

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

The Horizon Ballroom
Ronald Reagan Building
International Trade Center
1300 Pennsylvania Avenue, NW
Washington, D.C. 20004

Thursday, January 11, 2018
9:25 a.m.

COMMISSIONERS PRESENT:

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JON B. CHRISTIANSON, PhD, Vice Chair
AMY BRICKER, RPh
KATHY BUTO, MPA
ALICE COOMBS, MD
BRIAN DeBUSK, PhD
PAUL GINSBURG, PhD
DAVID GRABOWSKI, PhD
JACK HOADLEY, PhD
DAVID NERENZ, PhD
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[9:25 a.m.]

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DR. CROSSON: Okay. I think we can convene.

Good morning. I'd like to welcome our guests to the January meeting. We have a very full agenda today and tomorrow, and we're going to start with our annual Medicare Advantage program status report. We've got Scott Harrison, and Carlos is here as well. Scott, are you going to start?

DR. HARRISON: Good morning. I would like to thank Emma Achola for her work on this chapter. I'm going to very quickly summarize our analysis of the Medicare Advantage enrollment, plan availability, bids, payment, and coding intensity that you saw us present last month. A draft chapter is included in your meeting materials, and though you have seen almost all of the material before, this draft reflects your comments, questions, and requests for additional information from last month.

Of course, we are happy to address any questions you may have, and Carlos will present the draft recommendations on contract consolidation and quality reporting that you saw and began discussing last month.

Generally, the MA sector seems to be doing very

1 well. On average, plans bid below fee-for-service, and
2 putting aside excess coding intensity but including quality
3 bonuses, payments for MA enrollees are roughly equal to the
4 costs of covering them under Medicare fee-for-service.

5 More specifically, in 2017, MA enrollment grew 8
6 percent to 19 million enrollees, which was 32 percent of
7 all Medicare beneficiaries. In 2018, MA plans are
8 available to 99 percent of beneficiaries. The average
9 beneficiary can choose from among 20 MA plans, and the
10 enrollees are in plans that average \$95 per month in
11 rebates that fund extra benefits.

12 We estimate that in 2018 MA benchmarks, bids, and
13 payments will average 107 percent, 90 percent, and 101
14 percent of fee-for-service spending, respectively. The
15 quality bonuses, which are included in these numbers,
16 contribute an average of 3 percent to payments.

17 We do remain concerned that coding intensity
18 caused MA risk scores to be 2 to 3 percent higher than fee-
19 for-service after accounting for all adjustments.
20 Unadjusted coding differences decreased from last year's
21 estimate due to the full use of a new risk adjustment model
22 and faster fee-for-service risk score growth compared to

1 prior years.

2 Now, Carlos.

3 MR. ZARABOZO: We will be presenting two draft
4 recommendations to address the problem of unwarranted bonus
5 payments under the Medicare Advantage quality bonus
6 program.

7 First, we will review the issue and the concerns
8 that it raises. As you aware, MA contracts with a star
9 rating of 4 stars or higher receive bonus payments.

10 A strategy that companies have been using to
11 increase bonus payments is to consolidate or combine
12 contracts so that the star rating of one contract, the
13 surviving contract, determines the star rating of another
14 contract or contracts, which are referred to as "consumed
15 contracts." This practice has been going on for several
16 years, so far affecting 4 million enrollees, or about 20
17 percent of MA enrollees who were moved from non-bonus
18 contracts to bonus contracts using the consolidation
19 strategy.

20 We saw the largest impact last year when 17
21 contracts were moved to bonus status, affecting 1.4 million
22 enrollees.

1 The contract consolidations to boost star ratings
2 give rise to a number of concerns. One of those concerns
3 is that added program expenditures; for example, with about
4 1.4 million enrollees being moved to bonus status through
5 consolidations in the 2018 payment year, the Medicare
6 program will incur nearly \$400 million in unwarranted
7 additional expenses.

8 Another concern is the inaccurate information
9 conveyed to Medicare beneficiaries looking at quality
10 indicators in Medicare Plan Finder. Because a consumed
11 contract immediately acquires the star rating of the
12 surviving contract, beneficiaries are not getting accurate
13 information about the plan in their area. Then, in the
14 following year, when quality results are based on results
15 from a wider geographic area, the quality data is not
16 necessarily representative of the performance of the plan
17 in the beneficiary's local area.

18 Finally, allowing a contract to piggyback on the
19 star rating of a different contract from a different
20 geographic area creates an unfair competitive advantage in
21 the local market area. The extreme case would be where a
22 contract acquires a 5-star rating when it was originally

1 below 4 stars. Not only would the contract have more
2 rebate dollars available to finance extra benefits, it
3 would also have the added, and undeserved, competitive
4 advantage, granted only to 5-star plans, of being able to
5 accept enrollment year-round, outside of the annual
6 election period.

7 Here is an illustrative example of how contract
8 consolidation works to provide bonuses to plans whose
9 performance is below 4 stars. In this example, a Medicare
10 Advantage organization had two separate contracts -- one in
11 Maine, shown as Contract 1 on the left side of the slide in
12 the white box, along with Contract 2 in Hawaii, in the blue
13 box.

14 In its June 2017 bids for the 2018 payment year,
15 the company consolidated the two contracts under the more
16 highly rated Maine contract -- the smaller of the two
17 contracts. Contract 1 is the surviving contract; Contract
18 2 in Hawaii is the consumed contract, which is
19 discontinued. Contract 1 now covers both Maine and Hawaii.

20 Through the consolidation, the company was able
21 to immediately use the Maine 4.5-star rating as the basis
22 for determining benchmarks in Hawaii for the 2018 payment

1 year. Without the consolidation, the Hawaii contract at
2 3.5 stars would not have been in bonus status. So 25,000
3 additional enrollees became enrollees of a plan in bonus
4 status. Under the surviving consolidated contract,
5 Contract 1, the company has one plan in Maine with its own
6 bid (and with a benchmark that incorporates a bonus
7 increase), and one plan in Hawaii with a separate bid,
8 which also has a benchmark that incorporates a bonus
9 increase.

10 So the consolidation had the effect of
11 artificially boosting the benchmarks for this company's
12 Hawaii plan. In addition to the payment effect, contract
13 consolidations affect the information that beneficiaries
14 see on Medicare Plan Finder. In this case, CMS policy is
15 that the consumed contract, the Hawaii contract,
16 immediately acquires the star rating of the surviving
17 contract. Whatever the star rating is for the Maine plan,
18 that will be the star rating that Hawaii residents will see
19 when evaluating whether to enroll in the Hawaii plan.

20 To address the problem of artificially boosting
21 star ratings through contract consolidations, we propose an
22 immediate solution whereby the consolidation does not have

1 an effect on star ratings and bonus payments. The ratings
2 would be based on the pre-consolidation configuration of
3 reporting entities, including in the case of consolidations
4 that occurred at the end of 2017, which will be partially
5 affected by the first of our two draft recommendations, as
6 I will explain in subsequent slides. For the most recent
7 consolidations and future consolidations, quality should be
8 reported using the geographic units of pre-consolidation
9 configurations.

10 In the end, what we want is for quality to be
11 evaluated in each local market. A second draft
12 recommendation is based on work that dates from 2005 and a
13 number of subsequent reports regarding the appropriate
14 geographic units for payment and quality reporting in MA.
15 For quality reporting, geographic units should be defined
16 at the local market level so that when quality is
17 evaluated, what is being rated is the health care delivery
18 system that is available to beneficiaries and which
19 reflects the patterns of care that people receive in a
20 given geographic area. Stars would then be computed at the
21 local market level.

22 Before displaying the first draft recommendation,

1 we should note that the kinds of consolidations we are
2 concerned with are those involving different geographic
3 areas. The reason we mention this point is that, in some
4 cases, there are consolidations in which a combined
5 contract is an appropriate result. For example, if one
6 company buys another company and both operate an HMO in the
7 same county, it would reasonable to combine the two
8 contracts.

9 In most cases, though, the consolidations to
10 boost star ratings have involved separate non-contiguous
11 geographic areas. For the last round of consolidations,
12 only one of 17 such cases involved any overlap of service
13 areas. All other cases involved distinct, non-contiguous
14 geographic areas.

15 The draft recommendation number 1 is a modified
16 version of what was presented as the Chairman's draft
17 recommendation at the December meeting. The key
18 modification to the language is the inclusion of a specific
19 date establishing when the policy would apply. The policy
20 would apply to all future consolidations -- that is, from
21 now on quality reporting and star ratings will be based on
22 pre-consolidation configurations when separate geographic

1 areas are involved. The new draft language also makes
2 clear what happens between 2018 and the period when draft
3 recommendation 2 is implemented, which is that the
4 Secretary would maintain the geographic configurations that
5 existed prior to any consolidations until such time as the
6 Secretary establishes geographic reporting units that
7 reflect local health care markets. Using January 1, 2018,
8 as the effective date also means that the most recent round
9 of consolidations, those that occurred at the end of 2017,
10 will be affected, as I will explain in detail on the next
11 slide.

12 So the draft recommendation now reads:

13 For Medicare Advantage contract consolidations
14 involving different geographic areas, the Secretary should:

15 For any consolidations effective on or after
16 January 1, 2018, require companies to report quality
17 measures using the geographic reporting units and
18 definitions as they existed prior to consolidation, and

19 Determine star ratings as though the
20 consolidations had not occurred, and maintain the pre-
21 consolidation reporting units until new geographic
22 reporting units are implemented per draft recommendation

1 number 2.

2 The implications are for beneficiaries -- for the
3 spending implication of this draft, rather, is that,
4 relative to current law, this recommendation would decrease
5 Medicare spending by between \$250 million and \$750 million
6 in 2019 and by between \$1 billion and \$5 billion over five
7 years.

8 As for the effect of the draft recommendation for
9 beneficiaries, it improves the accuracy of information on
10 plan quality but results in a lower level of extra benefits
11 in some plans. Plans will see a reduction in bonus
12 payments, but there will be a more level playing field for
13 competing plans.

14 As I mentioned, by stating that the draft
15 recommendation applies to consolidations effective January
16 1, 2018, or later, it has the effect of undoing some of the
17 aspects of the consolidations that occurred at the end of
18 2017, which were effective on January 1, 2018.

19 We will return to our illustrative example of the
20 Maine and Hawaii contracts to show how some of the
21 consolidation effects can be undone. This company decided
22 to consolidate the two contracts because of the star

1 ratings it received in October of 2016. The way the MA
2 contracting calendar works is that the October 2016 ratings
3 are used to determine benchmarks and bonuses in the bids
4 that plans submitted in June of 2017 for payments in 2018.
5 In our example, in October of 2016, Maine got a 4.5-star
6 rating and Hawaii was at 3.5 stars, as shown in the white
7 and blue boxes on the left side of the slide. When it came
8 time to submit bids in June 2017, the company made the
9 Maine contract the surviving contract so that its 4.5-star
10 rating would put the Hawaii contract into bonus status
11 through the consolidation strategy. The 2018 payments
12 resulting from these bids, and reflecting the consolidation
13 of the Maine and Hawaii contracts, are now locked in place
14 and cannot be undone by draft recommendation number 1.

15 However, what can be affected by the draft
16 recommendation are future payments, and there can be an
17 immediate effect with regard to the information that
18 beneficiaries see on Medicare Plan Finder. The effect is
19 possible because of what happened in October of 2017. In
20 October of 2017, the two contracts were not yet formally
21 consolidated. It is CMS' policy to compute new star
22 ratings for any contract operating in October of a given

1 year, regardless of whether the contract is to be consumed
2 by another contract in the following year. In this
3 particular example, that means that both the Maine contract
4 and the Hawaii contract had separate star ratings computed
5 in October of 2017, as indicated in the bulleted text next
6 to the white and blue boxes on the left side of the slide.

7 For Medicare Plan Finder, when there is a
8 consolidation, as I mentioned, it is CMS' policy that the
9 consumed contract immediately acquires the star rating of
10 the surviving contract. So in October 2017, during the
11 annual election period, even though the Hawaii contract had
12 a new star rating computed, CMS uses the new Maine 5-star
13 rating as the star rating shown in Medicare Plan Finder for
14 residents of Hawaii looking to enroll under this contract.
15 CMS does not publicly reveal the new star rating for the
16 Hawaii contract; that rating is represented here by the two
17 question marks in yellow lettering next to the Hawaii box
18 on the left side.

19 Under CMS' current policy, in this illustrative
20 example, Hawaii residents are now being told that they have
21 a 5-star plan available. The draft recommendation would
22 require that whatever star rating the Hawaii contract

1 received in October 2017 -- that is, the unrevealed star
2 rating represented by the two yellow question marks -- is
3 the star rating that should be shown in Medicare Plan
4 Finder in Hawaii, as illustrated by the blue arrow box and
5 the last blue box on the right side of the slide
6 representing the continued separation of star ratings for
7 Maine and Hawaii. Only if the Hawaii contract also
8 received a 5-star rating would the company be allowed to
9 have year-round enrollment in 2018 in Hawaii based on its
10 unrevealed October 2017 star rating.

11 The future payment effect of the draft
12 recommendation is that it would require the company to use
13 the Hawaii October 2017 star rating when submitting its bid
14 for the Hawaii plan in June of 2018 for the 2019 payment
15 year. So payments in 2019 would be based on the
16 configurations prior to consolidation, separating Maine and
17 Hawaii, as opposed to the current policy whereby the Maine
18 contract's 5-star rating applies in Maine as well as in
19 Hawaii for bonus payments.

20 Finally, as stated at the bottom of the slide, if
21 for administrative reasons it is not possible to determine
22 separate new star ratings for Maine and Hawaii for October

1 2018 and the release of stars then, CMS should use the
2 earlier, separate Maine and Hawaii star ratings, from
3 October 2017, rather than any combined rating, in Medicare
4 Plan Finder data and for bidding purposes until there is a
5 new star rating computed for each of the two separate
6 geographic units.

7 Here is a summary of the effect of the first
8 draft recommendation by the time periods involved. For all
9 future consolidations -- which is to say any consolidation
10 occurring with the upcoming June 2018 bids and thereafter -
11 - quality reporting and the determination of stars will be
12 done at the pre-consolidation geographic level when the
13 consolidation involves different geographic areas, as
14 though there had been no consolidation.

15 For the most recent round of consolidations --
16 those affecting the 1.4 million beneficiaries moved to
17 bonus plans for the 2018 payment year -- the draft
18 recommendation would have the Secretary change the
19 information currently shown in Medicare Plan Finder to
20 reveal the actual October 2017 star ratings for each
21 geographic area. In our illustrative example, Maine and
22 Hawaii would have their respective October 2017 star

1 ratings shown in Medicare Plan Finder.

2 The separate October 2017 star ratings will be
3 the ratings used in the June 2018 bids to determine
4 benchmarks in each geographic area.

5 Future reporting of quality data and the
6 determination of stars will be separate for each of the
7 separate geographic areas. In our illustrative case, Maine
8 and Hawaii will report separately and get separate star
9 ratings.

10 If it is not possible to have separate new star
11 ratings computed for the enrollment period beginning in
12 October of 2018, the separate October 2017 star ratings
13 should continue to be used because they are more accurate
14 indicators of the quality of care in each market. In our
15 illustrative example, if the company had already begun
16 reporting quality data on a combined basis for Maine and
17 Hawaii, the combined star rating computed from that data
18 should not be used to determine the contract's star rating
19 and eligibility for bonuses.

20 As I mentioned, the second draft recommendation
21 would address the consolidation issues but also improve the
22 reporting of quality in MA. As discussed in the mailing

1 material, we have a recommendation dating from 2005, and
2 reiterated in a number of reports after 2005, regarding the
3 designation of geographic areas in MA. Essentially, in the
4 case of quality reporting and the ability of beneficiaries
5 to compare the options available in their area, including
6 fee-for-service Medicare, the geographic units should be
7 based on the patterns of care in each health care market
8 area. In 2005, we specified what those areas should be,
9 but there are a number of data sources that identify health
10 care market areas that can be the basis for determining
11 geographic areas for quality reporting.

12 The second draft recommendation reads:

13 The Secretary should:

14 Establish geographic areas for Medicare Advantage
15 quality reporting that accurately reflect health care
16 markets, and

17 Calculate star ratings for each contract at that
18 geographic level for public reporting and for the
19 determination of quality bonuses.

20 The implications for spending are uncertain and
21 depend on the distribution of star ratings in each year.

22 As for the effect of the draft recommendation on

1 beneficiaries, they will have more accurate information on
2 plan quality. Plans would have an increased reporting
3 burden for measures based on medical record sampling or
4 member surveys.

5 Thank you, and we look forward to your comments
6 on the MA landscape material and your vote on the
7 recommendations.

8 DR. CROSSON: Thank you, Scott.

9 Carlos, we're open for clarifying questions at
10 the moment. I see David first, Kathy.

11 DR. NERENZ: Thanks, Carlos.

12 If we could flip back to Slide 12. Again, this
13 is one of my classic semantic wording questions. I
14 appreciate the clarification from December till now.

15 In the second bullet, we talked about star
16 ratings for each contracts, but then down at the bottom, we
17 talk about more accurate information about plans. Clearly,
18 plan and contract are not the same thing. I wouldn't think
19 it's obvious that a contract-level star rating would tell
20 me much about plan-level quality.

21 So my question in this round is, Do we really
22 mean contract, or do we possibly mean plan in that second

1 bullet?

2 MR. ZARABOZO: Well, what we mean is we mean to
3 say here that the contract will have multiple star ratings.
4 It is not necessarily by plan.

5 So, for example, you as a contractor can have --
6 let's say Miami. You have three plans in Miami. We would
7 say that in Miami, all those three plans in this contract
8 get the same star rating.

9 DR. NERENZ: Which is the way it works now.

10 MR. ZARABOZO: No. the way it works now is if
11 I'm talking about a contract in Miami that also has plans
12 in Oregon, which is the case for one contract there, they
13 have a star rating that is for Oregon and Miami combined.
14 We're saying --

15 DR. NERENZ: Yes, yes.

16 MR. ZARABOZO: Right. We're saying --

17 DR. NERENZ: But it's still at the contract
18 level.

19 MR. ZARABOZO: At the contract level.

20 DR. NERENZ: Yes, understand.

21 MR. ZARABOZO: Yeah.

22 DR. NERENZ: Okay. I just wanted to clarify

1 that's what we mean. We mean what we say here.

2 MR. ZARABOZO: We mean what we say here, yes.

3 DR. CROSSON: Yeah.

4 MR. ZARABOZO: Sometimes we don't mean what we
5 say, but in this case --

6 [Laughter.]

7 DR. CROSSON: Perhaps it's somewhat
8 uncharacteristic, but we do, actually.

9 DR. NERENZ: Yeah, that's right.

10 Well, in Slide 10, we talk about star ratings for
11 plans, and so it just seemed like we're slipping back.

12 MR. ZARABOZO: And sometimes we use the term
13 "plan" in the English language, and we mean this company,
14 yeah.

15 DR. NERENZ: Okay. Just making sure.

16 DR. CROSSON: Okay. So we are working in
17 English.

18 I had Kathy and Jon and then Brian and then Pat.

19 MS. BUTO: So Slide 10 -- and here, I just want
20 to be sure I understand. So as of January 1st, 2018, under
21 current practice or law or whatever, Hawaii would get the
22 Maine star rating. In 2019, would it be a combined

1 weighted average weighting -- I'm just curious -- if they
2 didn't adopt our recommendations?

3 MR. ZARABOZO: Yeah. In 2019, it would be this
4 company reports data for enrollees coming from Maine and
5 Hawaii, and you get a result.

6 MS. BUTO: And it would be a weighted average.
7 So Hawaii might actually bring down the overall weighting
8 for Maine as well.

9 MR. ZARABOZO: Right, right, right.

10 MS. BUTO: I just want to understand if the
11 recommendation is not adopted. What would happen?

12 MR. ZARABOZO: Right. But, of course, we do have
13 cases of reconsolidation, where if Hawaii did bring down
14 Maine, they would say, "Well, we have another contract in"
15 --

16 MS. BUTO: Well, they have a plan in California.

17 MR. ZARABOZO: Yeah, in New Mexico or whatever
18 that will bring us up again.

19 MS. BUTO: Okay, got it. Thank you.

20 DR. CROSSON: Thanks. Thank you.

21 Jon?

22 DR. CHRISTIANSON: On Slide 9, Carlos, when you

1 talk about the implications in terms of spending, future
2 spending for the program, are you basing that and making
3 assumptions about what the rate of consolidation would
4 continue to be going forward? Is that your counterfactual
5 here when you talk about the impact on future spending?

6 MR. ZARABOZO: Yes. We're assuming that the
7 current practice will continue absent the recommendation.

8 DR. CHRISTIANSON: And say more about that,
9 assuming the current practice will continue.

10 MR. ZARABOZO: Well, for example, this year, we
11 had 1.4 million enrollees affected, and one of those was a
12 reconsolidation. So not only are companies consolidating,
13 but then they're reconsolidating when they find the need to
14 --

15 DR. CHRISTIANSON: So is it the percentage -- so
16 you're looking at a rate of consolidation, and then you're
17 assuming that the dollars involved would be the same as
18 they were last year or --

19 MR. ZARABOZO: Around the same number of people
20 each year, something like that. Yeah.

21 Now, this is, of course -- this is also CBO
22 estimates.

1 DR. CHRISTIANSON: Okay. So the other thing,
2 when you were talking about -- when you introduced all the
3 language about timing and so forth, which I fully support
4 the reason for going down that route, and your opinion was
5 to avoid a race to consolidate before the --

6 MR. ZARABOZO: Well, yes. The reason was to
7 address as quickly as possible, as much as we could
8 address, which is why we're bringing in the last round,
9 because they do have star ratings that are separate. So
10 you could say, well, actually you can undo this partially.

11 DR. CHRISTIANSON: So without the language,
12 though -- was the reason for adding language? Without the
13 language, you were concerned that you would get this huge
14 amount of consolidation in the short term before the new
15 law kicked in or the new regulation kicked in?

16 MR. ZARABOZO: Well, no. If it had been adopted
17 immediately, then it wouldn't have happened. Right. Yeah.

18 DR. CROSSON: Brian.

19 DR. DeBUSK: This is back to Chart 10, and this
20 is more of a technical and implementation question for both
21 of you. Have we looked at any of the technical challenges?

22 I mean, like right now, a star rating is a

1 feature of a contract. The MA companies manage it that
2 way. CMS manages it that way. Have we looked at any of
3 the technical hurdles? Because what we're really doing is
4 talking about making the star rating a two-way key in that
5 it's tied to a contract and a geography now. Is that
6 something that CMS is going to come back to us and say,
7 well, that's a fundamental programming change that's five
8 years out? Have we run those traps yet?

9 MR. ZARABOZO: Well, actually CMS in the recent
10 proposed regulation says we are considering alternative
11 ways of doing the star ratings, including, as I mentioned
12 in the mailing material, the plan-level rating.

13 But compared -- given the degree of consolidation
14 and some of the contracts that cover wide, wide geographic
15 areas, it is appropriate to undo a lot of what has been
16 undone. If you say we're going to a local geographic area,
17 often it might be a very small number, so that is an issue.
18 We talked about that in the 2010 report about how to do
19 appropriate quality reporting. So there can be issues if
20 you go down, way down to a small geographic area, a small
21 number of people.

22 DR. DeBUSK: So we don't anticipate CMS pushing

1 back on any technical implementation issues associated with
2 these

3 MR. ZARABOZO: Well, a little -- to some extent,
4 yes, but not in a major way. I mean, they can be dealt
5 with, I think.

6 DR. CROSSON: Pat and then Bruce.

7 MS. WANG: Carlos -- and thank you for the deep
8 exploration of this phenomenon. It was very, very good.

9 But picking up on Brian's point, do you feel --
10 so in the proposed regulation, CMS stated that it was
11 looking at computing, star ratings, maybe by plan, but as
12 you have pointed out, plans can span geographic areas as
13 well. As you sort of go down the hierarchy of reporting
14 unit or computation unit, which one -- I assume that CMS
15 could tomorrow just compute at a plan level because they
16 collect information that way.

17 To Brian's point, though, breaking a plan further
18 into geographic units to the extent that they're not
19 contiguous or they don't match a local geographic area, is
20 that a lift? I'm just wondering whether there is anything
21 that needs to be added to the recommendation that would
22 sort of urge -- like don't let the perfect be the enemy of

1 the good. If you can do something tomorrow, do it
2 tomorrow. If it would take longer to get to the local
3 unit, then do that afterwards. Don't wait until that's all
4 set up.

5 MR. ZARABOZO: Well, the big difference -- so,
6 for example, going to -- CMS could not right now compute a
7 plan-level HEDIS rate, for example, on a measure that
8 involves a sample. So because the sample is being -- if
9 you have a contract with 1 million enrollees, the sample is
10 411 people across whatever geography you're talking about.
11 So if you wanted to do it at a plan level, you would have
12 to sample each plan to get a rating or that particular
13 measure on that plan for those kinds of measures, which is
14 why we mentioned in terms of the impact on plans, they will
15 have to sample at a lower reporting level. So we're saying
16 geography for those measures that are done on a medical
17 record sampling basis, and then the sampling for CAHPS, for
18 example, would have to be appropriate for the area that
19 we're talking about.

20 So it can be, as we mentioned in the 2010 report
21 -- could be a problem for small plans, small numbers
22 essentially, and then you have alternative like combining

1 years or --

2 MS. WANG: Just to play that out then, do you
3 think that those new steps could be performed in what year?
4 For which bid?

5 MR. ZARABOZO: Well, see, that's why we're saying
6 that -- right now, in our example, Maine and Hawaii, they
7 are currently reporting together. So when they submit in
8 June 2018 the HEDIS data, that's sort of water under the
9 bridge. You are already reporting together. So it would
10 be the next round, which is the so-called "2018 measurement
11 year," as it's called. That's when you tell them here is
12 how you report it. Yeah.

13 MS. WANG: So just so that I am fully clear, the
14 recommendation on page 12 is for '18. Payment is whatever
15 it is because it's baked, but to the extent possible, the
16 plan finder and the year-round enrollment would be changed.

17 MR. ZARABOZO: Yes, yes.

18 MS. WANG: But the consumed contract would still
19 be paid as though it were --

20 MR. ZARABOZO: Right. There's nothing --

21 MS. WANG: Okay.

22 MR. ZARABOZO: The payments are in place already.

1 MS. WANG: Then starting with the 2019 bid.

2 MR. ZARABOZO: Right. 2019, they have star
3 ratings that will determine bonuses for 2019 already, so
4 yeah.

5 DR. CROSSON: Bruce.

6 MR. PYENSON: Carlos, I wonder if you could
7 comment on the scale issue, and what I mean by that is
8 large plans versus small plans and new entrants into the
9 market or new entrants into a geography. It strikes me
10 that the plan consolidation issue implies a large plan --
11 with a large organization with plans, multiple plans. But
12 how does that work out for new competitors in a region or
13 totally new organizations in a region?

14 MR. ZARABOZO: Well, new plans or new contracts,
15 the star rating, you don't get -- you get a new plan star
16 rating, which if your company is already involved in MA,
17 you get the average of that company star rating. Otherwise
18 you get -- I think it's three and a half stars is the
19 current new plan rating until you're able to report the
20 data.

21 And then also in the case of -- many small plans
22 do not have -- didn't have star ratings, but CMS decided it

1 would try to extend down into the smaller plan, so they
2 have changed the policy somewhat so that more small plans
3 do, in fact, get star ratings.

4 But, I mean, the big issue is we have these
5 large, large, large contracts that are reporting and saying
6 this is the star rating across, let's say, 23, 35 states,
7 whatever number, based on this large contract.

8 MR. PYENSON: So the gains from that are a
9 potential offset to generate a large rebate in the bid and
10 enhance a competitive position.

11 MR. ZARABOZO: Right, right. Yes.

12 DR. CROSSON: Okay. So seeing no other
13 questions, we'll proceed to the comment and discussion
14 period.

15 We do have a recommendation, but since this is a
16 status report, I'd invite comments on the entire report as
17 well as on the recommendation.

18 I see Jack, Pat.

19 DR. HOADLEY: So I think this is a very important
20 recommendation, even though it feels in some ways like it's
21 kind of technical and down in the weeds, and I think that's
22 emphasized by the fact that there is an actual savings

1 that's not trivial that CBO has been able to identify for
2 this, also that it's going to make a difference for
3 beneficiaries who are evaluating in your example, you know,
4 two states that had different performance, and they'll
5 actually be able to understand the quality of the plan that
6 serves in their area. And that's true both with the first
7 recommendation that's dealing with this gaming but also the
8 second recommendation that's trying to say, "If I live in
9 Virginia and the contract that I'm looking at to
10 potentially join serves those 35 states, as you mentioned,
11 but maybe the Virginia one is not doing very well, whereas
12 overall across the country they're doing better, I'll
13 actually get the accurate report of what's going on in
14 Virginia." I think that's a pretty important issue, and so
15 I'm glad we're going to be able to speak to that.

16 The only other thing I wanted to note -- and you
17 just talked about that a little bit in the questions, but
18 the comparison of what we're recommending versus what CMS
19 proposed to do in the current proposed rule. And I know
20 you have a paragraph after the recommendation that sort of
21 highlights that. I think there's probably a couple more
22 points that you can make that you've implicitly already

1 really said in terms of the advantages of our approach over
2 that CMS approach that uses a weighted average? I think
3 you make the point that it's more accurate from a point of
4 view of looking at a local plan. So instead of a five- and
5 a three-star plan getting a weighted average of 3.5 or
6 something, the people in the area with 5 will see the 5,
7 and the people in the area with the 3 will see the 3.

8 But it also moves in the direction that the
9 second recommendation calls for, so that we're beginning to
10 already start to think about ratings that reflect the
11 geographic location. And so I think there's probably a
12 couple more sentences that could be added to that comment
13 on comparing it to the weighted approach that just sort of
14 further emphasized why we think our approach is better.

15 There's been a lot of attention to the CMS
16 approach because people have been in the process of writing
17 comments to the proposed rules. So even though that's a
18 thing of the moment and our report is for the longer
19 period, I think that notion of a weighted approach, it
20 would just be useful to contrast that, so thank you for
21 this.

22 DR. CROSSON: Pat.

1 MS. WANG: I support the recommendations
2 strongly, and I do really commend you for -- as Jack said,
3 it may seem very technical and detailed. You really went
4 down and I think you pointed out the approach, some of the
5 things that CMS proposed, which they're obviously aware of
6 this and trying to get at this that they may not have
7 appreciated. So I think the further exploration and detail
8 of your work is good. So I think the recommendations are
9 very strong, and I support them.

10 In terms of the chapter, in the description of
11 the lead-in of stars, there's obviously a factual statement
12 that bonuses are available at four stars and above. I do
13 think completely accurate, 100 percent accurate -- I do
14 think that that's worth a pause, though, to note that the
15 stars program, unlike many quality incentive programs, have
16 a cliff. It's really all or nothing. You can be at 3.74
17 as a raw score and get zero bonus and then be at 3.75 as a
18 raw score and round them to 4, and you'd get 4 or 5
19 percentage points. It's a huge bonus.

20 I personally wonder whether some of the
21 creativity that some of these organizations have undertaken
22 reflect the fact that the imperative to get four stars and

1 above is just really that black and white.

2 I would also urge us to consider or perhaps note
3 that it may not -- it may be something that folks want to
4 look at in terms of the optimal structuring of a true
5 incentive program, which tends to give graduated rewards
6 for graduated performance as opposed to this all-or-nothing
7 cliff.

8 The other thing which was in the chapter that
9 we're not discussing here has to do with some of the
10 information that you gave on benchmarks. It was on page 21
11 and 23. There were two tables, essentially. Again, it's
12 sort of factual reporting without comment.

13 Just to summarize what the table on page 21
14 showed was with the ACA sort of creation of quartiles of
15 counties that bid at a fixed percentage of the fee-for-
16 service benchmark -- 9,500, 107.5, 115 -- that there has
17 been significant movement of counties from the time that
18 PPACA went into effect to today. So many of the counties
19 that are in the highest spending, the proportion of
20 enrollees in the highest-spending counties that are held to
21 95 percent of the benchmark has decreased significantly,
22 and the opposite is true of the low-spending counties and

1 the highest benchmarks, which has over time actually
2 created an increase in the average benchmark that is being
3 bid. So at the time of the ACA, I think that your table
4 showed it was around 101, and now it's closer to 104.

5 The other thing that you had in the report was a
6 couple of pages later, there was a figure that sort of
7 showed the differences in dollars of the fee-for-service
8 equivalent from quartile to quartile, and if you look at
9 that figure, what it shows is it's just a few dollars can
10 flip you from a 115 percent benchmark into a 107.5
11 benchmark, into a 100 benchmark.

12 The only reason I'm bringing this up is I think
13 that it's very important information, but there was no
14 comment on the information in the chapter, and I would
15 suggest that at a minimum, that presentation at least would
16 suggest that Congress might want to look at the system of
17 benchmarks to see, because there's no apparent, to me,
18 rhyme or reason of why these counties should be moving
19 around. And since the overall impact on the program seems
20 to be inflationary, it might be wise to step back and
21 evaluate whether the current sort of benchmark
22 configuration is really appropriate for the long term. I

1 would suggest that it's just a common -- it's not a
2 recommendation, but it's kind of like a -- the information
3 is there. It's just kind of taking one further step to say
4 people might want to take a look at this. That would be my
5 recommendation.

6 DR. CROSSON: I don't know if you want to
7 comment.

8 Pat, I think I understand your points about the
9 cliffs in the stars thing, and I think we have on the
10 docket to continue to work on stars.

11 In terms of the benchmark piece -- and I
12 understand that as well because it's the same sort of
13 thing, cliffs -- I think before we could -- in this current
14 status report, before we could say to the Congress or the
15 Secretary, "You should look at this because of perceived
16 inequities," I think we would want to have a Commission
17 discussion about whether or not that's a position we want
18 to take or not.

19 I think I would -- please comment, Jim, if you
20 want, but I do think that we could go further in this
21 report in pointing out the fact that these are cliffs and
22 some of the points that you made, which are facts, but I

1 think to go and say, therefore, it should be dealt with
2 probably goes a little bit beyond any discussion that we've
3 had here, if that's okay.

4 Okay. Dana.

5 DR. SAFRAN: So I thought this was a really
6 nicely done chapter, and I agree with the recommendations,
7 support them wholeheartedly.

8 The thought that I had was I'd like to see the
9 language be a little bit more clear about how important
10 this is from a beneficiary perspective. That this policy
11 recommendation really is made with the beneficiaries in
12 mind, both giving them the most accurate information we can
13 when they're making choices, because that's a big part of
14 what the star program is designed to do, is inform their
15 choice, and you've done a really nice job, especially with
16 the example of Maine and -- now I just blanked.

17 DR. HOADLEY: Hawaii.

18 DR. SAFRAN: Hawaii. Thank you. And remember
19 they couldn't be farther apart.

20 [Laughter.]

21 DR. SAFRAN: Maine and Hawaii consolidation, that
22 paints a very clear picture of how this is not informing

1 choice of what's happening in your market, but I think just
2 making the language clearer about the value of doing this
3 for them beneficiary, and then there's the cost side for
4 the beneficiary as well that you already point to. I would
5 like to see us do that.

6 That does mean that we also then have to, on the
7 flip side, acknowledge that we have to pay attention to
8 adequate sample sizes for these geographic regions. You do
9 that, but in a narrative that's going to sort of point out
10 the advantages for the beneficiary, we want to be sure to
11 underscore that too, both the sample sizes and then timing.
12 So there are some places here where we're saying if you
13 can't get the data soon enough, then just carry forward the
14 older data. And I think we should acknowledge that there's
15 a tradeoff there of older data but more proximate and how
16 that affects the beneficiary.

17 And then lastly, I would say I do think that
18 hearing, Carlos, you're really good explication during this
19 discussion about the ways that this will lead to the plans
20 having to pull an example and so forth, that we should just
21 be a little bit more detailed in drawing that out, that we
22 recognize that this is extra cost and effort on the part of

1 the carriers, but that, again, circling back to the value
2 for the beneficiary that we think it's important enough to
3 ask for that.

4 DR. CROSSON: Okay. Seeing no other comments,
5 we'll proceed to the vote on the recommendations. Could we
6 have Slide No. 9?

7 So the Draft Recommendation is before you. I
8 won't read it. Give you a chance to read it, if you
9 haven't.

10 All Commissioners in favor of Draft
11 Recommendation No. 1, please raise your hand.

12 [Show of hands.]

13 DR. CROSSON: All opposed?

14 [No response.]

15 DR. CROSSON: Abstentions?

16 [No response.]

17 DR. CROSSON: It passes unanimously.

18 We'll proceed to Draft Recommendation 2 on Slide
19 12.

20 All Commissioners in support of Draft
21 Recommendation No. 2, please signify by raising your hand.

22 [Show of hands.]

1 DR. CROSSON: All opposed?

2 [No response.]

3 DR. CROSSON: Abstentions?

4 [No response.]

5 DR. CROSSON: Seeing none, it passes unanimously.

6 That's the end of this presentation, discussion,
7 and vote. Thank you, Scott and Carlos. We'll move on to
8 the next presentation.

9 [Pause.]

10 DR. CROSSON: Okay. For the balance of the
11 morning, we're going to have another status report, in this
12 case on Medicare Part D drug program. Rachel and Shinobu
13 are here, and Rachel is starting out.

14 DR. SCHMIDT: Good morning. Shinobu and I are
15 here to bring you a status report for Part D, Medicare's
16 outpatient drug benefit. We would like to thank Jennifer
17 Podulka and Emma Achola for their contributions to this
18 chapter.

19 Part D is different from fee-for-service Medicare
20 in that private plans deliver drug benefits to enrollees,
21 and in return Medicare pays plan sponsors monthly capitated
22 amounts and other more open-ended subsidies. Part D uses a

1 competitive structure to provide incentives for plan
2 sponsors to offer attractive drug benefits yet manage drug
3 spending and keep enrollee premiums low.

4 In this presentation we'll describe the program,
5 key trends, and the strategies plan sponsors use to manage
6 drug spending. We'll look at developments in drug pricing
7 and in program spending. And in preparation for your vote,
8 we'll review the draft recommendations we brought to you in
9 November related to biosimilars.

10 In 2017, among nearly 59 million Medicare
11 beneficiaries, 72.5 percent were enrolled in Part D plans.
12 Nearly 3 percent got drug benefits through the retiree drug
13 subsidy, in which employers provided primary drug benefits
14 to their retirees in return for Medicare subsidies. The
15 remaining 25 percent was divided fairly equally between
16 beneficiaries with other sources of drug coverage as
17 generous as Part D and those with no drug coverage or less
18 generous coverage.

19 Medicare program spending for Part D was nearly
20 \$80 billion in 2016 -- predominantly for payments to
21 private plans and \$1 billion for the retiree drug subsidy.
22 Part D makes up over 13 percent of total Medicare outlays.

1 In addition, Part D enrollees directly paid
2 nearly \$13 billion in plan premiums, as well as amounts for
3 cost sharing.

4 Survey data continue to show that most enrollees
5 are satisfied with their drug plans.

6 Part D's defined standard benefit is shown on the
7 left of this slide. In 2018, it has a \$405 deductible, and
8 then the enrollee pays 25 percent of covered benefits and
9 the plan pays 75 percent until the enrollee reaches \$3,750
10 in total spending. After that point, there's a coverage
11 gap in which the enrollees pay more than 25 percent cost
12 sharing. Once an applicable enrollee accumulates \$5,000 in
13 out-of-pocket spending, they pay 5 percent, the plan pays
14 15 percent, and Medicare pays 80 percent through
15 reinsurance. In practice, nearly all Part D plans use
16 benefit designs that are different from this standard
17 benefit but have the same average benefit value. For 12
18 million beneficiaries who receive Part D's low-income
19 subsidy, Medicare pays for nearly all of their premiums and
20 cost sharing.

21 The right-hand side shows you how Part D's
22 coverage gap is being phased out between now and 2020, with

1 brand-name drugs (including originator biologics) at the
2 top and generics and biosimilars at the bottom. As a
3 condition for having their drugs covered by Part D,
4 manufacturers of brand-name drugs and originator biologics
5 have to provide a 50 percent discount in the coverage gap.
6 So in 2018, the manufacturer discounts 50 percent of the
7 price, the enrollee pays 35 percent in the gap, and the
8 plan pays 15 percent. In 2020 and thereafter,
9 manufacturers will continue to provide the 50 percent
10 discount, enrollee cost sharing will decrease to 25
11 percent, and plans will pay 25 percent. Notice at the
12 bottom that there's no manufacturer discount for generics
13 or biosimilars. As we talked about in November, the lack
14 of a discount on biosimilars affects incentives because it
15 makes originator biologics look relatively less expensive
16 to both beneficiaries and plans, and plan sponsors may be
17 less inclined to put biosimilars on their formularies.
18 Also, under current law, the manufacturer discount on
19 originator biologics moves enrollees toward the out-of-
20 pocket threshold more quickly because the discount is
21 counted as if it were the enrollee's out-of-pocket
22 spending, so Medicare pays more in open-ended reinsurance.

1 Here are a few highlights about the plans that
2 enrollees chose in 2017 and what's available for 2018.

3 In 2017, 59 percent of enrollees were in stand-
4 alone prescription drug plans and 41 percent in Medicare
5 Advantage drug plans, compared with 70 percent in PDPs and
6 30 percent in MA-PDs during 2007. In 2017, 29 percent of
7 all enrollees received the low-income subsidy compared with
8 39 percent in 2007; 36 percent of low-income subsidy
9 enrollees are in Medicare Advantage drug plans, which is
10 much higher than at the start of Part D, but still most LIS
11 enrollees are in stand-alone drug plans.

12 For 2018, plan sponsors are offering 5 percent
13 more stand-alone drug plans and 16 percent more Medicare
14 Advantage drug plans, so there is continued broad choice of
15 plans. There are 6 percent fewer PDPs that qualify as
16 premium-free to enrollees with the low-income subsidy. One
17 region, Florida, has two qualifying PDPs, but all the
18 others have three to ten qualifying PDPs in each region.

19 Since the start of Part D, enrollment has grown
20 at about 6 percent per year. Enrollment among
21 beneficiaries who do not receive the low-income subsidy has
22 grown faster than those with low-income subsidy. Since

1 2010, a number of employers have moved their retirees out
2 of the retiree drug subsidy and into Part D plans that are
3 set up just for employer groups. Today there's a sizable
4 share of Part D enrollees in employer group plans, and some
5 plan sponsors focus more on that market.

6 The average Part D premium has remained steady at
7 \$30 to \$32 per month between 2010 and 2017. However,
8 that's the average, and there's a lot of variation in Part
9 D premiums. The drug portion of premiums for Medicare
10 Advantage drug plans has grown a bit faster than premiums
11 for stand-alone plans.

12 Over the same period that average enrollee
13 premiums have been flat, there has been much faster growth
14 in Medicare's cost-based reinsurance payments to plans.
15 The Commission has been pointing this out for many years,
16 and in 2016 the Commission made recommendations that were
17 designed to address that issue. You'll see those in a
18 minute.

19 Part D enrollment is concentrated among a few
20 major plan sponsors, and this slide shows the main
21 strategies those organizations use to control benefit
22 spending.

1 Sponsors design formularies with differential co-
2 payments across cost-sharing tiers, and in Part D most
3 plans use five tiers.

4 Plan sponsors and their PBMs negotiate with drug
5 manufacturers for rebates in drug classes where there are
6 competing therapies. We've seen the aggregate amount of
7 rebates grow tremendously in recent years, and one reason
8 is because plan sponsors have negotiated for price
9 protection. Under these agreements, if a drug's price
10 increases above some threshold, the manufacturer rebates
11 the additional amount of increase to the sponsor. Price
12 protection rebates are concerning because they may keep
13 plan sponsors sanguine about manufacturers' mid-year price
14 increases.

15 In Part D, plan sponsors cannot exclude
16 pharmacies from their networks, but they can use lower cost
17 sharing to encourage enrollees to fill prescriptions at
18 certain pharmacies. Some sponsors may also use post-sale
19 pharmacy fees that have the effect of discouraging some
20 pharmacies from signing up for their networks.

21 Last September we talked about the issue of how
22 plan sponsors and PBMs dispense high-cost specialty drugs

1 through specialty pharmacies and the complicated incentives
2 around which entities control distribution and dispensing
3 of very expensive drugs. We'll continue to monitor how
4 those arrangements might affect the Part D program.

5 I mentioned that average Part D premiums have
6 remained flat at the same time that Medicare's reinsurance
7 payments have grown rapidly. Changes in the prices that
8 Part D enrollees pay at the pharmacy (before rebates) have
9 played a role in this. This slide shows the Commission's
10 Part D price indexes. These are measures that give an
11 overall look at how the prices that beneficiaries pay at
12 the pharmacy counter have been changing through 2015. If
13 you look at the left-hand side, you can see that all the
14 lines have a starting value of 1 in 2006. The blue line
15 provides a summary: It shows overall average price
16 changes, and you can see that it was flat and even declined
17 around 2012, but has subsequently ticked upward. The
18 yellow line at the bottom shows generic prices, which on
19 the whole have declined dramatically since the start of
20 Part D. At the top, the red line shows prices for brand-
21 name drugs, including biologics, which have grown
22 aggressively. These are list prices, so they don't take

1 into account rebates. Nevertheless, they're relevant to us
2 because it's list prices that often determine how much cost
3 sharing an enrollee pays, what phase of the benefit they've
4 reached, and whether they've hit the out-of-pocket
5 threshold, which is the point where Medicare pays 80
6 percent through reinsurance.

7 Looking again at the blue line in the middle, it
8 was flat earlier in the program because a lot of
9 blockbuster drugs lost patent protection and Part D
10 enrollees switched to generics. But, subsequently, fewer
11 drugs went off patent, and growth in brand prices
12 overwhelmed the moderating influence of generics.

13 Now we'll turn to how these trends in pricing are
14 reflected in program spending.

15 MS. SUZUKI: This table shows the different
16 components of Part D spending.

17 The top two rows show Medicare's subsidy payments
18 to plans to cover the cost of providing the basic benefits.
19 Direct subsidy is a monthly capitated payment, adjusted for
20 health risk. Reinsurance is a cost-based payment because
21 it reimburse plans based on actual spending. Those two
22 subsidies are designed to cover about 75 percent of the

1 cost. The low-income subsidy, which is shown below, is
2 Medicare's payments to plans to cover the cost sharing and
3 premiums for beneficiaries who receive the low-income
4 subsidy.

5 Payments for reinsurance have grown faster than
6 other components of Part D spending. Between 2007 and
7 2016, reinsurance payments grew by nearly 18 percent per
8 year on average, compared with slight decrease for the
9 direct subsidy.

10 As a result, in 2016, a much higher share of
11 Medicare's payments to plans were for reinsurance, which is
12 the cost-based part of Medicare's payments, rather than the
13 direct subsidy payments that gives plans insurance risk and
14 a stronger incentive to manage spending.

15 This chart breaks out the growth in spending per
16 enrollee -- shown in gray bars -- into growth in price --
17 in blue -- and growth in quantity, measured by the number
18 of prescriptions -- in white.

19 In 2015, 8 percent of Part D enrollees reached
20 the catastrophic phase of the benefit. Those high-cost
21 enrollees accounted for 57 percent of overall spending in
22 2015, up from about 40 percent before 2011. As growing

1 share of overall spending is accounted for by high-cost
2 enrollees, the average per capita spending across all Part
3 D enrollees is increasingly affected by spending for high-
4 cost enrollees.

5 The chart shows this has already been happening.
6 On the left, you can see that for high-cost enrollees, the
7 growth in the price per prescription has driven their
8 spending growth much more so than the quantity or the
9 number of prescriptions they've filled. Between 2010 and
10 2015, the average price per prescription for high-cost
11 enrollees rose by more than 10 percent per year. On the
12 set of bars to the right, you can see that per capita
13 spending for all Part D enrollees grew by about 4-1/2
14 percent annually. That reflects an increase of about 10
15 percent among the high-cost enrollees and a decrease of
16 about 2 percent for low-cost enrollees.

17 Going forward, as more enrollees use higher-price
18 drugs, there will be even stronger upward pressure on
19 Medicare program spending.

20 Many factors are converging to drive more
21 catastrophic spending. There has been a rapid growth in
22 Part D enrollment, particularly among the non-LIS

1 enrollees. We are seeing higher drug prices reflecting
2 both high launch prices for new therapies and increasing
3 prices for existing brand-name drugs and biologics. The
4 coverage gap discounts are moving non-LIS enrollees more
5 quickly into the catastrophic phase of the benefit. And,
6 finally, there may be cases in which plan sponsors find it
7 more financially advantageous to put higher-price drugs on
8 their formularies because of how rebates and coverage gap
9 discounts affect their net costs.

10 The result is more high-cost enrollees and a
11 rapid growth in Medicare's spending for reinsurance. This
12 trend is likely to continue as an increasing share of the
13 biopharmaceutical pipeline are for specialty drugs with
14 high prices, many of which are biologics. Those concerns
15 led us to recommend changes to the program in 2016.

16 The core idea behind the Commission's 2016
17 recommendations was to give plan sponsors greater incentive
18 and more tools to manage spending for enrollees who reach
19 the catastrophic phase of the benefit. I want to focus you
20 on key parts of the recommendation that are relevant to the
21 draft recommendation you will be voting on today.

22 One part of the 2016 recommendation changes the

1 LIS co-pay structure so that, for LIS beneficiaries,
2 biosimilars would have lower cost sharing than the
3 originator biologics. CMS recently proposed to do this
4 administratively.

5 Another part would discontinue counting the
6 coverage gap discount as true out-of-pocket spending. At
7 the time, we discussed how the discount disadvantages the
8 generics drugs relative to brand-name drugs and acts in a
9 similar way as co-pay coupons -- encouraging beneficiaries
10 to use higher-priced therapies. But we also recognized
11 that some enrollees would pay more in cost sharing. And to
12 limit that burden, the recommendation eliminated cost
13 sharing above the out-of-pocket threshold, effectively
14 putting a hard cap on beneficiary cost sharing.

15 More recently, we have been looking at
16 biosimilars and come to realize that we need to make
17 conforming changes to the prior recommendations to
18 encourage the use of biosimilars. While biosimilars are
19 expected to have lower prices than their originator
20 biologics, they can still have higher prices and high out-
21 of-pocket costs. The policy to add the out-of-pocket cap
22 would provide protection and would work in concert with the

1 draft recommendation, which I'll put up shortly.

2 Biologics will continue to grow in importance,
3 and their high prices raise concerns about the cost burden
4 on patients and the program. Biosimilars have the
5 potential to introduce price competition and improve
6 patient access.

7 As we discussed in November, some Part D policies
8 may negatively affect biosimilar use. For LIS
9 beneficiaries, because higher brand cost sharing amount
10 applies to both biosimilars and originator biologics, there
11 is no financial incentive to use biosimilars. And as I
12 just pointed out, we addressed this in our 2016
13 recommendation.

14 For non-LIS beneficiaries, the coverage gap
15 discount could make biosimilars more expensive than
16 originator biologics because the discount only applies to
17 the originator biologics.

18 From a plan sponsors' perspective, the distortion
19 in prices created by the discount means that it would often
20 be financially advantageous to put the originator product
21 on its formulary.

22 These distortions and incentives led us to the

1 current draft recommendation, which reads:

2 The Congress should change Part D's coverage gap
3 discount program to: require manufacturers of biosimilar
4 products to pay the coverage gap discount by including
5 biosimilars in the definition of applicable drugs; and
6 exclude biosimilar manufacturers' discounts in the coverage
7 gap from enrollees' true out-of-pocket spending.

8 We think the draft recommendation would remove
9 distortions against biosimilars and send better price
10 signals to plans. That, in turn, would tend to reduce
11 reinsurance spending so that Medicare would pay more of the
12 74.5 percent subsidy through capitated payments and less
13 through cost-based reinsurance.

14 Today there aren't many biosimilars that fall
15 under Part D, so the near-term savings are likely to be
16 small. But over the longer term, we expect more entry of
17 biosimilars, so savings could be larger.

18 Because the Commission considers this draft
19 recommendation to be an addition to its standing 2016
20 recommendation, we asked CBO to provide one combined
21 estimate inclusive of the new biosimilar component. That
22 means the estimate reflects the protection provided by the

1 hard out-of-pocket cap for anyone who incurs spending above
2 the out-of-pocket threshold, including those who take
3 biosimilars.

4 The combined effects put savings in the same
5 range as in 2016 -- more than \$2 billion in one year and
6 more than \$10 billion over five.

7 Because of the change in financial incentives,
8 plan sponsors would be more likely to place lower-priced
9 biosimilars on their formularies.

10 Excluding the discounts from the true out-of-
11 pocket cost would tend to reduce the number of enrollees
12 who reach the out-of-pocket threshold.

13 Non-LIS enrollees with spending high enough to
14 reach the gap phase could have higher cost sharing, but
15 under the combined recommendations, there would be a hard
16 out-of-pocket cap to protect beneficiaries with the highest
17 spending. And the recommendation would also result in
18 larger discounts paid by manufacturers.

19 I will put up the draft recommendation for your
20 discussion.

21 DR. CHRISTIANSON: All right. Bruce.

22 MR. PYENSON: Thank you very much. I'm wondering

1 if you have any insight into the -- to separate the
2 coverage gap discount from -- and the impact of that on the
3 presumed increased use of biosimilars, because of changing
4 the structures so that biosimilars and brands are on an
5 equal basis.

6 DR. SCHMIDT: So I don't think that we got that
7 level of detail out of CBO in their assumptions, and I
8 don't think that we, ourselves, have analyzed that to that
9 degree yet.

10 MR. PYENSON: Just what's -- part of what's
11 behind my question is that although some people had hoped
12 that biosimilars would produce savings to health care
13 system in the commercial world, that has not happened.
14 Many people have been disappointed by the uptake, the
15 impact of biosimilars, partly because of slow approval but
16 partly because of the competitive environment, even in the
17 commercial side.

18 So my question relates to whether this change,
19 which I think makes sense, is enough to move the dial on
20 biosimilars.

21 DR. SCHMIDT: In November's mailing materials I
22 think we talked to some of those issues that you're laying

1 out now. There's been slow approval of biosimilars and
2 that the competitive environment now is making it difficult
3 to gain market share for biosimilars.

4 You know, I don't know that we can deal with all
5 of the issues. Some of them are outside of Medicare, for
6 example, the whole issue of interchangeability and
7 acceptance of biosimilars by prescribers, and, you know,
8 what's considered by some as anticompetitive practices
9 among manufacturers and dealing with PBMs and formulary
10 decisions and all of that. But I think what we can do is
11 change the incentives within the Medicare program and at
12 least send a signal for the future that we're hoping they
13 be treated in a more equal manner with originators.

14 DR. CHRISTIANSON: So let's do Jack and then Amy
15 and then Kathy.

16 DR. HOADLEY: So just one clarifying question on
17 -- as you point out, in 2020 we'll hit the point where the
18 gap is no longer the gap. And I guess I still have not
19 heard any clarification on whether, at that point, plans
20 will have the flexibility to bring their tiered cost-
21 sharing designs into that gap phase or whether they are
22 restricted either by statute or by rules that CMS would

1 establish to just using a straight 25 percent coinsurance,
2 and, of course, complicated by the 50 percent manufacturer
3 discount that would start to interact if you went into some
4 other kind of tiered cost-sharing.

