you?

21 DR. STENSLAND: I think it would be hard -- you
22 know, we could -- it would be a lot of work to do between

1 now and then. You might have to almost survey people to
2 say, well, why did you ask this person to come in? And
3 then would they -- what answer would they say? They would
4 definitely say, "We want to improve their care
5 coordination," and, you know, "We have the quality metrics
6 we have to adhere to." So I think it seems difficult.

7 DR. SAFRAN: But you could look at what services
8 were provided when that patient was brought in to see
9 whether it looks like there are gaps being closed that had
10 been open before. But irrespective of whether we do that
11 work, I just think it bears mention that there could be
12 perfectly valid and, in fact, reasons that we would want to
13 encourage for bringing in patients who are yours toward the
14 end of the year for an annual wellness visit.

15 DR. CROSSON: Yeah, okay. Jonathan and then
16 Karen.

17 DR. JAFFERY: Thanks, Jay. So this was a great
18 report. You guys know that I've already spent some time
19 thinking hard about it, and I'll probably bring up some
20 more things in Round 2. But just two quick questions. I
21 guess actually one was going in the same place that Dana
22 was. There may actually be multiple reasons, I think, and

1 maybe some of them are more positive than others. Dana
2 brought up a very positive reason why we would be bringing
3 people in as ACOs are starting to think about how do they
4 capture care gaps for risk adjustment, which we may or may
5 not think is a great thing to encourage. That may be
6 another reason. And so I think just in terms of the
7 report, thinking through, there does seem to be an
8 implication that the annual wellness visits and that
9 increase near the end of the year may be more about gaming.
10 There's multiple reasons. So I won't ask the question
11 about that.

12 But the other question, in terms of retrospective
13 versus prospective assignment, I know you have spent some
14 time talking to different groups, different ACOs. Did you
15 see much -- did you ask, first of all, but if so, did you
16 hear much interest in continuing retrospective? Or do
17 people really prefer one versus the other? Do you have a
18 sense of that?

19 MR. GLASS: I think early on, there was certainly
20 really adamant positions for and against, and since then,
21 after our latest kind of round of talking to ACOs, but not
22 scientifically selected, was I think that has gone away a

1 little bit. People were more comfortable either way.

2 Then in the final rule recently, they are
3 allowing them to choose between retrospective and
4 prospective in the MSSP annually, which that seems unusual
5 to me.

6 I'm not sure. I think there may be still some
7 people who would have great objections against prospective,
8 but in our look at this, it certainly would seem to be a
9 better system.

10 DR. CROSSON: Okay. Jaewon.

11 DR. RYU: Yeah. I had a question about the
12 annual wellness visits. You made a comment -- and it was
13 in the materials -- that it is correlated with past and
14 current spending but not necessarily with future spending.
15 I found that a little confusing because you would think --
16 well, I'm not going to bias you.

17 What are your working hypotheses on why that is?

18 DR. STENSLAND: My working hypothesis would be,
19 first, if you're going to come in for a wellness visit,
20 you're probably more likely to do that if you haven't seen
21 the doctor three times already that month. So if you
22 haven't seen the doctor for a while, that may be why you're

1 coming in. So you're probably healthier there.

2 You also might want to do it just to maintain a
3 relationship with your physician. You're thinking, "I want
4 them to know me. I want to know them. I'm going to come
5 in periodically for a wellness visit," but if that's your
6 purpose of coming in, it's probably because you haven't
7 seen them a lot either.

8 Then I think the people that are really sick,
9 they're not going to be going in for a wellness visit. No
10 one checks out of the hospital to go to a wellness visit
11 and then comes back to the hospital.

12 So I think you're just going to have a group of
13 people that are doing the wellness visits that aren't all
14 healthy, but I think they're just going to be
15 disproportionately healthy. And I think that's what we see
16 in the numbers.

17 Then we would want to see something like, oh,
18 well, if they have these annual checkups, we would hope
19 that then this would lead to better care, better care
20 management, better outcomes down the line, and I think
21 that's a universal hope.

22 But in terms of the data of what we see in it, we

1 don't see a lot of data there. The one study, there's a
2 Cochrane study that looked at like who had physicals or
3 wellness visits, and they randomized the people, "We're
4 going to give you reminders to go get your wellness visit,
5 and these people, we won't." People with reminders end up
6 getting more wellness visit and then look to see who -- you
7 know, do they have different mortality rates? Are they
8 more likely to die of cancer if they didn't have these
9 checkups to catch things early? And they really didn't
10 find much of anything in there.

11 So that's why maybe you don't see so much down
12 the line, and I want to emphasize, though, that we do still
13 see slightly lower costs in 2016 for people who had a
14 wellness visit in 2015. It's just they started really low.
15 They grew more than average, but they didn't grow all the
16 way up to the average.

17 DR. CROSSON: David.

18 DR. GRABOWSKI: Thanks.

19 I really liked the way this chapter has
20 progressed, and it's good that you have Slide 11 up because
21 I really think this intent-to-treat model is the correct
22 one, and I just wanted to ask a couple of clarifying

1 questions about it.

2 You define it a little bit differently than the
3 McWilliams study, and that you define it based on
4 beneficiaries, and I think he and his colleagues do it
5 based on kind of the practices.

6 Is that basically the same? There's a lot of
7 overlap there, and you get the same result. I guess
8 there's not perfect overlap in those groups.

9 DR. STENSLAND: There is not perfect overlap, but
10 I kind of like the fact that it was done two different ways
11 because we basically say we're keeping the beneficiaries
12 the same. Once you're in, you're in. And he's saying
13 we're keeping the tax ID numbers the same. Once you're in
14 ACO, we're always going to consider you an ACO. That
15 eliminates some of those biases, so there is some
16 difference there.

17 Ours, I think, has a limitation, doesn't have
18 decedents. He has decedents. He has a different method of
19 assigning people, like he doesn't assign anybody by a
20 specialist. So that's a little differently, where we use
21 the CMS assignment algorithm. So there's differences, but
22 the general idea is similar. We put you on this path, and

1 then we're going to follow you out.

2 DR. GRABOWSKI: I very much think it's the right
3 path to studying this. I think the chapter does a really
4 nice job of outlining the biases with the other approaches.

5 It would be interesting to just -- I don't want
6 to send you down a rabbit hole, but just thinking about
7 what's the overlap there, because you're getting the same
8 findings. But if it's 80 or 90 percent of the same
9 individuals are in your groups here, in some ways that
10 would be interesting. But I don't want to create a lot of
11 work if that's hard to do.

12 DR. CROSSON: Okay. Thank you, David.

13 We will move to the discussion period. I want to
14 suggest a focus here. I have the sense -- and I may be
15 right or wrong -- that based on this discussion and some
16 previous discussions, there's a growing sense in the
17 Commission that prospective attribution makes more sense
18 than retrospective. I happen to share that.

19 For example, it makes this issue of why the
20 wellness visits, what the purpose and uses would be. It
21 kind of becomes moot in that situation.

22 I think I am going to pose the question here. Is

1 that a general sense that people share? And if so, I think
2 I would suggest that we move forward in the next cycle to
3 analyzing that a bit more thoroughly and perhaps move
4 towards a recommendation to that effect.

5 You can discuss other aspects, but I would like
6 to get a sense on that.

7 Who would like to comment? Dana, Paul.

8 DR. SAFRAN: I don't fully share it and would
9 love to confer with my colleague who is an actuary from
10 Blue Cross from when I was doing this work more actively
11 because there were some important reasons that we favored -
12 - we wouldn't ever call it retrospective. We called it
13 concurrent attribution, but it ended up that it's not until
14 the end of the year that you settle up on who was this
15 organization's member for enough of the year that they're
16 attributed there. And providers preferred that as well.

17 So I just would like to understand a little
18 better some of the math as well as some of the care flow of
19 where that thinking was coming from before going to
20 prospective.

21 Prospective always sounds like it makes sense,
22 like how can you take care of the population if you don't

1 know who they are, but there are ways that you know that
2 with a model that's settling concurrently or
3 retrospectively. So I'm not ready to jump on board with
4 prospective.

5 DR. CROSSON: Would you or would you not object
6 to us looking at it?

7 DR. SAFRAN: Absolutely should do that, yeah.

8 DR. CROSSON: Thanks.

9 Paul.

10 DR. PAUL GINSBURG: I think it would be very
11 worthwhile looking at that. I think when we do look at it,
12 I'd like to go a little broader. I'd like to consider what
13 about giving beneficiaries the opportunity to identify a
14 provider as their primary care provider and in this way.

15 I don't know. I think we'd have to work it
16 through whether that's a good idea or not, or is there a
17 way to make it feasible enough to actually do a lot of
18 that? But I'd like to broaden the discussion when we get
19 into attribution.

20 DR. CROSSON: I think that's perfectly
21 reasonable, and previous iterations, we called that, I
22 think, attestation or self-attestation or beneficiary

1 attestation. With or without incentives, that fits in
2 there. Right.

3 Karen and then Bruce.

4 DR. DeSALVO: I concur with what Paul just shared
5 and just want to relate back to the prior discussion, which
6 is that if we are going to think about a world in which
7 we're going to do a comparison of ACOs and MA, to me there
8 has to be some accountability for the person from the get-
9 go, not just in hindsight.

10 A nuance to that, which I don't know if it's
11 available in the data, my guess would be that people who
12 have less resources are less likely to get wellness visits
13 and be a part of the system, so they might get left behind
14 if we didn't prospectively identify them and link them to a
15 primary care physician and then make sure they were part of
16 a population going forward.

17 DR. CROSSON: Other discussion? Oh, I'm sorry.
18 Bruce.

19 DR. PYENSON: Yeah. I agree with Dana's view of
20 prospective versus retrospective.

21 In particular, if our goal is a system change, it
22 doesn't particularly make sense that a prospective or

1 retrospective attribution should make a big difference.

2 A question, Jay. Was one of the discussion
3 points you had whether or not the annual wellness visit
4 should be discontinued?

5 DR. CROSSON: No.

6 DR. PYENSON: I would like to raise that.

7 DR. CROSSON: Okay.

8 DR. PYENSON: I thought you had asked that. It
9 seems as though that's perhaps something that does not have
10 a lot of evidence. Perhaps it's not a lot of expense, but
11 both empirically and probably in the literature.

12 DR. CROSSON: I mean, that's a fair point, and
13 I've heard people basically say -- I've heard beneficiaries
14 say to me, "They told me to come in, and when I left, I
15 don't know what happened."

16 [Laughter.]

17 DR. CROSSON: So I think that's an attendant
18 issue that we could consider looking at.

19 Other discussion, commentary?

20 MR. GLASS: And we have started to look at annual
21 wellness visits in some of our site -- in the focus groups,
22 the beneficiary focus groups.

1 MS. TABOR: [Speaking off microphone.]

2 DR. CROSSON: Okay. So we will take a look at
3 that, then. Thanks.

4 I think that sounds like we've wrapped this up.
5 We've got a direction for some future work. David, Luis,
6 Jeff, thank you for the presentation.

7 That concludes the morning session, and we're now
8 open for public comment. If there are any of our guests
9 who would like to make a comment, please come to the
10 microphone.

11 Hang on for one minute, and I will provide some
12 instructions, if that's okay.

13 Please identify yourself and any organization or
14 institution that you are affiliated with, and I would ask
15 you to make your comments concise and limit them to
16 approximately two minutes. When you see this light come
17 back on, then the two minutes will have expired.

18 MS. BRENNAN: Great. Thank you.

19 Wonderful discussion this morning. My name is
20 Alison Brennan. I'm with the National Association of ACOs,
21 so very interested in the work that you're doing right now
22 and just wanted to make a couple different comments about

1 the discussion this morning and share some perspective from
2 what we hear from our members.

3 First of all, as we're looking at the savings,
4 when we're focusing on the first couple years of the
5 program, it is just important to recognize that when we
6 look back at ACOs getting up and running in 2013, that's a
7 long road. So when we talk about savings being small over
8 the course of those first few years, it has to be put into
9 context that this was a transition period as they were
10 embarking on this journey.

11 I think we will see greater savings over time as
12 the program continues. We all look forward to getting data
13 from 2017 to look at using kind of some of those
14 sophisticated statistical approaches, which we all used in
15 this recent report, but we do see from CMS that the 2017
16 performance data, based on benchmarks, does yield savings,
17 which is important. So I think we'll continue to see
18 positive trends.

19 Also, that when we couple in results from MSSP
20 and next-gen, that's an even stronger message for overall
21 results of ACOs.

22 Just a couple things on assignment, I think it is

1 a really important topic. One reason that I think ACOs --
2 some were reluctant to take on prospective assignment early
3 on is because it was always coupled with having to assume
4 risk, and so they weren't necessarily concerned about the
5 assignment moving to perspective. While it would have been
6 new, they were concerned about having to jump into a risk-
7 based model. So I think now that there is more flexibility
8 there, we could see more ACOs choose prospective
9 assignment.

10 I do think there is a reason to keep
11 retrospective assignment or at least to put in safeguards
12 with prospective assignment because a lot of ACOs will be
13 reluctant to have prospective assignment if they're worried
14 about being accountable for patients that are then going
15 all over the community and outside of the ACO to receive
16 their care. It's harder to control their costs if they're
17 not seeing providers in the ACO.

18 So those are just a couple comments and
19 appreciate your attention to these issues. Thanks.

20 DR. CROSSON: Thank you.

21 Seeing no one else at the microphone, we are
22 adjourned, then, until 1:15.

1 [Whereupon, at 11:59 a.m., the meeting was
2 recessed, to reconvene at 1:15 p.m. this same day.]
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1 next steps in outlining ways to accomplish the task of
2 improving the MA program.

3 Our presentation will first review the issues of
4 concern with the QBP, then describe a possible way to
5 redesign the program to be consistent with the Commission's
6 principles, in a manner similar to the Commission's
7 proposed redesign of Medicare's hospital value incentive
8 program. We will then discuss financing issues and the plan
9 for future modeling.

10 We are seeking your input on the measure set, the
11 approach to peer grouping, and the concept of making the
12 program budget neutral.

13 The MA star rating system is a method of rating
14 Medicare Advantage plans using a 5-star scale. The rating
15 system has been in place for a number of years. Originally
16 it was developed as a means of providing information to
17 Medicare beneficiaries about their health care choices, and
18 the Congress specified what kind of information
19 beneficiaries should receive, specifically information
20 about MA plans in each geographic area as well as
21 information about the quality of fee-for-service in a given
22 local area.

1 In 2010, PPACA called for the use of a 5-star
2 rating system that would be the basis of bonus payments to
3 higher-rated plans. The bonus would be in the form of
4 increases in plan benchmarks, which are the plan bidding
5 targets and the maximum level of Medicare program payment.
6 The law specified that plans at 4 stars or higher would
7 receive the higher benchmarks. By giving plans more money,
8 plans would be able to offer better benefit packages, and
9 Medicare beneficiaries would be more likely to choose
10 higher-rated plans because of those better benefit
11 packages. While beneficiaries might use a plan's star
12 rating as a factor in choosing among plans, premiums and
13 benefit packages are usually more important factors
14 affecting beneficiaries' decision-making.

15 The law also specified that the MA bonus payments
16 would be financed through additional program expenditures,
17 that is, new money over and above the basic MA payment
18 rates. Currently, the program spends about \$6 billion per
19 year on MA bonus payments.

20 For a number of reasons that the Commission has
21 been examining over the past several years, the star system
22 and the quality bonus program are not adequately serving

1 their intended purposes. A major reason is that stars are
2 assigned at the MA contract level. Currently, MA contracts
3 can cover wide geographic areas, and often cross state
4 boundaries. Nearly half of all coordinated care plan
5 enrollees are in contracts that include states across the
6 country that do not border each other.

7 To cite an example from the paper, for a contract
8 serving 11 states, the star rating represents the average
9 result for a given quality measure across the 11 states.
10 So the current star ratings often do not provide accurate
11 information about plan quality if the desire is to have
12 information that is valid for a local market area.

13 A policy that has compounded this problem is that
14 organizations have been allowed to consolidate or merge
15 contracts to boost the star ratings of lower-performing
16 contracts. A contract that is below 4 stars can be raised
17 to 4 stars or higher through a consolidation, and the
18 consolidation immediately affects the star rating that
19 beneficiaries would see at the Health Plan Finder website,
20 as well as immediately providing unwarranted bonus payments
21 for a plan that would have been below 4 stars, and,
22 therefore, not eligible for a bonus, in the absence of the

1 consolidation.

2 The Commission made a recommendation to the
3 Congress last year to address the consolidation issue.
4 Subsequently, a legislative change has partly, but not
5 completely, addressed the issue.

6 Ledia will now discuss the ways in which the MA
7 QBP program is not consistent with the Commission's
8 principles, and how those principles can be applied to
9 develop a redesigned system for MA.

10 MS. TABOR: We recently redesigned the hospital
11 quality programs into the HVIP, and now intend to design a
12 new Medicare Advantage Value Incentive Program, MA-VIP,
13 which I'll talk about over the next few slides.

14 Besides the contract consolidation issue that
15 Carlos spoke about, we are concerned that the QBP includes
16 too many measures, scores results using a tournament model,
17 and is possibly not effectively accounting for differences
18 in enrollees' social risk factors.

19 I want to highlight the long-discussed goal of
20 the Commission is to compare MA and FFS quality in local
21 geographic units and has recommended that the Secretary
22 take several action steps to foster Medicare's ability to

1 compare the quality of care across sectors. Consistent
2 with this goal we are designing the MA-VIP with the
3 anticipation that we can compare across MA, fee-for-
4 service, and ACO in the future as we continue to work
5 through data limitations.

6 The Commission maintains that Medicare quality
7 programs should include a small set of population-based
8 measures that are patient-oriented, encourage coordination
9 across the providers, and promote change in the delivery
10 system. The measures should not be unduly burdensome for
11 providers, so they should largely be calculated or
12 administered by CMS, preferably with data already being
13 reported, mainly claims and encounter data and survey
14 results.

15 Outside of the outcome and patient experience
16 measures scored in the MA-VIP, Medicare can use other more
17 granular quality measures and compliance standards to
18 monitor MA plan performance and to publicly report plan
19 information to beneficiaries.

20 As Carlos described, the QBP is tied to the star
21 rating system which is used for public reporting quality
22 information to beneficiaries. Today, we are going to focus

1 our discussion on the payment aspect of the program with
2 the assumption that the beneficiary reporting would
3 continue and be improved.

4 We propose a set of risk-adjusted, population-
5 based outcome and patient experience measure domains to
6 score in a MA-VIP. Most of these are existing measure
7 domains that the Commission has in the past discussed as a
8 basis for comparing MA and fee-for-service. Where
9 practical, these measures are also scored in the HVIP. The
10 MA-VIP measure set can continue to evolve as more measures
11 and data sources become available.

12 The measures are: readmissions, potentially
13 preventable admissions, potentially preventable ED visits,
14 patient experience such as getting needed care and rating
15 of the health plan, and patient-reported outcomes such as
16 improving or maintaining physical and mental health.

17 As Carlos described earlier, the Commission has
18 raised concerns that the star ratings are determined at the
19 contract level, so in the MA-VIP we will measure the
20 quality of each MA organization within a local market area.
21 Comparing the quality of care within market areas allows us
22 to evolve to eventually compare the quality of MA and fee-

1 for-service.

2 As described in your paper, the current QBP
3 scores plans on a "tournament model," under which plans are
4 scored relative to one another. For example, for a given
5 HEDIS measure, plans are grouped into the five star
6 categories through a statistical algorithm to determine
7 clusters of levels of performance. Under this scoring
8 methodology, a plan's reward depends only on its
9 performance relative to the performance of other plans;
10 thus, no plan knows how its performance will be judged
11 until after other plans' performance has been assessed.
12 This makes it difficult for providers and plans to manage
13 their quality improvement efforts.

14 As with the hospital value incentive program, the
15 MA-VIP will be designed to reward or penalize a plan based
16 on the individual performance the plan achieves relative to
17 a prospectively set system of targets for each measure
18 domain.

19 Medicare will define a continuous scale of
20 targets that converts performance to points.

21 The QBP takes into account differences in a
22 plan's patient population, including social risk factors,

1 not through adjustment measure results, but through
2 payment. CMS instituted a type of peer group mechanism
3 that adjusts a contract's overall star rating based on a
4 contract's share of low-income and disabled enrollees.
5 Even with this adjustment, plans that have a higher
6 proportion of lower-income beneficiaries continue to have
7 lower overall star ratings.

8 The MA-VIP will use an alternative peer grouping
9 mechanism to convert performance to rewards and penalties.

10 In the HVIP, at a national level, we classified
11 hospitals into 10 peer groups based on their share of
12 fully-dual eligible beneficiaries treated. We created the
13 peer groups at a national level because we did not believe
14 geography itself should be a factor in the quality of care
15 hospitals provide.

16 However in MA, it makes more sense to create peer
17 groups within local market areas. Plans can choose to
18 leave or enter market often leave or choose to not operate
19 in certain markets. In a sense, they choose their patient
20 populations. Also, beneficiaries can and often switch
21 plans within their local market areas because of changes in
22 cost.

1 Therefore, we propose to calculate the MA-VIP
2 within a local market area with stratified scoring and
3 pools of dollars for fully dual-eligible beneficiaries,
4 Peer Group 1, and non-fully dual-eligible beneficiaries,
5 Peer Group 2. The MA-VIP peer groups are groups of
6 beneficiaries, not groups of providers like in the HVIP;
7 however, the same principle of accounting for differences
8 in social risk factors through payment adjustment applies.

9 As in the HVIP, for the MA-VIP we anticipate that
10 peer groups with more social risk factors will receive a
11 higher reward for higher quality. Under the MA-VIP, we
12 also anticipate grouping different populations a plan
13 serves within a local area makes payment adjustments more
14 equitable compared with the existing QBP.

15 The MA-VIP will link payment to quality of care
16 to reward plans for efficiently providing high-quality care
17 to beneficiaries.

18 I will now turn it back to Carlos to financing
19 the MA-VIP.

20 MR. ZARABOZO: From a financing and payment point
21 of view, in addition to the concern over unwarranted bonus
22 payments and the adequacy of the peer grouping mechanism,

1 there are other concerns with the current QBP. We have
2 mentioned that the QBP is financed with new money, adding
3 \$6 billion per year to Medicare program expenditures.

4 This financing mechanism creates a non-level
5 playing field between fee-for-service and MA in how quality
6 incentive programs are financed. In fee-for-service, such
7 programs are budget neutral and can involve penalties,
8 resulting in reduced program expenditures rather than
9 increased program expenditures. This difference in
10 financing mechanisms also means that while the fee-for-
11 service programs can exert financial pressure on providers,
12 the MA bonus program does not.

13 Another issue is that there is a misconception
14 that bonus dollars always end up as extra benefits for
15 beneficiaries enrolled in MA. However, there is no
16 requirement that bonus dollars have to be used to finance
17 extra benefits, as we will illustrate on the next two
18 slides. A reason to talk about this point is that if the
19 QBP financing was budget-neutral, there would be a concern
20 that a major impact would be that beneficiaries would see a
21 reduction in the extra benefits they receive from MA plans.

22 This chart shows the relationship between changes

1 in benchmarks, which are the basis of Medicare's payments
2 to plans and plan bid, which are what plans state as the
3 revenue they need to provide the Medicare benefit. To use
4 shorthand terminology, the solid red bars show how much
5 Medicare payments increased, and the cross-hatched bars
6 show how much the plans said their cost of providing the
7 Medicare benefit increased or decreased.

8 If a plan's bid shows that its costs are below the
9 benchmark, the plan is required to use the difference to
10 provide rebates, that is, extra benefits, to their
11 enrollees. That was the case for all the groups shown
12 here. The first set of bars shows that when plans had no
13 change in their bonus status, Medicare payments increased
14 by 6 percent. So if a plan's benchmark in 2018 included a
15 bonus, and the plan is still a bonus plan, payments rose 6
16 percent. If the benchmark in 2018 did not include any
17 bonus, and the plan is still below 4 stars, payment rates
18 also went up 6 percent. In other words, the base Medicare
19 payment rates went up by 6 percent. In the first group, on
20 the left, plan costs rose by 4 percent, leaving room for
21 the provision of extra benefits.

22 For the other two sets of bars, their benchmarks

1 were influenced by changes in their bonus status. The
2 middle group had only a 1 percent increase in its
3 standardized benchmark rates, because the plans are leaving
4 bonus status and are thus not entitled to the 5 percent
5 add-on to the benchmarks that they had in 2018. They still
6 were able to provide extra benefits in 2019, primarily
7 because they reduced their bid, unlike the two other
8 categories shown here, which increased their bids.

9 The last set of bars shows that the group that
10 newly acquired bonus status had the 6 percent increase in
11 their benchmarks, plus the 5 percent bonus, or an 11
12 percent benchmark increase. At the same time, their stated
13 cost of providing the Medicare benefit rose by 10 percent,
14 leaving just a little room for extra benefits.

15 The two main takeaway points are that between
16 2018 and 2019, when plans received extra money in the form
17 of a boost in their benchmark by moving from non-bonus to
18 bonus status, the money was not all used to provide extra
19 benefits. In fact, most of it was not used for that
20 purpose. The other takeaway point is that when plans lose
21 their bonus status and have less money coming from the
22 Medicare program, they reduce their bid, or stated cost,

1 for providing the Medicare A and B benefit. That is, you
2 could say that they react to financial pressure by becoming
3 more efficient.

4 The next slide gives more detail about whether
5 Medicare's bonus payments to plans resulted in higher
6 levels of extra benefits for enrollees.

7 The two takeaway points from the last slide are
8 presented here, showing dollar amounts based on plans'
9 actual bids compared to expected benchmark-based payments.
10 The first row shows that plans losing their bonus status
11 had a bigger increase in their extra benefits than plans
12 gaining bonus status. Plans gaining bonus status had a
13 large increase in their bid, or stated cost, of providing
14 the Medicare benefit, \$83, as shown in the second row. The
15 next three rows decompose the components of the bid for
16 each group.

17 The non-bonus group had a much lower change in
18 net medical expenses, rising by \$30 as compared to the
19 over-\$50 rise in the new bonus group. The \$30 rise for the
20 non-bonus group was primarily due to a higher expected risk
21 profile for its enrolled population. The non-bonus group
22 did not apply any of incremental dollars towards the plan

1 margin or profit. Instead they actually reduced their
2 margins by \$10 per member per month. By contrast, the new
3 bonus group applied a significant portion of their bid
4 increase, \$33-per member per month, towards the plan margin
5 or profit.

6 For your reference during the discussion period,
7 here is an abbreviated version of the abbreviated table in
8 your not-so-abbreviated mailing material that summarizes
9 the issues that we have discussed and how they might be
10 addressed in a redesigned quality incentive program for MA.
11 The new system would be simpler and more patient-oriented.
12 It would encourage quality improvement and reward
13 efficient, high-quality plans.

14 As we did with the HVIP, it is our intention to
15 model the effect of the proposed MA VIP, though we may have
16 issues with data completeness, given that MA encounter data
17 would be one of our main sources of information on MA.

18 For your discussion, we would like your feedback
19 on the proposals we have presented, including the measure
20 set, the proposed peer grouping, and the change to
21 financing.

22 Thank you, and we look forward to your

1 discussion.

2 DR. CROSSON: Thank you, Carlos and Ledia. We
3 are now open for clarifying questions. Brian, Dana, Paul,
4 Pat, Marge.

5 DR. DeBUSK: First of all, thank you for an
6 excellent report. I am wildly supportive of the direction
7 this is going.

8 I had two pretty technical questions and then one
9 an open-ended question. The market areas that you are
10 referring to, I am assuming those are MedPAC units?

11 MS. TABOR: Yes. That is what we are planning to
12 use for the modeling, so it's MSA divided up into different
13 areas of the state and any MSAs across lines we split. So
14 it's about 1,200 areas.

15 DR. DeBUSK: And then you take all the other
16 outlying areas and you sort of create a quasi-MSA for
17 those?

18 MS. TABOR: Exactly.

19 DR. DeBUSK: Okay. Good. So they are MedPAC
20 units.

21 MS. TABOR: Yes.

22 DR. DeBUSK: And also -- and I think I know the

1 answer -- do you do the risk adjustment to all of the data,
2 to all of the five domains and then do the peer grouping,
3 just like you do in HVIP?

4 MS. TABOR: That was the plan, yes. So the
5 readmissions and the PPA and PPV measures would be risk-
6 adjusted for the standard clinical conditions, and then the
7 HOS data, which is the health outcome survey and the CAHPS
8 data is actually case-mix-adjusted.

9
10 DR. DeBUSK: Okay. So you do all the adjustment
11 first and then you peer -- so again, it is apples to apples
12 with HVIP.

13 MS. TABOR: Exactly.

14 DR. DeBUSK: Okay. The final question is more of
15 an open-ended question. I don't mean to put you on the
16 spot. If you could take HVIP and you could take this MA
17 program, put them side by side, can you describe to me how
18 you could move them each one step closer to each other, to
19 where you were getting closer to an apples-to-apples
20 comparison?

21 MS. TABOR: I guess I would think about -- I
22 think about it more as what incentives are we sending to

1 the delivery system, and because both programs include
2 generally the same types of measures, like readmissions,
3 like patient experience, we're having all of the delivery
4 system kind of focusing on these issues. There may be
5 nuances in kind of what weights are applied to the risk
6 adjustment and whether we're doing peer-grouping at a local
7 versus a national level, but I think that they are
8 consistent enough sending this message of these are the
9 important things that you should be doing and how it
10 defines value for the Medicare program.