5 But have we seen anything either in readings of
6 the statute or in guidance from CMS on that?

7 MS. SUZUKI: I don't think we have seen any
8 clarifications about how to proceed, how CMS would proceed,
9 but we can continue to look into this.

10 DR. HOADLEY: Yeah. You know, I think I may have
11 asked that a couple of years ago, but now we're actually
12 close to 2020, and it seems like plans would want to know
13 whether this is going to be an option for them. And I'll
14 come back to this in Round 2.

15 DR. CHRISTIANSON: Amy.

16 MS. BRICKER: Thanks for the chapter. Just a
17 couple of things. So we note the spike in brand spend in
18 the recent years associated with hep C. Have we been able
19 to look at corresponding medical data on those
20 beneficiaries and savings or, you know, perceived cure,
21 right, for these folks, associated savings on the medical
22 side?

1 DR. SCHMIDT: We have not, and we could try and
2 take a look at that. I think there was an ICER study that
3 came out to, what, a few -- around the time the hep C drugs
4 came out, that was disputing the notion that there were
5 large savings associated with it.

6 MS. BRICKER: It would be interesting.

7 DR. SCHMIDT: But we have not looked at the
8 Medicare data ourselves.

9 MS. BRICKER: Okay. Something maybe to
10 considering.

11 Switching on you topics. On page 18 of the
12 reading materials you -- we talk about late enrollment
13 penalty. What impact do you think that has on enrollment?
14 Is that -- and is it doing what we want it to do? So I
15 would imagine, at the inception of Part D, this was to
16 ensure folks enrolled, right? We didn't want to create a
17 plan and then, you know, stand up, you know, many offerings
18 across the country with no enrollment, right? So there
19 was, I assumed, this incentive to ensure that folks
20 enrolled. Well, we don't have a problem there with
21 membership of Part D.

22 Do you think that the late enrollment penalty is

1 still serving its purpose, or have you given that much
2 thought?

3 MS. SUZUKI: I don't have a thought, except to
4 say that the -- when we look at the coverage, drug coverage
5 for the Medicare population, it seems like an increasing
6 share of the population either -- increasing share has Part
7 D, but the share with a drug coverage has remained fairly
8 stable. So either they have a creditable coverage, which
9 is actually equivalent so they don't have to get the Part
10 D, or they have the Part D, or they have the Part D. And
11 those without drug coverage has remained on the order of 12
12 percent since the start of the program. So if it did
13 accomplish anything it's continued to.

14 MS. BRICKER: Interesting. Okay. One other
15 thing. Do you think beneficiaries understand the value
16 that is being achieved of that 50 percent in the coverage
17 gap? You know, this is a very complicated program, right?
18 It's unlike any other that anyone that is -- any other
19 prior commercial experience would actually then -- when
20 they roll into a Part D plan, really understand all of
21 these different phases and what they're responsible for.
22 Do you think that they -- that the average beneficiary

1 actually understands that this 50 percent rebate in the
2 coverage gap is helping them reach their deductible? Do we
3 have any sense?

4 DR. SCHMIDT: I would suspect not. You know,
5 they're just seeing what they're being asked to pay at the
6 pharmacy counter. It's not necessarily apparent to them.
7 But for people who are on the highest-cost drugs, they're
8 just noting that it's very high. They probably aren't
9 aware what the out-of-pocket threshold is and why what the
10 ultimately end up paying for the year is actually not that
11 full amount. So, no, there's -- I don't think they are
12 aware.

13 MS. BRICKER: I wonder if there's something we
14 can do -- this could be a roundtable -- something we can do
15 to help either simplify the benefit or communicate, really,
16 what is happening in these phases so that beneficiaries can
17 make educated decisions. We talk about this incentive that
18 could be -- this incentive that could be created because of
19 this 50 percent rebate, and is this really impacting
20 utilization, and I'm just trying to bridge that theory with
21 actual practice. We actually think because beneficiaries
22 know they're getting that, they are then feeling incented

1 to continue on high-cost, high-rebated drugs versus they
2 just follow whatever their doctor says. They don't really
3 have any idea.

4 DR. SCHMIDT: Yeah, you're right. I see the
5 discontinuity there. I think, you know, if we were
6 designing Part D from scratch we probably would have a
7 completely different structure. It might look more like
8 commercial -- I think the coverage gap discount program was
9 in there because we couldn't really afford, or that was the
10 political decision at the time, we could not afford a
11 continuous benefit, but wanted the coverage gap to be
12 smaller. So that's where we are.

13 MS. BRICKER: Thank you.

14 DR. CROSSON: I'd have to say, Amy, it's not just
15 beneficiaries that have trouble figuring out the coverage
16 gap. Every time we talk about it here I think I've learned
17 something new myself.

18 Kathy.

19 MS. BUTO: Just two quick questions on Slide 6, a
20 question about MA PDPs premium growth being higher than
21 standalone PDPs. Do we understand why that's happening or
22 what the underlying thing is there?

1 DR. SCHMIDT: Not completely. Part of this is
2 the MA-PD premiums are reflecting the Part C rebate
3 dollars, so part of the difference between the payment rate
4 and the bid is being used for Part D benefits to lower
5 their premiums.

6 MS. BUTO: Uh-huh.

7 DR. SCHMIDT: So there is that complication.

8 MS. BUTO: To lower the premiums, is what you're
9 saying, in Part D.

10 DR. SCHMIDT: Yeah.

11 MS. BUTO: Considering the growth is higher in
12 premiums.

13 DR. SCHMIDT: Right. So the MA-PD premiums
14 reflect the combination of those two things. And it also
15 could be that they just have been at a lower level so it
16 looks like a higher rate of increase. There is a variety
17 of changes there.

18 MS. BUTO: Okay. Then kind of a related
19 question, Slide 9, is, are we seeing the same trend in
20 growth in spending for reinsurance in MA-PDs as we are
21 standalone PDPs, because I wonder if there's something
22 going on there where MA plans are more effective in sort of

1 -- are more effective from the Medicare program standpoint
2 in keeping beneficiaries out of that reinsurance pool, or
3 whether we're seeing exactly the same trend.

4 MS. SUZUKI: So we have not looked at the plan
5 distribution recently. One thing about the people who
6 reach the catastrophic phase is that they're mostly low-
7 income subsidy populations, so they tend to be in PDPs more
8 so than MA-PDs.

9 MS. BUTO: Okay. Okay. Got that.

10 And last, just to comment on Amy's point about is
11 the late enrollment penalty still needed, I would say yes,
12 for every cohort of new beneficiaries who sign up for
13 Medicare you need that. Otherwise, people will delay
14 enrolling until they need drugs, or need expensive drugs.

15 DR. CROSSON: Jack.

16 DR. HOADLEY: I want to follow up on your first
17 question. Have you taken a look, at any point, at the MA-
18 PD premiums pre-rebate dollars to see if you can parse out
19 that trend?

20 DR. SCHMIDT: It's been a while since we've done
21 that, but we could, yes.

22 DR. HOADLEY: It could be a useful thing at some

1 point to get at that question.

2 DR. CROSSON: Okay. Seeing no further questions
3 we'll proceed to the discussion. And again, since this is
4 a status report, I will invite comments as you wish, not
5 just on the recommendation but on the report itself. So I
6 see Jack.

7 DR. HOADLEY: So thank you. You know, I was
8 reflecting, as I read this chapter, that this is the sixth
9 such status report I've read in my six years on the
10 Commission, in addition to some other reports in June
11 chapters and so forth, and I just, you know, just want to
12 comment on the impressive staff work that's gone into this
13 work over that period and acknowledge and thank Rachel and
14 Shinobu and John before that, and others who have
15 contributed to all of this great work. I just think it's -
16 - we've done a real service in providing information on
17 this program.

18 To the recommendation first, I do support the
19 recommendation. You know, I think it's just trying to
20 correct what I think is just a -- whether it was an
21 intentional omission or an unintentional omission, I think
22 it's making a correction to the status.

1 You know, we do point out -- you do point out in
2 the surrounding text that the exclusion of the discounts
3 from the true out-of-pocket cost is consistent with our
4 2016 recommendations, and make the point, I think, very
5 clearly, that we should really be -- that people should
6 view these all as a package. It may be worth a sentence
7 just to say that if Congress were to do this more piecemeal
8 that it wouldn't make sense to do the true treatment
9 differently for the originator biologics and the
10 biosimilars, or we could further complicate the things.
11 Obviously, if they did all of what we recommend, that
12 wouldn't be a problem.

13 Somewhere in the implications discussion I think
14 I'd like to see us reiterate the one comment, that language
15 we had in 2016, about the ability to use any greater
16 savings that might be achieved to protect the non-LIS
17 beneficiaries with high cost-sharing. We made that point
18 in 2016, and it would be worth just repeating that here.

19 And I would note that, you know, on the 2016
20 recommendation about -- and I think you noted this too --
21 on eliminating the LIS cost-sharing for biosimilars, that
22 the CMS proposed rule moves partly in that direction. Of

1 course, we recommend completely eliminating it, and they
2 would only move it to the current lower category. But that
3 might be more prominently mentioned in the chapter, sort of
4 that contrast.

5 So the other things I wanted to do today was to
6 just comment more broadly on probably what constitutes some
7 ideas for future work. I think that the graphic -- and you
8 had it on Slide 8 and you had it in some more detailed
9 versions of that in the text material, on the growth and
10 the price index, is particularly, as you added in the mail-
11 out on insulin and MS drugs, where the index reaches 3.0 or
12 larger, that we really have what we see here as probably
13 the most alarming trend going forward. And you focused on
14 this quite a bit in the presentation, combining that with
15 the reinsurance payment trends.

16 Obviously, our 2016 recommendations partly go to
17 that point and try to identify changes in the reinsurance
18 that would allow, you know, putting more pressure on plans
19 to try to do this, and I'm glad we're reprinting that and
20 putting that in this broader context. But I think at some
21 point, you know, we're going to have to go further to
22 address the pricing strategies that are engaged by

1 manufacturers in setting high prices and raising them a lot
2 more than inflation, and things that really are out of the
3 ability of plans to do a whole lot about, particularly for
4 sole-source drugs, you know, where there is only the one
5 market alternative and the plan doesn't have a lot of
6 leverage to do anything, or where we've seen this sort of
7 tandem increases for insulins or MS drugs or some of the
8 others where, you know, in theory, the plan should have the
9 leverage to play one off against the other.

10 In practice, it's not clear that that's working,
11 and, you know, whether we need to look at some greater role
12 for a government negotiation or some other step for
13 particularly these kinds of drugs, to try to get them, and
14 I'd like to see us look into that, as well as, as we talked
15 about in November, the various rebating games and questions
16 of whether beneficiaries get full advantage of the
17 discounts, whether plans are doing all they can do to save
18 money, and so forth, and whether some of the manufacturer
19 games to extend patents abuse the orphan drug policies, and
20 so forth. And I think trying to look at some of these
21 things, you know, that push a little beyond what we
22 normally talk about, but really are trying to -- you know,

1 if we have a Part D program that's relying on marketplace
2 competition, these are places where the market is just not
3 allowing that to happen.

4 Another angle I thought would be useful to look
5 at in the future is -- and you've highlighted this in some
6 of the data -- some of the PDPs, over the course of the
7 program, over the more than a decade of running the
8 program, have managed to hold the line on premiums pretty
9 substantially. Others have seen much, much larger
10 doubling, in some cases, of premiums over that decade-plus.
11 There are a lot of things that may go into that -- risk
12 segmentation, plans that have -- you know, or company
13 sponsors that have planned their different plan offerings
14 to perhaps segment risk and have some cheap plans and some
15 more expensive plans, different uses of cost-sharing,
16 different uses of formularies, co-insurance management,
17 especially drugs.

18 But, you know, it seems like it might be valuable
19 to try to take a deeper drive into how different plans have
20 approached cost management, whether it's sort of a false
21 cost management and they're managing their premiums but not
22 necessarily their overall costs, or whether the ones that

1 are keeping premiums down are actually keeping overall
2 costs down. And if there are differentials, then what are
3 some doing that others aren't being able to do? What is
4 the tradeoff between premium growth and other factors that
5 affect beneficiaries?

6 And related to that is how, then, can we offer
7 beneficiaries more information when they're making choices,
8 not just on premium -- and we know that beneficiaries tend
9 to choose mostly on premiums and a little bit on, you know,
10 if they go through the plan-finder their total out-of-
11 pocket costs. But how could we give beneficiaries more
12 information about which plans are using different
13 strategies on tight formularies?

14 You know, we've talked about this a lot in terms
15 of -- in the commercial world, in terms of, you know,
16 people are actively making tradeoffs between narrow
17 provider networks and lower premiums. Help people think
18 about, am I willing to have a tighter formulary to get a
19 lower premium? Am I willing to have tighter utilization
20 management to get a lower premium -- if that's, in fact,
21 the way these tradeoffs work. So not only see what's
22 working but also figure out, then, how we could help tell

1 beneficiaries the differences, not just about the cost of
2 their current drugs but sort of how this plan is
3 approaching things.

4 And then I wanted to mention a few others, and I
5 won't go into detail, but to the question I raised in the
6 first round, you know, I think it would be useful for us to
7 comment or potentially even develop a position on how cost-
8 sharing should work in 2020 and beyond, in the gap phase.
9 Should we allowing tiered cost-sharing? If that's what
10 seems to be working for plans, it seems like plans would
11 want to do that. It would help potentially plans that are
12 more aggressive about sort of brand versus generic
13 strategies. It would help them -- give them more tools.

14 But obviously we would have think how that
15 interacts with the 50 percent manufacturer discount, which
16 is like a statutory version of the rebate strategies that
17 we sometimes worry about. If you had a 50 percent copay
18 and there's a 50 percent discount, the plan is paying
19 nothing, you know, there's a lot of funny interactions they
20 could do, and it seems like we're working through it, some
21 of that would be useful, as well as the jump-up in the
22 catastrophic threshold as of 2020, that I think we

1 mentioned at the last meeting.

2 Another one is whether there should be more
3 transparency in further waivers for the employer PDPs and
4 MA-PDs. I think there are some issues there that are worth
5 raising. Amy already mentioned the LEP. I think it would
6 be just useful to get some data on how many people are
7 subject to the LEP. And I know you mentioned at some past
8 session some figures on the frequency with which LEP falls
9 into appeals process. I know, for myself, I got told by my
10 plan that I was going to have a late enrollment penalty,
11 even though I did not -- I had fully continuous coverage.
12 And after I told them, you know, that I had continuous
13 coverage I got a second notice that still said I was
14 eligible for the late enrollment penalty. I haven't had to
15 pay a penalty, but I kept getting these notices. So it
16 makes me wonder sort of how that's being administered and
17 whether there are some issues there.

18 I'd like to see us try to seek out some better
19 data on take-up of the LIS. The last time we've seen data
20 which was a long time ago it seemed like of those who don't
21 get the LIS automatically that as many as 50 percent of
22 those who look like they're eligible for the LIS don't

1 actually sign up for it. But that was 10-year-old data and
2 I don't know if there's been anything more recent. I
3 haven't seen anything more recent. But that seemed like a
4 problem then, of a lot of people not taking advantage of a
5 benefit that they were deserving of.

6 And then lastly, on the star ratings, which you
7 didn't talk about during the presentation but there's some
8 material in the chapter, you make the statement that
9 current quality measures may not help a lot with
10 beneficiary choice, which I think is true, having done some
11 of this myself now. In fact, the only three outcome
12 measures which get the higher weights in the things are
13 adherence measures. And when you think of that as a
14 beneficiary, my plan has greater adherence, well, I'm going
15 to make my own decisions about whether I adhere to my drug,
16 and for the most part nothing the plan is doing is probably
17 going to -- now, yeah, plans could take certain steps to
18 remind people, and so it's not a completely useless thing
19 to measure. But I looked at one example for a friend, and
20 it turned out that the one thing that drove the star rating
21 higher for a particular plan they were looking at was the
22 adherence measures. And, otherwise, it was a worse-

1 performing plan than the alternative they were looking at,
2 and it seemed like the things that were more useful to them
3 in making a choice were not that adherence measure if they
4 were going to take the drugs that they were prescribed
5 anyway.

6 And so trying to think more about getting the
7 right outcome measures and getting a more beneficiary-
8 helpful set of star ratings or something down the road,
9 that it seems like it would be useful to look at. So thank
10 you again for a really helpful chapter.

11 DR. CROSSON: Well, thank you, Jack. Jim is
12 carefully taking notes about all the additional work.

13 DR. HOADLEY: I said over a period of time [off
14 microphone].

15 DR. CROSSON: I think he may be reaching out to
16 you to see if you would like to be employed in the near
17 future.

18 [Laughter.]

19 DR. CROSSON: As usual, your comments are
20 terrific. Thank you.

21 Where were we? Let's see. We'll start with
22 David.

1 DR. NERENZ: Jack, if you could just talk a
2 little bit more about the last couple points you were
3 making about the star ratings and the quality measures. I
4 know the chapter points out that a star rating here is kind
5 of an unusual concept because these plans are not providers
6 of any medical care services, nor do they pay for the
7 provision of medical care services. And it just strikes me
8 in my own view that the star ratings are kind of strange
9 and potentially useless.

10 What would be good and appropriate measure here?
11 What does quality mean for a Part D plan?

12 DR. HOADLEY: Well, certainly some of the things
13 that are in the measures do make sense -- the
14 responsiveness of a call center, am I going to be able to
15 get help when I have a problem. I think things about
16 dealing with exceptions and ability to get things you need
17 when they're not on the formulary but your doctor thinks
18 they're important, you know, are things.

19 You know, we probably -- and there's some
20 discussion about a future look at medication therapy
21 management. The ability to do things like that, to do the
22 medication reviews, to make sure that you're not taking

1 drugs that aren't useful to you. I mean, the examples, you
2 know, we talked about many times. The most telling example
3 I heard recently was in some article it talked about a
4 person who was taking thyroid medication and had been
5 taking it for like 40 or 50 years. The reason they were
6 originally given the thyroid medication was not because of
7 a problem with their thyroid, but because the doctor
8 thought it might help them lose weight. And so they had
9 been dutifully taking this thyroid medication for 50 years
10 without actually having a thyroid problem, and nobody ever
11 bothered to ask that question.

12 So, you know, doing those reviews, looking at the
13 drugs that are not appropriate for somebody who's 75 or 80
14 years old, and how well plans have programs to monitor
15 those things seems like would be some good examples.

16 DR. NERENZ: Right, and just to embellish the
17 point, the expectation would be this is a legitimate plan
18 function that beneficiaries could expect the plan to do as
19 opposed to the primary care physician, or at least in
20 conjunction with the primary -- okay. That's fine. Thank
21 you.

22 DR. CROSSON: Amy.

1 MS. BRICKER: So I'm in support of the
2 recommendation with respect to the treatment of
3 biosimilars. You know, I've been pretty vocal previously
4 about ensuring that biosimilars actually do have the
5 opportunity to come to market and influence pricing to the
6 extent that we all hope that they will. Double-click on
7 the settlement between AbbVie and Amgen with respect to the
8 pay-for-delay of Humira, the largest by spend drug in the
9 specialty category, and we won't see a biosimilar likely
10 for many, many, many, many, many years because of that
11 settlement. And what impact that has on this plan in
12 particular is astonishing.

13 You know, Jack had a lot of interesting points,
14 and I think, you know, I would like for us to take a look
15 at more holistically what we can do with respect to the
16 management of the Part D program. More specifically, you
17 know, it was envisioned to be managed in more of a free
18 market sort of fashion, yet there are still tremendous
19 limitations on plan sponsors to allow them the ability to
20 manage networks, to manage formulary, to make mid-year
21 formulary changes, to, you know, their appeals and
22 exceptions process. You mentioned in the reading material

1 it's still unique to this plan different than the
2 commercial plan and the outcomes associated with appeals
3 and exceptions. And while, of course, we need to take care
4 of the beneficiary, are we, in fact, doing the best thing
5 by the beneficiary and the overall program with respect to
6 how we manage exceptions and appeals?

7 One of the threads I wanted to pick up that we
8 didn't emphasize in the materials here were the data points
9 you had around LIS. So if I got it right, you said here 8
10 percent, but I thought your reading materials on page 40
11 said 9 percent of enrollees reach catastrophic phase; of
12 those, 72 percent are LIS. Okay, 72 percent of the 9
13 percent are LIS.

14 You also talk about the disproportionate amount
15 of brand drugs that this LIS population take in comparison
16 to non-LIS, if I got that right.

17 So shouldn't we then be managing that population
18 and the benefit associated with the LIS differently? Maybe
19 it wouldn't be crazy for us to look at the extension of
20 that 50 percent rebate in that coverage gap for LIS to go
21 beyond the coverage gap, so indefinitely. Who's
22 benefitting from the fact that there's a disproportionate

1 amount of brand drugs in this LIS population? Pharma. So,
2 you know, if the thinking is LIS is sort of not really
3 feeling the impact of these high-cost drugs because their
4 cost share is low -- I'm not suggesting that it should be
5 different -- do you, in fact, then extend the
6 responsibility to pharma to ensure that that rebate
7 continue indefinitely while that LIS population is on their
8 drugs in a disproportionate way? Just something to
9 consider.

10 Overall, though, I would encourage us to continue
11 to look at the program holistically, looking at ways that
12 we can ensure that the plans have all tools that are
13 available to them to manage cost and ensure that the
14 biosimilar market and manufacturers associated with the
15 biosimilar pipeline are encouraged to come to market to put
16 price pressure on the remaining class.

17 Thanks.

18 DR. CROSSON: Thank you, Amy. Interesting
19 suggestions.

20 Where are we? Rita.

21 DR. REDBERG: So I want to add my thanks for
22 really excellent work and an important topic. Just in

1 terms of background, and you did get to this in the chapter
2 and your remarks, but there are a lot of really high-priced
3 drugs coming on the market, and the FDA has clearly
4 signaled this is going to increase in number in the next
5 few years. You know, we have this new breakthrough status,
6 which essentially means that drugs can get on the market
7 with a lower bar for evidence, and there's supposed to be
8 more post-marketing. I think certainly beneficiaries, when
9 they see breakthrough, don't understand that that means the
10 evidence bar was lowered. It looks actually like things
11 are even better. And there are, you know, currently really
12 no controls, as Jack said, on pricing and so drugs are
13 coming on the market at extremely high prices, and there is
14 nothing that currently Medicare can do, or the plans, about
15 these, particularly the single source and with the
16 formulary rules. So this is a really big problem already.
17 You showed \$34 billion in reinsurance. It's staggering to
18 me, and it's clearly going to get higher unless we do
19 something now. You know, we made these recommendations two
20 years ago, and now we're making them again with even, I
21 think, incredible urgency.

22 When I see direct-to-consumer ads, as I do --

1 every time I go to the gym, there's a bank of TVs over
2 there, and, you know, earlier this week it was irritable
3 bowel syndrome drugs, and they said, "I know, I had
4 irritable bowel syndrome, and I can take this new drug."
5 It's very suspicious to me when I see ads. It means
6 there's a lot of money in these drugs. And I don't think
7 direct-to-consumer advertising is the right kind of avenue
8 for this, but it all means more costs to the program.

9 I agree with the recommendations on biosimilars.
10 I do have concerns that not just they're coming on the
11 market slowly, but they're coming on at high prices. Some
12 of the biosimilars we've talked about in the past are
13 coming on at higher prices than brand-name drugs. I guess
14 there's the phenomenon of sticky pricing, I heard, but if
15 brand names can get it, you know, there's sort of not that
16 much incentive to get lower. And then there are other
17 issues with the artificial problems with the coverage gap
18 discount.

19 So I just support the recommendations, and I
20 think this is really an urgent problem because right now we
21 have just an incredible lot of cost, much more less clear
22 amount of benefit from our beneficiaries, because as Jack

1 pointed out, adherence is not always a good thing. An
2 adherence for a drug that you don't need or is doing you
3 more harm than good is not a good thing. It was in their
4 mailing materials, the article about de-prescribing and how
5 Medicare beneficiaries often feel much better after the de-
6 prescribing programs. So I think certainly drugs can be
7 good, but there has to be a lot more attention to are these
8 appropriate drugs for our beneficiaries if we're going to
9 have adherence as a quality measure, because adherence
10 alone isn't really the quality measure. It is the drug.
11 Are you likely to be better off taking this drug than not
12 taking it?

13 So I support the recommendations and congratulate
14 you on this work.

15 DR. CROSSON: Comments?

16 DR. GRABOWSKI: Great. I'm also supportive of
17 the draft recommendation. I wanted to come back to one of
18 the points Jack raised, and that was around Plan Finder.
19 I've been really struck by the literature suggesting lots
20 of beneficiaries end up in plans that aren't necessarily a
21 good match given their drug needs. And some of that is
22 just due to how complicated it is, and Jay touched on that.

1 There is bound to be error, and people's drug needs are
2 changing over time.

3 Some of that is how Plan Finder is structured,
4 how you make choices within that, the information. You
5 touched on this, Jack, whether I'm choosing based on
6 premium or my total cost. And I would like to see us --
7 this is an area for future work -- think a little bit more
8 about Plan Finder and think about the architecture there
9 and how we might make some recommendations to help
10 beneficiaries maybe choose the plan that best meets their
11 drug needs. I think there's real opportunity there.
12 There's a nice literature suggesting lots of error occurs
13 currently. I think we can really improve on that.

14 Thanks.

15 DR. CROSSON: Jack.

16 DR. HOADLEY: Yeah, I think that's a really
17 helpful point. As a new Medicare beneficiary myself in the
18 last year or so, looking at the Plan Finder to make choices
19 and finding the challenge with the various pharmacy network
20 differences and no real ability to sort of say, okay, I'm
21 willing to switch plans, switch pharmacies, and switch
22 drugs, I can't sort of move all those levers around at the

1 same -- let alone sort of the quality kinds of things. And
2 something that really would do that would help, and there
3 is actually a group of stakeholders that the National
4 Council on Aging has been convening that's going to have
5 some kind of a report soon on some Plan Finder issues, both
6 for Part C and Part D. So that might be something to help
7 trigger some conversation.

8 DR. CROSSON: Bruce.

9 MR. PYENSON: Thank you for an excellent report.
10 I'd like to remind the Commissioners that our 2017 report
11 in March had a real explanation on why the structure of
12 Part D creates incentives to increase prices and to favor
13 the highest-price drugs, and that nothing has changed to
14 disrupt that. So we should -- what we're looking down the
15 path at is a system that is structured to promote higher
16 prices and higher spending in catastrophic. So the
17 recommendations, 2016 recommendations, which I support,
18 would fundamentally change that. But I think the work that
19 was done in the last couple years really was excellent in
20 explaining why the Part D structure is engineered to
21 promote higher and higher prices and higher and higher
22 catastrophic spending. So I think we've dealt with the

1 fundamentals on that.

2 I would say in terms of topics for further work,
3 I support an examination of the food chain from
4 manufacturers through distributors, PBMs, pharmacies,
5 benefits consultants, and plans for the component of how --
6 what that food chain is.

7 Now, that's a big task. I think the manageable
8 part of that, the most manageable part of it is probably
9 for Part B where Medicare already has a focus on ASP,
10 average sales price, and a reporting mechanism. So already
11 within the structure of Part B we should have some sort of
12 visibility to the bottom of that food chain. And I'd
13 suggest to make this manageable that if we're concerned
14 about resources and priorities, that would be an excellent
15 place to start in the next sessions.

16 DR. CROSSON: Dana.

17 DR. SAFRAN: I also want to congratulate you on
18 great work and lend my support to the recommendations. I
19 had a couple of comments.

20 First, on Slide 10, if we could just go back to
21 that, I found this an incredibly powerful visual, and maybe
22 what I'm about to say about it, the first thing I'm about

1 to say about it should have come in the first round as a
2 question. But in other work we reviewed for today, on the
3 medical side we looked at a distinction that you make
4 between number and volume, where volume is kind of taking
5 into account the complexity of the service. And I just
6 wondered if there's an analog that we could employ here so
7 that we could differentiate -- you know, it's so striking
8 that it's not -- what we're seeing in spending is not
9 explained by the numbers of drugs, and so the question that
10 I'm left with is: How much is it explained by the sort of
11 added complexity or intensity of the drugs versus share --
12 increases in the cost of the existing drugs? And I think
13 if there was a way to visually parse that, it would be
14 important.

15 Then that raises for me the question about
16 something that we do on a commercial insurance side that I
17 haven't seen us do, and I wonder if we could, which is we
18 always look to see in our overall medical spending trend
19 what percentage -- you know, how are the different sectors
20 driving that, and so what do we know about how the
21 increasing spending on drugs is driving the increasing
22 spending overall in Medicare? I feel like that would have

1 a place in this chapter or potentially in another chapter.
2 But I haven't seen us address that, and that seems
3 important, and also how that's changing over time because
4 of specialty drugs and specialty pharmacies and so forth.
5 So to really have the readership understand the role that
6 pharmacy is playing in driving overall trend and how that's
7 changing over time I think is an important piece.

8 Two last points. One is maybe a delicate one,
9 but we don't currently in this country get comparative
10 effectiveness information from drug manufacturers. Other
11 countries do. For other countries it's a requirement as
12 part of getting a drug on the market. And it seems to me
13 that somewhere in the narrative we have here about how much
14 more we're spending, we could make some comments about the
15 fact that we don't receive the information that tells us
16 what we're getting for these dollars, what these new drugs
17 are contributing in terms of improved quality of life,
18 longer length of life, and yet manufacturers typically have
19 that information, especially if they want to market their
20 products in other countries that require it. So I offer
21 that point.

22 The final thing, just to comment on this little

1 bit of dialogue we've had about adherence as a quality
2 measure or not, I actually do think that there's a lot that
3 a plan can do to improve adherence. First of all, we know
4 that cost of drugs plays a very important role in
5 adherence, so how a company is pricing medication is going
6 to be a big driver of that.

7 But there are other things in terms of the
8 barriers to adherence, understanding what a drug is for,
9 and other barriers, motivation around how this drug is
10 going to help you in your condition or not.

11 So I do think there is an important role that
12 plans could be asked to play with respect to adherence,
13 notwithstanding Rita's point that there's probably many
14 drugs that beneficiaries are on that aren't appropriate.
15 So that has to be dealt with in a different kind of
16 measurement, but I just wanted to add into the conversation
17 that I think adherence is a reasonable thing to hold these
18 plans accountable for and a way to assess them as one
19 dimension of quality.

20 DR. CROSSON: Dana, can I just ask you to clarify
21 one thing? I couldn't quite understand the concept of
22 intensity. By that, do you mean the amount of drug, the

1 frequency, whether it's administered? I'm not sure what I
2 --

3 DR. SAFRAN: I don't know exactly how this
4 concept would get applied in the pharmacy world, but the
5 kind of biologicals, for example, are a much more complex
6 expensive kind of medicine, I think, than other medicine,
7 and --

8 DR. CROSSON: Absolutely. So I thought you were
9 making a distinction between cost and everything else.

10 DR. SAFRAN: I was trying to make the distinction
11 between the sheer number of medications people are on, the
12 type of medications they're on, sort of how complicated are
13 those medicines, and there are just more expensive
14 medicines that people are taking now versus they're on the
15 same medicines they were on last year, but the price of
16 those medicines has escalated. So parsing those three
17 elements of number, complexity, and price feels useful if
18 we can do it.

19 DR. CROSSON: Okay. Thank you.

20 I don't see any further comments. I want to make
21 one myself, and I think it's reflective of some of the
22 comments that Commissioners have made here.

1 We have been spending a number of years working
2 on the issue of drug costs, and I think despite the fact
3 that we've done a lot, more recently in both Part D, the
4 work that Rachel and Shinobu have done, and Part B, where
5 we have worked within the constraints that we have; in
6 other words, we have a structure for drug payment which his
7 different from the structure that we generally deal with in
8 other parts of the Medicare, where in fact Medicare is a
9 direct payer. And we make annual updates. We don't have
10 that because of the way Medicare pays indirection, if you
11 want to say that, for drugs.

12 And I think we've gone and made some very good
13 recommendations, which by the way have not been implemented
14 to date, and yet there is a sense of frustration on the
15 Commission that persists. And I share it. I think it's
16 not just an issue for the Commission. It's shared broadly
17 in society right now, which is the cost to pharmaceuticals,
18 despite the benefits provides, and they're substantive --
19 by new pharmaceuticals, appear to be escalating at a rate
20 which is beyond reason, and eventually, I think if not
21 already, beyond the affordability broadly and is pushing
22 out other societal values, not only within the delivery of

1 health care itself but even beyond that.

2 We take it very seriously. We are going to
3 continue our work in this area. I think we have a number
4 of suggestions that have been made here, which are very
5 good. They range from the detailed to the more aggressive,
6 and I think that from my perspective, we're going to do
7 everything we can, even if it involves pushing the envelope
8 a little bit as we go forward in the next couple of terms.

9 So thank you for the discussion. We'll now take
10 a vote on the recommendation, which is on Slide 16. I'll
11 give you an opportunity to read that.

12 All the Commissioners in favor of the
13 recommendation, please raise your hand.

14 [Show of hands.]

15 DR. CROSSON: All opposed?

16 [No response.]

17 DR. CROSSON: Abstentions?

18 [No response.]

19 DR. CROSSON: The recommendation passes
20 unanimously.

21 Shinobu and Rachel, thank you very much. I
22 appreciate the work that you've done for this and all the

1 time that you've spent on these difficult issues.

2 We now have an opportunity for a public comment
3 period. If there are any members here, guests who would
4 like to make a public comment, please come forward so we
5 can see who you are.

6 I'm going to make a little bit of a preamble
7 here. Let me just wait for the place to clear out a little
8 bit. Otherwise you're going to be lost in the madding
9 crowd back there.

10 So I would point out this is an opportunity to
11 provide input to the Commission. It's not the only
12 opportunity. There are others, perhaps even better, prior
13 to our discussions through the MedPAC staff and the MedPAC
14 website.

15 I would ask you to identify yourself and any
16 organization that you're associated with and confine your
17 remarks to two minutes. When this light comes back on,
18 that two minutes will have expired.

19 MR. AMERY: Thank you for the opportunity to
20 address the Commission. I'm Mike Amery of the American
21 Academy of Neurology. I am representing the cognitive
22 specialty coalition, which includes 115,000 members of the

1 associations representing asthma, allergy and immunology,
2 neurology, endocrinology, rheumatology, psychiatry,
3 infectious diseases, and neuropathology.

4 Later on, the Commission will continue its
5 discussion of policy options for rebalancing the Physician
6 Fee Schedule towards ambulatory evaluation and management,
7 or E&M services, to increase payment for primary care.

8 And while the Coalition strongly supports efforts
9 to improve payment for E&M services, we want to ensure that
10 the Commission is considering those efforts in the broader
11 context of cognitive care delivery. Cognitive specialists,
12 those physicians who build the very same E&M codes as
13 primary care physicians, are treating higher-cost Medicare
14 beneficiaries, with more complex chronic conditions and
15 must be included in any improvements for E&M services.

16 The Coalition thanks Dr. Nerenz for his
17 recognition at a recent meeting of the Commission that
18 physicians do not bill Medicare for primary care services.
19 Physicians bill Medicare for new or return-patient E&M
20 services. Efforts to improve E&M service is solely for
21 primary care services, works to pick winners and losers in
22 the payment system, that over the long run will have

1 negative consequences to the most important stakeholder,
2 America's seniors that depend on the Medicare program and
3 its providers.

4 We remind the Commission the cognitive
5 specialists are experiencing the same shortages as primary
6 care. The members of the Cognitive Coalition strongly urge
7 you improve payment for E&M for all physicians who provide
8 cognitive specialty care through the delivery of E&M, not
9 just primary care providers. The result will be a better
10 mix of physicians providing E&M for patients, those in need
11 of primary care, and those with more complex conditions,
12 where cognitive specialists have the requisite expertise
13 and years of additional training to accurately diagnose,
14 comprehensively treat, and fully manage those patients.

15 We would appreciate your recognition of the value
16 that cognitive specialists bring to the Medicare program
17 and the beneficiaries as you deliberate forthcoming
18 recommendations.

19 DR. CROSSON: Thank you.

20 We are adjourned until 12:45 today. 12:45.

21 [Whereupon, at 11:19 a.m., the meeting was recessed
22 lunch, to reconvene at 12:45 p.m. this same day.]

1 AFTERNOON SESSION

2 [12:43 p.m.]

3 DR. CROSSON: Okay. I think it's time to begin
4 the afternoon session. We are now going to have a series
5 of discussions and votes on the update. These will be our
6 final dates -- final votes on the updates for this term,
7 and we're going to start with hospital inpatient and
8 outpatient services. We've got Stephanie, Jeff, and Zach
9 here, and Stephanie looks poised to begin.

10 MS. CAMERON: Thank you. Good afternoon. This
11 session will address issues regarding Medicare payments to
12 hospitals. Thank you to Dan Zabinski, Craig Lisk, and
13 Ledia Tabor for your contributions to this work.

14 As we discussed last month, we use a common
15 framework to evaluate the adequacy of Medicare payments.
16 When data are available, we examine provider capacity,
17 service volume, access to capital, quality of care, as well
18 as providers' costs and payments for Medicare services.
19 Today we will briefly discuss these measures of payment
20 adequacy in addition to costs and margins for 2016, and
21 provide a projected Medicare margin for 2018. We will also
22 provide supplemental information that you requested last

1 month.

2 As you'll recall from December, the draft update
3 recommendation would affect \$116 billion in inpatient
4 payments and about \$61 billion in outpatient payments. The
5 update would also affect Medicare Advantage benchmarks and
6 the prices MA plans pay hospitals, as we discussed in your
7 mailing materials.

8 To summarize our payment adequacy findings that
9 we presented in detail last month, access to care is good
10 with excess hospital capacity in aggregate, access to
11 capital remains strong, and quality is improving, as we see
12 risk adjusted readmission and mortality rates both
13 declining.

14 If current law holds, we would expect slightly
15 more negative Medicare margins in 2018 compared with 2016,
16 even for the relatively efficient providers.

17 Warner, last month you asked about the trend in
18 Medicare marginal profit, an indicator of whether providers
19 have an incentive to admit an additional Medicare patient.
20 As you can see, the margin profit has decreased since 2012,
21 from 14 percent to 8 percent in 2016. The trend in
22 marginal profit that you see largely mirrors the trend in

1 aggregate Medicare margin. However, you'll notice a larger
2 decrease in marginal profit between 2013 and 2014. This
3 decrease in marginal profit reflects the change in how
4 Medicare pays for uncompensated care.

5 Pat, you asked about Medicare revenues as a share
6 of total revenues. The dotted green line at the top shows
7 you that Medicare patients are a slightly increasing share
8 of hospital patients. However, Medicare prices have grown
9 slower than commercial prices. In addition, many uninsured
10 individuals became insured, resulting in higher revenue for
11 those patients. The growth in Medicare share of patients
12 offset the slower increase in Medicare prices. The net
13 effect, as you can see from the yellow line, is that
14 Medicare's share of revenue was about flat.

15 The bottom dotted line shows that hospital
16 commercial price growth through 2015 was high enough to
17 more than offset the slower Medicare price growth. The net
18 effect was operating margins rising up to a record high in
19 2015, of 6.4 percent.

20 Alice and others asked about margins for high DSH
21 hospitals. Here we show that Medicare margins tend to be
22 higher for DSH hospitals. Note that these high DSH

1 hospitals tend to have lower overall all-payer margins and
2 thus have more pressure to control their costs. Lower
3 costs lead to higher margins. For-profits also tend to
4 better at controlling their costs, even when they do not
5 face low non-Medicare margins. The lower costs of for-
6 profits lead to higher Medicare margins.

7 With that, and based on the payment adequacy
8 indicators we discussed today and in December, the hospital
9 draft recommendation reads:

10 For 2019, the Congress should update the 2018
11 Medicare base payment rates, inpatient and outpatient, for
12 acute care hospitals by the amount determined under current
13 law.

14 This language reflects a technical change from
15 our December meeting with the continued intent to reflect
16 current law for the 2019 payment update. As this
17 recommendation would provide the current law update, we
18 expect no impact on program spending or on beneficiaries or
19 providers.

20 The current law update is appropriate given that
21 beneficiaries maintained good access to care, outpatient
22 volume growth remained strong, providers continued to have

1 strong access to capital, all while quality improvement
2 continued, despite negative Medicare margins for most
3 providers. The current law update balances the need to
4 have payments high enough to maintain access to care and
5 the need to maintain fiscal pressure on hospitals to
6 control their costs.

7 And with that I turn it back to Jay.

8 DR. CROSSON: Thank you, Stephanie. So we'll now
9 take clarifying questions. I see Kathy and Warner and
10 David.

11 MS. BUTO: I'm just curious whether the
12 Commission has ever recommended -- or I won't say "ever" --
13 recently recommended an increase above current law update,
14 statutory updates, that you can recall?

15 DR. MATHEWS: Not in recent memory, no.

16 DR. CROSSON: Warner.

17 MR. THOMAS: On Slide 7, do we have this data for
18 -- because we run this for the Medicare margin -- do we run
19 this for the total margin? I know we make the comment
20 about total margin and the health of this sector of the
21 industry. I just didn't know if we looked at this by total
22 margin or not.

1 MS. CAMERON: We can -- we do have the data to do
2 that. Are you looking for a specific --

3 MR. THOMAS: No. I'm just curious. I mean, I
4 think there is a widening disparity on performance and I
5 would just like to understand that more. I think we look
6 at one number for the industry and kind of, you know, come
7 to a conclusion of where it is -- what's happening. But I
8 think it may be interesting to kind of look beyond that a
9 little bit it, on an overall basis, to see whether it's
10 rurals or urban or academic medical centers. Kind of what
11 does that look like on a total basis. Because I'm not sure
12 that just looking at an aggregate, like we have, you know,
13 may tell the whole picture. So it's just a question, not
14 necessarily for this report. I mean, if we had it I think
15 it would be great. But I do think it's something we ought
16 to be looking at on a go-forward basis.

17 The second question I had was really more around
18 the determinants of cost for hospitals, and we've talked
19 about this. I've brought this up, you know, previously.
20 You know, for example, devices or drugs. Do we have a
21 sense of the increase in cost in those components of the
22 inpatient cost structure and that impact on, you know,

1 Medicare margin, which obviously now for, you know, for
2 efficient hospitals is negative. It's the first time since
3 I've been on the Commission that that's the case. So I'm
4 just trying to understand, do we have an idea of what those
5 trends look like and how big an impact they're having on
6 the performance of the industry?

7 MS. CAMERON: So in page 26 of your mailing
8 materials we talk a little bit about the trend in growth in
9 cost for drugs and devices as well as some other areas.
10 So, and just as a reminder to everybody, since 2014, there
11 was about a 12 percent increase in the cost of drugs in
12 this sector, and drugs and devices comprise about 19
13 percent of all hospital costs.

14 MR. THOMAS: Right.

15 MS. CAMERON: However, they account for about a
16 quarter of the growth in per-Medicare discharge spending --
17 or excuse me, cost per Medicare discharge, about a quarter
18 of that comes from this. You know, I haven't looked at
19 individual -- I don't have the corollary in my mind right
20 now of what the drug piece was, but we could certainly look
21 at that.

22 MR. THOMAS: Okay. Thank you.

1 DR. MATHEWS: And, Stephanie, can you refresh my
2 memory. Are we using cost reports as the basis for
3 determining the growth of these components?

4 MS. CAMERON: We are, yes.

5 DR. MATHEWS: Okay. And so from the cost report
6 data, we are not able to ascertain the relative
7 contributions of increases in volume versus price for
8 either drugs or devices in the hospital sector. Is that
9 correct?

10 MS. CAMERON: That is correct.

11 DR. MATHEWS: Okay.

12 MS. CAMERON: Right. So it could be, you know, a
13 blend of either one of those things.

14 DR. MATHEWS: That's what I wanted to establish,
15 yes.

16 MS. CAMERON: Yes.

17 DR. STENSLAND: And just to be clear, I think the
18 12.4 percent is over two years, so it's --

19 DR. CROSSON: David.

20 DR. NERENZ: Thanks. I just want to clarify the
21 wording change between December and now. I know in
22 December we had a number of 1.25. So just so I track

1 correctly, the current law -- and I'm looking at page 39 --
2 really has three significant components, right? There's a
3 market basket adjustment that goes up, but then there's a
4 productivity adjustment down, and then there's a PPACA
5 adjustment down. And the 1.25 we estimated is the net of
6 those three, one up and two down. And it may end up in
7 practice a little different, but, okay. So that's where we
8 are.

9 So the effect of that in terms of how we project
10 our recommendation to margins is if the market basket
11 update, that is to reflect input price increases, right?
12 So, essentially, in the bottom line, our recommendation is
13 essentially to stay even. Would that be a fair summary,
14 that if hospitals' input prices are going up, and then you
15 do the other factors, the adjustment, our recommendation is
16 that the CMS payment should essentially keep up with the
17 market basket price increase. Is that a fair restatement,
18 or did I miss something?

19 DR. STENSLAND: I think it's -- because what
20 we're saying is it would be the same as in current law.

21 DR. NERENZ: Yes. Understood.

22 DR. STENSLAND: So, and the market basket is

1 projected to be, I think, what is it, 2.8 percent.

2 DR. NERENZ: Yes.

3 DR. STENSLAND: But then there are some
4 reductions of that that gets you down to about 1.25.

5 DR. NERENZ: Yes. Right.

6 DR. STENSLAND: So we're saying we would expect,
7 if this goes through and there's no unexpected changes in
8 all those factors, that the underlying input price
9 inflation would go up by 2.8 percent --

10 DR. NERENZ: Yes.

11 DR. STENSLAND: -- and the payments would go up
12 by 1.25 percent.

13 DR. NERENZ: Yes, and then the other two
14 adjustments. Okay. I'm just trying to clarify the point
15 that we're not making a recommendation that, on itself, all
16 else even would improve the margins we're looking at as we
17 look forward. It's essentially a stay-even. Okay. I just
18 wanted to get that -- make sure we had that.

19 DR. STENSLAND: Like we're not saying -- we're
20 not setting the updates so that the margins don't change.
21 We're setting the updates so that the expected path of the
22 margins under current law is the same as it would be under

1 our recommendation.

2 DR. NERENZ: Yes, okay. That's okay. But,
3 anyway, I think we're saying the same thing. I don't think
4 --

5 DR. CROSSON: And to be clear, this assumes that
6 there's no further improvement in the cost structure.

7 DR. NERENZ: That's also true, right.

8 DR. CROSSON: Okay. Questions? Bruce.

9 MR. PYENSON: On page 26 of the material you note
10 that inpatient surgery volume has increased and, in
11 particular, hip and knee replacement. And I'm wondering if
12 you -- and that's over the -- I think that's over the
13 period 2014 through 2016. I don't know if you have any
14 thoughts on what might be going on there.

15 MR. GAUMER: So this is something that we've been
16 curious about as well. We've been looking into it and we
17 plan to do more work on it in the coming year. You know, I
18 think in the chapter we indicate that this could be related
19 to the CJR program, or the demo that's going on, but we --
20 that's still unknown. We need to evaluate that a little
21 bit more.

22 I'd say the only information that we have

1 gathered in between December and now on this is that -- and
2 someone here suggested that maybe there's an age component
3 to this and people are getting younger. That's not
4 necessarily the case. That we've been able to look at.
5 And so we're still --

6 MR. PYENSON: [Off microphone.]

7 MR. GAUMER: Okay. Yeah. These surgery cases
8 are not getting younger, in this case, so it's about the
9 same over those two, three years. So we're looking into
10 it, and if you have thoughts on how we can do that, I'm
11 happy to take them.

12 DR. CROSSON: Okay. Seeing no further questions
13 we're open for comment and discussion. In this case, the
14 discussion should be focused on the recommendation, which
15 is on Slide 8.

16 Discussion? Warner.

17 MR. THOMAS: So the -- I just want to -- this may
18 be a little bit of a question as well. So going back to
19 David's question -- so, basically, with our recommendation
20 that's outlined here, we would essentially think the
21 projection is anticipate to see a continued deterioration
22 in performance. Is that correct, based on our

1 recommendation?

2 [Staff nod heads in affirmative.]

3 MR. THOMAS: Okay. So I guess the general
4 comment I would have is just -- and I brought this up
5 previously -- but I would like to see us have us stronger
6 language in the chapter around these input costs that, you
7 know, frankly, have -- don't have a lot of opportunity for
8 control, specifically, you know, device and drug cost. And
9 I do think, if the data cannot be derived from the cost
10 reports, as Jim was indicating, I think there are studies
11 out there that indicate what specifically drug cost pricing
12 increases and device pricing increases are causing and the
13 impact they're having here, because I think it's an
14 important trend and it's an important component to be
15 highlighted as part of this.

16 So I would just ask that we have stronger -- I
17 know you've referenced it in that page, and I appreciate
18 that. I would just like to see, to the extent if there's
19 any other data that we could pull in that would help inform
20 that, if there's other studies that are out there that can
21 inform that, I think it would be helpful, because I think
22 it's a trend that's not going to slow down, and when we're

1 looking at increases of a point or a point and a quarter, I
2 mean, that is erased -- probably more than erased by just
3 drug pricing increases, frankly, and I'm concerned about
4 that.

5 The second comment -- and I've, you know, asked
6 for the data on looking at the profitability by the group -
7 - but I think the second comment is just to continue to
8 think about how we look at all of these pricing and rate
9 changes and how we analyze the industry and kind of look at
10 the -- if we're going to look at profitability for Medicare
11 and all-payer, like we do here in the hospital, that we do
12 the same thing in the other arenas. So I'll make those
13 comments later as well, but I just think that's an
14 important component to this.

15 And I had another -- oh, and this is a question,
16 Jay, and I just don't know, going back to Kathy's question.
17 So our recommendation, you know, would be going with the
18 market basket, and these other reductions are automatic.
19 Is that how that works? Those are automatic reductions?

20 DR. CROSSON: Formulaic, yes.

21 MR. THOMAS: Formulaic. So there's -- you know,
22 regardless of what our recommendation is, we have no impact

1 on those whatsoever.

2 DR. CROSSON: Well, if our recommendation is
3 current law, this is the way current law is structured.

4 MR. THOMAS: I've got it. So, essentially, we're
5 saying we would agree with the reductions based on this
6 situation. Okay. I just wanted to make sure I understood
7 exactly how that played out.

8 I do think it's something -- I can be comfortable
9 with the recommendation. I do think going forward we need
10 to look at those reductions and look at the overall input
11 pricing here and make sure that we are not putting this
12 area in a difficult situation, especially with efficient
13 hospitals now being negative. So I think that's an
14 important thing to consider.

15 DR. CROSSON: Let me just pick up on that,
16 because you didn't make that particular point this time,
17 but I think you were implying it towards the end, and that
18 has to do with the fact that this recommendation -- and
19 this is the historical way we've done this -- the
20 recommendation is for all hospitals. And I think, as you
21 say, we've noticed, for the first time, that the efficient
22 hospital, as defined, has a negative Medicare margin. So

1 in previous discussions that we've had leading up to today,
2 we have talked about the question of whether or not we want
3 to consider, as a Commission, differential updates in the
4 future. And how we would do that, based on what
5 categorization, I think is up to us to discuss and
6 determine. But I just wanted to make note of the fact that
7 we have had that discussion and we will have that
8 discussion going forward.

9 Amy.

10 MS. BRICKER: This might be Round One. It just
11 dawned on me and I apologize if I missed it. Do we reflect
12 the value of 340B on hospital margin? Is that in here?

13 DR. STENSLAND: [Nods yes.]

14 MS. BRICKER: Oh, it is. Okay. Apologies.

15 MR. THOMAS: Just one last comment, and I think
16 this -- and I don't know if we have an estimate or if we
17 think it's really material, the impact of -- I mean, in all
18 these numbers is all the ARRA funding, and that's all
19 essentially, you know, ended now. So that will essentially
20 have a -- for some organizations, a pretty material
21 negative impact on their overall economic picture. So it's
22 probably, as we go forward, we want to look at as those

1 ARRA funds will be gone. That certainly has probably
2 buoyed some performance over the past couple of years, that
3 we may just want to be aware of.

4 DR. CROSSON: Yes. Jack.

5 DR. HOADLEY: so I wanted to follow up on
6 Warner's first topic on the drug and device, and, you know,
7 thinking about the conversation we had this morning about
8 drugs, and obviously one of the things going on in the drug
9 world is so many more very expensive drugs, which
10 translates into drugs that are often administered in the
11 hospital, and in some cases in inpatient settings, in many
12 cases in outpatient settings.

13 And I wondered if it would make sense to look at,
14 over the next cycle or two, sort of where those are playing
15 out in the system, to what extent drugs are being handled
16 in various ways in the payment system, whether it's through
17 driving outlier payments, because the drugs are so
18 expensive that they're pushing hospitals into those,
19 whether it's handled through some of the other adjustments
20 and the outpatient handled through pass-through costs and
21 so forth. It might give us a way to get a little more
22 insight into where these are just kind of being directly

1 passed on at some percentage -- you know, with the various
2 percentages that those reflect, what it does for incentives
3 to the hospitals around using those drugs, around, you
4 know, trying to negotiate for prices. In many cases
5 there's not much negotiation if it's a single-source drug,
6 as we talked about this morning.

7 But it just seemed like that would be a way to --
8 another window into getting into how the higher drug costs
9 are playing out, particularly focusing on those very high-
10 cost drugs as opposed to some of the more standard drugs
11 that have kind of been in the system and going through. So
12 that's just a suggestion. And otherwise I'm good with the
13 recommendation we have here.

14 DR. CROSSON: Okay. Seeing no further comments,
15 we'll proceed to vote. Can we put up the recommendation
16 and give everyone a chance to read the recommendation
17 again. Can I see the hands of all Commissioners in favor
18 of the recommendation?

19 [Show of hands.]

20 DR. CROSSON: Opposed?

21 [No response.]

22 DR. CROSSON: Abstentions?

1 [No response.]

2 DR. CROSSON: Let the record show Commissioner
3 Wang was not present for the vote.

4 DR. MATHEWS: And Warner.

5 DR. CROSSON: Right. Okay. Warner, the vote is
6 in suspension here. What's your vote?

7 MR. THOMAS: I'm in favor.

8 DR. CROSSON: In favor. Thank you.

9 Okay. Thanks very much for the presentation.
10 And we will move on to the next.

11 [Pause.]

12 DR. CROSSON: There will be a small hiatus.

13 [Pause.]

14 DR. CROSSON: Okay. So the next item of business
15 is the update for physicians and other health professional
16 services as well as our recommendation on the MIPS program.
17 Kate, Ariel, and David are here, and, Kate, you're going to
18 begin?

19 MS. BLONJARZ: So as Jay said, this session will
20 cover the two draft recommendations you saw last month:
21 the payment update recommendation for physician and other
22 health professional services in 2019, and the

1 recommendation to eliminate MIPS and create a new voluntary
2 value program in its place.

3 This is the background slide on Medicare's
4 payments for physicians and other health professional
5 services that you saw last month. Medicare fee-for-service
6 spending on clinician services was about \$70 billion in
7 2016, and there are about a million clinicians billing the
8 program.

9 Germane to both discussions today, the Medicare
10 Access and CHIP Reauthorization Act of 2015 established
11 payment updates in law and also established two incentive
12 programs: an incentive for A-APM participation, and the
13 merit-based incentive payment system. For 2019, the
14 statutory update for this sector is 0.5 percent.

15 Most indicators of payment adequacy for the
16 sector are stable. Individuals can obtain care when
17 needed, and the rates of beneficiaries reporting trouble
18 obtaining care stabilized this year as compared to last
19 year's slight decrease. Participation and assignment rates
20 remain steady, as has the number of clinicians billing the
21 program.

22 The ratio of Medicare payment rates to private

1 PPO rates declined from 78 percent in 2015 to 75 percent in
2 2016 because commercial rates have risen while Medicare's
3 rates were stable. Quality is indeterminate, and our
4 continued concern about Medicare's quality programs has led
5 to the MIPS recommendation. This year, we also see an
6 increase in the volume of services of 1.6 percent, higher
7 than last year.

8 Overall, payment rates for clinician services in
9 Medicare appear adequate. So the draft recommendation
10 reads:

11 For calendar year 2019, the Congress should
12 increase the calendar year 2018 payment rates for physician
13 and other health professional services by the amount
14 specified in current law.

15 There is no change in expected spending relative
16 to the current law baseline, and we don't expect the
17 recommendation to affect beneficiaries' access to care nor
18 providers' willingness or ability to furnish services.

19 So turning to the merit-based incentive payment
20 system, just to remind everyone again, the recommendation
21 you'll vote on today addresses only the MIPS part of MACRA,
22 not the other parts, which repealed the SGR, set statutory

1 updates, and created the A-APM incentive payment.

2 MIPS is an individual-level payment adjustment
3 based on quality, cost, care information, and practice
4 improvement activities that a clinician undertakes. It is
5 substantially similar to prior value-based purchasing
6 programs for Medicare clinician services, including the
7 physician quality reporting system, the physician value-
8 based payment modifier, and meaningful use of electronic
9 health records.

10 This slide summarizes the Commission's findings
11 on MIPS, which have been covered in detail over the past
12 two years -- nine presentations that resulted in two June
13 report chapters and three comment letters to CMS.

14 Our intent is for the draft mailing materials you
15 received to be a stand-alone chapter in our March report,
16 with any recommendation that you make today.

17 The slide lists some of our concerns with the
18 program. I won't go through them now, but they are in your
19 mailing materials in some detail.

20 The key point is that MIPS will not succeed in
21 helping beneficiaries choose clinicians, helping clinicians
22 change practice patterns to improve value, or helping the

1 Medicare program to reward clinicians based on value.

2 Therefore, the Commission has generally reached a
3 consensus that MIPS should be eliminated.

4 In addition to eliminating MIPS, the draft
5 recommendation also includes a new voluntary value program
6 in its place. Our motivation in creating the new program
7 is to keep a value component in traditional fee-for-service
8 aligned with other value-based purchasing programs in
9 Medicare as well as the incentives in A-APMs. The new
10 program would have more modest financial incentives than
11 those possible in A-APMs and would thus act as an on ramp
12 for clinicians who may wish to join or form A-APMs.

13 The design of the voluntary value program, or
14 VVP, would entail a withhold applied to all fee schedule
15 payments. Clinicians could join a voluntary group and have
16 their performance assessed at the voluntary group level;
17 join an A-APM (and receive their withhold back); or make no
18 election and forfeit their withhold. And the Medicare
19 program would use a set of population-based measures to
20 assess each group's performance and eligibility for a value
21 payment.

22 So, altogether, the draft recommendation reads:

1 The Congress should eliminate the current merit-
2 based incentive payment system; and establish a new
3 voluntary value program in fee-for-service Medicare in
4 which clinicians can elect to be measured as part of a
5 voluntary group; and clinicians in voluntary groups can
6 qualify for a value payment based on their group's
7 performance on a set of population-based measures.

8 Here are the implications.

9 For spending, payment increases in the VVP would
10 be designed to offset payment decreases. This generates
11 savings relative to MIPS because of the \$500 million per
12 year in funding for exceptional performance in MIPS. Our
13 plan is to reinvest that \$500 million into other priorities
14 in Medicare clinician payment so that overall the policy
15 would be budget neutral.

16 The recommendation is unlikely to affect
17 beneficiaries' access to care. It would significantly
18 reduce provider burden by eliminating all quality measure,
19 ACI, and CPIA reporting. Providers could incur some
20 administrative cost in creating or joining voluntary
21 groups, but the burden would be significantly less than
22 current law. Some providers would see a reduction in

1 payments, others a modest increase.

2 So I'll conclude with the two draft
3 recommendations on one slide, and we look forward to your
4 discussion.

5 DR. CROSSON: Thank you, Kate.

6 We are now open for clarifying questions. We'll
7 start with Brian.

8 DR. DeBUSK: My questions are around one of the
9 bullet points on Chart 6 regarding MIPS payment adjustments
10 will be minimal in the first two years, large and arbitrary
11 in the later years.

12 First of all, I really enjoyed your chapter, and
13 I think it's well written and really makes the case that's
14 on this slide. Do we have enough information, though, to
15 meaningfully model those large and arbitrary adjustments?
16 Because I have a suspicion that if we could demonstrate
17 just how large these swings could be, I think it would help
18 communicate the fundamental problem with this program.

19 MS. BLONIARZ: So I can make some guesses based
20 on what CMS has put forward so far. So in the third year
21 of the program -- that will be 2021 -- the payment
22 adjustment can be 7 percentage points up and down. I

1 assume based on what CMS has said that the median
2 performance, MIPS performance score is going to be well
3 above 80 points, somewhere between 80 and 90 points. So
4 what you could have is a situation if the MIPS performance
5 score is 90 points, then between 90 and 100, which is the
6 max, you have to basically make up 7 percentage points, you
7 know, in payment adjustments plus whatever comes up for the
8 MIPS exceptional performance bonus. So I think you could
9 be talking about, you know, over a fairly tight band of
10 performance, you know, anywhere from 10 to 20 percentage
11 point swings.

12 DR. DeBUSK: In the mailing materials, I saw some
13 of the work that -- how you described that. I just
14 wondered -- and this may be an unfair ask -- if we have
15 enough data and we can use some assumptions, because I
16 think when a clinician really looks at this and says, look,
17 if your flu shot PQRS measure drops from 97 to 96, you're
18 going to go from 3 up to 4 down. Do you really want 7
19 percent of your pay based on your flu shot? I just wonder
20 if we could be that explicit.

21 MS. BLONJARZ: I can add in some more color and
22 kind of, you know, do some thinking about fleshing --

1 DR. DeBUSK: Great.

2 MR. GLASS: We would have to -- we could
3 approximate -- you'd have to make assumptions about various
4 things such as where is the median and what the range of
5 scores would be. But we could do something illustrative, I
6 think.

7 DR. CROSSON: But you are touching, Brian, on one
8 of the fundamental inequities we see coming down the line
9 in MIPS, and, you know, one of the reasons why we've come
10 to where we are.

11 David? I'm sorry. I've got the wrong list.
12 Sorry.

13 [Laughter.]

14 DR. CROSSON: Uh-oh, wrong list. Other
15 questions? Paul.

16 DR. GINSBURG: You know, one of the reasons for
17 our proposals was a concern that we could have situations
18 where coming out very well on MIPS leads a well-organized
19 provider group to not pursue advanced APMs, and we want to
20 avoid that. I was thinking that under the VVP, because
21 there's a lot of uncertainty about what proportion of
22 physicians will get into groups to participate in the -- do

1 we have a wrinkle to actually prevent the situation where
2 going into the VVP virtually guarantees you're going to do
3 really well? I presume that wouldn't last very long
4 because that would attract more into the VVP.

5 MS. BLONIARZ: So if like only the winners come
6 in kind of a situation. I think the way we would try to
7 handle that is by putting a cap on the total VVP payment or
8 just I think the idea would be to not make it too
9 attractive to stay in traditional fee-for-service, at least
10 relative to incentive payments on kind of the A-APM side.

11 DR. CROSSON: Again, your point, Paul, is a good
12 one to remember, and that is, one of the other concerns we
13 have about the way MIPS is constructed is just what you
14 say, which is that it's very likely, given the complexity
15 of reporting, the cost and expense, for example, that we
16 would imagine that the larger, more well-funded practices
17 would do better at the expense of the smaller physician
18 practices.

19 DR. GINSBURG: Yes, and I was thinking that the
20 large, well-organized practices would be doing so well that
21 it would make no economic sense for them to go into APMs.

22 DR. CROSSON: And that's the second point, yeah.

1 DR. GINSBURG: Yeah.

2 MS. BLONJARZ: And if I could actually make
3 another point here, there's also incentives in the current
4 MIPS program for providers to kind of stay in what they
5 call MIPS APMs, which is like Track 1 ACOs. It's another
6 set of models that don't qualify as advanced. They get
7 special scoring in MIPS, and we kind of expect that that
8 group of providers will get pretty high scores. They also
9 have a reduced reporting burden.

10 DR. CROSSON: Clarifying questions? Kathy.

11 MS. BUTO: I guess a question for Paul, really.
12 Are we really opposed to physicians doing well under the
13 VVP if the measures, population-based measures are good
14 ones? In other words, there may be a circumstance where we
15 want them to be able to -- if they're not able to form an
16 A-APM -- do well enough that there's some incentive to join
17 the VVP versus just dropping out. So I want to make sure
18 we don't make that unattractive, if you will, particularly
19 for those groups or those individuals that cannot get into
20 an A-APM.

21 DR. GINSBURG: I think that's a really good
22 point, and I think it comes down to how much confidence we

1 have in the population claim-based measures that we have
2 now to do the VVP compared to the measures that are used to
3 reward or penalize A-APMs. So, in a sense, if we really
4 have confidence -- which I don't know that I have -- if
5 those measures are as strong, then we wouldn't be as
6 concerned. But if we don't have that confidence, then I
7 think we want to avoid a major diversion from APMs by those
8 organizations really best prepared to thrive and push
9 forward the APM concept.

10 MR. GLASS: And the other aspect is attribution.
11 You need to have confidence in the attribution, and perhaps
12 that might be stronger in A-APMs than VVP.

13 DR. CROSSON: Kathy -- Sue.

14 MS. THOMPSON: Kate, I'm curious about the 2
15 percent withhold. Provide a little color in your thinking
16 about is it enough, will it motivate? Does it stair-step
17 up or what's your thoughts? Have you thinking that you
18 want to share?

19 MS. BLONJARZ: So, yeah, this is definitely
20 something we've thought about a little bit, and I think
21 there's a couple of parameters. One is, you know, it's
22 probably not enough to result in some kind of practice

1 change. You know, you think that -- you need to be talking
2 about probably 10 percentage points to do that. You know,
3 these groups are somewhat ephemeral. They're not strongly
4 organized, tightly related groups, you know, that maybe
5 could undertake transformative practice redesign. So in
6 that sense, you know, it's not designed to, you know, kind
7 of really get big changes, so maybe it doesn't -- it
8 shouldn't be that big.

9 I think the other point is it's somewhat
10 comparable to other value-based purchasing programs. I
11 think the hospital value-based purchasing program is about
12 2 percentage points. I think keeping it more modest also
13 kind of recognizes that, you know, outcomes in fee-for-
14 service are the result of a number of different actors,
15 including clinicians, but not only them. And so, you know,
16 kind of like a shared responsibility kind of thing. But
17 you could definitely say, you know, I want it to be bigger,
18 I want it to increase over time as they get comfortable
19 with it.

20 MR. GLASS: And the other issue being keep it
21 less than the A-APM incentive.

22 DR. GINSBURG: You know, another aspect of this

1 is that, of course, the 2 percent was pulled out of the air
2 somewhat, and that it may be a matter of how much of a
3 discount do we need to fund, you know, meaningful VVP
4 rewards for the ones that do really well, you know,
5 considering there will be some -- many won't do it at all
6 and some won't do well. They won't be penalized, but they
7 won't be rewarded either. So it can be actually kind of
8 backed out as to how much of a discount do we need to fund
9 it, in at least the first few years.

10 DR. CROSSON: So I think to be clear, what you're
11 saying is that because the withhold is 2 percent, it
12 doesn't mean that the reward for high-performing voluntary
13 groups would only be 2 percent. It's likely that it would
14 be more, actually.

15 DR. GINSBURG: That's right and we could have a
16 situation [off microphone] where just say 10 percent sign
17 up for this initially, which, you know, 2 percent discount
18 would give us far too much money to reward the more
19 successful ones in that 10 percent.

20 DR. CROSSON: Is that clear? Okay. Jack and
21 Alice.

22 DR. HOADLEY: I have two questions about sort of

1 timing. One is, I mean, we haven't said when this should
2 happen. Obviously, we're speaking to Congress, and so --
3 but for -- I mean, this would all have to go through the
4 normal rulemaking process if Congress made a decision. So
5 I assume that practically speaking, unless Congress hears
6 what we're saying now and doesn't even wait for the printed
7 version and gets on their -- gets to do this, you know,
8 we'd be talking about a change in 2020 at sort of the
9 earliest. And I guess it -- is that a fair assessment of
10 timing?

11 MS. BLONJARZ: You will probably want a Notice
12 and Comment period. Yeah.

13 DR. HOADLEY: And then are we assuming that the
14 elimination of the current MIPS and the establishment of
15 the VVP has to happen in the same year, or do we have a
16 thought that there could be a lag between the two? And if
17 so, what happens in that interim period?

18 MR. GLASS: Well, I think eliminating MIPS could
19 be done fairly quickly, but developing a VVP and putting in
20 the rules and regs and all that would take time. So there
21 could clearly be a difference in timing there.

22 DR. HOADLEY: And would you just divert to sort

1 of the normal statutory updates for non-A-APM?

2 MR. GLASS: Right. Yes.

3 MS. BLONJARZ: Right. I mean, it would be like
4 prior to the value modifier. The update is set in law, and
5 there is not kind of value-based component to the payment.

6 DR. CROSSON: As a matter of fact, Jack, I think,
7 as you know, many physician representations have been so
8 far to delay many parts of MIPS.

9 DR. HOADLEY: Right. So it would be comparable,
10 in a way.

11 DR. CROSSON: It would essentially -- this could
12 -- I'm not even sure this could be done administratively,
13 but it might be to simply suspend it until the second part.

14 DR. HOADLEY: Okay. Thank you.

15 DR. CROSSON: Yes, Brian.

16 DR. DeBUSK: On a related note to that, couldn't
17 we just give CMS the discretion to set the threshold for
18 one more year? Wouldn't that also address it so that you
19 could go through the notice and rulemaking process?
20 Because the real issue is when they lose the ability to set
21 that.

22 DR. CROSSON: Yes.

1 MR. GLASS: In the meantime, it's all the
2 reporting that has to be done.

3 MS. BLONIARZ: That's right. That's still
4 happening.

5 MR. GLASS: If you eliminated them, you eliminate
6 the reporting.

7 DR. DeBUSK: Yeah. It's probably a billion
8 dollars.

9 MR. GLASS: Yeah. You want to eliminate the
10 burden on the clinician.

11 DR. DeBUSK: Okay. Fair enough.

12 MS. BLONIARZ: And I think you would also be
13 constrained even with that. CMS is still applying all of
14 the other rules of the project like what the weights are
15 and how the benchmarks are calculated. That still is all
16 happening even though the threshold is 3 points out of 100.

17 DR. DeBUSK: So what I'm saying is the minimum
18 fix, to Jack's point, that we're looking at 2020, the
19 minimum fix would be suspension of MIPS, not just
20 necessarily giving them the authority of set the threshold.

21 Thank you.

22 DR. CROSSON: Alice.

1 DR. COOMBS: I had asked this question earlier,
2 and I'm trying to remember if we ever addressed it. I
3 think you took it down. You know what I'm going to ask
4 you.

5 In Table 2, you have this number of clinicians
6 that's really, really large, and then in our other section,
7 we have a much smaller number, 950, 2,000. And so I know
8 the dentists are not in here. Okay. So what's the big
9 delta? And what portion of this big delta, the nearly 1.4
10 million clinicians -- what portion of that would be
11 physicians and advanced mid-levels?

12 MS. BLONIARZ: So the first question is when we
13 talk about the physician update, we often say there's about
14 900,000 or about a million clinicians billing a program.

15 We apply like a de minimis threshold, and I think
16 it's 25 patients.

17 MR. GLASS: At least 15 beneficiaries.

18 MS. BLONIARZ: Fifteen beneficiaries a year. So
19 that gets you from about 1.3 down to about a million.

20 Then in the mailing materials, I went through the
21 groups that are extended, exempted. Let me just find it.

22 So the second line -- so all of those exempt

1 would be otherwise part of MIPS. So that's APRNs, PAs, and
2 physicians. They would otherwise be subject to MIPS, and
3 they are taken out.

4 DR. COOMBS: So this big number that you have,
5 like the AMA has a database, MGMA --

6 MS. BLONIARZ: Yeah, yeah.

7 DR. COOMBS: -- this number, does that 1.4
8 million clinicians jive with what they have in terms of
9 being able to reproduce the portion of physicians that's in
10 this large number?

11 MS. BLONIARZ: So the 1.4 definitely includes
12 therapists, dentists.

13 DR. COOMBS: The other does as well, though,
14 right?

15 MS. BLONIARZ: The AMA master file, I believe is
16 only physicians.

17 DR. COOMBS: Right. But the number we have in
18 our chapter --

19 MS. BLONIARZ: The 1 million that we have in our
20 chapter is physicians, APRNs --

21 DR. COOMBS: Chiropractors.

22 MS. BLONIARZ: -- and APs.

1 MR. GLASS: And also other practitioners.

2 MS. BLONJARZ: And other practitioners.

3 DR. COOMBS: And the physician segment of that,
4 where do you get that number from?

5 MS. BLONJARZ: So it's all specialty -- you know,
6 it's all physician specialties on the claim -- or a
7 physician specialty that billed to Medicare service.

8 DR. COOMBS: So it is possible that some would --
9 either -- in either sector, they have multiple TINs, tax ID
10 numbers?

11 MS. BLONJARZ: This would be at the NPI level, so
12 they shouldn't have multiple NPIs. So, yeah, the 1.4
13 million and the 1 million that we refer to should not be
14 duplicated across for one doctor that's billing under
15 multiple TINs.

16 DR. COOMBS: So I notice that the exemption chart
17 that you have, so that if as proposed by the Chairman's
18 Draft Recommendation, if MIPS were eliminated, that would
19 mean that advanced nurse practitioners, PAs would be also
20 subject to the 2 percent withhold as well?

21 MS. BLONJARZ: Yes.

22 DR. CROSSON: Okay. Seeing no further questions,

1 we'll go on to the comment and discussion. We'll take both
2 recommendations together in the discussion, although we'll
3 have separate votes.

4 Comments? Discussion?

5 [No response.]

6 DR. CROSSON: Seeing none, we'll -- oops. Dana.

7 DR. SAFRAN: Just a couple thoughts. One, I
8 thought that -- I think it's a really well-written chapter,
9 but I'd love to include in the points that you make about
10 MIPS to include the point that based on the history of the
11 programs that came together to form MIPS. We think it's
12 highly unlikely to meaningful improve quality, and it's a
13 lot of money to spend to accomplish very little gain.

14 I also wondered whether -- whether it would be
15 valuable in this report to kind of make the point that
16 quality improvement, particularly when we are focusing
17 increasingly on trying to achieve better outcomes, not just
18 better process, isn't an individual sport, and that it's
19 not only the sample sizes that we can't hope to achieve at
20 the individual level, but just the effort to improve on
21 population-based outcomes is what we want to do and can
22 only be done in a more collaborative way.

1 And then in a text box or some other way,
2 actually create some illustrations of how members in a VVP
3 might actually be able to work together to improve some of
4 the measures that you're suggesting. I think that would be
5 a valuable addition.

6 DR. CROSSON: Alice.

7 DR. COOMBS: On that note, I have -- I know that
8 there are problems with MIPS, and I've spoken about this
9 before. I do not support the draft recommendation, and the
10 reasons are a multitude. One is the timing of it, and one
11 has to do with the sheer mass of number of providers that
12 are going to be forced to acclimate in a short period of
13 time. And I do think that some of the parts of the MIPS is
14 actually good. I actually believe that. Some of it is
15 frustrating. There are barriers and challenges even within
16 it, and so the framework of it is a problem.

17 I do believe that physicians just started this.
18 In 2015, MedPAC did not say anything about eliminating
19 MIPS. In our report last year, I don't remember a bold
20 recommendation ever saying anything. So just one year ago,
21 we've shifted from maybe tweaking it to getting rid of it
22 in 12 months' time.

1 So it might be something going forward in the
2 future, and part of it is the alternative to MIPS that I
3 have a problem -- getting rid of MIPS, I have a problem
4 with. The value-based programming is fraught with so many
5 different problems, and I'm just imagining the sheer
6 numbers.

7 We're saying right now in the two-sided risk
8 program, there's somewhere, at the max, 20 percent are
9 participating in advanced APMs. You're talking about
10 moving this large mass of clinicians in a short period of
11 time to a value-based program, and I know that in
12 Massachusetts, I was involved with us going to global
13 payment for which Dana's boss, Andrew Dreyfus, was on.

14 We were strategic. We thought about how can we
15 get these providers, and so we had to actually have an
16 infrastructure for success. And a lot of doctors were
17 "Hell, no, I won't go," but there were a lot of doctors who
18 said, "I'll listen." And then with time, the culture
19 changed. So it's a cultural adaptation that needs to
20 happen, and I can't say what that timing is like.

21 I can say one thing, is that if done well, it
22 will accomplish the things that you want. If done wrong,

1 there are lots of risks that can happen and even to the
2 point of access.

3 And I hear the discussion about a 10 percent
4 withhold. I get chills by that because I'm thinking about
5 the doctors who are in the trenches taking care of
6 vulnerable patients, and that population might be Watts --
7 or Compton is where I came from, and if there is a few
8 doctors trying to do health care on Compton and Compton on
9 Rosecrans Boulevard, you know what? We need those doctors
10 there, and if that community all of a sudden gets a 10
11 percent withhold because they don't have the infrastructure
12 or they couldn't get the IT \$100,000, it's going to affect
13 primary care doctors as much as specialists. And granted,
14 I am a specialist, but I think these are the concerns I
15 have.

16 MIPS has a lot of problems. I agree with
17 everyone around the table on that one, but this whole
18 notion of the transition right now -- and I want people to
19 think about your own personal physicians and what it would
20 mean if this were to undergo. And we have not seen one
21 specialty physician group yet say, "You know what? I like
22 getting rid of MIPS, and I like this VVP. Let's go with

1 it." I haven't seen that, and I practice in two different
2 states, both Massachusetts and Virginia.

3 So I agree with the sentiment that MIPS has a lot
4 of problems, but my major objection is that the timing and
5 the whole strategy in infrastructure.

6 DR. CROSSON: Alice, just to be clear, it's a 2
7 percent withhold, not 10 percent.

8 DR. COOMBS: I was just responding to -- we had
9 this discussion the last time about increasing the
10 percentage of withhold, whether or not 2 percent was enough
11 to cultivate a change.

12 DR. CROSSON: Right. But I think the point we
13 made just a little bit earlier in the discussion is
14 depending upon the participation, and this could change
15 over time. That perhaps even though the withhold is 2
16 percent, the actual reward could very well turn out to be
17 more, but it's not a 10 percent withhold.

18 DR. COOMBS: And my only other question is, Would
19 there be a problem if the \$500 million was involved for the
20 slush fund?

21 [Laughter.]

22 DR. CROSSON: Go ahead. Sorry.

1 DR. COOMBS: [Speaking off microphone.]

2 DR. CROSSON: Paul.

3 DR. GINSBURG: I use different language.

4 [Laughter.]

5 DR. GINSBURG: But I've been sitting here
6 thinking about how we've used 2 percent. I think it's
7 going to be much lower to withhold, and I think it's making
8 it harder for physician groups to get comfortable with this
9 because they see 2 percent.

10 If you consider about that most won't get into
11 groups, of those that get into groups, some are going to
12 get rewards, some won't -- you know, I almost wonder about
13 half a percent, 1 percent.

14 And then what I thought that Alice was going to
15 get at is that maybe for the first few years, it could be
16 funded by that 500 million fund rather than withhold, which
17 again might make an even easier transition and more
18 appealing to get support for this.

19 DR. CROSSON: So, Paul, I think what I heard you
20 say was it's going to be lower. What I think what you
21 meant was it could be lower. It could, from a policy
22 perspective, be lower and still work.

1 DR. GINSBURG: Yeah.

2 DR. CROSSON: Okay. Thank you.

3 Comments?

4 David.

5 DR. NERENZ: Thanks.

6 I spoke at some length against the VBP part of
7 this in November. In fact, I had 11 specific points, and
8 people can look at the transcript.

9 I hadn't planned to say anything today figuring
10 that this was already on the track, and I knew which way it
11 was going to go. I will vote against the VBP
12 recommendation.

13 A couple of my colleagues that maybe I should
14 just take a minute and repeat a couple of the concerns,
15 maybe just for the record or for folks here who weren't
16 here in November.

17 So I did a better job in November, I think, but
18 here's just a few things. We call it voluntary, but at
19 least as we're talking about, it's not. If there's a
20 withhold for not participating. It's not voluntary, and
21 although the recent discussion was maybe a smaller one,
22 when Craig was here, he was talking about a bigger one. So

1 I have concern about that.

2 I raise a concern that there is a significant
3 amount of social engineering going on here with no real
4 evidence. We're talking about pushing physicians into
5 groups that have to be a certain large size in order to
6 have denominators big enough to do the least sensitive of
7 the measures. And I've looked and looked, and I see no
8 empirical evidence that that structure is better than other
9 structures. I'm very concerned about that.

10 We don't have evidence that the groups, as we're
11 talking about, will vary much in their performance. So the
12 objection we have on the MIPS side, I think could carry
13 over just as well to this side.

14 I think there's going to be a dynamic here that's
15 going to be analogous to fraternity and sorority rush. The
16 cool people will get together and make groups, and they're
17 cool because they know they have good performance, maybe
18 because they take care of people who are affluent and
19 educated and stay out of the hospital and take good care of
20 themselves. Those who aren't included in the cool people,
21 rush process are going to be left out. And I'm not quite
22 sure what they're going to do because if the formation of

1 the groups is voluntary, it's not enough to say you can
2 want to be in one. You have to be accepted in one, and I
3 don't know how that's going to play out.

4 I am concerned about adjustment for social and
5 economic risk factors. I know there's some mention in here
6 about using peer groups, but essentially, we're leading up
7 to CMS to figure that out. And I think we know, and it's
8 no secret. CMS is very, very reluctant to do that, has
9 been reluctant to do this, only currently is doing it when
10 congressionally mandated, so I do not have confidence that
11 that will go well. And poor people will be hurt by this.

12 I don't see any meaningful role for specialists
13 in which as we've put it together. I'm not convinced at
14 all by the observation that there are a lot of specialists
15 and ACOs. I think that's a nominal involvement. I don't
16 think that's a meaningful active care improvement
17 involvement, although I'm sure there may be some examples.
18 But I can think of counter examples. So I don't know where
19 this program takes specialists.

20 Claims-based measures, notoriously sort of
21 insensitive to issues of case mix and disease severity, and
22 we say these are things beneficiaries care about, but I

1 don't know that. I don't see evidence of that. I'm happy
2 to see it if it's out there.

3 What I do see is evidence that beneficiaries want
4 to know who's a good surgeon, who's a good cardiology,
5 who's a good oncologist. That's not what this is about.
6 So I think in the area of what information beneficiaries
7 will use to choose, I think Yelp will prevail. These
8 measures will be ignored; Yelp will win.

9 And finally, reporting as a group presumably
10 requires some element of coming together and actually
11 behaving and integrating as a group, but we don't really
12 talk about how that's going to happen, where is the funding
13 for that is going to happen, how is that going to be built.
14 And it's sort of, we think ACO dynamics will occur, but
15 without any ACO structure, without some of the financial
16 underpinnings.

17 So I'm sorry if I'm being redundant, and I'm not
18 hoping that I'm going to turn the room, but I will explain
19 my concerns.

20 DR. CROSSON: Further comments?

21 Rita and then Warner.

22 DR. REDBERG: I support the recommendations and

1 really appreciate the work in this chapter and the past few
2 years.

3 You know, I think the problems -- and you kind of
4 succinctly summarized them on Slide 6, but MIPS does not
5 support the goals of the program. It's not going to
6 improve quality, and it's not going to improve value. It's
7 an incredible burden for physicians. These quality
8 measures that are going to be capricious and arbitrary as
9 just not something that any physician I've talk to wants to
10 do, not to mention the billion-dollar cost.

11 I mean, I think we all want to achieve value, and
12 this is just not going to do it. And I think it's urgent
13 to do it because once we start -- I mean, any bureaucracy
14 has its own weight, and I think a lot of the resistance now
15 is because people have already started working towards
16 MIPS. And I understand that, but even terrible programs
17 don't go away because we have the infrastructure and
18 everyone has invested in it. I wouldn't want to see us
19 start down that road.

20 I think the voluntary value program is incredibly
21 thoughtful and achieves a lot of the goals. I have a lot
22 of confidence in my physician colleagues' ability to come

1 up with groups and to be able to adapt and make changes to
2 new payment structures, but we have to change the
3 incentives in order to have physicians do that, and I think
4 the voluntary value program is a great start to do that.

5 So I strongly support these recommendations.

6 DR. CROSSON: Warner.

7 MR. THOMAS: Yeah. I have a lot of questions
8 about the program. I do agree with Alice that I'm
9 concerned that there hasn't been any support from the
10 physician community around this, and I think we should be
11 cautioned by that fact.

12 Now, I know that all have not weighed in, and
13 obviously reading, it sounds like some of your colleagues
14 feel good about the new program. But I think there's a lot
15 of complexity there that is unclear and needs to be sorted
16 out as well, and I get concerned about that.

17 I wonder if there's an option to make
18 recommendations to modify MIPS to make it better or
19 different. I firmly believe in APMs, and I really want to
20 see advancements in APMs, but I also understand that there
21 are concerns with some areas that just have trouble getting
22 into APMs. And I understand that, especially maybe in more

1 rural areas.

2 So I, too -- I've got a lot of concerns about it,
3 and I don't know if there's any more thoughts from the
4 staff around any of those comments. That would be helpful
5 for us to consider and think about.

6 DR. CROSSON: Let me jump in, Warner.

7 So, first of all, just let me say in general I
8 appreciate the concerns that have been raised. This is a
9 complex issues. As was pointed out in the presentation,
10 we've been talking about this for over 2 years, and we've
11 been talking about it during a period of time that the MIPS
12 program has started through implementation. So I think
13 it's a fair comment to say I wish, Alice, we could have
14 come to this conclusion two years ago. It would have been
15 better, but we did not. And the reason we did not was we
16 look a fair amount of time doing exactly what Warner just
17 suggested, which is trying to figure out whether or not the
18 MIPS program as it exists could be modified in such a way
19 that it would objective the objectives that it was intended
20 for.

21 And I think as a Commission, we came to the
22 conclusion in the end, and I wish it had not taken a year,

1 but it did -- we came to the conclusion that, no, it's
2 simply not fixable for the reasons of cost, the reporting
3 requirements, the burden on practicing physicians, the fact
4 that it was very likely that the quality data was not going
5 to be relevant and salient and useful, so that essentially
6 an expenditure of money that would not produce a result.

7 That in the end, because of the way the law is
8 constructed and the way the regulations were written, that
9 we would experience a compression where for all the work
10 and money that the physicians would put in, in the early
11 yards, there would virtually be no reward or significant
12 penalty.

13 But then down the line, as Kate pointed out for
14 the same reason, because of the way it's drafted, for very
15 small differences in quality results, there could be very
16 dramatic and unexpected changes in income. And this could
17 be very bad for physicians and potentially very bad for
18 physicians in smaller practices, and that's how we came to
19 the conclusion that we did and how we came to -- remember
20 we said at one point how about if we just say let's get rid
21 of MIPS and not replace it with anything else, and we
22 walked back from that because we felt, no, we don't want to

1 do that.

2 We do have goals, as Dana expressed a little
3 while ago, about having all physicians involved in quality
4 improvement, and we do have longer-term goals where we
5 think that it's more likely that patients are going to get
6 better care if physicians have a notion that they are, in
7 fact, part of a team, whether that's an actual team or a
8 virtual team. And while the VVP doesn't cement that, it
9 does tend to move both the philosophy in that direction and
10 eventually, if it's successful, the actuality is physicians
11 begin to realize that they can do better financially if
12 they in fact associate themselves with other physician
13 practices.

14 So while I do understand and appreciate the
15 concerns, I do think that this has been a thorough process.
16 It's one where we have looked at the alternatives, doing
17 nothing, fixing MIPS itself, and in the end, collectively,
18 we came to the conclusion that we face today.

19 So, Kathy.

20 MS. BUTO: I don't know if there's anyone else
21 who wants to speak to this, but I've been listening to the
22 conversation, and I have to say that it has changed my mind

1 a little bit. I believe that the most consensus among
2 Commissioners is that MIPS itself needs to be repealed. I
3 don't sense -- I don't feel totally comfortable with the
4 VVP model as I start listening to people's reservations
5 about it, starting with Paul saying, well, you know, if I
6 had more confidence in the population-based measures, then
7 I'd feel better about allowing that that's a real option
8 and not pushing toward APMS. I don't know that we know
9 that much about APMS yet. So I guess I'd say I could
10 support the recommendations, but I would like to -- I guess
11 I would rather see us focus more on some of the uncertainty
12 of things like the size of the withhold, whether there
13 should be a very small withhold, whether it should be
14 funded out of the \$500 million, whether we want to look at
15 things like the issue Dave raised about socioeconomic
16 disparities. That really struck a chord. The idea that we
17 could actually be creating or encouraging a greater
18 disparity in physicians who treat low-income populations, I
19 think that's something to worry about.

20 So I guess I'd just say if we could be a little
21 more tentative or lay out some of the issues around the VVP
22 that need to really be looked at, and I would also add to

1 that this issue of MIPS, VVP, and APMs, and whether we see
2 or acknowledge that in some cases physicians are going to
3 really end up in one of those categories for a much longer
4 period. It's not just a transitional thing where they're
5 going to just move from one to the other. There may be
6 some physicians who never make it to the APM for a variety
7 of reasons that are not in their control.

8 So I'd just like to see a little more of a
9 discussion about the difficulties or the issues that really
10 need to be tackled, and, unfortunately, we have time to do
11 that because it takes a while for Congress to act and for
12 the administration to put out regulations, if Congress does
13 pass legislation.

14 So, again, I could support the recommendations,
15 but I see some issues here that I think we ought to
16 acknowledge exist.

17 DR. CROSSON: So I think there's two things that
18 I'm hearing, and I think there's two things that we could
19 do.

20 Number one is we could take some of the concerns
21 that were raised before and raised again today and address
22 them -- I know Kate has done some of this, but we could

1 address them more thoroughly in the writeup for this, and
2 we will do that.

3 And, secondly, I think it's entirely conceivable
4 and we probably should, depending upon what Congress
5 decides to do down the line, if they, in fact, do pick this
6 up and we see it moving in that direction, that we could
7 spend more time as a Commission working through some of
8 these issues. I think we would have to do that, because we
9 would be responsible for this movement, and I would suggest
10 that we should do that.

11 All right. I've got Amy, Warner, Bruce, Jack,
12 and Paul.

13 MS. BRICKER: So, Jay, I agree with -- I'm with
14 Kathy. I feel like the issues that were raised by Alice
15 and Dave and others, I concur. I feel like there needs to
16 be a little bit more work. How do we then, given the
17 recommendation, take that on? To approve the
18 recommendation would mean that we accept it as proposed
19 versus vetting some of these things that have been
20 highlighted. The infrastructure stands out for me. You
21 know, if the model is something similar to the reform done
22 in Massachusetts, do we have an infrastructure to support

1 this? Paul's suggestion around redeployment of the value
2 to ensure the success, just for my own edification, how
3 would one approach that given the recommendation at hand to
4 ensure that those things are vetted?

5 DR. CROSSON: Well, Amy, remember, I think one of
6 the things we're doing here is we're making a distinction
7 between A-APMs, which really means ACO or other types of
8 organized delivery systems, which either have or need to
9 construct a significant infrastructure in order to do this.

10 In the VVP program, we're using information,
11 largely, that CMS already has, right? So the
12 infrastructure demands, if you will, for VVP, while there
13 may be a requirement for somebody, you know, to list who
14 is, in fact, in the VVP, it doesn't imply the kind of
15 infrastructure that one would need in order to create the
16 quality data and report it and the like. In fact, one of
17 the reasons for this is to remove that burden, you know,
18 from physicians individually but even from physicians
19 collectively.

20 So, you know, I think, again, we use the term
21 "infrastructure" kind of loosely here, but I would not, you
22 know, be thinking this is creating an ACO-like

1 infrastructure. It's really quite the opposite. We're
2 trying to get rid of that reporting burden by doing this.

3 MS. BRICKER: So you're right, apologies. My
4 concern was around connecting these folks, these virtual
5 groups. How do we ensure that the ones that aren't the
6 popular kids, to use David's term, are connected in a way
7 that they can join a group? That's the infrastructure
8 reference.

9 DR. CROSSON: Right. So I didn't want to sort of
10 take -- I mean, David has a right to make his points. I
11 didn't want to sort of take up time and say, you know, I
12 disagree with that, I disagree with -- but, in fact, if we
13 look through the models that we've suggested for what the
14 virtual group could be, yes, somebody could decide to form
15 a group and say, you know, I only want these people and I
16 don't want others. But that's not the only model.

17 We've used, for example, models of a hospital
18 medical staff, which doesn't include every physician in the
19 community but includes most of the physicians who practice
20 there.

21 We've used the model of the county medical
22 society, which, again, doesn't include every physician if

1 they choose not to join, but they're perfectly free to join
2 those medical societies.

3 So I think to get the idea that this is somehow
4 going to be a club that will only have certain physicians
5 in it, then the rest will be out in the cold with their
6 noses pressed against the glass is not, in fact, the
7 reality, nor is it what we propose. So I hope that's
8 helpful.

9 Okay. Warner?

10 MR. THOMAS: Yeah, I come back to I think what
11 I'm concerned about is going through a situation where
12 we're eliminating a program and don't have a clear step
13 without these issues to move to. And I think going to
14 Kathy's point, I think there is more of a -- there's more
15 momentum around, okay, we understand some problems with
16 MIPS, but it seems like there's a lot of concerns around,
17 you know, the proposed new program as well. And if that's
18 the case, perhaps we ought to take a step back and just say
19 are we headed in the right direction and make sure if we're
20 going to take it -- because this is a major message to
21 physicians about how we think about Medicare. And I just
22 want to make sure we get that message right.

1 The thing about MIPS is that it is a message to
2 everybody that you do need to take quality into
3 consideration and be tracking quality measures. I
4 understand that there's time and energy that goes into
5 that. Frankly, it should be being done anyway, but,
6 regardless. And I think this -- you know, the message here
7 is, okay, if we're going to go in this direction, I think
8 we're still saying quality, but now you've got to come
9 together. And I'm not necessarily opposed to that model.
10 Once again, I think the APM model is the preferred model.
11 It's just I also don't think we want to send a message to
12 all physicians that there's a lot of adversity from those
13 groups about it, and I do get a little concerned about
14 that.

15 I'm not afraid to make an unpopular decision, but
16 I think we want to make sure we do something that is
17 constructive and headed in the right direction. That's
18 really what I'm concerned about.

19 DR. CROSSON: Jack.

20 DR. HOADLEY: So I'm prepared to vote for this
21 recommendation, but I was having similar thoughts to what
22 Kathy and then others have expressed. And, you know, I

1 sort of look back at the recommendation, you know, we're
2 fairly general in what we say about the VVP here. We talk
3 about it being something in which clinicians can elect to
4 be measured as part of the voluntary group and then those
5 who qualify for a value payment or they're able to qualify
6 for a value payment based on performance.

7 A lot of the things we've been talking about, the
8 2 percent withhold and some of the other structural things,
9 are not specifically, as I read that, part of the
10 recommendation. They're examples. And maybe in some ways
11 we've gotten -- we've allowed ourselves to be too fixed --
12 sometimes we build an example because it really is exactly
13 the direction we want to go. We're not writing all the
14 details into a recommendation. But we feel like it's
15 pretty well thought out and it's the model. But what I'm
16 hearing is some potential variation, so, you know, maybe it
17 adds some comfort to this if we modify some of what's in
18 the text -- I mean, the text isn't wrong the way it's
19 framed. It says take, for example, a 2 percent withhold.
20 But maybe that's followed up by saying, well, that's one --
21 you know, that's one example. Another example could be for
22 a series of years, no withhold and use the 500 million, or

1 a half -- you know, we could include other examples of what
2 things could look like in terms of phasing something in, in
3 terms of developing it, recognize that it would go through
4 a development, like you said, give ourselves the
5 possibility to come back in a year and put a little more
6 flesh on that after thinking it through.

7 Right now, if we vote yes, it seems like what we
8 would be doing is saying, A, we don't like the MIPS and we
9 want to get rid of it; B, we don't want to just get rid of
10 it without any replacement, but we've structured the
11 replacement in just a general directional sense. And if we
12 say more, maybe some of the concerns -- and I don't know,
13 you know, I don't imagine this would change, you know, what
14 Alice or David are going to vote, but maybe some of the
15 reactions out there in the broader community will be more
16 open to it if some of these things like 2 percent coming
17 off your thing and guarantee you a lot of people are going
18 to be down 2 percent is made less of a specific part of
19 what we're proposing given that we never actually meant to
20 say -- to lock that in in the first place. So that's my
21 thought on it.

22 DR. CROSSON: So you're proposing changes to the

1 text, Jack?

2 DR. HOADLEY: To really just to re-emphasize
3 what's already, I think, clear but takes on a life as we
4 build up an example and it starts to feel like that example
5 is the proposal.

6 DR. CROSSON: Right. I mean, the conundrum here
7 -- and we've had this discussion in several different
8 directions, but it seems to me at one of our earlier
9 discussions, at least a number of Commissioners said, well,
10 flesh out the details as to how this would work. And so,
11 you know, we've fleshed out some examples. And then, as
12 you say, when you flesh out the example, people can say,
13 well, you know, we don't like that example, how about if we
14 do it this way? So we're kind of caught on a little bit of
15 the horns of a dilemma.

16 DR. HOADLEY: Just pushing harder on the notion
17 that it is an example and maybe by giving a second example
18 on some of the details or -- I mean, we don't need to write
19 up a whole new second scenario, but each time we give a
20 detail, to be able to say or there could be this or there
21 could be this, and then it doesn't lock that example into
22 people's minds.

1 DR. CROSSON: All right. Dana, do you want to
2 come in on his point? Jon, I got you.

3 DR. SAFRAN: I think so [off microphone].

4 DR. CROSSON: Okay. All right.

5 [Laughter.]

6 DR. SAFRAN: I guess what was thinking listening
7 to this is in some ways your point, Jay. We are caught on
8 the horns of a dilemma, and the dilemma I hear is I don't
9 hear a single Commissioner who's saying we must preserve
10 MIPS or even we should try to preserve MIPS. The strongest
11 endorsement of MIPS is like people have spent a lot of time
12 and money getting ready for MIPS, and so it's challenging
13 to take that out from under them.

14 So I just want to flag that because I want us to
15 not feel like, well, let's just walk away from this whole
16 thing. I mean, we, I think, are very clear in our own
17 thinking that MIPS is going to spend a lot of money and not
18 gain any ground in quality for beneficiaries. And so I
19 think we have a duty to point that out.

20 The question I'm sitting with -- and in some ways
21 it's just my unfamiliarity still with, you know, how we can
22 do our work -- is: Do we have to have a fully fleshed out

1 proposal or can we now, given this conversation, say, you
2 know, the concept that we're talking about is something
3 voluntary, but that, you know, there are these challenges?
4 For example, you know, we want to be sure that those who
5 are serving more socioeconomically disadvantaged
6 populations are not going to end up hurt by this so,
7 therefore, we would consider a model in which those who
8 come together voluntarily and serve such a population might
9 actually get, you know, higher payout for whatever reward
10 they're going to get? You know, sort of point to some of
11 the challenges and then maybe propose a development period
12 that includes input from the key stakeholders that we need
13 input from in order to walk that bridge from the
14 preparation that's been done for MIPS to something else.

15 DR. CROSSON: Okay. Bruce.

16 MR. PYENSON: I strongly support both
17 recommendations, and I want to address a couple of issues.

18 One is the responsibility that professional
19 societies have had to prepare for the existing laws. Of
20 course, any professional society that didn't do that would
21 be in big trouble with their members if they hadn't
22 prepared and nobody listened to MedPAC. So it should not

1 be surprising that professional organizations have invested
2 heavily in getting ready for this, and the dynamics, I
3 mean, the people here, you know, part of professional
4 organizations and, you know, the dynamics there, I think at
5 MedPAC we have the flexibility to revisit things that's
6 much more than most professional organizations would. So I
7 don't -- it doesn't worry me at all that other -- that
8 professional organizations haven't signed on to the
9 proposed recommendation.

10 The other, I'd like to echo Jack's view that what
11 we have is a principle-based proposal, and I'm fine with
12 that. I think that's what we should often strive to do.
13 And some of the concerns seem out of proportion to the
14 reality of the physician world. We're talking about a
15 couple of percent of Medicare, and if you think of the
16 reality of physicians where, you know, the kinds of changes
17 that go on in the commercial world, where a good portion of
18 an employed population might, going from December to
19 January, all of a sudden be in a high-deductible plan, or
20 physicians get kicked out of the network or there's a
21 consolidation or they're now in a network. There's -- I
22 mean, it seems out of proportion to the reality, the bigger

1 reality that physicians live in to be all that concerned --
2 I mean, worried about the kind of change that VVP would
3 make.

4 So I think it's -- so I don't see a downside in
5 going down that path. Of course, there's going to be
6 unintended consequences. That's part of reality, there's
7 unintended consequences. But in the scale of things, I
8 view this as the principle that we're shifting in some way
9 the entire system to value as much as we can. So I would -
10 - I don't know if I'm going to sway David or Warner or
11 Alice, but I'm comfortable with this kind of approach, and
12 I really don't see a downside.

13 DR. CROSSON: Paul.

14 DR. GINSBURG: Yeah, I support both of the
15 recommendations, and, you know, given the discussion we've
16 had, it reminded me of thoughts I had in prior Commission
17 meetings where we discussed this, which is that, you know,
18 I feel the most urgent thing -- and I feel, as Rita said,
19 it is urgent -- is to eliminate MIPS. And I think the
20 urgency comes from a political dimension that MIPS, after a
21 few years, is going to have some real winners who know who
22 they are. They're going to be doing much better than if

1 they had gone to APMs. This just makes it difficult down
2 the road to do things like this. Much easier before anyone
3 knows for sure they're going to be the big winners.

4 But I do feel that if all Congress did was
5 eliminate MIPS and they did not do an alternative, like the
6 VVP, I think that would be progress. I think it would be
7 better if they did something like the VVP, which is why I
8 support both recommendations. But I think it's important
9 that our language, you know, makes it clear to Congress
10 that, you know, the most critical thing they do now is
11 eliminate MIPS. And we also believe that there
12 opportunities to do something value-based with the non-APM
13 population, and the VVP is our idea. There may be other
14 ideas.

15 And so I'm just really talking about the language
16 to set that up.

17 DR. CROSSON: Did I have Brian? No. Sorry. Jon
18 next.

19 DR. CHRISTIANSON: Yeah, just a really quick
20 reaction to something that Warner said, but so much water
21 is over the dam since then, probably you guys won't
22 remember it.

1 [Laughter.]

2 DR. CHRISTIANSON: No, he said that one of the
3 virtues of MIPS such as ours, that it provides a signal to
4 physicians that they have measured on quality. My own
5 perception is kind of like exactly the opposite -- it
6 provides them with the signal they don't have to. And Kate
7 gave us some data a while ago about how many people will be
8 exempted from this, and particularly when you're measuring
9 at the individual physician level, you're exempting lots of
10 people for legitimate reasons, that David couldn't expound
11 on, in terms of small numbers and reliability of measures
12 and so forth.

13 So one of the things I thought the second part of
14 the recommendation did was give us some potential, in the
15 future, and no matter how that turns out, no matter how the
16 details get worked out, to have more physicians being
17 measured at some level, at least, on quality. And it's not
18 going to be the individual level, and for most physicians
19 that's not going to happen anyway, or shouldn't happen
20 anyway, because of reliability issues.

21 And I agree with what you were saying, is that
22 this is a set of principles and we've kind of maybe even

1 burdened it with all the examples, except that the
2 Commission has demanded examples of how the principles
3 might play out, in fact. But I really do think it's a we
4 think eliminate MIPS, there's a lot of work to be done, and
5 we think we should move in this direction, and then it will
6 be incumbent on the Commission to do a lot of that work, I
7 think.

8 DR. CROSSON: Okay. I have Warner, Brian, Paul.

9 MR. THOMAS: So, Jon, I agree with you. I
10 understand your comment. I understand your comment, and I
11 guess I would say this. I think if we could -- what I'm
12 concerned about would be with the new proposed program is I
13 don't want to replicate what we're talking about with MIPS,
14 where essentially you had something that was probably not
15 as well thought out as it could have been, and yet it was
16 put together and, you know, made law and implemented. So I
17 just want to make sure we're not down that road.

18 I think if we could make sure we are saying,
19 look, the principles here are around quality, that we want
20 to tie more dollars there, that we want to provide a real
21 incentive for folks to move more to APMS and to start to
22 evolve more to group, then I think that is something --

1 quantifying that there are components that need to be
2 worked out around the details of that. I can get my head
3 around that and understand that being directionally there.
4 And I understand the downfall with MIPS, and I get that.

5 I just want to make sure we're not replicating
6 that issue with our recommendation and that perhaps we just
7 are very clear about the principles, what needs to be
8 accomplished, and that the details need to be worked out as
9 part of, you know, the next phase of the process. That I
10 could be supportive of.

11 DR. CROSSON: Brian.

12 DR. DeBUSK: I support both recommendations as
13 written, but as someone who was pushing for more
14 specificity -- I was one of several -- I feel a little bit
15 guilty here --

16 [Laughter.]

17 MS. BUTO: Be careful what you ask for.

18 DR. DeBUSK: -- because -- I know, be careful
19 what you ask for here. Again, I think the text was a very
20 well-written chapter. I think that the VVP is an excellent
21 framework, starting point. So again, I do support both as
22 written. But to Jack's point, if people wanted to -- and I

1 think Bruce touched on this too -- wanted to look at this
2 really as more of just an example, and maybe we do take
3 some time and build out some alternative frameworks and
4 some choices, I would be very supportive of that as well.
5 But I do think to the point that several people just made,
6 is maybe this request for specificity may have actually
7 gotten this proportion more tangled in the weeds than it
8 needs to. To Paul's point, the big issue here is getting
9 rid of MIPS, before we have these huge winters and all
10 these other issues come to the surface.

11 So again, hopefully we could retreat to the point
12 where this is an example and we can treat it as such.

13 DR. CROSSON: David. David and Paul.

14 DR. GRABOWSKI: Thank you. Good timing to follow
15 Brian's comments. So first, I'm supportive of the draft
16 recommendations as written. Similar to Dana, I was really
17 struck by the discussion here. Nobody seems to like MIPS,
18 and that's pretty obvious. Obviously, there's been some
19 concerns about the VVP as written. I would be comfortable
20 with moving back, and I guess it's where this group
21 started, was just to eliminate MIPS.

22 And so I would be very comfortable -- I feel like

1 if that's -- if we couldn't agree on the Voluntary Value
2 Program, I would be very comfortable with just saying let's
3 repeal MIPS. MIPS is a step in the wrong direction. I
4 won't go through it. I've been very direct about it my
5 comments about it at prior meetings. It really introduces
6 some large, arbitrary distortions in our payment system.
7 We need to repeal it. I would like to replace it with the
8 VVP but I'm comfortable with just repealing, if that's
9 where we end up, because I do think just -- if those are
10 the choices on the table. Thanks.

11 DR. CROSSON: Well, good luck, Jay.

12 [Laughter.]

13 DR. CROSSON: You know, this is tough. I don't
14 know how to proceed, but I'm going to suggest something.
15 We have had that choice discussed before, that is, let's
16 just repeal MIPS. In the course of, I don't know,
17 somewhere in the last two years we looked at that. We had
18 a couple of concerns with that. One was, do we really want
19 to -- first of all, is that actually likely to happen -- it
20 would just be repealed but nothing to replace it? Now, you
21 know, you can argue about the political likelihood of this,
22 that, or the other thing. That's fine.

1 But I think, also, I think we felt that it would
2 be a retreat on the part of the Commission from a strongly
3 held principle, you know, which is that there ought to be
4 accountability for quality at every level that we can
5 suggest that. And to simply say let's, you know, eliminate
6 800 or 900 or however many thousands of physicians we're
7 talking about, from any representation of quality reporting
8 -- or not even reporting, actually, just accountability --
9 would not be a strong policy position for us to take.

10 So while I understand that that might be an
11 easier path forward, I think, in the end, we might regret
12 doing that, and I think the likelihood that change would
13 result would be lessened.

14 So I would -- I do think I need to remind people
15 that, as was pointed out in the presentation, that we got
16 here, to where we are today, after a long period of
17 discussion, we have gone back and forth about how much
18 detail we want. We've had some people wanting more detail,
19 now maybe some people want less detail, and I understand
20 all that. I also think I understand that I'm not sure
21 that, you know, more debate is going to produce a different
22 result. I wish that were the case.

1 But I would come forward and say I can commit to
2 two things. Number one, a number of the concerns raised
3 here, Warner and others, have to do, I think, with how we
4 cast this. And, as you know, it will take some quick work,
5 but we do have an opportunity, all of us, to re-look at
6 this chapter as it's written and make suggestions. Lord
7 help the staff who have to bring these all together. But
8 we do have an opportunity, I think, to construct, and
9 Kathy, I think some of your concerns also can be dealt
10 with, in terms of how we rewrite the final version of this
11 chapter.

12 And the second thing I would commit to -- I've
13 already mentioned one -- and that is, if we get the sense
14 that this is going to go forward, that Congress is going to
15 act on the repeal of MIPS and that there is genuine
16 interest in the VVP, then not only will we, but we must
17 come back, subsequently, and work out some of this
18 material.

19 So again, I'm committed, myself, to support the
20 draft recommendations that we have before us.

21 So if there are no further comments, we'll
22 proceed to take votes and we'll do it individually. The

1 first is the draft update recommendation, the first draft
2 recommendation. I'll give you a chance to read that.

3 All Commissioners voting -- this is the update
4 itself, not the MIPS recommendation -- all Commissioners in
5 favor please raise your hands.

6 [Show of hands.]

7 DR. CROSSON: All opposed?

8 [No response.]

9 DR. CROSSON: Abstentions?

10 [No response.]

11 DR. CROSSON: Seeing none, it passes unanimously.

12 And then we have the draft MIPS recommendation, its bullet
13 points included. I'll give you a chance to read that
14 again.

15 DR. SAFRAN: Can I ask a question?

16 DR. CROSSON: Yes, Dana.

17 DR. SAFRAN: So given the conversation that we've
18 had on the two, I think, kind of commitments that I just
19 heard you making, is voting in favor of these sort of with
20 the understanding that there will be some rewriting to kind
21 of put this forward as principles, not as a baked program?

22 DR. CROSSON: Yes, as long as the people who want

1 the more detail are willing to accept that version. So we
2 may have to have some iteration here, but yes.

3 DR. DeBUSK: I'm out. No more requests for
4 detail.

5 DR. CROSSON: Okay. With that clarification, all
6 Commissioners in favor please raise your hands.

7 [Show of hands.]

8 DR. CROSSON: All opposed?

9 [Show of hands.]