11 Does that answer your question? Okay.

12 DR. CROSSON: Dana.

13 DR. SAFRAN: Thanks.

14 I'm really excited about this redesign work, so
15 thank you.

16 I have a few questions. The first questions
17 relate to the new measures that you're working with the
18 contractor to develop. One question about that is, Do you
19 plan on trying to get NQF endorsement? To use new measures
20 in a high-stakes way like this could be challenging,
21 especially when one of the new measures is a measure that
22 already exists with other specifications, the readmissions

1 measure. I'm just curious how you're thinking about sort
2 of progressing to the point of readiness for the MA-VIP.

3 MS. TABOR: Yes. I think we were not intending
4 to submit it for NQF endorsement because I think we're
5 seeing it as really just modeling out a proof of concept,
6 and then CMS should take what we've done and have it go
7 through the normal rulemaking process to really kind of
8 create the perfect system. But we're doing something that
9 I think tests the model.

10 DR. SAFRAN: That makes sense.

11 Another question also about those new measures is
12 -- and you reference this right at the very end -- does the
13 absence of good encounter data stand in the way of
14 realizing this vision for those first three measures?

15 MS. TABOR: I think the particular, the PPV
16 measure, the potential preventable ED visits is the one
17 where we could potentially run into the most issues. We
18 haven't started kind of really diving into it yet, but
19 because of what Andy and Jennifer have found, the Part B
20 data is less accurate.

21 We think that the PPA and the readmissions
22 measure that combine the encounter data with the MedPAR

1 data are going to be able to have pretty good results, but
2 again, we'll find out this summer.

3 DR. SAFRAN: Great.

4 Then two other quick questions. One is I'm
5 curious about -- I understand your rationale for wanting to
6 do the social risk factor stratification at the market
7 level. It makes good sense. I just wonder whether you've
8 looked at viability of that in terms of sample sizes.

9 MS. TABOR: We've done some thinking about that,
10 more like thinking about how many insurers do you actually
11 need in the market to kind of make this work, and we think
12 that enough of the markets will have enough insurers to do
13 it. We may have to combine a couple market areas, which we
14 could think of rules on how to do that.

15 As far as sample size for the population, that is
16 going to be something that we're going to struggle with in
17 some areas, particularly for the CAHPS and the HOS data,
18 because we are limited by what is collected right now. And
19 since there is the contract's level across contiguous
20 states, that Carlos has spoken about. There may be some
21 markets where we can't test this out because we don't have
22 a minimum for that.

1 DR. SAFRAN: Yeah.

2 MS. TABOR: So, again, we'll find out more this
3 summer.

4 DR. SAFRAN: Yeah. Great.

5 Then my last question is just more about how
6 things currently work, not about the new model. I probably
7 should know this, but I don't. Do plans deliberately bid
8 below the benchmark in order to give themselves that
9 cushion to offer additional benefits? That seemed to be
10 your point in Slide 14 and in the chapter materials. I
11 just am trying to understand that.

12 MR. ZARABOZO: Well, if you bid over the
13 benchmark, you are required to charge a premium for the
14 Medicare benefit package. So you can only have extra
15 benefits if you're bidding below the benchmark.

16 DR. CROSSON: Paul.

17 DR. PAUL GINSBURG: I've got two questions. One
18 is that this relationship between low-income subsidy people
19 being in the lower-rated plans, and the concern, I guess,
20 is that whether they are pulling down those plans, star
21 ratings, because of the challenges of treating them.

22 Is it also a possibility that because the prices

1 of higher star rating plans are higher and the fact that
2 some low-income people don't have the tools to find the
3 best plans, that that could be a part of the relationship
4 as well?

5 MR. ZARABOZO: If it's a matter of price, a low-
6 income person is entitled to the Part D subsidy. So you
7 have plans that are again directed to them, and then you
8 have the dual eligible special needs plan. So there are
9 many plans that are actually directed towards this
10 population. So you would be disinclined to choose a plan,
11 for example, saying we have a foreign travel benefit; we
12 have SilverSneakers, whatever else. It may not be of great
13 interest to that particular population.

14 DR. PAUL GINSBURG: Thanks.

15 The other question is about the tournament
16 models. It seems to me that in the budget-neutral world
17 that we're envisioning, how can you have anything but a
18 tournament model other than just saying, well, okay, for
19 any one year, you're going to know your target, but over
20 time, it's obviously at tournaments?

21 MR. ZARABOZO: That's correct. If you're going
22 to redistribute all of the money in a given year based on

1 relative performance, then, yes, that is essentially a
2 tournament model.

3 But the issue is -- you know, you can set the
4 targets in advance. So the relative performance will be
5 different among the different plans. So you have more
6 money going to the better-performing plans. So part of it
7 is how good are you at setting targets in advance to
8 promote improvement.

9 DR. PAUL GINSBURG: Yeah. I think that the --
10 presumably, you will get good at that over time, and in a
11 sense, I mean, I have no problem with tournament models, in
12 general, as you may know from the past because of the fact
13 that I think when we have policymakers setting targets,
14 they're going to set them to be too easy. And a tournament
15 model at least avoids that.

16 So, in a sense, I think that's a reasonable
17 accommodation. Then, in any one year, every plan knows
18 exactly their targets. It will be fine if plans actually
19 do better than on the average, what was projected, because
20 they're responding to these incentives. But then, in a
21 sense, that gain is one time, and they're in the tournament
22 again next year, again, with a fixed target. But the

1 tournament actually sets the targets for the future.

2 DR. CROSSON: So let me ask a question on this.
3 You've introduced a new thought here for me. Is it
4 possible to combine the two models and to have essentially
5 a target set? And it might be set too low, but a target
6 set and then a tournament model built above that? In other
7 words, unless you reach the target, you don't qualify at
8 all, and then, but above that, you have a relative
9 performance and a relative gain or lack of gain.

10 MR. ZARABOZO: I was thinking that the tournament
11 aspect comes in over time, so that you just have a fixed
12 target. As I say, if it goes well, you'll actually -- it
13 won't be budget-neutral in that year. The quality will
14 have improved more than it has, but that come the next year
15 in setting the target again --

16 DR. CROSSON: Yeah, I get that. No, I was just
17 trying to think about is there a hybrid model where you
18 could construct it in such a way that you could reach
19 budget neutrality.

20 Yeah, Jon.

21 DR. PERLIN: Wouldn't the scenario actually be
22 the other way around? Because in the beginning, you may

1 not know where to set the targets, and part of the problem
2 with the tournament model is once you reach the cap of
3 performance, 100 percent or whatever --

4 DR. CROSSON: Right.

5 DR. PERLIN: -- then a single case really can
6 swing from a 25th to a 75th percentile or something that's
7 really not proportionate or commensurate with measures. So
8 it would seem like you may want to calibrate it if you
9 don't know the performance level going in and then switch
10 to an absolute performance once you've hit a measure that's
11 near top.

12 DR. CROSSON: And I think Paul has made that
13 similar point in the past.

14 Okay. Dana, on that?

15 DR. SAFRAN: On that point, there are really
16 sound empirical methods that you can use even at the very
17 beginning if you have a dataset with the measures in it to
18 define absolute targets. I'm happy to talk about that at
19 some point.

20 DR. CROSSON: So are you saying that absolute
21 targets are or are not compatible with budget neutrality?

22 DR. SAFRAN: I think they can be, absolutely.

1 Yeah.

2 I think one of their advantages is that they're
3 transparent to the provider community like, "This is what
4 we expect of you. You can plan multiple years of
5 performance improvement," et cetera.

6 DR. CROSSON: Right. I was trying to work off of
7 this issue that -- and I thought, Paul, you were initially
8 saying we have a null set here in the sense that if we
9 wanted to have absolute targets and budget neutrality, we
10 have to pick one or the other.

11 DR. PAUL GINSBURG: No.

12 DR. CROSSON: No. Okay.

13 DR. PAUL GINSBURG: I was really saying that I
14 think we do -- what makes the situation challenging is that
15 we're hoping to get quality to improve, and that's a
16 dynamic thing. We'll set fixed targets for a year, and
17 whether it's exactly budget neutral that year or not, we
18 won't know. We'll actually hope it's not because then
19 we'll achieve quality.

20 But still, on the next -- well, I don't want to
21 repeat myself again. I think when you move into year to
22 year, you get budget neutrality over time. You just don't

1 do it again every single year.

2 DR. CROSSON: Right. So I think maybe we're
3 saying that there may be an incompatibility within a given
4 year, but you're saying over time with adjustments, you can
5 get to budget neutrality over some period of years.

6 But I thought I heard Dana saying something
7 different from that. Is that not the case, or is that the
8 case?

9 DR. SAFRAN: I believe it can be designed so that
10 you're using absolute targets and having budget neutrality
11 each year, but I would defer to staff and their modeling,
12 though I'd be happy to provide information on how to get
13 absolute targets.

14 DR. CROSSON: Okay. So you two can duke it out
15 while you're sitting next to each other.

16 [Laughter.]

17 DR. CROSSON: But I suspect the answer is subject
18 to analysis, and we could get there.

19 Paul.

20 DR. PAUL GINSBURG: Yeah. I think it all depends
21 on the behavioral response. That's very hard to predict.
22 I mean, I think that with no behavioral response, Dana's

1 method could predict it pretty well. But we're hoping to
2 have a behavioral response, a positive one, so that's what
3 makes it -- well, you won't hit it every year, but I think
4 you can design it so that you hit it over -- cumulatively
5 you hit it over many years.

6 DR. CROSSON: Okay.

7 MS. TABOR: And I'll just add in the HVIP. I
8 think it does accomplish what both of you were saying, and
9 I think the MA-VIP would also do the same thing. It's
10 designed to be budget neutral, but if performance goes
11 above a certain target, then it may not be. But that's
12 kind of a good thing because that means quality has
13 improved, and then you can adjust the targets next year to
14 help make it more budget neutral.

15 DR. CROSSON: Okay, good.

16 Pat.

17 MS. WANG: Thank you.

18 With the approach of moving to local market areas
19 and redoing things this way, what are the implications for
20 the policy for new plans, which are granted a four-star
21 rating?

22 MR. ZARABOZO: One way to do this is to say that

1 new plans will not participate because we don't have any
2 information about them, so they won't be penalized or they
3 won't be rewarded until they can participate in the
4 program.

5 MS. WANG: Okay. Thank you.

6 What happens to the Part D measures? I mean,
7 most MA plans are MA-PD. So are you planning on
8 incorporating something on med adherence or med whatever,
9 you know --

10 MS. TABOR: So since we're focusing just on the
11 QBP, the payment part of the program in our work today, I
12 think we wouldn't necessarily have the individual Part D
13 process compliance measures as a part of this MA-VIP
14 because, hopefully, if the Part D plans or MA-PD plans are
15 doing a good job, we are going to have low readmissions,
16 low potential preventable admissions, ED visits.

17 But there is still this idea that those Part D
18 measures that are in existence now can continue for public
19 reporting if Medicare wants to continue with it as well as
20 compliance overall from CMS.

21 MS. WANG: Okay. Because it's much more than
22 compliance. There's medication adherence, medication

1 reconciliation. Those are more outcomes measures.

2 MS. TABOR: Right.

3 MS. WANG: So you're saying that those would
4 become sort of reporting or display informational because
5 those are tournament models? So, in your thinking, that
6 would go away sort of or get converted to something?

7 MS. TABOR: Right. For some, tied to payment.

8 MS. WANG: Okay. A question about PPVs. I heard
9 a lot about them. Are they in use? I've heard about
10 Medicaid programs talking about them, but I'm not really
11 aware of anybody who's actually using them.

12 MS. TABOR: So we are planning, hopefully
13 September, October, to come back to you with more
14 discussion about what the measure looks like and we've ran
15 some fee-for-service data on it. So I don't want to kind
16 of preempt that discussion too much.

17 But we have heard that some ACOs are starting to
18 look at it internally. We know that ACOs and MA plans are
19 looking at ED utilization overall, and one of the HEDIS
20 measures is a risk-adjusted ED utilization measure. This
21 potentially preventable concept is a little newer, but
22 again, I think people out in the delivery system are

1 starting to use it more because it's more actionable by the
2 providers if you have a distinct list of things that you
3 should be working to prevent.

4 MS. WANG: Final question. In the identification
5 of possible peer groups for the HVIP model ten -- and here,
6 you would be modeling two. So the characteristics of dual
7 eligibles are much more uniform than non-dual. Within the
8 non-dual, there's a whole range. There's partial dual.
9 There's LIS look-alike, and then at the top, there's folks
10 who otherwise would be buying a Medigap policy are in an MA
11 plan.

12 I realize that you're kind of shrinking it to the
13 comparison to local market area and then peer groups, so
14 you probably don't want to load it up. But I just wondered
15 if you had thought about that.

16 MS. TABOR: We've had a little bit of internal
17 discussion about it, and we kind of thought that this two-
18 peer-group approach would be a little simpler, and it's
19 also more consistent with HVIPs, since that was how we
20 defined -- or what kind of variable we used to define the
21 peer groups. But we can discuss if there's other ways that
22 we should be defining the peer groups.

1 MR. ZARABOZO: And this is mainly for modeling
2 because, as you know, in the MA world, disability is the
3 other factor that is a peer grouping factor, essentially.
4 So we could consider to look at that as a possibility too.

5 DR. CROSSON: Okay. Let me see now. I've got
6 Marge, Warner, David, and I see Bruce. Is that everyone?

7 Okay. Marge.

8 MS. MARJORIE GINSBURG: Thank you.

9 Actually, this question sort of relates to what
10 Pat just said. My first question is, in looking at the
11 peer group structure of duals and non-duals, it occurred to
12 me that one of the other categories that might be very
13 relevant to this is age. I know you obviously look at age
14 when you look at risk adjustment and things like that, but,
15 of course, we're not looking at risk adjustment. We're
16 looking at quality, and that's different than risk
17 adjustment.

18 So I wondered whether -- because I would imagine
19 typical 70-year-olds have different health care needs
20 mainly than 85-year-olds, and so for MA plans that
21 particularly have an older population, I would imagine the
22 kind of work evolved in optimal health is going to be

1 different in the 70-year-old.

2 So I just wondered whether you had considered
3 broad age categories as one possibility.

4 MS. TABOR: I think we have because we think that
5 -- so there's -- I think about the risk adjustment for the
6 actual clinical quality measures. So the readmission rate
7 is calculated as an observed over expected, and the
8 expected is based on the plan's population of who they
9 expect to go to the hospital or be readmitted. And that's
10 based on age, clinical categories, HCCs and male versus
11 female. So we're hoping that the age piece is already kind
12 of taken care of in the clinical risk adjustment.

13 MS. MARJORIE GINSBURG: The Commission has
14 emphasized that we're financially neutral between MA and
15 what is still fee-for-service. So I'm curious whether the
16 new system that's going to bring these bonus payments now -
17 - so it's not going to make the MAs above 100 percent
18 anymore, we assume. That we will eventually be paying MA
19 plans less than the benchmark for fee-for-service. If that
20 happens -- and I can envision it happening -- is that
21 consistent? Is that model still consistent with
22 maintaining financially neutral choice, or was that even

1 discussed about how this was going to change the relative
2 payment between MAs and fee-for-service?

3 MR. ZARABOZO: Well, the current situation, you
4 could say it is relatively close to being financially
5 neutral because we're paying, on average, across the
6 country a little bit more than fee-for-service to the MA
7 plans.

8 But within that payment, it's not really equal
9 because within that payment to the MA plans, they're
10 providing extra benefits. So from a beneficiary point of
11 view, it is not financially neutral if you're just saying,
12 "Well, the value to me, it's better to be in MA because I'm
13 getting all these extra benefits that otherwise would have
14 come out of my pocket." So it's not a strict --

15 MS. MARJORIE GINSBURG: But would we ever have
16 any MA plans that puts their bid forward at the benchmark
17 and then still gets a bonus on top of that, bringing them
18 above the 100 percent, with no extra benefits?

19 MR. ZARABOZO: Well, they could get -- yes. They
20 could get a bonus. They could get a bonus.

21 MS. MARJORIE GINSBURG: And then the last
22 question sort of related to that is that, were the bonus

1 dollars then required to be under the medical loss ratio of
2 85 percent? Assuming that they're bidding with that
3 percent in mind, if you get a lot of bonus dollars, are
4 those dollars -- MA Plans get to spent however they want?
5 In other words, the bonus dollars are or are not part of
6 the medical loss ratio?

7 MR. ZARABOZO: They would be in the medical loss
8 ratio. Again, they can also spend them however they want.

9 Now, you see in the illustration that we gave,
10 the plans had to reduce their administrative cost to stay
11 within the medical loss ratio.

12 MS. MARJORIE GINSBURG: Okay.

13 MR. ZARABOZO: So that medical loss ratio still
14 comes into play.

15 MS. MARJORIE GINSBURG: Okay, good. Thank you.

16 DR. CROSSON: Thank you.

17 Warner.

18 MR. THOMAS: I think that answered my question on
19 Slide 15. On the general features of the MA value
20 incentive plan, where do we see capturing ambulatory
21 quality? I see hospital readmissions, preventable
22 admissions, ER visits. I guess just in typical ambulatory

1 quality, where do you see capturing that?

2 MS. TABOR: I guess through those measures,
3 hoping, again, if the whole delivery system is working
4 together, the whole ambulatory care system is working
5 together, that those things would be affected, and also
6 just kind of thinking about what measures do we have
7 available to us that we can calculate with claims-based
8 administrative data.

9 MR. THOMAS: And how would you see the patient-
10 reported outcomes, you know, on physical and mental health
11 status? How would you see that working? Is that like just
12 a general questionnaire that everybody is supposed to fill
13 out?

14 MS. TABOR: So we would base that -- so there is
15 currently the Health Outcomes Survey, which MA plans
16 currently collect and report as a part of Medicare, and it
17 is -- actually some of the measures are scored now in the
18 quality bonus program. So the survey follows a cohort of
19 beneficiaries over time to assess change or improvement in
20 mental health status and improvement in physical health
21 status over time.

22 I will say that there are some concerns with the

1 validity of the kind of current sample size that are
2 required for those surveys, so that's something we need to
3 kind of think about more, and we will as we're modeling
4 this out.

5 DR. CROSSON: Karen, on this?

6 DR. DeSALVO: Just that the Health Outcomes
7 Survey has a subset of questions that are pretty close to
8 the Healthy Days instrument from CDC, which some plans also
9 use, and that latter one -- they're not exactly the same,
10 but the cluster of four questions has been studied by a
11 group like, you know, the Robert Wood Johnson Foundation,
12 and the inputs to the responses to that in senior
13 populations are things like food insecurity and social
14 isolation, some social drivers, and then it's related to
15 utilization and expenditure on the other end. So there is
16 a little bit of science to show that even those questions
17 relate to utilization and spend but also personal health, a
18 sense of well-being.

19 MR. THOMAS: But are they really more social
20 determinants or are they really ambulatory quality?

21 DR. DeSALVO: Oh, I'm sorry. They're not
22 ambulatory quality. They're patient-reported health

1 outcomes. But they reflect -- so, yeah, they definitely --
2 which was my question.

3 DR. CROSSON: Okay. David. Oh, I'm sorry.

4 DR. DeSALVO: I wanted to add on for you all to
5 think about, in the social risk stratification, if you're
6 going to have data on self-rated health or healthy days, or
7 some subset from the Health Outcomes Study, that might be
8 an approach to stratifying the population. If you're
9 trying to do a social stratification, you might look at
10 whether that's an additional, besides just income,
11 opportunity to understand more of the nuances of the non-
12 low-income subsidy.

13 DR. CROSSON: Okay. I have David and Bruce.

14 DR. GRABOWSKI: Thanks. This is exciting work,
15 and I'm particularly intrigued by this opportunity to
16 compare the quality of MA with the quality of fee-for-
17 service, especially and including ACOs in local market
18 areas. I think that's a really exciting development.
19 Obviously, valid encounter data would solve a lot of our
20 problems.

21 In the meantime, however, you do have a series of
22 utilization measures based around HEDIS data, and I just

1 wanted to think about how does HEDIS -- measures generated
2 from HEDIS data in MA compare with kind of claims-based
3 measures in fee-for-service and ACOs. And I've used some
4 HEDIS data, but I would like to hear you guys tell us a
5 little more about that kind of difference there.

6 MS. TABOR: I'll start off on this one. So with
7 the HEDIS data, our internal analysis, I think the biggest
8 issue that we have is that HEDIS risk-adjusted measures are
9 based on a small subset of MA encounter data, which is kind
10 of like what's available for them to use for risk
11 adjustment, or as we have all of fee-for-service to use to
12 calculate our risk adjustment model. So I think what we
13 can do in-house with encounter data and what CMS can do
14 perhaps is a little stronger, especially if we're trying to
15 compare across the three models. I would say that's the
16 biggest issue. There may be little nuances like who's
17 included in the population versus not between HEDIS
18 measures and maybe what we use in-house. But I would say
19 the biggest difference is kind of the risk adjustment model
20 and the weight behind it.

21 DR. GRABOWSKI: Do you think we could get there
22 with -- I mean, actually put something up that says this is

1 a -- we can do a valid comparison here with the risk
2 adjustment issues?

3 MS. TABOR: Yes, I think -- and I'm open to the
4 Commission's thoughts on this -- what we're going to try is
5 to use this fee-for-service -- so use a risk adjustment
6 model based on the entire fee-for-service population, just
7 thinking it's so big that it's got to be good, and use that
8 to apply -- use that to calculate the expected results
9 across all three sectors, and then use, you know, claims
10 and encounter data to calculate the observed. So that's
11 something we're hoping to do as a part of this work.

12 DR. CROSSON: Bruce.

13 MR. PYENSON: Thank you. Terrific work. I've
14 got two questions.

15 One is if you could help me connect between
16 what's on Slides 14 and 15, which I view as a segment of an
17 underwriting cycle and management response to bad news or
18 good news in the market, to the recommendation, the summary
19 issues in 16. Is there any connection -- so you have this
20 -- identify this dynamic. I don't see the connection of
21 that to the summary.

22 MR. ZARABOZO: Well, there are two reasons that

1 this is being presented. One reason is that there is --
2 many people have the opinion apparently that all the bonus
3 dollars go to extra benefits. So, no, all the bonus
4 dollars do not go to extra benefits from year to year.

5 MR. PYENSON: Why would people have that idea?

6 [Laughter.]

7 MR. ZARABOZO: Well --

8 MR. PYENSON: I'm just puzzled. Why is that even
9 an issue? You know, it's --

10 MR. ZARABOZO: One trade group in the industry
11 has said specifically that bonus dollars all go to extra
12 benefits. Another entity that sort of monitors the MA
13 program that is neutral has also said all these dollars go
14 to extra benefits. So the answer is, no, they do not go to
15 extra benefits.

16 The other point is the question if the bonus
17 dollars go away, that produces financial pressure on the
18 plans, so we're just illustrating here in this middle group
19 that when there is a financial pressure on the plans, they
20 do become more efficient. They reduce their bids, which is
21 sort of your underwriting cycle in a way.

22 MR. PYENSON: Well, but you don't know whether

1 that's moving money from surplus to regain market share. I
2 mean, you don't if that's what's going on or if they're
3 becoming more efficient.

4 MR. ZARABOZO: Well, our only measure of being
5 more efficient is your bid is lower this year than it was
6 last year is this particular approach to evaluating
7 efficiency.

8 MR. PYENSON: Okay. But under the -- we're not
9 saying the bonuses go away. We're saying we have a
10 different --

11 MR. ZARABOZO: Well, the financing of the bonuses
12 could be budget-neutral, that is, there will not be the \$6
13 billion add-on. You will be taking money from the sector
14 and redistributing the money within the sector.

15 MR. PYENSON: But do you think the behavioral
16 response, what I call the underwriting cycle, would change
17 under the different bonus system?

18 MR. ZARABOZO: Well, I think, I mean, it is
19 similar to what happened with the PPACA changes in payment.
20 You had different reactions, you know, different behavior
21 based on the reduction in payments. So you would see a
22 similar thing happening here, which is reduced payments; if

1 you want to maintain market share or if you believe you
2 have to have a certain level of extra benefits, you would
3 take a reduced margin, for example.

4 MR. PYENSON: My second question is, you know, in
5 the stars there's all sorts of measures on -- a few
6 measures on things like cancer screening or flu shots. And
7 what do you think would happen to performance if plans
8 weren't being measured on them?

9 MR. ZARABOZO: Well, I mean, a lot of those -- if
10 the medical community believes those are important measures
11 and they are valid for tracking the continuing health of
12 the membership -- for example, a flu shot is -- you know,
13 that's a very important thing to have. And a lot of health
14 plans remind people every time they come in, "Did you get
15 your flu shot? You can get it anywhere you want to get it,
16 but you really need to get your flu shot." So I would
17 imagine they would continue to pay attention to those
18 measures even without a financial incentive specifically
19 tied to those measures. A flu shot, for example, if you
20 don't get a flu shot, you could have a hospitalization that
21 really could be considered as a preventable
22 hospitalization, for example.

1 MS. TABOR: And also, you know, there's the idea
2 that public reporting of these types of things could
3 continue. I know in discussions with plans that, you know,
4 the public reporting really does drive their own internal
5 improvement. So hopefully there would be aspects of that
6 that are still tied, even though we're only tying payment
7 to these big population-based measures.

8 DR. CROSSON: Okay. Thank you. We are ready to
9 move on to the discussion phase. Dana and Paul are going
10 to lead that. I'd like to ask you to put up Slide 16,
11 Ledia. I'd like to see if we can't direct the discussion
12 to the right-hand column and the five numbered points there
13 -- lack of support, support, relative support -- so we get
14 a sense of the Commission.

15 Dana, you look ready to go.

16 DR. SAFRAN: Ready to go, so thanks. I think,
17 you know, we've all emphasized over the course of this
18 discussion the important advance this could make over the
19 current QBP program. As the payment reform has taken shape
20 both in public payment and private payment, I think the
21 corresponding outcry about too many measures and, you know,
22 not the right measures has really been noteworthy and with

1 ever-increasing volume on how important that issue is,
2 tying it to physician burnout, et cetera. And, you know,
3 at the end of the day, I think we all share a point of view
4 that moving toward outcome-oriented, big-dot measures, when
5 you're asking provider organizations to be accountable for
6 a population for the total cost and health outcomes and
7 quality for that population, it makes sense not to
8 micromanage and, you know, measure on each little component
9 of care.

10 So I'm extremely excited about what you're
11 putting forward here with, you know, a parsimonious
12 outcome-based, patient-centered set of measures.

13 I think that the inclusion of the Health Outcomes
14 Survey is a very exciting prospect and bold, and imagine
15 that if we could have this play out at the market level the
16 way you're designing it, which I think is a very
17 interesting and laudable approach, for individuals to be
18 able to be choosing their plan based on this set of things,
19 including how well one plan versus another does at helping
20 people avoid decline in functional status or even achieve
21 improvement is profound in how it could change health care.
22 So very exciting set of prospects.

1 I think I'll mention just a couple things that I
2 think need a little bit of attention as you do the work
3 over the summer. One is in my experience you don't ever
4 want an accountability measure to start with the word
5 "potentially" in it. Providers will not accept, you know,
6 in my experience, being assessed in a high-stakes way on
7 something where it's potentially this but potentially
8 something else. So I think you just want to give that some
9 thought. And, you know, I understand your response about
10 the NQF piece, but I do think some process to really
11 validate and gain acceptance of these new measures is going
12 to be critical.

13 I would also highlight that the three new
14 measures that you're talking about do kind of double down
15 on the cost incentive in Medicare Advantage in a way that's
16 sort of twice paying for savings, you know, avoiding
17 readmissions, for example. And I don't really have a
18 problem with that. I think of those as efficiency-tinged
19 quality measures. But I think that's okay.

20 I do, as I think some of my colleagues intimated,
21 think you might want to add in something that gets into
22 other aspects of primary care and ambulatory care,

1 particularly around prevention. So maybe there is a
2 preventive care composite that encompasses some of the
3 types of preventive services that have been included here,
4 because I think if we're only focused on these sort of
5 avoidance of hospital, avoidance of complications, we're
6 missing something important in the quality space.

7 And then I guess two final thoughts. One is a
8 question, and maybe there's some modeling you could do
9 about whether the perceived takeaway that this will now be
10 budget-neutral, do we think that could drive some MA plans
11 to leave the program? And sort of corresponding to that,
12 it would be very interesting to have some focus groups with
13 consumer advocacy groups or consumers themselves to just
14 understand how would Medicare beneficiaries respond to this
15 and to the opportunity to have this kind of information to
16 inform their choice of plan.

17 And then, finally, I didn't see anything in here
18 on the possibility of multiyear targets, but I do think
19 that's one of the advantages when you're setting targets in
20 absolute terms, that if providers sort of know what the
21 targets are and there's a range of targets, which I think
22 is part of the value of what you're putting forward here,

1 then, you know, if you have multiple years to plan your
2 quality improvement journey, that we could really see this
3 start to -- help us make progress on the important measures
4 that you're looking to include here.

5 So those are some starter thoughts. Thank you.

6 DR. CROSSON: Thank you, Dana. Paul.

7 DR. PAUL GINSBURG: Yes, I'm really glad you took
8 up this topic, and you did a great job on it. To me, the
9 star system is out of control. You know, for one thing, it
10 has a weak foundation as far as what you've shown of the
11 report with not a strong link to outcomes. And I think the
12 rewards are much too large today, basically rewarding plans
13 twice. You give them a star bonus, and they're also going
14 to get more enrollees because enrollees do pay attention to
15 star ratings. I think just attracting more enrollees
16 should be enough of a reward. So I support all of your
17 recommendations on page 16, right-hand column. I think
18 this is the way to go.

19 DR. CROSSON: Thank you, Paul.

20 Further discussion? We'll start with Jon -- no,
21 oh -- okay.

22 DR. CHRISTIANSON: You like that phrase.

1 [Laughter.]

2 DR. JAFFERY: I'd like some more discussion in
3 this chapter about peer grouping at the local level. I
4 like peer grouping at the local level, but peer grouping
5 when you have, you know, 12 or 20 competitive plans versus
6 when you have two, what are the implications of that? Is
7 there anything there that we need to be concerned about?
8 Stability of ranking over the years in terms of no strength
9 of signal versus random noise going on in terms of how
10 people get -- how plans get evaluated? I mean, there's
11 lots of things, I think, to think about what I'd like to
12 have you write about next time.

13 DR. CROSSON: Jonathan.

14 DR. PERLIN: Let me thank you for a terrific
15 presentation on this. Your question, generally support the
16 recommendations, but I do have a couple of additional. I
17 want to associate with Dana's comment on the vetting and
18 testing of accountability metrics.

19 Second, in the reading material, there was
20 discussion of a particular proprietary, black-box
21 adjustment mechanism. I have a categorical dislike for
22 those because, really, we want both the accountability and

1 implicit in that is improvement. And you don't want people
2 to know at the end of a marking period how well they've
3 done. What you want is them working on the features that
4 contribute to the improvement over that marking period, and
5 so I would really recommend categorically against sort of
6 black-box proprietary, closed adjustment systems because I
7 think they defeat the ability to use the accountability to
8 drive the improvement that you want.

9 Dana also brought up the notion of prevention,
10 and the challenge of prevention is that it's really
11 difficult to get to the outcome measures because, you know,
12 if you do the prevention right, then you thwart the
13 immediate or even near-term occurrence of things. Things
14 like immunization, cancer screening, and substance use
15 screening are great categories of prevention. Of course,
16 those then become process measures.

17 The reason I feel they're so important is that I
18 generally support the approach to the peer grouping, and
19 this is going to sound somewhat heretical, but, you know,
20 we don't want to inadvertently disadvantage disadvantaged
21 populations with inferior outcomes, and the great part
22 about process measures that focus on prevention is that,

1 one, you don't actually need to risk-adjust them, but you
2 do know that they may actually carry more impact in the
3 disadvantaged population. So I think linking those two
4 thoughts together is important in terms of creating that
5 slate in terms of ultimately a balanced scorecard of good
6 care.

7 Thanks.

8 DR. CROSSON: Thank you. Kathy.

9 MS. BUTO: I probably should have brought this up
10 in Round 1, but it occurred to me as I was looking at the
11 outcome and patient experience measure domains that you set
12 out that they're really very hospital-focused, and I
13 understand why, because that's where a lot of the money is,
14 and that makes us better able to compare across fee-for-
15 service and MA. But I'm wondering if you thought about
16 including some element that I think we associate with MA,
17 which is more related to coordination of care or some
18 aspect, and I guess where I would see this as being more
19 concrete is, say, post-acute care as related to hospital
20 inpatient care, something where what we think of as MA
21 strength should actually be better measured than just
22 following a lot of domains that focus on hospital

1 readmissions and preventable ED visits and things like
2 that. So I just wondered if you had done that.

3 By the way, I support the recommendations as laid
4 out, but I just felt like there was something missing.

5 MS. TABOR: I guess the one -- just to help
6 answer your question, the good thing about the CAHPS survey
7 that we would score for this is an MA CAHPS survey, so it
8 focuses on more broader aspects of care than the HCAHPS.
9 So there actually is a part of the MA CAHPS survey that
10 asks about care coordination. So was your care
11 coordinated, or do your doctors -- like no lab results
12 after -- when you've gone to different doctors, did the
13 doctor follow up with you about lab results? So we're
14 hoping that that measure as well as kind of overall access
15 measures that are asked in the MA CAHPS could get at that.

16 MS. BUTO: That's something we want to keep our
17 eyes on, because I feel like as we talk about accountable
18 care, we're not just talking about did something bad
19 happen. We really want to know is something good going on
20 as a result of this approach.

21 DR. CROSSON: Brian.

22 DR. DeBUSK: First of all, I'm really excited to

1 see all this. You harmonize all this work, really excited
2 to see the similarities between HVIP and the new MA
3 program, so congratulations. I hope you keep going.

4 A couple things. I do want to just once again
5 caution, when you're using these observed versus expected,
6 you know, basically the random effects model, it does still
7 concern me doing a risk adjustment across such a broad
8 population. I mean, when you go all the way from a dual,
9 you know, to a very healthy beneficiary, I mean, just --
10 what I've said before is on the record. I would just be
11 careful with using the random effects model across
12 populations that are so broad in a homogeneous way.

13 The other thing I was going to throw out there --
14 and this is maybe wishful thinking on my part, but if we
15 ever did get encounter data, which I genuinely hope we do,
16 we may be able to calculate an MSPB using reference values,
17 just the standard Medicare fee schedule for the cost data,
18 and it would be interesting to be able to look at an MSPB
19 across an MA plan versus an ACO. And if I'm not mistaken,
20 I think MSPB is one of the HVIP domains anyway. So, again,
21 it's another step toward comparability.

22 The other thing I remember from the HVIP, I know

1 we stratified into ten deciles, but if I remember
2 correctly, there were pretty much -- there was a low lobe
3 and a high lobe, and then there was sort of this big, vast
4 middle that really didn't change that much. If you're
5 already at two peer groups in the MA plan and the HVIP sort
6 of looked a little, you know, three -- maybe if you looked
7 at some, maybe it had five lobes on it at best, I'm just
8 wondering if you could ever get to peer groups that were
9 roughly comparable, because it just seems like ten to two
10 is a little bit of a spread. And if you have the
11 opportunity as you develop this work, you know, I hope
12 we're constantly holding HVIP up against this new plan and
13 looking at opportunities to move them incrementally closer.

14 And I do think, my final point, there's some real
15 novelty in what you've done with these market areas with
16 the plans and the way you're breaking them up. And when I
17 was doing the reading, the one thing that popped into my
18 head, I remember Jonathan, when we were talking about HVIP,
19 talking about, well, what do you do about these
20 beneficiaries who are coming in saying to our health system
21 and this is maybe the one and only contact they'll have, or
22 this is an infrequent contact that they would have, just,

1 again, as you're holding these two plans beside each other,
2 we might want to do HVIP and introduce that concept of a
3 market area, because, I mean, in theory a hospital could
4 have more than one MSA that it's serving. Sort of picture
5 one hospital say in a metropolitan area that is maybe
6 pulling patients in from two or three other highly rural,
7 highly dual-eligible MSAs. Well, you may average that
8 population together and think you're sitting at, say, a 30
9 percent dual-eligible rate, when what you're really -- or
10 40 percent, and what you're really sitting at is a 10
11 percent dual-eligible rate plus three outlying counties
12 that are sitting at 50 or 60 percent.

13 And so, anyway, the novelty in what you were
14 doing with applying the MedPAC units to create these
15 boundaries on the MA plans, it makes me wonder if there's
16 some applicability. And, Jonathan, I don't mean to put
17 words in your mouth, but I just remember the point that you
18 made. It really stuck in my head, and I saw that again
19 with this reading.

20 Thank you.

21 DR. CROSSON: Thank you, Brian. Further
22 discussion? I see Pat, Warner, and Jonathan and Bruce.

1 DR. WANG: Very thought-provoking, great step
2 forward.

3 This is just a minor thing but I think it's
4 important. We use the term "patient" a lot in the slides
5 as well as in the chapter, and I think when you're thinking
6 about MA land we're not talking about patients because
7 that's not the universe that an MA plan hopes to see. You
8 know, so it's a subtle difference but beneficiary or member
9 or enrollee, I think, is a better term.

10 Along those lines, I think Kathy and some others
11 mentioned this, the focus on the measures that are in
12 there, very hospital-focused, not ambulatory-focused, it
13 might be worth looking again at the -- there are some good,
14 tough outcomes measures. They're hybrid measures, you
15 know, blood sugar control, things like that, that, in
16 theory, you know, would be reflected in readmission rate,
17 but maybe it would be worth looking at that.

18 I'm very glad that you are sensitive to the
19 issues around sample size on the HOS. I think the HOS is a
20 very important instrument, but I do happen to think there
21 is an issue with sample size and extrapolating from those.

22 I think the goal of sort of trying to align the

1 measures as much as possible with the provider system are
2 very important, and along those lines I would ask that in
3 CAHPS that you look at some of the questions to where there
4 is overlap, to really make sure that they are as similar or
5 identical as possible. And the couple that come to mind
6 for me are in the access and availability measures.

7 So in the MA CAHPS it's like in the past six
8 months did you get seen within 15 minutes of your scheduled
9 time? You know, that is, I think, in the physician CAHPS
10 but it's not counted towards anything. The sort of
11 satisfaction with access to care, you know, did you get an
12 appointment as quickly as you wanted in the last six
13 months? It's a very different question than I think what
14 exists in some of the physician CAPHS measures, which are
15 more specific to an appointment, a point in time. It would
16 really help with conversations between plans and their
17 delivery system to align those metrics and have everybody
18 paying attention to the same thing and be incentivized to
19 pay attention to the same thing.

20 I look forward to hearing more about the PPVs.
21 As I had mentioned before, I do think -- I realize that for
22 modeling purposes you need to kind of make this

1 straightforward and doable, but I am little worried about
2 the dual versus non-dual hard and fast line as to peer
3 groups. I kind of feel like it will not really capture the
4 complexity, and as Carlos said, I mean, in the current CMS,
5 you know, the categorical adjustment index, which is their
6 SES adjustment, which many people believe is not refined
7 enough, there are nine deciles of dual-ness, five quintiles
8 of disability-ness, and folks feel like that's not enough.
9 So I would just mention that.

10 On the readmission measures, I guess that the
11 thing that I am a little confused about, and it's just
12 maybe you can help me understand later, all of the work
13 that went into the HVIP to make sure that hospitals were
14 appropriately grouped so that the readmission statistic
15 reflected their patient population, I don't really quite
16 understand how that gets reflected in the peer grouping
17 suggestion for the MA program. And I may be getting
18 confused, but, you know, if an MA plan that serves a lot of
19 low-income folks are using those hospitals that are in the
20 highest decile of low-income members in the HVIP, is that
21 going to get picked up in the evaluation of their
22 readmission experience? It's just a question and I can

1 follow up with you.

2 You posed questions about financing and how to
3 get to a place where this is a budget-neutral program, and
4 I think it's a really important -- really important
5 question -- and ultimately, I think, to move to a system
6 where there is a withhold of some kind. A couple of
7 considerations. I think it is essential as a threshold
8 before talking about withholds to talk about benchmarks,
9 because there's the phenomenon that Paul raised in the last
10 conversation. There are some areas that are 60 percent MA
11 now. Like what is the meaning of a fee-for-service
12 benchmark at all? The benchmarks that are in existence
13 now, as a result of PPACA, range from 95 percent to 115
14 percent, and that range contributes to some of this
15 observation that, overall, payments to MA plans are higher
16 than fee-for-service, and in some areas they are quite a
17 bit lower than fee-for-service.

18 You've written about this before. I think it's
19 very important. It's a great opportunity in talking about
20 moving to a different quality program to standardize those
21 or look at those again, and, you know, from my perspective,
22 move much closer to 100 percent of fee-for-service

1 equivalent or something even more refined than that, to
2 take into account these highly penetrated markets before
3 talking about a withhold, because right now the withhold
4 would be -- have very arbitrary effects in benchmarks that
5 were somewhat arbitrarily set back in the day.

6 The other thing -- and just because you asked for
7 ideas about how to move to that system -- is potentially to
8 think about the money that is in the quality bonus, passing
9 through the quality bonus program now and that is part of
10 MA financing and part of the baseline for MA, and maybe
11 sort of starting to blend what's there into the new program
12 along with benchmark reform simultaneously, so that you can
13 ultimately wind up in a place where the money is in the
14 system but it's coming out in the form of a withhold
15 instead of an add-on.

16 Thanks.

17 DR. CROSSON: Thank you, Pat. Warner.

18 MR. THOMAS: Just a couple of comments, briefly.

19 I would agree with a lot of what Pat just went through.

20 On the quality metrics, I do think the ambulatory
21 metrics being more specific, it's important. I would go to
22 Jonathan's comment around process measures, which I

1 understand the hospital readmissions and preventable
2 admissions are in the outcome measure eventually. But, you
3 know, I think the process measures, which can be
4 specifically measured, such as certain screenings and those
5 types of things, are very important. We know that they
6 eventually lead to improved outcomes measures, and
7 especially if we can catch certain diseases in earlier
8 states that's important as well.

9 So I would encourage us to add that and maybe
10 even think about it replacing the physical and mental
11 health stats, just given some concerns about the sample
12 size. And, once again, I'm not sure how that feedback kind
13 of gets back to the plan and back to the delivery system.
14 I'm not sure that information ever gets back to the
15 delivery system. And I think, once again, we want to have
16 information there that can be actionable and can motivate
17 folks to do a better job.

18 And plus I think you'd probably get a lot of
19 those components, or some of those components on the
20 patient experience and people's specific ideas, or how they
21 think about their experience with the delivery system and
22 with the MA plan.

1 So those would be my comments. Thank you.

2 DR. CROSSON: Thank you, Warner. Jonathan.

3 DR. JAFFERY: Yeah, thanks, Jay. So, generally,
4 I'm very supportive of all these recommendations on the
5 right side of the slide and in this direction. I really
6 appreciate, we have seen over the course of the year
7 multiple situations where we are moving more towards these
8 common set of Commission principles.

9 In terms of the metrics, and particularly about
10 people's comments and concerns about not having enough
11 ambulatory measures, and thinking about Dana's comment
12 about the word "preventable" -- or "potentially," rather --
13 and how providers may react to that, I don't know if this
14 is where you were going with this but, you know, the notion
15 of ambulatory care sensitive conditions seems like maybe
16 gets to both of those questions and has maybe some
17 acceptance in a way that we would think, even though it's
18 really about preventing an activity that would be in the
19 hospital, it's really driven by that care coordination that
20 happens in the ambulatory setting.

21 The only other comment I wanted to make was maybe
22 to tie back to this morning and thinking about, as we're

1 going forward, you know, one of the Commission principles
2 is about equitable treatment to providers and thinking
3 about how this ultimately can connect with our ACO
4 programs, where we don't have a budget. I mean, we don't
5 have extra money going in for quality payments. In fact,
6 it is based on usually some withhold or withhold measure
7 against the benchmark.

8 And then also just thinking about how do we get
9 our measures aligned so that everybody feels like they're
10 moving in the same direction, providers, whether they're
11 taking care of patients in an ACO or an MA, or what happens
12 very often, both, are moving towards the same measures and
13 then beneficiaries can ultimately judge quality and
14 performance based on the same set of metrics.

15 DR. CROSSON: Thank you, Jonathan. Bruce.

16 MR. PYENSON: Thank you very much. This is great
17 work, and I support the five points out there.

18 I do have three points I want to make, and one is
19 to pick up on Paul's comment on the tournament model, and
20 especially in the context of the Medicare Advantage plan.
21 We are talking about organizations that are inherently
22 competitive. Their life is a tournament, competing against

1 other health plans. Although the benchmarks are known in
2 advance the benefits of their competitors are not known, or
3 their offerings, in advance. So they are inherently in a
4 tournament of much bigger stakes than the quality bonus --
5 in addition to the quality bonus, but probably a bigger
6 order of magnitude competing for members, and that also
7 applies to PDPs, perhaps even more so.

8 So given their inherent ability to manage risk --
9 after all, they're insurance companies -- I think in that
10 context some of the concerns about tournament models are
11 probably not as applicable, and that's something to think
12 about in the context of MA plans.

13 Another point I would like to make is I would
14 hate to see an underlying assumption in this work that we
15 can't do certain things because we don't have encounter
16 data, because we have another stream that's going to make
17 sure we are getting encounter data pretty quickly. So I
18 wouldn't want that to be used as a reason why we shouldn't
19 get certain information, especially on the population
20 health. We are going to get it. It will be there. So
21 let's assume that and let's go for the merits of what works
22 best.

1 And, finally, I'd like to echo Pat's Round 1
2 question about Part D quality metrics. I think Part D in
3 an MA-PD takes on a different character and I think there
4 are quality metrics there that would make a lot of sense,
5 probably involving a polypharmacy or other things that you
6 could pull out of the data and actually attribute to the MA
7 plan, because the MA plan's also responsible for the
8 prescribers. So I'd echo Pat's -- I think that's what you
9 were saying, Pat.

10 DR. WANG: And there are existing outcomes
11 measures that are quite tough but that would get -- you
12 know, I mean, medicate adherence, for example, there are
13 three, triple-weighted medication adherence measures that
14 are highly correlated with outcomes. I mean, they exist.
15 They don't have to be developed, and PQA has been very
16 actively involved. So it might be something to take a look
17 at, to fold into this, because they are included together
18 now in the stars bonus.

19 DR. CROSSON: Dana. Last comment.

20 DR. SAFRAN: Yeah. This is just a quick comment
21 about some of the discussion on health outcomes survey and
22 sample size concerns. So I just want to reassure folks

1 that based on some work that I have done, and I would be
2 happy to share, we don't have to worry about that, that,
3 you know, you can, at the MA plan level, you get to stable,
4 reliable information on outcomes on HOS with 1,000
5 beneficiaries.

6 So while the current sample sizes are not
7 adequate, I think I actually, in a paper I wrote fairly
8 recently, cited a MedPAC report, saying that 99 percent of
9 plans included some vast number of beneficiaries so that we
10 could certainly get to 1,000 in pretty much any plan, and
11 1,000 is what you need at the plan level. You actually
12 need much less, about a third of that, at the clinical
13 level or practice level, to get stable, reliable
14 information on HOS.

15 DR. CROSSON: Okay. Good discussion. I think
16 we've got broad support for this general direction. I
17 think in the next cycle we're going to see us moving
18 towards recommendations.

19 There was a theme here, which I think we need to
20 be consonant of, with respect to balance between hospital-
21 based and ambulatory-based outcome measures. Having said
22 that, I think it's important to recognize that,

1 readmissions aside, preventable admissions and preventable
2 emergency department visits are part and parcel to the work
3 in the outpatient arena. I mean, that's not the only thing
4 but that's a lot of what caregivers are working towards.
5 So it's mix. Those are mixed in my mind, something to do
6 with how well the hospitals took care of people and that
7 they don't come back, and perhaps the same thing for
8 emergency, but they fundamentally reflect, to a large
9 degree, the quality of outpatient care, and I think patient
10 experience and reported outcomes do as well.

11 That said, you know, I think that we have to
12 strike a balance between slip-sliding back into a whole
13 list of process measures, which is what we're trying to get
14 away from, but to the extent, Carlos and Ledia, you can
15 think of something maybe more to add in the ambulatory
16 arena, I think that would be welcomed. So we look forward
17 to seeing that in the next iteration.

18 Thanks very much. Carlos and Ledia, good work.
19 We will see you again in the fall, I believe.

20 We will move on to the next presentation.

21 [Pause.]

22 DR. CROSSON: Okay. The second presentation this

1 afternoon, again, is focused on the Medicare Advantage
2 program, and we are, I think, about to reach a conclusion
3 on work that we've done over the last year or so on trying
4 to provide stronger incentives for plans to provide
5 complete and accurate encounter data.

6 Andy and Jennifer are going to take us through
7 that, and then we will have a recommendation and a vote.

8 MS. PODULKA: Thank you, Jay.

9 Today, Andy and I will present information on
10 Medicare Advantage encounter data in follow-up to our
11 multiple presentations over the past year. Because much of
12 the information was included last month, we'll move more
13 quickly through several slides to allow more time for the
14 new material.

15 We'll cover the encounter data background, our
16 efforts to validate the available files, and the expected
17 outlook going forward.

18 And, finally, we'll review the draft
19 recommendation, which has been modified a bit to reflect
20 your discussion last month.

21 First, a note on terminology. MA organizations
22 sign contracts with Medicare to deliver the MA benefit to

1 enrollees. These contracts can include one or more
2 multiple plan benefit packages, and all of our analyses
3 were conducted at the contract level. But we'll use the
4 terms "contract" and "plan" interchangeably.

5 MA encounter data have a long history that began
6 with the Balanced Budget Act of 1997.

7 Initial efforts to collect encounter data
8 proceeded with some fits and starts until in 2008, CMS
9 called to resume collection of detailed encounter data for
10 all Medicare services. And the collection began in January
11 of 2012.

12 I want to highlight the value complete encounter
13 data could have for the MA program. Detailed encounter
14 data are the best vehicle for learning about how care is
15 provided to the one-third of Medicare beneficiaries
16 enrolled in MA. Ensuring that the Medicare benefit is
17 administered properly to all beneficiaries is an important
18 function for program oversight.

19 Second, plans have the flexibility to implement
20 practices that could allow them to provide care more
21 efficiently than in the traditional program, moving the
22 program from strict fee-for-service to value-based payment,

1 and we would like to evaluate how these techniques are
2 employed in addition to what their effects are, using
3 encounter data to potentially inform and improve Medicare
4 policies more broadly.

5 Finally, complete encounter data could replace
6 various data collection efforts and would ensure that the
7 program relies on data that are internally consistent and
8 conform to program rules.

9 We have evaluated the MA encounter data files to
10 determine if they are ready for use in various analyses and
11 risk adjustment. Our methodology includes two main
12 categories.

13 First, we checked if each plan successfully
14 submitted any encounter data for each of the six settings.
15 We also compared plans' reported enrollees to CMS's
16 database that track plan offerings and beneficiary
17 enrollment.

18 For a second step of the validation, where
19 available, we compared MA encounter data to other data
20 files that also include information on MA utilization. For
21 these comparisons, rather than trying to validate all data
22 elements, we focus just on first- and second-order

1 questions, which means we check to see that the same
2 enrollees who received a service that's documented in the
3 encounter data are also identified in a comparison dataset.

4 And where possible, we checked that dates of
5 service matched or at least overlapped.

6 You've noted concerns about the completeness of
7 these comparison datasets, and we recognize that like all
8 datasets, they do have shortcomings, which is why our
9 comparisons aren't designed to match up each and every
10 variable in the encounter data and the comparison datasets.
11 Again, we're checking to see, for example, that a hospital
12 reported that they treated a person, that that same person
13 shows up somewhere in the MA plan's reported encounter
14 data.

15 So on the comparisons of encounter data to other
16 sources, the four shown here are independent or external
17 data in the sense that they are derived from information
18 reported by providers; in this case, including hospitals,
19 dialysis facilities, home health agencies, and skilled
20 nursing facilities.

21 In 2015, 90 percent of enrollees included in
22 independent data reported by hospitals were also included

1 in encounter data. However, of the inpatient stays in the
2 hospital-reported data, only 78 percent had matching or
3 overlapping dates of service for the encounter data.

4 The enrollee match rates were 89 percent for
5 dialysis, 46 percent for home health, and 49 percent for
6 skilled nursing.

7 We note that the results in 2015 are a bit better
8 than they were the prior year, and we expect that once
9 we're able to review more recent data files, we'll find
10 improvements year to year.

11 However, given the importance of encounter data
12 and the amount of time that has already passed since its
13 collection began, the Commission has grown increasingly
14 concerned about the pace of that incremental improvement.
15 The current outlook for encounter data does not suggest
16 that the pace will pick up without some intervention.

17 First, there are report cards that CMS uses to
18 provide feedback to plans which tally total records and
19 compare these to regional and national averages, but they
20 only include one comparison to external, those for
21 inpatient stays.

22 Second, CMS recently implemented a set of

1 performance metrics that assesses the timing of submissions
2 and compares encounter data to plan-submitted risk
3 adjustment, or RAPS data. However, the thresholds for
4 these metrics are designed to identify only plans that are
5 outliers due to very low submission rates.

6 And, finally, encounter data are used to identify
7 diagnoses for risk adjustment, which provides an incentive
8 to submit some inpatient, outpatient hospital, and
9 physician records, which are only three of the six required
10 settings. There is no risk adjustment incentive to submit
11 records for the other settings or for encounters from these
12 three that do not reveal additional diagnosis codes.

13 So, again, based on the current set of feedback
14 and incentives, we expect that encounter data will continue
15 to improve. However, your recent discussion has reflected
16 a concern about the pace of that incremental improvement
17 and a preference for taking additional steps to increase
18 encounter data completeness and accuracy, which Andy will
19 now discuss.

20 DR. JOHNSON: The next few slides review the
21 three main policies included in today's draft
22 recommendation. These policies are designed to improve the

1 assessment of completeness and increase incentives to
2 submit encounter data. Information about the first two
3 policies is largely unchanged from our presentation last
4 month. These policies are expanding the performance metric
5 framework and applying a payment withhold.

6 However, the policy to use Medicare
7 Administrative Contractors to collect encounter data
8 directly from providers has been updated based on the
9 Commission's discussion in the March meeting.

10 The first policy is to expand the performance
11 metric framework. Performance metrics currently focus on
12 the timing of encounter submissions and comparisons to RAPS
13 data. Compliance in the current performance framework uses
14 a single threshold to identify low-performing outlier
15 plans. However, our analysis found incompleteness to be an
16 issue for nearly all plans, not just a few outliers.

17 One way to improve this framework is to add
18 metrics that compare encounter data to external and plan-
19 generated data sources. CMS could publicly report
20 statistics showing aggregate performance for the MA program
21 on these metrics. Feedback to plans could be more
22 specific, including information about each instance of

1 missing encounter data.

2 To improve compliance with the performance metric
3 framework, we find that a payment withhold would more
4 appropriately address the scope of incompleteness in the
5 encounter data.

6 To apply a payment withhold, the amount withheld
7 could be based on a percentage of each plan's monthly
8 payment, making the size of the withhold correlated with
9 enrollment in the plan and the expected number of encounter
10 records. The amount to be returned to the plan would be
11 based on a plan's performance relative to a range of
12 standards.

13 For example, plans with better performance would
14 receive more of their withhold in return, and plans with
15 worse performance would receive less in record.

16 Initial withhold return standards could be set at
17 a generous level, with a high rate of return being easy to
18 attain, and then standards could increase over time. If MA
19 plans collectively submit complete and accurate encounter
20 data, the withhold policy could be phased out.

21 The final policy for improving encounter data
22 submission is for providers to submit claims for MA

1 enrollees directly to Medicare Administrative Contractors,
2 or MACs. Providers currently submit to MACs all fee-for-
3 service Medicare claims and information-only claims for MA
4 enrollees using inpatient hospital and skilled nursing
5 services. MACs currently forward fee-for-service claims to
6 Medigap plans and Medicaid agencies that have cost-sharing
7 obligations.

8 To use this process in MA, MACs would receive
9 claims from providers and apply fee-for-service data edits
10 to Part A and B services, ensuring that those records are
11 complete. Then MACs would forward claims to MA plans for
12 payment processing and would also forward a duplicate claim
13 to CMS for compilation into encounter data. For
14 supplemental services, MACs could forward records directly
15 to MA plans with minimal data checks.

16 The MAC process would collect payment data,
17 similar to the current process. In either case, the plan's
18 fee schedule or contractual amount would be the source of
19 payment data collected. Many providers currently use a
20 claims clearinghouse to submit claims to MACs or other
21 payers. This policy would not require any change to these
22 clearinghouses in claims processing.

1 In March, we described implementing two parts of
2 this policy. First, MA organizations that prefer to use a
3 MAC to process claims and to submitting encounter data
4 could elect to do so.

5 Second, a set of completeness thresholds would
6 apply at the MA organization level. If an organization
7 fails to meet a threshold, only that organization would be
8 required to use MACs.

9 Based on the Commission's discussion last month,
10 we have added a third part to this policy. Another set of
11 completeness thresholds would apply to the entire MA
12 program. If all MA organizations, collectively, fail to
13 meet a program-wide threshold, all MA organizations would
14 be required use MACs.

15 Last month, several Commissioners also commented
16 that the MAC policy should be implemented sooner than the
17 proposed 2024. On this slide, we lay out an ambitious
18 timeline of actions to implement the draft recommendation,
19 showing that many recommendation activities would take
20 place sooner than 2024.

21 Starting immediately, CMS would develop new
22 performance metrics and provide feedback to plans about

1 their performance for the most recent year of encounter
2 data. Spring 2020 is the next opportunity for CMS to
3 notify plans about the specification of new metrics and the
4 payment withhold standards. Policies announced at this
5 time apply to payment year 2021, which is the first payment
6 year that the payment withhold would apply. The withhold
7 policy and feedback reporting would continue in each
8 subsequent year.

9 During the next notification of changes to
10 payment policy, in the spring of 2021, CMS would inform
11 plans about the mechanism for using MACs and the thresholds
12 that would trigger their use. The MAC thresholds and the
13 option for MA organizations to opt to use MACs would first
14 apply in payment year 2022 and would continue for
15 subsequent years.

16 In early 2023, CMS would assess whether MAC
17 thresholds were met and notify any organizations that
18 failed to meet thresholds. If there were any such
19 organizations, MAC use would be triggered for payment year
20 2024, which given this timeline is the earliest year we
21 think CMS could implement the MAC policy.