10 DR. CROSSON: We have two. Abstentions.

11 [No response.]

12 DR. CROSSON: None. We have 16 voting
13 Commissioners, 14 in favor, 2 opposed.

14 That's the end of this discussion. Thank you
15 very much, Kate, Ariel, and David.

16 [Pause.]

17 DR. CROSSON: Okay. Now we're going to proceed
18 with two presentations on -- no, well, this presentation
19 and then the next. I'm sorry. Two presentations of
20 multiple presentations, and these are part of the -- for
21 those of you in the audience, these are part of our annual
22 update process.

1 In this first presentation, we're going to take
2 those portions of the Medicare payment that are not
3 physician and hospital or Medicare Advantage but are not
4 post-acute care, and we're going to do it through what we
5 have referred to in the past as an expedited voting
6 process, which means that in the opinion of the Commission,
7 because we asked for opinions in our December meeting, we
8 have had a thorough discussion, and so we will have a brief
9 presentation of the basis for the recommendation, the
10 recommendation, a brief period of final questions, and then
11 we will proceed to the vote. And then after this panel,
12 we'll have a second panel of the same nature.

13 So having described that, Dan, you look anxious
14 to begin.

15 DR. ZABINSKI: All right. At the December 2017
16 meeting, we presented update information for ambulatory
17 surgical centers and provided draft recommendations.

18 The Commissioners made several comments about
19 stronger language regarding ASCs submitting cost data, and
20 in your draft chapter, we have added statements that
21 strengthen idea that the Commission sees no reason why ASCs
22 cannot or should not submit cost data.

1 Facts about ASCs in 2016 are that Medicare
2 payments to ASCs were nearly \$4.3 billion, the number of
3 ASCs was 5,532, and 3.4 million fee-for-service
4 beneficiaries were treated in ASCs.

5 We found that beneficiaries' access to ASC
6 services is stable. In 2016, the volume per fee-for-
7 service beneficiary decreased by 0.5 percent; the
8 number of fee-for-service beneficiaries served decreased by
9 0.4 percent; the number of ASCs increased by 1.4 percent;
10 and Medicare payments per fee-for-service beneficiary
11 increased by 3.5 percent.

12 Also, growth in the number of ASCs suggests that
13 access to capital is good. Also, there has been a fair
14 amount of acquisitions and partnerships with ASCs by
15 hospital groups and other health care companies, which
16 requires access to capital.

17 We emphasize that our analysis is limited for two
18 reasons.

19 First, even though ASC quality data are available
20 to the public, the Commission believes that CMS could
21 improve the ASC quality reporting system by including more
22 claims-based outcomes measures, more measures of subsequent

1 hospitalizations that apply to all types of ASCs, and
2 surgical site infection measures.

3 Second, we're not able to assess margins or other
4 cost-based measures because ASCs don't submit cost data
5 even though the Commission has recommended on several
6 occasions that these data be submitted.

7 So for the Commission's consideration today, we
8 have the following draft recommendation:

9 The Congress should eliminate the calendar year
10 2019 update to the payment rates for ambulatory surgical
11 centers.

12 Given our findings of payment adequacy and our
13 stated goals, eliminating the update is warranted. This is
14 consistent with our general position of recommending
15 updates only when needed.

16 The implication of this recommendation for the
17 Medicare program is that it would produce savings of less
18 than \$50 million in the first year and less than \$1 billion
19 over five years.

20 We anticipate this recommendation having no
21 impact on beneficiaries' access to ASC services or
22 providers' willingness or ability to furnish those

1 services.

2 In a separate draft recommendation, we have that:
3 The Secretary should require ambulatory surgical centers to
4 report cost data.

5 Collecting these data, as Medicare does for other
6 providers, would improve the accuracy of the ASC payment
7 system. The Secretary could limit the burden on ASCs by
8 using a streamlined system of cost submission.

9 Implementing this recommendation would not change
10 Medicare program spending. We also anticipate no effect on
11 beneficiaries. However, ASCs would incur some added
12 administrative costs.

13 I'd like to turn things over to the Commission.

14 DR. CROSSON: Thank you, Dan.

15 Questions for Dan on the ASC recommendations?

16 [No response.]

17 DR. CROSSON: Seeing none, we'll put up draft
18 recommendation 1. All Commissioners in favor of the
19 recommendation, please raise your hand.

20 [Show of hands.]

21 DR. CROSSON: All opposed?

22 [No response.]

1 DR. CROSSON: Abstentions?

2 [No response.]

3 DR. CROSSON: Seeing none, it passes unanimously.

4 [Dr. Coombs not present for the vote.]

5 DR. CROSSON: Draft recommendation number 2, and
6 I will note that I'm not sure how many but there have been
7 many, many years that we have made the same recommendation.

8 DR. ZABINSKI: I don't know either.

9 DR. CROSSON: All Commissioners in favor of the
10 recommendation, please raise your hands.

11 [Show of hands.]

12 DR. CROSSON: Opposed?

13 [No response.]

14 DR. CROSSON: Abstentions?

15 [No response.]

16 DR. CROSSON: Seeing none, it passes unanimously.
17 Thank you very much, Dan.

18 [Dr. Coombs not present for the vote.]

19 DR. CROSSON: We'll now turn to Nancy Ray, who is
20 going to present the dialysis recommendation. That's the
21 order I have.

22 MS. RAY: During this session I will summarize

1 the information on the adequacy of Medicare's payments for
2 outpatient dialysis services that we discussed at the
3 December 2017 meeting.

4 With respect to the questions you asked us during
5 the December meeting, we have tried to address them in the
6 draft chapter, as indicated in the cover memo. In
7 particular, several Commissioners asked about factors
8 affecting the use of home dialysis. We have added a text
9 box on patient-level and provider-level factors that affect
10 the use of home dialysis and a summary of Medicare's home
11 dialysis payment policies. There were some questions that
12 we could not address either because data were not available
13 or because of time constraints. We are contemplating these
14 issues for the next cycle.

15 First, I will review some key facts. Outpatient
16 dialysis services are used to treat most patients with end-
17 stage renal disease. In 2016, there were more than 390,000
18 fee-for-service dialysis beneficiaries treated at roughly
19 6,700 facilities. In 2016, fee-for-service spending was
20 about \$11.4 billion for dialysis services.

21 Moving to our findings on payment adequacy,
22 access to care indicators are favorable. Between 2015 and

1 2016, growth in treatment stations -- a measure of dialysis
2 capacity -- grew slightly faster than fee-for-service
3 beneficiary growth. For-profit and freestanding facilities
4 account for the increasing capacity. Quality is improving
5 for some measures. For example, between 2011 and 2016,
6 home dialysis use has increased, and we have seen declines
7 in hospital admissions overall, admissions related to ESRD
8 comorbidities, and mortality. On the other hand, we do see
9 an increase in ED visits.

10 The dialysis industry appears to have good access
11 to capital. For example, during the last several years,
12 the two large chains either acquired or purchased majority
13 stakes in health care-related companies.

14 Moving to our analysis of Medicare's payments and
15 providers' costs, the 2016 Medicare margin is 0.5 percent,
16 and the rate of marginal profit is roughly 17 percent. The
17 2018 Medicare margin is projected at 0.4 percent,
18 approximately the same as the 2016 Medicare margin.

19 So this leads us to our draft recommendation, and
20 it reads: For 2019, the Congress should update the
21 calendar year 2018 Medicare end-stage renal disease
22 prospective payment system base rate by the amount

1 determined under current law.

2 The draft recommendation's language reflects a
3 technical change from our December meeting. But there is
4 no change in the draft recommendation's intent to reflect
5 current law for the 2019 payment update.

6 The draft recommendation has no effect on federal
7 program spending relative to the statutory update. Under
8 current estimates of the market basket index and
9 productivity adjustment, this would result in an update of
10 1.4 percent. Given this sector's large marginal profit and
11 other indicators of payment adequacy, this recommendation
12 is not expected to have an adverse impact on beneficiaries'
13 ability to obtain dialysis care. This recommendation is
14 not expected to have an effect on providers' willingness
15 and ability to care for dialysis beneficiaries. And with
16 that I'll turn it back to Jay.

17 DR. CROSSON: Thank you, Nancy.

18 Questions for Nancy? Yes, Bruce.

19 MR. PYENSON: Just a comment for the next cycle.
20 I believe in a few years end-stage renal disease
21 beneficiaries will be able to join Medicare Advantage
22 plans. I forget when that will happen, but --

1 MS. RAY: 2021.

2 MR. PYENSON: 2021. So I would like to get some
3 consideration of that into the next cycle.

4 DR. CROSSON: Okay. Seeing no other questions,
5 the draft recommendation is before you -- oh, wait.

6 MR. THOMAS: Jay, one quick question [off
7 microphone].

8 DR. CROSSON: Go ahead. Sorry.

9 MR. THOMAS: Just a quick question and just from
10 a broad -- from a policy perspective. So the
11 recommendation here is a 0.7 percent increase, which I
12 guess it must be the current law. Is that correct? Or I
13 guess it's 1.4 and there must be an adjustment to take it
14 down to 0.7. Is that correct?

15 MS. RAY: No. The market basket is 2.1.

16 MR. THOMAS: Okay.

17 MS. RAY: Less the productivity adjustment,
18 brings it to 1.4.

19 MR. THOMAS: Okay. So the adjustment's 1.4 that
20 we're making the recommendation. Is that correct?

21 MS. RAY: That's what the update would be
22 currently valued at right now. However, when CMS does put

1 into place the update, the market basket forecast will --
2 could change.

3 MR. THOMAS: Could change it some.

4 MS. RAY: Yes.

5 MR. THOMAS: So it's around 1.4, roughly.

6 MS. RAY: Yes.

7 MR. THOMAS: And we have an overall marginal
8 profit of 17 percent. I know there's several areas that
9 we're kind of going with a zero increase. So is there a --
10 just from a global perspective, what's the -- I just want
11 to make sure I understand the rationale of dollars here,
12 you know, versus other areas where we kind of have it
13 zeroed out.

14 DR. CROSSON: You're talking about the marginal -
15 - the marginal profit, difference in marginal profit from
16 one Medicare payment segment to the other.

17 MR. THOMAS: Yes, well, I'm just saying in some
18 areas we've zeroed out -- we're kind of recommending a
19 decrease or a zero here. I mean, we're essentially -- in
20 the hospital, which we covered earlier, there's a negative
21 Medicare margin, pretty substantial, so I think we kind of
22 said, okay, we should have an increase there. Here we're

1 going with the increase. I just wanted to make sure I
2 totally understand as we go with that -- and I'm not
3 opposed to it at all. I'm not opposed to the
4 recommendation. I just want to make sure I understand it.
5 That's all.

6 DR. CROSSON: Right. So maybe I shouldn't talk
7 for the staff, but one of the issues you've brought up in
8 the past, Warner, has to do with the relative dependency on
9 Medicare as a payor. Right? So I -- Nancy, do you want to
10 sort of expound upon what I just said?

11 DR. MATHEWS: Or Nancy could --

12 MR. THOMAS: I think you just --

13 [Laughter.]

14 DR. MATHEWS: Warner, one way to address your
15 question would be, you know, we look at a suite of payment
16 adequacy indicators for each sector where they exist, and
17 when we look at this, none of the indicators are absolutes
18 that when you combine them all together result in a score
19 that says this is what the update should be. And so there
20 was a fair amount of judgment that takes place --

21 MR. THOMAS: Right.

22 DR. MATHEWS: -- even at the staff level, as we

1 were working up the analysis and developing a
2 recommendation for your consideration. But then also among
3 the Commissioners, you know, this requires some judgment on
4 your part as well. So with respect to the dialysis sector,
5 we see most of the indicators moving in a positive
6 direction. We see access sufficient to meet demand and not
7 a lot more. We see not, you know, excessive profits in the
8 sector. And so we came to a determination of, with your
9 consent, a current law update seems appropriate for the
10 sector.

11 Now, to your point that with respect to
12 hospitals, we have a slightly different set of indicators,
13 where for the most part things seem to be moving in a
14 positive direction, but the exception is the financial
15 performance, and so your question here is why are we still
16 at the same current law update for hospitals that we are
17 for --

18 MR. THOMAS: Well, I'm not just comparing it to
19 hospitals. I'm looking at other -- I mean, we've looked at
20 draft recommendations in other areas last month, and so if
21 you look at whether it's skilled nursing, home health,
22 IRFs, et cetera. So I'm just trying to understand with the

1 marginal -- and, once again, I mean, if it's just -- I
2 mean, the judgment and we kind of look at it, we feel like
3 they're still Medicare dependent, that's the rationale,
4 okay, I mean, I understand that. I'm just trying to
5 understand with the marginal profit of 17 percent, you
6 know, kind of just trying to understand that. That's all.
7 I mean, if the answer is, well, in our judgment, given the
8 Medicare dependency, given the importance here, we want to
9 have the right access because so many folks are, you know,
10 Medicare dependent in dialysis, okay. I'm just trying to
11 understand it. That's all.

12 MS. BUTO: Hospice, for instance, has a marginal
13 profit of 13 percent, yet we're recommending there sort of
14 no update. The real difference I saw was the Medicare
15 margin's pretty healthy for hospice. So I get where he's
16 going. I think it's helpful just to better understand.

17 MR. THOMAS: Right.

18 DR. CROSSON: And I'll just reiterate one general
19 comment here, that as we, I think, discussed in December,
20 there is a certain degree of subjectivity, if you want to
21 call it.

22 MR. THOMAS: Yep.

1 DR. CROSSON: And as you've pointed out, Warner,
2 a bunch of moving pieces in terms of the numbers. And so
3 it is our intention to spend collectively together a little
4 bit more time on that when we have the time to do that so
5 that everybody is kind of clear, and to the extent that we
6 need to change the uniformity or the process by which we
7 present the data, we will undertake that consideration as
8 well.

9 DR. GINSBURG: Can I come in on this? You know,
10 the dialysis looks different in the relationship between
11 the marginal and the average than most others because it's
12 unusual in the very high degree of fixed costs. So it's
13 not a surprise.

14 I think to me, I look at the average Medicare
15 margin. That's most important. The marginal really is
16 more a thing of is there any short-term risk of declines in
17 access, and that's clearly not the case here. But the
18 overall margin does not seem excessive at all.

19 DR. CROSSON: Thank you for the economist point
20 of view.

21 MR. THOMAS: Just as a general comment, and this
22 would just be overall, I think -- and maybe this is for a

1 planning session. But I think access for beneficiaries to
2 care for Medicare for the most part, given the size of
3 Medicare, is not probably the measure we need to look at in
4 general, because, I mean, for example, hospitals, dialysis
5 centers, ASCs, for the most part they need to take
6 Medicare. I mean, they just do in order to exist. So I'm
7 not sure that's the measure we've got to look at around
8 whether, you know, payment is adequate or not. But it's
9 just an aside.

10 DR. CROSSON: As I said, we'll have a chance to
11 spend some time on that.

12 David, do you still have a point?

13 DR. NERENZ: It was essentially Paul's point. I
14 think the -- I basically disregard the marginal profit
15 things. They all look about the same to me. If Medicare
16 payment ever dropped so low that it didn't even cover
17 marginal costs, I think we'd already know it and have a big
18 problem. So the same point, don't worry about it.

19 DR. CROSSON: Okay. Thank you.

20 So we have the draft recommendation. Seeing no
21 other questions, all Commissioners in favor of the draft
22 recommendation, please raise your hand.

1 [Show of hands.]

2 DR. CROSSON: All opposed?

3 [No response.]

4 DR. CROSSON: Abstentions?

5 [No response.]

6 DR. CROSSON: It passes unanimously.

7 And, Kim, I think you're going to take us through
8 hospice services.

9 MS. NEUMAN: Yes. I'm going to review indicators
10 of hospice payment adequacy that we discussed at the
11 December meeting, and that's described in detail in your
12 mailing materials. We revised the mailing materials based
13 on your December conversation. For example, Brian, we
14 added information on live discharge rates by diagnosis.

15 All right. Next slide. Okay, so key facts about
16 hospice. In 2016, over 1.4 million beneficiaries used
17 Medicare hospice services, including about 50 percent of
18 beneficiaries who died that year.

19 About 4,400 providers furnished services to those
20 beneficiaries, and Medicare paid those providers about
21 \$16.8 billion.

22 So now we'll look at our indicators of payment

1 adequacy. First, our indicators of access to care are
2 positive. The supply of hospice providers continues to
3 grow, increasing more than 4 percent in 2016. For-profit
4 providers account almost entirely for the net growth in the
5 number of providers.

6 Hospice use also increased. About 50 percent of
7 Medicare decedents used hospice in 2016, up from about 49
8 percent in 2015.

9 Average length of stay and median length of stay
10 among decedents increased slightly in 2016.

11 Also, quality data recently became available for
12 individual hospice providers for seven process measures.
13 Even at this early stage of having these new quality
14 measures, performance on the measures is quite high, and
15 the measures generally seem topped out.

16 In terms of access to capital, the continued
17 growth in the number of providers suggests capital is
18 accessible.

19 So then this brings us to margins. As you'll
20 recall, margin estimates assume cap overpayments are fully
21 returned to the government and exclude nonreimbursable
22 bereavement and volunteer costs.

1 For 2015, we estimate an aggregate Medicare
2 margin of 10 percent and a rate of marginal profit of 13
3 percent.

4 For 2018, we project an aggregate Medicare margin
5 of 8.7 percent.

6 So on the basis of these positive payment
7 adequacy indicators, we have the draft recommendation, and
8 it reads:

9 The Congress should eliminate the fiscal year
10 2019 update to the Medicare payment rates for hospice
11 services.

12 The implications of this recommendation are a
13 decrease in spending relative to the statutory update of
14 between \$250 million and \$750 million over one year and
15 between \$1 billion and \$5 billion over five years.

16 In terms of beneficiaries and providers, we do
17 not expect an adverse impact on beneficiaries, nor do we
18 expect any effect on providers' willingness or ability to
19 care for these beneficiaries.

20 That concludes the presentation, and I'll turn it
21 back to Jay.

22 DR. CROSSON: Thank you, Kim.

1 Questions for Kim on hospice?

2 [No response.]

3 DR. CROSSON: Seeing none, we'll proceed to vote.

4 All Commissioners in favor of the draft recommendation,
5 please raise your hand.

6 [Show of hands.]

7 DR. CROSSON: All opposed?

8 [No response.]

9 DR. CROSSON: Abstentions?

10 [No response.]

11 DR. CROSSON: Seeing none, it passes unanimously.

12 Thank you to our panel, and we'll move on to the
13 next panel.

14 For those of you in the audience who may have
15 joined us in the last few minutes, we're going to have
16 another session of what's referred to as "expedited
17 voting," and these relate to the update payment for post-
18 acute care. Expedited voting means that in our December
19 meeting Commissioners indicated support for the
20 recommendations, and, therefore, we will not have a full
21 presentation but we will have an expedited presentation,
22 questions, and move to a vote.

1 The first presentation -- well, let me see.
2 Carol, how are you going to do this first one?

3 DR. CARTER: So I'm going to start with the
4 equity of PAC payments and then go through the SNF update,
5 and then we'll go in order with the other post-acute care.

6 DR. CROSSON: Okay.

7 DR. CARTER: But we'll break for voting in
8 between each of them.

9 DR. CROSSON: Thank you very much.

10 DR. CARTER: Okay. So turning to the PAC equity
11 recommendation, at the December meeting, we discussed a way
12 to increase the equity of payments within each post-acute
13 care setting before implementing a unified PPS.

14 The Commission's recommended design of a unified
15 PAC PPS would increase the equity of Medicare's payments by
16 redistributing payments across conditions, raising payments
17 for medically complex care, and lowering them for stays
18 that currently receive therapy that is not related to the
19 patient's condition.

20 The redistribution would narrow the relative
21 profitability across conditions, and as a result, providers
22 would have less incentive to avoid medically complex

1 patients.

2 Before implementing a unified PAC PPS, it would
3 be possible to increase the equity in payments within each
4 setting by using a blend of the current setting-specific
5 relative weights and the relative weights from the unified
6 PAC PPS to establish payments. This would begin to
7 redistribute payments across conditions and based on a
8 provider's mix of patients and its current therapy
9 practices across providers.

10 The redistribution of payments would narrow the
11 financial performance of providers, all else being equal.
12 Total payments to the setting would remain at the
13 recommended level of spending.

14 Warner, you asked about how this would work, so I
15 added more discussion of the mechanics in the chapter.

16 There are several reasons to begin to blend the
17 relative weights within each setting before implementing
18 the PAC PPS. Most importantly, it would increase the
19 equity of payments so that providers do not favor taking
20 some patients over others and avoiding other patients.

21 Payments would be more closely aligned to the
22 cost of care. In addition, the redistribution would begin

1 to correct the known biases of the current SNF and home
2 health payment systems and encourage providers to begin to
3 make the kinds of changes they will want to make to be
4 successful under the unified payment system.

5 It will also support update recommendations that
6 more closely align payments to the cost of care without
7 undesirable financial impacts.

8 The Draft Recommendation reads: "The Congress
9 should direct the Secretary to begin to base Medicare
10 payments on post-acute care providers on a blend of each
11 setting-specific relative weights and the unified PAC
12 prospective payment system's relative weights in fiscal
13 year 2019.

14 In terms of implications, program spending will
15 not change relative to current law.

16 For beneficiaries, access would be more equitable
17 and would increase for those with medically complex care
18 needs. Providers will have less incentive to selectively
19 admit beneficiaries, and disparities in Medicare margins
20 across providers would be reduced. The impact on individual
21 providers will vary based on their mix of cases and their
22 current practice patterns.

1 And I'll turn the voting back to Jay.

2 DR. CROSSON: Thank you, Carol.

3 Questions for Carol?

4 Warner.

5 MR. THOMAS: Carol, can you refresh our memory
6 about -- because I know we've received some feedback that
7 we've looked at data that's somewhat dated on this. I
8 think '08. Can you just take us through just very briefly
9 what the dataset is that we've looked at to analyze this
10 and to come to the recommendation?

11 DR. CARTER: Yes, I can do that.

12 So the original mandated report required us to
13 use the data that was collected under CMS's post-acute care
14 payment reform demonstration, the PAC PRD, but the problem
15 with that dataset is it has a limited number of stays and a
16 limited number of providers.

17

18 So we took a two-part strategy. We used the 2008
19 data from the PAC PRD to get a sense about whether it was
20 possible to predict payments based on patient
21 characteristics. Once we proved to ourselves that we could
22 do that, we put that data aside, and we rebuilt a model

1 using 2013 PAC stays.

2 And in our report that we issued to Congress
3 saying that this was possible, we used those 2013 stays.

4 Then next year, when we were asking you to think
5 about the level of payments, when one would go to implement
6 the payment system, we wanted to update those estimates
7 using the same stays, but inflating the cost and payments
8 to 2017, to give a more accurate position sort of at the
9 level of spending. So we used 2013 stays but estimated
10 them up through the spending levels in the payment
11 increases and the cost increases to 2017.

12 I will say just one footnote, using the PAC PRD
13 allowed us to learn one very important thing. Even though
14 the dataset was limited, it allowed us to model a prototype
15 design with and without function, and in doing that, we
16 learned that function was not the game changer. That it
17 was okay to proceed with the design without that
18 information and fold that in over time in the future if
19 that was seen as a desirable thing.

20 So even though it was a limited set and we didn't
21 want to use it for impacts, we learned some very important
22 things from that study.

1 MR. THOMAS: And from '13 to -- you say current
2 data. I know you updated it for kind of the trend of cost.
3 Has there been any major utilization moves, one way or the
4 other, or has it been pretty stable?

5 DR. CARTER: So I would refer to each of those
6 things. I would not describe them as major changes of
7 utilization from them.

8 MR. THOMAS: Okay, okay. Great. Thank you.

9 DR. CARTER: Do you guys agree with that?

10 [No response.]

11 DR. CARTER: Okay.

12 DR. CROSSON: Other questions?

13 [No response.]

14 DR. CROSSON: Okay. We'll proceed to the
15 recommendation vote. You have the recommendation before
16 you. Carol has read it. All Commissioners in favor of the
17 recommendation, please raise your hands.

18 [Show of hands.]

19 DR. CROSSON: All opposed?

20 [No response.]

21 DR. CROSSON: Abstentions?

22 [No response.]

1 DR. CROSSON: Commissioner Wang was not present
2 for the vote.

3 Okay. Carol, you're going to take us through now
4 the SNF update?

5 DR. CARTER: Yes.

6 Let me remind you of a thumbnail sketch of this
7 sector. In 2016, there were about 15,000 providers that
8 furnished services to 2.3 million fee-for-service stays.
9 About 4 percent of beneficiary used SNF services, and
10 Medicare fee-for-service spending totaled \$29.1 billion.

11 Reviewing the indicators of payment adequacy, we
12 see that access to SNF services is adequate. In 2016,
13 supply was steady. Even though covered admissions and days
14 decreased between 2015 and 2016, these trends are
15 consistent with the decline in inpatient hospital stays,
16 which is a requirement for Medicare coverage, and with
17 expanded MA enrollment and alternative payment models,
18 which are more likely to use fewer SNF services.

19 Quality performance was mixed, with small changes
20 from 2015.

21 Access to capital is adequate and expected to
22 remain so. Medicare remains the provider's preferred

1 payer.

2 The Medicare margin in 2016 was 11.4 percent, and
3 that was the 17th year in a row that the average was above
4 10 percent.

5 For efficient providers--those with relatively
6 low cost and high quality--the average Medicare margin was
7 18.2 percent, and we project the 2018 margin to be 9
8 percent.

9 In considering how payments should change for
10 2019, the broad circumstances of this industry have not
11 changed. Medicare SNF margins have been among the highest
12 of any sector for over 15 years. The PPS continues to
13 favor the provision of therapy and needs to be revised.
14 The wide variation in Medicare margins reflects differences
15 in patient selection, service provision, and cost control.

16 The Draft Recommendation reads: The Congress
17 should eliminate the market basket update for skilled
18 nursing facilities for fiscal years 2019 and 2020; direct
19 the Secretary to implement a redesigned prospective payment
20 system in fiscal year 2019 for skilled nursing facilities;
21 and direct the Secretary to report to the Congress on the
22 impacts of a revised PPS and make any additional

1 adjustments to payments needed to more closely align
2 payments with the cost of care in fiscal year 2021.

3 The implementation of a revised SNF PPS would
4 redistribute payments across conditions and narrow the
5 differences in profitability across them. Based on their
6 mix of patients and current practices, payments are going
7 to shift across providers. The redistribution across
8 providers would enable the Commission to recommend and for
9 policy makers to implement a level of payments that is more
10 closely aligned with the cost of care.

11 In terms of implications, the recommendation will
12 decrease spending relative to current law by between \$750
13 million and \$2 billion for fiscal year 2019 and by more
14 than \$10 billion over 5 years.

15 The recommended changes will increase access for
16 beneficiaries who are disadvantaged by the current payment
17 systems, such as those who are medically complex. Given
18 the level of Medicare margins, we expect providers to be
19 willing and able to care for beneficiaries. The impact on
20 individual providers will vary based on their mix of cases
21 and their current therapy practices.

22 On average, payments will shift from freestanding

1 SNFs and for-profit SNFs to hospital-based providers and
2 non-profit providers. As a result, the recommendation
3 would reduce the disparities in Medicare margins across
4 providers.

5 I'll put the recommendation up.

6 DR. CROSSON: Questions for Carol?

7 Yes, Bruce.

8 MR. PYENSON: Just a question for the next cycle.
9 On the second bullet of the redesigned prospective payment
10 system, I'm wondering if we could get insight into moving
11 from a per diem to an episode-based payment that's
12 prospective.

13 DR. CARTER: Well, that's actually in statute, so
14 that would take congressional action. CMS doesn't have the
15 authority to do that. So am I answering your question?

16 MR. PYENSON: Well, it's a next-cycle question.
17 It's not part of this.

18 DR. CARTER: Okay. All right. We'll take it up.

19 DR. MATHEWS: I think what Bruce is asking is if
20 we could start to think about --

21 DR. CARTER: Oh, I see.

22 DR. MATHEWS: -- changing the unit of payment.

1 DR. CARTER: Got it. Got it. Okay. Thank you,
2 Jim.

3 DR. CROSSON: Okay. Seeing no other questions,
4 the Draft Recommendation is before you. It's been read.
5 All Commissioners in favor, please raise your hands.

6 [Show of hands.]

7 DR. CROSSON: All opposed?

8 [No response.]

9 DR. CROSSON: Abstentions?

10 [No response.]

11 DR. CROSSON: Seeing none, it passes unanimously.

12 Thank you, Carol.

13 Evan, you're going to talk to us about home
14 health.

15 MR. CHRISTMAN: Good afternoon. Now we're going
16 to look at the framework as it relates to home health.

17 Next slide, please.

18 As a reminder, Medicare spent \$18.1 billion on
19 home health services in 2016. There were over 12,200
20 agencies, and the program provided about 6.6 million
21 episodes to 3.4 million beneficiaries, and home health
22 accounted for about 5 percent of total fee-for-service

1 spending.

2 Turning back to our framework, here is a summary
3 of our indicators. Beneficiaries have good access to care;
4 99 percent live in an area served by home health; 86
5 percent live in an area with five or more.

6 The number of episodes decreased slightly in
7 2016, and the share of beneficiaries using the service also
8 experienced a small decline.

9 In terms of quality, functional measures of
10 quality improved in 2016, but the rate of adverse events
11 such as hospitalization and emergency room use did not
12 change significantly. Access to capital is adequate. We
13 continue to see interest in the sector by outside investors
14 with some outside firms buying home health agencies to
15 expand their presence in the sector.

16 Margins for freestanding agencies for 2016 are
17 projected to equal -- excuse me. Margins for 2016 equal
18 16.6 percent, and the marginal Medicare profit for
19 freestanding home health agencies is 17.4 percent. And
20 the estimated Medicare margins is 14.4 percent.

21 I would note that these are average margins, and
22 our review of efficient providers success that better

1 performing agencies can achieve good outcomes with profit
2 margins that are significantly higher.

3 Next slide, please.

4 Overall, our indicators are positive indicating
5 that payments are more than adequate. Because of the
6 consistently high margins, the Chairman's recommendation is
7 to pursue a payment reduction of 5 percent in 2019,
8 followed by a rebasing that would address the high margins
9 of home health agencies.

10 In addition, we have noted a problem with the
11 incentives of the home health PPS, that it uses the number
12 of therapy visits provided in an episode to set payment.
13 Under this system, payment increases as the number of
14 visits rise. The Commission and others have noted that
15 this incentive distorts decisions about care, and the
16 higher rate of volume growth for these episodes may reflect
17 financial incentives and not patient needs.

18 As a response, our recommendation will include a
19 clause calling for the end of therapy visits as a payment
20 factor and would make the system fully prospective by
21 basing payment solely on patient characteristics.
22 Implementing this second change would be budget neutral,

1 generally moving funds from providers that do more therapy
2 to those that do less.

3 Our proposed recommendation with these components
4 reads that Congress should reduce Medicare payments to home
5 health agencies by 5 percent in calendar year 2019 and
6 implement a two-year rebasing of the payment system
7 beginning in 2020. The Congress should direct the
8 Secretary to revise the prospective payment system to
9 eliminate the use of therapy visits as a factor in payment
10 determinations, concurrent with rebasing.

11 The impact of this change would be to lower
12 spending by 5- to \$10 billion over five years and \$750
13 million to \$2 billion in 2019. The impact to beneficiary
14 should be limited. It should not affect provider
15 willingness to serve beneficiaries.

16 Eliminating therapies of payment factor would
17 budge-neutral as I mentioned, but redistributive. The
18 policy would shift funds to hospital-based agencies that
19 generally do less therapy and away from freestanding for-
20 profit agencies, which typically do more therapy.

21 That completes my presentation.

22 DR. CROSSON: Great. Questions for Evan?

1 Amy.

2 MS. BRICKER: On the prior slide, could you
3 clarify the impact? 750?

4 MR. CHRISTMAN: To \$2 billion.

5 MS. BRICKER: Million or Billion?

6 MR. CHRISTMAN: Yeah, yeah.

7 DR. MATHEWS: 750 million to 2 billion.

8 MR. CHRISTMAN: I'm sorry. 750 million to 2
9 billion. That's what -- the 750 should have a "million"
10 after it and the 2 should have a "billion" after.

11 MS. BRICKER: Gotcha. Okay. Thank you.

12 DR. CROSSON: Okay. Any other questions,
13 comments, or anything else?

14 [No response.]

15 DR. CROSSON: The Draft recommendation is before
16 you. It's been read. All Commissioners in favor of the
17 recommendation, please raise your hands.

18 [Show of hands.]

19 DR. CROSSON: Opposed?

20 [No response.]

21 DR. CROSSON: Abstentions?

22 [No response.]

1 DR. CROSSON: It passes unanimously. Thank you.

2 And now we'll move on. Dana has appeared, and
3 she's going to present the IRF recommendation.

4 MS. KELLEY: Last month, the Commission discussed
5 the findings from our update analysis of inpatient
6 rehabilitation facilities. I will review those findings
7 and then present the Draft Recommendation for your
8 consideration.

9 Just as a reminder, here is some background
10 information on IRFs. In 2016, there were just under 1,200
11 IRFs. They furnished about 391,000 fee-for-service stays,
12 at a cost to the Medicare program of \$7.7 billion.

13 Overall, our indicators of payment adequacy are
14 positive. Between 2015 and 2016, the supply of IRFs
15 remained fairly steady. The number of IRF discharges per
16 fee-for-service beneficiary grew by 1.4 percent in 2016.
17 The average IRF occupancy rate was 65 percent, indicating
18 that capacity was more than adequate to handle current
19 demand for services.

20 To assess the quality of care in IRFs, we looked
21 at discharge to the community and to SNFs and readmissions
22 to the acute care hospital. We also looked at measures of

1 improvement in motor function and cognition. These
2 measures have generally improved since 2011.

3 We then considered access to capital. Hospital-
4 based IRFs have good access to capital through their parent
5 institutions. Large chains also have very good access to
6 capital. We were not able to determine the ability of
7 other freestanding facilities to raise capital.

8 And finally, the aggregate 2016 margin was 13
9 percent. Marginal profit in 2016 was 29.8 percent.

10 We expect that cost growth is likely to exceed
11 payment growth in 2017 and 2018, and so we've projected
12 that the aggregate margin will fall to 11.9 percent in
13 2018.

14 So that brings us to the update for 2019. You'll
15 recall that the Commission recommended that the update to
16 IRF payments be eliminated for fiscal years 2009 through
17 2017. Then, as the aggregate margin neared historic highs,
18 the Commission recommended a 5 percent reduction in the
19 payment rate for 2018.

20 In the absence of legislative action, CMS has
21 been required by statute to increase payments for each of
22 these fiscal years. Though cost growth picked up in 2016

1 and margins declined somewhat, we project that aggregate
2 payments will remain well above the costs of caring for
3 beneficiaries in 2018. Indications, then, are much as they
4 were last year.

5 So our draft recommendation for fiscal year 2019
6 echoes last year's recommendation. It reads: The Congress
7 should reduce the fiscal year 2019 Medicare payment rate
8 for inpatient rehabilitation facilities by 5 percent.

9 We do not expect this recommendation to have an
10 adverse effect on Medicare beneficiaries' access to care or
11 out-of-pocket spending. Eliminating the update for 2019
12 will reduce program spending by between \$250 million and
13 \$750 million in 2019 and between \$1 billion and \$5 billion
14 over five years. Even with a 5 percent reduction in the
15 payment rate, we project that the aggregate margin for IRFs
16 will remain above 5 percent.

17 This Draft Recommendation may increase the
18 financial pressure on some low-margin providers, but the
19 recommendation would be coupled with MedPAC's previous
20 recommendation to the Secretary to expand the high-cost
21 outlier pool. Expanding the outlier pool would reduce
22 potential misalignments between IRF payments and costs by

1 redistributing payments within the IRF PPS to high-cost
2 cases.

3 As you know, we've always considered that to be a
4 short-term fix. We've also recommended and would reiterate
5 here our recommendation that the Secretary improve payment
6 accuracy overall and program integrity as well by reviewing
7 IRF assessment and verifying the tool's inter-rater
8 reliability.

9 So that concludes my presentation, and I'll turn
10 it back to Jay.

11 DR. CROSSON: Thank you, Dana.

12 Questions for Dana?

13 [No response.]

14 DR. CROSSON: Seeing none, the Draft
15 Recommendation is before you, and it's been read. All
16 Commissioners in favor of the Draft Recommendation, please
17 your hand.

18 [Show of hands.]

19 DR. CROSSON: All opposed?

20 [No response.]

21 DR. CROSSON: Abstentions?

22 [No response.]

1 DR. CROSSON: Seeing none, it passes unanimously.
2 And then the last presentation in this segment
3 and the last update discussion is on long-term care
4 hospitals.

5 Stephanie is here. Off to you.

6 MS. CAMERON: Thank you. Now, moving to our
7 review of last month's LTCH presentation and your mailing
8 materials, you'll recall that in 2016, Medicare paid LTCHs
9 about \$5.1 billion dollars for about 126,000 discharges.
10 The average Medicare payment in 2016 was about \$41,000
11 across all cases and \$47,000 for certain qualifying cases.

12 In our payment adequacy analysis, we first looked
13 at access to LTCH services. Remember that many
14 beneficiaries live in areas without LTCHs and receive
15 similar services in other settings. Occupancy rates across
16 the industry have remained stable. Although the volume of
17 LTCH services per fee-for-service beneficiary declined,
18 this decline is in large part from the implementation of
19 the patient-level criteria as intended by law.

20 Next, we considered changes in quality. We
21 continue to rely on claims data to assess gross changes in
22 aggregate mortality and readmissions, and since 2010, these

1 measures have been stable or improving.

2 In considering access to capital, this year
3 availability of capital says more about the uncertainty
4 regarding the regulations governing LTCHs, the effect of
5 the moratorium which recently ended, and uncertainty
6 regarding the industry's ability to comply with the new
7 patient level criteria, than it does about the actual
8 payment rates. The Commission expects continued industry
9 consolidation, limited need for capital and limited growth
10 opportunities until after the LTCH patient criteria becomes
11 fully implemented and LTCHs adjust accordingly.

12 As we discussed last month, the 2016 aggregate
13 Medicare margin was 4.1 percent across all cases. Because
14 the implementation of the dual-payment policy began in
15 fiscal year 2016, we calculated a pro forma margin that
16 includes only cases that would have qualified to receive
17 the full LTCH standard payment rate. Using the most
18 recently available claims data, we calculated this margin
19 to be 6.3% in 2016.

20 Looking ahead, we project that the 2016 LTCH
21 margin for cases that qualify to receive the full LTCH
22 standard payment rate will decline in 2018. We expect cost

1 growth to be higher than current law payment growth since
2 updates to payments in 2017 and 2018 were reduced by PPACA-
3 mandated adjustments equaling over one percentage point
4 each year. Using historical levels of cost growth, we
5 project that LTCHs' Medicare margin for qualifying cases
6 paid under the LTCH PPS will be 4.7 percent in 2018.

7 With that, the draft recommendation reads:

8 The Secretary should eliminate the fiscal year
9 2019 Medicare payment update for long-term care hospitals.

10 Eliminating this update for 2019 will decrease
11 federal spending relative to the current law payment update
12 between \$50 and \$250 million in 2019, and by less than \$1
13 billion over five years.

14 We anticipate that LTCH's can continue to provide
15 Medicare beneficiaries with access to safe and effective
16 care and accommodate changes in cost with no update to the
17 payment rates for qualifying cases and LTCH's in fiscal
18 year 2019.

19 And with that I turn it back to Jay.

20 DR. CROSSON: Thank you. Questions for
21 Stephanie? Yes, Alice.

22 DR. COOMBS: These margins are without the short-

1 stay and the high-cost outliers?

2 MS. CAMERON: No. The margins do include the
3 short-stay and the high-cost outliers. The margins we
4 presented for 2016, both the cases that qualify, the all-
5 case margin, and the marginal profit include all of that --

6 DR. COOMBS: Okay.

7 MS. CAMERON: -- whether or not you're a high-
8 cost outlier or a short-stay outlier or you're just a
9 regular LTCH, standard payment rate.

10 DR. COOMBS: And what about CCI cases?

11 MS. CAMERON: So that's where the difference
12 comes in. So the margin I presented for qualifying cases,
13 that was for the cases that meet the criteria or the CCI
14 cases according to law. Those may be short-stay outliers.
15 They could be high-cost outliers. But they just meet the
16 criteria to be paid the LTCH standard payment rate.

17 Our projected margin for those cases is the 4.7
18 percent I presented, and that also includes all CCI cases,
19 so it's made up of all CCI cases, regardless of whether
20 they were just a regular, straight-up payment for the
21 standard payment rate, or whether they were short-stay
22 outlier, or a high-cost outlier.

1 DR. COOMBS: Okay, because Carol did the
2 calculation, I think it was last month, of projections of
3 what this looks like, combining the PPS with the non-CCI
4 cases, right, in terms of where they would go?

5 MS. CAMERON: I'm not sure.

6 DR. COOMBS: So there's some of the LTCH cases
7 that are in common in that bridge for the blended rate.
8 And so what I was wondering is how this would intertwine
9 with that.

10 MS. CAMERON: So we haven't looked at --
11 actually, we have looked at how the blended rate would
12 affect some CCI cases, in terms of when we start doing the
13 unified PAC payment plan that we spoke about. And,
14 generally, while we didn't -- I don't have the exact amount
15 wired in my head on how that would change, there was an
16 increase, for example, for patients on ventilators. We
17 didn't build that into the 2018 margin projection, however.

18 DR. CROSSON: Okay. Seeing no other questions,
19 we will proceed to the vote. The recommendation is before
20 you. It's been read.

21 All Commissioners in favor of the recommendation
22 please raise your hands.

1 [Show of hands.]

2 DR. CROSSON: All opposed?

3 [No response.]

4 DR. CROSSON: Abstentions?

5 [No response.]

6 DR. CROSSON: Seeing none, it passes unanimously.

7 Thank you very much, and we will proceed to the
8 last presentation today.

9 [Pause.]

10 DR. CROSSON: Okay. Today's final presentation
11 returns us to policy discussions. We've finished with the
12 update process for this year. And the first issue we're
13 going to take on is, in fact, a mandated report, actually
14 an extension of a mandated report on the effects of the
15 Hospital Readmissions Reduction Program. As many of the
16 Commissioners know, there has been some reports in the
17 literature, even in the popular press, about this issue.
18 And so Craig and Jeff are going to present us with the
19 requirements of the mandated presentation, but extend that
20 into this set of other questions.

21 Craig, it looks like you're going to start.

22 MR. LISK: Yes, I am. Good afternoon. This

1 session is the first discussion of a congressionally
2 mandated report on the Hospital Readmissions Reduction
3 Program. This report is due in June of this year.

4 First, some background on how increased awareness
5 of excess hospital readmissions led the Congress to
6 enacting the Hospital Readmissions Reduction Program.

7 In 2008, the Commission was concerned that a lack
8 of care coordination and poor transitions between acute and
9 post-acute settings resulted in more readmissions than were
10 necessary. There was a belief that the care transitions
11 could be improved and readmissions reduced, but hospitals
12 did not have a financial incentive to improve care that
13 occurred outside of their walls. To create a financial
14 incentive to better coordinate care and reduce
15 readmissions, the Commission recommended publicly reporting
16 readmission rates and reducing payments to hospitals with
17 relatively high readmission rates. Following the
18 commission report there were several articles suggesting
19 readmission rates were higher than they needed to be.
20 Then, in 2009, CMS started to publicly report hospital
21 readmission rates. in 2010, Congress enacted the Hospital
22 Readmission Reduction Program, and in 2013, hospitals with

1 above average readmission rates during 2010 to 2012 had
2 their hospital inpatient payments reduced.

3 Following the passage of the program, readmission
4 rates declined. Several pieces of data suggest that the
5 program was a key contributor to the decline in
6 readmissions. First, surveyed hospital administrators
7 report that they increased their efforts to reduce
8 readmissions due to the program. Second, readmissions
9 declined on a raw and a risk-adjusted basis. Third, the
10 declines in readmission rates were faster for conditions
11 covered by the program than for other conditions. Fourth,
12 a study that compared reductions at hospital affected by
13 the policy found that their rates declined faster than
14 rates at critical access hospitals that were not covered by
15 the policy. Therefore, the evidence is strong that the
16 program was at least partially responsible for the decline
17 in readmissions.

18 However, in recent years some researchers have
19 raised some concerns about the policy. One concern is that
20 patients may not be readmitted, but still cared for in the
21 hospital under observation status. The concern was that
22 care patterns and care coordination were not really

1 improving, but patients that used to be admitted as
2 inpatients were just being held as observation patients at
3 the hospital. In other words, did hospitals just
4 substitute observation care for inpatient admissions rather
5 than truly improve care?

6 A second concern is that changes in risk-adjusted
7 readmissions primarily reflect coding changes, rather than
8 a real improvement in care. A third concern is that
9 necessary readmissions were not occurring, resulting in
10 higher mortality for some heart failure patients. There is
11 limited evidence of this, but it did receive attention in
12 the popular press.

13 That brings us to the mandate for this study. In
14 the 21st Century Cures Act, the Congress required that
15 MedPAC examine if reduced readmissions are related to
16 changes in outpatient and emergency services furnished.

17 In this report we examine relationships between
18 the change in readmissions and three things: changes in
19 observation stays, changes in ED visits, and changes in
20 mortality during the stay and the 30-day period following
21 discharge.

22 Our mandate is to examine the effect of the

1 Hospital Readmission Reduction Program. Therefore, we
2 start by looking at all admissions that are covered under
3 the CMS readmission measures. These are admissions for
4 beneficiaries age 65 and older, enrolled in fee-for-service
5 Medicare with certain exclusions, such as left against
6 medical advice or beneficiary that had a prior admission
7 for the same diagnosis within 30 days.

8 As we discussed in your paper, there was a big
9 drop in admissions per capita suggesting that the profile
10 of patients admitted changed over time. Therefore, risk
11 adjustment is important to capture this change. Therefore,
12 we use a clinical categorical model of risk of readmissions
13 developed by 3M. However, because risk adjustment is
14 imperfect, we also present raw readmission rates, measuring
15 the rates prior to risk adjustment.

16 Finally, because there are many concurrent
17 factors affecting readmissions and mortality, we want to
18 look at more than simple time trends. Therefore, we also
19 look at correlations between changes in readmissions and
20 changes in other variables of interest.

21 So we will start by presenting raw readmission
22 rates.

1 The red line at the top of this slide is the all-cause
2 readmission rates without any risk adjustment. We see a
3 downward trend in readmissions. This is reassuring,
4 especially given that the number of initial admissions also
5 declined during this time frame.

6 Second, we turn to the green double line. This
7 is the trend in unplanned readmissions. The line has the
8 same slope as the red line, but is slightly lower because
9 it excludes certain planned readmissions to the hospital
10 such as scheduled surgery, maintenance chemotherapy, or
11 rehabilitation. These are the readmissions captured in
12 CMS's readmission measures.

13 Third as a crosscheck on the data. We also
14 looked at changes in potentially preventable admissions.
15 This is a 3M measure that only looks at readmissions that
16 appear to be clinically related to the initial admission.
17 The level of these readmissions is lower due to more
18 exclusions.

19 However, the main point is that across all three
20 measures readmission rates are declining and the slope of
21 the trend lines are similar.

22 From here on out we will focus on unplanned

1 readmissions, the type covered by the policy.

2 This slide shows the decline in raw readmissions
3 for five specific types of services covered by the
4 readmissions policy through 2016, and there are two main
5 points to this graphic. First, notice that all of the
6 lines are trending downward. That is good. Second, notice
7 that the green line represents all conditions, including
8 those not covered by the policy. The slope of the green
9 line is not quite as steep as the other lines. This
10 indicates that raw readmission rates were declining
11 slightly faster for conditions covered by the policy than
12 for other conditions.

13 So far, we have just showed you the raw
14 readmission rates. Now, we switch to risk adjusted rates.

15 In your mailing materials, we discussed why we
16 believe patient complexity among those admitted has
17 increased over time. Therefore, risk adjustment is
18 important. And the main point to this slide is that risk
19 adjusted rates are declining and that the slope of the
20 lines is a little steeper than we saw for the raw
21 readmission rates on the previous slide.

22 We state in your paper that we think the increase

1 in patient complexity reported on the claims at least
2 partially reflects the admitted patients becoming more
3 difficult. We do not think it is all coding. The reasons
4 are, first, admissions per capita declined by 17 percent.
5 We expect that it is the easier cases that are no longer
6 being admitted to the hospital. Second, when we look at
7 the data, we see that there are fewer one-day stays. This
8 is consistent with the incentives that occurred when the
9 Recovery Audit Contractors started to deny payments for
10 short stays in 2010. The activities of the RACs, which
11 were concurrent with the program, could have resulted in
12 some short stay patients, who are less severely ill, being
13 shifted to observation.

14 While we are saying that it appears that patients
15 being admitted to the hospitals are sicker on average, we
16 are not saying that there is no change in coding. Part of
17 the change in reported complexity could have been due to
18 changes in coding.

19 Now let's shift our focus to our mandate. Are
20 observation and ED visits acting as substitutes for
21 inpatient care?

22 This slide examines per capita changes in use of

1 inpatient care, observation care, and ED services. These
2 are per capita numbers for all Medicare beneficiaries over
3 age 65, not just those readmitted. The green line shows
4 declines in initial admissions -- that's where we saw a 17
5 percent decline -- the red line increases in ED visits --
6 as we discussed in your mailing -- and the orange line
7 increases in observation stays. As we discussed in
8 your mailing, observation and ED visits increased broadly.
9 That means that the rate of increase for patients without a
10 prior admission to the hospital was similar to the rate of
11 increase after a discharge for patients admitted to the
12 hospital. Another way to look at this is to examine the
13 share of all ED visits that took place after a hospital
14 discharge, and this share was the same in 2010 and 2016.

15 Now we shift to looking only at care received
16 after an admission. The top green line shows that risk-
17 adjusted readmission rates are going down. The red line
18 shows that risk-adjusted ED rates are going up for those
19 recently discharged, with a big jump in 2012. We are not
20 sure of the cause of the jump in 2012, but it may have
21 partially been due to the RAC program, which reduced
22 initial admissions and encouraged substituting ED care for

1 inpatient admissions. It also could have been partially
2 due to the readmission program. Finally, the orange line
3 shows that observation care was steadily increasing over
4 this time.

5 So next we try to see if there is a correlation
6 between declines in readmissions and increases in ED visits
7 and observation stays. This slide shows that hospitals
8 with bigger declines in readmissions were slightly more
9 likely to have larger increases in observation and ED
10 visits. This suggests that to some degree ED visits and
11 observation visits can substitute for readmissions. But
12 the correlation is relatively weak and the reduction in
13 readmissions only explains about 3 percent of the variation
14 in changes in ED and observation rates. So there may be
15 some effect, but it appears that the readmission program is
16 not the main driver behind the ED and observation growth.

17 So another way to look at this is to examine
18 changes in readmission rates, observation stays, and ED
19 visits for the conditions covered by the program and for
20 those not covered. The first set of bars looks at
21 conditions covered by the program. The green bar shows
22 that these conditions had a 2.9 percentage point drop in

1 readmissions from 2010 to 2016, which was much larger than
2 the 1.3 percentage point drop for conditions not covered by
3 the program.

4 But now if we look at change in use of
5 observation, the orange bars, and ED, the red bars, we see
6 that the change in use of these services was almost
7 identical for conditions covered and not covered under the
8 program. If we were to expect hospitals were using
9 observation and ED settings to avoid readmission penalties,
10 we would expect to see larger increases in use of
11 observation and ED for conditions covered by the program,
12 but we do not.

13 Jeff?

14 DR. STENSLAND: All now. Now we're going to
15 shift gears to talk about mortality. We are presenting
16 data on mortality because a recent article raised a concern
17 that the readmission program may be causing mortality rates
18 to rise. We do not find any evidence of this, and will
19 walk you slowly through the data.

20 First we look at raw mortality rates, and I want
21 you to start by looking at the solid green line in the
22 middle of the graphic. That is the raw mortality rate

1 across all admissions. Note that the readmission rate
2 climbed up slightly from 2010 to 2015, and that increase
3 could be due to the 17 percent drop in initial admissions.
4 As easier cases are no longer admitted to the hospital,
5 patient complexity increases, and we would expect increase
6 in the raw, meaning not risk-adjusted, mortality. Given
7 the decline in initial admissions we see, increasing raw
8 mortality rates should not be unexpected.

9 What is surprising is the blue and orange lines
10 at the top of the paper. The blue line shows raw pneumonia
11 mortality rates declining, the orange line shows raw AMI
12 rates declining. The declines in pneumonia and AMI
13 mortality have not received much attention, but what has
14 received a significant amount of attention is the red line.
15 It shows a slight increase in raw mortality for heart
16 failure patients. Because this coincides with the time
17 frame of the readmission program, one study raised
18 questions whether the program has somehow contributed to
19 the increase in heart failure mortality. The concern is
20 that hospitals are turning away necessary readmissions to
21 avoid the readmission penalty.

22 But taken together, the data show large mortality

1 declines for two HRRP conditions, two readmission
2 conditions, and a small increase for one. This is not
3 consistent with the readmission program causing an increase
4 in mortality.

5 Of course, this is just raw rates. We should
6 also look at the risk-adjusted rates to see how mortality
7 rates look after adjusting for patient severity.

8 When we look at risk-adjusted rates we see all
9 five conditions showing a decline in mortality, and this
10 could be due to better care, or it could be due to increase
11 in coding of comorbidities, or both. We expect that at
12 least some of the change in risk adjusted mortality is
13 real, given the big drop in initial admissions. Therefore,
14 we think at least some of the improvement in mortality
15 across the conditions covered by the Readmission Reduction
16 Program appears to be real.

17 Nevertheless, risk adjustment is imperfect, so we
18 want another method for looking to see if changes in
19 readmissions are associated with changes in mortality.

20 This graphic looks at the correlation between
21 changes in readmissions and changes in mortality from 2010
22 to 2016. Each green dot represents a hospital. The yellow

1 dotted line represents a linear regression line, and we see
2 that the correlation is weak but the positive slope is
3 reassuring. The positive slope tells us that falling
4 readmission rates are associated with falling mortality
5 rates.

6 Now the slide here only looks at the relationship
7 for risk-adjusted mortality of heart failure patients, but
8 we examined the other correlation and found that the
9 positive correlation holds for all five conditions covered
10 by the readmission policy. It also holds when looking at
11 either risk-adjusted or the raw rates.

12 The bottom line is that the data we have suggest
13 that declines in readmissions are not causing increases in
14 mortality.

15 The positive clinical outcomes we have seen in
16 terms of reduced readmissions and reduced mortality, now we
17 now shift to looking at costs.

18 We computed what the cost of readmissions would
19 have been if the 2016 readmission rates were still as high
20 as they had been in 2010. We found that the Medicare
21 program spent \$2.28 billion less on readmissions in 2016
22 than it would have if readmission rates had not declined.

1 The program did spend a bit more on observation visits and
2 ED visits, but these costs are relatively small. On
3 average, the payment for an observation stay is about 1/5th
4 the payment for a readmission, and the payment for an ED
5 visit is about 1/20th the payment for a readmission.

6 The bottom line is that the changes in use of
7 post-acute services resulted in Medicare spending being
8 reduced in 2016 by about \$2 billion.