22 That brings us to the draft recommendation, which

1 reads: "The Congress should direct the Secretary to
2 establish thresholds for the completeness and accuracy of
3 Medicare Advantage encounter data and rigorously evaluate
4 MA organizations' submitted data and provide robust
5 feedback; concurrently apply a payment withhold and provide
6 refunds to MA organizations that meet thresholds; institute
7 a mechanism for direct submission of provider claims to
8 Medicare Administrative Contractors as a voluntary option
9 for all MA organizations that prefer this method, and
10 starting in 2024, for individual MA organizations that fail
11 to meet thresholds or for all MA organizations if program-
12 wide thresholds are not achieved."

13 This recommendation may reduce program spending
14 relative to current policy, if the performance of some
15 plans results in less than the full withhold amount being
16 returned to those plans. Given that withhold standards may
17 be generous at first, this policy may reduce spending by
18 less than \$50 million in one year and by less than \$1
19 billion over five years.

20 The recommendation would not have any direct
21 effect on beneficiaries.

22 The impact of the potential use of MACs to

1 collect encounter data on plans and providers would vary
2 depending on each entities' current procedures for
3 processing claims and submitting encounter data.

4 Before we wrap up, I want to point out two issues
5 requiring future work that go beyond the topics covered in
6 the draft recommendation.

7 First, independent data sources for assessing
8 encounter data for physician, outpatient, and certain other
9 Part B services are lacking. We would like to develop
10 metrics for these services that could be added to the
11 performance metric framework.

12 To develop these metrics, it may be necessary to
13 patch together comparisons of subsets of these services;
14 for example, using Part D event and inpatient data to
15 identify evidence of a physician encounter. Alternatively,
16 we could develop aggregated comparisons to utilization
17 information at the service-type level from plan bids.

18 Such comparisons to plan bids would also help
19 address the second issue, which is evaluating whether
20 incentives and performance metrics are having the intended
21 effect. In this context, comparisons to plan bid
22 information can assess whether the encounter data are

1 generally consistent with each plan's spending.

2 An alternative approach to address this issue
3 would be to develop an additional program audit area to
4 assess consistency between encounter data and the plan's
5 financial data for payments to providers.

6 We highlight these two issues for future work to
7 differentiate them from the policies included in today's
8 draft recommendation.

9 And now I'll turn it back to Jay.

10 DR. CROSSON: Okay. Thank you, Andy, Jennifer.

11 Let's go to clarifying questions.

12 Jaewon and then Kathy.

13 DR. RYU: Yeah. I had a question about you
14 referenced with the use of the MAC that there be a
15 potential delay of a few days in the claims processing
16 cycle or the submission cycle.

17 I think there are programs with some MA plans
18 that rely on that timeliness for a clinical event to take
19 place. I think the best example might be ED visit, working
20 together with hospitals and so forth, to get timely
21 notification that might then trigger and outreach to the
22 patient for follow-up.

1 Have we gone through and looked at what some of
2 those programs might be that have a dependency on the time
3 where that delay may end up being a factor?

4 DR. JOHNSON: My understanding of those types of
5 notifications is that they would be based off of the
6 electronic health record technology and that if an
7 inpatient admission took place and it was notifying the
8 plan or primary care provider that it would not use the
9 claims process but would use other health information
10 technology.

11 DR. CROSSON: Kathy.

12 MS. BUTO: I just wondered whether you all had
13 checked to see whether the MACs could absorb this workload
14 and how long it would take them because it's been a while,
15 but my experience working with contractors is it always
16 takes longer than you expect to make systems changes so
17 they can accommodate a new function. So I wondered if you
18 had worked that into your time frame.

19 MS. PODULKA: Well, the MACs, of course, are
20 contractors to CMS. So, we discussed with the CMS MAC
21 group rather than the MACs themselves.

22 They note that we have ambitious goals and an

1 ambitious timeline, but as usual, they stand ready to serve
2 if called upon by the Congress to do something that they
3 had not yet done before.

4 MS. BUTO: That sounds like an answer --
5 [speaking off microphone.]

6 DR. CROSSON: Right.

7 [Laughter.]

8 MS. BUTO: I would definitely have given that
9 answer to you if I had met with you when I was at CMS.

10 DR. CROSSON: Karen.

11 DR. DeSALVO: I wondered to understand a little
12 more about this new concept around the failure of the whole
13 program-wide and how you solve the peer pressure playing
14 out. That's what I'm guessing is what you think you would
15 want to see happen, or how did that become I think a
16 priority, and how do you expect that to help?

17 DR. JOHNSON: I think the rationale for the
18 program-wide threshold was that if -- that we think that
19 having this data complete for all plans and all MA
20 enrollees is important enough that we wouldn't want a
21 situation to be going on where a certain number of plans
22 just decided they didn't ever want to figure out this

1 process and make it efficient, and that they could
2 continually pay a withhold and not get the sufficient
3 return back, but that at some point, you would want a
4 threshold that applies to everyone and says that these
5 types of providers want to -- types of plans wouldn't be
6 holding back the completeness of the entire data.

7 DR. DeSALVO: A follow-up question that I
8 generally don't understand, which I probably should, but if
9 Medicare's increasingly using encounter data to set
10 payment, isn't that also an incentive for their overall
11 payment? And I just wondered what would keep a plan
12 wanting to not submit good encounter data if that's also
13 going to be not part of the penalty piece but the reward of
14 payment.

15 DR. JOHNSON: So the payment data is based off of
16 diagnoses submitted on outpatient, inpatient, and physician
17 encounters. So there is some incentive to submit those
18 encounter records. But if a plan has submitted all the
19 diagnoses for a particular enrollee but not all the
20 encounter records, there really isn't another incentive to
21 submit those additional encounter records for those service
22 types. And as Jennifer noted, that also doesn't address

1 the home health, skilled nursing, and other PAC settings
2 that aren't used for setting MA payment rates.

3 DR. CROSSON: Okay. I see Pat. I'm sorry. Are
4 you passing? Round 2, okay.

5 So we have clarifying questions, we have the
6 recommendation on the table here, which will be the order
7 of business. And I would ask for discussion here, and
8 discussion should be directed towards the draft
9 recommendation, support, lack of support, and then we'll
10 proceed based on that discussion to a vote. Pat?

11 [Laughter.]

12 MS. WANG: I apologize. The wording is kind of
13 general about more robust feedback from CMS to plans to
14 assist in, you know, getting encounter submission where
15 everybody wants it to be. You guys probably have a list of
16 specific suggestions, and I just want to make sure that you
17 have shared those with CMS. I mean, they know what to do,
18 too. Last time we met, I had suggested that they add
19 dollars into their reports back to plans so that it's not
20 just matching the member and the dates, but dollars are a
21 way of just identifying am I talking about the same
22 encounter or are we off? I think that would be very

1 valuable information. I'm hoping that you would kind of
2 compile those in a more specific way to give to CMS,
3 because I think that, you know, there's stakes all around,
4 but more robust feedback is desired by many and is not
5 quite there yet.

6 In terms of the recommendation, I had also
7 suggested -- mentioned that in the MAC process I would
8 still consider -- well, there's two things. The program-
9 wide trigger is -- you know, Karen's question I think is a
10 good one. It's an unusual step to take when sort of the
11 sector -- if somebody in California is not submitting,
12 that's going to affect plans in, you know, New Hampshire.
13 It's an interesting notion. We still have provider types
14 that don't submit cost reports, and we don't penalize the
15 entire provider community. We don't even penalize them for
16 not submitting cost reports. I'm thinking about our
17 perennial discussion around am-surg centers. So I think
18 it's a bit of a -- it's a little bit out there in terms of
19 sort of a last hammer.

20 And then the final thing is I continue to think
21 that if a MAC process is used and maybe it will be a better
22 and more efficient process for encounters, if everything

1 works the way it's supposed to, that plans still be allowed
2 to submit their own encounter data for purposes of risk
3 adjustment, because I think many plans would be reluctant
4 to just turn over that function to a MAC when they
5 themselves, you know, like go back and forth, you know,
6 multiple, multiple, multiple times every week to make sure
7 that their submissions for risk adjustment are correct. So
8 I would kind of carve that out of the general MAC.

9 DR. MATHEWS: Pat, if I could just say one thing
10 on the middle point you raised about the industry-wide
11 trigger being potentially problematic here. I'll take some
12 responsibility for how that has been articulated in this
13 revised element of the draft recommendation. Recall that
14 in March there were some Commissioners who had expressed
15 reservations about using the MACs at all in this capacity,
16 and there were other Commissioners who said, "Why are we
17 not going to use the MACs right now?"

18 And so what we were trying to do here is let the
19 current process continue to unfold, given the investments
20 that have been made, but try to goose that by having, you
21 know, more robust targets and feedback to incentivize plans
22 to hit those targets, but then given the importance of

1 having robust, complete program-wide encounter data, that
2 at some point if the industry as a whole had not achieved
3 those targets, then this option would be triggered.

4 DR. CROSSON: Karen.

5 DR. DeSALVO: Yeah, just to continue that
6 conversation, I appreciate that, and I was thinking also of
7 provider categories, for example, where if one of my peers,
8 physician peers, didn't submit data, then would I have to
9 change all my processes? But I wonder also, equity aside,
10 I wonder about timeline. And if the process is, as I
11 understand it, starting to work better between CMS and the
12 plans for the data to be received and more accurate and
13 people trust it more, if 95 or 99 percent of the industry
14 got all that right and one didn't, there'd have to be a new
15 process started with the MACs, and I wonder if that would
16 delay the timeline further.

17 DR. MATHEWS: So If I understand your question
18 correctly, you're asking if a very, very small percentage
19 of the industry had failed to meet the target, would that
20 trigger -- so it would depend on how one, you know, defined
21 the thresholds in question. Would it be, you know, a
22 percentage of MA plans? Would it be a percentage of MA

1 enrollment whereby if some of the larger organizations had
2 managed to get -- to meet all of the targets, would they
3 sort of carry the industry as a whole and prevent that from
4 happening?

5 So there are a number of operational decisions
6 that would come into play in terms of defining how and when
7 this kind of option would be triggered.

8 DR. DeSALVO: The second part of my -- and it
9 doesn't quite read that way to me, by the way, so I would
10 just wonder about some clarity. But the second part of my
11 question was about timing. So if, you know, whatever
12 threshold isn't met, however we would define that, and then
13 we had to move to MAC pathway, MAC would have to get stood
14 up. They'd have to build the interfaces. There would be a
15 series of steps that would then have to resume, which might
16 push the timeline out further, would be my -- because I'm
17 thinking somewhere in '25 we'd say, "Oh, we're not there,"
18 so then we have to start this other pathway for everyone,
19 not just for those who can't comply.

20 DR. MATHEWS: Sure, that is a possibility, but
21 one would hope that under this revised system of
22 incentives, you know, clear targets, withholds that would

1 be redistributed based on performance, that this would help
2 increase the completeness of the data that's being
3 submitted.

4 DR. CROSSON: Marge.

5 MS. MARJORIE GINSBURG: This may be a part one
6 question. Do we have any knowledge as to why some MA plans
7 are so slow or unable to submit data on time? And I ask
8 this question because I was originally thinking about let's
9 add another part, because if you don't do it, we'll cut you
10 off. I mean, do you ever -- does CMS ever disenfranchise
11 an MA plan for whatever reason?

12 But before that option, do we have any idea, have
13 they said why this is so challenging for MA plans to get
14 their information in?

15 DR. JOHNSON: There have been some challenges
16 early on working with CMS and the feedback they were given
17 that many plans have acknowledged. But I also think it
18 goes to the incentives for them to submit certain types of
19 data and that as their risk scores and payments were -- the
20 portion of their payments that rely on encounter-based risk
21 scores has increased, some of those types of services have
22 increased incompleteness as well, and those have been what

1 plans have openly said, you know, as we're going provider
2 type by provider type, we started there because that's what
3 matters the most for our payments. And once we get that
4 settled, we'll, you know, maybe work through some of the
5 other provider types.

6 But to the extent that there is right now not any
7 feedback about how complete are your skilled nursing
8 encounters or home health encounters, that that's why we
9 think some of the new performance metrics need to focus on
10 those services, and part of it incentives.

11 MS. MARJORIE GINSBURG: And do you think these
12 incentives are strong enough to stimulate better responses?

13 DR. JOHNSON: I think the -- well, whether the
14 incentives are strong enough might depend on how the
15 withhold policy and MAC thresholds are established, and we
16 hope that they can be established in a way that incents
17 plans to improve their data. I'll leave it at that.

18 CMS does have the authority, on your second
19 question, for plans who have a 2.5 star rating for several
20 years in a row to discontinue their contract.

21 MS. MARJORIE GINSBURG: [off microphone]?

22 DR. JOHNSON: Once or twice? Carlos says yes.

1 DR. CROSSON: Kathy.

2 MS. BUTO: I'm sort of thinking along the same
3 lines that you are, Marge, and I was wondering -- we just
4 talked about the quality bonus program, which really kind
5 of depends on good encounter data to track some of these
6 outcomes. And I'm wondering whether we ought to consider
7 either, you know, tying star ratings or the quality bonus
8 program results or payout in part to -- this is a process
9 measure, obviously, but in part to the submission of
10 encounter data to the extent that we define complete
11 encounter data or relatively complete encounter data.

12 There ought to be some cross-reference here
13 between the bonus program and whether or not you're
14 submitting data that helps you know whether you're actually
15 achieving outcomes.

16 DR. JOHNSON: I think that is a good point for
17 everyone to discuss. I think the one concern that we have
18 discussed internally is whether or not stars are used as a
19 signal to beneficiaries if a plan's submitting complete
20 encounter data, it fits that role like it does about
21 readmissions and some other things.

22 MS. BUTO: I understand. But we're talking about

1 sort of a withhold both with the bonus program and with
2 this. There ought to be some kind of convergence there, I
3 think.

4 DR. JOHNSON: Sure.

5 DR. CROSSON: I think, Kathy, you're making a
6 distinction between a star rating and how much you get
7 paid?

8 MS. BUTO: I'm just saying there ought to be a
9 penalty that people care about, and it usually follows
10 payment. If you don't get some payment that you think
11 you're entitled to, then you might pay attention and do
12 what you're supposed to do.

13 DR. CROSSON: What I'm saying is you could still
14 have a plan rated four stars, but they wouldn't get the
15 four-star payment because you could have a corollary to
16 that, which is, you know, it gets reduced proportionate to
17 encounter data submission.

18 MS. BUTO: I don't want to design it. I just
19 think there ought to be a consequence if you don't submit
20 the data beyond just not getting your withhold back.

21 DR. CROSSON: And I think this is a concept that
22 could be incorporated into the text as a suggestion. I

1 think it's a good one.

2 Okay. I see no other -- yes, I do. Brian.

3 DR. DeBUSK: One other quick comment. I made it
4 the last time we looked at this chapter, too. On page 21,
5 you talk about calibrating the HCC, the risk adjustment
6 model, against the encounter data itself. I still want to
7 point out that's a circular reference. I realize it
8 doesn't affect the recommendation, but it's just the
9 quality of the materials is so incredible, I'd hate to see
10 a logic flaw make it into the published June report. If I
11 have fee-for-service data -- a thought experiment here. If
12 I have fee-for-service data, I calibrate against that.
13 Let's say I find the coefficient for diabetes. So now I
14 have the payment adjuster for diabetes. Well, if the MA
15 plans develop some breakthrough and now they're managing
16 diabetes at, you know -- and their adjuster is a half of
17 the adjuster that fee-for-service has, well, you'd want to
18 leave that in place because, I mean, that arbitrage, that's
19 administration cost, that's plan profit, and that's
20 essentially what we're paying them to do, is do things
21 differently and do things better. So if we were
22 continuously calibrating the HCC model against the

1 encounter data itself, it's a self-referring cycle. I
2 mean, we would just be absorbing the improvements they made
3 into new HCC coefficients.

4 DR. JOHNSON: I think you're right, and there are
5 some people who argue that there is a benefit to that
6 circularity and that there is payment accuracy that comes
7 along with it and argue that that's more important than
8 having that arbitrage opportunity as you described. And
9 then there's other people who say the opposite, so --

10 DR. DeBUSK: Well, I would be in the camp of if
11 we're paying them to do things better and different -- and
12 I wouldn't want to calibrate a model that basically knocks
13 them back down every time they do something better or
14 different. As a matter of fact, we'd actually be
15 incentivizing them to do things more poorly, because if
16 they would calibrate against the model, the more
17 inefficient they got, the more they'd get paid for
18 diabetes, essentially.

19 DR. JOHNSON: The section in the chapter should
20 reflect that this is one policy change that might be coming
21 in the future and that we haven't heard much about it
22 recently, but it's intending to describe what it is and

1 what the implication of it would be. But we'll make sure
2 that there's not language that says one way or the other
3 whether or not we have opinions.

4 DR. CROSSON: Okay. Seeing no further
5 discussion, we'll proceed to vote on the recommendation
6 that's before you. It's depicted on the slide and on page
7 13. All Commissioners in favor of the recommendation,
8 please raise your hand.

9 [Show of hands.]

10 DR. CROSSON: All Commissioners opposed?

11 [Show of hands.]

12 DR. DeSALVO: [off microphone].

13 DR. CROSSON: I understand. Abstaining?

14 [No response.]

15 DR. CROSSON: The recommendation is passed.

16 Andy, Jennifer, thank you very much. We'll proceed with
17 the next presentation.

18 Okay. The next item, we're going to return to
19 the issue of post-acute care, and particularly whether or
20 not functional assessment of patient status is going to be
21 a tool that would be useful to employ in the assessment of
22 post-acute care providers. Ledia and Carol are here, and

1 Ledia -- carol is going to start.

2 DR. CARTER: This presentation follows up on a
3 discussion we had back in November on patient assessment
4 data submitted by PAC providers. We had proposed an
5 approach to examine the quality of these data and now we
6 are presenting the results of that analysis.

7 Functional status is an important dimension of
8 post-acute care. The information is used to adjust
9 payments, gauge provider performance, and establish care
10 plans for patients.

11 However, we know that providers respond to the
12 incentives of payment policies and quality reporting. If
13 providers respond to incentives by recording function in
14 ways that do not reflect patients' care needs, then program
15 payments will be unnecessarily high, payments for
16 individual stays will not be aligned with resource needs of
17 the patient, and providers will appear to have achieved
18 better outcomes than they have. Beneficiaries could select
19 a provider that is not, in fact, as good as reported. And
20 ACOs and MA plans could build their networks of PAC
21 providers around data that is, in fact, inaccurate.

22 The setting-specific PPSs and quality reporting

1 programs create incentives for providers to pay attention
2 to the way they record a patient's functional status.
3 Three of the prospective payment systems include functional
4 status as a risk adjuster, so providers have an incentive
5 to adapt their recording of functional status to maximize
6 payments.

7 Change in function is an outcome measure that is
8 reported in each setting's quality reporting program. The
9 IRF and SNF quality reporting also include a measure of
10 attainment of function at discharge. The change and
11 attainment measures create incentives for providers to
12 record function to show improvement, higher function at
13 discharge compared to admission.

14 In November, we discussed examples of the
15 reporting of functional status that appear to be influenced
16 by value-based purchasing and PPS incentives. We also
17 reviewed numerous examples of provider responses to payment
18 policies. We outlined strategies CMS could pursue to
19 improve the quality of the functional assessment data and
20 discussed a measure of function that avoids provider
21 reporting, and that would be patient-reported outcomes.

22 Today we present our evaluation of the functional

1 assessment data, and the question to keep in mind is,
2 should function data be used to establish payments and
3 measure patient outcomes?

4 We plan to include this information in this
5 year's June report.

6 Each PAC setting uses its own patient assessment
7 tool that include different questions, definitions of
8 activities, look-back periods, and scales to record
9 information on the same domains of activities, such as
10 walking. Therefore, we needed a systematic crosswalk so we
11 could compare the items recorded by the different
12 assessments. For each tool, we defined each level of
13 function in terms of points, for example, 15 points for the
14 independent category, 10 points for requiring limited
15 assistance, 5 points for extensive assistance, and 0 points
16 for total dependence. And we did this for four activities:
17 eating, transferring, walking and toileting.

18 Then, for each patient's assessment, we assigned
19 points to the level of function recorded for that patient.
20 We created a total score by summing the points for each
21 activity. Then, based on a patient's total score, we
22 assigned that patient's functional ability to one of 5

1 broad categories.

2 Three of the assessment tools also now include
3 additional uniform items that are used for quality
4 reporting. Because the items are uniform, they are
5 directly comparable. They also allow us to compare items
6 recorded for payment -- those are the setting-specific
7 items -- with those recorded for quality improvement -- and
8 those would be the new uniform items.

9 To evaluate the function data we focused on the
10 consistency of the assessment information in three ways.
11 First, we compared assessment information with other
12 beneficiary characteristics, such as their age and risk
13 scores.

14 Second, we looked at the assessments of
15 beneficiaries who transitioned between PAC settings. For
16 the same patient, we compared the assessment at discharge
17 from one setting with the admission assessment at the next
18 setting. In the diagram, you see two stays, with the
19 discharge assessment of the first stay highlighted in
20 yellow and the admission assessment to the next in green.
21 We included only pairs of assessments that occurred within
22 three days of each other.

1 The third analysis focused on the consistency of
2 reporting of information that is used for payment -- the
3 setting-specific items -- with the items used for quality
4 reporting, and again, these are assessments items reported
5 for the same beneficiaries.

6 To gauge consistency, we looked for general
7 agreement between the broad categories of function assigned
8 by different assessments for the same patient. We were not
9 looking for perfect matches. While no one analysis is
10 definitive, together they raise questions about how and
11 whether this information should be used to adjust payments
12 or to measure provider performance.

13 Our first comparison looked at whether the broad
14 levels of function -- that's low, medium, high, and so on -
15 - were related to other patient characteristics, and we
16 found that they were. For example, the highest-functioning
17 beneficiaries were younger, with an average age of 73 years
18 compared to 78 for the lowest-functioning group. The
19 highest-functioning beneficiaries also had lower risk
20 scores, on average, compared to the lowest-functioning
21 beneficiaries. Beneficiaries in the highest-functioning
22 group were less likely to have diagnoses that involved

1 multiple body systems, have a cognitive impairment, or a
2 higher severity of illness compared to beneficiaries in the
3 lowest-functioning group.

4 These results suggest that when looking at groups
5 of patients, the functional assessment data generally track
6 other patient characteristics. But you will see that when
7 we look at the differences in the recorded function for the
8 same patient we have concerns about the consistency of this
9 information.

10 Our second analysis compared assessments
11 conducted at discharge from one PAC setting and at
12 admission to another for the same patients. This chart
13 compares the function level recorded for patients assessed
14 at discharge from IRFs with the functional level recorded
15 at admission to home health agencies. We show the percent
16 of assessments at admission that were two or more levels
17 lower than the assessment at discharge, and one level
18 lower, the same level, and one and two or more levels
19 higher.

20 We found that the reported levels of function
21 were inconsistent and favored recording lower levels of
22 function at admission. Only 7 percent of patients

1 discharged from an IRF and then assessed were assessed at
2 the same level when they were admitted to the home health
3 agency.

4 The level of function recorded on the home health
5 admission assessment was lower than what was recorded on
6 the discharge assessment of the prior IRF stay for 92
7 percent of patients, the 66 plus 26 percent.

8 The large share of assessments for the same
9 patients that vary two or more levels, and the bias of the
10 differences raised questions about the consistency of the
11 recording of function by providers. A lower function
12 recorded on admission to home health agencies would
13 establish higher home health payments for them and be more
14 likely to show improvements in function. A high function
15 at discharge from the IRFs would likewise be more likely to
16 show improvement for IRFs.

17 This is a similar comparison but this one shows
18 assessments completed at discharge from IRFs and at
19 admission to SNFs. Discharge and admission assessments for
20 the same patients agreed less than one-third of the time.
21 The recorded function on the SNF admission assessment was
22 lower than the level recorded on the prior IRF discharge

1 assessment for 58 percent of the patients. That's the 21
2 plus the 37 percent. The recording of lower function at
3 admission establishes higher payments for SNFs and would be
4 more likely to show improvement, while the higher level of
5 function recorded by IRFs would be more likely to show
6 improvement.

7 Now let's look at beneficiaries who transition
8 between institutional PAC providers, before for them we
9 have uniform assessment items that are directly comparable.
10 There is no issue in using a crosswalk between the
11 different assessment tools. We would expect the function
12 levels recorded at discharge from one setting and at
13 admission to the next would be the same, and for the
14 mismatches to be more or less evenly distributed in both
15 directions.

16 Yet even comparing these uniform items for the
17 same patients, we found that the function levels recorded
18 at discharge from one setting and admission to the next
19 were the same less than half of the time. And again we
20 found that the mismatches predominantly occur in the
21 direction of function being assessed lower at admission to
22 the second setting. A much larger share of assessments at

1 SNF admission recorded lower function -- that's the 12 plus
2 the 32 percent -- compared with the share that recorded
3 higher function -- that's the 9 plus the 2 percent. IRFs
4 would have an incentive to record high function at
5 discharge while SNFs would have an incentive to record a
6 low-function admission, both to show improvement.

7 MS. TABOR: We also examined the consistency of
8 reporting of function items within each setting. We
9 compared the admission assessment results for function
10 items that are used for payment -- the setting-specific
11 items -- with those used for quality reporting, or the
12 uniform items.

13 We found that, for both IRFs and SNFs, less than
14 half of the admission assessments recorded the same
15 function category in the information used for quality
16 reporting and the setting-specific items used for payment.
17 Again, the recording favors one direction. The items
18 recorded for quality reporting were more likely to be
19 recorded one function level higher than the information
20 used to establish payments.

21 These results indicate that even within a setting
22 the uniform items are reported inconsistently.

1 Our results may be explained by the financial
2 incentives of the payment systems to record function as low
3 at admission. Quality reporting and value-based purchasing
4 may encourage providers to record function to show
5 improvement. It is possible that some of the differences
6 in levels of function recorded may be due to differences in
7 the setting-specific assessment tools. Further, the
8 recording of the uniform items is relatively new, and
9 assessors may be gaining experience with it, so these data
10 may be improving over time.

11 Finally, there will always be some degree of
12 subjectivity of the assessments. Even with these factors,
13 the magnitude of the differences and the directional
14 differences raise questions about the integrity of these
15 data.

16 Our examination of the functional assessment
17 information submitted by PAC providers indicates that the
18 information is currently inconsistent and shows signs of
19 being influenced by payment incentives. Therefore Medicare
20 should not use this information to adjust payments.

21 Our results also raise questions about whether
22 this information is reliable for quality measurement.

1 However, maintaining and improving function is a key
2 outcome measure for PAC providers, so Commissioners may
3 want to encourage CMS to improve the reporting of this
4 information.

5 In November, the Commission discussed three
6 strategies that CMS could employ to improve the accuracy of
7 the patient function assessments or alternatives to those
8 assessments. Per the Commission's feedback, in the chapter
9 we have added more detail on the implementation issues CMS
10 should consider with these strategies.

11 First, CMS could improve its monitoring of
12 provider-reported assessments by performing analysis of the
13 consistency of the data like we did in this paper. CMS
14 could conduct on-site audits of providers that have
15 submitted aberrant data and assess penalties on providers
16 with poor data quality. CMS should require medical records
17 to include sufficient documentation to support the patient
18 functional assessment information.

19 A second strategy is to require hospitals to
20 complete assessments of patients when they are discharged.
21 Because a large share of PAC is not preceded by a hospital
22 stay, this strategy has limited applicability.

1 A third strategy is to gather patient-reported
2 outcomes, or PROs. PROs would sidestep the problem of
3 providers' financial incentives influencing their reporting
4 of patients' functional status. However, there are
5 currently no PROs collected in PAC settings or included in
6 PAC quality programs. Further, many PAC patients have high
7 severity of illness and cognitive impairments that would
8 affect the ability to collect accurate PRO results.

9 More research is needed to determine if proxies,
10 like family members, can reliably complete assessments.

11 This brings us to your discussion. Carol and I
12 can answer any questions you have about our analysis. We
13 would then like you feedback on whether the Commission
14 should move towards a future recommendation on the use of
15 function to adjust payments to PAC providers, as well as
16 whether the Commission should encourage CMS to adopt
17 strategies to improve, or alternatives to provider-reported
18 data.

19 DR. CROSSON: Thank you, Ledia and Carol. We now
20 move to clarifying questions.

21 I see Sue and Marge and David.

22 MS. THOMPSON: Thank you, ladies.

1 In terms of the difference in the assessment
2 tools and the subjectivity that might be applied, how
3 significant is that in this whole scenario? I mean, how
4 many different tools do we have and how much variability is
5 being introduced into this formula?

6 DR. CARTER: I'm pretty comfortable with the
7 crosswalk that we used. We did define, for each tool on
8 its own, definitions of independence and sort of moderate
9 supervision required, moderate assistance, more assistance,
10 and then total dependence, and we tried to be, and really
11 worked hard, to make sure that within each tool we were
12 defining things in the same way but also that the
13 definitions were consistent across them.

14 But also because we are adding the scores for
15 each dimension together to create a total score, no one
16 thing can get you in one of the categories. It has to be a
17 combination of your dependence on each of the four
18 activities. And so we are trying to develop broad-brush
19 definitions of somebody's functional status, and by, I
20 think, relying on a broad definition I think it helps with
21 being more confident in these results.

22 MS. THOMPSON: And does that apply to the health

1 care professional who is doing the functional assessment as
2 well? Do you feel confident?

3 DR. CARTER: Each of the tools was validated way
4 back when, and the uniform items that were developed as
5 part of the PAC payment demonstration, the PAC PRD, those
6 were validated both within setting, across setting, and
7 across disciplines. So probably the most bulletproof
8 comparison is the uniform items, because there aren't any
9 differences in the definitions, and those were validated
10 because they wanted that tool and those items to be able to
11 travel with the patient as they went across the different
12 assessment tools.