9 So the data we have presented suggests a few
10 things. First, readmissions declined. Second, while
11 observation stays increased, they did not fully offset the
12 decrease in readmissions. Third, while ED visits also
13 increased, those increases appear to largely be due to
14 factors other than the readmission program. And fourth, in
15 addition, all of the evidence we examined suggests that the
16 readmission program did not result in increased mortality.

17 Now while the program is not perfect, it has
18 appeared to generate some benefits for patients and
19 taxpayers. Patients benefit by not having to endure as
20 many readmissions. Patients spend less time in the
21 hospital and appeared to have at least equal outcomes.
22 Second, the readmissions program is a contributing factor

1 to the \$2 billion reduction in spending on readmissions.
2 This will help extend the financial viability of the
3 Medicare trust fund.

4 As I said, the program is not perfect. In the
5 past, we've discussed how the program could be improved.
6 We outline some of those options such as fixing the payment
7 penalty formula in your mailing materials, and we'll
8 discuss those changes further when we discuss potential
9 changes overall to hospital incentive programs in the
10 spring.

11 Now I'll turn it back to Jay for your discussion.

12 DR. CROSSON: Craig and Jeff, thank you very
13 much. This is really excellent work -- dense but
14 fascinating. Thank you.

15 So we're now open for clarifying questions. I
16 see David first, Jon.

17 DR. NERENZ: Thanks. Just to fill me in in a
18 little more detail, let's start with the first bullet here
19 about the program has reduced readmissions. If we could
20 then flip to Slide 12? There are a couple others we could
21 do, but let's see that one. Top line. This is risk-
22 adjusted unplanned readmissions, probably a good precise

1 measure. I see no program effect there whatsoever.
2 Readmissions were coming down before the program. The
3 slope continues at exactly the same rate. I see no program
4 effect. And we could point to three other graphs that have
5 essentially the same pattern. What am I missing here?

6 DR. STENSLAND: Let's look back to the four
7 points we've made. I think some people have said, "Look,
8 it's just a downward slope, there's lots of downward
9 slopes."

10 But I think first if we go out and we talk to
11 people and they say, "We've actually done things to try to
12 reduce readmissions," and they say it's due to the program.
13 And then we go and we talk to the pharmacist who says
14 they're doing pharmacy reconciling medications before
15 discharging the patient, and they weren't discharging
16 before, so there's at least some stories of things
17 happening.

18 I think the second thing that we had was that
19 there was actually a decline in the raw -- in the risk-
20 adjusted readmission rate, so we don't think it's just a
21 coding thing.

22 The third thing is we see a steeper drop for the

1 readmission rates that are in the program than the ones not
2 in the program. So if you compare across the two different
3 groups, you see that difference there. And I think if you
4 also look at the Ibrahim study where they compared it, what
5 happened to the readmission rate reductions for hospitals
6 that are affected by the program and the critical access
7 hospitals that are not affected by the program, the
8 hospitals that are affected by the program had a steeper
9 drop in their readmission rates than the other ones.

10 So you have all of those different pieces of
11 information that are all lining up together, suggesting
12 it's doing something.

13 DR. NERENZ: Okay. Maybe we can get into this
14 more in Round 2. I just wanted to know if there was a
15 statistical test or something that I was missing that was
16 actually making that point from those graphs.

17 DR. CROSSON: Okay. Let's see. I had Jon, Pat,
18 Bruce, David.

19 DR. COOMBS: Jay, can I ask a question on this
20 [off microphone]?

21 DR. CROSSON: On that, yes, Alice.

22 DR. COOMBS: Jeff, you said that the possibility

1 of a different -- like a larger cohort of not as sick
2 patients in this DRG classification might have resulted in
3 some of that decline early on? I guess the severity of
4 illness for the DRG, did you say something along those
5 lines?

6 DR. STENSLAND: Right. So if we look at what was
7 happening at the same point in time as the readmission
8 reduction program took place, at the same point in time
9 there was the RAC program, and what the RAC program did was
10 it told -- for certain cases, the RAC auditors were coming
11 in and saying this didn't really need to be an admission;
12 therefore, we're not going to pay you. And they were
13 really focusing on these short-stay cases.

14 And so what we believe happened is if you look at
15 the data you see a decline in the short-stay cases, and you
16 see those short-stay cases tended to have very low
17 readmission rates. Okay? So when you get rid of those
18 short-stay cases, we think the remaining cases are more
19 difficult cases that would tend to have higher readmission
20 rates. So if anything, the readmission rates at least in
21 those kind of 2010-2014 period would probably maybe have
22 been a greater improvement than you would expect just by

1 looking at the raw rates because the people got more
2 difficult.

3 DR. COOMBS: So you're saying there was softer
4 diagnosis for the DRG in the large cohort of the early --
5 say early on, if you had a diluted, in terms of severity of
6 illness, for that DRG, you're seeing those patients not
7 being -- the readmission is not impacted -- I mean is
8 actually looking better than what it really is.

9 DR. STENSLAND: For the early years before the
10 RAC program, yeah.

11 DR. COOMBS: Yes, yes.

12 DR. CHRISTIANSON: Thanks for this paper.
13 There's certainly a lot of discussion that I feel about
14 this. So you said this is due in June.

15 DR. STENSLAND: Yes.

16 DR. CHRISTIANSON: Will we be seeing another
17 version at some other time then?

18 DR. STENSLAND: I guess that's depending on how
19 much additional information comes out of this discussion.
20 It's possible.

21 DR. CHRISTIANSON: I would say it depends on how
22 much additional information comes out of the field in part

1 two. In fact, I think I just sent you another paper last
2 week. I mean, it would really understate things to say
3 that this has become a cottage industry among health
4 services researchers.

5 [Laughter.]

6 DR. CHRISTIANSON: And I expect that we're going
7 to continue to see things. So my question is: Did you
8 have plans to sort of, you know, keep us abreast of the new
9 stuff that comes out, and then at some point you just lock
10 the door and say, "That's as far as we can go"? And if so,
11 what's that point?

12 DR. STENSLAND: I think we can do that one of two
13 ways. You know, we could keep you abreast and put things
14 in the paper before it goes out for your final review. If
15 you think it's actually worthy of all your time to have
16 another session, that's possible also. But that's kind of
17 a hierarchy of the importance of --

18 DR. CHRISTIANSON: There's so much going on, I
19 just don't want us to release a paper that could be more
20 updated but wasn't because we just have some rule that says
21 we can't do it after such-and-such a date. So we should
22 talk about this.

1 Pat, you're next.

2 MS. WANG: I just wondered, on Slide 18,
3 obviously the effectiveness of the program is good for
4 beneficiaries avoiding unnecessary care. It's really good.
5 On Slide 18, though, which tries to kind of get at some
6 sort of cost ROI, I guess you could say, has there -- is it
7 feasible or has there been an attempt to look at the total
8 cost of care for beneficiaries who may have been in the
9 cohort of those who avoided unnecessary readmissions,
10 whether that is increased care at home, you know, physician
11 visits to the home? Both medical care as well as maybe
12 what you would call administrative costs, sending a pharm
13 tech to bedside to do a medication reconciliation before
14 somebody goes home? You know, doing more with social
15 workers or care coordinators once the person does go home?
16 I just wonder whether -- I just wonder whether there is any
17 usefulness in looking at a total cost of care, including
18 the use of, you know, certain post-acute-care resources.
19 Even if it came out to be even, which I doubt, it's still a
20 good thing. But this is part of the picture, so -- I know
21 that this was the mandate, but I was just curious what you
22 think of it, even, and is it worth looking at?

1 DR. STENSLAND: I think that would be
2 interesting. I'm reluctant to say that we could do it
3 well. At least when I think of -- at least I think there's
4 one kind of working paper that Jon sent, but that looked at
5 the extra costs of these people in the hospital that was
6 charged to them. You know, was there more stuff charged to
7 them in the hospital? But I think a lot of the things
8 they're doing are not stuff that you actually have a charge
9 for in the hospital. So it's hard to track those costs.
10 Like if they have somebody that's setting up a follow-up
11 appointment with the primary care physician as part of the
12 discharge planning, or if they're having that pharmacist I
13 talk about doing a reconciliation of the medication and
14 they have a Pharm.D. doing it and maybe just a nurse was
15 doing it before, it's hard to figure out how we would get
16 data on how much that stuff is costing. I think this
17 number is probably an upper bound because you're going to
18 have some of those other costs.

19 MS. BUTO: What about post-acute, Jeff [off
20 microphone]?

21 DR. STENSLAND: We could look at higher post-
22 acute if we could come up with a good counterfactual of who

1 are these people that would have been readmitted. I don't
2 think we could do a good job of that between now and
3 whenever we hand out our June paper.

4 DR. CHRISTIANSON: Okay. Bruce, I think you're
5 next.

6 MR. PYENSON: Thank you. A really terrific
7 paper.

8 I noticed on page 6 of the drug cartels, the
9 majority of hospitals, 81 percent, will have a penalty, but
10 the penalties are small. And I was curious about if you
11 had thoughts about the impact of the penalty since the
12 penalties we're talking about are relatively small, if
13 there's any scale effect there, you know, maybe -- so the
14 implication is if we doubled the penalty or tripled the
15 penalty, maybe the results would be even better, or not.
16 That's one question.

17 And a related question on the penalty is that the
18 -- I think there was some discussion -- this is on page 11
19 -- on the socioeconomic status, hospitals who have more
20 poor patients would -- the recommendation, I think, from
21 2013 that Congress did mandate a peer grouping. And my
22 question about the penalty there is -- it seemed to me the

1 penalty would go down for hospitals with more poor
2 patients. Would it go up for hospitals with fewer poor
3 patients so that the average stayed the same?

4 DR. STENSLAND: Yes.

5 MR. PYENSON: And on the first question, whether
6 you have thoughts on the scale of the penalty.

7 DR. STENSLAND: When we've talked before, I think
8 we've talked about not increasing the size of the penalty
9 per readmission but actually decreasing the penalty for
10 readmission by removing what I call the "multiplier,"
11 because now the penalty is really large for one extra
12 readmission, and part of the thought we had discussed back,
13 I think, in 2012, 2013, when we talked about this before,
14 was taking the readmission penalty and expanding it to all
15 conditions, but then having a smaller penalty for each
16 readmission and make the size of the penalty more
17 equivalent to the cost of that extra readmission. Right
18 now the size of the penalty can be, you know, anywhere from
19 five times the cost of the initial admission in a heart
20 failure case to 25 times the cost of the initial admission
21 in the case of hip and knee. So I think, if anything,
22 especially in the hip and knee cases, the size of the

1 penalty for one excess readmission is probably too large,
2 not too small.

3 DR. CROSSON: Okay. Let's see. David next, and
4 then I see Sue, Dana, and Jack.

5 DR. GRABOWSKI: Great. Thanks for this chapter.
6 I enjoyed it a lot. Could we look at Slide 9?

7 So when you say "all conditions" here, do you
8 mean all other conditions not included within the HRP? Or
9 does that include all readmissions?

10 MR. LISK: That includes all.

11 DR. GRABOWSKI: All. So this was an issue I had,
12 and I promise it's a question, but why not compare the HRP
13 conditions against all other conditions as your comparison
14 group? That's what most researchers in the literature have
15 done. You have those great parallel trends in the pre-
16 period, and you can see the impact. That really gets at
17 David's question earlier. What's the real impact of HRP
18 here? I think you could show that. Why were you reticent
19 in the chapter to do that? I kept waiting for you to show
20 me the effect of the program, and you ever did, and it's
21 sort of -- you took us most of the way there. You have the
22 data. Why not show us the effect of the HRP? Why is that

1 not --

2 MR. LISK: I mean, that's what this slide is
3 showing, so this is showing -- this slide's showing that.
4 It's showing -- we're showing like all readmissions, but
5 this is showing the same thing in terms of what that slide
6 would be there.

7 DR. GRABOWSKI: If you go to Slide 10, you could
8 do this for all of -- you could do this for op stays. You
9 could do it for ED. You could do it for coding.

10 MR. LISK: Sure.

11 DR. GRABOWSKI: I think that would be a great way
12 to sort of frame the chapter. And if you showed that for
13 each of these steps, you could actually show kind of what
14 was the true effect here, both intended and unintended, of
15 the HRP. I would find that more convincing than some of
16 the arguments that were made.

17 DR. CROSSON: Okay. Thank you. Sue.

18 DR. REDBERG: Jay, can I 00

19 DR. CROSSON: Oh, I'm sorry. Rita.

20 DR. REDBERG: On this slide, we're talking about
21 a difference of a hundredth of a percentage point here?
22 It's between 0.013 -- zero point --

1 MR. LISK: That's actually -- that's percentage
2 point change and that's actually -- it's 1.3 percentage
3 points. The labeling got -- yeah.

4 DR. STENSLAND: The labeling is wrong because --

5 DR. REDBERG: Okay.

6 DR. STENSLAND: The labeling says percentage
7 points, but it's really in decimal points. So, yeah.

8 MR. LISK: It's really in decimal points, so
9 that's -- it's 1.3 percentage points and 2.9 percentage
10 points.

11 DR. CROSSON: Sharp eyes. We got sharp eyes
12 here. Sue.

13 MS. THOMPSON: I'm going back to the questions in
14 the discussion around post-acute and considering -- causes
15 me to wonder a bit about total knees now being removed from
16 the inpatient only category and what impact that will have
17 on all of this. And is there an opportunity ahead of the
18 game to think about how to structure watching that?
19 Granted, you know, it will be the lower-risk patient that
20 will be going to the outpatient setting. Nevertheless,
21 there's going to be some readmissions, and I just have some
22 curiosity about it. Have you thought at all about that,

1 Jeff?

2 DR. STENSLAND: I haven't thought about it, but
3 it's a great idea, because I think there's a real danger
4 that the readmission program will stop the movement to the
5 outpatient basis, because the penalty for an excess
6 readmission on the hip and knee is so huge, you might be
7 reluctant to move your hips and knees to an outpatient
8 basis where the easy cases go over there and you end up
9 having high readmission rate and pay the huge penalty.
10 That's a really good point.

11 MS. THOMPSON: Yeah, prospectively, I think it's
12 one for us to keep our eye on.

13 DR. CROSSON: Brian, on this.

14 DR. DeBUSK: To that point, though, if I do a
15 knee on an outpatient basis, I don't have an initial
16 admission to trigger the readmission, do I?

17 DR. STENSLAND: No, you don't have an initial
18 admission to trigger the readmission, so you're safe on
19 that one. But the question then, what does it do to your
20 rate?

21 DR. DeBUSK: But if an outpatient knee comes back
22 to me and I admit the patient, I don't have a readmission.

1 I have an admission.

2 DR. STENSLAND: Right.

3 DR. DeBUSK: So I should -- maybe I'm missing
4 something, but I think I'd be okay, wouldn't I?

5 MR. LISK: It's more the issue of the cases that
6 remain.

7 DR. DeBUSK: Oh, you'll get -- sicker patients
8 will be the inpatients and then you'll have to risk-adjust
9 for those patients.

10 DR. STENSLAND: Yes, so I think the real question
11 is: Can the risk adjuster fully account for how much
12 sicker the patients that are still going to be inpatient?
13 If the risk adjuster was perfect, we got no problem.

14 DR. DeBUSK: On a number of fronts.

15 MR. LISK: The other issue with hip and knee is
16 the multiplier, and actually, it actually has a relatively
17 low readmission rate. But, actually, in percentage terms,
18 it had one of the biggest declines in readmission rates,
19 probably because of the steeper penalty that they would be
20 receiving.

21 DR. DeBUSK: That was to Bruce's earlier point.
22 Could increasing the penalties actually improve the

1 performance of the program? Bruce, I don't mean to put
2 words in your mouth. Was that what you were --

3 MR. PYENSON: Those were my words [off
4 microphone].

5 DR. CHRISTIANSON: Well, Bruce, Brian; Brian,
6 Bruce.

7 [Laughter.]

8 DR. CROSSON: So far not today. I did do a Paul-
9 David thing, but that's okay. Sue, you're good? Dana.

10 DR. SAFRAN: So I was wondering whether you tried
11 at all to tease out the effect of ACOs which launched in
12 the midst of your observation period here. And it seems
13 like a good thing to do if you haven't. I really like
14 David's idea of, you know, doing that comparison of the
15 conditions that were not covered by the program and the
16 conditions that were. Once you introduce the ACOs, they
17 have the incentive to reduce all readmissions, so you could
18 look at sort of the interaction of these things. I think
19 it's worth looking at to try to really get at the impact of
20 the program. But the ACO program's certainly rowing in the
21 same direction, so it would be, I think, instructive.

22 DR. CROSSON: Okay. Jack?

1 DR. HOADLEY: I'm jumping from methodology
2 questions to process questions. First of all, I was trying
3 to remember the 2013 recommendation -- or improvement
4 suggestions, were those formal recommendations or were they
5 more general?

6 DR. STENSLAND: They were more general policy
7 options. There was no vote.

8 DR. HOADLEY: Okay. And then when you say on the
9 last slide potential improvements and then we'll discuss in
10 the spring, is that within the context of this report that
11 we would talk about these improvements? Or is this more
12 going into a more general outside of the context of this
13 report? What do you have kind mind? And did you have in
14 mind formal recommendations?

15 DR. STENSLAND: We started this in the fall where
16 Ledia came up and led the discussion on the hospital value
17 improvement program where we talked about shifting from
18 these individual silos of different programs into one
19 combined program where you would combine the readmission
20 and mortality and maybe patient experience, and you have
21 all these things creating a single score and then a single
22 adjusted rather than multiple adjusters, which sometimes

1 can overlap. And while that discussion is going on, there
2 will be some discussion of how maybe to evaluate
3 readmissions or incent readmissions differently than we're
4 doing right now.

5 DR. HOADLEY: So the report that specifically
6 responds to this mandate would not be all that stuff, it
7 would be just basically the analytical work that you're
8 doing here.

9 DR. STENSLAND: Right.

10 DR. CROSSON: The intent here, as I understand
11 it, is, assuming that we have general support, this would
12 be the discussion leading to the final mandated report, and
13 then other issues we can take -- if we decide we want to
14 take on, we could take on subsequently.

15 Okay. So I see no further questions, so let's
16 proceed to the discussion and comment period, and I think
17 Rita is going to lead off.

18 DR. REDBERG: Thanks, and thanks for an excellent
19 chapter and mailing materials. It's a very complex issue,
20 and I think you summarized the literature well. It just
21 leaves me with a slightly different conclusion, though,
22 because I think it's really hard to know what's going on

1 here.

2 It's all observational data. There are questions
3 about temporal trends, other programs going on. I mean,
4 clearly there were good things that happened with the
5 readmissions penalty. Hospitals all started outpatient
6 programs, pharmacists, nurse to call the patient, but then
7 clearly, there were other things going on. And some things
8 are just not preventable, and it may have created perverse
9 incentives not to readmit patients. We don't know.

10 Also, there were other questions that you
11 mentioned about Ibrahim and the coding issue and whether
12 what we were seeing was a change in coding severity and not
13 an improvement in risk-adjusted mortality.

14 I don't know what -- the real savings because I
15 think, as Pat said, there were big, bigger -- you know, we
16 were looking at 1-, 2 billion in admissions, but there are
17 a lot of costs of heart failure in the programs and other
18 things.

19 Last week, when I was in the hall of the
20 hospital, one of the heart failure cardiologists had just
21 come back from rounding, and they said to me -- I said,
22 "How are you doing?" and they said, "Oh, it's so

1 discouraging seeing so many heart failure patients now
2 getting all these unnecessary procedures," and that's not
3 usually what the other -- mostly, she was talking about
4 ventricular assist devices, which is sort of not covered in
5 here. But Medicare pays a lot of money -- I don't know --
6 60-, 70,000 for these beds. And they used to be used for
7 people that were very sick as a bridge to transplant, but
8 now there is this destination therapy, which essentially
9 the idea is that you put them in people with heart failure,
10 and then they go out the rest of their lives with them.

11 The data is very unclear what the tradeoffs are.
12 This is a pretty invasive device that you're now attached
13 to. It has a lot of problems with thrombosis and pump and
14 all of that.

15 But the other issue, there was a very interesting
16 trial presented at the American Heart meetings in November
17 on shared decision-making, and it turned out that a lot of
18 people, as happens, getting these devices really didn't
19 have an idea of what they were in for before they signed up
20 for it, and their families didn't know. And it's quite a
21 commitment for not just the patient but their family
22 because it requires a lot of care.

1 This was a randomized trial they presented, the
2 people that had what they called shared decision-making had
3 a much lower rate of accepting the beds, which, by the way,
4 also happen to be, as I said, very expensive.

5 We've had other studies where we know
6 defibrillators, which again is very expensive, can be a
7 life-saving intervention, but are overused. We know that
8 the study published in JAMA a few years ago suggested like
9 25 percent of defibrillators that Medicare was paying for
10 were outside of the cardiology guidelines, and now there's
11 talk about maybe changing the guidelines.

12 Clearly, I think if our goal is to improve the
13 care of patients with heart failure and to improve value,
14 there are other places we could look that I think would
15 have more bang for the buck and working more on this
16 readmissions, which to me I feel like we've gotten a lot of
17 the benefit from it, and there are much bigger pockets in
18 all the people getting, for example, beds and
19 defibrillators, particularly near end of life, that don't
20 have the benefit of shared decision-making and may not have
21 chosen to go that way.

22 So I just think we might start looking at other

1 avenues if we're trying to improve care for our heart
2 failure patients.

3 DR. CROSSON: Thank you, Rita.

4 I just want to be clear on one point. I think I
5 understand, and I think I agree with what you're saying.
6 But I just want to be clear. You're not implying, I don't
7 think, that the increased use of ventricular assist devices
8 as an outpatient is a result of the hospital readmission
9 program.

10 DR. REDBERG: I wasn't linking those at all.

11 I think at least what this cardiologist --

12 DR. CROSSON: Right.

13 DR. REDBERG: There's the draw of technology, and
14 they are reimbursed very well.

15 DR. CROSSON: Yes.

16 DR. REDBERG: They're profitable for the
17 hospital.

18 DR. CROSSON: No, I understand that.

19 DR. REDBERG: I don't think it's related to
20 readmissions.

21 DR. CROSSON: I just want to be clear.

22 Okay. So where are we? Discussion. Brian --

1 I'm sorry. Let's move down this way. We got almost
2 everybody. Sue, do you want to start?

3 MS. THOMPSON: Well, I think this was a wonderful
4 chapter to end the day's discussion, and I want to build on
5 the question that was raised. I think it was Dana who
6 asked about taking a look at ACOs to see if there's any
7 correlation to improving and reducing readmissions.

8 Actually, I think this discussion relates nicely
9 to our chapter on MIPS and transforming or making
10 recommendations that works to transform our health care
11 system to move from fee-for-service to value.

12 Improving quality or reducing readmissions is not
13 a solo opportunity. It really is a team sport, and having
14 come from a hospital background in my past life, you don't
15 reduce hospital readmissions without the support
16 particularly of your specialty community and especially in
17 the five diagnoses that are reviewed. So I think this just
18 underscores the importance of the recommendations we've
19 made earlier today, and I thoroughly enjoyed this topic.
20 So thank you for your good work here.

21 DR. CROSSON: Thank you.

22 David.

1 DR. GRABOWSKI: Yes. Thanks again for the
2 chapter.

3 The Hospital Readmissions Reduction Program has a
4 very blunt policy, and the good news is that blunt policies
5 often have their intended effect. The bad news is they
6 often have lots of unintended effects.

7 And I think it's important here that we figure
8 out both of those. Is it truly reducing admissions? And
9 two, does it have any unintended consequences, whether that
10 be coding changes or increased mortality, ED, ob stay? So
11 I think we should continue to look in all of those
12 dimensions.

13 There is a robust literature, as Jon noted, on
14 all of those issues. I think, however, that MedPAC, given
15 the data that we have access to and sort of the framework
16 that we can apply to this, I think we can actually sort of
17 put this all on sort of a common framework and take a close
18 look at these issues.

19 I will say again that I think it's really
20 important when we're framing each of these issue, both
21 examining the intended effect but also all these unintended
22 effects, that we compare those HRP conditions against other

1 conditions over time.

2 I think we should do that for the decline in
3 readmissions. I also think we should look at the coding
4 issues. I think that's very important.

5 I found the Ibrahim paper very compelling and
6 interesting, and I agree with the bullet that you had up
7 earlier. Coding may explain some of the effect. I don't
8 think it explains all of the effect, and so I hope that
9 maybe we could put a bound on how much of the readmissions
10 effect is due to coding and how much is due to truly a
11 decrease in readmissions.

12 And I think also looking at mortality, I think my
13 read on the mortality work, including your work on this,
14 suggests -- I don't think we've seen a big mortality effect
15 associated with the HRP.

16 And then finally, looking at ob stays and ED
17 visits, I think that's really important too. So I look
18 forward to your work on this going forward.

19 Thanks.

20 DR. CROSSON: Brian.

21 DR. DeBUSK: I would also like to thank you both
22 on a very well-written chapter. It was a good read.

1 You mentioned this in the paper, and I realized
2 that this isn't going to be an integral part of the report
3 coming up this summer, but developing out and reusing this
4 concept of peer grouping, I mean, I think there's a lot of
5 power. We almost let risk adjustment get away from us
6 because when you tell me that something is risk adjusted, I
7 have no idea. I mean, is it age? Is it gender? Is it
8 full HCCs? It sort of proliferated the different
9 techniques.

10 I think we have an opportunity here with SDS
11 showing up in so many things. We mentioned it in the VVP
12 earlier today as well. I think now getting a standard
13 treatment where maybe we peer group into quintiles or
14 deciles, but it's all tied, say, to SSI percentage, the
15 more off the shelf we can make it and the more facile we
16 can become with using it in all the different programs, I
17 think it will be a huge benefit for us. So I hope we
18 develop it out and continue to test it and see it appear in
19 lots of different analysis areas.

20 DR. CROSSON: Okay. Warner.

21 MR. THOMAS: I think this was very informative as
22 well.

1 I just think having the proper incentive here for
2 hospitals to be doing the right thing and to not readmit is
3 a great direction. I think we're seeing changes in
4 readmission. I guess we got to continue to determine
5 whether these are causal or not, but it's not having a
6 negative impact from a mortality perspective, according to
7 the data. So I would just encourage us to keep pushing
8 programs like this forward.

9 DR. CROSSON: David.

10 DR. NERENZ: Yeah. Thanks.

11 Just to build a little bit on my question -- and
12 I guess I'll express it now as a caution -- I really look
13 forward to this, and I think the work done here is really
14 important and really good. But in every one of these line
15 graphs I looked at, I was impressed by the fact that the
16 trend line started coming down all the way to the left side
17 of the graph, and what my eye was impressed with was more
18 just the continuation rather than a change, and so I guess
19 I feel cautious in saying the program had certain effects
20 because they certainly don't jump out of the graph
21 visually. And since we only have a few time points, I
22 don't think we have statistical tests about changing the

1 trend line. I wish we did. That's usually how you try to
2 do it.

3 I would be curious about what those trends look
4 like further back in time, just again to enrich that line,
5 but maybe it's very expensive or impossible to do that.

6 So I guess all I can say is caution, and even on
7 your point about the target conditions declining less than
8 the others, that's -- what was that? Slide 9? Well,
9 there's that. The differences are not that great. We
10 don't say what were these lines doing before 2010. Were
11 they converging any -- were these lines moving in the same
12 direction, anyway? I guess it seems uncertain.

13 And then just to echo Dana's point that there are
14 other things happening in the environment. You got ACO
15 initiatives in the environment. You've got other things
16 happening in the environment. So I'm not disputing the
17 numbers, but to say just as a clear unqualified conclusion,
18 the program reduced readmissions, I'm not so sure.

19 DR. CROSSON: Okay. Bruce.

20 MR. PYENSON: I think this was a terrific study,
21 and I'd like to give you, the fellow Commissioners, my
22 perspective on this, which is this is trends that we don't

1 often see in looking at the data. So something good is
2 going on here.

3 And I don't want to take apart something that's
4 fundamentally good and unusual to try to tease out exactly
5 what happened in South Dakota versus what happened in
6 Missouri. So I think as programs go, this was implemented
7 and the outcomes are successful. Guess what? In the real
8 world, you're probably never going to know all the
9 determinants of what happens.

10 So I think the work -- I just don't want this to
11 become an academic exercise and MedPAC to become involved
12 in the cottage industry of publishing. So congratulations
13 on terrific work.

14 DR. CROSSON: Jon, on this?

15 DR. CHRISTIANSON: Kind of on this, I guess,
16 yeah, and on what David and David said.

17 So it is an interesting question. Most of the
18 time, MedPAC is a consumer of research, and that's kind of
19 what we're doing here, except we're also contributing our
20 own data. And I think, David, you kind of suggested we
21 should continue to do this kind of stuff going forward, and
22 then, David, you said we need to have more timeline here to

1 really get a sense of what's going on. We need to back but
2 also track it forward, both of which suggest that we do
3 contribute to the cottage industry.

4 So I think we need to kind of make a decision
5 about what we want to do here, and I think part of the
6 reason -- so this was mandated. When I looked at it, I
7 thought, "Wow. Why?" Maybe we kind of did something to
8 get it mandated, but it's something we should have done,
9 anyway. Sometimes the mandated stuff is stuff that we are
10 less happy with, but I think we should be really happy we
11 did this mandated report.

12 And this is really important stuff. Just a
13 little anecdote, I just finished five days of executive
14 education, four to six hours a day with a group of doctors,
15 about 30 doctors, and we had a whole section on
16 measurement. So I walked through the readmission measure
17 and whether it was good or bad. I'll tell you, they all
18 hate it. Every one of them hate measurement, and they hate
19 the readmission, but they love the paper that said there
20 was probably or there could have been a relationship
21 between mortality and readmission. They all knew about
22 that paper, and they took that like it was gold, right?

1 So the kind of stuff you're doing is a real
2 benefit, I think, to the field to be able to sort through
3 everything that you're seeing that's going on here and try
4 to sort of provide some context for us also.

5 I'm kind of leaning in the we need to continue to
6 do this for a little bit, even though it's not normally
7 what we do and even though it won't be mandated in the
8 future. I think there's going to be so much stuff coming
9 out, and there's going to be continued need to put it in
10 context, and I think that's what you were saying too,
11 David, is that we have a context we can put it in. So I
12 hope we do, even though it's kind of out of the norm for
13 us.

14 MR. PYENSON: So are we going to apply for a
15 clinical trial grant?

16 [Laughter.]

17 DR. CHRISTIANSON: Well, you can sign me on as a
18 consultant if you'll do the work.

19 DR. CROSSON: Jim, you may want to comment on
20 this. I mean, generally speaking we do our work. We
21 publish our reports to Congress. We send letters to CMS,
22 and we let it go at that. I mean, that's where we stand.

1 It's possible that this particular situation and
2 the value of this research, as Jon is pointing out, might
3 suggest that we do a little more than we normally do.
4 That's something that we're considering doing.

5 DR. CHRISTIANSON: We did jump into this sort of
6 discussion around cross-subsidies of pay -- Medicare
7 payment and kind of try to put a new perspective on that
8 and publish that, go into the Journal and then you publish
9 that. And this might be another kind of example of that
10 sort of topic where some clarification is useful.

11 DR. CROSSON: Okay. Alice and then Dana and
12 Paul.

13 DR. COOMBS: So I read the Ibrahim article, but I
14 also read the Gupta article too.

15 I just want to say something about -- we kind of
16 broaches this, what, 2013? And back then, I talked about
17 experiences that we were having in the community with this
18 readmission that was correlated with the shuttle effect,
19 and that would be that the patient would have a high-
20 intensity procedure and then would go to a rehab, a post-
21 acute care, and then within a short period of time would
22 find themselves on the door steps of community hospitals.

1 So they're not being necessarily readmitted back to the
2 parent institution -- and how that's tracked. It's almost
3 like a shuttle because it's very hard to get back into the
4 elite tertiary center when it's a post-operative
5 complication and it doesn't involve some of the more
6 initial interventional kind of procedures.

7 I think this is not unique, and I was wondering
8 if we could look at the readmissions and whether or not the
9 readmissions were -- and I think you can do this to the
10 parent institution of the original admission, because I do
11 think that there's something at work here. It can't be
12 that I've seen this multiple times and no one is being
13 aware of it.

14 Now, two things can be in operation. One is that
15 because there's no continuity of care, there might be a
16 lower threshold to readmit that patient back to the
17 secondary institution where they arrive on the doorsteps,
18 because they're usually coming from a place like -- they
19 might be coming from an IRF, and the IRF says this patient
20 has to go somewhere. They find themselves in the emergency
21 room, and something must be done with this newfound
22 symptom. So that's a piece of it.

1 It may be that if the patient actually went back
2 to the parent institution that they may have an e-visit,
3 but they may not necessarily be admitted to that facility
4 because there's continuity of care. Hopefully, there's
5 some kind of coordination with the service.

6 The particular institution that I am referring to
7 is a highly integrated system, one of the largest in the
8 country, on the East Coast. So it's not necessarily that
9 these places are not ACOs and these are advanced -- the
10 Cadillac model of an APM or ACO. So I think that that
11 piece has always bothered me when it comes to that.

12 Initially, when we had the discussion, Jeff and
13 Craig, I thought that all-cause readmission would be a
14 problem because of the randomness of how some hospitals
15 have a proclivity to have certain diagnoses, whereas other
16 hospitals might be more pulmonary, and so that I was
17 concerned about that skewed population that some hospitals
18 may have with DRGs versus others.

19 That will be another interesting piece because I
20 read the summary of how many hospitals are subject to the
21 readmission penalty, and I think it's nearly 3,000 or
22 something close to that. I should check my data before I

1 quote that, but I think it's a large number that is subject
2 to the readmission penalty and looking at how that looks
3 under the umbrella because it could tell us something about
4 just the whole notion of coordinated care.

5 DR. CROSSON: Thank you.

6 Dana.

7 DR. SAFRAN: So just a couple of thoughts, I
8 guess. I hear, particularly in David's comments, a kind of
9 skepticism about whether the policy has worked, and I guess
10 as I think about that, certainly some of the analyses that
11 we've suggested and follow up to here will help us tease
12 that out. You know, I think there's something in this
13 picture that, yeah, up on the screen, that helps us get at
14 that.

15 But one of the comments I wanted to make was that
16 from a qualitative perspective, I have no question in my
17 mind that this set of policies has changed the way
18 hospitals are thinking about care and behaving and the work
19 that they're doing.

20 So then it comes to the question of, you know, if
21 it's true that it was already declining, and, you know,
22 that the trend hasn't really changed, then I think the

1 question becomes, why not? Why aren't all the things that
2 all these institutions are trying not working?

3 And so there I would just add a couple of points
4 from my own experience. One is a hospital that's in our
5 network that in order to reduce CHF readmissions - and they
6 had a quite high rate when all this started -- hired a
7 caseworker to call every CHF member post discharge, every
8 single day, and then only wean off that daily phone call
9 until they started to feel secure that that patient sort of
10 understood what they needed to do to take care of
11 themselves, et cetera. And they got their CHF readmissions
12 to zero and kept them there. So that's one observation
13 that, you know, I see for sure folks are working on this.

14 I also see, in our data, that before 2010, rates
15 were high and undifferentiated. Everybody's rates were
16 high, which makes sense to me because nobody was shining a
17 light on it and nobody was really working on it. After
18 2010, you start to see some differentiation. You start to
19 see some perhaps best practices emerging.

20 So I guess I wanted to inject that into this
21 conversation because I don't have any skepticism myself
22 that these policies have changed behavior. How well they

1 are -- how effective the interventions are is a different
2 question. And the last thing I'll say, because I know this
3 comes up often, is -- and I don't think it's all about SES,
4 because, in fact, in our market some of the organizations,
5 some of the hospitals that have the most socioeconomically
6 vulnerable populations made the biggest improvements,
7 because they took a serious look at who is our population
8 and what would it take to reduce readmissions, and they
9 started to do those things. Not every hospital that serves
10 a low SES population did that, and therefore not everyone
11 was so successful. But I've heard stories of the same from
12 other markets, from Warner's market.

13 So I just wanted to inject those few thoughts.
14 Thanks.

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

16 DR. GINSBURG: Yeah, and I went and reread the
17 mandate which you had in the paper, and the mandate does
18 call for a research study, as we discussed. And I think
19 that's fine because there are some real advantages that the
20 MedPAC staff and Commissioners have in doing this. For one
21 thing, the staff knows the Medicare data so much better
22 than most researchers publishing in the academic

1 literature.

2 But it brought the question to my mind, is that
3 even though they didn't ask for any policy advice as to how
4 to improve the readmissions program, should we contemplate
5 giving them some advice?

6 DR. CROSSON: We have that scheduled separately?

7 DR. MATHEWS: Yeah, we do.

8 DR. CROSSON: Yeah. So, again, this is a little
9 bit of a function of segmenting the work here. So we're
10 kind of viewing this as the mandated report, although we've
11 added on the mortality piece. But then there's additional
12 work anticipated in the spring to begin a broader question
13 on that topic, which is how could it be improved.

14 DR. GINSBURG: Yeah, I think there are a lot of -
15 - you know, Bruce mentioned the issue of calibrating the
16 penalties. I've always thought that -- been interested in
17 changes so that the incentives to reduce readmissions don't
18 fall only on the hospitals with poor performance, that we
19 have some incentives for the hospitals with the average
20 performance, or maybe even somewhat better-than-average
21 performance, so that they can reduce their readmissions as
22 well.

1 DR. CROSSON: Okay. Good discussion. Now I want
2 -- David.

3 DR. NERENZ: Just very quickly, I won't belabor
4 it. I think, Dana, I think you and I basically agree and I
5 just want to, perhaps, for the group and get it on the
6 record. I'm not against this program in any way. I'd love
7 to see this work. I'd love to see huge drops in
8 readmission. I'm not a fan of readmissions. But I just
9 want us to draw conclusions that are driven directly from
10 the data we have in front of us, and if the trend lines
11 don't seem to be moving, I'm worried. I'd like to see them
12 move more than I'm seeing.

13 And just to follow on your point a little bit,
14 what I would accept, absolutely, although we don't have
15 data on it in the report, is how much money and time
16 hospitals are spending on this issue. But that's part of
17 my concern. I want that money to be spent effectively, and
18 that time to be spent effectively, because it's being spent
19 here. It's not being spent on something else.

20 And so that's part of my concern about, you know,
21 wanting to see more dramatic effects here, is that if
22 there's a lot of people spinning their wheels and not

1 getting powerful effects, that's not a good thing.

2 MR. LISK: Just to say, on the trend line, is
3 that to say actually that the trend line is steeper since
4 the program went into effect from the short time before
5 period that we have here, and we didn't go back before
6 that. If we went back before that, from other data we had,
7 it was not as steep. In fact, I think it was flat going
8 back before 2008, but I'd have to go back and confirm that.

9 The other thing is that actually we saw the
10 steepest decline in 2016, from 2015 to 2016. So just to
11 say is that there actually -- even though it's harder to
12 see, there was reductions going on before that, but --

13 DR. NERENZ: No, I did notice that.

14 [Overlapping speakers.]

15 DR. NERENZ: I'm just surprised you didn't remark
16 on that, you know, what's going on there, because it --

17 DR. CROSSON: Okay. Okay. All right. Paul and
18 then Jack.

19 DR. GINSBURG: Just to follow up on David, in a
20 sense, you know, conceptually, when we have things like
21 ACOs and bundled payments, a readmission program is a very
22 second-tier program, in a sense. We'd rather focus on the

1 big picture, on overall quality, on overall spending. And,
2 in a sense, you know, the readmission program probably was
3 conceived long before that, and was a -- you know, let's
4 focus on this thing that we can measure very well. Because
5 we can get the hospitals to pay lots of attention to it,
6 and as you said, maybe that's not for the better. But I
7 guess that's just the reality of the world we live in, that
8 we'll bite off something easy, succeed with it, and that's
9 probably okay as long as it doesn't have major long-term
10 diversion of energy from higher potential activities.

11 DR. CROSSON: Jack.

12 DR. HOADLEY: Yeah. I was just going to observe,
13 I mean, given some of this last round of discussion, I
14 mean, some of -- you cite some of the qualitative -- a
15 couple of qualitative sites sort of early on in setting the
16 stage, but, you know, the kinds of things that Dana's
17 talking about could be bought in, in a discussion of these
18 results, at the end, more some of the broader kinds of
19 things that we've been talking about here, in terms of how
20 much you can draw this conclusion, how much there's
21 multiple things going on. I mean, making sure -- on the
22 one hand we want to present the statistical analysis very

1 cleanly, but then in talking about what we learned from it,
2 what we take away from it, I think what you've got here is
3 a number of ideas for how to set that in a context. That,
4 I think, will just make the discussion all the stronger.

5 DR. CROSSON: Okay. So I think there's two ways
6 we could proceed here, and it has to do with whether or not
7 we feel we've had an adequate discussion and input, and
8 whether the product, the final product would be a lot
9 better if we, let's say in April, went over this again,
10 versus having the staff take the input -- and I'm looking a
11 little bit at you, David, because I think you had the most
12 thorough comments in this direction -- have the staff take
13 the input about how to express the data mill a little
14 differently, add data. You know, in some cases make it,
15 you know, clearer, maybe expand that curve, if that --
16 backwards, if that's important, in terms of looking at
17 trends. But, you know, fundamentally, make a set of
18 improvements in the final report that would satisfy the
19 discussion here, or whether people think we need to have
20 another presentation in April with that data, before the
21 report is finalized.

22 So -- because I'm sort of --

1 MS. BUTO: What was the first option, Jay?

2 Sorry.

3 [Laughter.]

4 MS. BUTO: I thought that was the first option,
5 April and --

6 DR. CROSSON: It's 4:30, Kathy. No, that's fine.
7 The first option would say, in terms of the mandated
8 report, not all of our work on readmissions policy, but in
9 terms of the mandated report, where we're done with that
10 discussion, we've made our comments, we will now trust the
11 staff and verify, because we'll get a chance to look at the
12 next version of that and have input into that, or whether
13 we have such a concern about the data that we want the data
14 to be brought back and presented again in April, or March,
15 rather -- I'm sorry -- March or April. March. March.
16 April. March. March or April, before the report is
17 finalized.

18 Dana, Jack, Bruce.

19 DR. SAFRAN: I guess my point of view of that is
20 it's not that we have so much concern but there were so
21 many ideas and suggestions here, including, you know,
22 further methods work, that for us to land sort of all on

1 the same page about what do we know about this -- I mean,
2 this is a very important policy intervention. And so I
3 think it is helpful to come back and have a substantive
4 discussion about the revised piece and not just all read it
5 and think our own thoughts about it.

6 DR. CROSSON: Jack.

7 DR. HOADLEY: I would just, to some degree, just
8 leave it to the discretion of Jim and the staff. If the
9 thing evolves -- like if there's -- and Jon was talking
10 earlier, you know, there's all this literature. Well, if
11 some significant new articles come out that, or if you get
12 some significant new results that feel like they need, you
13 know, our input, you know, that's a good excuse. I think
14 Dana's point could be fine too. I mean, if there's enough
15 evolution in sort of how you frame the conclusion, or maybe
16 you bring us just the conclusion, ask us to talk about a
17 conclusion section or a discussion section without
18 necessarily going back through all the data, I mean, it
19 seems like there are some options sort of in between.

20 DR. CROSSON: Oh, my gosh. I thought there were
21 only two.

22 DR. CHRISTIANSON: So I heard concerns about do

1 we have enough data to reach conclusions, but I also heard
2 some concerns about the conclusions that were reached --

3 DR. CROSSON: Yes.

4 DR. CHRISTIANSON: -- and those are the ones that
5 would suggest to me that we probably need to come back.

6 DR. CROSSON: Okay. I'm seeing a semi bobble-
7 headed consensus that we would like to --

8 MR. PYENSON: I think the report is wonderful as
9 it is and I'd leave it to the discretion of the staff and
10 Jim to push it through.

11 DR. CROSSON: Okay. We've got double bobble-
12 heading. Okay. This is why I'm bringing the question up,
13 because I sort of sensed we were split in this. Let's try
14 this. Let's do a straw poll. This is not a vote. This is
15 just a straw poll. All those who would suggest that we
16 leave it to the staff to take these suggestions and rework
17 it and then provide us with a reworked final report that we
18 would then provide input into, that's going to be Option A.
19 Option B is we come back in March or April, depending on
20 the schedule, and we do it as a committee of the whole.
21 That would be Option B.

22 So Option A, can I see a straw poll for -- oh,

1 I'm sorry.

2 DR. MATHEWS: Can I offer an Option C?

3 [Laughter.]

4 DR. MATHEWS: And it's a variation of Option A.

5 DR. CROSSON: Okay.

6 DR. MATHEWS: You know, I understand you guys
7 having, you know, grave reservations about giving the staff
8 broad latitude here, and if I were in your position I would
9 have those same reservations. But in addition to
10 accommodating the discussion here, and keeping track of any
11 developments in the literature that come out over the next
12 six to eight weeks, which is literally the timeline we're
13 talking about to close this out, we could also go back and
14 revisit some of the display issues here, and, you know,
15 particularly with respect to differentiating trends for the
16 conditions subject to the HHRP versus all other conditions,
17 make that clear. And we can see if there are any
18 additional analytic work that we can do in response to this
19 conversation. And if we do determine any significant
20 differences in our findings, interpretation, or message, we
21 could commit to coming back to you in April to have that
22 discussion.

1 But if we did all of that, incorporate your
2 discussion, make sure all of your thoughts are
3 accommodated, and we didn't find anything that takes us off
4 of what we've presented here today, we would reserve the
5 option of not coming back in April and instead giving you a
6 memorandum, here's what we did. And so basically giving us
7 the toggle to come back.

8 DR. CHRISTIANSON: So let me just say something,
9 to add on to that. But ultimately, as a Commission, the
10 decision we're making on this mandated report is whether
11 that one or two sentences we agree with -- did it have the
12 effect that was intended, in this, and then you brought up
13 the mortality.

14 So that's what we have to be comfortable with.
15 And so all of the other stuff is great, but ultimately,
16 when we approve the report, we're really approving that
17 conclusion, whatever it is. So think about that when you
18 think about what you want to do.

19 MS. BUTO: And I guess I'm wondering why we are -
20 - I mean, we usually go through two or three rounds on a
21 number of important issues. This one's Round One. Are we
22 short of time? Didn't we just buy ourselves a bunch of

1 time by really doing a fantastic job on updates? I'm just
2 wondering why we won't allow ourselves to go ahead and
3 schedule that now. Are we concerned about the amount of
4 work for June?

5 DR. MATHEWS: We do currently have a full
6 schedule and, you know, we would need -- and coming back to
7 this discussion in April is currently contemplated in our
8 agenda for the spring. And so we can definitely come back.
9 The question is we've got a number of other competing
10 issues and a limited, you know, amount of time. And the
11 question would be given, you know, work that we want to get
12 in front of you on low-value care, this cycle, given work
13 that we are trying to put into the calendar to follow up on
14 the fee schedule work that we're presenting tomorrow, you
15 know, we want to come back later with a more primary care-
16 focused policy option for you, the question is given the
17 competing demands, does this, here and now, rate a decision
18 to come back definitively in April.

19 DR. CROSSON: Okay. I think I know what's going
20 to happen here, but I'm going to do it anyway.

21 MR. PYENSON: Can we narrow this to two choices,
22 because I'm confused.

1 DR. CROSSON: Well, Jim is making a distinction
2 between simply saying that the report would be reworked and
3 sent out, and the report might be reworked or might be
4 brought back, depending on staff discretion, judgment on
5 that issue, as opposed to the specific content issues.

6 So let's try this again. So A is we give the
7 staff complete discretion to take the input today, write
8 the report, we're done. B is we definitely want it to come
9 back to be reworked at the March or April meeting, before
10 the report is finalized. And C is we give the staff
11 discretion to rework it, but also discretion to determine
12 whether or not it comes back or not, based upon changes
13 that might take place or further staff discussion.

14 DR. GINSBURG: Can I suggest dropping A in favor
15 of C? Isn't that the way we usually work it?

16 DR. CROSSON: Drop A --

17 DR. GINSBURG: -- in favor of C. Make B and C
18 the only options.

19 DR. CROSSON: Okay. Yeah, okay. Does B become A
20 now, or does B --

21 [Laughter.]

22 DR. HOADLEY: Just call them B and C.

1 DR. CROSSON: All right. I'm okay with that. So
2 we now have option B, which is -- I've forgotten.

3 [Overlapping speakers.]

4 DR. CROSSON: We bring it back automatically or
5 we give staff discretion in terms of whether to bring it
6 back or not. Is everybody clear on that except me? Okay.

7 So all in favor of Option B, please raise your
8 hands.

9 [Show of hands.]

10 DR. CROSSON: Okay. Well that's --

11 [Overlapping speakers off microphone.]

12 DR. CROSSON: Mandatory coming back. Okay, we've
13 got three.

14 Staff discretion as to whether to bring it back
15 or not.

16 [Show of hands.]

17 DR. CROSSON: That follows, that carries, and
18 that's what we'll do.

19 MR. LISK: I appreciate your faith in the staff.

20 DR. CROSSON: Okay. Okay. Well, thanks very
21 much, Jeff and Craig. I guess I was surprised. Okay.

22 [Laughter.]

1 DR. CROSSON: So we have completed the work for
2 today. Thank you, everybody. It's been exhilarating, to
3 say the least.

4 So now we have time for public comment period.
5 Anyone who would like to come up and address the
6 Commission, please stand at the microphone. Sharon, in a
7 minute I'm going to ask you who you are, and what
8 organization you come from. You know the rules. Two
9 minutes for your remarks. And let me just wait and see if
10 anybody else is heading up. I don't want them to get in
11 your way.

12 Okay, Sharon, we're off and running.

13 MS. McILRATH: All right. I'm Sharon McIlrath
14 with the American Medical Association. So I wanted to talk
15 a little bit about MIPS. I don't think it's a surprise to
16 anyone here that we did not support the VVP for the reasons
17 that David Nerenz and Dr. Coombs laid out. We do agree
18 that there are problems with MIPS -- the complexity, a lot
19 of methodological issues. Some of those methodological
20 issues are going to have to be resolved even if you went
21 with the VVP.

22 So where we are is that we would like to fix it

1 rather than kill it, and partly that's because we don't
2 like sending sort of shifting messages to the physicians.
3 It's kind of like, you know, are they going to invest in
4 building an infrastructure on shifting ground.

5 There's a problem that is coming up and that
6 needs to be resolved quickly. We don't think that it is
7 political viable to think that you're going to go up there
8 and get the Hill to kill MIPS. We had -- the medical
9 profession came together and agreed on a very restricted
10 sort of policy. The intent is to sort of pause the program
11 briefly and to stop a couple of hammers that are going to
12 come down in 2020 -- well, 2019 for the performance year.

13 So those are that the -- it's not just a question
14 of what the size of the threshold for -- the performance
15 threshold is. It's that it has to be the mean or the
16 median, which at CMS was once interpreted as 50 percent of
17 the people have to fail. And in addition to that, you
18 can't do what they did in the VBM, which was to have a
19 range and only the people at both ends were winners or
20 losers. Now, anybody on one side of that threshold loses
21 and on the other side of that threshold they win.

22 So then the other issue is the cost measures.

1 The cost measures that are in the VBM are -- they're
2 irrelevant for a lot of physicians. They have a lot of
3 flaws. And we're working with CMS and a contractor to try
4 to come up with some good cost episodes. That's taking
5 time. It won't be ready in 2019, so we don't want that
6 weight to go up to 30 percent.

7 My concern is that if you say that nothing other
8 than repeal will do, are you going to then, you know, say,
9 well, if we want to pause the program and at least fix
10 what's there and prevent the worst outcomes from happening,
11 that you don't want to do that.

12

13 DR. CROSSON: Thank you, Sharon.

14 Okay. So we are adjourned until 8:00 a.m.
15 tomorrow morning [off microphone].

16 [Whereupon, at 4:39 p.m., the meeting was
17 recessed, to reconvene at 8:00 a.m. on Friday, January 12,
18 2018.]

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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, January 12, 2018
8:10 a.m.

COMMISSIONERS PRESENT:

FRANCIS J. CROSSON, MD, Chair
JON B. CHRISTIANSON, PhD, Vice Chair
AMY BRICKER, RPh
KATHY BUTO, MPA
ALICE COOMBS, MD
BRIAN DeBUSK, PhD
PAUL GINSBURG, PhD
DAVID GRABOWSKI, PhD
JACK HOADLEY, PhD
DAVID NERENZ, PhD
BRUCE PYENSON, FSA, MAAA
RITA REDBERG, MD, MSc
DANA GELB SAFRAN, ScD
WARNER THOMAS, MBA
SUSAN THOMPSON, MS, RN
PAT WANG, JD

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P R O C E E D I N G S

[8:10 a.m.]

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DR. CROSSON: Okay. I think we can begin now. Glad to see all the Commissioners bright-eyed and bushy-tailed this morning. It does my heart good.

So the first presentation of this morning's session will be the final report on telehealth services. This is a mandated report, and we are going to be preparing this information for the Congress at their request. Zach, Amy, and Andrew, you're on.

MS. PHILLIPS: Good morning. Today we'll be wrapping up our work on telehealth services and the Medicare program.

In today's session we are going to go over the final draft of the report in compliance with the mandate covering background information, Medicare coverage, commercial insurance coverage, and our principles for evaluation of telehealth. This material is based on extensive discussions last year that came on the back of the Commission's June 2016 chapter on telehealth in the Medicare program, so this presentation is going to take a less detailed, higher-level approach. However, if you have

1 specific questions, we are happy to take them. The goal
2 today is, like the unified PAC PSS report, to approve to
3 forward the report in its entirety to Congress.

4 Through the 21st Century Cures Act of 2016,
5 Congress mandated MedPAC to provide a report by March 15,
6 2018, answering three questions. As a reminder, the first
7 question was what telehealth services are covered under the
8 Medicare fee-for-service program. The second addressed
9 what telehealth services do commercial health plans cover.
10 And the third addressed how telehealth services covered by
11 commercial health plans might be incorporated into the
12 Medicare fee-for-service program. To complete our work and
13 deliver it in March, we are back here today to have you
14 review the entirety of our findings and gather your final
15 thoughts.

16 Telehealth services encompass a variety of
17 clinical services, technologies, and modalities. Per your
18 request and for the sake of our discussion and Medicare
19 focus, we have narrowed the telehealth down to three forms:
20 direct to consumer, or DTC; provider to provider, or PTP;
21 and remote patient monitoring, or RPM. For your reference,
22 on the slide and in your mailing materials you can find

1 further explanation.

2 In June 2016 the Commission concluded that
3 existing evidence on the efficacy of telehealth was mixed
4 and that the incentive for using telehealth services
5 differed among the various types of payment systems. In
6 addition to Medicare, we know that several government
7 programs cover telehealth services, but to varying degrees.
8 In addition, to date, 35 states have passed telehealth
9 parity laws requiring commercial insurers to cover certain
10 telehealth services equal to in-person services.

11 Across commercial and government payers, the most
12 common physician services used via telehealth were basic
13 office visits and mental health services.

14 Under the physician fee schedule, the use of
15 telehealth services was low in 2016. This low use was also
16 reported by the DOD and those commercial plans we
17 interviewed as part of answering Question 2 of the mandate.

18 While use was low, the growth in telehealth use
19 has been rapid. Between 2014 and 2016, the number of
20 telehealth visits per 1,000 beneficiaries increased 79
21 percent among Medicare beneficiaries. The most rapidly
22 growing services were for subsequent nursing care,

1 psychotherapy, and pharmacy management. Keep in mind that
2 one factor in this rapid growth is that the base use in
3 2014 was extremely low. While advocates say that the
4 growth being shown in use is a good sign and indicates
5 there should be expanded access, critics cite the increased
6 growth as a warning that telehealth services may
7 supplement, rather than replace, in-person services, which
8 would ultimately lead to costs increases if growth is
9 sustained.

10 In attempting to answer the question if
11 telehealth is a supplement or a substitute, we used
12 Medicare data to assess E&M claims and found that, after
13 controlling for patient risk score, telehealth users and
14 non-telehealth users had equal numbers of in-person E&M
15 claims in 2016; however, telehealth users had an additional
16 1.6 telehealth E&M claims. This suggests that telehealth
17 E&M claims might be supplemental.

18 In addressing mandate issue one, we looked at
19 Medicare coverage of telehealth across all sectors with a
20 focus on the physician fee schedule. We found that under
21 risk-bearing entities such as MA and ACOs, flexible
22 coverage of telehealth exists. We also found that flexible

1 coverage exists for fee-for-service coverage other than the
2 physician fee schedule. Lastly, we found that Medicare
3 coverage of telehealth is most constrained under the
4 physician fee schedule and is the focus of the mandated
5 report.

6 The most flexibility to use telehealth in the
7 Medicare program occurs in the Medicare Advantage ACOs.
8 Under MA, payments to plans are capitated and plan coverage
9 must include telehealth services covered under fee-for-
10 service Medicare. Plans also have the flexibility to
11 finance the coverage of additional telehealth services
12 through a supplemental premium or through their rebate
13 dollars, and those added telehealth costs may not be built
14 into the plan bid. Under CMMI, organizations selected for
15 several programs have waivers to use telehealth services
16 beyond the limits of PFS coverage. While outside the scope
17 of the mandate, the Commission has expressed support for
18 expansion of flexibility for these entities. You can refer
19 to your mailing materials for a more detailed discussion of
20 this.

21 Among the other fee-for-service systems,
22 telehealth is contemplated as a fixed payment for a

1 beneficiary episode. In these cases, the physicians have
2 the flexibility to use telehealth as they see appropriately
3 to achieve higher quality or more effective care while
4 being held at risk if the cost exceeds the fixed payment.
5 Within these areas and with their current payment
6 structure, we believe enough flexibility exists and,
7 therefore, it is not a focus of the rest of our analysis.

8 Under the PFS where telehealth is most
9 constrained, there is a limited set of telehealth services
10 on a fee-for-service basis that are restricted based on
11 originating locations, geographies, and modalities. You
12 can find much more detail of this in your mailing
13 materials. CMS largely determines which fee schedule
14 service codes are covered as telehealth services, and I'd
15 like to highlight that since our September presentation,
16 Medicare now permits remote patient monitoring as one of
17 the approved telehealth modalities, but remote patient
18 monitoring must still occur under the same restraints as
19 the other telehealth services. There is one exception of
20 all of these rules which is a variety of management codes
21 where services are bundled together, and in telehealth it's
22 considered part of the covered services that may be used to

1 deliver care under these codes at the physician's
2 discretion.

3 MR. GAUMER: The Congress also asked us to
4 evaluate the extent to which commercial insurance plans
5 cover telehealth. We sampled a large group of diverse
6 plans and interviewed over a dozen insurers. We found that
7 most plans covered some telehealth services, but few did so
8 comprehensively. There was wide variation in coverage, but
9 basic physician visits and mental health visits were among
10 the most common types of services covered. Plans covered
11 telehealth in urban and rural areas. Cost-sharing levels
12 varied by plan and service type.

13 Plans often used pilot programs to test
14 telehealth services before implementing them more broadly.

15 Plan representatives consistently stated that
16 cost reduction was not their primary rationale for covering
17 telehealth services. But, instead, their aim was to
18 respond to employer demand and to compete with other
19 insurers.

20 In terms of outcomes, plans reported low levels
21 of use, as we've said, that access and convenience had been
22 expanded, and that only one insurer noted cost reductions.

1 In response to the third question of the mandate
2 concerning how to incorporate commercial coverage into
3 Medicare, the Commission has several points about doing so
4 being complicated and how it should be approached
5 differently.

6 Overall, plans do not offer a clear and
7 homogenous model for Medicare to follow.

8 Plans appear to consider cost reduction as a
9 secondary rationale, but cost is a critical piece of
10 Medicare coverage decisionmaking.

11 While plans have a variety of tools at their
12 disposal to control volume incentives and any potential
13 misuse, under the fee schedule taxpayers are not
14 indemnified against this incentive, and telehealth may be
15 more vulnerable to misuse.

16 Plan cost sharing varied widely, while under the
17 fee schedule Medigap policies often shield beneficiaries
18 from cost sharing.

19 In general, plans use pilot programs to test
20 telehealth coverage, while Medicare to date hasn't tested
21 telehealth to the same degree.

22 Therefore, the Commission recommends that

1 policymakers exercise caution in further incorporating
2 telehealth services into the fee schedule.

3 In an effort to simultaneously exercise caution
4 and advance the Medicare program, the Commission recommends
5 that policymakers use the following three principles to
6 guide the evaluation of individual telehealth services for
7 their potential incorporation into the program. While a
8 given telehealth service may not demonstrate evidence of
9 all three principles, a service should strike a balance
10 between these three.

11 The first principle is reducing costs, the second
12 principle is expanding access, and the third principle is
13 improving the quality of care.

14 Based on the Commission's discussion, we
15 developed several illustrative examples of how the
16 principles can be applied to telehealth services that were
17 commonly used by commercial plans. I will walk through
18 three of these examples, which demonstrate: first, a
19 telehealth service where the evidence of balancing the
20 principles is clear; a second where the evidence of balance
21 is less clear; and, third, where the evidence of balance is
22 unclear.

1 The first example is telestroke services. These
2 are currently covered by the fee schedule in rural areas,
3 but policymakers could consider expanding telestroke to
4 urban areas.

5 By applying the three principles, we believe that
6 telestroke is likely to increase program costs, by
7 increasing the number of these consults that are occurring.
8 However, cost increases may be mitigated by this service's
9 low risk of misuse and its potential to reduce long-term
10 disability.

11 Telestroke may improve timely access to
12 neurologists. In terms of quality, health systems cite
13 reductions in mortality and disability from their
14 telestroke programs.

15 Therefore, because the evidence of the principles
16 is fairly clear and balanced, policymakers may decide to
17 consider telestroke services for incorporation into
18 Medicare.

19 The second example are tele-mental health
20 services, which are currently covered under the fee
21 schedule in rural areas, but policymakers similarly could
22 consider to expand these services to urban areas or to the

1 patient's residence.

2 Program costs are likely to increase because
3 roughly 30 percent of beneficiaries report a mental health
4 condition.

5 This service would expand access to mental health
6 clinicians, which the AHRQ reported being in short supply
7 last year.

8 The evidence that these services improve quality
9 is less concrete.

10 Due to the expectations for cost increases and
11 the gaps in the evidence of quality improvement, the
12 overall evidence of balanced principles is less clear for
13 tele-mental health services. Policymakers may need to use
14 their best judgment and could pair implementation of this
15 service with utilization control policies or with other
16 oversight.

17 DTC services are not covered under the fee
18 schedule, but Medicare could consider covering them in
19 urban and rural areas.

20 DTC may significantly increase costs because
21 these services would be available to all beneficiaries, are
22 used for routine care, are vulnerable to misuse, and

1 Medigap policies shield beneficiaries from cost-sharing
2 responsibility.

3 DTC would expand access and convenience
4 significantly.

5 There is potential for DTC to improve quality,
6 but the evidence of this is unclear to date.

7 Therefore, due to the potential for cost
8 increases and the lack of evidence of quality improvement,
9 the evidence of balanced principles is unclear for DTC.
10 Therefore, policymakers could consider testing this service
11 within CMMI.

12 Over the course of this analysis, we have found
13 that Medicare covers telehealth services in several areas
14 of the program. Coverage is more constrained in the fee
15 schedule. Commercial plan coverage varied and was
16 motivated by the demands of employers and competition
17 rather than cost reduction. Commercial plan coverage as a
18 whole is not a clear and consistent model for Medicare.
19 And due to the lack of commercial homogeneity and the fact
20 that under the fee schedule cost increases will be passed
21 along to taxpayers, we identified three policy principles
22 that policymakers can use to evaluate individual telehealth

1 services. When telehealth services demonstrate evidence of
2 balancing these principles, policymakers could consider
3 incorporating them. When the evidence is unclear,
4 policymakers could consider testing the service more
5 thoroughly through CMMI.

6 Okay. This concludes our presentation and our
7 work in this area, and we will now pass this off to Jay,
8 who will walk you through the Q&A and then the vote.

9 DR. CROSSON: Thank you so much. Nice work.
10 Really appreciate it. Let's do clarifying questions. Sue.

11 MS. THOMPSON: Thank you, Zach, Amy, everybody.
12 On page 45 of the reading material and I think on one of
13 the slides as well, in the direct-to-consumer analysis, you
14 cite a very large increase in cost on Table 8. And then on
15 Slide 5, telehealth utilization, we talk about number of
16 claims for telehealth and non-telehealth users. What's the
17 assumption behind claims? I mean, is the assumption that
18 the claim for a telehealth encounter is equal to a claim if
19 a beneficiary goes to an office visit? I mean, are we just
20 measuring claim to claim, or are we quantifying by dollars
21 this big increase in cost?

22 MR. GAUMER: We're thinking of, you know, the

1 utilization, 0.3 percent of beneficiaries. That's on a
2 beneficiary basis. That's our assessment of the
3 utilization. But, generally, we think of this on a claim
4 level.

5 MS. THOMPSON: Has there been any analysis of the
6 difference in intensity of service when I pick up the phone
7 or get on my iPhone and have an encounter because I have a
8 sore throat and I need something to get to work tomorrow,
9 as opposed to if I go to an office visit and all of the
10 ancillary services that might be added to that claim?

11 MR. GAUMER: So we haven't dived into the
12 different codes that are appearing on these claims in
13 addition to just the telehealth code. We've looked to see
14 that, you know, maybe a basic E&M code, a physician visit,
15 if it's paired with mental health services and other types
16 of things. We have looked to see what other things have
17 been the second-most likely condition or service to appear
18 on the claim, but we haven't compared the broad scope of
19 services appearing on claims of telehealth versus other
20 office visit claims. So that's something we haven't done
21 yet.

22 MS. THOMPSON: Okay, which was a wonderful segue

1 to my next question, which relates to mental health, and if
2 30 percent of beneficiaries have some diagnosis that
3 relates to mental health. And our assumption is that if we
4 open up telehealth, the costs will go up. Well, have we
5 thought about the impact that we might have on improving
6 the beneficiary's quality of life and adherence to their
7 medication protocols and activities of daily living if
8 their underlying depression was addressed? I mean, I'm
9 curious to know if we're connecting those dots.

10 MR. GAUMER: I think what you're seeing
11 especially on Slide -- let me flip here, on Slide 15, when
12 we say that the evidence of quality improvement is less
13 clear or it's limited, I think we just haven't seen
14 specific evidence in the literature or in our own work that
15 we would have a definitive improvement in outcomes if this
16 -- if tele-mental health services were made more widely
17 available.

18 That doesn't discount what you're saying, and
19 that's why here we've said potential for improvement. I
20 think it is clear that there's great potential for
21 improvement, but we haven't seen definitive evidence of
22 this, and that's where we were trying to go.

1

2 MS. THOMPSON: Thank you, Zach.

3 DR. CROSSON: Jon, on this topic. Then I'll call
4 on Jack.

5 DR. CHRISTIANSON: Yeah, I appreciated that you
6 put in there, too, that it's not like everybody that wants
7 to get care will necessarily be able to get care. We've
8 talked a lot about shortages in mental health care
9 professionals as well. So that might somewhat limit what
10 we would hope would be a positive effect of this.

11 DR. CROSSON: Paul and then Jack.

12 DR. GINSBURG: Yeah, I was going to raise the
13 same thing about the constrained supply of mental health
14 services, which are, you know, extremely constrained in
15 Medicare. And another possibility, I call it "crowd-outs."
16 In a sense, maybe rather than a big increase in supply,
17 maybe there's little increase in supply, and the result is
18 that some beneficiaries getting mental health services
19 would no longer have them because the supply is diverted
20 into tele-mental health. I don't know if you've thought
21 about that.

22 MR. GAUMER: So the point that Paul and Jon both

1 made here was something that has come up in our work in the
2 past, and since the last round we've incorporated some
3 ideas about these things into the draft. So hopefully
4 we've reflected what your thoughts are.

5 DR. CROSSON: Jack.

6 DR. HOADLEY: So on the comparison and the
7 examples on Slides 15 and 16, I thought I was clear when I
8 read in the paper, but as I sort of go through what you put
9 here, I'm struggling to sort of see what's the level of
10 difference that puts the tele-mental health one at sort of
11 this category of less clear evidence and the DTC as unclear
12 evidence. You talk about, you know, both have potential
13 for misuse and increased cost; both have some ability to
14 expand access; both have potential for improvement in
15 quality. But I was struggling to remember what you're
16 really seeing is the key difference here.

17 MR. GAUMER: The difference here, I think,
18 quality is both unclear and there's great potential for the
19 quality improvement. The difference that I see between the
20 two is that the potential for cost increase is higher for
21 DTC based upon the fact that you've got this applying to a
22 much larger population of people. It's routine services

1 that anyone is likely to use as opposed to in tele-mental
2 health services, yes, they're available to everybody, but
3 we're seeing that as somewhat of a smaller pool of
4 beneficiaries just because, you know, the research tells us
5 that 30 percent of beneficiaries have a mental health
6 condition, you know, it's probably higher than that. The
7 pool of potential users is probably higher. But we're just
8 seeing a difference in cost.

9 DR. HOADLEY: Okay. Thank you.

10 DR. MATHEWS: And if I could jump into this as
11 well, I agree with everything Zach said. I would also
12 point out that in mental health we do have a lot of
13 evidence of, you know, potentially constrained access, a
14 lot of which is related to the supply. But we do not have
15 similar evidence of access problems with respect to garden
16 variety face-to-face E&M. So that's another reason why we
17 would, you know, think there is a potentially greater
18 rationale to increase access to mental health services
19 through telehealth than there is for standard direct-to-
20 consumer kinds of interventions.

21 DR. HOADLEY: And I assume on any of these
22 distinctions, if more research appears, I mean, it might

1 push us one way or the other, either development of issues
2 over time, like changes in the availability of mental
3 health providers. But even just studying some of these
4 things would give us a chance to push it up or down in the
5 --

6 DR. MATHEWS: That's exactly right.

7 And the other general thing to keep in mind here
8 is that as part of our assessment of the landscape, we have
9 found that utilization of telehealth tends to be very low
10 across the board. Medicare, commercial payers, Medicaid --
11 I think GAO came out with an evaluation of DoD use of
12 telehealth, and it's again in the same low single-digit
13 rates of utilization. So a lot of the evidence just isn't
14 there, which is why we've come down on the side of here are
15 some principles that you should use to determine whether or
16 not you want to expand coverage rather than definitive
17 statements saying yes, you should expand coverage for this
18 service in this way.

19 DR. HOADLEY: Thank you. That's helpful.

20 DR. CROSSON: Rita and then Bruce.

21 DR. REDBERG: I think I'll wait until Round 2.

22 DR. CROSSON: Then Bruce and Warner.

1 MR. PYENSON: Thank you very much.

2 I think a lot of the focus here has been on
3 potential impact on the physician fee schedule, but it
4 strikes me that at least some of what we're talking about
5 is more connected with the underlying infrastructure that
6 Medicare and others don't pay for through a physician fee
7 schedule that they would pay as part of a DRG or case rate
8 or something like that.

9 To what extent is this an issue that is best
10 handled through things like licensure? So, for example,
11 probably emergency rooms require running water. It's not
12 something Medicare pays for separately.

13 When it comes to telestroke or other emergency
14 room kinds of things, I think there's requirements -- and
15 it may vary by state, but access to certain kinds of
16 services to be considered a stroke center or even top-rated
17 emergency room.

18 So I'm wondering where you draw the line on some
19 of these services.

20 MR. GAUMER: So I think we can talk to telestroke
21 and licensure. We did a little looking around at the
22 qualifications criteria for stroke centers, and what we

1 found is that generally the Joint Commission, JCAHO, when
2 they're accrediting stroke centers, what they'll say is
3 that a stroke center does not have to have telemedicine in
4 place, but it can. The critical component for the stroke
5 centers is that they must be 24/7 and have access around
6 the clock. They can use the telemedicine instead of in-
7 person care if they choose. So it's not a requirement that
8 the stroke center have telemedicine, but they can use it.

9 We are seeing kind of an opening the door in the
10 licensure world. They are opening the door to telehealth
11 but not requiring that telestroke or telehealth be a part
12 of the process.

13 MR. PYENSON: Just a follow-up question. In the
14 telestroke example -- forgive me if this was in the
15 material, whether the stroke centers have moved to that
16 because it's more efficient than other ways or not.

17 MR. GAUMER: That, I'd say we don't have a good
18 sense of.

19 Do you --

20 MS. PHILLIPS: Count.

21 MR. GAUMER: Yeah. And the coming of this is a
22 little unclear to us as well. We're looking at what the

1 Joint Commission does now, but I'm not sure if that
2 happened five years ago or last year.

3 DR. CROSSON: I think I see Rita and Kathy on
4 this point.

5 DR. REDBERG: Just on this, because I had
6 forgotten until you said that. In the telestroke session,
7 which you considered to have the better evidence, I saw
8 that UVA, for example, said it was better, but I didn't see
9 actual references that were kind of -- I like to see
10 references.

11 MR. GAUMER: Sure, sure.

12 DR. REDBERG: Were there studies that also said
13 it was better?

14 MR. GAUMER: Yeah. There's been a bunch of
15 studies on telestroke specifically. That's probably where
16 the research is most robust, and so we can put some of that
17 in there.

18 DR. REDBERG: And the idea is then they are
19 diagnosing remotely, but someone is on hand to treat that
20 wouldn't have felt comfortable treating was the impression
21 I got without the remote diagnosis.

22 MR. GAUMER: Yeah.

1 And do you want to talk about the ambulance
2 stuff?

3 We've seen telestroke happening out of ambulances
4 as well in some markets, and it seems like that might be
5 kind of a new frontier for telestroke in general. So
6 you've got an EMT on one end and not just -- you know,
7 maybe a standard physician in a rural ER connecting with an
8 neurologist. It's happening with nurses and EMTs as well.

9 DR. REDBERG: That sounds great.

10 MS. BUTO: Bruce, back to you point, I thought
11 what you were trying to get at -- and correct me if I'm
12 wrong -- is don't hospitals, stroke centers have
13 flexibility to use telestroke methodologies, and I think as
14 the paper, I thought, pretty well laid out with DRGs and MA
15 payments, there's a lot of flexibility to do that kind of
16 substitution.

17 But I think the question here is really whether
18 the physician involved remotely gets paid, and so I think
19 even though the stroke center -- and correct me if I'm
20 wrong, that this is where you were headed -- may have
21 flexibility and licensing and so on and may somewhat
22 dictate what services they can offer or have available or

1 substitute.

2 The question is still whether the physician on
3 the other end of that gets paid.

4 MR. PYENSON: Well, sometimes maybe the physician
5 at the other end is not going to know whether the patient
6 is Medicare-eligible or not or which carrier, so this is
7 different. It might be a service requirement that the
8 hospital has to do this, has to make it available just like
9 they have to have 24-hour access. The physician in that
10 case doesn't know whether they're going to get paid or not.

11 MS. BUTO: I'm sorry. I just meant I thought
12 that the question we were trying to address as a Commission
13 was whether this service ought to be legitimately and
14 clearly covered by Medicare for physicians, so that a
15 statement is made that for telestroke, anyway, that meets
16 these criteria, the physician should get a payment or the
17 consulting stroke expert ought to get some sort of payment.
18 So I misunderstood where you were going with that. Sorry.

19 MR. PYENSON: I think I was going there.

20 DR. CROSSON: Okay. Alice, on this point?

21 DR. COOMBS: Yeah. I just wanted to say -- as a
22 stroke center -- and it forms clinical affiliations with

1 surrounding hospitals whereby the strokes -- as a stroke
2 center, it has people on call 24/7, makes itself available
3 for the radiologic interpretation of the CT scan. As soon
4 as it's done in the community hospital. Someone reads it
5 remotely, and they say, "Oh, this is a problem. There's no
6 hemorrhage. We can drop TPA and ship the patient to the
7 center." So it's a whole arborization of services that are
8 incurred.

9 But the stroke center usually doesn't have a
10 requirement that you know what the payment structure is
11 like. It could be no insurance at all. So it depends on
12 where you're located, but the requirement to be a stroke
13 center, it doesn't have anything to do with geography. It
14 is the resources that the facility says, "I have these
15 resources. We need this to serve our community." So it
16 can vary anywhere in the country. There's some places
17 where it's available because the resources of the tertiary
18 center has the availability of those resources, and they're
19 on for 24/7 but not just for one entity, but for many. And
20 the small hospital might be one that says we would like to
21 tie into this, and we want a clinical affiliation. And so
22 they would have to be able to have the connection in terms

1 of being able to have someone to do a CT really quickly and
2 be able to be available to say, "Okay. Administer TPA,"
3 that kind of thing.

4 The variation in the clinical infrastructure
5 changes, depending on where you are. So there's not a
6 mandate. There is a need to meet community needs so people
7 will rise to that occasion based on the resources that they
8 have.

9 DR. CROSSON: Okay. Warner.

10 MR. THOMAS: I guess one question I have is it
11 seems like you're making an assumption. You're concerned
12 about the increase in utilization and cost. I mean, what
13 do we do today to impact utilization just in offices? Why
14 do you think this is more susceptible to a cost run-up or
15 utilization challenge than just general visits, which there
16 is really on control of today?

17 MR. GAUMER: I think the argument that's made for
18 this, for this being higher potential for misuse, is the
19 concept of convenience and just having more access, easier
20 access, especially with DTC where you can pick up your
21 telephone, connect with your physician's office.

22 I think generally there's concern that some folks

1 will just overuse this service or that providers will
2 connect with patients maybe when they're not needing the
3 service. So that's what I'd say.

4 There are some things in place in the Medicare
5 program, some limitations for just standard office visits
6 that do apply to telehealth. For example -- and I'll be
7 very general here, and the physician crowd over here will
8 probably say I'm wrong to a certain degree. But you cannot
9 have more than one office visit, just a standard office
10 visit per day under Medicare. There's a limitation on
11 that. So the same limitation applies to telehealth
12 currently and would, if they just decided to expand this to
13 urban.

14 So I don't know if that answers your question
15 completely, but the convenience thing is why, the fear.

16 MR. THOMAS: So is there a concern that someone
17 will essentially have a telehealth visit and still have an
18 office visit or -- or it sounds like really the concern is
19 multiple -- just multiple telehealth visits, you know,
20 potentially even same day or, you know, just that a
21 potential recipient, Medicare recipient may just try to
22 over-utilize from that perspective. Is that the thinking?

1 MR. GAUMER: I think that there is that, and
2 there is concern that folks may do both, in person and the
3 televisit, have a televisit. The problem may or may not be
4 solved. Therefore, the patient may have to go in and see
5 the doc face-to-face. That's the other side of the
6 concern. So it may generate other visits is the argument.

7 DR. CROSSON: Pat.

8 MS. WANG: Going back to the discussion of
9 telestroke, because each of these modalities is really very
10 different, I think, but going back to telestroke, I have
11 the impression that telestroke is, borne out by your paper,
12 used by many, in many different areas beyond rural, and I
13 guess if the question on the table for telestroke is
14 physician fee schedule payment as Kathy articulated, is
15 there evidence that the current lack of physician fee
16 schedule payment for telehealth consults outside of these
17 rural areas has constrained the availability of use of that
18 service?

19 MR. GAUMER: I think we have not heard that from
20 beneficiary groups. We didn't hear that, I think, in the
21 beneficiary focus groups that we did. So we have not seen
22 or heard that argument.

1 MS. WANG: I guess what I'm getting at is for
2 different kinds of telehealth services, there are different
3 ways of obtaining those services, other than fee schedule
4 billing. Sometimes they are contractual arrangements with
5 a vendor type of entity that will supply, and so it's a
6 different payment mechanisms, perhaps.

7 So on telestroke in particular, which I think
8 everybody recognizes is quite valuable and important, I
9 just am curious whether in an urban area, for example,
10 hospitals or others, ambulances that are employing
11 telestroke effectively have complained or feel like, well,
12 if we don't get physician fee schedule, specific payment
13 for telehealth, we have to stop doing this, or we would
14 make it more -- it seems like it's happening somehow.

15 MS. PHILLIPS: Yeah. Everyone we talked to said
16 they were implementing these programs irregardless if they
17 were going to get payment from Medicare or insurance
18 companies. Some said they were starting to get commercial
19 payments. Some said as long as they had a certain number
20 of telestroke visits a month, it paid for itself in the
21 other savings. And so people are saying this is something
22 they believe in to do, regardless of if they were going to

1 get payment. No one expressed that they were going to stop
2 if they didn't get payment in the next year or anything
3 like that.

4 DR. CROSSON: Paul.

5 DR. GINSBURG: I wouldn't be surprised if the
6 telestroke centers have to compensate the neurologist. So
7 if the neurologist is not getting payment from Medicare,
8 the center does it, but as they're saying, it's worth it.

9 DR. CROSSON: Warner.

10 MR. THOMAS: Just on this comment or on this
11 issue. So we have 65 hospitals on a telestroke network.
12 We get whatever minimal payment from Medicare. It's an
13 amazing service that I think people need to -- I would
14 encourage you to look at this more because essentially what
15 happens here is if someone doesn't get this TPA or gets it
16 inappropriately, as you know, that's pretty bad, and if
17 they don't get the TPA, essentially the cost of the program
18 with a negative outcome on that stroke is significant.

19 So I would really just encourage us to make sure
20 we fully understand that before we kind of pass judgment on
21 these programs because they're critically important. I
22 mean, I'm sure you see it in your area, so --

1 DR. CROSSON: Okay. Jack, Pat, and we're going
2 to have to move on to the discussion soon.

3 DR. HOADLEY: Yeah. I was looking at the
4 conclusion on implications for policymaking, and I think
5 I've got this right. Where you talk about CMMI testing,
6 that's something that wouldn't require any kind of
7 statutory measure. They've got the full authority to do
8 that.

9 With the other areas -- so for something like
10 telestroke, if somebody wanted to read this and say, well,
11 we really need to move forward and broaden the telestroke
12 coverage, to just do that would take a statutory
13 adjustment?

14 MR. GAUMER: Yes. It's written into statute now
15 that rural-originating sites are permitted and urban is
16 not. So they would have to change law.

17 DR. HOADLEY: And do you anticipate or did you
18 think about any way that Congress could sort of write
19 something more along the lines of our principles, give CMS
20 authority to add things if it met a set of principles that
21 might look something like what we're setting? Is that also
22 a possibility?

1 MR. GAUMER: I imagine it could be.

2 DR. HOADLEY: Yeah. Okay.

3 DR. CROSSON: Pat.

4 [No response.]

5 DR. CROSSON: Okay. So what I'd like to do now
6 is have a round, and we are a little behind, but
7 nevertheless, I think this is the opportunity to give final
8 thoughts to the authors here who are going to prepare this
9 report for delivery to Congress in March.

10 So we'll start with Brian.

11 DR. DeBUSK: Well, first of all, congratulations
12 on a really well-written report. I mean, it's a good read,
13 very informative.

14 On Chart 3 -- and I promise this isn't a Round 1
15 question. It's a legitimate Round 2. I held it for that
16 reason. You know, the third part of our mandate speaks to
17 ways in which telehealth services covered under private
18 insurance plans might be incorporated into the Medicare
19 fee-for-service program. I love the research that we've
20 done, that you've done, and I really like the examples.
21 You have a table on page 45 that actually lays those
22 examples out.

1 I realize this homework assignment has to be
2 turned in real soon. So I was even nervous about even
3 mentioning this, but did we stop just a little bit short of
4 what they may be asking for? And this is an honest
5 question. This isn't rhetorical.

6 I almost wonder if they wanted us to be a little
7 bit more prescriptive in saying here's a pool of things --
8 not just telestroke, for example -- here are a pool of
9 things that we consider very low risk that maybe you should
10 encourage CMS to adopt, again, along the lines that you've
11 done. But did we pull up and stop just a little bit short
12 of giving them something? Is there a risk that a
13 policymaker could read this and say, "So what am I supposed
14 to do?"

15 DR. MATHEWS: So, Brian, if you don't mind, I'll
16 take a stab at answering that. If anyone has to take the
17 fall for misinterpreting congressional intent, it should be
18 me rather than the staff.

19 But you are correct. In addition to the
20 statutory language of the mandate, there was a sense of the
21 Congress language underneath the mandate that said exactly
22 what you're saying. There was a presumption that Medicare

1 should be doing more telehealth, and MedPAC should look for
2 ways to try and facilitate the importation of commercial
3 practices into Medicare.

4 The problem that we found ourselves facing was
5 that when we looked at private plans coverage -- and I
6 think we looked at 48 different plans offered by 40
7 different managed care and commercial payer entities --
8 beyond things like face-to-face -- or the equivalent of
9 face-to-face visits, the telehealth equivalent of E&M
10 visits, we found a lot of heterogeneity in terms of what
11 types of modalities private plans covered, limitations that
12 they would impose on the use, a lot of heterogeneity in
13 terms of cost sharing that they would impose. Some had
14 cost sharing equivalent to face-to-face visits. Others
15 said, "You're going to pay full freight for the
16 intervention. Feel free to use." And the motivations for
17 private-sector coverage were different than what might
18 motivate the Medicare program.

19 I'll get to the punchline here. We did not find
20 a very clear-cut set of examples that could be imported
21 lock, stock, and barrel into the Medicare program, and so
22 we felt the best we could was come up with a set of

1 principles so that if something out in the environment did
2 have potential to be brought into Medicare, here is a
3 structure by which you would be able to evaluate that.

4 DR. DeBUSK: First of all, thank you. That's
5 perfect. So what we're really saying is that we can't --
6 we've answered the question as best we can because Mandate
7 3 says it's within the context of what we see in commercial
8 -- or private insurance plans or commercial plans. Perhaps
9 then if they re-ask the question for MedPAC to develop a
10 road map for telemedicine adoption, that would be maybe
11 step two.

12 DR. MATHEWS: Potentially, yes.

13 DR. CROSSON: Kathy and then Jack.

14 MS. BUTO: Just two things. One is just kind of
15 an observation. The cost, access, and quality criteria are
16 really good ones, the principles that you've laid out. But
17 I did notice that under cost, most of our examples are cost
18 increasing. So, yes, we ought to consider cost or it ought
19 to be considered, but I think what you're acknowledging
20 here is that a lot of telemedicine is about increasing
21 access through other means rather than reducing costs by
22 some kind of substitution.

1 So the impression I didn't want to leave in the
2 report is that cost reduction should be an important
3 criterion for moving forward on telehealth because I think
4 -- my recollection of the history of this has always been
5 it was an effort to figure out how to improve access for
6 services that were critical.

7 So, yes, we ought to look for cost reducing, but
8 that's not the compelling issue, and you do lead with cost
9 as the criterion. So that's sort of what got me thinking
10 about this.

11 The other thing is -- and I think I brought this
12 up last time -- I think we acknowledge that MA plans, along
13 with hospitals under DRGs, should have greater flexibility
14 because of the fixed payment to use telehealth services.
15 And I think the stroke example was a good one where many
16 hospitals are doing that.

17 But I keep seeing in the text references to
18 either in terms of, quote-unquote, expansion of telehealth
19 in MA plan coverage, that either it'll be done through a
20 supplemental or potentially included in the original bid.
21 I think they have as much flexibility as a hospital does
22 under DRGs to substitute whenever they want to. That

1 doesn't really come across. So if that's what we -- if
2 we're clear about that, I think we need to be clear about
3 that, because our narrative really just goes into there are
4 these two avenues, and I think an important other avenue is
5 they're MA plans. The idea was to allow them the
6 flexibility, because they're accountable for quality and
7 access, to make these substitutions. So if we could weave
8 that in a bit more, I think it would be a stronger message.

9 And then I guess the last thing -- and this is a
10 point Paul mentioned at some point -- is I actually think
11 we are teetering on the edge of a couple of
12 recommendations, Jim, and one of them is around telestroke.
13 And you sort of point out that, you know, this is not an
14 area that's really subject to a lot of abuse. Yes, there's
15 always the issue of, well, gosh -- Warner mentioned this --
16 hospitals are already doing this. Why should Medicare pay
17 extra? Well, I think Medicare's responsibility is to pay
18 for services that it ought to be paying for.

19 So I would just raise that question of aren't we
20 just teetering on that one and then, you know, anything
21 else in the flexibility area could be stated strongly in a
22 recommendation that, whether it's MA plans or two-sided

1 risk ACOs, where we really feel strongly there ought to be
2 the kind of flexibility, urban and rural, to use these
3 services. I see that we're there in the narrative, but we
4 don't go that last step, as Brian was saying, of going
5 ahead and, you know, making the recommendations.

6 So just a couple of thoughts.

7 DR. CROSSON: Thank you. Jack.

8 DR. HOADLEY: I was going to play directly off of
9 what this discussion has been, but it also relates to the
10 question I asked. But in the very last paragraph in the
11 chapter under implications, you know, we make some
12 statements. We talk about the cost, quality, and access,
13 and we say when the evidence is sufficiently compelling,
14 policymakers should consider implementing these services.
15 So that's the amount to which we get up to that edge.

16 But I wonder if that sentence could be followed
17 with a "for example." I mean, we're not presumably going
18 to move to a formal recommendation because we haven't gone
19 through the procedural stuff to do that. But we could take
20 it one step closer to that edge, to use Kathy's phrase, by
21 saying, "for example, telestroke," blah, blah, blah, you
22 know, "seems to meet this." We still don't have to say

1 "should." We could still say "could." But we could put --
2 and the other one that has clear evidence we haven't been
3 talking about today, but, you know, if we felt like -- or
4 maybe the telestroke is the cleanest one, but using that as
5 an example there. And then, similarly, you know, maybe in
6 the next sentence or two beyond that, it talks about the
7 CMMI should consider -- and there we do so say "should" --
8 conduct more testing. Again, maybe even just building in
9 one or two of those examples to make it a little more
10 concrete and come a little closer to being instructive,
11 even while phrasing it in terms of "for example" so we're
12 not sort of at that bold pace level.

13 DR. CROSSON: Could I just see the hands here
14 again? Because I think I missed -- I've got Pat, Paul,
15 Alice, Bruce, Warner, Rita, David. Okay. Let's go down
16 that way and come back up this way.

17 MS. WANG: Sort of picking up on Kathy's point
18 about cost, I think that the -- what we're really talking
19 about here is cost effectiveness. So in a capitated
20 environment, in an MA plan, within a DRG system, telehealth
21 has tremendous -- telehealth in general has tremendous
22 potential to improve quality outcomes, beneficiary

1 experience. The issue, I think, that we're afraid of is
2 that it will be cost inflationary without an offsetting
3 benefit in improvement in outcomes, effectiveness, quality
4 of life, et cetera. We don't want to create a low-value
5 telehealth benefit, right? That's what people are
6 concerned about. So that's why I feel like in the --
7 certainly in the more sort of global budget environment,
8 whether it's an ACO kind of situation or an MA situation or
9 a DRG, there is less concern because, by definition, there
10 are constraints. And so what we're really talking about
11 here is fee-for-service.

12 I would just encourage us to think about -- and
13 so to echo the point, in an environment when somebody is at
14 risk for needing to show sort of an ROI on using a
15 different modality that may cost something, you know, it
16 has to result in a better outcome, basically, to continue
17 doing it.

18 And my question earlier about telestroke and the
19 availability of telestroke was not to say that I don't
20 think it's valuable. I think it's very valuable. The
21 question is kind of don't fix it if it ain't broke. If
22 folks are feeling like it's worthwhile to do it, even

1 without a private fee-for-service or a physician fee-for-
2 service payment on the other end, they've already kind of
3 figured out because it results in a more cost-effective
4 approach to treating stroke.

5 So I would urge us to kind of maybe -- it's not
6 specifically reducing cost. You know, I talk a lot about
7 total cost of care. I know that's difficult to get at in a
8 fee-for-service environment, but I do think that that is
9 kind of the measure that we should be using.

10 DR. CROSSON: Paul.

11 DR. GINSBURG: Yes. First, let me repeat this.
12 This is a really good report. I thought it was very
13 focused and very nuanced and very thorough.

14 I think one of the main contributions the report
15 has is showing how the experience of commercial insurers is
16 far less relevant in this sphere than it might often be for
17 Medicare because the employer's motivations are different,
18 including keeping people at the work site saving them time,
19 doesn't come up here.

20 I also felt, as I stated before, that I think
21 there is some opportunities to be a little more forceful in
22 the policy recommendation area without taking a formal

1 vote. I actually thought that I really was concerned about
2 Medicare Advantage being constrained by having to put this
3 in as a supplemental benefit. And the possible principle
4 that we could propose is that where a service appears to
5 have potential to reduce costs, that should clearly be in
6 the bid, not as a supplement, and that supplements should
7 be reserved for things where it looks predominantly to
8 increase patients' convenience, because that could be seen
9 as something extra.

10 And we probably can't get into it, but, you know,
11 the notion that legislation says that you can be paid for
12 telestroke in a rural area and not an urban area, Medicare
13 has to get away from this type of micromanagement. So kind
14 of a broad theme is that, you know, if this is going to be
15 a very nuanced area, some services are going to be
16 worthwhile, some are not. This just has to be delegated to
17 CMS to work through.

18 DR. CROSSON: Thank you. Dana.

19 DR. SAFRAN: So one of the things that strikes me
20 is a kind of irony about worrying about the cost
21 inflationary nature of this, and that's deserved. We worry
22 about it, too, on the commercial side, and we've had some

1 conversations about that along the process here. But as we
2 think about all of the things that are introduced as new
3 treatments, new technologies in Medicare all the time,
4 there's a part of this conversation that's making me think,
5 you know, why are we thinking about this one so differently
6 from all the other things that get added year after year
7 that we know are going to be cost inflationary?

8 And so there are things that are different about
9 this, and, you know, in one case we think it could improve
10 access, and/or it could create a substitution effect that,
11 frankly, with the rest of what we've been talking about
12 over the last two days, we want to encourage, you know,
13 calling to mind a clinician calls it "breaking the tyranny
14 of the office visit," right? Or, you know, just building-
15 centered care, right? Moving away from that, we want to
16 encourage it.

17 So I guess for me I'd like to see us find a way
18 to encourage that these modalities could improve access and
19 quality, including quality of life. We have to be mindful
20 of cost, and that we should, therefore, be monitoring those
21 three elements that you frame up as principles as these are
22 implemented to be sure that it's having the desired effect.

1 But this kind of treatment of it as something that we have
2 to be afraid of introducing because it could be cost
3 inflationary, I understand; but, on the other hand, we
4 don't do that with anything else.

5 DR. CROSSON: Okay. Alice is next.

6 DR. COOMBS: First of all, it's an excellent
7 report, and I think, Zach, Amy, and Andrew, you guys got it
8 right. And, Amy, you said something that was really
9 important in that this progression of telestroke, the
10 availability of it is proceeding because of the need to
11 meet community needs. And I think that's the most
12 important piece of this, is that hospitals, community
13 hospitals, providers are actually already there, and I
14 think we're not in the infancy of this whole process with
15 telestroke. We're actually far along. And because of
16 that, I really feel that it's part of the duty of the
17 institution to help meet the needs of the community, and
18 they're doing it already.

19 So I think we're right at the right place. I
20 wouldn't go any farther with a starter recommendation. I
21 would wait to see what other literature there is along the
22 lines of the distribution of telestroke centers. We know

1 geographically, I think, there are so many studies that
2 look at the Stroke Belt, and if you looked at the Stroke
3 Belt and telestroke didn't go with the Stroke Belt, then
4 you'd say, okay, there's some major problems with access.
5 But that would be one thing that CMMI could do, is actually
6 look at the distribution and determine whether or not the
7 demand is adequate -- the supply is adequate for the
8 demand.

9 But I think you guys got it right. This is a
10 really difficult field because the potential for dire
11 consequences is enormous, and I've seen people who've
12 gotten tPA, the \$11,000 drug, and actually have a
13 hemorrhagic event whereby they went from maybe being
14 cadaveric in an arm and a leg and all of a sudden they're
15 in a severe vegetative state because of a bleed on top of
16 that. So it requires a lot of expertise. No way in the
17 world would I ever want it to be expanded beyond what the
18 clinical services are available to really make sure it's a
19 good program. But, you know, there's 800,000 strokes a
20 year, and, you know, it's the leading cause of death
21 amongst beneficiaries. But I think right now people are
22 trying to get to the place where they develop a good stroke

1 service, and I think this is one of the areas where it's
2 really important that we stay right there in terms of
3 studying the supply and demand.

4 So I think that I like the report. I like where
5 it is. I do not think that MAs should get a special
6 inclusion of this in their bids. I think that that's part
7 of the duty of a plan.

8 DR. CROSSON: Okay. Coming up this way -- I'm
9 sorry, Bruce. I didn't see your hand.

10 MR. PYENSON: Thank you. I like the report as it
11 is and would suggest a couple of thoughts for the next
12 cycle if the Commissioners agree with pursuing this.

13 I'm concerned that some elements of what we think
14 of as telehealth are really pretty old technology, and I
15 can remember companies selling transtelephonic EKG services
16 in the 1980s, and if you think of the pace of technology
17 change and what that would mean for price and cost, so the
18 venture capital that's pouring into telehealth perhaps
19 looks at office visit fees, but envisions servicing that
20 with physicians without a practice expense, or maybe even
21 without a malpractice expense.

22 So the trade-off with telehealth, since we're

1 jumping heavily into a fast-moving new technology
2 structure, should be a dramatically reduced set of fees for
3 many of the services. So I think -- that's my hypothesis,
4 but I think if that's the sort of direction we're going in,
5 I think that deserves a look in the next cycle. But I'm
6 very happy with the report as it stands.

7 DR. CROSSON: Thank you. I think I saw Warner
8 first.

9 MR. THOMAS: Yeah, I think it's a really
10 important topic, and I think it does a good job in the
11 report. I would just encourage us -- and I agree with many
12 of Dana's comments that, I mean, this is a technology that
13 is critically important for access. I feel like we're
14 having a little bit of the Blockbuster-Netflix discussion
15 here, and so, you know, I think if a patient is taken care
16 of via telemedicine and they're satisfied and taken care
17 of, they're probably not going to get in the car and go
18 down to the physician's office.

19 So I think we need to facilitate and support
20 this, and I think especially in rural areas or -- and I'll
21 tell you, there's relative urban areas that don't have
22 appropriate stroke capability. And to be able to connect

1 with the appropriate people, going to Alice's point, has a
2 significant positive impact on patients.

3 So I would encourage us to facilitate and
4 accelerate this and support this. It may have some short-
5 term cost impact. I'm not sure. But I think this is
6 something we should bet on, and it's a potential service
7 that could really help beneficiaries and I believe over
8 time can have a cost reduction impact. But I don't think
9 that should necessarily be the leading indicator for
10 whether we add every single service. I think this is just
11 something that will facilitate better access to care, and,
12 frankly, the reason we have a lot of cost issues in the
13 program is because people don't have timely, appropriate,
14 preventative access to care and then we deal with things on
15 the back end. So I think this may help mitigate some of
16 those issues.

17 DR. CROSSON: Thank you. Rita.

18 DR. REDBERG: Thank you. I first want to
19 compliment you. The report was really excellent. It's a
20 very complex area and you really, I think, had a great
21 organization and clearly put a lot of work and talked to a
22 lot of people.

1 I will say, though, I don't agree -- I mean, I
2 don't think our problem in Medicare about cost is all
3 because of not access, and I actually think a lot of our
4 access indicators are really good. I think a lot more of
5 our problems are related to fee for service and
6 inappropriate services. You know, I want access to things
7 that are helping our beneficiaries. But fee for service,
8 you know, paying for things that have never been shown to
9 help our beneficiaries and are harming them is, I think,
10 what's really driving up our costs.

11 And when Bruce mentions that venture capital is
12 pouring into telehealth, one has to think that they're
13 seeing a lot of money from Medicare coming into this area
14 and that, you know, should raise some red flags, I think.

15 You know, I think you laid it out very nicely in
16 terms of the evidence, and as we were talking about with
17 telestroke, if there's good evidence that's great, but I
18 think having Medicare coverage get out ahead of the
19 evidence is going to be something that we're going to
20 regret, and it's very -- it's always hard to pull back once
21 Medicare has started paying for things. So I don't think
22 the argument that, well, we pay for everything else so

1 let's start paying for this is a good reason to start doing
2 things. I think we should apply the, you know, principles
3 of, is this going to improve our beneficiaries' health.

4 And because as you laid out very carefully,
5 telehealth is a lot of different things, and, you know,
6 some of them -- it really depends on what the alternative
7 is. You know, if the alternative is something that, you
8 know, this person wouldn't have gotten care and this is
9 going to be an improvement, that's great. But if that's
10 not what the alternative is, or it's an add-on or it's not
11 useful, that is not a good thing, and we really need to
12 have the evidence.

13 If we just start paying, particularly as you laid
14 out in a fee for service system, we're not going to get the
15 evidence and we're going to end up, you know, with
16 something that may not be good at all for beneficiaries,
17 and clearly is going to be very costly. That's different
18 in a capitated system, and I think we were talking about
19 that, where then, you know, you are going to be focused on
20 outcomes and what you're putting in and what you're getting
21 out.

22 And the last thing I just wanted to say is, you

1 know, for some -- I mean, maybe I'm old-fashioned but some
2 things are better face-to-face, and particularly for our
3 elderly patients. I mean, I don't know that everyone --
4 there are people, if you're -- certainly if you're an
5 employee, you're going to work, you're rushing around.
6 You'd rather go, you know, have a phone call if that's the
7 -- going through a place in offices, and lots of people do
8 that, and I don't think this -- but there also is value for
9 a face-to-face visit, and, you know, I don't -- I think
10 there is potential for telehealth, and great potential in
11 circumstances. But I think the way you laid it out in the
12 chapter, in terms of the evidence and looking at the type
13 of systems, is really the way to go.

14 DR. CROSSON: Okay. David.

15 DR. GRABOWSKI: Great. Thanks. Once again, this
16 was a great chapter. Zach, I wanted to pick up on a word
17 you used, "convenience," because I actually think in fee
18 for service convenience is both telehealth's greatest
19 selling point but also its greatest challenge, in that for
20 certain service it can really open up the floodgates. And
21 for that reason, I really like the framework you've set up.
22 We want to think about -- not just think about cost. We

1 also want to think about cost in the context of quality and
2 access. It's really a value construct.

3 And I think we want to cover telehealth in fee
4 for service, in those instances where there's high value,
5 and obviously not in those instances where there's not
6 value there. And I think that's a very simple construct,
7 and I think that's what you were trying to get at with the
8 framework, of thinking about not just spending but spending
9 in the context of quality and access. In a kind of ACO
10 risk-based framework or in MA, let them cover it, but in
11 fee for service, I think we want to be really thoughtful
12 here about the evidence and what it says in terms of value.
13 Thanks.

14 DR. CROSSON: Thank you. Sue and then Jon.

15 MS. THOMPSON: I'll be quick. Again, thank you.
16 The report frequently cites lack of evidence. It's tough
17 to study something that we have been so restricting. So I
18 just strongly support the chapter. I strongly support
19 continuing to work with CMMI to study what we can. This
20 has great application in our value-based environments. And
21 so, you know, go forward, do great work with us.

22 DR. CROSSON: Thank you. Jon.

1 DR. CHRISTIANSON: Yeah, I agree with Alice and
2 Sue, and I think the chapter is where it should be right
3 now, and that we are where we should be.

4 I do have a question in terms of the framework,
5 to follow up what you said. So in describing the framework
6 you used phrases like "incorporating in the Medicare
7 program," that the chapter is all about -- mostly about
8 coverage. So I'm not sure whether incorporating in the
9 Medicare program in your framework means finding ways to
10 cover or whether it means something else.

11 And then the framework starts out by saying
12 telehealth should reduce costs, and so forth. Is what
13 we're looking for in the framework what telehealth should
14 do in these areas or what coverage for telehealth should be
15 about for Medicare? And I think those are very different
16 things, and so I think when we think about this framework
17 we need to be careful in terms of laying this out. I
18 believe that if somebody gets to this point in the chapter
19 their mind is going to be about coverage.

20 DR. CROSSON: Okay. Thank you. Good discussion.
21 I'm not going to try to summarize it. I think we're not
22 heading towards a point decision here. You've got good

1 support for the report. I think you've had a number of
2 suggestions for maybe some added emphasis, and we will look
3 forward to your final report. Thank you so much.

4 DR. MATHEWS: Do you want a show of hands vote
5 for the report?

6 DR. CROSSON: If you'd like. Yeah. So, sorry.
7 This is not a formal vote but sometimes when we do reports,
8 Jim reminded me, we do an informal show of hands for
9 support for the report, so I'd like to do that now.

10 All Commissioners supporting the report as it
11 will be revised please raise your hand.

12 [Show of hands.]

13 DR. CROSSON: Thank you. All opposed?

14 [No response.]

15 DR. CROSSON: Abstentions?

16 [No response.]

17 DR. CROSSON: We have unanimous support for the
18 report. Thanks very much Andrew, Amy, Zach. We will head
19 on to the next topic.

20 [Pause.]

21 Okay. I think we can move forward with the next
22 presentation and discussion. We're going to come back to

1 our discussion which has been going on for a number of
2 years now, with respect to the fee schedule, particularly
3 with respect to balance among specialties. And Ariel and
4 Kevin are here to take us through that discussion.

5 MR. WINTER: Good morning. Today, we will be
6 talking about rebalancing Medicare's physician fee schedule
7 towards ambulatory evaluation and management services.
8 This is a follow-up to a presentation we gave at the
9 November meeting, and we expect to include this work as a
10 chapter in the June report.

11 During your discussion at the November meeting,
12 it became clear that are dealing -- we are trying to
13 address two separate issues. The first issue is that the
14 fee schedule underprices ambulatory E&M services relative
15 to other services. An example of an ambulatory E&M service
16 is an office or outpatient visit. Today we will be
17 discussing a policy option to increase payment rates for
18 these services when they are provided by any clinician.

19 The second issue relates to primary care, and
20 concerns about whether the fee schedule is well-designed to
21 support primary care services and clinicians. We will
22 describe a policy option there for a special payment for

1 primary care clinicians. If you are interested in pursuing
2 this option, we could develop it further in future
3 meetings.

4 I want to note up front that we modeled the
5 impact of each policy option in isolation. We did not
6 model the combined effects of both options.

7 Our work on these issues is part of a broader
8 agenda on clinician payment policy. Yesterday, as well as
9 last month, we presented our annual assessment of payment
10 adequacy for physician and other health professional
11 services, and you approved an update recommendation for
12 2019. Yesterday, you also approved a recommendation to
13 repeal MIPS and establish a new voluntary value program.

14 We have also done work on advanced alternative
15 payment models and ACOs, which will be presented right
16 after this session.

17 The fee schedule underprices ambulatory E&M
18 services relative to other services. Payment rates for
19 clinician work are based on estimates of the relative
20 amount of time and intensity required for each service.
21 E&M services are labor intensive. A clinician takes the
22 patient's history, examines the patient, engages in medical

1 decision-making, and so forth. These activities do not
2 lend themselves to reductions in the time it takes to
3 provide the visit.

4 By contrast, the time needed for other services,
5 such as procedures, often declines over time due to
6 productivity gains and changes in clinical practice and
7 technology. Ideally, the prices for these services would
8 also be reduced to reflect these efficiency gains.

9 Because the fee schedule is budget neutral, a
10 reduction in the prices of these services would raise
11 prices for ambulatory E&M visits. But this two-step
12 sequence often does not occur, which means that payment
13 rates for ambulatory E&M visits are too low relative to
14 other services. The Commission has called this problem
15 "passive devaluation."

16 This slide illustrates the extent to which
17 certain services have become overpriced. We hired a
18 contractor in 2014, to compare the actual number of hours
19 worked with the number of hours assumed in the fee schedule
20 for services provided by clinicians in four practice
21 groups: cardiology, family practice, orthopedics, and
22 urology. If a physician actually worked 10 hours per day,

1 but the fee schedule assumed that the services provided by
2 that physician take 15 hours, this difference implies that
3 the time estimates in the fee schedule are too high.

4 The contractor's study found that the hours
5 assumed in the fee schedule exceeded actual hours worked
6 for physicians in all four practices. However, the
7 discrepancy was much greater for the practices that focus
8 on procedures, which suggests that the services they
9 provide may be based on inflated time estimates. For
10 example, the hours assumed in the fee schedule were 24
11 percent higher than actual hours worked for family
12 practice, but 64 percent higher in cardiology, and 92
13 percent higher in orthopedics.

14 Since 2008, CMS has reviewed many potentially
15 mispriced codes, but we believe the process has not been
16 sufficient. Although the review process has been going on
17 for several years, many services have not yet been
18 reviewed. These unreviewed services account for 35% of fee
19 schedule spending. Even for services that CMS reviewed and
20 reduced their work RVUs, the RVUs did not decline as much
21 as might be expected, given the decline in the amount of
22 time that it takes to provide the services.

1 From 2008 to 2016, CMS decreased the work RVUs,
2 the time estimates, or both, for 607 services. The time
3 estimates for these services decreased by an average of 18
4 percent, but the work RVUs decreased by an average of 9
5 percent. A potential explanation for this disparity is
6 that decreases in time were partially offset by increases
7 in intensity.

8 Prior incremental efforts to address the relative
9 underpricing of ambulatory E&M services have not succeeded
10 in rebalancing the fee schedule. Therefore, the Commission
11 may wish to consider more significant changes.

12 Based on your discussion from the November
13 meeting, we are presenting an option to increase payment
14 rates for ambulatory E&M and psychiatric services by 10
15 percent when they are billed by any clinician, regardless
16 of specialty. This option recognizes that many specialties
17 provide ambulatory E&M services and are affected by the
18 underpricing of these services.

19 This option would increase total spending for
20 these services by about \$2.7 billion. To maintain budget
21 neutrality, payment rates for all other services would be
22 reduced by 4.5 percent.

1 The E&M services included in a payment rate
2 increase are E&M codes for office visits, home visits, and
3 visits to patients in long-term care settings; chronic care
4 management and transitional care management codes; and
5 Welcome to Medicare visits and annual wellness visits.

6 The payment increase would also apply to
7 psychiatric services, which include psychiatric diagnostic
8 evaluation and psychotherapy. We included these services
9 because of concerns about beneficiaries' access to
10 behavioral health care. Also, the psychotherapy codes are
11 based on the amount of time spent with a patient, which
12 makes it difficult to improve productivity.

13 A question for you to discuss is whether we
14 should include Welcome to Medicare and annual wellness
15 visits in the payment increase. Both Choosing Wisely and
16 the U.S. Preventive Services Task Force recommended against
17 annual general health checkups.

18 In addition, we have heard from ACOs and
19 physicians in our focus groups that third-party companies
20 sometimes provide annual wellness visits to beneficiaries,
21 during which they recommend unnecessary tests. Also, the
22 beneficiary's primary care clinician is unable to bill for

1 a wellness visit during that year if a third-party company
2 has already billed Medicare for one for the same patient.