13 But even for the setting-specific comparisons,
14 because we were trying to do the comparisons at a general
15 level, I'm pretty comfortable with them.

16 MS. THOMPSON: Okay. I have one more question.
17 I don't know why this caught my eye, but -- and I probably
18 should know this, for all the time we have spent on this
19 work -- but on page 29 of our reading you referenced that a
20 large share of post-acute is not preceded by a hospital
21 stay. And there was something about that statement that
22 seemed almost like counterintuitive. I mean, post-acute

1 implies acute. So just kind of expand on -- I mean, what
2 is that large share?

3 DR. CARTER: It's about half, and it's because
4 two-thirds of home health space are not preceded by --
5 that's the benefit. You can be community admitted, and the
6 majority of home health patients are. But I think about 15
7 percent of ERF and LTCH patients are also admitted from the
8 community, so that's where it comes from.

9 MS. THOMPSON: Thank you.

10 DR. CROSSON: Thank you. Marge.

11 MS. MARJORIE GINSBURG: Well, there may not be
12 much data on this but I was curious, in your research,
13 whether patients who are not under Medicare but are under
14 commercial plans, they are still under 65, and we do have a
15 few of them in home care, but I wonder whether commercial
16 plans have the same problem of the assessments being wildly
17 variable, or is that situation so different in terms of who
18 gets paid when and they're separate payers or whatever?

19 But I wondered whether -- if Medicare is
20 compensating post-acute providers at a relatively -- at a
21 much lower level than if they were commercial patients, you
22 know, is this mis-assessments being done to try to make up

1 for that by getting the higher level?

2 So, anyway, the question is, do we know anything
3 about whether this happens in the commercial market at all?

4 DR. CARTER: I don't know about that, but I will
5 say that my guess is the commercial rates are actually
6 lower than Medicare's rates in post-acute care.

7 DR. CROSSON: Okay. David.

8 DR. GRABOWSKI: Thanks for this work.

9 I wanted to ask you about one of the strategies
10 you put forward, audits, and I feel like that's something
11 groups like us call for a lot, especially in this area, and
12 I feel like there's a lot of examples of calls to CMS to
13 increase oversight that really haven't been met.

14 So I'm curious. Do you have ideas of how to
15 actually put some teeth behind that? First of all, am I
16 correct in that, that generally speaking, we don't see a
17 lot of auditing here, whether it's the staffing data,
18 whether it's the assessment data? And then on top of that,
19 what can we do to put some teeth behind that?

20 MS. TABOR: I think there is no auditing going on
21 right now for this patient assessment data. It is an
22 attestation that it is valid.

1 We've spoken with providers as well as CMS
2 contractors, and they do a lot of training and put out a
3 lot of FAQs on kind of how to interpret these questions and
4 how to report reliable information, but yet we're still
5 finding these big differences.

6 So I think although it would require more
7 resources for CMS to do this auditing, I think that they
8 can do the types of analysis that we did to perhaps
9 identify providers who need more help or just have
10 misreporting that needs to be fixed.

11 So although it is something that we as a
12 Commission say could occur more, I think this could be
13 another opportunity for us to say we need to do more
14 auditing.

15 DR. GRABOWSKI: And as you said, maybe this is a
16 Round 2 comment, but actually put some money behind it and
17 maybe mandate or have some triggers in there.

18 I did have a second question. We've been talking
19 a lot, obviously, over the last couple of years and even
20 longer than that on the unified PAC system, and I guess,
21 Carol, maybe I should know this. But do we also call for a
22 unified assessment instrument as part of that, or would you

1 still keep the OASIS and the MDS and the different
2 assessment instruments? Would you need to sort of unify
3 the assessment as well? Not just the items, but the actual
4 instruments.

5 DR. CARTER: When we were first talking with the
6 writers about the IMPACT Act, I think providers -- there
7 was quite a bit of pushback for having a unified
8 instrument, and I think people thought that if you just
9 glue to the bottom of the individual tools that every
10 industry was used to, that that would be sufficient.

11 So I think you'd have to balance out having
12 uniformity across the entire instrument or whether -- where
13 I think there might be continued pushback or whether you
14 can live with having separate items, but with uniform items
15 at the bottom.

16 I mean, things like diagnosis and theory should
17 be uniformly collected, right, across the things, and I
18 know that at least in the SNF space, I think they've moved
19 from write-ins to checkboxes to try to narrow down kind of
20 how much variation there is across sort of "What do we mean
21 by hypertension?" But right now, those -- even the
22 collection of what might be seemingly a slam-dunk, like a

1 diagnosis, each of the items collects those differently.

2 DR. CROSSON: Okay. We'll move to the
3 discussion, and I'd like to suggest that we have two parts
4 to that, which we'll run simultaneously.

5 If you'll throw up Slide 13. I think the middle
6 bullet point there is -- we have a suggestion that Medicare
7 should not use this information to adjust payments. What
8 do people feel about that? Because that's going to --
9 depending on what people say here, it will take us in one
10 direction or the other.

11 Related to that to some degree, but not
12 completely, is the information on the next slide, which is
13 irrespective of the use of the information -- and I would
14 say, for example, either to improve the information for
15 payment purposes, or if we decide that we don't think
16 that's going to work because the incentives are too strong
17 for manipulation, as pointed out in the presentation, but
18 we do think that provider-reported assessments of
19 functional status could play a legitimate role in other
20 areas; for example, the assessment of quality.

21 Then what tools? Are these the right tools, or
22 are other tools needed in order to even get that

1 information to have utility?

2 I'm sorry to make it complicated, but I think
3 we'd like to try to get the answers in both those areas.

4 And David is going to start out.

5 DR. GRABOWSKI: Great. Thanks.

6 Once again, I really enjoyed this chapter, and I
7 think it's a really important piece of work.

8 I wanted to start with a little bit of history.
9 Obviously, in the late 1990s, early aughts, we moved from
10 cost-based post-acute care payment to prospective payment
11 in each of the four sectors, and we spent a lot of time in
12 this Commission talking about the need to unify the four
13 PAC payment systems.

14 We didn't just decide to pay the four systems
15 differently. We also chose to assess them differently, and
16 that's obviously led to a lot of problems around payment
17 and quality reporting. And it's only taken us 20 years. I
18 don't know if that's faster or slow in health policy time,
19 but we finally have some common items in place across the
20 four assessment instruments. And that's obviously an
21 exciting development.

22 The less exciting part of this or less good news

1 here is that the data are still self-reported, and as Ledia
2 suggested, there's real issues with the integrity of these
3 data.

4 I thought the chapter did a great job at just
5 laying out the case for why we shouldn't trust these data,
6 and I just wanted to pull out two examples because they
7 were so compelling. I won't repeat what Carol and Ledia
8 just worked through.

9 The first, this idea that I could move from an
10 inpatient rehab facility to a home health agency a day or
11 two days later and be assessed two days apart and have
12 dramatically different levels of functioning is really
13 worrisome.

14 The other example is even within an assessment as
15 an inpatient rehab facility or a skilled nursing facility,
16 there will be items for quality and items for payment, and
17 they would indicate a different level of functioning, also
18 incredibly troubling.

19 So, Jay, to answer your question very directly, I
20 don't think these data are ready for payment purposes. I
21 would not recommend that.

22 I do, however, think there are some steps, and

1 I'm really excited about some of the steps that Carol and
2 Ledia have laid out here to help improve these data and
3 move us down that path towards using them for different
4 purposes.

5 In terms of auditing, I think that's a great
6 idea. As I touched on in my first round of questioning,
7 however, I feel like we make this recommendation a lot, and
8 yet we don't often put anything behind it.

9 And so, first, I think we need to give the
10 auditors resources. I think that's the first important
11 part of this, and then, secondly, I do think there have to
12 be kind of real penalties for poor quality data. I think
13 that's really important here that there's some teeth behind
14 this and some implications for having bad data.

15 So I am in favor of auditing, but I think we need
16 to do that in a serious and meaningful way.

17 I think, Ledia, you did that part of the
18 presentation. I think you said it very well that it's just
19 really hard, given with the hospital discharge assessments,
20 given the fact we just don't have them for almost half of
21 the post-acute care episodes, it's just really hard to
22 imagine using that hospital data as a way of assessing

1 functioning. So I don't think that's actually a viable way
2 forward.

3 I'm not an expert on patient-reported outcomes.
4 I know Dana and others around the table have quite a bit of
5 background in this. However, I did want to make two
6 points.

7 I'm intrigued by it, but with kind of two issues.
8 The first -- and I think you raised this in the chapter,
9 and you raise it specifically to LTCH patients about their
10 high level of cognitive impairment. And, Ledia, you raised
11 this during the presentation.

12 We've seen in our data a high level of cognitive
13 impairment across the post-acute care spectrum. It
14 wouldn't just be an issue for LTCH patients. It obviously
15 would be an issue for inpatient rehab and skilled nursing
16 and home health.

17 And then this idea of proxies also seems
18 intriguing or interesting. I worry there, however, that
19 there are individuals in our system that don't have
20 proxies, especially those dually eligible beneficiaries,
21 and they're disproportionately the individuals who have to
22 go to institutional post-acute care. And so I just would

1 worry if we relied too heavily on proxies, whether we'd
2 introduce some potential biases.

3 So I would like to sort of explore that option
4 more, but I'm a little worried about some of the issues
5 underlying the data.

6 But I think I'll stop there, Jay. Once again, I
7 don't think these are ready for payment purposes, but I'm
8 really excited about some of the checks that are outlined
9 here.

10 Thanks.

11 DR. CROSSON: Thank you, David.

12 I do take the point -- and it occurred to me also
13 when I read it -- about what you call teeth, which is, you
14 know -- what would actually really make the providers pay
15 attention to the accuracy of the information they're
16 submitting for whatever purpose, and it just struck me that
17 one of the things that I've seen in my past life and I
18 think exists broadly in the financial world is attestation
19 by the accountable individuals. I'm talking about CEOs,
20 owners, boards, and this type, to the accuracy of their
21 information, which can carry with it civil monetary
22 penalties.

1 I'm just saying that depending on how seriously
2 we take this -- and there's a lot of money at stake here
3 for the program -- we might want to ratchet up something in
4 that direction, requiring that sort of periodic attestation
5 that in fact the data that's being submitted is accurate
6 and that there is an individual or set of individuals
7 responsible for that who can be held accountable for that
8 information.

9 Okay. Further discussion? Karen.

10 DR. DeSALVO: I keep borrowing Jaewon's mic.

11 First of all, this is really incredible work, so
12 thank you guys for the thoughtful methodology to clarify an
13 issue, apparently a series of them.

14 I agree. I don't think this can be used for
15 payment, but I had an out-of-the-box idea about a
16 validation which is, Is this a place where maybe technology
17 could be helpful to do short video clips of people doing
18 the function and be required to store it in the way that
19 you might store pathology or radiology images, or do that
20 as a part of a random audit process?

21 DR. CROSSON: Interesting.

22 I wasn't quite sure. Amy.

1 MS. BRICKER: I was sitting here thinking about
2 how we could use technology. I don't know how cumbersome
3 that would be, but I like that or some sort of remote
4 monitoring, something that you could then say take the
5 subjectivity out of it. I like that general direction of
6 if there is something there or others have thoughts on how
7 we could maybe do that.

8 DR. CROSSON: Jon and then Dana.

9 DR. PERLIN: Let me add -- thanks for this -- on
10 this point. I was thinking the same thing about the
11 technology. I was also thinking how does this and how
12 would this work in a commercial world.

13 You wouldn't play the post hoc game. You'd
14 actually have someone check out, and I was thinking you
15 would have case managers assess the patient. In fact, I
16 think Karen has added the golden piece to that, is that you
17 could actually do some of that remotely and just remove.

18 The part that troubles me is that we're very
19 consistent about our use of risk adjustment in virtually
20 every other domain. What we're really talking about is a
21 risk adjustment here. So it seems unfortunate to forego
22 that.

1 So I think the question we need to answer,
2 getting to part two of Jay's outline, is how do you get to
3 data that have the characteristics -- that are robust
4 enough that they use it responsibly. And I think this
5 thread of conversation is really the one that could help
6 you get there.

7 Thanks.

8 DR. CROSSON: Dana and then Paul.

9 DR. SAFRAN: Yeah. So I was thinking down the
10 same path about can technology help us. I love the idea,
11 the metaphor of storing the video clip like radiology,
12 because I was thinking video, but then that seemed
13 cumbersome. But maybe it's not.

14 I was also thinking I know there's some
15 technology sort of Fitbit-like that can sense somebody's
16 gait and other things. So what we're talking about is how
17 do we validate the information.

18 So I should have started by saying I totally
19 agree. This isn't ready for payment, and so then how do we
20 validate? Technology might help us. I also, like Jon,
21 thought about could there be case manager, could that
22 happen remotely, and could we take a page from our Medicare

1 encounter data quality conversation to say that there's
2 some kind of penalty for data that aren't accurate and
3 complete.

4 So those are just a few ideas that were floating
5 around my mind.

6 DR. DeSALVO: I just have a follow-up. I think
7 it's a follow-up to this, which is maybe also to try to
8 take out some of the operator error, in this case, manager
9 model, to see that the same person does the assessments at
10 each of the points. Even if they don't work in that
11 particular organization, they're assigned as a case
12 manager, and they transcend the settings, and they are
13 accountable for making sure that the person is improving or
14 not.

15 DR. CROSSON: Interesting. Okay. Some good
16 avenues here to think about that have come forward.

17 Warner.

18 MR. THOMAS: I like some of the ideas around
19 video.

20 Another thing to think about is whatever the
21 assessment is done on the person continues with the person,
22 so that there isn't an assessment done in IRF and then an

1 assessment done in skilled. There's an assessment done
2 that stays with the patient. That way, the entities have
3 to agree on the assessment if there's a transition, either
4 from acute care to post-acute or from a post-acute setting
5 to a different post-acute setting, that there is a
6 consistent assessment that everybody agrees on, because
7 then I think you get out of this information that it just
8 is -- it's kind of hard to sit there and understand how it
9 can be that different, and I would agree it doesn't make
10 sense to tie payment to this.

11 But that would just be an idea to just have it
12 follow the patient, regardless of which setting that they
13 sit in.

14 DR. CROSSON: Paul.

15 DR. PAUL GINSBURG: Yes. I really like the way
16 the discussion is going. I think the emphasis needs to be
17 on the checking of bad data and penalties for it, but
18 rather than, as David pointed out, just saying audit, we
19 need to spend some time of ways to actually do this.

20 I think what Warner suggested of the comparison
21 of the assessments for the same patients, it would be very
22 much -- have great incentive effects as well as auditing

1 benefits. So I'd really like to invest more and figuring
2 out ways to identify and penalize bad data.

3 DR. CROSSON: Okay. Excellent discussion, a lot
4 of innovative thinking here, particularly this late in the
5 afternoon. I'm pretty damn impressed.

6 [Laughter.]

7 DR. CROSSON: Ledia, Carol, thank you very much.
8 We'll see you again on this topic, I'm sure.

9 And we'll move on to our final presentation of
10 the day.

11 [Pause.]

12 DR. CROSSON: Okay. Dan is here. Just to remind
13 the Commissioners and for the benefit of our guests, at the
14 previous meeting in March, we had a discussion about
15 Medicare spending for emergency department services, and
16 part of the discussion focused on the question of whether
17 or not there ought to be national guidelines for coding
18 emergency department visits. And it was the sense of the
19 Commission at the time that there was a strong enough
20 consensus that we should, in fact, move at this meeting to
21 a recommendation and a vote.

22 Having said that and having had a thorough

1 discussion in December, we have elected to take this issue,
2 similar to issues that we have taken before where we have
3 consensus at a prior meeting we need to come to a voting
4 recommendation, we'll have a rather circumscribed
5 presentation.

6 Then I will take questions in the context of our
7 -- somewhere between Round 1 and Round 2, questions or
8 comments on changes that have occurred or have not occurred
9 in the material between the March and April meeting, and
10 then we'll proceed to a vote. Dan?

11 DR. ZABINSKI: Thank you. Okay. Today we'll
12 have our final presentation for options for slowing the
13 growth of Medicare fee-for-service spending on emergency
14 department services. At the March meeting, we had a
15 thorough presentation of non-urgent care in emergency
16 departments and hospital ED coding practices. At the end
17 of that presentation, the Commission saw a draft
18 recommendation about ED coding around which there was
19 general agreement.

20 Today we'll have only a brief discussion of
21 hospital ED coding practices, and the Commission will
22 consider the recommendation.

1 So when a Medicare beneficiary receives care in a
2 hospital emergency department, the hospital codes the visit
3 into one of five levels, and each code reflects a different
4 level of expected resource use needed to treat the patient.

5 In 2005, the coding of these ED visits across
6 these five levels approximated a normal distribution, as
7 illustrated in this diagram. CMS found this a reassuring
8 result because it indicated that hospitals were billing the
9 full range of visit codes in an appropriate manner.

10 The Commission expressed interest in the coding
11 of ED visits because it has steadily shifted to higher
12 levels. Since 2005, the shift has resulted in the
13 distribution of ED visits being far from a normal
14 distribution now in 2017. For example, the share of ED
15 visits coded as Level 5 increased from 11 percent in 2005
16 to 30 percent in 2017.

17 In your paper and at the March meeting, we had a
18 full discussion about the coding of ED visits that had
19 shifted to higher levels, and this slide is a summary of
20 that work.

21 Now, some have argued that the coding of ED
22 visits has changed because patients are sicker, lower-

1 acuity patients have shifted from the ED to urgent care
2 centers, and the care that is provided to ED patients has
3 become more intensive and has produced better outcomes.

4 Alternatively, others have countered these
5 arguments, saying that because hospitals use their own
6 internal guidelines for coding ED visits, some hospitals
7 have taken advantage of this lack of strict rules.

8 Our data analysis shows that: the conditions
9 that are treated in EDs has changed very little over time;
10 the increased use of urgent care centers has had very
11 little effect on the coding of ED visits; and despite no
12 change in the conditions treated, the number of services
13 provided during ED visits has increased, especially EKGs
14 and CT scans.

15 So because we now have a high share of ED visits
16 coded at Level 5 with no change in the patient conditions,
17 it's likely that Medicare payments are too high for many ED
18 patients.

19 So to improve the coding of ED visits, CMS could
20 replace the internal guidelines that hospitals currently
21 use with national guidelines. Potential benefits of
22 national guidelines include that payments would accurately

1 reflect hospital resources used to provide ED care,
2 hospitals would have a clear set of rules for coding ED
3 visits, and CMS would have a firm foundation for assessing
4 and auditing hospitals' coding practices.

5 So we have this draft recommendation that the
6 Secretary should develop and implement a set of national
7 guidelines for coding hospital emergency department visits
8 under the outpatient prospective payment system by 2022.

9 Implications for this recommendation are that
10 there would be no effect on spending because it would be
11 implemented budget-neutral; for providers, the
12 recommendation would improve equity because all providers
13 would have the same rules for coding ED visits. Also,
14 there would be reduced opportunities for hospitals to
15 upcode ED visits; and, finally, payments for ED visits
16 would more accurately and consistently reflect provider
17 costs. And for beneficiaries, we anticipate no effect on
18 their access to ED services.

19 That completes the presentation, and I turn it
20 back to Jay.

21 DR. CROSSON: Thank you, Dan.

22 So as I mentioned, we'll take questions or

1 comments on the changes to the reading material between the
2 March version and the April version. Marge.

3 MS. MARJORIE GINSBURG: I'm a little concerned
4 that the draft recommendation language might not be strong
5 enough and wondered whether we ought to consider changing
6 the word "guidelines" to "standards." "Guidelines" is
7 really -- there's a lot of wiggle room in a guideline.

8 DR. CROSSON: Interesting. Dan, can you remind
9 me what language we used in March? What is "guidelines" or
10 "standards"?

11 DR. ZABINSKI: Yeah, we used "guidelines," and
12 the reason you say "guidelines," it's sort of the term that
13 is just used for these -- well, guidelines. I don't know.
14 That's just, you know, how they're described and defined.
15 Personally, I have nothing against "standards," but --

16 DR. CROSSON: Well, I mean, we're really sort of
17 talking a term of art thing here. So is what you're saying
18 that in comparable areas from CMS the term "guideline" is
19 the term of art, generally speaking, or not?

20 DR. ZABINSKI: Yes. Perhaps let me give you an
21 example. You know, the American College of Emergency
22 Physicians has a set of guidelines for ED visits that were

1 offered up quite a few years ago for, you know, national
2 guidelines for ED visits, and the general idea of those
3 guidelines is that they sort of -- ACEP ranks all the
4 interventions that can possibly occur during an ED visit,
5 and they base the -- under those guidelines, they base the
6 level on whatever is the highest-level intervention that's
7 provided during the visit. And they call those
8 "guidelines." If that, you know, meets the level of
9 "standard," I'm not sure. But that's sort of the way they
10 -- I think the end result would look something like that
11 for a national set of guidelines.

12 DR. CROSSON: Okay. Jon.

13 DR. PERLIN: Just first to respond to Marge's
14 point, the terminology may be less relevant than the
15 consequence. The consequence is that if there are
16 guidelines or standards, whatever they're called, and
17 hospitals or providers were to go outside of that, then the
18 penalty would be very severe, as, you know, occurs when any
19 misrepresentation of coding would occur.

20 I think the problem that, you know, I understand
21 this Commission is trying to resolve is that for whatever
22 reasons, the current state of the art is that there are no

1 standard standards. There are at least three standards to
2 choose from and probably variable implementation of those
3 standards. And, you know, we had, moving to the second
4 point, pretty robust discussion in past sessions that, you
5 know, hospitals in particular, to avoid concerns about
6 being, you know, subject to penalties for inappropriate
7 recording of services rendered, you know, adopt either AHA
8 or ENA or ACEP and, you know, test themselves against them.
9 The problem is that's not a standard standard. It's like
10 that old saw on informatics: "Aren't standards wonderful?
11 There are so many to choose from."

12 If there are that many to choose from, it's
13 obviously not a standard, and so whatever it's called, this
14 would resolve that.

15 I want to move to a couple points because I
16 think, you know, the Commission has provided pretty clear
17 direction in this area.

18 First, in the reading materials, I want to thank
19 you for incorporating some of the discussion. I think
20 there may have been a couple things that were inadvertently
21 left out, you know, for example, the prevalence of CTs on
22 urinary tract infections. It's actually pretty

1 understandable when a Medicare beneficiary presents with
2 altered mental status, you know, you rule out the
3 neurologic and you work your way to a diagnosis, and UTI in
4 an older patient is a pretty frequent occurrence.

5 Second, I think our conversation before also
6 included a discussion that the EHR, many of its attributes
7 -- it has many attributes, but one is a full recording of
8 all of the conditions that a patient may present with, and
9 that may itself change, you know, some of the way in which
10 a visit is recorded and ultimately coded.

11 Finally, this is a big deal. We note that,
12 according to Harlan Krumholz's group, in 2017, 22 percent,
13 roughly -- a little over 22 percent of Medicare
14 beneficiaries went to an emergency department. So assuming
15 that a quarter of the population goes to the emergency
16 department every year, that's a lot of emergency department
17 visits. I've forgotten the exact number. It's over 30
18 million. In fact, probably much higher than that. But the
19 assumption that we can come out with a guideline or set of
20 standards that works perfectly the first time out of the
21 gate I think is dangerous. And while we've had discussion
22 of making sure that we don't needlessly delay, I would

1 recommend that, you know, CMS do a PIT test of the model
2 used because the goal of this model ultimately is -- I
3 understand the exercise is to really be able to distribute
4 the levels of acuity from lowest acuity to highest acuity,
5 with some sort of distribution amongst the different -- you
6 know, obviously it would be a failure if it re-created
7 exactly what we have now.

8 So those are my recommendations on that. With
9 those recommendations, I can support the overall bold-faced
10 recommendation.

11 DR. CROSSON: Thank you, Jon.

12 Other comments?

13 [No response.]

14 DR. CROSSON: Seeing none, we'll proceed to vote
15 on the draft recommendation before you. All Commissioners
16 in favor, please raise your hand.

17 [Show of hands.]

18 DR. CROSSON: All opposed?

19 [No response.]

20 DR. CROSSON: Abstentions?

21 [No response.]

22 DR. CROSSON: Seeing none, the recommendation

1 passes unanimously.

2 That brings us to the end of our agenda for
3 today. We now have time for a public comment session. If
4 there are any of our guests here who would wish to make a
5 comment to the Commission, please come forward to the
6 microphone.

7 [No response.]

8 DR. CROSSON: Seeing none, we are adjourned until
9 8:30 tomorrow morning. Thank you very much.

10 [Whereupon, at 4:06 p.m., the meeting was
11 recessed, to reconvene at 8:30 a.m. on Friday, April 12,
12 2019.]

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MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

The Horizon Ballroom
Ronald Reagan Building
International Trade Center
1300 Pennsylvania Avenue, NW
Washington, D.C. 20004

Friday, April 5, 2019
8:31 a.m.

COMMISSIONERS PRESENT:

FRANCIS J. CROSSON, MD, Chair
JON B. CHRISTIANSON, PhD, Vice Chair
AMY BRICKER, RPh
KATHY BUTO, MPA
BRIAN DeBUSK, PhD
KAREN DeSALVO, MD, MPH, Msc
MARJORIE GINSBURG, BSN, MPH
PAUL GINSBURG, PhD
DAVID GRABOWSKI, PhD
JONATHAN JAFFERY, MD, MS, MMM
JONATHAN PERLIN, MD, PhD, MSHA
BRUCE PYENSON, FSA, MAAA
JAEWON RYU, MD, JD
DANA GELB SAFRAN, ScD
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SUSAN THOMPSON, MS, RN
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P R O C E E D I N G S

[8:31 a.m.]

1
2
3 DR. CROSSON: Okay. Maybe we can start the
4 meeting. I'd like to welcome our guests. This is the
5 final meeting of the Commission for the 2018-2019 cycle.
6 As a consequence, we have almost every year some
7 Commissioners whose terms have expired, and what I'd like
8 to do right now is to take a moment to have those two
9 Commissioners stand up so they can be recognized. Jon
10 Christianson, the Vice Chairman of MedPAC, and Amy Bricker,
11 please stand up and be recognized.

12 [Applause.]

13 DR. CROSSON: Thanks to both of you for fabulous
14 service to this Commission, to the Medicare program, and
15 the beneficiaries. Your work is appreciated and will last
16 for a long time.

17 This morning we are going to take up once again
18 our efforts to try to overcome the increasing cost of
19 pharmaceuticals, particularly in this case in Medicare Part
20 D. Rachel and Shinobu are here, and you have the floor.

21 DR. SCHMIDT: Good morning. In response to the
22 Commission's continued strong interest in addressing drug

1 pricing, we're introducing two new ideas for you to
2 consider in Part D. One is relatively narrow in scope,
3 aimed at limiting cost sharing on specialty tiers. And the
4 second is a much broader structural change to the benefit
5 that builds on the Commission's 2016 recommendations.

6 In this presentation, we'll give you background
7 about spending for specialty-tier drugs in Part D and
8 describe beneficiary cost sharing for those medicines.
9 Then Shinobu and I will introduce two distinct approaches
10 that try to address the affordability of specialty drugs.
11 We're looking for your feedback on whether to pursue these
12 ideas further, and we plan to put this material into a
13 chapter in the June report to the Congress.

14 Specialty drugs are used for conditions such as
15 cancer, hepatitis C, HIV, rheumatoid arthritis, and
16 multiple sclerosis. Some of them are self-injectable
17 biologics, but the term "specialty drug" also includes oral
18 and inhalable drugs. Patients who take specialty drugs
19 often require closer clinical management, and the drugs
20 tend to have much higher prices.

21 For Part D, CMS allows plans to put drugs on a
22 specialty tier of their formulary if the drug's average

1 price at the pharmacy is \$670 per month or more. Since
2 Part D began, spending for drugs on specialty tiers has
3 grown from about \$3 billion in 2007 to \$37 billion in 2017.
4 That is shown by the blue bars. The red line shows that in
5 2017, specialty tier drugs made up about a quarter of Part
6 D gross spending. However, according to the Congressional
7 Budget Office, spending for specialty drugs makes up an
8 even higher share on a net-of-rebate basis. On the right,
9 you can see examples of specialty tier drugs with the
10 largest Part D spending in 2017. Average prices at the
11 pharmacy for these drugs range between about \$1,500 to
12 \$31,000 per claim.

13 Now let's consider cost sharing for specialty
14 tier drugs. Here we'll use the example of a beneficiary
15 who does not receive Medicare's low-income subsidy. She
16 uses a tumor necrosis factor inhibitor to treat rheumatoid
17 arthritis, and the full price of her drug at the pharmacy
18 before rebates runs about \$5,400 for a 30-day supply.

19 Her cost sharing is front-loaded in the year
20 because plans can charge 25 percent to 33 percent
21 coinsurance initially for each specialty tier prescription
22 and then 25 percent for brand-name drugs in the coverage

1 gap. Once this patient hits the catastrophic phase, she
2 pays 5 percent for each prescription on an open-ended
3 basis. The price of her drug is high enough that she
4 reaches the catastrophic phase early in the year. So even
5 though her out-of-pocket costs seems like a lot, over the
6 full year she pays an average coinsurance rate of about 7
7 percent.

8 For some but not all specialty tier drugs, plan
9 sponsors negotiate rebates from manufacturers. However,
10 beneficiaries pay coinsurance on the undiscounted price.
11 So early in the year when this patient pays 25 to 33
12 percent coinsurance, she's effectively paying a higher
13 percentage of the net-of-rebate basis.

14 How does cost sharing affect patients' use of
15 specialty drugs? Out-of-pocket costs matter, but other
16 factors also affect the decision to use medicines. Some
17 specialty drugs treat conditions that are life-threatening
18 or progressively disabling, and filling those prescriptions
19 may be a very different decision from ones for other
20 diseases. There's not a deep literature on cost-related
21 nonadherence for specialty drugs, especially in the
22 Medicare population. But, still, some literature suggests

1 an association between higher out-of-pocket spending and
2 greater likelihood of a patient not initiating therapy or
3 abandoning a prescription at the pharmacy.

4 There are multiple goals that we try to achieve
5 for the Part D program. As use of specialty tier drugs has
6 grown, one policy goal that's become more apparent is to
7 provide coverage that reduces some of the financial
8 barriers to filling appropriate prescriptions. However,
9 within the context of Part D, we would like to do this in a
10 way that still provides strong incentives for plan sponsors
11 to manage their enrollees' spending. And since Part D
12 relies on private plans to negotiate drug prices, if we
13 take steps to make specialty drugs more affordable to
14 beneficiaries, we want to do that in a way that leaves
15 tension on drug manufacturers with respect to their pricing
16 decisions. If manufacturers choose to raise prices, that
17 should have implications for plans' formulary decisions.
18 Finally, we want to retain or strengthen Part D's original
19 approach of a competitive system that keeps downward
20 pressure on enrollee premiums and Medicare program
21 spending.

22 One approach that certain employers and states

1 have taken is to limit the maximum amount a plan may charge
2 in cost sharing for each prescription. For example, if
3 policymakers set a \$200 per prescription maximum in Part D,
4 the beneficiary would pay the greater of 25 to 33 percent
5 cost sharing or \$200 for a 30-day supply. The out-of-
6 pocket limit could be indexed over time and adjusted for
7 the number of days' supply.

8 In 2017, about 400,000 Part D enrollees would
9 have had lower cost sharing under such a policy, and on
10 average the amount of cost sharing they paid would have
11 been about two-thirds lower. If this more generous
12 coverage had been financed through higher premiums paid by
13 all Part D enrollees, premiums and Medicare program
14 spending would have increased. Alternatively, plan
15 sponsors could be required to adjust their cost sharing to
16 pay for the new benefit -- through higher deductibles,
17 copayments, and coinsurance on non-specialty tiers.

18 In your mailing materials, we give you a sense of
19 the magnitude of such a policy's effect in 2017, but we
20 also note that it is not a formal cost estimate. To build
21 a cost estimate, CBO or others would need to think through
22 the likely behavioral effects of the policy. Also, the

1 drug development pipeline is full of new specialty
2 treatments, so more enrollees will likely take specialty
3 drugs in the future. Also, here we have not applied the
4 per prescription limit to LIS enrollees, but that may also
5 be a policy option.

6 There are advantages and disadvantages to using a
7 per prescription cap. The policy would provide more
8 generous coverage to beneficiaries who take specialty drugs
9 and pay cost-sharing amounts that can be burdensome on a
10 limited income, especially when lower-cost therapies are
11 less effective for their condition. A per prescription cap
12 would even out their cost sharing over the year, which may
13 affect their decisions about initiating therapy and not
14 abandoning prescriptions at the pharmacy.

15 While capped cost sharing may encourage more use
16 of appropriate treatments, it may also encourage greater
17 use of drugs that are not as appropriate or effective.
18 When there are competing therapies available, a dollar
19 limit on cost sharing may make it more difficult for plan
20 sponsors to encourage beneficiaries to use a preferred drug
21 and negotiate for rebates. All enrollees in Part D would
22 pay either higher premiums or higher cost sharing for non-

1 specialty drugs to finance the more generous benefit, and
2 taxpayers would face higher Medicare program spending. And
3 with capped patient cost sharing, manufacturers may find it
4 easier to increase prices or launch high because prices and
5 price growth would be less obvious to beneficiaries.

6 The first option focuses narrowly on cost sharing
7 for each prescription. However, in a minute Shinobu will
8 describe a broader approach that restructures the benefit
9 and includes an annual limit on out-of-pocket spending.
10 Both of these ideas help with the affordability of
11 specialty tier drugs, but we think of the two approaches as
12 distinct because the per prescription limit doesn't address
13 some fundamental issues about the structure of Part D that
14 may be contributing to high launch prices and growth in
15 drug prices.

16 Today plan sponsors negotiate for rebates from
17 manufacturers in certain drug classes that have competing
18 therapies. The fact that Part D plans attract enrollees
19 through premium competition has meant that plan sponsors
20 have generally used rebates to help keep their premiums
21 low.

22 Over time, there have been changes in law that

1 have resulted in two different benefit structures -- one
2 for low-income subsidy enrollees and another for those
3 without the low-income subsidy. The coverage gap was only
4 phased out for non-LIS enrollees, so the underlying benefit
5 for LIS enrollees still has a coverage gap like the one
6 that existed at the start of Part D. Brand manufacturers
7 do not pay any discount for LIS enrollees, and plans are
8 not liable for any benefit spending in the coverage gap.
9 Instead, Medicare's low-income cost-sharing subsidy pays
10 for most everything in an LIS enrollee's coverage gap
11 except for their nominal copayments. In contrast, a non-
12 LIS enrollee has the manufacturers' discount in their
13 coverage gap.

14 If you look at both of these two benefit
15 structures, there are large portions -- the coverage gap
16 and the catastrophic phase -- where plans have low
17 liability for their enrollees' spending. Other sources of
18 financing cover the spending: brand discounts, LIS cost-
19 sharing subsidies, and reinsurance in the catastrophic
20 phase. Meanwhile, plans negotiate for rebates on
21 prescriptions filled across all of those phases, even when
22 the plan's liability is low.

1 We think that leads to misaligned incentives. In
2 some cases, plan sponsors may make decisions about which
3 drugs to put on their formularies that emphasize high-
4 rebate drugs. And certain rebates, combined with
5 Medicare's reinsurance in the catastrophic phase, may mean
6 that plan sponsors do not confront manufacturers' launch
7 prices and price increases as much as they would otherwise.

8 MS. SUZUKI: One unique feature of Part D is the
9 brand discounts paid by manufacturers that Rachel just
10 talked about. The discount rate is 70 percent today, and
11 that sounds like a substantial discount. But because the
12 discount only applies to a limited range of spending in the
13 coverage gap, below the out-of-pocket threshold, it mostly
14 affects non-specialty tier drugs rather than specialty tier
15 drugs with higher prices.

16 For example, in 2017, the coverage gap discount
17 totaled about \$5.8 billion. Over half of that amount was
18 for drugs in three classes: diabetic therapy, asthma/COPD
19 therapy, and anticoagulants. Most commonly used drugs in
20 these classes had prices that ranged from about \$480 to
21 \$580 per claim.

22 Drug classes that are typically placed on

1 specialty tiers -- like antivirals, cancer drugs, and
2 therapies for inflammatory conditions -- each accounted for
3 3 percent or less.

4 The second policy option would restructure the
5 Part D's benefit to achieve the goals Rachel outlined
6 earlier, including providing better formulary and pricing
7 incentives. This approach would retain parts of the
8 Commission's 2016 recommendations, but there are also
9 differences.

10 One notable difference is that under this option,
11 the coverage gap discount would be eliminated and replaced
12 with a cap discount that manufacturers would pay in the
13 catastrophic phase of the benefit.

14 There would also be a new catastrophic benefit,
15 which, as Rachel described earlier, is where most of the
16 costs of high-priced products occur. This option is
17 similar to the recent idea proposed by the American Action
18 Forum to change the Part D benefit, and I'll come back to
19 the details of the benefit structure under this option
20 shortly.

21 But the idea is that, under this policy option,
22 there would be: stronger incentives to use generics, an

1 increase in the affordability of high-priced products for
2 enrollees and Medicare; stronger incentives for plans to
3 manage high spending; and it may also provide disincentives
4 for manufacturers to set high launch prices or increase
5 prices as rapidly as they have in recent years.

6 Rachel also talked about how there is now a
7 different benefit structure for LIS and non-LIS
8 beneficiaries. And because plans have no benefit liability
9 for LIS enrollees during the coverage gap phase, they may
10 face worse incentives for LIS enrollees.

11 To simplify and remedy this misaligned incentive,
12 this option could also equalize the LIS and non-LIS
13 benefits.

14 Under the policy, risk corridors would remain,
15 and it would continue to protect plans from large losses,
16 at least initially.

17 The figure on the left shows the 2020 benefit
18 structure under current law, with the coverage gap discount
19 in black. The restructured benefit under the policy is
20 shown on the right.

21 Note that under the policy, plan liability would
22 fill in for what used to be paid by manufacturers in

1 coverage gap discounts. Under the policy, beneficiaries
2 would -- the benefit would cover a consistent 75 percent
3 between the deductible and the out-of-pocket threshold, and
4 it would be the same for brand-name and generic drugs.

5 Above the out-of-pocket threshold, shown as the
6 cross-hatched piece, is where policymakers would need to
7 decide how to finance the new catastrophic benefit.

8 Currently, enrollees pay 5 percent cost sharing.
9 Under the new benefit, policymakers could use a lower
10 coinsurance rate, select a dollar co-payment amount, or
11 eliminate cost sharing altogether as in our standing
12 recommendation from 2016.

13 Medicare's reinsurance would be reduced. It
14 could be 20 percent as in our standing recommendation or a
15 percent that's lower, or it could be eliminated. Any
16 reduction would be offset by an increase in the direct
17 subsidy so that the overall subsidy rate would remain at
18 74.5 percent.

19 The reduction in enrollee and Medicare's
20 reinsurance shares would be offset by some combination of
21 higher plan liability and the new cap discount. These are
22 the two key parameters, which I'll turn to next.

1 Striking the right balance between plan and
2 manufacturer liability will be crucial in providing better
3 plan incentives while restraining high price growth.

4 The figure shows the range of options. At the
5 extremes are where plans or manufacturers pay for all of
6 the costs in the catastrophic phase of the benefit, other
7 than the amounts paid by Medicare's reinsurance or enrollee
8 cost sharing.

9 As you move from the center to the left, you have
10 plan liability taking on a greater share. Less paid by
11 manufacturers means higher benefit costs and higher
12 enrollee premiums.

13 But because plans are taking on more insurance
14 risk, that provides them with stronger incentives to manage
15 spending.

16 Plans may also negotiate harder for larger
17 rebates, but this only works for therapies in competitive
18 classes. Plans would have limited ability to negotiate
19 rebates for unique therapies.

20 As you move to the right, manufacturers will pay
21 an increasing share in cap discount. More paid by
22 manufacturers means lower benefit costs and lower enrollee

1 premiums. But lower plan liability would also mean weaker
2 plan incentives to manage spending.

3 At the same time, there would be a guaranteed
4 discount, which would be valuable particularly for
5 therapies in classes with few or no competitors. Given
6 that the amount of discount increases proportionately with
7 prices of drugs that fall into the catastrophic phase of
8 the benefit, it may slow price growth. But that would
9 likely vary across manufacturers and likely also depend on
10 Medicare's market share of a given product.

11 The new cap discount would increase the incidence
12 of discounts on high-priced drugs and biologics.

13 This pie chart shows the cap discount simulated
14 using the 2017 claims data. And as you can see, the
15 incidence of the discount is very different from the
16 distribution that you saw with the coverage gap discount.

17 The cap discounts are more likely to apply to
18 high-priced drugs typically placed on specialty tiers and
19 less on more traditional drugs like diabetic therapy.

20 Many drugs that would be subject to the cap
21 discount would have price per claim in the thousands of
22 dollars to over \$30,000.

1 Four classes -- antineoplastics, antivirals,
2 anti-inflammatories, and therapies to treat multiple
3 sclerosis -- would account for more than 50 percent of the
4 discounts, up from about 12 percent under the coverage gap
5 discount.

6 Note that the incidence across therapies would be
7 different if prescriptions filled by LIS enrollees are not
8 included in the cap discount program.

9 There is another key benefit parameter that
10 policymakers would likely need to consider, and that is
11 where to set the out-of-pocket threshold.

12 As we discussed in your mailing material,
13 eliminating the coverage gap discount would result in some
14 individuals paying more to reach the out-of-pocket
15 threshold.

16 Policymakers could lower the out-of-pocket
17 threshold, but there are tradeoffs. An obvious benefit is
18 that it would reduce the cost for those enrollees affected
19 by the policy. It may also lower benefit and premium
20 costs, and this is somewhat counterintuitive, but it
21 happens when the benefit liability above the out-of-pocket
22 threshold is lower than 75 percent. That means as you

1 lower the out-of-pocket, that expands the benefit phase
2 with lower benefit liability. But this assumes no
3 behavioral change.

4 Certain behaviors could push up benefit and
5 premium cost, and these are the potential disadvantages.

6 Because enrollees would pay lower or no cost
7 sharing once they reach the out-of-pocket threshold, a
8 lower threshold could lead to an increase in use of both
9 clinically appropriate and inappropriate therapies.

10 The policy may also weaken plans' incentives to
11 manage high spending if their liability above the out-of-
12 pocket threshold is set too low.

13 So this slide summarizes at a very high level the
14 two policy options measure in achieving the program goals
15 laid out earlier.

16 Relative to the current benefit structure, both
17 policies would reduce financial barriers to use clinically
18 appropriate medications that are placed on specialty tiers.

19 But other goals, like addressing plans'
20 incentives to manage spending, manufacturers' pricing
21 decisions, and keeping downward pressure on program costs
22 and enrollee premiums, would only be addressed by the

1 option that restructured the benefit.

2 Another key difference relates to implementation.
3 We think that the per-prescription cap could be implemented
4 in a relatively short time frame, while restructuring the
5 benefit would be more complex, and would likely take years.

6 So we have introduced two new policy ideas today
7 to get your feedback and see if you would like to pursue
8 these ideas in the next cycle. We are also looking for
9 suggestions and guidance on any information that you think
10 would be helpful in thinking about these policy options.

11 DR. CROSSON: Thank you, Rachel and Shinobu. I
12 just want to compliment you on this work and particularly
13 in the chapter. I thought it was quite brilliant really,
14 and it also required me to read it three times because this
15 area we are talking about right now is extremely important
16 and also very complex. Solutions by their nature, it would
17 seem, are going to be complex as well. I think this
18 breakthrough thinking takes us into a whole new area, and I
19 appreciate that.

20 So we'll start with clarifying questions.
21 Jonathan.

22 DR. JAFFERY: Thanks, Jay, and I agree. This was

1 an incredible chapter, and I'm glad to hear I wasn't the
2 only one who had to read it multiple times.

3 I have two questions. Can you speak little bit,
4 explain a little bit more about how the risk corridors
5 would work to help protect the plans?

6 The other question is, Is there something about
7 or could you speak to the drugs that are in protected
8 classes and if things change there, how that may or may not
9 impact what you presented?

10 MS. SUZUKI: So under the policy, a lot more of
11 the spending is going to be paid under the direct subsidy
12 payments, which are the capitated payment, and that's the
13 amount that's in the risk corridor. So bigger amounts,
14 bigger share of the benefit spending would be inside the
15 risk corridor. So they would get protection for those
16 spending.

17 The protected classes, some of them are on
18 specialty tiers, like the cancer treatments. Those are
19 typically on specialty tiers. They would now, under the
20 policy, incur cap discount if you go with the second
21 option.

22 Under the first option, beneficiaries would get

1 protection on cost sharing.

2 DR. SCHMIDT: And just as context, some of those
3 oncology drugs are orals that have gone generic, but the
4 newer ones are not, obviously. If they don't have
5 competitors, generally there aren't rebates associated with
6 them. There's been a little bit of published work kind of
7 suggesting that the magnitude of rebates associated with
8 protected class drugs in general -- the number of drugs
9 that have rebates is small within the protected classes,
10 and the rebates are much lower than other classes.

11 DR. CROSSON: Questions? Bruce.

12 DR. PYENSON: Yeah. I give my compliments as
13 well. This was a wonderful chapter, and I really enjoyed
14 how you created -- presented the options.

15 I have a question about Slide 11. In particular,
16 when I first read this, I was scratching my head saying,
17 "What's that shaded region on the right?" and then realized
18 that's kind of the discussion for the next year on what
19 goes in there.

20 A question I have is the American Action Network
21 proposal is for a coinsurance approach, similar to what
22 exists now in catastrophic, where there is a flat

1 coinsurance. One piece is plan; another piece, government;
2 another piece, the patient.

3 Have you thought about a graded scale in that so
4 that the higher the price of the drug, the higher the
5 manufacturer contribution or a system where somehow there's
6 a stop-loss on the total patient spending that a
7 manufacturer might be responsible for? It could all be the
8 same dollars, but sort of moving it around in different
9 ways. I don't know if that's on the table for the next
10 year or things you've thought about.

11 MS. SUZUKI: I think those are things that you
12 could certainly think about.

13 In the example we presented today, we have taken
14 the approach of setting some cost-sharing approach, I guess
15 you mentioned. So it would be a fixed percent, but the
16 idea was that as you -- the higher the price of the drug at
17 the pharmacy, the larger the discount you would be liable
18 for. And it was a simpler approach than maybe what you
19 were contemplating, but I think various options could be
20 considered.

21 DR. CROSSON: Brian, Kathy, Amy. Okay, Brian.

22 DR. DeBUSK: First of all, thank you. The work

1 was incredible, insightful, and I really appreciate and
2 like the direction you're going. So the questions I'm
3 about to ask are in no way a criticism of the work. It's
4 genuine interest.

5 I too had some questions on Chart 11. Thank you
6 for the cross-hatched area. That threw me too when I was
7 looking at it because I wasn't sure where that money was
8 going to come from.

9 If I read the color version of that chart
10 correctly, though, I mean, we're basically exiting -- the
11 government and Medicare is exiting the reinsurance
12 business, or would there be a residual portion in that
13 cross-hatched area that would be provided, would be
14 Medicare money?

15 DR. SCHMIDT: I think we intended this as a
16 policy decision for you to discuss.

17 DR. DeBUSK: Oh. Well played.

18 [Laughter.]

19 DR. DeBUSK: That was in the cross-hatch. I was
20 looking. I was trying to figure out where the white, what
21 was whiter. Well, I can see where this is headed, then.

22 [Laughter.]

1 DR. DeBUSK: I would be interested in
2 understanding that. What portion would Medicare need to
3 remain in to not have some adverse effect on premiums?

4 But the other thing, since this is related to
5 that question, we all agree this 5 percent beneficiary
6 exposure in the catastrophic phase is too much. Is zero
7 too little? I mean, are there some unintended consequences
8 or some behavioral shifts that we could inadvertently
9 trigger if we truly remove the beneficiary from any
10 exposure?

11 DR. SCHMIDT: You see different points of view
12 strongly held on this very question, right? On the one
13 hand, you'll hear beneficiary advocates in particular argue
14 that by the time somebody has reached the catastrophic
15 phase of a benefit, they're in a treatment pattern.
16 They've paid a lot of money out of pocket, and anything
17 more would just be a penalty on those particular people for
18 unfortunately having this particular disease.

19 On the other hand, you hear others say that if
20 you relieve them of any cost sharing whatsoever, it makes
21 it relatively easier for manufacturers to raise prices
22 because it's not so obvious when those price increases

1 occur.

2 I'm not going to state my personal opinion. I'm
3 not sure that I have a strong one, but those are what you
4 hear out there.

5 DR. DeBUSK: So future iterations of the work
6 would address that.

7 The other question, knowing -- well, not knowing,
8 but speculating that the government will have some
9 component of reinsurance, even if it's 5 or 10 or 20
10 percent, that brings up the issue of DIR. Can you speak to
11 how the current misallocation of DIR could potentially
12 spill over into this program as well?

13 MS. SUZUKI: So I think under the restructured
14 benefit, if plans were liable for a consistent share
15 through the out-of-pocket threshold and some proportion
16 that's greater than their current 15 percent, I would think
17 the weighting based on what CMS is currently doing is on
18 gross spending. But that would be proportionately more
19 accurate reflection of their benefit liability compared to
20 current.

21 DR. DeBUSK: So the DIR bug would correct itself?

22 MS. SUZUKI: Between Medicare and plan sponsors,

1 the ratio would be better because right now what's
2 happening is in the coverage gap, there is very little
3 benefit liability for plans, but there are rebates to --
4 for some drugs, there are rebates, and you're using gross
5 spending above and below to allocate the dollar amounts to
6 plans and Medicare. And that leads to a larger share of
7 spending offset by DIR on the plan liability side rather
8 than the reinsurance side.

9 DR. DeBUSK: So you think that would be somewhat
10 self-correcting.

11 That last question is a "what if," but then I
12 promise I'm done.

13 Assuming the government retains some portion of
14 that reinsurance and assuming that we still have this DIR
15 issue to content with, is there some theoretical rebate
16 level -- 70 percent, 80 percent, 90 percent -- where they
17 could still beat the system by simply driving up the rebate
18 so high, counting on even a modest misallocation of DIR and
19 basically undoing what we're trying to do here today?

20 DR. SCHMIDT: I think you're giving us a math
21 problem as homework.

22 [Laughter.]

1 DR. SCHMIDT: I don't think that I can quite
2 answer that on the fly.

3 DR. CROSSON: Bruce, do you want to comment on
4 that question?

5 DR. PYENSON: Yeah. I think the devil is in the
6 detail there, but as I understand the plan, it would
7 maintain the federal share of total program cost. And
8 that's the share that gets used to split the IR between the
9 federal government and the plan. So that ratio now is
10 about a third government, two-thirds plan.

11 So if you have 100 percent rebate -- you can't
12 get higher -- well, I guess you could get higher than that,
13 but say 100 percent on the list price. The plan share of
14 that would be roughly two-thirds, 67 percent. If the
15 plan's liability is 70 percent or 75 percent, the plan
16 liability exceeds the retained rebate, and I think that's
17 the key to solving that.

18 DR. DeBUSK: That's the hole we have to close.

19 DR. PYENSON: Yeah. That's why flipping the 15-
20 85 to 80-20 or something would close that.

21 DR. DeBUSK: So what you're saying is there is a
22 theoretical ratio that we could achieve that you couldn't

1 defeat the system with a rebate?

2 DR. PYENSON: Correct.

3 DR. DeBUSK: Thanks.

4 DR. PYENSON: Now, you could actually design a
5 Part D plan, for example, that had no generics, it only had
6 drugs that had rebates, and under the current world, that
7 would be very profitable for the Part D plan. I think
8 under this proposal, it wouldn't be.

9 DR. CROSSON: Okay. Let me see if I've got this.
10 I got Kathy, Amy, Warner, and Pat. Have I got that right?
11 On this point, Amy.

12 MS. BRICKER: Yeah.

13 DR. CROSSON: Yeah.

14 DR. SCHMIDT: That's not actually possible.
15 There's not a formulary that you could create that today
16 would just generate rebates. I just want to be clear.

17 And we're talking about specialty, and with
18 respect to specialty as a percentage of drugs, very few
19 actually offer rebates. So I just want to caution.
20 There's a lot of misconception I think generally in this
21 space around what's available in the market.

22 DR. CROSSON: Okay. Kathy.

1 MS. BUTO: Yeah. I had two questions. One was I
2 recall from the reading materials that about half of -- at
3 least the way the proposal was laid out -- beneficiaries
4 who now reach the out-of-pocket threshold would not under
5 the restructured proposal, so that's question one. I'm
6 sure we could set the threshold in different places, and
7 that would obviously affect.

8 The second question was about whether the cap
9 discount approach would actually stimulate higher launch
10 prices. I'm assuming it would. Obviously, there are
11 tools, including cost sharing and greater beneficiary
12 liability, that would work against that, but I'd be curious
13 to find out from you what you've done to look at that, both
14 of those issues.

15 MS. SUZUKI: So on the latter question about
16 manufacturer launch prices, I think it's definitely
17 possible that some manufacturers, knowing that they're
18 liable for a fixed share of their cost -- or their price as
19 a discount, that may affect their pricing decisions. But
20 what we think is that may depend on their market power,
21 market share in the Medicare market. They do have
22 commercial to deal with. So we think it probably would

1 vary by manufacturer and by product.

2 And another thing, maybe for some very high-
3 priced product, there may be PR issues to consider. If
4 they raise a price to completely offset or more than offset
5 the discount, that may get noticed.

6 MS. BUTO: What about the number of beneficiaries
7 who don't reach the cap? Your assumptions about that?

8 DR. SCHMIDT: I'm not recalling exactly, but I
9 think the answer that you proposed to adjust the out-of-
10 pocket threshold would deal with the numbers involved. I
11 mean, there is actually an increase, a bump up in the
12 current-law out-of-pocket threshold, so you may want to
13 consider that, anyway.

14 DR. CROSSON: Okay. Amy.

15 Dana, on this point or what?

16 DR. SAFRAN: In the queue.

17 DR. CROSSON: Okay. Amy, you're up.

18 MS. BRICKER: This chapter was really amazing
19 work, and I just want to commend you both for putting it
20 together in a way that I think is consumable, even though
21 it is quite complex.

22 Just some clarifying questions, if I could. Page

1 13, you referenced that rebates grew 19 percent.
2 Specifically in specialty, or was that just a general
3 number based on --

4 DR. SCHMIDT: That was a general number of all
5 DIR.

6 MS. BRICKER: Okay. So I think that's important
7 because, again, to the point I was making just briefly a
8 moment ago, while in pockets, you see tremendous value
9 coming from manufacturers on branded product, in specialty
10 that's not really the case. So I just want to provide that
11 context.

12 Is there a clear line, a bright line, because
13 drugs that are used more predominantly in the list
14 population versus non? There was some reference. Do you
15 have additional context on that?

16 MS. SUZUKI: So we had this in the March chapter.
17 There was more use of antidepressant, antipsychotics, that
18 sort of drug, by LIS population compared to non-LIS
19 population, more diabetic therapies among LIS population.

20 For non-LIS population, we saw a lot of multiple
21 sclerosis, inflammatory conditions in cancer drugs.

22 MS. BRICKER: So more specialty product

1 utilization by non-LIS?

2 MS. SUZUKI: Right.

3 MS. BRICKER: So that might get to the point,
4 Brian, you were making. Is zero too low? In the LIS
5 population, it is zero, right? And we are not seeing a
6 disproportionate amount of people over-utilizing. If the
7 theory is zero is going to result in over-utilization, you
8 might need to maybe think more about why is that. Is it
9 demographic? What other contributing factors result in the
10 fact that we're seeing more specialty utilization, that
11 those actually have a cost-sharing amount? I think that's
12 interesting.

13 Foundation. So we know in the Medicare
14 population, copay coupons are not permitted. Have we been
15 able to get at any data on foundation dollars or charitable
16 giving that's applied to this Medicare population? Because
17 we do know that those dollars are in play.

18 DR. SCHMIDT: I haven't seen data along those
19 lines other than some of the court cases that have been
20 raised most recently against some of the foundations.

21 MS. BRICKER: Okay. I'll save that one, another
22 comment on that, for Round 2.

1 And just one other. The cap, the \$200 cap that's
2 proposed, did we think about -- you raised the issue it
3 could hamper the ability for a plan sponsor to manage the
4 formulary, you know, preferred agents, non. So did we
5 contemplate a non-preferred, out-of-pocket structure, maybe
6 where the \$200 is applicable to preferred agents but
7 there's some other cost share for non-preferred, or it's,
8 you know, the traditional cost sharing?

9 DR. SCHMIDT: For this paper we hadn't come up
10 with that idea but that's, you know, potentially a good one
11 we could explore.

12 MS. BRICKER: Okay.

13 DR. CROSSON: Okay. I have Warner, Pat, and
14 Dana.

15 MR. THOMAS: I've just got a couple of quick
16 questions. I think part of this, building off of Amy's
17 question, on Slide 3 where we talk about the gross Part D
18 spending, the question I had was what does this number look
19 like net of rebates? And it sounds like, from Amy's
20 comment, that maybe rebates are immaterial or not
21 significant. Do we know what this number looks like net of
22 rebates?

1 DR. SCHMIDT: There was a CBO study that just
2 came out that was looking at specialty drug spending net of
3 rebates, and that's slightly different from what we're
4 saying here. These are drugs that aren't specialty tiers
5 and there may be some specialty drugs that are not on
6 specialty tiers. And I'm not remembering the magnitude of
7 that spending but it's not much lower than this. I think
8 it was \$25 billion or so in 2015. We don't have quite
9 comparable years. They have to do a lot of empirical work
10 to come up with the estimate.

11 But there's been also a Milliman study, I
12 believe, that was looking at the magnitude of rebates for a
13 sample of plans that volunteered their information to
14 Milliman on what specialty tier rebates look like, and I
15 think it was something like 14, 17 percent, somewhere along
16 those lines.

17 MR. THOMAS: Okay.

18 MS. BRICKER: On that point, just for
19 clarification, where those dollars come from are like hep
20 C. So when you have a very high list price competitive
21 market, tremendous rebate values there. So we just will
22 get into traps if you use average, because it's

1 predominantly that class, PCSK 9's, that you'll see high
2 rebates, but overall, in specialty drug classes, you don't
3 see rebates.

4 MR. THOMAS: So it might be better to try to
5 understand the -- I mean, we have the specific drugs so it
6 might be better to understand the specific drugs kind of
7 net of rebates, or at least be able to note the drug
8 classes that there are rebates in, and I guess ones that
9 are not, right? Because I guess there are some that have
10 rebates, some that do not have any.