3 We modeled the net effect of a 10 percent
4 increase to payment rates for ambulatory E&M and
5 psychiatric services, and a 4.5 percent decrease to the
6 rates for all other services to maintain budget neutrality,
7 and here we show the specialties that would have the
8 greatest net increase in their fee schedule payments.

9 The top three specialties are licensed clinical
10 social workers, which would have payment rates going up by
11 10 percent, clinical psychologist, by 8 percent, and
12 endocrinology, which would increase by 6.5 percent.

13 It's important to note that LCSWs are paid 75
14 percent of the full fee schedule amount.

15 In the last row, you will see internal medicine,
16 which would have a net increase of only 2 percent. That is
17 because this specialty performs a lot of services other
18 than ambulatory E&M, and the rates for those services would
19 drop by 4.5 percent.

20 Later on, we'll talk about a targeted payment to
21 support primary care clinicians, and this table does not
22 show the effects of such a payment.

1 We also looked at which specialties would account
2 for the largest share of the total payment increase across
3 all specialties, and this is shown in the second column.
4 Internal medicine would account for 18 percent of the total
5 increase, or \$493 million, and family practice would
6 account for about 16 percent of the total increase, \$423
7 million. Taken together, all the primary care specialties
8 would account for 45 percent of the total increase, or \$1.2
9 billion.

10 Several specialties, not shown on this slide,
11 would experience payment reductions of more than 4 percent
12 because they provide very few E&M or psychiatric services,
13 and these include radiology, pathology, physical therapy,
14 and occupational therapy.

15 Up until now, we've been talking about an option
16 to increase payment rates for ambulatory E&M and
17 psychiatric services when they are billed by any clinician,
18 regardless of specialty, and now we're going to switch
19 gears and talk about another topic, primary care.

20 The fee schedule is not well-designed to support
21 primary care because it is oriented towards discrete, face-
22 to-face services, while a major component of primary care

1 is ongoing, non-face-to-face care coordination. Another
2 issue is that the nature of fee-for-service payment allows
3 specialties that focus on procedures to more easily
4 increase the volume of services they provide than primary
5 care clinicians, who tend to focus on E&M services. This
6 is because it's easier to achieve productivity improvements
7 for procedures than for E&M services.

8 As we've discussed before, compensation for
9 primary care physicians is substantially less than for
10 other specialties, which could deter medical school
11 graduates and residents from pursuing primary care careers,
12 and the pipeline of future primary care physicians appears
13 to be shrinking. The share of third-year internal medicine
14 residents who planned to practice primary care dropped from
15 54 percent in 1998 to 21.5 percent in the 2009-2011
16 academic years. We note in your paper that multiple
17 factors influence physicians' specialty choices, but income
18 differences among specialties have an especially strong
19 influence.

20 The Commission has been working on primary care
21 issues for several years, and this slide lists our key
22 recommendations in this area. In 2008, for example, we

1 recommended that Congress create a budget-neutral bonus for
2 primary care services, and this eventually became the
3 Primary Care Incentive Payment program, or PCIP. In 2015,
4 we recommended that Congress establish a per-beneficiary
5 payment for primary care clinicians to replace the PCIP,
6 which ended in 2015.

7 An option for you to consider is whether to
8 establish a special, targeted payment for primary care
9 clinicians to address the concerns that we've outlined,
10 namely, that the fee schedule does not adequately support
11 care coordination activities, if compensation for primary
12 care is much less than other specialties, and the pipeline
13 of future primary care physicians is shrinking. This
14 special payment would be on top of the 10 percent increase
15 in payments for ambulatory E&M and psychiatric services
16 billed by all clinicians.

17 This is an issue that we could work on and flesh
18 out during future meetings. There would be several
19 important design issues to consider. How should eligibility
20 for a special payment be determined? Options include the
21 specialty designation, the share of payments that they
22 derive from ambulatory E&M services, or both. Should

1 clinicians from specialties besides primary care be
2 eligible for a special payment? How much money should be
3 allocated to a special payment, and where should the
4 funding come from?

5 One option would be to use the \$500 million per
6 year from the MIPS exceptional performance bonus, which
7 would be available if MIPS were repealed. But keep in mind
8 that this money is scheduled to expire after six years.
9 Another option is an across-the-board payment reduction for
10 non-ambulatory E&M services.

11 Another important question is how to distribute a
12 special payment for primary care. One option is to
13 distribute it based on the number of eligible E&M services
14 billed by a primary care clinician. This would be easier
15 for CMS to administer, but it would reward clinicians who
16 provide more discrete visits. Another option is to
17 distribute it based on the number of beneficiaries
18 attributed to each clinician, consistent with our
19 recommendation from 2015. However, a per-beneficiary
20 payment does raise questions about how to attribute
21 patients to primary care clinicians, and whether the
22 payment would need to be risk adjusted.

1 We've raised several design questions in the last
2 few slides, and the answers to those questions would affect
3 any future modeling that we might do. But to illustrate
4 the potential impact of a special payment for primary care
5 clinicians, we used a fairly simple scenario, which is
6 similar to the PCIP program. We assumed that the special
7 payment would be equal to a 10 percent increase for
8 ambulatory E&M services, and it would be provided to
9 primary care clinicians who derive at least 60 percent of
10 their fee schedule revenue from ambulatory E&M services.
11 In this scenario, the special payment would total \$1
12 billion and would be paid to about 220,000 clinicians.

13 To maintain budget neutrality, payment rates for
14 services other than ambulatory E&M services, such as
15 procedures, imaging, and tests, would be reduced by 1.7
16 percent. This reduction would be smaller if the add-on
17 were partially funded with \$500 million from the MIPS
18 exceptional performance bonus.

19 During your discussion, we'd like to get your
20 feedback on the two policy options that we talked about.
21 And this concludes our presentation, and we'd be happy to
22 take any questions.

1 DR. CHRISTIANSON: [Presiding.] Amy.

2 MS. BRICKER: Really quick clarification on Slide
3 9, the chart that lists the specialties. Which specialty
4 is nurse practitioner and physician assistant?

5 MR. WINTER: They're listed on the slide. Are
6 you asking for clarification about what subspecialties
7 might be within those?

8 MS. BRICKER: Well, nurse practitioner is just a
9 license. What is the --

10 MR. WINTER: Okay. So these are self-designated
11 by the clinician when they enroll with Medicare, so they
12 are self-reported by the clinician.

13 MS. BRICKER: So this nurse practitioner could be
14 working in the cardiology office --

15 MR. WINTER: Yes.

16 MS. BRICKER: -- or could be working in the
17 family practice office.

18 MR. WINTER: Yes. Yes, absolutely. Yes.

19 MS. BRICKER: Okay.

20 MR. WINTER: Yeah, and the same with physician
21 assistant, same thing with internal medicine, and any of
22 the other clinicians who are listed here. And that's one

1 of the weaknesses of relying on this specialty designation.
2 It's reported by the clinician when they enroll with
3 Medicare. There's no requirement for them to update it if
4 they change their practice patterns.

5 DR. REDBERG: So we don't know how many nurse
6 practitioners are working in primary care as opposed to
7 specialties or others.

8 MR. WINTER: So AHRQ did a report in 2010 where
9 they estimated that about 43 percent of PAs focused on
10 primary care and about 52 percent of NPs focus on primary
11 care. And if you look at a mix of services they provide,
12 NPs about three-quarters of their fee schedule payments are
13 for ambulatory E&M, which, you know, may or may not be
14 primary care, and for PAs it's lower. It's something like
15 in the 50 percent range.

16 DR. CHRISTIANSON: And I think Alice, you wanted
17 to get in on this question too?

18 DR. COOMBS: Yes. I was going to go straight to
19 the slide, and the reason, Ariel, is because this piece is
20 a really difficult complex and I want you to tell me, can
21 you decipher between Incident 2 billing, because some of
22 these individuals are working under the direction of a

1 physician.

2 MR. WINTER: Right.

3 DR. COOMBS: Now, they are salaried but yet the
4 office is billing under Medicare and what they -- this
5 increase that we see doesn't reflect what actually they
6 get. It's that they may be working under primary care
7 physicians. Right?

8 MR. WINTER: You are correct that if a service is
9 provided by an NP or a PA, but it's billed by the physician
10 as an Incident 2 service, that it would show up -- it would
11 be attributed to that physicians and not to the NP or PA.
12 So we have no ability to discern, based on claims, whether
13 the service was provided Incident 2, and we have suggested
14 to CMS, more than once, that they change the claim to add a
15 modifier so that we would be able to distinguish between
16 Incident 2 and other services.

17 DR. COOMBS: So this, depending on states,
18 because some states allow MPs and PAs to work without
19 collaboration or supervision, and that's okay, but this
20 graph is artificially maybe lower or higher for any of
21 these entities without us being able to appreciate that
22 specific.

1 MR. WINTER: I would say it doesn't fully capture
2 the number of services being provided by MPs or PAs, and a
3 portion of those are being billed under the physician's
4 identifier.

5 DR. CHRISTIANSON: Sorry to interrupt. I need to
6 see some hands. I've got Brian on the list. Okay. So
7 then I've got Pat and Paul. Go ahead, Brian.

8 DR. DeBUSK: Ariel, I just wanted to follow up on
9 something too. When you were commenting on Chart 9, again,
10 just to make sure I understand this, you know, there is a
11 weakness here in that they designate their primary
12 specialty when they enroll in Medicare, and there's a
13 weakness there in that it isn't necessarily accurate or
14 properly updated. But there's actually a second weakness
15 here in that we treat nurse practitioners and PAs as a
16 specialty. I mean, it's really a structural issue in the
17 data and how the data -- I mean, it's not just a matter of,
18 oh, we need to keep up with how they designate better. We
19 actually need to change the way that designation is done,
20 in that you almost need to say this is my specialty and
21 then within that specialty I am a physician or I am a PA or
22 I am a nurse practitioner. It's almost like you designate

1 to a specialty, and -- okay, I just wanted to make sure
2 that, at least in my mind, how the world should work is
3 correct, because that would be a really bad thing.

4 MR. WINTER: Yes. That level of detail or
5 refinement would be helpful for us as analysts.

6 DR. DeBUSK: Okay. And then to build on Alice's
7 point, we've been talking about Incident 2 services. That
8 is a separate but somewhat related data integrity issue,
9 and I don't think -- and to go back to Chart 9 as a
10 clarifying question -- 9? I don't have my glasses.

11 Oh, that didn't help. Chart 5 is a --

12 [Laughter.]

13 DR. DeBUSK: I need to really get my prescription
14 worked on.

15 Back to Chart 5, the fact that Incident 2
16 services to occur, I don't think that gets us a pass to
17 say, "Oh. Well, we can't trust these numbers," and I don't
18 think we're saying that at all.

19 And Incident 2 may distort some of these numbers,
20 but you see extenders used in all of these professions.
21 And I don't know that we can definitively say that they're
22 disproportionately used in any one.

1 So it's fair to say that there is some
2 contamination there, but it's spread across the spectrum of
3 specialties. It isn't just something that's lumped onto
4 one specialty.

5 DR. HAYES: Can I just clarify? On this
6 particular project, we did not allow Incident 2 billing to
7 kind of contaminate the data. In other words, we did
8 require a separation of the practitioner from the volume of
9 services, from the time spent.

10 DR. DeBUSK: Well, that's, first of all,
11 excellent. I mean, that's great.

12 But if the claim comes through and it has the
13 physician's NPI, but the actual work was done by the PA or
14 nurse practitioner but it's billed Incident 2, can we even
15 tell the difference? I don't know that we can see that in
16 the data, can we?

17 MR. WINTER: We can't.

18 DR. DeBUSK: Okay.

19 MR. WINTER: And in addition to our strong
20 suggestion to CMS that they change the claim to reflect
21 that, OIG has made the same recommendation because of
22 program integrity issues as you raised. We're not the only

1 ones saying this.

2 DR. DeBUSK: Okay. Not to belabor this, but if
3 you notice, every public meeting, we have a data integrity
4 issue, and I think making claims smarter may need to be a
5 chapter someday. That's my plug.

6 MR. WINTER: That's a good point.

7 DR. CHRISTIANSON: Good point.

8 MR. WINTER: If I could just clarify something
9 about this table, the policy option we're trying to model
10 here is would an increase in ambulatory and psychiatric
11 services, regardless of the specialty that billed for the
12 service, it would not apply to certain specialties but not
13 others. And what we're trying to do here is to show you
14 the impact by specialty because we know there have been
15 concerns about certain kinds of specialties perhaps being
16 under -- having lower compensation or perhaps access
17 concerns or pipeline concerns. That's why we're showing
18 you by specialty. The intent here is not to have the
19 policy applied differently by specialty.

20 DR. DeBUSK: Well, a corollary to that -- and
21 again, I promise I'll get off this issue -- if we go back,
22 for example, and change -- let's say we do try to do a

1 designation for nurse practitioners or PAs. We're going to
2 have to either assume their primary care or not, won't we?
3 Because we won't have the luxury of knowing their
4 specialty. I guess we'd have to base it on their E&M
5 codes, wouldn't we?

6 MR. WINTER: Right. One thing you could do --

7 DR. DeBUSK: Okay.

8 MR. WINTER: -- which is what PCIP did is to base
9 it on the share of their fee schedule revenue that are
10 derived from ambulatory E&M as a proxy.

11 DR. DeBUSK: You are a couple steps ahead of me.

12 Thank you.

13 MR. WINTER: And the same issue would apply to
14 internal medicine because many internal medicine physicians
15 so specialize.

16 DR. CHRISTIANSON: Okay. So I've got Pat, Paul,
17 and Kathy.

18 Thank you, Brian. I think we've got a new --
19 besides your points, I think we have a new potential MedPAC
20 principle, so how the world should be according to Brian.
21 It's very good.

22 [Laughter.]

1 DR. DeBUSK: It should be right there with paying
2 similar --

3 DR. CHRISTIANSON: Yeah, I think so.

4 DR. DeBUSK: -- for similar rates.

5 DR. CROSSON: It's right up there with that.
6 Yeah.

7 MS. WANG: Staying on Slide 9, can you remind me
8 why some of the cognitive specialties like neurology don't
9 show up on this list?

10 MR. WINTER: So I will look up in a second what
11 their specific impact was.

12 So what we think of as cognitive specialties,
13 they're doing -- yes, they're doing ambulatory E&M, but
14 they're also doing other services. They're doing inpatient
15 E&M. They're doing procedures, imaging, and test some of
16 them, and so those services would be reduced by 4.5
17 percent, the rates for those services.

18 For some services, you're getting an increase.
19 Other services, it's a decrease. And so for certain
20 specialties, the net effect is not large, and if you will
21 give me a moment, I'll just quickly look up -- do you want
22 me to look up neurology, or was that just an example?

1 MS. WANG: Don't take the time of the group. We
2 can follow that up later.

3 Also, I understand that Slide 9 is just showing
4 sort of like this is what it would look like and this is
5 how it falls down by specialty, but you did a good job, I
6 think, elsewhere in the material about talking about the
7 concerns around primary care physician shortages, pipeline,
8 et cetera, et cetera.

9 Do we have evidence that the non-physician
10 specialties that sort of fall out in this analysis is
11 having a lift in compensation or in similar shortage
12 situations? Applications to PA school, for example, are
13 through the roof. I'm just curious about --

14 MR. WINTER: As you pointed out, there's been an
15 increase in NP and PA students, and there's been an
16 increase, fairly substantial, in the number of NPs and PAs
17 treating Medicare beneficiaries. So it went up from, I
18 think, 3.3 per thousand beneficiaries in 2014 to 3.9 per
19 thousand beneficiaries or 3.6 per thousand beneficiaries in
20 2016. So there was a marked increase.

21 DR. CROSSON: Okay. Paul.

22 DR. GINSBURG: Actually, most of what I want to

1 say was covered by others, but I just wanted to make sure
2 we come back later to -- the full payment of a physician
3 fee under Incident 2, I think is a growing problem, and I
4 guess that's what you meant by the program integrity issue.
5 I think it's really worth some of our attention.

6 DR. CROSSON: Let's see. I've got Kathy, Warner,
7 and Jack.

8 MS. BUTO: I just wondered whether we have kind
9 of walked away from the top-down approach and gone to the
10 10 percent add-on as a way of sort of short-circuiting or
11 cutting through, cutting to the chaise, if you will, and
12 raising payments for E&M services, because I thought you
13 did a really good job of explaining how that would begin to
14 really address underpricing of services. So I'd be curious
15 just to know that.

16 DR. MATHEWS: Kathy, can you refresh my memory as
17 to what you're referring to by top down?

18 MS. BUTO: This is the approach that's laid out
19 where we look at the changes in time related to procedures,
20 and there's a growing disparity between primary care or E&M
21 services and other procedural. And I think you called it
22 the top down. Am I getting that wrong?

1 DR. HAYES: No. That's correct.

2 MS. BUTO: Maybe you can explain it better than I
3 can.

4 DR. HAYES: This slide is an illustration of how
5 the top-down approach would work. We would have
6 information on what the fee schedule estimates as the total
7 amount of time worked for all services furnished during a
8 given time period, and then we would compare that to hours
9 worked, actual hours worked for the same individual, for
10 the same individual, for the same physician, nurse
11 practitioner, PA, whoever it would be. And you would sort
12 of compare the two, and that would be an indication of
13 where in the fee schedule there might be problems. And it
14 would require a more focused look on the specific services
15 that went into accumulating into the fee-for-service time
16 and the hours worked that are shown, but it would give you
17 a starting point. The issue is that we've got 7,000 or so
18 codes in the fee schedule, and it kind of becomes a
19 question of where do you start. And so that's what this
20 kind of thing is meant to do.

21 DR. CROSSON: Just to remind people, that's in
22 distinction -- terminology is a little cumbersome. That's

1 in distinction to what we have called "bottom up," and
2 bottom up would be sort of time-in-motion studies, sending
3 somebody around to actually find out on a sample basis how
4 long it takes to do a colonoscopy, et cetera, et cetera.

5 MS. BUTO: Right. What I was trying to get at,
6 Jay, was really have we walked away from that approach and
7 moved to this 10 percent add-on to E&M services for all
8 specialties as sort of a proxy and then reducing. To me,
9 it's sort of the issue of more of a rough-cut approach
10 versus one that's based on the actual data that reflects
11 the time in performing these services, so I'm just curious.

12 MR. WINTER: I think there's a -- I'll let Paul
13 speak to this, and then I'll jump in.

14 DR. GINSBURG: Actually, I was going to say this
15 is a major issue I was going to get into in Round 2 --

16 MS. BUTO: Okay.

17 DR. GINSBURG: -- is that have we failed year
18 after year with the bottom-up approaches that now we have
19 to contemplate what some other countries have done and do
20 it top down.

21 MS. BUTO: Right. But I think they've gone yet
22 another step. Am I wrong? The 10 percent is your latest

1 version of that, which is sort of an across-the-board, not
2 a specific look at the differences in time so much as just
3 an across-the-board increase for E&M services and then a
4 reduction.

5 DR. GINSBURG: That's how I interpret it, but
6 Ariel --

7 MR. WINTER: Yes. Yeah, I think you're correct.
8 This would reflect a policy judgment that because of many
9 years of MedPAC and others making recommendations about
10 ways to improve the process and the data by which services
11 are valued and frustration that the system process and the
12 data have not improved and therefore there are still big
13 differences, there's still a significant relative
14 underpayment of E&M, ambulatory E&M relative to other
15 services, that there needs to be a different approach, sort
16 of a mechanical adjustment to make up for many years of --
17 make up for this underpricing.

18 So, ideally, the process by which we've -- the
19 process -- the change that we've recommended over the last
20 decade-plus would have addressed a lot of the over-
21 valuations that we've been seeing. But we think the
22 process has not been sufficient. The data are not there,

1 and so we're making sort of a -- we're suggesting a
2 mechanical adjustment.

3 But you could still -- we still -- I mean, one
4 way to look at it is that going forward, you still want to
5 do the things that we've been recommending, like a top-down
6 approach, improving the data, improving the process,
7 because you still need to maintain the entire system.

8 DR. CROSSON: Kathy, I just want to be clear. Is
9 what you're asking why not take the top-down data, which is
10 the data that we have? Because we found out that it's too
11 difficult and too expensive to do it bottom up, and I think
12 that's still a question, but that's the issue.

13 Why not sort of take a numerical approach based
14 upon the ratios, et cetera, et cetera? Is that the point?

15 MS. BUTO: That's exactly what I was --

16 DR. CROSSON: Yeah. Got it. Okay, thanks.

17 Warner.

18 MR. THOMAS: I just had a question, a little
19 different angle. Did we consider or look at the
20 opportunity to expand primary care-specific training
21 options, GME slot specifically around primary care? I
22 mean, I know we have capped those for many years, but the

1 idea to just target this specific area?

2 MR. WINTER: It's something we talked about in
3 our 2008 chapter. We made a recommendation for a bonus for
4 primary care clinicians. We talked about some ideas for
5 targeting GME and IME dollars to improve the supply of
6 primary care; for example, targeting some of those dollars
7 to primary care residencies specifically. And there's some
8 other ideas along those lines, but we have not really
9 discussed it since that 2008 report.

10 MR. THOMAS: And I guess based on what we know,
11 was there any work done in -- I mean, I know this is really
12 focused primarily on the economics and the payment, and I
13 think there's -- I guess the question is do we -- did we do
14 any work on pipeline as part of this? Do we have any
15 knowledge of kind of what that looks like?

16 MR. WINTER: Yeah. We talked about that in the
17 chapter in terms of the change in the number of family
18 medicine residents --

19 MR. THOMAS: Right, right.

20 MR. WINTER: -- and internal medicine residents,
21 and then we provided some data on percent, the decline in
22 the percent of internal medicine residents who say they

1 intend to pursue a primary care career.

2 MR. THOMAS: And I guess that kind of gets back
3 to my point of is there a way to think about that being
4 targeted specifically because, as we know, folks that are
5 in internal medicine, they can go in a lot of different
6 directions. So this idea of targeting -- so is there -- do
7 we have a handle on what that exact number looks like of
8 primary care-only slots?

9 MR. WINTER: Oh, in terms of residency slots?
10 I'd have to look into that.

11 DR. CHRISTIANSON: So since we made our
12 recommendation in 2008, of course, there's been a major IOM
13 report on graduate medical education, and it had some
14 recommendations about how the Medicare funding for it
15 should be redone. We probably want to try to build off of
16 that or use it as a starting place if we decided to go down
17 this path.

18 DR. CROSSON: Okay. Jack.

19 DR. HOADLEY: So I had a question on Slide 14
20 where you illustrate the special payment, and I'm just
21 trying to make sure I understand these numbers.

22 So you get 220,000 eligible clinicians by this

1 definition, and that's -- as I read this, that's people who
2 meet two criteria. One is they've got a designated primary
3 care, and second, that they meet the 60 percent payments
4 from the eligible services.

5 Do you have numbers on how many meet one but not
6 both of those criteria? So either they're getting 60
7 percent from eligible services, but they're not primary
8 care, or vice versa?

9 MR. WINTER: I feel like we had some of that
10 information for the November meeting. I don't recall it,
11 but I can get back to you with that.

12 DR. HOADLEY: Yeah. It would just be a helpful
13 context to understand, if you wanted to loosen that either
14 way, what kind of set of people were you talking about.

15 The other question I had was you talk in the
16 chapter about making the assumption and modeling the 10
17 percent increase that it would apply to all charges,
18 including beneficiary cost sharing, but that that's
19 potentially a design decision. What tradeoffs did you have
20 in mind particularly in terms of the beneficiary cost
21 sharing?

22 MR. WINTER: So if you include the beneficiary

1 cost sharing, there's more revenue to the clinicians.

2 That's sort of one upside.

3 A downside is if this payment were separated from
4 a visit, a separately billed visit, and the beneficiary
5 just got a bill in the mail for 20 bucks, 100 bucks,
6 because their clinician was getting a monthly payment from
7 a Medicare program, they might be confused. They might
8 wonder what's this about, "I didn't see the clinician last
9 month." So there's going to be some confusion.

10 And we've heard about this issue coming up with
11 the chronic care management codes, which are billed on a
12 monthly basis and are not linked to a specific visit, and
13 the beneficiaries have been confused when they get a bill
14 in the mail for the coinsurance for that. So that would be
15 a downside.

16 Another downside could be why should we ask the
17 beneficiary to pay more to address this issue with primary
18 care.

19 DR. HOADLEY: Thank you.

20 DR. CROSSON: Alice? I'm sorry. I thought I saw
21 your hand.

22 DR. COOMBS: I just had a question about the

1 percentage of primary care patients as being an index of
2 being a primary care physician, and so my concern is
3 obviously that someone can be an FTE that's .4 versus a .3,
4 and they could have 100 percent of their patients in
5 primary care. But in terms of them meeting access needs in
6 a given community, it's problematic.

7 And then the other question is you have a very
8 productive -- you know, as mentioned yesterday, you have a
9 very productive neurologist, who's seen as much primary
10 care. Maybe he has a multiple sclerosis patient where he
11 coordinates the primary care, and when you do absolute
12 percentages, it becomes problematic. And that the volume
13 of, say, someone who is not necessarily designated family
14 practice or internal medicine might be doing more primary
15 care because of the sheer number of patients that they're
16 seeing.

17 MR. WINTER: Yeah. We've looked at different
18 points both for the November meeting and for our 2008
19 chapter. We can talk about a 40 percent threshold, 50, 60,
20 75, and if you lower the threshold, then more clinicians
21 are going to be eligible, which means you're spending more
22 money.

1 DR. COOMBS: Well, I wasn't thinking about
2 lowering the threshold. I was having an "or" in there for
3 a very productive person. So if you were to say whatever
4 percentage one should decide, then there should be an "or"
5 this person is actually doing above and beyond the call of
6 duty of procurement, which merits some kind of
7 accountability to us paying attention to them as well.

8 MR. WINTER: So are you suggesting more like an
9 absolute number of beneficiaries seen, an absolute number
10 of ambulatory E&M visits?

11 DR. COOMBS: Yeah. So if you took the average
12 number of a panel for internals, say 1,000, 1,500 patients,
13 and if you said this is the average expectation in terms of
14 how many patients correlate that with ours, then you might
15 come up with an absolute number that says, okay, this is a
16 reasonable amount of primary care patients that should be
17 as a part of it. And you could use the percentage, but you
18 could also use an absolute "or" as well.

19 DR. CROSSON: Okay. I've got Bruce and Dana and
20 then Pat.

21 Bruce.

22 MR. PYENSON: Thank you. I've got a question

1 related to Slide 5. In the decade since RBRVS, as I think
2 you've pointed out, there have been various solutions to
3 the issue we've identify of the disconnect between primary
4 care and specialists or, as we're perhaps characterizing
5 it, E&M, ambulatory E&M and procedures. So I think each of
6 those was perhaps an attempt to make the relativities here
7 look similar, and over time it fell out of sync for I think
8 the reasons you've described as the ability for procedures
9 to take less time.

10 So my question is: Can you estimate how long the
11 10 percent fix would last before we're back in this
12 situation?

13 MR. WINTER: Yeah. It's really hard to say. I
14 think part of it depends on whether there are improvements
15 in the data and the process for updating and validating the
16 RVUs. If there are no changes, then the effect of that 10
17 percent increase is going to, I think, wear off over time.
18 If there are improvements, then you may see a greater -- a
19 similar relativity across types of services and specialties
20 that persist. I think it really depends on where the
21 process goes from here.

22 DR. CROSSON: Dana.

1 DR. SAFRAN: Thanks. My question relates to the
2 added payment, not the 10 percent, and I guess I'm trying
3 to understand whether the added payment -- the fundamental
4 goal of the added payment is to further ensure the adequacy
5 of payment for primary care. And if that's the goal, my
6 reading, anyway, of what you're showing on Slide 5 is that
7 even with the balance issues that we have -- could you put
8 Slide 5 back? -- that in family medicine, for example,
9 payment was actually more than adequate to time being
10 spent.

11 So I question it from that perspective. If the
12 goal of the added payment is to encourage primary care to
13 do added services -- care coordination and so forth -- I
14 think the evidence is really weak coming out of the
15 patient-centered medical home research, that doing that is
16 very effective, that those added payments -- so I'm not
17 going to make a Round 2 comment about what I, therefore,
18 think about it, but I just am asking the question about
19 whether -- which of those things is your goal for this
20 added payment?

21 MR. WINTER: I think that's really a question for
22 you all to think about, to put the ball back in your court.

1 But, you know, is the goal here -- we laid out a variety of
2 concerns, and we think that a special payment for primary
3 care could address some or all of these concerns, the issue
4 of how there's a mismatch between a fee-for-service payment
5 and the need for ongoing, non-face-to-face care
6 coordination, issues of compensation disparities, issues of
7 the future pipeline of primary care clinicians. And it's
8 really a judgment call as to whether a special additional
9 payment for primary care could address one or all of these
10 concerns, or whether some other options should be pursued.
11 We're laying this out here for your discussion, and as you
12 know, the Commission is on record with the 2015
13 recommendation that there should be a per beneficiary
14 payment, but that was three years ago, and you might want
15 to reconsider that, particularly in the light of the first
16 policy option that we're raising, which is a new direction
17 for the Commission, potentially new direction.

18 DR. CROSSON: So it is up to -- that's why we're
19 having the discussion. It is up to the Commission. You
20 know, but thinking back to 2015, to may be a very little
21 reductionist, I think the concern here was -- or is, or was
22 at the time, anyway, that we think there's a fair

1 likelihood that the pipeline for primary care physicians --
2 now, it gets very tricky because I think we've included in
3 this other providers of primary care services, and I think
4 the question of whether there's a shortage or not is a good
5 one. But I think if you look at the pipeline for family
6 practice doctors and internal medicine physicians
7 practicing internal medicine and the decrement that's
8 occurred in the last decade or so, and you project that
9 forward in a pipeline that may be seven to nine years long,
10 there's a good possibility that if we don't act or make a
11 suggestion to change that, that we could find a situation
12 in a few years where a significant number of Medicare
13 beneficiaries who want to see a physician for primary care
14 services are unable to do that because they're not there.
15 That's about as close to the problem statement as I can
16 get.

17 Now, the solution for that is, of course,
18 difficult, right?

19 MR. WINTER: If I could provide one more piece of
20 background about the 2015 per beneficiary recommendation,
21 at the time the PCIP, which was a 10 percent increase for
22 primary care, was about to expire, and the Commission

1 believed that letting it expire without replacing it with
2 anything would send the wrong signal to primary care
3 clinicians. And that was coupled with an intent to try to
4 move away from fee-for-service payment towards a broader
5 type of payment for primary care.

6 DR. CROSSON: Thank you. Pat.

7 MS. WANG: Going to Slide 14, this kind of puts
8 the additional screen of 60 percent of payments from
9 eligible services, 220,000 eligible clinicians. Do we have
10 this information broken down by the categories in Slide 9,
11 what specialties, what type of clinician to see who's in
12 that 220,000? Is that available?

13 MR. WINTER: I'd have to go back and look at the
14 November meeting materials, but I can --

15 MS. WANG: Was it in there? Okay.

16 MR. WINTER: I believe there was something very
17 similar to that in there, the distribution by specialty.
18 You're going to see the larger specialties, like internal
19 medicine and family medicine are going to represent the
20 bulk of the clinicians who get the additional payment.

21 MS. WANG: Okay, but in addition, all clinician
22 types, which was helpful to see in Slide 9 --

1 MR. WINTER: You mean the specialties we showed?

2 MS. WANG: Yeah, physician and non-physician.

3 MR. WINTER: Yes, sure. We can do that.

4 MS. WANG: Okay, who was in there.

5 The other question I had was: Is Slide 14
6 related to the information in Table 3 on page 21 in the
7 report? There's a table, primary care practitioners and
8 certain other specialties derive much of their fee schedule
9 payments from ambulatory E&M, and then there's a column.
10 So does this Table 14 then exclude geriatricians?
11 Geriatricians are not represented in the 220,000 eligible
12 clinicians? They don't have 60 percent of their payments,
13 according to this table.

14 MR. WINTER: Right, so the table on page 21,
15 Table 3, is showing the average percent. So there's a
16 distribution around that average.

17 MS. WANG: Okay.

18 MR. WINTER: So geriatric medicine, across the
19 entire specialty they derive 56 percent of their revenue
20 from ambulatory E&M, but there are many geriatricians who
21 get more than 60 percent and, therefore, would qualify for
22 this additional payment.

1 MS. WANG: It would be so helpful to see this
2 cohort of -- if we move from with this approach, it would
3 be so helpful to see this 220,000 broken down into the same
4 categories as Table 9.

5 MR. WINTER: Absolutely, we can do that.

6 MS. WANG: Thank you.

7 DR. CROSSON: Okay. I think we're going to move
8 forward now to the discussion, try to move this issue
9 forward a little bit, see where we think we should go. And
10 Paul and then Kathy are going to -- have asked to begin the
11 discussion.

12 DR. GINSBURG: Yes, well, I thought that this
13 document that you sent made real progress since November by
14 making the distinction between dealing with the distortion
15 that affects all E&M services versus the particular issues
16 that where fee-for-service payment is not very suitable for
17 a lot of current contemporary primary care activities.

18 But, Ariel, your answer to Dana's question made
19 me wonder if you really believe what you wrote, but we can
20 get back to that later.

21 DR. CROSSON: Okay. But I think we need to give
22 Dana a chance to answer while he's thinking. Go ahead,

1 Paul.

2 DR. GINSBURG: Sure. So in a sense, I think the
3 key thing is the distinction. You know, I think the -- you
4 didn't get into why only outpatient services, and I started
5 thinking of some reasons, but better that you stated them
6 than I come up with something.

7 So when we get to the shortcomings of inpatient
8 payment for primary care, I think some of these
9 shortcomings do affect some of the other cognitive
10 specialties who have the same issues in care coordination
11 and non-face-to-face visits. And there really are a range
12 of ways to address these primary care issues beyond RVS
13 changes. And one thing that I'd like us to look into and
14 if you have or haven't talked to Bob Berenson, his ideas
15 about coming up with new codes suitable for primary care,
16 he's told me he thinks it can solve a lot of some of these
17 fee-for-service shortcomings for primary care.

18 I do have concerns, as many others have, about,
19 you know, a per physician payment for primary care in this
20 non-HMO, non-organized environment, with problems for
21 attribution and, as Dana mentioned, you know, the lack of
22 encouraging results from the patient-centered medical home

1 demonstrations.

2 DR. CROSSON: Okay. I apologize. You all look
3 confused, so, Ariel, do you want to respond?

4 MR. WINTER: I believe everything I wrote.

5 [Laughter.]

6 MR. WINTER: But this is -- it's not just my
7 document. It's, you know, the combined efforts of Kevin
8 and Jim and other staff as well. But I think what we were
9 trying to get at is react to the feedback we got at the
10 last meeting, where there was both an interest in
11 addressing the undervaluation, underpricing of specifically
12 ambulatory E&M, but also addressing issues and concerns
13 about primary care. And so we tried to separate those two
14 concerns into separate policy options.

15 With regards to the second one, which I think is
16 what you're referring to, Paul, in my response to Dana's
17 questions, if you provide more payment, it's going to
18 address to some extent the compensation disparities,
19 particularly if private sector -- if commercial payers and
20 plans follow suit. It's not going to, you know, completely
21 equalize compensation. I don't think that's the goal. But
22 it should help improve the disparities or reduce the

1 disparities.

2 In terms of coordination and improving care
3 management, I think that depends on whether you want to
4 impose any requirements, in terms of practice requirements,
5 and the evidence about practice requirements on improving
6 care coordination is mixed. We noted that in our 2015
7 chapter. And so that's probably the best response I can
8 make.

9 DR. GINSBURG: You were really talking about
10 Option 2 when you were answering Dana.

11 MR. WINTER: Yes, I --

12 DR. GINSBURG: I was afraid you were abandoning
13 Option 1.

14 MR. WINTER: And I'm not abandoning either
15 option.

16 DR. CROSSON: Okay. Kathy.

17 MS. BUTO: So I think I expressed some concerns
18 at the last meeting, and I continue to have them. Let me
19 just say, as I think about this issue, I think we're all
20 trying to grapple with, first of all, recognizing that we
21 believe -- I think you correctly say in the preamble or
22 beginning of the report, the chapter, that E&M -- that

1 primary care is undercompensated and underpaid for services
2 rendered. You lay out, I think very well, some of the
3 problems, so the underpricing of primary care or E&M
4 services, which I think you make a compelling case for;
5 secondly, the issues of income disparity and concern about
6 the future supply of physicians; thirdly, you talk about
7 the important role of primary care. I think this is a
8 goal, actually, that we are somehow trying to strive for,
9 making primary care more of a central, more powerful role
10 in the Medicare sort of fee-for-service system, that it
11 actually gets both the compensation and kind of the
12 authority it should to do better on managing fee-for-
13 service patients.

14

15 So if I start with the problem set, underpricing
16 of primary care, back to the issue of the 10 percent and
17 then the across-the-board cut, I really like better the old
18 top-down or the top-down approach that you proposed as an
19 alternative to bottom-up, which is more numerically based,
20 as Jay was articulating. And the reason for that is that's
21 something that MedPAC -- that doesn't rely on MedPAC coming
22 back every five years and recommending a 5 percent or a 10

1 percent increase, sort of Bruce's question of how often
2 would we need to be doing this.

3 If it's numerically based, it ought to have some
4 momentum of its own that continues to rebase the system, if
5 you will, and so that to me has some real power to it.

6 On the issue of income disparity -- and I think
7 this gets partly -- we're trying to partly address this in
8 the primary care special add-on section. I looked at the
9 various options and think that a 10 percent increase in
10 income, Medicare income, is not going to make much of a
11 difference. I don't think it gets to the problem we're
12 concerned about, which is the supply of primary care
13 physicians or practitioners down the road.

14 So that leads me to the question of, you know,
15 what would -- and I do have some thoughts about that. I
16 think you laid out very well that some of the other
17 concerns that physicians in training have are things like
18 medical school debt. Maybe we should look at a flat
19 payment that helps to compensate for medical school debt
20 related to primary care for Medicare. If you want to come
21 into Medicare and you're willing to have, you know, a
22 patient panel that represents 60 percent of your practice,

1 we will help you to some extent with your medical debt.
2 Maybe we ought to look at those kinds of issues rather than
3 trying to use the fee schedule as the vehicle for, you
4 know, ensuring a supply for the future. I don't know.

5 The last thing, which is the issue of are we
6 hoping that enhancing payments for primary care will
7 actually improve coordination of care and management of
8 patients, I don't think either of these options really does
9 that. So that leads me to ask the question: Should we be
10 thinking more about that issue? I don't know what Bob
11 Berenson's coding changes would be, but maybe that's -- I'm
12 assuming they're more bundled, they're more -- no?

13 DR. GINSBURG: [off microphone].

14 DR. CROSSON: Microphone, Paul.

15 DR. GINSBURG: I think some of them are codes for
16 additional services that are not paid for today.

17 MS. BUTO: Okay. So there may be a way to work
18 with those and maybe add to them. But it just strikes me
19 that the area that we hope we're getting to, which is to
20 have more authority, more accountability, and more
21 management, the primary care physician, and then I guess
22 more of a relationship between the primary care physician

1 and the patient over time. We're not getting at that, and
2 it just strikes me that the current codes for coordination
3 of care and chronic care management don't get there either.

4 So that's an area that I hope we'll try to build
5 into this in some way. But bottom line, I'm worried that,
6 because of our collective frustration with what's happening
7 with primary care and E&M, that MedPAC is trying to in a
8 sense take over the responsibility that should be CMS' of
9 updating and making these adjustments, rebasing and so on,
10 the idea that every so many years we might have to
11 recommend another adjustment of 10 percent or 5 percent.
12 I'm hoping that it doesn't rely on us to do that, that
13 there's something that we can recommend systematically that
14 should be done much more automatically by the agency. And
15 maybe it involves taking some of that authority that was
16 delegated to RUC back. Having been involved in the
17 original delegation, I mean, maybe it's time to take
18 another look at what would that look like. Would that mean
19 that CMS would need to develop its own structure for
20 updating, for looking at overpriced procedures, et cetera?
21 I don't think we talk about that. But we're sort of
22 wrestling with this is the world we're living in, we

1 haven't seen any progress, let's go ahead and make some
2 bold changes. I get that. I just don't feel like that's -
3 - I don't feel comfortable with that right now.

4 DR. CROSSON: Okay. So let's open up the
5 discussion. We'll start down there with David.

6 DR. HOADLEY: Jay?

7 DR. CROSSON: Sorry?

8 DR. HOADLEY: Could you speak to where we're sort
9 of trying to head with this procedurally? Are we trying to
10 get to the point of some recommendations at the March and
11 April meetings for the June report? Are we still just
12 envisioning an array of options of the sort that the way
13 this is currently structured?

14 DR. MATHEWS: Yes, so this particular
15 presentation, again, tries to separate the two policy
16 options that got conflated a little bit at the November
17 meeting, and what we're trying to do at this point is, now
18 that they have been separated, gauge the Commission's
19 interest in pursuing the mechanical fee schedule
20 rebalancing option, and if so, that's something that we
21 could continue to model and come back to you. And then as
22 a companion piece of that, we're putting some markers down

1 as to how we might proceed on the related path of improving
2 payments for primary care physicians.

3 So I don't think we are aiming towards bold-faced
4 recommendations this cycle. I think we would package this
5 up in an informational chapter in our June report. You'll
6 recall we tend to do this when we are in a policy
7 development phase. We'll have an informational thing in
8 June first, and then we could come back, depending on the
9 specificity of your guidance and interests here, in the
10 fall of this year, this upcoming fall, to, you know,
11 develop more specific draft recommendations if that's where
12 you end up.

13 DR. HOADLEY: That's helpful because otherwise it
14 would seem like we need to really push to where we're --

15 DR. CROSSON: Yeah, and I wish we could,
16 honestly, Jack. I'm not sure how many years we've had this
17 discussion. From my perspective, there's, you know, kind
18 of a core problem. I described it five minutes ago. I'm
19 not going to repeat it. We're looking for a solution. We
20 had one a few years ago. Congress adopted it; then they
21 let it sunset. We came back and said let's do it again but
22 do it better, and it has not been enacted. So we still

1 have, I think, a significant problem facing the Medicare
2 program and beneficiaries coming forward. The solution
3 space, though, is complicated. No matter how you kind of
4 try to dice it, there's a problem associated with it.

5 You know, just based on the questions so far
6 today, I don't think we're going to nail anything, you
7 know, in the next however many minutes we talk about it.
8 So this clearly is going to be, I think, a chapter for June
9 that kind of lists our deliberations, you know, the pros
10 and cons of different ideas, but I really hope that we can
11 find the time, you know, during the next cycle to come up
12 with a solution we can all agree on. Otherwise, I think
13 we've probably not done our job.

14 David?

15 DR. NERENZ: Okay, thanks. I'll try to be brief
16 here. First of all, let me just echo Paul's thank you for
17 the changes from the last time we looked at this. I think
18 they're really good. The two things specifically
19 separating ambulatory E&M and primary care, recognizing
20 they're not synonymous terms, I really appreciate that. I
21 was going to say it if Paul didn't say it, but he beat me
22 to do it. That's good.

1 And also, I think, opening the door to discussion
2 that not everything on the E&M side should receive the same
3 treatment, and you gave us one example, and I'll get back
4 to that in a second. So, first of all, thank you for that.

5 A few things, concerns, but I think are all
6 addressable as this moves forward. First of all, just the
7 issue that a 10 percent uptick is not going to completely
8 solve the problem of the pay disparities. It's too bad
9 Craig is not here. You know, two years ago he was
10 absolutely eloquent on this point, so I'll try to rephrase
11 what he said. You know, what we're going to do here is
12 take a \$250,000 pay gap and turn it into a \$247,000 pay
13 gap. And it doesn't mean that the thing shouldn't be done.
14 It just means that other things have to be considered and
15 addressed at the same time if ultimately we're talking
16 about people's choice, for example, to go under primary
17 care.

18 There's a literature on that. There are other
19 practice dissatisfiers, and I think we could probably say
20 even more about those, and then perhaps talk about, in the
21 section of this, not on primary care, what might be done.
22 You know, just as an example, when we think about, you

1 know, why there's not been much uptake of some of the
2 chronic care codes or perhaps why there hasn't been much
3 behavior change in some of these demos, you know, if you
4 look at the regulations of what doctors are asked to report
5 and certify and attest to, you know, to bill for \$20 like
6 care coordination code, you know, it's expensive, and there
7 seems to be evidence that those barriers, those burdens,
8 are the take-up of those codes.

9 Well, I think we could extend the concept and
10 say, you know, what burdens or what requirements does
11 Medicare impose in either the domain of ambulatory E&M or
12 primary care, or their overlap, that perhaps could be
13 relieved? It's not a money issue but it still is in the
14 domain of payment.

15 I do -- I was going to link with Dana on this.
16 She stepped out. And I was going to borrow her term from a
17 few minutes ago about the tyranny of the office visit. You
18 know, I am a little concerned about the proposal here
19 focusing on face-to-face office visits when I think it is
20 important to look at better ways to compensate physicians
21 for work done the other way. I just read something, a
22 recent study in Health Affairs primary care physicians now

1 spending only half their time actually seeing patients
2 face-to-face. The rest of the time is spent in backroom
3 things. Again, it doesn't mean this is bad, but it just
4 means that it focuses on one part, and perhaps a shrinking
5 part. So it's perhaps a little bit behind, but, you know,
6 it just means that we should be thinking about those other
7 things and how do we address those, recognizing, as Dana
8 pointed out, recent evidence that it's not easy. You know,
9 we've tried some things and they haven't worked all that
10 well.

11 Okay. Last two things. I did mention last time
12 we talked about this, I used the phrase it's a "blunt
13 instrument" that we're talking about here, and I just want
14 to repeat that concern. You know, we've taken the domain
15 of physician practice, divided it into two big chunks, and
16 say, okay, we're going to pay more for everything on one
17 side, we're going to pay less for everything on the other
18 side, and I was concerned about that a month or two ago and
19 I'm still concerned about it.

20 But you've actually opened the door to that. On
21 the bottom of Slide 8, you asked us the question, you know,
22 what about, say, the annual wellness visit. Should that be

1 in or not? I would say no, based on as you described it.
2 But I think I would just extend that concept and say we
3 really ought to look carefully and say, well, it's not all
4 ambulatory E&M that should get the update, nor should it be
5 everything on the other side that should go down. Now we
6 have to think through what are then the criteria. You
7 know, but we've been down this path before. When we did
8 the site-neutral recommendations in 2012 and 2013, there
9 was a finite list of codes that met an explicit list of
10 criteria, and we said these are the things to which the
11 policy would apply, but other things that are sort of like
12 them, we don't apply. So I'd like to have us work through
13 that here.

14 And then the last thing. I'll use the term
15 "collateral damage" here. It's a familiar term in the
16 military context. What it means is you try to attack a
17 target but in the course of doing that innocent bystanders
18 are harmed. I see that here and I hope we can figure out a
19 way to avoid it.

20 Page 24, and then you mentioned it briefly in the
21 presentation, physical therapists, occupational therapists,
22 you have their pay reduced 4.5 percent. It doesn't seem to

1 me that we have any evidence in front of us that they're
2 overpaid or that, you know, their work is, you know,
3 somehow, you know, become more efficient. They're face-to-
4 face. It's very time-dependent, but it's billed as a
5 procedure.

6 So I don't think we should be hurting innocent
7 bystanders, and I have the same concern about a procedure
8 like colonoscopy. You know, for the appropriate people
9 it's a lifesaving procedure. Should that payment go down
10 4.5 percent? I don't know. So if we could just be more
11 fine-grained in carrying this forward I think it would be
12 better.

13 DR. CROSSON: David, thank you. I think your
14 concerns about lack of uptake of the care coordination and
15 chronic care management codes is a good one for us to keep
16 in mind as we start thinking about solutions, because, you
17 know, a few years ago that seemed like, you know, it was
18 going to be a good solution. And I thought you did a nice
19 job channeling Craig. The only concern I had was that you
20 weren't loud enough.

21 DR. NERENZ: I could try it again but I think
22 everybody heard it.

1 DR. CROSSON: Okay. Amy.

2 MS. BRICKER: So just to echo a few things that
3 I've heard so far. I was, too, left with the question of,
4 you know, if the average salary is \$230,000 and so now
5 you're given a \$20,000 increase, does that then, you know,
6 result in more people entering the field? It's a nice
7 gesture, but I'm not sure that it actually gets to the
8 question at hand, which is, you know, this decline of
9 practitioners entering the field. I like where Kathy was
10 going. I think that's interesting. That would send a
11 stronger message.

12 And have we spent -- do we feel like we've spent
13 adequate time with med students to understand why they are
14 selecting the fields that they are, and would something
15 like Kathy's suggestion sway them one way or the other? I
16 think that would be an interesting survey or feedback, and
17 if there are other things that might sway those decisions I
18 think also it would be quite interesting.

19 DR. CROSSON: Rita.

20 DR. REDBERG: I thought the chapter was excellent
21 and I liked the separation. I really wanted to make the
22 sort of bigger philosophical sort of comment on the

1 Medicare world as it should be. You know, to me, I feel we
2 can make these changes but a lot of the problem is in fee
3 for service Medicare, because we're just rewarding -- you
4 know, even with these change, we're rewarding procedures.
5 We're not rewarding, necessarily, things that patients
6 value, and that I see sort of rebalancing primary care as
7 part of what we were talking about yesterday, and moving
8 towards alternative payment models, voluntary value
9 program, because I think in that model we will do much
10 better at the balance between primary care and specialty.

11 And I feel like a lot of times, you know, we
12 spend a lot of time rebalancing and the problem is really
13 that the fee for service system is broken and it's very
14 hard to, you know, make changes in the system and that we
15 should be spending more of our energy talking about the
16 alternative payment models that we're trying to move
17 towards, which I think would be better for beneficiaries,
18 better for the program and for physicians.

19 DR. CROSSON: Thank you. That's a good point,
20 and I think, to a certain degree, that was the notion
21 inherent in trying to move away from the 10 percent add-on
22 to a per-beneficiary payment, although it's kind of a tiny

1 change in that direction.

2 Yeah, Brian.

3 DR. DeBUSK: Well, first of all, congratulations
4 on a very well-written chapter. I'm really excited to see
5 us not treating this as a choice now and saying let's look
6 at the 10 percent payment and let's look at an additional
7 special payment. So I like the all-of-the-above approach.

8 Just to build on something that Jay was talking
9 about earlier, his concern about the future of primary care
10 physicians. I would argue that the pipeline is collapsing
11 now, and part of that is being masked by nurse
12 practitioners and PAs. And I would urge us to all watch
13 the literature closely, particularly on the number of tests
14 and other procedures done by the extenders, because we may
15 be trading a \$260,000 primary care physician for a \$100,000
16 extender, who may be ordering hundreds of thousands of
17 dollars of additional tests and misdiagnosis.

18 So we may be experiencing a more detrimental
19 effect than we even anticipate. And I know the reading
20 materials we're talking about, how the shortfall in PCPs
21 per thousand beneficiaries was being filled by these
22 extenders. So I think we should watch the literature

1 closely, because I think, you know, we may be pennywise and
2 pound foolish.

3 The other thing that I want to talk about, and
4 these are little bit more technical issues, I really like
5 the top-down approach as a way to identify potentially
6 misvalued codes. I think the frustration there is that we
7 probably can't analytically solve that problem. I think,
8 at best, we can just identify the codes, because you've got
9 7,000 CPT codes that are spread across all these different
10 specialties. And I know you guys can do some pretty
11 complex regressions but I don't think you're ready to
12 regress every specialty across 7,000 codes and say adjust
13 this code up, adjust this code down. So I think the top-
14 down approach is a wonderful approach but it's probably
15 more of a weather vane to point us toward the misvalued
16 areas, more so than it is an analytic base to come up with
17 a numeric solution to exactly how much to adjust a
18 particular work RVU.

19 The other thing -- and again, these are more
20 technical issues but they're in the weeds -- I think it was
21 Bruce who mentioned, or who asked the question about, well,
22 if we make a one-time change to say that TCM, CCM, and

1 ambulatory E&M codes, what's to prevent the distortions
2 from not occurring, or passive devaluation from occurring
3 again? I hope we can explore the idea of using separate
4 conversion factors. You know, the RBRVS used separate
5 conversion factors for a few years, but it was really
6 around a designation of primary care versus the procedural
7 specialties.

8 In this case, what we would do is we would
9 separate them out into a subset of E&M, TCM, CCM type
10 codes. So really what you'd be doing is segregating based
11 on code, not based on specialty. But if we did it that
12 way, and used separate conversion factors, it wouldn't
13 interfere with the underlying RUC process. So, you know,
14 you wouldn't -- I mean, there's an obstacle that's being
15 addressed, but you'd also have independent control of how
16 you want to manage payments for what we would consider
17 primary care-associated services versus other procedures.
18 And again, I know that's a very technical issue but I think
19 that would be an interesting way to get control, on an
20 ongoing basis, without having to go back and try to argue
21 work RVUs for, you know, 99213 or something like that,
22 because I think that gets us into the weeds in a hurry.

1 And then, really, the final issue is I really
2 like this idea of a separate payment to people who are
3 designated primary care. I think doing it on a per-member,
4 per-month basis is a great idea, and I also do think that
5 it needs to have some type of risk adjustment, say like a
6 CPC+ type risk adjustment, where you're trying it to HCCs
7 but maybe you're breaking it into quartiles or quintiles.
8 I like that too, because -- just one other plug -- I still
9 want to get all these fee for service beneficiaries fully
10 coded, because I think there's benefit to knowing more
11 about them, plus as you recalibrate the model each year,
12 you're actually reducing the need for that coding intensity
13 adjustment, or at least part of that coding intensity
14 adjustment as well.

15 So there's benefit on both sides to getting these
16 patients properly coded, and if this is another step toward
17 that, so be it. Thanks.

18 DR. CROSSON: Some good points coming up here.
19 Sue.

20 DR. THOMPSON: I'll be quick. I just -- Jay, I
21 thought your comments outlining this problem were right on
22 the money and I appreciate that. An unintended

1 consequence, and to build on Brian's comments about the
2 fact that we do have ARNPs and PAs filling these roles,
3 especially in rural parts of our country, I'm not quite so
4 pessimistic about what the data may show as we study that,
5 but I think it is wise for us to keep an eye on what's
6 happening with quality and cost as it relates to panels of
7 patients that are being cared for by extenders. And I
8 think we're going to be asking that question so it's a good
9 time for us to get ahead of that.

10 And then last but not least, I don't know that
11 we've gotten this into the discussion today but we have 56
12 percent of psychiatrists in this country that actually take
13 Medicare, and I'm not sure that a 10 percent boost in their
14 \$200,000 average income is going to change their idea about
15 -- and I think we talk about psychiatry whether we're in
16 telehealth, or -- it seems like every discussion we
17 reference the grim shortage of behavioral health. And in
18 the context of our country, I think that's worth including
19 in this discussion and thought going forward as we work on
20 this chapter.

21 DR. CROSSON: Thank you. Jon.

22 DR. CHRISTIANSON: Yeah. I also have three

1 comments. I guess one is I agree with Paul. I think
2 separating the chapter in the way that you've done it is
3 good and I think we can see that in the discussion here. I
4 think it's helped the discussion.