11 MS. BRICKER: Right.

12 MR. THOMAS: Okay.

13 And then -- I think I know the answer to this
14 question but I'm going to ask it anyway -- do we have any
15 idea of the margins associated with any of these specialty
16 drugs, from the manufacturer?

17 DR. SCHMIDT: High, I would imagine.

18 MR. THOMAS: Like bigger than a breadbox? Like
19 really high? Really high. Okay. Because I think that's
20 another -- anyway, I'll get that in Round 2. So we just
21 know it's high but we don't really have a range or have any
22 sort of -- okay. Thanks.

1 DR. CROSSON: Pat.

2 DR. WANG: Can you clarify, I guess maybe by
3 using Slide 11, what the thinking around the cap proposal
4 does to LIS?

5 MS. SUZUKI: So for the LIS population, I mean,
6 it depends on the parameter, but generally speaking what
7 Medicare pays would change. Medicare currently pays all of
8 the 5 percent cost-sharing from LIS enrollees, and to the
9 extent that you eliminate or just lower the cost-sharing
10 for beneficiaries the low-income cost-sharing subsidy would
11 go down.

12 For the rest of the benefit it is the same, so
13 the reinsurance goes down similar to what happens to the
14 non-LIS beneficiaries, and the benefit cost is somewhere
15 between whatever reinsurance plus plan subsidy is, plan
16 liability is, minus whatever cap discount is.

17 DR. WANG: This is really complicated so let me
18 just try to -- and forgive me if I'm trying to oversimplify
19 this, because I need it to be simple to understand it.

20 So if you look at the left side, where the
21 manufacturer discount is, which I didn't know that the
22 manufacturer discount was not available for LIS

1 beneficiaries, so that's really interesting. So that 70
2 percent, which, in the non-LIS converts to premium to the
3 plan, right. What happens with LIS, because that portion
4 is now being picked up by CMS. Does that also get
5 converted into premium to the plan, to manage benefits?

6 MS. SUZUKI: So that was one of the ideas we
7 proposed, that currently LIS has a different benefit
8 structure and essentially 100 percent minus the nominal co-
9 pays for LIS is paid by low-income cost-sharing subsidy.
10 The idea was to equalize those two benefits, so that plans
11 would have 75 liability for all of their enrollees in the
12 gap phase.

13 DR. WANG: Okay. So LIS, non-LIS is all
14 converted to premium.

15 MS. SUZUKI: Mm-hmm.

16 DR. WANG: Okay. Fine.

17 So on Slide 9, it says that in 2017 coverage gap
18 discounts totaled about \$5.8 billion. So for non-LIS, like
19 just conceptually that's getting converted into premium to
20 the plan. I was wondering what the equivalent number is
21 that the low-income subsidy has been paying.

22 DR. SCHMIDT: We haven't calculated it but we can

1 get that for you.

2 DR. WANG: Okay. I'm just trying to figure out
3 what's getting converted into premium in terms of the
4 insurance risk.

5 The other thing I'm just a little bit confused
6 about is -- so on Slide 9, it says that the coverage gap
7 discounts were concentrated among non-specialty tier drugs,
8 and then on Slide 13 it says that in the cap discount the
9 discounts would apply to specialty drugs. So what's the
10 implication of that? I guess -- and I'm just thinking
11 aloud -- the implication is that what is today covered by
12 coverage gap turns into insurance risks to the plans and
13 then the special drugs are what gets discounted in the
14 reinsurance phase?

15 I see. Okay. Thank you.

16 DR. CROSSON: Okay. Dana.

17 DR. SAFRAN: Thanks for this work. Unlike
18 others, even with rereading I'm still trying to understand
19 this. And I guess my question might be incredibly basic,
20 but the question is, if you think from a behavioral
21 economics perspective, which I think is something you're
22 trying to do, in Slides 11 and 12 it brought this up for

1 me. What are the changes that we could make that would
2 have plans have a stronger motivation to keep the overall
3 price and use of, or inappropriate use of medications down?
4 You know, so to sort of have plans rowing in the same
5 direction as the Medicare program and as beneficiaries, in
6 terms of really being a champion for keeping inappropriate
7 use and to minimum -- and costs to a minimum.

8 Like what are the changes -- and maybe they're
9 the ones that you are proposing -- I just want to be able
10 to think about it through a behavioral economics lens of
11 like -- you know, because I can see where, in Slide 11,
12 with the way that the 70 percent works right now, it kind
13 of removes an incentive from the plan to be concerned about
14 the price. And so I can see that by moving to where you
15 are going on the right side of that, maybe that's part of
16 what's in your mind. I just hope you understand my
17 question. I'm trying to understand how you think about
18 that.

19 DR. SCHMIDT: So I think the more that you unify
20 the interest of -- the more insurance risk that you're
21 putting on the plan you're aligning the interests of the
22 Medicare program, which has to pay for that risk, and the

1 plan sponsor. I think probably the plan sponsors would say
2 "but you also need to give us the tools to manage." So you
3 can incentive, lots and lots of incentive, but if it's, you
4 know, very restrictive formularies allowed, or, you know,
5 tools that aren't available to them that they use in the
6 commercial markets then they're going to say "well, we have
7 incentive but not the tools to do so." So it's a
8 combination of trying to get that right.

9 DR. CROSSON: Jon.

10 DR. PERLIN: Well, let me thank you as well.
11 This is a great exposition of an incredibly complex area.
12 Whenever I find myself in an area that's so complex I try
13 to get back to first principles. And so this really
14 follows on from Dana's, but even goes back a step further.

15 As sort of a novice in this area, the rebates,
16 without question, obfuscate the transparency, transparency
17 of cost and pricing, and they distort the sensitivities of
18 the different actors in the equation, really, to Dana's
19 point, in terms of sensitivities of the prescriber, the
20 patient, and the plan, in terms of your ultimate alignment.

21 So my question is this, is that if we get back to
22 first principles, if rebates weren't a part of the equation

1 what would the impact be on the proposals you make, or, in
2 fact, would you be thinking of a different set of proposals
3 in absence of those? Thanks.

4 DR. SCHMIDT: I think we'd probably be getting
5 somewhere similar. The weird structure of Part D, I think,
6 is just developed because of the budgetary need to keep the
7 program within a certain, you know, cost estimate, frankly,
8 and so it had this coverage gap, and then we saw that that
9 was creating issues for beneficiary adherence, potentially.

10 And so there was a political pressure to fill in
11 that coverage gap over time, and the way they financed --
12 the policymakers chose to finance it was with this
13 manufacturer discounts for the non-LIS enrollees. And then
14 we've seen, as rebates have grown, that there has been this
15 very strange incentive now for, in some cases, not all, to
16 put higher-priced, high-rebate drugs on formularies. So
17 that's kind of a synopsis of the situation of where we are
18 today. So the current structure has poor incentives, that
19 we argue, in terms of formulary decision-making.

20 But if you were creating the Part D benefit anew,
21 you know, you'd probably want it to look like commercial
22 insurance, which is not so different from what you see on

1 the right-hand side of this slide here. It's a relatively
2 simple benefit, and where you put an attachment point for
3 reinsurance, you know, might be debatable. The out-of-
4 pocket cap might be debatable. But I don't think that it
5 would be radically different from what we're proposing.

6 DR. CROSSON: Yeah, Paul.

7 DR. PAUL GINSBURG: I'm glad you mentioned,
8 Rachel, the commercial structure, because that's something
9 that would probably be useful to include in a discussion,
10 saying that this is not something we just, the crazy
11 Commission, made up. This has a reality sense because this
12 is similar to what typical commercial structures are.

13 DR. CROSSON: Bruce.

14 MR. PYENSON: In our January reading material I
15 think there was an article from the Wall Street Journal
16 that talked about the risk corridors that are retrospective
17 protection on plans. I'm not going to ask you if you've
18 investigated that in this context, but I wonder if it would
19 make sense to look at that process while we're looking at
20 these alternatives. Your thoughts on -- does that make
21 sense to do that in this context?

22 MS. SUZUKI: I think under the policy we think

1 there is less ability to benefit from higher rebates that
2 are not in the bids. I think to the extent the plans now
3 are liable for a much larger share of the benefit spending
4 and there is pressure for premium competition, we think
5 that under the policy there would be less ability for plans
6 to gain from the risk corridor setup.

7 DR. CROSSON: I have one question. In the cross-
8 hatched area, you know, where you're looking at the
9 division between the financial responsibility of the
10 manufacturer and the plan, did I hear you say, Rachel,
11 because now I can't remember whether I heard right or not,
12 that one notion would be that that percentage division
13 would increase based on the cost of the drug. In other
14 words, the manufacturer's liability as a percentage of that
15 cross-hatched section essentially would go up,
16 asymptotically as the price of the drug went up. Is that
17 what you said?

18 DR. SCHMIDT: I think that was Bruce's idea.

19 DR. CROSSON: Was that Bruce's -- oh, I'm sorry.
20 Okay. I get the two of you confused.

21 [Laughter.]

22 DR. CROSSON: So if that were the design it would

1 seem to me that that would be an additional disincentive
2 for the manufacturer, you know, to keep -- obviously you're
3 dealing with an asymptotic situation, but to keep the
4 manufacturer from continuing to increase the price of the
5 drug to try to deal with the discount in the catastrophic
6 cap -- the catastrophic phase.

7 Okay. So we're going to go on to the discussion
8 now. We've got Bruce and Amy who are going to lead the
9 discussion, and then what I'd like to do is ask that we
10 direct our comments to the two options that are on the
11 table -- support, not support, I could support if it were
12 done this way or that way -- that sort of thing, so Rachel
13 and Shinobu can go off with some sense of the Commission's
14 intent.

15 Bruce.

16 MR. PYENSON: Well, thank you very much. As I
17 was thinking about the chapter, going back to fundamentals,
18 as Jonathan mentioned, that the structure of Part D creates
19 this moral hazard that is kind of Insurance 101, that an
20 insurance company, you're taught as a young actuary that
21 there's a reason why you don't sell insurance for a house
22 that's already on fire and there's also a reason why you

1 don't sell life insurance to someone who might have an
2 interest in someone dying.

3 But it strikes me as a very similar analogy to
4 what we've gone through with skilled nursing facilities,
5 where although there is a bundled payment, in a case rate
6 for SNF, you know, or perhaps for home health, different
7 types of reimbursement are much more profitable than
8 others, different types of patients. So, for example,
9 patients who are getting physical rehab in a SNF are much
10 more profitable than patients who need intensive medical
11 care. And we've tried to address that in the work we've
12 done on PAC.

13 I think this is a very analogous situation when
14 you boil it down. In simplicity, there's a lot of
15 different -- there's a maze of how the money flows, but
16 fundamentally it's the same kind of thing that we see over
17 and over again, that we try to address in the work of the
18 Commission, where somehow incentives are created to favor
19 more of the more profitable services and less of the less
20 profitable. This is slightly more complicated because of
21 the structure of Part D but fundamentally the same.

22 So I see this as very much in line with the other

1 work that the Commission has done, and for very similar
2 reasons, despite its complexity. So I am really thrilled
3 we are going in this direction.

4 As early as the end of next week we might get the
5 final rule on the point-of-sale rebates, or if not next
6 week, sometime, but I agree with, Rachel, your comment that
7 that rule would perhaps complement, but would certainly not
8 replace the fundamental changes that we're seeking here.
9 So I'm thrilled that you have set a clear agenda for the
10 next year, maybe more, of MedPAC activity, and I think this
11 could be an area where we actually succeed in inducing
12 deflation into health care spending. So I want to thank
13 you, and I really like Slide 11. Thank you.

14 DR. CROSSON: Thank you, Bruce. Amy.

15 MS. BRICKER: This is my last opportunity, so if
16 you'll bear with me, I've got a couple additional things
17 I'll add on her just because.

18 On behalf of Express Scripts plan sponsors, last
19 year we delivered a negative trend for Medicare. So
20 despite what you might read or believe, there actually are
21 plans and in reality we see plans that deliver negative
22 trends. That's not to say that government had a negative

1 trend, but those that are managing the benefit did. So
2 there is hope.

3 The theme of getting back to basics, I think
4 we've got to ensure a few things with respect to the
5 ability to manage the benefit. First and foremost,
6 formulary. I know in 2016 we made recommendations around
7 protected classes. That's still continuing to bite
8 specifically within specialty classification and cancer
9 therapy. So, you know, this is a class that is growing.
10 There are tremendous advances in medicine, but because the
11 class is protected, we do not see rebates here, and we
12 continue to see list prices.

13 There is some conversation that rebates are the
14 result of -- I'm sorry, list price increases are the result
15 of rebates, and that's a really good example of list prices
16 continuing to inflate and there are no rebates. So while
17 on the surface protected classes say, well, you know, those
18 should be available to beneficiaries -- and I don't
19 disagree that they should be available in part where it
20 makes sense clinically -- having that protected class
21 actually causes prices to inflate without a governor to get
22 that back-end discount from a manufacturer.

1 Having the ability to exclude a product at launch
2 is the single biggest tool that a commercial plan has and
3 manufacturers fear. So you're right, where there are drugs
4 that don't have competition, you have very little leverage.
5 You absolutely can create leverage with the threat of
6 excluding that launch. This is not unique to just U.S.
7 commercial. This is what European nations do that get
8 manufacturers to the table. So offering plans the ability
9 to do that will go a very long way. It's just a really
10 nice stick in the event you're not able to get there
11 otherwise.

12 Having that cap -- I do love the cap, the idea of
13 the cap. I hate the idea of a coinsurance for
14 beneficiaries because, you know, in the material we talk
15 about, well, if we have this coinsurance and it's really
16 hard for beneficiaries, that will put pressure on
17 manufacturers. It doesn't. A senior, one voice, you know,
18 ten voices don't actually influence list prices. You can
19 get a headline in the Wall Street Journal. You can, you
20 know, hear about these stories in pockets. But it does not
21 impact the decisions of a manufacturer. So I like the idea
22 of capping the out-of-pocket for beneficiaries and ensuring

1 that the plans are advocating on their behalf and PBMs are
2 advocating on their behalf, but we shouldn't put that on
3 seniors in this country.

4 So what is the price? That is a really good
5 debate. I think personally \$200 is a lot of money, and so
6 if you're faced with, you know, these disease states that
7 require very expensive products, I think that's a
8 tremendous amount of money to ask someone to pay. So I
9 think we should debate what is the right number. But I am
10 in favor of a cap. So that was formulary and benefit
11 design.

12 Network is also really critical. So in specialty
13 pharmacy, just like in traditional pharmacy, if you are any
14 willing provider, you can dispense the product. We talk
15 about in the paper -- they talk about in the paper some of
16 the clinical attributes that you'll see as outcomes. What
17 is the adherence of a specialty patient? Is it cost? Are
18 there other factors that are contributing to clinical
19 outcomes?

20 What specialty pharmacies can do are very
21 different in their ability to manage a patient than a
22 traditional retail pharmacy. So if you actually have a

1 cancer diagnosis, you don't want -- I promise you, you
2 don't want your chemotherapy dispensed by your community
3 pharmacy. You want the specialist pharmacist who all they
4 do all day long is dispense chemotherapy to be your
5 advocate in this space. It's less about on the surface
6 narrowing access. It's about providing the best care for
7 those beneficiaries. And so I would argue that there
8 should be ability for us to look at outcomes at the
9 pharmacy level and allow plans to narrow that network of
10 pharmacies so that they can then get the best discounts, of
11 course, but also the best care for their patients.

12 And, thirdly, they have the best access and
13 infrastructure for foundation dollars. So one of the
14 things that I asked in Round 1, I don't know, in fact, that
15 Medicare beneficiaries are subject to the extent we believe
16 to the out-of-pocket. I think there's an opportunity here
17 to explore the dollars that pharmacy manufacturer-backed
18 foundations that at the point of sale are covering much of
19 the out-of-pocket. So if there's an ability to explore
20 that, I'm happy to connect you with Accredo. I think
21 that's also something for us to just consider as a third
22 rail there.

1 We should consider value-based contracts as part
2 of this. So, again, commercial market, and I spoke about
3 it yesterday, allow the plan to work with the manufacturer
4 to develop programs that, if their drug does not work,
5 there absolutely is some, you know, recourse that's
6 available to the plan that helps the beneficiary, that
7 helps the plan, that helps all parties and aligns the right
8 incentives. So this is already complex, but, again,
9 thinking about how you cannot just play whack-a-mole here,
10 but look at the specialty benefit in total will, I think,
11 drive some real savings for the plan.

12 Lastly, so I mentioned it, but I'll restate. So
13 rebates are really hard to come by in this space.
14 Protected classes, of course, are a part of that. The
15 other is competition is really tough here. We still have
16 not seen in the traditional pharmacy benefit side
17 biosimilars. And we don't have a robust generic pipeline
18 or a biosimilar pipeline, and we all know too well the
19 success of the originating manufacturer to keep competition
20 out. So I don't know that you're going to see, you know,
21 in the near future this influx of rebates and discounts in
22 this space.

1 So what we do know is that the pipeline is rich
2 with really, really, really expensive products. Gene
3 therapies are here. They are million-dollar-plus products.
4 And so we really need to think about how we can get the
5 manufacturers' skin in the game, and I think what you've
6 suggested here with the restructure is exactly where I
7 think we'll get the best outcome associated with balancing
8 of dollars from manufacturers. I think it's brilliant. I
9 love it. I think that it aligns all of the right
10 incentives. It is complicated, though.

11 So kudos to both of you. I think this is -- I
12 think it's great, and I'm enthusiastic about the direction.
13 So thanks.

14 DR. CROSSON: Thank you very much, Amy.

15 Further discussion on the options before us?
16 Kathy, Brian, Paul, Warner, Pat.

17 MS. BUTO: So I just want to add my enthusiastic
18 praise to Rachel and Shinobu. I was blown away by this
19 work. Then I stopped and said, you know, if we -- as you
20 said, Rachel, if we had been designing the benefit in a
21 rational way without budget constraints, this is more or
22 less the way we would have designed it. I think the

1 difficulty we're going to have or Medicare will have in
2 moving to something like this is that people are now
3 entrenched in the current very bizarre structure that's
4 been created. And so I think plans, beneficiaries, and
5 manufacturers will all find something to hate about this
6 approach.

7 Plans -- I think Pat touched on it -- face quite
8 a bit of unknown, and it really depends on the specific
9 parameters, additional risk. They were sort of more or
10 less off the hook during the coverage gap and then much
11 lower liability in the catastrophic phase.

12 Manufacturers have gotten used to the coverage
13 gap, the discounts that are given there, and then being
14 able to have beneficiaries quickly move to the catastrophic
15 phase.

16 Beneficiaries are going to move, in my view --
17 under almost any scenario, fewer of them are going to reach
18 the out-of-pocket threshold, so they'll have more cost
19 sharing. It might be lower, but I don't think we know yet.

20 So I think as much as I like this, I think it's
21 daunting moving from the current system.

22 I have to say one reason I really prefer this

1 approach of really a radical redesign of Part D and the
2 structure of the benefit is that it does rely more on
3 getting the incentives right in the whole drug benefit as
4 opposed to trying to have the government set prices.
5 Having been in the government regulator role, I just don't
6 think the government does that very well. And so if we can
7 really focus on getting the incentives right for this
8 benefit, I think we'll have advanced a much better approach
9 even than binding arbitration, quite frankly. I know we
10 love it, but reference pricing, binding arbitration, these
11 are all ways -- where you go when you don't have other
12 options, quite frankly.

13 So what I'd like to see -- I would, first of all,
14 say let's advance this approach and further develop it.
15 What I would like to see us dive down a little more deeply
16 on is the issue how to reach the right balance amongst
17 greater beneficiary liability during the non-catastrophic
18 part of the benefit and then plan risk in particular and
19 how those -- and then, of course, Medicare, the government,
20 how do you balance those out? So I really -- I think
21 that's where the work is. I think the way you've
22 structured it, the incentives look like they're really

1 going in the right direction.

2 Just a word on the cost cap. I don't support
3 that approach. I think you laid it out pretty well. It is
4 beneficial to the beneficiary, but it does really nothing
5 about pricing, and it actually is bad for plans. I think
6 it really increases the risk without giving plans
7 additional tools to manage the costs. So I think -- I
8 don't favor it. I think it's not a good approach. It
9 appeals on an emotional level to want to have individuals
10 not have to face high prices. And so we ought to think
11 more about within the structure that you've laid out, are
12 there other ways we can put more downward pressure on
13 patient cost sharing or what patients have to pay? But I
14 would try to do it within the context of this restructured
15 incentive that you've laid out rather than putting a flat
16 cap on cost sharing.

17 And I really agree with Amy; I think the value-
18 based contract approach should be one that's made much more
19 available, more flexibility for plans to enter into
20 arrangements that are outcomes-based. Maybe they've got
21 that flexibility. I don't even know that they don't have
22 it, but maybe some incentives within the structure that

1 actually encourages them to pursue those approaches. And I
2 think manufacturers would go for those as compared with
3 having to pay unlimited rebates in a catastrophic phase.
4 Maybe there is something else that they'd be willing to
5 come to the table on to avoid those.

6 So I think there is in the structure increased
7 pressure to come to the table, and we might be able to give
8 plans the flexibility to use that.

9 DR. CROSSON: Thank you, Kathy. Brian.

10 DR. DeBUSK: First of all, again thank you for
11 the work. It was a very impressive chapter.

12 Speaking specifically to Chart 15, I do support,
13 prefer, strongly support the redesigned benefit with the
14 cap discount option, really like it. I do want to make two
15 points here.

16 Number one, I do think that Medicare is going to
17 remain in the reinsurance business in some capacity. I
18 think we can't make the numbers work without it. And as
19 Bruce alluded to, there is a rule that would fix the issue
20 with even having to allocate DIR that's still out for the
21 comment period right now. If that rule goes through, I
22 don't think we're going to have the DIR issue anymore. In

1 the event that we do, just one recommendation for future
2 work. If you would plot out a scenario where the
3 reinsurance program gets paid the DIR first and once that
4 is fully paid off then we begin allocating it back to
5 Medicare and the plan, you will get the same effect of this
6 new rule around rebates, possibly finalizing it, because I
7 think the original, as the Commission pointed out in the
8 2016 chapter, Improving Medicare Part D, there a
9 fundamental hole in how the reinsurance program works.
10 Eliminating the rebates would fix a portion of that, a
11 small portion of that. But I think even if we don't,
12 again, if the DIR has to be applied first to reinsurance, I
13 think you would get a similar effect. I think you would
14 close what might be the next potential hole in the program.

15 The other thing I wanted to mention -- I
16 mentioned this two years ago -- I do hope we'll also look
17 in this at polypharmacy. I would like to connect you, the
18 staff, to what I know is a successful program run out of a
19 large academic medical center where they're looking at the
20 -- they're working with pharmacists and with the
21 specialists to try to incorporate a beneficiary's capacity
22 to manage all these different drugs. I mean, there are

1 beneficiaries who really can only take four or five
2 medications at a time. There are others that can
3 effectively manage 20. And I think that may be a source,
4 especially in these really heavy utilizers, I think that
5 may be another thing that we would like to incorporate into
6 this to try to address some of the most expensive
7 beneficiaries.

8 Thank you.

9 DR. CROSSON: Thank you, Brian. Paul.

10 DR. PAUL GINSBURG: Okay, thanks. A terrific
11 presentation and paper. As context -- I think you have
12 this in the paper, but I just wanted to say it -- it's
13 really amazing how much has changed since 2003 when the
14 Part D benefit was developed in Congress to now as far as
15 the nature of drugs, the role and growing role of specialty
16 drugs. So long overdue, revamping this Part D design.

17 I also noticed that you said that Medicare is
18 responsible for about a third of revenues in pharmacies,
19 and this is one of the few areas where we can make Medicare
20 policy and perhaps have positive spillovers beyond Medicare
21 as far as if Medicare can influence the prices.

22 You had a very extensive discussion of adherence,

1 which was worthwhile, but I want to make sure we always
2 point out that it's not just adherence, that it's financial
3 protection. And there's opportunities for great financial
4 pain to adherent patients who have trouble paying the
5 bills. So, you know, let's always keep in mind the
6 insurance function, the protection, as well as, you know,
7 its effect on utilization.

8 I certainly support your focusing on specialty
9 drugs. That's where the issue is today. It's going to be
10 much more extreme tomorrow, as pointed out. And to me, on
11 Slide 15, with the four objectives, I have a particularly
12 high priority on the objective of getting prices lower
13 because I think that's a particularly compelling problem.
14 And this is why I support the redesign benefit with a cap
15 discount and not the per prescription out-of-pocket limit
16 because that only deals with, one, about the barriers to
17 patients and ignores these other really important aspects.

18 DR. CROSSON: Thank you, Paul. Warner.

19 MR. THOMAS: Thanks for the work. I think it's
20 obviously a major issue and certainly a major issue of cost
21 for the program.

22 It strikes me just looking at the trends, this

1 has pretty much been a windfall for the manufacturers, and
2 just hearing that we're not sure what the margins are on
3 these specialty drugs, but they're very large.

4 So I think getting back to this idea of what's
5 the principle, I think Jonathan's point is a good one.
6 What is the principle? You've got to align the risk,
7 right? So where should the risk be on this? It shouldn't
8 all be on the Medicare program with the escalation.

9 I think the idea I would support that Amy brought
10 up about excluding drugs at launch, I think is a good one.
11 I think that's one that should be included in here.

12 I agree with the structure that's been laid out
13 here and basically sharing the risk going forward, but I
14 also think that it disproportionately ought to be shared
15 with the manufacturer and not the plan. I think they need
16 to basically be involved financially and taking risk in
17 this situation.

18 Other concepts we talked about, which have not
19 been included -- I didn't see in the chapter -- is the idea
20 of a cap on inflation. So should we be thinking about
21 capping what the increase on a special drug should be going
22 forward? So if you have the idea that you can essentially

1 exclude at launch and cap inflators, it would give you some
2 control, potentially, going forward, and then if there's
3 risk shared disproportionately with the manufacturer, I
4 think they would probably be more aligned with the overall
5 system.

6 I agree that I don't think we should put more
7 financial burden on the beneficiary. I think the
8 beneficiary has enough burden, and frankly, going from a 2-
9 or \$3,000 out-of-pocket to \$6,000 is a big differential for
10 a beneficiary -- or most beneficiaries. So I don't agree
11 with that. I think we ought to continue to limit the risk
12 that the beneficiaries have and put more risk on the
13 manufacturers.

14 So those are a couple ideas that I think would go
15 along with your construct of essentially having that shared
16 risk, but I would really encourage us to put more of the
17 risk on the manufacturer and not on the plan.

18 I do think the plan and obviously the PBMs have
19 some control, but I still think the manufacturers need to
20 have risk in this as well.

21 DR. CROSSON: Thank you, Warner.

22 Pat.

1 MS. WANG: So thank you also for very thought-
2 provoking concepts and in particular the rethinking of the
3 reinsurance layer and shared responsibility. I like
4 Warner's comment.

5 I just want to focus a little bit on the
6 implications of converting what is now manufacturer
7 discount and LIS subsidy into insurance risk because just
8 in general, shifting risk is not like sort of -- I think it
9 sets off warning bells, and I know that the intent is that
10 by shifting risk, plans will have more incentives and
11 ability to really manage costs. And so I'll get back to
12 that in a second.

13 But to me, some of the implications of converting
14 this exposure into insurance risk for plans include, first,
15 the necessity of really, really much better risk adjustment
16 so that premiums have a reasonable assurance of covering
17 the cost of the drug exposure that would be included.

18 I am a little concerned about timing. You see,
19 there's an underlying theme in here that the way that the
20 reinsurance benefit is structured today, it's basically
21 cost based, and that's true.

22 But there is a reason for that. The cost of new

1 drugs, new launches, new therapies that just come on to the
2 market are not knowable the way that a plan might know or
3 be able to project their cost for inpatient, you know,
4 physician, et cetera. It's a different kind of benefit,
5 and it is evolving and changing every day.

6 When the hep C drugs came onto the market, it was
7 miraculous. That was not included in anybody's premium
8 because nobody knew about it. So I guess I have a little
9 bit of a concern with just as a timing matter how premiums
10 keep up with the tremendous development and new costs that
11 are introduced into the pharmacy world every day.

12 In a sense, the system that we have today, it is
13 supported by a lot of different components of this whole
14 ecosystem.

15 The list that Amy described of things that would
16 be necessary to really try to get your arms around this
17 risk, manage this, et cetera, I think people should pause
18 and think about because it's really true.

19 Right now, it is a cost-based system in a lot of
20 respects, but that reflects how we have allowed the benefit
21 to be structured. There's very little in -- I mean, there
22 are a lot of beneficiary protections in there, so I think

1 people need to be sort of aware that everything has to be
2 looked at, whether it's any willing pharmacy, including
3 drugs at launch, dealing with anticompetitive behavior
4 about competitor products, protected classes.

5 I know that the Commission made some
6 recommendations in 2016 to remove protected status from a
7 couple, but it still exists for some of the most highly
8 utilized drugs. And you triggered that thought, Shinobu,
9 when you reminded me that behavioral health drugs are
10 really most used by the LIS population, and that those are
11 protected, so for example.

12 I think as we proceed, we have to -- I'm sorry
13 that Amy won't be here to remind us of this, but I think it
14 kind of all goes together if you're going to ask people to
15 manage the cost and the benefit a different way.

16 Then on that last statement about giving more
17 incentive to plan sponsors to manage the cost, there's two
18 components of that. One is managing utilization by their
19 members. I think Kathy raised a good point that that might
20 have implications.

21 The other is managing price. I would say I don't
22 know -- I think that the large plan sponsors probably have

1 thoughts about what to do here. I'll just speak about my
2 concern about the ability of smaller, regional, what have
3 you, Medicare Advantage prescription drug plans, which are
4 not PDPs, but offer prescription drugs as part of the
5 benefit of manage their MA members who do not have their
6 own formularies, who contract with a PBM, and who do not
7 control their internal formulary, the ability to manage the
8 risk.

9 In particular, I think there needs to be more
10 focus on how to handle LIS. LIS is a difficult benefit to
11 manage because the members have no financial
12 responsibility. So the use of brand drugs, specialty
13 drugs, where there are substitutions is very difficult to
14 address.

15 You can interfere with prescriber preference and
16 patient preference and say to people, "No, you can't have
17 that," which nobody is willing to do as far as the
18 discussion with the patient, restricting formularies. For
19 example, if there's a generic substitution, there's no
20 access. You could do things like that, but most
21 organizations really don't restrict their formularies just
22 for their LIS members.

1 So I think it's a difficult -- it's a more vexing
2 population, and the benefit is more vexing because the
3 tools to actually change enrollee behavior, changing
4 prescriber behavior can be done, but it's really more at
5 the margins. I mean, of course, if a prescriber really
6 wants to prescribe a certain thing for their patient, you
7 have to think twice about whether you really want to ask
8 plans to sort of get more aggressive about getting in the
9 middle of that, which is sort of the implication of if
10 you're at risk for that, you have to do something.

11 So I'm a little concerned about LIS, and I don't
12 know what the answer is, but I think that we should
13 continue to think about how that should be structured.

14 Thank you.

15 DR. CROSSON: Thank you, Pat.

16 This was a good discussion. I believe we have
17 helped here, Rachel and Shinobu, giving you a sense of a
18 preference on the part of the Commission, and we look
19 forward to the next phase of your work. Thanks very much.

20 While we are getting rearranged here, I just want
21 to take a moment to recognize one of the MedPAC staff who
22 is going to be leaving and ask Kate to stand up and be

1 recognized, now that you came in.

2 [Applause.]

3 DR. CROSSON: Thank you so much for your
4 excellent work.

5 [Pause.]

6 DR. CROSSON: Okay. I think we're ready for the
7 final presentation. We're going to be talking about the
8 issue of improving payment for low-volume and isolated
9 outpatient dialysis facilities. Nancy and Andy are here to
10 help us through this, and Nancy is going to begin.

11 MS. RAY: Good morning.

12 During our December and January meetings,
13 Commissioners raised concerns about the Medicare financial
14 performance of low-volume and rural dialysis facilities.

15 During today's session, Andy and I discuss how
16 the ESRD prospective payment system, the PPS, pays
17 facilities that are low volume and rural, and we will also
18 discuss an alternative approach that may better target
19 facilities necessary to ensure beneficiaries' access to
20 care.

21 So here is a roadmap of today's presentation.
22 First, I'll first give you a very brief overview of the

1 ESRD PPS and review the most recent Medicare financial
2 performance of low-volume and rural facilities.

3 Next, I will summarize the Commission's
4 principles on payments to rural providers which guided our
5 analysis of and concerns with the ESRD PPS's low-volume and
6 rural payment adjustments.

7 Andy will present an alternative approach that
8 would create one payment adjustment that could replace the
9 two current factors, that might better target low-volume
10 and isolated facilities.

11 We seek comments from Commissioners on the
12 material presented. This is the first step in our
13 discussion about improving the accuracy of the ESRD PPS.

14 Since 2011, the ESRD PPS payment bundle includes
15 drugs and laboratory services that Medicare previously paid
16 separately. Beginning in 2020, facilities will be paid
17 separately, outside the bundle, for new drugs.

18 For each covered treatment that a facility
19 furnishes, its base rate is increased using the patient-
20 and facility-level factors listed on the slide.

21 Today, we are discussing issues with the two
22 separate facility-level adjustments for low-volume and

1 rural location.

2 Over the next year, we expect to come back to you
3 to discuss concerns with the drug passthrough policy and
4 the payment-level adjustment factors.

5 So moving to the Medicare financial performance,
6 you saw these 2017 Medicare margins in December and
7 January. What really influences the Medicare margin is
8 treatment volume. The Medicare margin is decidedly lower
9 for facilities in the lowest-volume quintile, compared to
10 facilities in the top-volume quintile.

11 Among rural facilities, the Medicare margin
12 decreases as total treatment volume decreases. Rural
13 facilities are on average smaller than urban ones.

14 This figure shows 2015, 2016, and 2017 cost per
15 treatment, adjusted for differences in the cost of labor.
16 The Medicare financial performance for rural and low-volume
17 facilities that I showed you on the previous slide is in
18 large part due to the correlation between dialysis
19 treatment volume and costs.

20 Under the ESRD PPS implemented in 2011 and even
21 the payment method prior to the PPS, we have consistently
22 found that cost per treatment decreases as the number of

1 treatments a facility furnishes increases.

2 The smaller facilities on the left-hand side of
3 this figure have much higher costs per treatments than
4 facilities on the right-hand side of the figure.

5 As we evaluated the ESRD facility-level
6 adjustments, we were guided by the principles that the
7 Commission developed to evaluate rural special payments
8 over the course of several meetings and that were published
9 in 2012. The Commission stated that payments should be
10 targeted toward low-volume isolated providers, that the
11 magnitude of payment adjustments should be empirically
12 justified, and that the adjustments should encourage
13 provider efficiency.

14 In 2017, about 5 percent of dialysis facilities
15 received the low-volume payment adjustment, referred to as
16 the LVPA, which increased facilities' base payment rate by
17 23.9 percent. Eligible low-volume facilities are those
18 that furnished 4,000 treatments in each of the 3 years
19 before the payment year under question.

20 Our first concern with the low-volume adjustment
21 is that it may not be targeting all isolated facilities
22 necessary to ensure beneficiary access to care.

1 The low-volume adjustment only factors in the
2 distance to the next facility if both facilities are owned
3 by the same parent organization and within five miles from
4 one another. This means that a low-volume facility can be
5 located next door to another facility as long as they are
6 owned by different parent organizations. In 2017, 40
7 percent of low-volume facilities were located with five
8 miles of the nearest facility.

9 A second concern with the low-volume adjustment
10 is that it uses only one volume threshold of 4000
11 treatments. This so-called "cliff effect" might be
12 encouraging some facilities to limit services, and the
13 current low-volume adjustment does not address the higher
14 cost of facilities with volumes of between 4,000 and 6000
15 treatments per year that I showed you on Slide 5.

16 This slide shows that low-volume facilities are,
17 indeed, more isolated compared to all facilities. However,
18 note the two blue bars on the left showing that 40 percent
19 of facilities were located within five miles of the nearest
20 facility.

21 Moving to the 0.8 percent rural adjustment, this
22 is also applied to the base rate and supplied to the base

1 rate of facilities located in rural areas. Eighteen percent
2 of all facilities received this adjustment. Like the low-
3 volume adjustment, our concern here is the targeting of
4 this adjustment.

5 In 2017, about 30 percent of rural facilities
6 were located within 5 miles of another facility, and in
7 2017, 20 percent of rural facilities were high volume,
8 furnishing more than 10,000 treatments, and had
9 substantially lower adjusted cost per treatment than lower-
10 volume facilities located in rural areas.

11 DR. JOHNSON: Now we are going to discuss an
12 illustrative policy option to replace the current low-
13 volume and rural payment adjustments. This single
14 adjustment is designed to preserve access to dialysis by
15 increasing payment to facilities that are both low-volume
16 and isolated, or LVI.

17 The LVI adjustment would jointly apply two
18 criteria. First, eligible facilities must be farther than
19 five miles from the nearest facility to be considered
20 isolated. This definition is more strict than the current
21 low-volume definition which, as Nancy described, in some
22 circumstances can apply to facilities within five miles of

1 another facility.

2 Second, eligible facilities must have low volume
3 of treatments during each of the preceding three years.
4 To mitigate the cliff effect of the current low volume
5 definition, and to better account for the higher costs of
6 relatively low-volume facilities, the LVI adjustment would
7 expand the definition of low volume by applying one of
8 three categories.

9 The lowest category would apply to facilities
10 with fewer than 4,000 treatments in each of the three
11 preceding years. The next category would apply to
12 facilities that had fewer than 5,000 treatments in each of
13 the preceding three years, but do not meet criterion for
14 the first category. The third category would apply to
15 facilities that do not meet criteria for the first two
16 categories, but that had fewer than 6,000 treatments in
17 each of the preceding three years.

18 The next few slides will show how that the LVI
19 adjustment would better target low-volume and isolated
20 facilities compared to the current low-volume and rural
21 adjustments.

22 This figure compares the current low volume

1 adjustment to the proposed LVI adjustment. Along the
2 horizontal axis, facilities are grouped by the number of
3 dialysis treatments provided in 2017, with a cap at 6,000
4 treatments. The green dotted bars show the number of
5 facilities that received the current low-volume adjustment
6 in 2017. As you can see, most facilities receiving the
7 current low-volume adjustment continued to provide fewer
8 than 4,000 treatments in 2017, but a few provided more
9 treatments and migrated to higher categories.

10 The white bars show the number of facilities that
11 would receive the new LVI adjustment. Because, the LVI
12 adjustment would expand the definition of low volume, more
13 facilities with greater 2017 treatment volume would receive
14 the LVI adjustment. Recall from Slide 5 that all of these
15 facilities providing fewer than 6,000 treatments annually
16 have relatively high adjusted treatment costs.

17 There are somewhat fewer facilities receiving the
18 LVI adjustment in the 0-to-4,000 treatment group because
19 some current low-volume-receiving facilities are within
20 five miles of another facility. These facilities would not
21 receive the LVI adjustment.

22 Overall, the LVI adjustment would redistribute

1 payments from facilities within five miles of another
2 facility to isolated facilities and to facilities that meet
3 the expanded definition of low volume.

4 This figure is organized in the same way as the
5 previous figure and compares facilities that received the
6 rural adjustment in 2017, the green dotted bars, to the
7 facilities that would have received the proposed LVI
8 adjustment, the white bars. The right side of the figure
9 shows that the majority of facilities receiving the rural
10 adjustment had higher volume, providing more than 6,000
11 treatments, and for some facilities, providing more than
12 15,000 treatments. These higher-volume facilities have
13 lower costs per treatment, suggesting that the 0.8 percent
14 rural adjustment could more effectively preserve dialysis
15 access if it were shifted to lower volume and isolated
16 facilities.

17 Overall, the LVI adjustment would redistribute
18 rural adjustment payments from higher-volume to low-volume
19 facilities and from non-isolated rural facilities to
20 isolated facilities.

21 One additional note about the size of the rural
22 adjustment. This figure shows that rural facilities have a

1 wide range of treatment volumes, and therefore have a wide
2 range of average costs per treatment. Payment adjustments,
3 like the rural adjustment, that are empirically estimated,
4 capture the cost variation that is common among facilities
5 within the adjustment group. We think one reason why the
6 rural adjustment is so small, just 0.8 percent, is that
7 there is little similarity in costs among rural facilities.

8 We have not yet estimated the size of LVI payment
9 adjustments. That is something we plan to do for this
10 fall. We anticipate that the empirically estimated
11 adjustments will be proportional to the average costs in
12 each of the categories. Our preliminary analysis confirms
13 that average treatment costs align with the LVI categories
14 as expected, and are consistent with the overall
15 relationship between volume and cost.

16 We believe that the LVI adjustment would more
17 accurately target higher-cost facilities, and particularly,
18 we think relatively low-volume facilities that are not
19 receiving the current low-volume adjustment would see
20 improvement.

21 Of the LVI-eligible facilities, the 2017 Medicare
22 margin for those facilities that receive the current low-

1 volume adjustment was -3 percent. However, for LVI-
2 eligible facilities that did not receive the low-volume
3 adjustment the 20171, their Medicare margin was -17
4 percent. These facilities would likely see substantially
5 improvement in their margins due to the LVI adjustment.

6 This slide summarizes the key aspects of the LVI
7 adjustment. First, there would be a single payment
8 adjustment for low-volume and isolated facilities, that
9 would replace the two current adjustments that apply
10 separately for low-volume and rural location. Second, the
11 LVI payment adjustment would consider a facility's
12 proximity to any other facility, not just those under
13 common ownership. Some facilities receiving the current
14 low volume adjustment would not receive the LVI adjustment
15 as they are in close proximity to another facility.

16 And finally, the LVI adjustment would expand the
17 definition of low volume. The proposed three categories
18 are designed to mitigate the so-called cliff effect and to
19 account for the higher treatment costs of facilities
20 providing between 4,000 and 6,000 treatments per year.

21 We intend to return in the fall to continue our
22 discussion of a low-volume and isolated adjustment,

1 including our estimation of payment adjustment sizes. We
2 also plan to address other ESRD PPS concerns, which are in
3 the appendix to your mailing material. These include
4 issues with patient-level adjustments and the PPS
5 regression estimation method.

6 Finally, of particular interest to several
7 Commissioners, we also plan to address ways to improve the
8 transitional drug add-on payment adjustment, or TDAPA. We
9 look forward to your comments, including suggestions for
10 other factors we should consider as we continue our
11 analysis. And now I'll turn it back to Jay.

12 DR. CROSSON: Thank you, Andy and Nancy. We'll
13 take clarifying questions.

14 Okay. David, Dana, Marge. I'm sorry. David, go
15 ahead.

16 DR. GRABOWSKI: Thanks. I appreciate this work.
17 It's a really nice chapter and presentation.

18 I wanted to ask you about the five-mile
19 threshold. Did you guys think about kind of variation on
20 either side of that? I guess there's nothing magical about
21 that five miles, but why is that the right number?

22 DR. JOHNSON: I think we started there now

1 because it is part of the current rules and so it was an
2 easy number to estimate and has some basis in current
3 policy, but that's something that we could consider
4 modeling some alternatives for this.

5 DR. GRABOWSKI: And one other question, Jay. I
6 like how you're trying to mitigate the cliff effects. I
7 guess there's still, under your kind of step thresholds
8 here, there's still kind of potential for cliffs there,
9 especially at 6,000. And you probably can't get away from
10 that cliff, but is there a way to do a more continuous
11 measure underneath that? I'd want to think more about
12 that, but is there a way to kind of go from steps to some
13 sort of continuous share measure?

14 DR. JOHNSON: That's certainly something we can
15 work on. I think, again, this illustrative policy was
16 trying to take the ideas that the current policy is based
17 on and just expand them as a conceptual way to illustrate
18 what we're trying to do. But, yeah, a continuous
19 adjustment might be better.

20 DR. GRABOWSKI: Thanks.

21 DR. CROSSON: Dana.

22 DR. SAFRAN: Thanks for this work. My question

1 is about the other aspect of the criteria and that's the
2 volume aspect.

3 As I think about it, I'm not clear why we want to
4 maintain volume as a criterion. What I worry about is
5 creating incentives to be just enough below the volume
6 cutoffs that you're getting extra support. And so
7 understanding that what we're trying to do here is assure
8 access for rural beneficiaries who need dialysis, I wonder
9 why would we not want to consider the criteria just being
10 one piece of it, however weighted, because you're rural,
11 another because you are some distance -- and I had the same
12 question about why five miles -- but some distance from the
13 next nearest facility, and just drop the volume pieces. I
14 wonder what you think about that.

15 DR. JOHNSON: So there are isolated facilities,
16 at least based on our five-mile criteria, in all of the
17 volume categories. And so I think if we just considered
18 the isolated facilities there would be some facilities that
19 are on the right end of Slide 5 that have very low costs
20 and are able to achieve positive margins now that we would
21 not want to focus the adjustment dollars towards those
22 facilities. But I think, as David mentioned, maybe a

1 continuous adjustment might help mitigate some of the
2 concerns about volume.

3 DR. CROSSON: Okay. I've got Marge and then
4 Brian.

5 MS. MARJORIE GINSBURG: So currently the Medicare
6 margin for the rurals are -5.5. What proportion of the
7 dialysis programs are made up of Medicare versus commercial
8 plans, and are these that have such a negative margin able
9 to survive because commercial pays much more? So I don't
10 know where that balance is, and do some facilities actually
11 have mainly, if not entirely, Medicare? Some may be
12 entirely commercial and are the price differences that
13 significant?

14 MS. RAY: So commercial payers do pay, on
15 average, a higher payment rate than Medicare. I would have
16 to come back to you concerning the mix of patients and how
17 that varies between isolated facilities and non-isolated
18 facilities, in terms of the percentage that are Medicare
19 versus commercial. Just off the top of my head I would
20 think that in the more rural, isolated areas you're going
21 to tend to see a slightly greater share of Medicare
22 patients, but I would want to go back and double-check on

1 that.

2 MS. MARJORIE GINSBURG: Have any facilities
3 closed because they were not able to make it financially?

4 MS. RAY: So certainly we see facility closures
5 every year. We also see a net increase from year to year.
6 That has been the trend through 2017.

7 DR. CROSSON: Okay. On that point?

8 DR. JAFFERY: Real quick, just to remind folks
9 that ESRD is a Medicare eligibility category, so that
10 changes things a little bit from some other circumstances.

11 DR. CROSSON: Brian.

12 DR. DeBUSK: First of all, I really enjoyed the
13 chapter and, to David's point, I think a continuous
14 adjuster for volume, I think it would be superior.

15 But I had a second question and I promise this
16 isn't a rhetorical question. But when we talk about
17 excluding, you know, this five-mile exclusion, are we
18 showing a certain amount of indifference to consolidation
19 or to maybe a policy that could inadvertently drive
20 consolidation? I mean, when I was reading the first part
21 of the chapter I thought, I wonder if these are the same
22 people who don't keep a spare tire in their trunk.

1 And again, this isn't a comment. This really is.
2 I mean, have we considered that the unintended consequence
3 of driving more consolidation than we need? I mean, is
4 competition good?

5 DR. JOHNSON: That's certain a concern, and I
6 think a question for you is how does that concern balance
7 with the benefit of redistributing some of the adjustment
8 dollars to facilities that we think might be more necessary
9 to preserve access to dialysis.

10 MS. RAY: And I --

11 DR. DeBUSK: Quick question -- sorry.

12 MS. RAY: And I also think another issue to
13 consider is the incentive to promote provider efficiency.
14 I mean, if you do have a low-volume provider and he is
15 within two miles of a much bigger provider, you know, one
16 has to wonder about whether or not that low-volume provider
17 needs a little bit more incentive.

18 DR. DeBUSK: Agreed. Clearly there are
19 efficiencies with scale. Do we also see some dis-
20 efficiency, or dysfunction that goes along with that scale,
21 would be my question back.

22 DR. JOHNSON: I think that's something we can

1 consider further.

2 DR. CROSSON: Paul.

3 DR. PAUL GINSBURG: On this point I can see the
4 concern with monopoly. This sounds more like a situation
5 of macro monopoly, you know, when you have few sellers in a
6 market. It's because there are such economies of scale,
7 and that's the only way to achieve them.

8 I think in this market, I mean, concentration is
9 never a good thing but it's probably less harmful here
10 because it's so dominated by Medicare, you know, much of
11 the commercial services for people that haven't reached the
12 two-year points, as far as gaining ESRD eligibility. So I
13 think the data you showed showed that there are some very
14 substantial scale economies here and I think we need to
15 accommodate that.

16 DR. CHRISTIANSON: [Presiding.] Are there any
17 other clarification questions? Comments? Amy.

18 MS. BRICKER: I was just thinking about in-home
19 versus in-facility and how we should think about either
20 access for in-home or costs associated with in-home versus
21 within-facility. Is that a dimension that you've
22 considered as part of this analysis?

1 MS. RAY: So when CMS implements the low-volume
2 adjustment it does include home treatments, just as it
3 includes in-center treatments.

4 MS. BRICKER: The costs associated with one
5 versus the other for the facility, do you have insight into
6 that?

7 DR. JOHNSON: The management of home patients
8 still requires some cost from the facility, that those
9 nurses are monitoring the patients. So it is not
10 necessarily the same cost, but the facility is involved in
11 treating those patients as well, even though they are at
12 home.

13 MS. BRICKER: And one follow-on. Do we see that
14 population growing, or the ability to service the patient
15 in home as obviously more desirable, but is there anything
16 within policy that we think will hinder further adoption of
17 in-home? I'm just ignorant on the subject. Is it more
18 about advancement of that patient and therefore they're not
19 able to be serviced at home, and how can we keep more
20 people at home if, in fact, the cost structure is less,
21 and, obviously, I'm sure it would be more desirable for the
22 patient.

1 MS. RAY: So under the PPS we have seen an
2 increase, a modest increase in the use of home dialysis.
3 One of the factors that I think has sort of hindered the
4 growth in the last couple of years was a shortage of a
5 particular solution that was needed by the predominant home
6 dialysis modality, peritoneal dialysis.

7 I think you raise a good point, though, about
8 considering, you know, any changes to the low-volume
9 adjustment and, you know, and considering the effect on
10 home dialysis.

11 DR. CHRISTIANSON: Okay. We don't have -- oh,
12 I'm sorry. Go ahead.

13 MS. BUTO: Nancy, could you elaborate on that a
14 bit? The low-volume adjustment doesn't affect the payment
15 rate for home dialysis, does it?

16 MS. RAY: For adults it does not. Now facilities
17 do receive a training add-on payment when they first train
18 the patient, and they can also receive a payment for
19 retraining a patient, but there is no difference in the
20 payment right now for home versus in-center dialysis.

21 MS. BUTO: Yeah. Just one point of
22 clarification. There was a period of time when home

1 dialysis was being paid almost at twice the rate as in-
2 center, and it ended up being the subject of a lawsuit in
3 order to rein payments back in. It was an area of abuse.
4 So I'd just be careful in thinking about home dialysis, not
5 to think that poor home dialysis isn't being reimbursed
6 appropriately. It's now, I think, capped at the level of
7 in-center, if I'm not mistaken.

8 DR. CHRISTIANSON: Okay. We don't have a leader
9 of the discussion part here, so I think they give us some
10 pretty straightforward direction in terms of where they
11 want us to go, and that is on page 15. So I think the main
12 thing is to be very clear about whether we think this is a
13 policy direction we'd like to see them pursue further, and
14 then beyond that, what specific areas do we think the most
15 work is needed in. So, Jonathan, you were going to start?

16 DR. JAFFERY: Yes. Maybe I can make a few
17 comments leading into the discussion questions particularly
18 related to some of the things that people have brought up.

19 I think that, you know, generally speaking, we do
20 want to think about how do we make sure that beneficiaries
21 have the options that are best for them, whether those are
22 in-center or home dialysis, and home dialysis comes in two

1 different modalities, as Nancy alluded to. There's
2 peritoneal dialysis, and then there's also sort of the
3 growing in-home hemodialysis modality that people are
4 using.

5 But I think we just want to be careful that we
6 just don't assume that in-home is not necessarily better
7 for everybody. There are a lot of patient-specific
8 characteristics and patient preferences that I think play
9 into this. There's a lot, as you can imagine, to be done
10 if you need to do some of these things at home. And your
11 home environment may or may not actually be set up for
12 this. That can be a pretty big hurdle sometimes.

13 I think, you know, the other thing, thinking
14 about the five-mile distance, you know, there is an
15 interesting balance here because my recollection of the
16 history of some of this, which goes back before I was doing
17 any sort of dialysis work, is that peritoneal dialysis --
18 this was before probably home hemo was really a thing, but
19 peritoneal dialysis was a much bigger -- had a much bigger
20 use in this country. And one of the things that decreased
21 its use was we had dialysis centers kind of cropping up in
22 more rural areas. So one might look at that and think that

1 maybe that was a negative to have them crop up everywhere,
2 but, again, it can be somewhat of a hardship sometimes for
3 folks, maybe particularly in rural areas, to get to places.
4 So I think, you know, any number of miles is probably
5 always going to be arbitrary, which is why I think the
6 cutoff points -- we thought those were arbitrary, and I
7 would definitely agree with David that having a more
8 continuous approach to that is probably desirable.

9 But if we think about patient access to things,
10 whether we're thinking about in rural areas or just in
11 general, we often think about those as what people need to
12 get to on an occasional event, and this is not an
13 occasional event for people. This is somebody who is
14 spending three days a week, half of a day each of those
15 days, at this unit, and that's a big deal. And it's not
16 just a big deal for the patient; it's a big deal that often
17 family members have to be able to drive them, and you can
18 think of some of these remote areas that may be in places
19 where half the year there's lots of snow or maybe there's
20 mountains, and so it can be a big deal.

21 To me, I think we want to be conscious of that,
22 and so I'm personally supportive of continuing to think

1 about how to make adjustments and maintain that kind of
2 access.

3 In terms of the specific proposal, I think
4 simplifying things to have a single adjustment has an
5 appeal to it, and I think that slide, whatever is the slide
6 that shows the cost per -- yeah, Slide 5, it's pretty
7 compelling that there's a volume-related cost associated
8 for facilities. So I'm very supportive of developing
9 further the proposal that you put forward.

10 And then, finally, just to speak to -- you know,
11 you talked a little bit about other factors to consider,
12 and I think that maybe piggybacking on this idea of how
13 difficult it may or may not be for people to get places,
14 thinking about some of the social factors for individuals
15 and social determinants and how that may or may not make it
16 easier for dialysis providers to manage patient populations
17 may be helpful. There's a lot of time and effort that goes
18 into trying to arrange transportation for people, and as
19 one can imagine, it's hard to do that if somebody doesn't
20 have stable housing, for example.

21 I'll leave it at that.

22 DR. CROSSON: Thank you, Jonathan.

1 Let's see. Paul, Dana. Paul.

2 DR. PAUL GINSBURG: I just wanted to compliment
3 you that I think your proposal analysis was a great example
4 of the MedPAC culture of, you know, ways to focus the
5 Medicare dollars on where they'll do the most good,
6 avoiding cliffs. I could probably go on.

7 I'm very comfortable with the direction and
8 encourage you to continue to work and come back with
9 recommendations.

10 DR. CROSSON: Thank you. Dana.

11 DR. SAFRAN: Yeah, I second that. And the only
12 thing I'd add is in relation to this figure and some of the
13 comments I included in my question about volume, I think
14 this issue about home dialysis would be valuable to
15 incorporate here because I just can't help -- I don't know
16 the field of dialysis very well, but I know in the field of
17 quality measurement in general we start to worry when there
18 are low volumes about quality. So I still worry about this
19 idea of using volume as a criterion to add additional
20 payments. And maybe that is what we need to do to promote
21 access, but I just want to turn over every rock before we
22 decide that that's the right thing in terms of activities,

1 quality, safety, and cost. And it seems like exploring
2 home dialysis in the areas where there are such low
3 volumes, you know, what's the intersection there of the
4 patients who could be treated at home and what that would
5 cost versus being treated in centers that are low volume
6 where they might need this adjustment seems worthwhile.

7 DR. CROSSON: Thank you, Dana. Kathy.

8 MS. BUTO: Maybe Jonathan could speak to this,
9 but I don't think we should think of home dialysis as
10 people being treated. A lot of it is self-treatment, as I
11 understand it. I don't think the cost of an assistant is
12 covered. I think there are training opportunities and so
13 on, but I think a lot of it relies on the person. So it's
14 not a complete interchange between a low-volume facility
15 and somebody being able to get their dialysis at home. You
16 have to have the capability, I think, to either have an
17 assistant in your family or otherwise to help you.

18 DR. SAFRAN: Understood, but if we think about
19 from the perspective of the program and the patient, what
20 is more advantageous? If we should be really driving to
21 more home dialysis as opposed to center dialysis,
22 particularly in places where there's an access problem, we

1 should look at how to encourage that. What are the policy
2 levers to encourage that?

3 MS. RAY: Right, and I just would like to clarify
4 here that under the ESRD PPS, the payment bundle for home
5 and in-center is the same. Medicare does not pay for any
6 special assistant or helper for patients who dialyze in the
7 home. Patients either dialyze by themselves or often with
8 the aid of a caregiver. And we wrote in, if I'm getting my
9 years straight, either the March 2017 or the March 2018
10 report, there are a lot of factors affecting the take-up on
11 the use of home dialysis, and, in particular, it's a very -
12 - as Jonathan stated, it's a very individualized decision
13 as to whether or not the person feels comfortable and able
14 and has the space and often the caregivers necessary to do
15 home dialysis.

16 DR. JAFFERY: Just to add one other thing to it,
17 and if we can talk about this a lot offline, I suppose it
18 would be helpful, too, but there are some physical
19 characteristics that prevent people particularly from doing
20 peritoneal dialysis, and then there are situations where
21 people may be doing peritoneal dialysis for a period of
22 time, and then as times goes on it's no longer a viable

1 modality, and then they switch to in-center -- or switch to
2 hemodialysis. There are a lot of hurdle sometimes for
3 individuals to be able to choose in-center hemo versus --
4 or home hemo versus in-center hemo.

5 DR. CROSSON: Okay. Good discussion. Andy,
6 Nancy, thank you for the work. We look forward to the next
7 iteration when you come back to meet us in the fall.

8 That brings an end to this morning's discussion
9 as well as the 2018-2019 MedPAC cycle. We now have an
10 opportunity for public comment. If there are any of our
11 guests who would like to make a comment now, please come to
12 the microphone.

13 [No response.]

14 DR. CROSSON: Seeing none, we are adjourned, and
15 I wish everybody a wonderful summer interlude. We'll see
16 you again soon. And thank you again for your work as a
17 Commission, and thank you to Jim and Dana and the staff,
18 and safe travels, everyone.

19 [Whereupon, at 10:40 a.m., the Commission was
20 adjourned.]

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