5 I think Jay's problem statement isn't in the
6 chapter. So, yeah, if the problem is there's not going to
7 be enough primary care physicians in the future and the
8 goal is to increase the number of primary care physicians,
9 we need to be pretty explicit about that in the chapter.
10 There are a few set of allusions to if we increase payment
11 rates maybe that will affect the choice of specialty, and I
12 think David's comment about, you know, channeling Craig I
13 think is right.

14 So I think Kathy is also right. I think if the
15 problem statement is as Jay has articulated, the chapter
16 needs to be redone and we need to think about, from what we
17 know at least from behavioral economics, give them money up
18 front to repay their cost of going to medical school and
19 we're going to get a lot more primary care physicians than
20 depending on a trickle-down theory of a very small increase
21 in payment, which will increase your income maybe over
22 time, sometime in the future, while you're trying to pay

1 down your medical school debt for the first 20 years before
2 that sort of really makes a material difference.

3 And then, finally, to something I say all the
4 time, when we have this discussion, so I might as well say
5 it again, since I know what I want to say, so there's no
6 guarantee at all anymore, in the world of primary care
7 physician employment, that increasing the payment for
8 primary care services is going to trickle down into higher
9 incomes for primary care physicians, because that payment
10 will go to organizations, and organizations will decide
11 what to do with it, and it's additional revenue and maybe
12 it'll go to invest in the newest cardiac procedure, because
13 that's going to generate more retained earnings, if it's a
14 nonprofit organization or if it's a profit organization.

15 So thinking that we're going to, even with a
16 materially large increase in primary care service payment,
17 that's going to all turn into magically primary care income
18 is not necessarily going to happen. And then the other
19 part of that is -- getting back to Brian's comment -- there
20 is a market for primary care out there, and if I'm a --
21 we're pushing ACOs, we like ACOs, if I'm managing an ACO,
22 my problem is how do I provide primary care services more

1 efficiently for my population. So back to what Sue was
2 kind of saying, more and more we're seeing these kinds of
3 organizations turn to advanced practice nurses and others
4 to do this. And we actually have quite a bit of data about
5 what's happening in retail clinics, which are increasingly
6 becoming owned by and part of these organizations, and that
7 is the practitioners in those organizations are more and
8 more getting into chronic illness management. So, you
9 know, they're located in drugstores makes all the sense in
10 the world. You can buy your drugs for your chronic
11 illness, while you're there seeing the advanced practice
12 nurse.

13 So what's my point? My point is that there is a
14 market here, a labor market here, in which, for many
15 services, owners and managers of ACOs are going to see
16 advanced practice nurses as close substitutes, and that is
17 going to depress incomes for primary care physicians, and
18 that is the way it is. So we are sort of thinking about a
19 small change in payment as the way to sort of counteract
20 what I think is a major shift in the market and how we
21 think about primary care, and I don't think that will be
22 successful.

1 So if we want to increase the number of primary
2 care physicians in the future, I think we have to go back
3 further upstream and talk about educational subsidies and
4 things like that.

5 DR. CROSSON: Thank you. Pat.

6 DR. WANG: I appreciate and want to thank you for
7 the additional work that you did modeling the top down, et
8 cetera, et cetera, because I think that what it
9 demonstrated to me anyway is that that's a very kind of
10 overly broad and crude approach, you know, that doesn't
11 really get at the problem statement that was just discussed
12 here, and that -- because it involves clinician types that
13 are not in short supply, it includes specialties that may
14 or may not be providing primary care, it seems not to
15 include others. So, you know, the issue of undervalued
16 services, I do kind of think that as frustrating as it has
17 been, finding other approaches, bottom up, to address that
18 is very important.

19 I do think that we need to be clear, as a
20 Commission, of what exactly we are trying to -- as we
21 iterate this conversation -- what we are trying to address,
22 and I do endorse trying to come up with, if you call it

1 top-down or, you know, lateral or something like that, to
2 address very specifically the issue of increasing the
3 supply and practice presence of primary care clinicians,
4 about whom we have concerns about pipeline, primary care
5 physicians who, in particular, specialize in the care of
6 older adults, and, you know, that includes geriatricians.
7 It's not exclusive to geriatricians but I don't want to
8 leave them out of the mix, because, to me, you know, all
9 care of older adults aspires to the quality of board-
10 certified geriatricians, period, end of story.

11 And there's, you know, lots of great primary care
12 delivered by other primary care specialties, but I don't
13 want to lose sight of that, and that's why, you know, I
14 look for them in all of these analyses. Are they popping
15 up to the top of the list? And the fact that they're not,
16 you know, suggest that the approach is a little too
17 blunderbuss.

18 I think that if the concern also is, you know,
19 sort of clinician types shortage pipeline, particular focus
20 on care of older adults, because this is a Medicare
21 program, we do slide into lots of other areas and medical
22 education training, medical school debt. Frankly, you

1 could get as far as to think about whether the training of
2 physicians is equipping our entire physician workforce for
3 the realities of how care is delivered today, which is
4 increasingly population-based, increasingly team-based, et
5 cetera.

6 So I would encourage us to -- I think the top-
7 down, the 10 percent, as well as per-beneficiary are very
8 important exercises to look through, but for me, you know,
9 just seeing the -- sort of the results of the 10 percent
10 bump approach, as well as the 10 percent screen of certain
11 percentages -- I wouldn't really take that approach
12 further, personally, and I think that we should focus on
13 how you correct undervalued codes through the system so
14 that it's self-perpetuating, and then focus in a very
15 targeted way on Jay's problem statement.

16 DR. CROSSON: Dana.

17 DR. SAFRAN: Thanks. I do really appreciate the
18 way this chapter split things out. I think we're hearing
19 how that's benefitted our discussion.

20 I think Jon's comments captured a lot of what I'm
21 thinking because I think that so much of primary care
22 payment now is driven by the organizations that primary

1 care physicians increasingly are a part of. That I'm
2 finding myself struggling with how this lever that we're --
3 or set of two levers that we're trying to use is actually
4 going to accomplish what we want to accomplish.

5 So that led me to think about payment adequacy in
6 sort of three categories. Are we trying to accomplish
7 better equity? Are we trying to accomplish better supply
8 and in so doing assure access, or are we trying to be sure
9 that payment is aligned with value and what we think is
10 valued?

11 I guess on all three counts, I am finding both of
12 these approaches coming up short. It maybe helps the most
13 with equity, but then there's that challenge about how
14 payment actually gets shaped by the organizations providers
15 are a part of. So I struggle with whether it even
16 accomplished that, but maybe it's not a bad idea for that.

17 On the supply piece, I am extremely skeptical
18 that anything we could do with either of these, the 10
19 percent or the lump sum, is going to accomplish some of
20 what, Jay, you outlined as our problem statement.

21 I do say that in our market, as ACOs really took
22 hold and in particular in a payment model that Blue Cross

1 has championed, we saw a huge increase in both the valuing
2 of primary care by organizations that knew they couldn't be
3 successful on either the quality incentives or the resource
4 use incentives without really strong primary care. So we
5 saw tremendous investment in primary care, both through
6 compensation models, but also in the kinds of
7 infrastructure enhancements for primary care, and we saw
8 our state starting to get primary care providers coming
9 from other states.

10 So that's in my thinking as I consider what are
11 the real levers that are going to increase supply, and I
12 also -- I really liked Kathy's suggestion about medical
13 school debt because I've been removed for a while from that
14 literature and that line of inquiry about what shapes
15 people's decisions about their career, but back when I was
16 closer to it and the little bit that I still interact with
17 medical students, it seems like it's an awful lot to do
18 with the kind of esteem that they believe they'll be held
19 in by the profession and what their mentors are pushing
20 them and encouraging them to do coupled with a concern
21 about their ability to make a living that will pay off this
22 debt. So I did like that idea a lot.

1 Then finally, I really feel that the added per-
2 member payments are not going to really get us anything on
3 any of these goals. That it wouldn't help us with supply.
4 It wouldn't get us better care for the reasons I was
5 indicating before from the evidence.

6 I'm concerned about spending that money and not
7 really getting a return on it for any of our goals. So
8 those are some thoughts.

9 DR. CROSSON: Thank you.

10 Jack.

11 DR. HOADLEY: So again, thank you for what you've
12 put together in this chapter, and I'm glad that we're not
13 trying to get ourselves to a recommendation in the next two
14 meetings because I don't think we'd get there.

15 And I guess I'll focus on a few things where I
16 feel like I need more information or I need more help in
17 thinking about either literally data or maybe, in some
18 cases, it's our continued conversation about these things.

19 One of them is the whole issue of primary care,
20 specialty designations, codes, and going back to some of
21 the questions from the data about we're identifying these
22 physicians based on a specialty that they may have

1 designated at some point historically, and if that becomes
2 a channel to how we're paying, the accuracy of that
3 definitely becomes a concern.

4 And that then spills into the sort of, well, who
5 is really delivering primary care, and what do we mean by
6 it, and these notions that we've talked about so often.
7 While lots of people are getting their primary care from a
8 family physician or something like that, sort of the
9 classic mode, others who have a cardiac history may really
10 be getting their primary care from a cardiologist or a
11 diabetic, from an endocrinologist or whatever, and do we
12 understand that well enough to be able to actually draw
13 that conclusion. And that's, of course, the notion of
14 percentage of services that are E&M and some of that stuff.

15 Another area is this whole NP/PA role, and I'm
16 hearing some very different perspectives on whether there
17 are challenges in that. I'm hearing data perspectives.
18 Just the Incident 2, the question of how many of these NPs
19 and PAs are actually doing specialty care and where we're
20 going to wrap the up in any kind of payment adjustment, and
21 from a workforce perspective, are we concerned about or are
22 we happy about the notion that NPs and PAs may become the

1 dominant providers of the classic primary care? And I
2 think the more we can get some sense of that built into
3 this, that feeds into this.

4 The per-beneficiary payment, I mean, Dana was
5 just raising issues about that. I think of some of the
6 specific issues like the attribution and this notion of
7 which patients are you really getting this for that we've
8 struggled with so often, the psych services, is any of this
9 really addressing this, is this part of this issue, or is
10 this really a separate issue? Should we be dealing both
11 with the adequate payment for psych services and the
12 adequate supply of people to deliver those services through
13 some completely different mechanism or is it for the
14 moment, we were sort of piggybacking it on this, which
15 could work?

16 And then last, I hope we don't forget the cost-
17 sharing angles on this. I do think, to Ariel's comment
18 earlier, if we do go in some kind of a per-beneficiary
19 direction, this notion that you get billed for cost sharing
20 sort of out of the blue for something that's very nebulous
21 doesn't make a lot of sense, and yeah, it may get picked up
22 on a supplemental coverage, and so at some point, people

1 won't necessarily notice it. But that seems problematic.

2 If we're just correcting the fee schedule -- and
3 that means that cost sharing is going up for primary care
4 services -- well, it would have been up had the fee
5 schedule not gotten out of this line, so that's not much of
6 a problem. But I just want to flag that we should continue
7 to pay attention to sort of where that plays out.

8 So that's a list of things where I feel like I
9 need help before I can draw a better conclusion.

10 DR. CROSSON: Okay. Alice and then Bruce, and
11 then we'll move on.

12 DR. COOMBS: So I won't echo everything that's
13 been said so far, which is a lot, but I want to piggyback
14 on Kathy and Brian and Warner and Jon on the whole thing
15 with the workforce.

16 Dana, you talked about supply and equity, income
17 disparities, but this key piece, when I came on in 2012, I
18 went to Glen and I said, "Glen, we've got to deal with GME
19 because it's really an important piece for primary care."
20 And at the end of this coming near six years -- you know,
21 we did it in 2010. I think we should go back to that. The
22 Institute of Medicine, as Jon has said, has done a piece on

1 this in terms of how we fund GME. It's really important.

2 And there's been some analysis, Dana, that
3 actually looked at -- it's not just how much you get paid
4 as a primary care doctor. It is also this whole notion of
5 who is your mentor while you're training in medical school.
6 You get someone in internal medicine that's frustrated
7 because of the pay, I think this is what that's for.

8 I think that giving everyone across the board a
9 10 percent increase, on Slide No. 9, we probably shouldn't
10 show that slide again until we get some of the questions
11 answered that Jack and many people around the table have
12 spoken about because this whole notion of how specialties
13 are kind of conflated with nurse practitioners versus PAs -
14 - and there's actually been several studies in "Health
15 Affairs" that say that the migration of mid-levels from
16 rural areas into urban areas, they want to go to the same
17 place physicians want to go. And they want to practice in
18 specialties that are similar to what physicians have.
19 There's two articles, one with PAs specifically and one
20 with advanced nurse practitioners. So I think that's
21 really important.

22 So we have to have a multi-prong approach. One

1 is to deal specifically with the supply and medical school
2 decision-making with the students and all of the factors
3 that influence them, which is the sum total experience.

4 The other thing I want to mention is that I think
5 that we do get a different type of practitioner, rapidly
6 turnover in field with internal medicine and family
7 practice in terms of mid-levels. It's a very different
8 kind of provider that's how there, and I can only say my
9 experience is the ICU doctor being called to the emergency
10 room. When I see PA who says, "I got five consults, and I
11 did a CT, angiogram, and I did this," to me I'm like,
12 "Well, what about this patient who has an obvious acute
13 appendicitis?"

14 There's a different type of thought process from
15 a physician who is seasoned, a primary care physician who
16 has been seasoned, and it has a lot to do with experience,
17 but it also has a lot to do with just the sheer fact of
18 training and the intensity of training.

19 I'm saying that we don't have enough data in this
20 area of cost. I think, Brian, you hit it -- and so did Sue
21 -- about this whole notion saying they're equivalent to
22 physicians, and I think that this is an area that we're

1 going to enter in.

2 And I haven't seen any studies yet that actually
3 look at cost per APRNs, cost per independent practicing
4 PAs, or even cost for aggregates of mid-levels who are
5 working together in comparison to -- and risk-adjusted and
6 looking at the type of patients that are being cared for.

7 I think that this thing of ACGME is really
8 important, and I just want just for us to focus on that at
9 some point going forward.

10 DR. DeBUSK: May I build on that?

11 DR. CROSSON: Yes.

12 DR. DeBUSK: Just briefly.

13 I really appreciate what you are saying there,
14 particularly about the culture of medical schools. I worry
15 that when you take a prospective primary care physician and
16 you dump them into a medical school where the person on
17 their left is going to become a cardiologist and the person
18 on the right is going to become an orthopedic surgeon, I
19 think it creates a culture where it is hard to do, to do
20 primary care. And I think we need to go back and look at
21 institutions. What are the characteristics as we address
22 the pipeline? What are the characteristics of institutions

1 that produce higher rates of primary care physicians?

2 I mean, there are schools out there that have 70,
3 75, 80 percent rates of primary care conversion. One of
4 the challenges is a lot of those are DO schools, and now
5 that the DO residencies are being harmonized, ACGME and AOA
6 are being harmonized, I suspect you're going to see DOs
7 begin to specialize at allopathic rates.

8 We talk about these pipeline issues, but I think
9 there's some medical school cultural issues. I loved what
10 Kathy and Jon were talking about, about addressing student
11 debt and some of the other behavioral economic issues, but
12 I think there's a whole -- and maybe it's a whole separate
13 chapter on pipeline, but it needs to look at the culture of
14 medical schools, and it needs to look at the threats on the
15 horizon because I think what you're seeing is -- the
16 primary care pipeline crashed. I think it crashed years
17 ago, and I think it's been backfilled by nurse
18 practitioners, PAs, and DOs. And I think all of those have
19 some issues now that we're going to need to address because
20 I think there will be a snap effect. Once we realize
21 what's happened, it's going to be too late. We're going to
22 be 10 years out from fixing the pipeline.

1 DR. CROSSON: Okay. Bruce, last comment.

2 MR. PYENSON: I hate to add to Jack's list, but
3 one issue that I would welcome some help in is whether the
4 disparity is that primary care is paid too little or
5 specialists are paid too much.

6 But I would like to, second point, support
7 Brian's idea of a separate conversion factor, and if we
8 think about a longer-term solution, I think we can find
9 very strong evidence that productivity increases over time
10 for procedures. So rather than coming back every couple of
11 years to fix that, that should be built into the fee
12 schedule, perhaps through the conversion factors, so some
13 real technical issues there.

14 MR. THOMAS: Jay, may I make one quick one?

15 DR. CROSSON: Last one, yeah.

16 MR. THOMAS: I just would echo Kathy and Jon's
17 comments around pipeline. I think the idea of the loan
18 repayment probably has the quickest impact, and it's
19 something that would be more immediate. Some of these
20 others are going to be long term, but I think if we could
21 look at the GME primary care-only slots coupled with loan
22 repayment, I think we would have some immediate impact.

1 And I would encourage us to try to expedite some of those
2 ideas.

3 DR. CROSSON: Okay. Very good discussion. It
4 would come as no surprise to anybody that we have more work
5 to do on this topic, and so we look forward to further
6 analyses, suggestions, and ultimately coming to some
7 conclusions.

8 Thank you very much, Ariel, Kevin. Appreciate
9 it.

10 We will now move on to the last presentation and
11 discussion for the meeting.

12 [Pause.]

13 DR. CROSSON: Okay. So our last presentation and
14 discussion is a status report on ACOs, Medicare ACOs
15 specifically, and we've got David, Sydney, and Jeff here.
16 Sydney, are you going to begin? Go ahead.

17 MS. McCLENDON: Good morning. In this session
18 we'll be discussing the status of Medicare's Accountable
19 Care Organizations, or ACOs. Before we begin, I'd like to
20 thank Ledia Tabor for her help with this presentation.

21 I'll begin today by giving some brief background
22 on Medicare's ACOs and an overview of the status of ongoing

1 and completed ACO programs. From there we'll look at
2 quality and financial performance in 2016. I'll then turn
3 it over to David to further discuss the net savings
4 results, potential concerns when creating and rebasing
5 benchmarks, and some policy issues for your consideration.

6 So what are ACOs?

7 ACOs are groups of health care providers who have
8 agreed to be held accountable for the cost and quality of
9 care for a group of beneficiaries. If the ACO does well on
10 cost and quality measures, it is rewarded with shared
11 savings.

12 Medicare's ACOs were created with a goal to
13 improve quality and slow Medicare spending growth by
14 rewarding efficient and high-quality providers for better
15 coordinating their beneficiaries' care.

16 There are three basic concepts at the core of
17 ACOs, though individual ACOs and ACO models vary somewhat
18 in the details.

19 The first is the composition of the ACO group.
20 ACOs can be composed of whatever health care providers they
21 choose, which can include primary care clinicians,
22 hospitals, or specialty practices, as long as they have the

1 minimum number of beneficiaries attributed to them as
2 required by their model.

3 To attribute beneficiaries to an ACO, CMS looks
4 at beneficiary service use. If an ACO is responsible for a
5 plurality of a beneficiary's evaluation and management
6 services in a year, the beneficiary is attributed to that
7 ACO. Starting in 2017, beneficiaries also have the option
8 to voluntarily align themselves with MSSP ACOs. And when
9 attribution happens depends on the ACO model. Some ACOs
10 have beneficiaries attributed to them prospectively, at the
11 beginning of the performance year, while others have
12 beneficiaries attributed to them retrospectively, at the
13 end of the year.

14 To judge ACO financial success, CMS creates
15 benchmarks. The benchmark is an estimate of expected
16 Medicare Part A and B spending for an ACO's beneficiaries,
17 and at the end of the year CMS assesses whether spending
18 was above or below the benchmark. The majority of
19 Medicare's ACOs are in one-sided risk arrangements where
20 they earn shared savings if spending is below the
21 benchmark, but are not responsible for losses if spending
22 is above it. ACOs can also choose two-sided arrangements

1 where they earn shared savings yet are responsible for
2 shared losses.

3 Medicare has multiple ongoing and completed ACO
4 models, which are listed here, and more detailed
5 information on these models can be found in your mailing
6 materials. But I'd like to highlight a few things here.

7 First, the Medicare Shared Savings Program
8 includes three tracks and is a permanent part of Medicare.
9 Track 1 is a one-sided model, while Tracks 2 and 3 are two-
10 sided models. And about 90 percent of MSSP ACOs are in
11 Track 1.

12 The rest of the ACO programs are demonstrations,
13 and most of these are two-sided models.

14 The first of these demonstrations was the Pioneer
15 ACO demonstration, which began in 2012 and ended in 2016.
16 The Pioneer ACO model was the foundation for the Next
17 Generation ACO demonstration, which began in 2016.

18 There's also the ESRD Seamless Care
19 Organizations, or ESCOs, that began in 2016. ESCOs differ
20 from the other ACO models in that they are only comprised
21 of ESRD beneficiaries on dialysis, so they are often
22 responsible for fewer beneficiaries that are also higher

1 cost.

2 So CMS has recently begun releasing the number of
3 participating ACOs for a few of the models in 2018, but for
4 our presentation today we will be focusing on performance
5 year 2017 and earlier.

6 As you can see from the chart, the number of
7 Medicare ACOs has been growing since 2012. If you look to
8 the far right bar, which highlights the number of ACOs in
9 2017, you can see that MSSP Track 1, a one-sided model,
10 contained the largest number of ACOs at 438, although the
11 number of ACOs in MSSP Track 2 and 3 grew to 42 in 2017.
12 The number of NextGen ACOs and ESCOs also grew in 2017, to
13 44 and 37.

14 And as the number of ACOs continues to grow, so
15 does the number of beneficiaries attributed to them. In
16 2017, there were approximately 10.5 million beneficiaries
17 attributed to ACOs, or about a third of the beneficiaries
18 in fee-for-service.

19 So a goal of ACOs is that providers come together
20 voluntarily to give coordinated, high-quality care to their
21 Medicare patients. And CMS has defined a set of about 30
22 measures to evaluate ACO quality.

1 In each ACO's first performance year, they are
2 only scored on whether they report quality information. In
3 the second and future years of the ACO, each ACO's
4 performance is converted to a quality score, and that
5 overall quality score affects the ACO's ability to earn
6 shared savings payments.

7 We find that ACOs meet the reporting requirements
8 and have relatively consistent and high overall quality
9 scores. Across the models, overall quality scores for
10 individual ACOs ranged from 76 to 100 percent in 2016.

11 However, in all ACO models, more than half of the
12 quality measures used are process measures, like influenza
13 vaccination rates and medication reconciliation. These
14 measures are inconsistent with the Commission's principles
15 that Medicare quality programs should include small sets of
16 population-based measures such as outcomes, patient
17 experience, and value measures.

18 Where data were available, we looked specifically
19 at results for patient experience and outcome measures. We
20 found that ACOs are maintaining at least average results.
21 For example, MSSP ACOs had slightly higher performance on
22 readmission rates compared to fee-for-service readmission

1 rates, while ESCO patient experience results are around the
2 national average for dialysis facilities.

3 In addition to being judged on the quality of
4 care they provide, ACOs are judged on their financial
5 performance, and on this slide we have financial
6 performance by ACO model for 2016.

7 The first bar for each ACO model is what we'll
8 call "savings" and is displayed in green. We calculated
9 this savings value by subtracting actual expenditures for
10 the year from the CMS-computed benchmark. Overall, actual
11 spending for beneficiaries in MSSP Track 1, MSSP Tracks 2
12 and 3, Pioneer and the NextGen demonstrations was less than
13 the benchmark, constituting a savings for the program.

14 The second bar for each ACO model, which is
15 displayed in red, shows the amount of shared savings CMS
16 paid to ACOs, and the white bars show the shared losses
17 that CMS recouped from ACOs in two-sided risk arrangements.
18 Because shared savings payments are money paid out by CMS,
19 we've displayed them as a loss to the program.

20 So when you combine these three values, meaning
21 the savings relative to the benchmark, the shared savings
22 payments, and shared losses, we obtained a net savings

1 value for each program, which is shown in blue.

2 For MSSP Track 1, which is comprised of ACOs in
3 one-sided risk arrangements, CMS paid out more in shared
4 savings than what ACOs reduced relative to their
5 benchmarks. This resulted in a net loss to the program of
6 0.1 percent. MSSP Tracks 2 and 3, the Pioneer and the
7 NextGen demonstrations, which are all two-sided
8 arrangements, resulted in net savings of 0.7 percent and
9 1.2 percent. These findings are not surprising given that
10 two-sided ACOs by design will not cost the program
11 additional money because CMS can recoup losses from these
12 ACOs.

13 It's also worth noting that NextGen's net savings
14 may appear higher than would be expected based on the
15 values displayed in green, red, and white. And this is due
16 to an ACO-specific reduction to the benchmark, called the
17 "discount," that occurs for all NextGen ACOs and generates
18 additional savings for Medicare.

19 Now, you may remember from our October 2016
20 presentation on ACOs that we provided analysis showing
21 service use in an ACO's market area was the best predictor
22 of ACO success, with ACOs in high-use areas generating

1 larger savings than ACOs in low-use areas. And we've
2 continued to explore the relationship between savings and
3 service use in a preliminary analysis of the 2016 MSSP
4 data.

5 For this analysis, we first price-adjusted the
6 ACO benchmarks so that they could serve as a proxy for an
7 ACO's historical service use. We then separated the ACOs
8 into quintiles based on the adjusted benchmarks. So ACOs
9 with the lowest adjusted benchmarks were placed in the
10 first quintile, while ACOs with the highest adjusted
11 benchmarks were placed in the fifth quintile.

12 On the chart we've displayed the percentage of
13 ACOs in each quintile that received shared savings. You
14 can see that as the average price-adjusted benchmark
15 increased, more ACOs earned shared savings payments, and
16 this is consistent with the hypothesis that efficient ACOs
17 may have a harder time generating savings, while initially
18 less efficient ACOs may have unnecessary service use to
19 cut. Part of this unnecessary service use appears to be
20 utilization of post-acute care, and some studies have found
21 that ACOs are beginning to reduce PAC. Taken together,
22 these findings indicate that ACOs with high historical

1 service use, especially high PAC use, may have an advantage
2 in generating savings.

3 Now we'll take a look at the financial
4 performance of a slightly different ACO program, the ESCOs.
5 Overall, ESCOs are responsible for fewer beneficiaries than
6 other ACO models, but because they focus on a high-cost
7 population, ESRD beneficiaries on dialysis, their
8 benchmarks per beneficiary are about nine times higher.

9 All 13 ESCOs in 2016 reduced spending for their
10 beneficiaries relative to the benchmark, and even when
11 factoring in the resulting shared savings payments, they
12 generated a net savings of 1.7 percent for the program.

13 The higher savings percentage for ESCOs relative
14 to the other ACO programs could potentially be explained by
15 more frequent beneficiary contact with their providers.
16 ESRD beneficiaries see their providers more regularly,
17 which could create more opportunities for providers to
18 better coordinate their beneficiaries' care and decrease
19 unnecessary utilization.

20 Now I'll turn it over to David to further discuss
21 the ACO net savings results.

22 MR. GLASS: Thank you, Sydney.

1 A key question is whether or not ACOs are saving
2 money for the Medicare program.

3 As Sydney just discussed, relative to the CMS
4 benchmarks, the one-sided MSSP, which has by far the most
5 ACOs, had a small loss, and two-sided models had gains
6 ranging from 0.4 percent to 1.7 percent of Part A and B
7 spending for their attributed beneficiaries.

8 However, some have argued that the CMS benchmarks
9 are not the right measure for savings. That is, they are
10 not necessarily a good estimate of what spending would have
11 been in the absence of the ACOs.

12 Therefore, we looked at what other researchers
13 have found. For example, McWilliams and colleagues found
14 savings of 0.7 percent for MSSP and 1.2 percent for
15 Pioneer. And the Office of the Actuary at CMS found
16 savings of 1.2 percent for MSSP and 2.1 percent for
17 Pioneer.

18 The bottom line is all agree that ACOs model with
19 two-sided risk show greater savings than models at one-
20 sided risk, and savings are in the 0 to 2 percent range.

21 But the other studies find that MSSP ACOs are
22 reducing program spending by a small amount and the

1 benchmarks do not. Does that mean that the benchmarks
2 should be rethought?

3 Well, we would say that benchmarks should not be
4 rethought simply because they do not match some estimate of
5 what spending would have been without the ACO. This is
6 because benchmarks are intended to create incentives and
7 incorporate policy goals, not strictly to represent the
8 counterfactual. The question is, rather, what policy goals
9 should be incorporated into the benchmarks?

10 One goal, for example, could be equity within a
11 market. In other words, should an efficient ACO have a
12 lower benchmark than an inefficient ACO? Or should they
13 face similar benchmarks?

14 Another goal could be equity across markets. As
15 Sydney has just pointed out, the most important factor for
16 achieving shared savings is the service use in the ACO's
17 market. Higher service use is associated with greater
18 savings. Should a goal be to make it easier for ACOs in
19 low-use markets to meet their benchmarks?

20 Another goal might be equity over time. It may
21 become more difficult to achieve savings as benchmarks are
22 rebased to reflect past success.

1 Current ACO models are taking different
2 approaches to these issues. For example, the Next
3 Generation demonstration explicitly includes factors for
4 efficiency within a region and for efficiency across
5 regions when calculating its discount. The higher the
6 efficiency, the lower the discount, thus the easier for the
7 ACO to keep spending below the benchmark.

8 MSSP is blending historical performance and
9 regional fee-for-service spending when rebasing benchmarks
10 to address equity within a market and over time.

11 A separate issue that we have found in a
12 preliminary analysis is that beneficiaries who move in and
13 out of ACOs seem to have systematically different levels of
14 spending growth. This could have implications for setting
15 benchmarks and for estimating savings from ACO programs.

16 With these finding in mind, we would like to know
17 which policy questions you might want us to pursue. Here
18 are some possible issues for your consideration.

19 First, how should quality assessment change to be
20 more consistent with our quality principles? This could be
21 particularly important as we move beyond MIPS to a
22 voluntary value program so that the two will align.

1 Second, in general, how should benchmarks be set
2 to correctly incentivize ACOs and keep them in the program
3 long term? For example, already efficient two-sided ACOs
4 may find it difficult to generate savings, so should
5 benchmarks be adjusted to account for that?

6 Also, how can we better encourage ACOs to take on
7 two-sided risk? We could explore, for example, how Track
8 1+ is doing and consider approaches such as asymmetric risk
9 corridors.

10 Finally, should voluntary alignment be encouraged
11 to stabilize attribution? That is, in light of our
12 findings on differential spending growth for beneficiaries
13 moving in and out of ACOs, would it be helpful for
14 beneficiaries to designate a primary clinician in addition
15 to claims based attribution? And how can that be
16 encouraged?

17 So we look forward to your views on these issues
18 and would be happy to answer questions on the status of
19 ACOs.

20 DR. CROSSON: Okay. Thank you very much. This
21 is both an update and I think also an opportunity for us to
22 discuss policy issues of further changes to the ACO model.

1 So let's do clarifying questions. We'll start with Warner.

2 MR. THOMAS: Thanks for the information.

3 Sometimes I know the benchmarks continue to move. I mean,
4 have we looked at by any of these different tracks, whether
5 it be NextGen or Pioneer or MSSP, the different tracks, the
6 trend over time compared to just traditional, you know,
7 Medicare trend?

8 MR. GLASS: Well, we haven't looked at that
9 explicitly. There is a trend that's really a nationwide
10 trend in MSSP that's reflected in the benchmarks as they go
11 from year one to year two to year three. So they're set
12 for the first year on historical and then that's trended
13 forward by the national increase. So, in other words, it
14 should look pretty similar, but we could certainly look and
15 see if that is, in fact, what happened.

16 MR. THOMAS: And I understand they're benchmark -
17 - I mean, and I think that's part of the issue is the
18 benchmark continues to move. I think what I'm trying to
19 figure out -- and it's hard to ascertain from the
20 information -- is, you know, if Medicare trend is -- I'm
21 just making up numbers -- 4 percent overall for the
22 program, is the trend on ACOs 4? Is it 5? Is it 3? Is it

1 2? Like, what is it in aggregate? And I think that's what
2 I'm trying to understand, because I think, you know, what
3 happens is we -- you know, we keep looking at the
4 benchmarks and the savings paid out and what-not, and I
5 think at the end of the day the question to me is: Is the
6 trend different over time? And I don't think you can look
7 at it one period of time. I think you need to look at it
8 over multiple years. I'm just trying to get a handle on
9 where that is.

10 MR. GLASS: We can see if we can compute that.
11 Jeff?

12 MR. THOMAS: Because if you look at Table 5 in
13 the chapter -- and I understand the population of ACOs
14 keeps changing, but the actual spending from '12 to '13
15 through '16 keeps dropping. But my guess is that that's
16 because the population of ACOs is different. So it would
17 be nice to know for ones that are in in '16 and were also
18 in in '12, would did that look like? You know, just kind
19 of consistently through.

20 MR. GLASS: Yeah, we can --

21 MR. THOMAS: I'm just trying to get a handle on
22 what that trend, the overall trend for total cost in, looks

1 like comparatively.

2 DR. CROSSON: I think I saw Brian.

3 DR. DeBUSK: First of all, really well-written
4 chapter, great information. I had a question on page 13,
5 and you alluded to this at the end of your presentation,
6 but I really want to just set myself up for a Round 2
7 comment. But I won't get there, I promise.

8 Your last bullet point, when you talk about the
9 benchmarks and the fact that, again, you know,
10 beneficiaries entering the ACO versus those leaving, that
11 does introduce a bias in the benchmark -- or I guess in the
12 cost of the beneficiary. And are we -- when you suggest
13 this in that bullet, are we proposing to use basically a
14 numerical solution to an underlying attribution problem?
15 Can you speak to -- would you rather try to just solve the
16 attribution issue and not have to face this potentially
17 difficult numeric correction?

18 MR. GLASS: This is why we brought up this
19 question of the voluntary alignment, where a beneficiary
20 says this is my primary care provider, and if that provider
21 is in the ACO, then the beneficiary is attributed to that
22 ACO.

1 And you can play that out in various ways. You
2 can say that that's going to trump any attribution based on
3 use, and you could have it just keep going until the
4 beneficiary changes that.

5 DR. DeBUSK: Well, in keeping this as a pure
6 Round 1 question, let me ask you a slightly different way.
7 If we as a Commission come up short and can't agree on a
8 better attribution mechanism and we just sort of throw this
9 problem over the fence and say, well, you know, "Sydney,
10 David, and Jeff, figure out how to adjust for this
11 numerically," how comfortable are you with making that
12 numeric adjustment?

13 MR. GLASS: Well, if you make it Jeff, how do you
14 do it, then I'm perfectly comfortable with it. Yeah.

15 [Laughter.]

16 MR. GLASS: But there are a lot of subtleties
17 involved. Are you doing prospective, retrospective
18 attribution? Do we have enough data to really estimate
19 what it is? Is it different for physician-only ACOs, or is
20 it ones with hospitals? There are a lot of things that
21 might enter into it.

22 DR. DeBUSK: So you are comfortable doing the

1 numeric adjustment?

2 MR. GLASS: I'm not too comfortable, but Jeff
3 might be.

4 DR. STENSLAND: I think I'm moderately
5 comfortable, and I have a little bit of hope that the
6 problem we're talking about is a lot less severe when you
7 have prospective adjustment. So if you're getting
8 attributed by your visit this year to the doctor and that
9 attributes to who you are going to be aligned with next
10 year, that's less of a problem.

11 The problem of the mixing of the attribution and
12 the spending is more severe when the attribution is
13 happening at the same year as the spending.

14 DR. DeBUSK: So the retrospective attribution is
15 more problematic than prospective attribution?

16 DR. STENSLAND: Yes.

17 MR. GLASS: That's what he's saying.

18 DR. DeBUSK: Okay. So if you get 18 opinions out
19 of 17 people on how to do attribution, you're still okay as
20 long as it's prospective. You can do the adjustment.

21 DR. STENSLAND: I think something could be done
22 or we could -- maybe even a perspective, maybe just live

1 with it.

2 DR. DeBUSK: Okay.

3 DR. CROSSON: Thank you.

4 David.

5 DR. GRABOWSKI: Great. Thanks for a great
6 chapter.

7 I wanted to ask you about that first bullet. I
8 guess this connected a couple of dots for me. I know how
9 MedPAC thinks about quality assessment. I guess I knew how
10 the ACOs were being assessed, and I just had never thought
11 about that, that they weren't being assessed in a way that
12 was consistent with MedPAC principles. Have you gone back
13 and sort of thought about what that would have meant, how
14 they've actually fared given -- if you had applied this
15 sort of MedPAC framework historically?

16 MR. GLASS: Yeah. That's why we talked -- can
17 you turn to the slide on quality? That's why we're talking
18 about the third bullet on population-based outcome and
19 patient experience measures. They're at least average, and
20 some are --

21 DR. GRABOWSKI: But you haven't gone back and
22 sort of actually looked at sort of payments or anything

1 like that and said that --

2 MR. GLASS: About what?

3 DR. GRABOWSKI: Or just how they've been assessed
4 and who would have been -- who wouldn't have been -- who
5 wouldn't have qualified, I guess, for a payment.

6 MR. GLASS: Oh, I see. Yeah.

7 DR. GRABOWSKI: Yeah. No, we haven't done that.

8 DR. CROSSON: On that Dana?

9 DR. SAFRAN: Yes.

10 DR. CROSSON: Yeah.

11 DR. SAFRAN: I had a similar question about --
12 you know, in Appendix A, you list out all the ACO measures.
13 Have you actually looked to see what performance in the
14 different programs, different ACO programs looks like on
15 those measures compared to fee-for-service?

16 MR. GLASS: I can turn that over to Ledia who I
17 think has actually done that.

18 MS. TABOR: So in the process measures, we
19 haven't, because we don't have a good comparison point,
20 since for MA its plan to report it and for fee-for-service
21 we don't have the clinical data to be able to do it.

22 We did look at readmissions because we have the

1 fee-for-service results for that, and ACOs were slightly
2 better, so about 14.7, at least for MSSPs, compared to
3 about the 15 percent that we learned yesterday. And
4 patient experience is around the national average.

5 There's some of the ambulatory care sensitive
6 condition measures that we couldn't compare because CMS
7 kind of changed the way they reported out the results.
8 They did publicly report the results, but -- and not in a
9 way that's comparable over time.

10 DR. SAFRAN: But you can compare the ACO programs
11 to each other in terms of performance on those.

12 MS. TABOR: Right. And they were all pretty
13 consistent because, again, a lot of those process measures
14 are kind of topped out.

15 DR. SAFRAN: Yeah.

16 MS. TABOR: So there wasn't much variability
17 between the programs.

18 DR. CROSSON: Okay. Questions. I see Jack.

19 DR. HOADLEY: Yeah. Can you just explain again
20 the next-gen discount sort of what's both the -- how does
21 that work, and what's also the logic that's going on with
22 that?

1 MR. GLASS: I'm glad you asked that question.

2 DR. HOADLEY: Gee --

3 [Laughter.]

4 MR. GLASS: So I didn't know if we wanted to get
5 into this level of detail or not.

6 So the next-gen, there is an ACO-specific
7 reduction to the benchmark, and it could range from .5
8 percent to 4.5 percent, the standard discount being 3
9 percent. And the discount varies based on ACO's quality.
10 So the discount could be zero if you're, I guess, perfect
11 on quality or minus -- well, no, it's the other way around.
12 Minus 1 is if you're really good on quality. It's minus 1.

13 The efficiency relative to region is plus or
14 minus 1 percent. So you look at the ACOs risk-adjusted
15 benchmark relative to fee-for-service spending, risk-
16 adjusted in the region, and if you're more efficient, you
17 get -- let's see. Which is it? A lesser discount. And
18 again, efficiency relative to the nation, the same thing.

19 So you can work your discount down to .5 percent.
20 If you're really good on quality, you're efficient relative
21 to the region, and you're efficient relative to the nation.
22 So if you have a smaller discount, then that means your

1 benchmark essentially is bigger.

2 DR. HOADLEY: So therefore harder to --

3 MR. GLASS: Easier --

4 DR. HOADLEY: Right.

5 MR. GLASS: So that's how it works, and it's an
6 interesting way to do it. It has some good features, if we
7 think that -- if you think it's good to give ACOs that are
8 more efficient some leg up.

9 DR. HOADLEY: Okay. Thank you.

10 DR. CROSSON: Questions. Bruce and then Warner,
11 and then we'll move on.

12 MR. PYENSON: Thank you very much.

13 I've got a question that gets at the viability of
14 the ACO programs.

15 Table 1 in the materials shows a remarkable
16 popularity of ACOs over time. There's no shortage of
17 interest in organizations becoming ACOs, and that's
18 increasing. I was struck, the 10 million figure that you
19 showed today is, as I said, about a third of fee-for-
20 service beneficiaries. That's just huge in just a couple
21 of years, so lots of organizations want to do this, but
22 it's hard to see.

1 Apparently, they're not doing it because of the
2 shared savings, because the shared savings seems rather
3 modest.

4 Now, perhaps there's the belief that they'll get
5 lots of shared savings in the future, but the evidence is
6 that shared savings from most organizations are thin. What
7 do you think is going -- the contrast there? I can see the
8 popularity if shared savings were substantial.

9 MR. GLASS: Yeah. Well, a couple of years ago,
10 we went and talked to ACOs and tried to figure out what's
11 going on, and a lot of them just thought that they didn't
12 want to be left out of the move away from fee-for-service
13 to value, and that this was a good way to get into it,
14 particularly the Track 1, which is one-sided. You don't
15 have a chance at a loss.

16 Then as MACRA comes into effect and the A-APM
17 bonus of 5 percent if you're -- for the clinicians who are
18 in ACOs and have a sufficient number of people, blah-blah,
19 as that comes in, a lot of people don't want to be left out
20 of that. So that's going to provide another impetus, and
21 some of them really are achieving lots of shared savings.
22 And they're going to continue to want to be in it.

1 But the Track 1+ model, which is just starting in
2 2018, has attracted, I think, 55 ACOs into that, just in
3 the first year -- and Warner, for example, now as a proud
4 owner of a Track 1+ ACO, and perhaps he can explain what
5 the attraction is to that model. But it does get you --
6 it's considered an advanced APM model, so the clinicians in
7 it will get the 5 percent. There's a chance of shared
8 savings, and it's asymmetric in the sense that the shared
9 savings rate is 50 percent, and the shared loss rate is 30
10 percent. So -- and it also has a small cap on total losses,
11 4 percent of the benchmark, or if it's all physician, then
12 maybe a rural hospital thrown in, then it's 8 percent of
13 the practice's revenue. So that one has a lot of
14 attraction to it, I think.

15 MR. PYENSON: SO that's all Medicare kind of
16 issues.

17 MR. GLASS: Right.

18 MR. PYENSON: Do you think there's attractions
19 behind Medicare?

20 MR. GLASS: Oh, for sure, I think what I meant to
21 say, the first part is not being left out of value-based
22 purchasing, and the move away from fee-for-service holds

1 not just for Medicare, but also for commercial. And there
2 is -- I forget how many -- 700 or something commercial.

3 MR. PYENSON: Most states have about 780 or
4 something like that.

5 MR. GLASS: Yeah, yeah. A commercial variance of
6 ACOs, and there are all sorts of different designs for
7 that.

8 DR. CROSSON: Jack, on this?

9 DR. HOADLEY: Related to where Bruce started out,
10 of the 10.5 million beneficiaries, how many of them are in
11 two-sided?

12 MR. GLASS: [Speaking off microphone.]

13 MS. McCLENDON: Yes. So there were about 9
14 million overall in the MSSP program. So that 10.5, 9
15 million were MSSP, and like most of those are Track 1
16 still. So it's really a good chunk of them are still --

17 DR. HOADLEY: So the share that are in the two-
18 sided, less qualifying as A-APM, is still pretty small?

19 MS. McCLENDON: Yeah.

20 MR. GLASS: Yeah. That's before the Track 1+
21 came in. Yeah.

22 DR. HOADLEY: Do we know how many beneficiaries

1 are represented in Track 1+ yet? Too early?

2 MR. GLASS: I don't think we have the number.

3 MS. McCLENDON: No. CMS gave an overall number
4 for how many beneficiaries are going to be in all of MSSP
5 when they have started really seeing this first wave of who
6 is going to be in MSSP in 2018, but they haven't broken it
7 out yet by track.

8 MR. GLASS: On the table back there, we have the
9 fast facts from the MSSP.

10 DR. CROSSON: Warner.

11 MR. THOMAS: Do you have any thoughts or is there
12 any comments around the different ways to engage patients
13 in the different types of models and the impact that that
14 had on outcomes or any feedback you got as you were talking
15 to the ACOs and on ways to do things differently there and
16 engaging patients, or do you see any correlation to how
17 patients are engaged, results, or anything like that?

18 MR. GLASS: I mean, that was a real, I guess,
19 sore point at the very beginning of all the ACO business
20 was do you even tell the beneficiaries they're in the ACO.
21 First, they sent out a letter, and that managed to confuse
22 approximately everybody. And they quit sending out the

1 letter saying, "Congratulations. You're now in an ACO,"
2 because no one knew what it meant.

3 So this has been a big issue because people said,
4 "Well, how can we help coordinate their care if we can
5 really only see the patient once?" I think that's
6 something that no one has quite figured out yet.

7 What they are doing is making sure people come in
8 for annual wellness visits because they don't have any cost
9 to the beneficiary, and they help people get attributed to
10 the ACO. Well, Rita is not here, but she might question
11 whether those are particularly helpful.

12 DR. CROSSON: Questions. Sue.

13 MS. THOMPSON: You've alluded to it, but are you
14 leaning towards recommending prospective attribution versus
15 retrospective attribution, or do you have any comment on
16 that?

17 MR. GLASS: Well, I think the Commission has come
18 out several times in favor of prospective attribution in
19 our comment letters. I don't think we ever put it in a
20 bold-faced recommendation or not.

21 We've written -- I don't know -- five comment
22 letters on ACOs over the years, and we've often said

1 prospective seems to be a much better bet than
2 retrospective, and the new Track 1+ is prospective, as is I
3 think Track 3 in the MSSP. So there is a move -- and of
4 course, next-gen. So there is a move towards prospective.

5 DR. CROSSON: But we could very well in the next
6 set of sessions, if we come to some conclusions -- we could
7 very well come up with a set of bold-faced recommendations.

8 Yeah. Bruce.

9 MR. PYENSON: I thought your attention in the
10 report to the churn issue and how that distorts makes it
11 difficult to set benchmarks, the applicability of
12 benchmarks, where patients who come in or leave. And I
13 wonder if you have a directional solution, so the
14 suggestions for dealing with that.

15 MR. GLASS: Well, I may turn it to Jeff for
16 thoughts on that.

17 I would say the fact that the churn is pretty
18 high, I think has been concerning for many people, and can
19 you really coordinate care for people if they're moving in
20 and out of the lot? Just the initial thinking behind the
21 ACO design was you take historical spending for this group
22 of beneficiaries or for beneficiaries in these practices.

1 Then you trend it forward, and that's going to work great
2 because people are loyal to their doctors and stay there.
3 And then it turns out attribution is not quite working out
4 that way. So there's two approaches to it. One, you
5 change how you do attribution, and the other is you try to
6 make some numeric adjustment for in and out. And Jeff, I
7 think addressed that.

8 DR. STENSLAND: Yeah. I think when we look at
9 it, at least with MSSP in our preliminary results, you tend
10 to underestimate the performance of the MSSP due to the
11 fact that when people get attributed to you, they get
12 attributed because they're actually coming to see you. And
13 if they're coming to see you, it's kind of an indicator
14 that maybe they're going to need some care.

15 So there is this problem that is not going to be
16 picked up -- all that is not going to be picked up with the
17 risk adjustor either.

18 That would imply to me that if we moved -- and we
19 haven't done the prospective yet, though I think your
20 organization did some analysis with the Pioneer, that it
21 wouldn't be as large of an effect. And I think the
22 magnitude of the effect might be fairly small, like it

1 might even be less than a 1 percent effect, which could
2 just be kind of like this -- you know, this little
3 benchmark adjustment they have in next-gen.

4 So I'm not sure if the problem, if it's
5 prospective alignment, it would be so large that it would
6 need to be addressed. We might just say that you are going
7 to maybe have to overcome a little bit of this. It might
8 ding you three- or four-tenths of 1 percent, but you're
9 going to have to overcome that.

10 DR. CROSSON: Okay. Go ahead, Brian.

11 DR. DeBUSK: A question on the prospective
12 alignment. I understand what you're saying that it reduces
13 the magnitude of the difference, but isn't that just
14 because it falls back on the law of averages? I mean, the
15 idea is that a few people will -- you know, there's still
16 this high churn, and the fact is a few people come in, a
17 lot of people come in, a lot of people come out, and I'm
18 really just falling back on the fact that there's sort of a
19 nominal person that I can start with, with prospective
20 attribution. I mean, is that a fair statement?

21 DR. STENSLAND: I may have not followed it, but I
22 think it more just has to do with you are measuring

1 spending say in 2014, and that 2014 spending is just going
2 to be more correlated with whether you had that office
3 visit in 2014 and whether you had it in 2013.

4 DR. DeBUSK: Agreed. But what I'm saying is
5 let's say that I'm looking at the 100 percent, and 15
6 percent churn in, 15 percent churn out, well, that's 30
7 percent of my base shifting in a year.

8 DR. STENSLAND: Right.

9 DR. DeBUSK: Prospective attribution isn't really
10 fixing anything. What it's really doing is it's sort of
11 using a plug number. It's using an average to blend that.
12 We weren't really fixing anything as much as we're
13 mathematically smoothing over a problem because those
14 biases in theory should average out if my base isn't
15 changing. Is that --

16 DR. STENSLAND: Right.

17 DR. DeBUSK: Okay.

18 DR. STENSLAND: Yeah, because you're going to
19 have a lot of people that you're responsible for that you
20 didn't see that year.

21 DR. DeBUSK: Right, right.

22 DR. STENSLAND: So you're relying on the fact

1 that those aren't disproportionately swinging one way or
2 the other.

3 DR. DeBUSK: You're coasting off the ones that
4 are going away, and you're taking a hit on the ones that
5 come in, but it's averaging out because you're prospective.

6 DR. STENSLAND: Right.

7 DR. DeBUSK: Again, I'm going to get close to a
8 Round 2, and then I'm going to stop. I promise. I won't
9 do Round 2.

10 But Bruce and you were just having a conversation
11 about is this an issue of prospective attribution versus
12 retrospective or is this an issue of adjusting the numeric
13 benchmark. I would ask the question: Have we looked at
14 addressing ways to address the underlying churn? Because
15 that's really -- that would really fix the bigger issue,
16 and to that point -- and again, not Round 2, because I'll
17 do Round 2, but is this -- do we need to incorporate some
18 type of beneficiary engagement mechanism that creates maybe
19 a financial incentive to stay within the ACO and a
20 financial penalty if you leave the ACO? Is it time to give
21 ACOs a beneficiary engagement mechanism?

22 DR. STENSLAND: And that, again -- the Commission

1 has also addressed that in the past, that if there are
2 shared savings, why aren't they shared with the beneficiary
3 as well? And through that sort of thing where you have
4 lower cost sharing if you see someone in the ACO or not.
5 So that's been contemplated, and we can certainly look at
6 that again.

7 DR. CROSSON: Okay. I think we're going to
8 proceed to the discussion.

9 Let me just point we have run over -- I'd like to
10 try to get us done by noon because people are going to have
11 travel issues to deal with pretty soon. Paul is going to
12 start the discussion. Then we'll have a discussion. I
13 have a few remarks I'll make towards the end.

14 Paul?

15 DR. GINSBURG: Okay. This is a very valuable
16 paper. I'm particularly pleased that you clarified the
17 benchmark versus counterfactual issues and assessing it. I
18 think we all benefit from that.

19 On the policy priorities, I think to me the areas
20 I think most fruitful would be doing more work on
21 benchmarks. You know, you've covered a lot in the Round 1
22 discussion. One other factor is just thinking about,

1 again, the business case for investing in doing better,
2 that this was the problem in just pure, you know, rebasing
3 to new historical data, an option to stay at the older
4 historical data for some time, which I gather Dana's plan
5 did initially. She might have something interesting to
6 say.

7 And then the attribution alignment issue, I think
8 that's very important. I'd like us to perhaps consider
9 network models where the beneficiaries share in the
10 savings, they have incentives to use physicians that the
11 ACO puts in a network around the ACO as opposed to other
12 physicians, and this is a way of involving specialists more
13 in ACOs, which would help us on APM, advanced APMS, if they
14 did.

15 Sorry about my voice.

16 DR. CROSSON: Thank you. Okay. So let's have a
17 discussion. I will press for conciseness. Issues, people
18 who want to comment? We'll start with Jon.

19 DR. CHRISTIANSON: Yeah, just a quick comment as
20 we move along to all of these suggestions that we've heard.
21 Just to think about it, at what point do we say, you know,
22 it looks like an MA plan, it quacks like an MA plan, why

1 isn't it an MA plan? You know, so it gets us back to, I
2 think, the discussion of what exactly were we trying to
3 accomplish? Were ACOs going to be the sort of gateways to
4 moving more providers in MA plans? Or did they have
5 distinct features that we valued that were separate from MA
6 plans? Because most of what I hear about next steps has to
7 do with moving them towards looking more like an MA plan.

8 DR. CROSSON: And, in fact, there is a proposal
9 I've looked at recently by a physician organization to do
10 just that, to sort of pick up on the old PSO concept,
11 Kathy, that we've talked about and move certain types of
12 ACOs into risk-bearing arrangements similar to MA plans.

13 DR. CHRISTIANSON: And there are people,
14 organizations, in that business to try to help you take the
15 next steps.

16 DR. CROSSON: Right. Dana.

17 DR. SAFRAN: Yeah, so my brief answer on all of
18 the policy issues there is yes, that we should be looking
19 at all those things. On the quality piece, I would think
20 it would be valuable in the paper, even if it does go in an
21 appendix, to not just list out the ACO measures but to show
22 the analysis, Ledia, that you said you've done, and

1 wherever we have it, to have the fee-for-service comparison
2 data, because I think keeping our eye on how quality is
3 going in these programs is really important.

4 The issue of benchmarks has been so incredibly
5 important that I think we have to look at that.
6 Particularly given what NextGen is doing with the
7 rebalancing and everything, really anything we can do to
8 really understand how that is succeeding or not at keeping
9 the more efficient providers in and encouraging those that
10 aren't efficient to perform better, you know, that feels
11 like the Holy Grail. So that seems really important to
12 understand.

13 On the issue of taking on two-sided risk, you
14 know, my two cents on that is that it's very hard to get
15 organizations off of one-sided risk if that's where they
16 start. But I do think a policy treatment of that question
17 is very, very important, particularly in light of the
18 numbers that you showed us of, you know, where the bulk of
19 ACOs are and how weakly they are performing compared to the
20 others.

21 And a definite yes on encouraging voluntary
22 alignment. I think, you know, you had -- I forget if it

1 was in this paper or another one -- a statistic that 97
2 percent of Medicare beneficiaries report having a regular
3 source of care. So it's not that our beneficiaries don't
4 have someone they would identify, and so just asking them
5 to tell us who that is, and perhaps considering, you know,
6 cost-sharing benefits if they do that and stay within their
7 network, though I know there are some Medigap products --
8 we had the first one -- that try to help ACOs in that way,
9 and members.

10 So, anyway, yes, on all of that.

11 DR. CROSSON: Paul -- Jack.

12 DR. HOADLEY: Actually, Jay, I meant to ask --
13 you said something about eventually moving towards
14 recommendations. Like I asked on the last one, is the
15 assumption for this year that we're just at a discussion
16 chapter again?

17 DR. CROSSON: That's correct.

18 DR. HOADLEY: So I'll focus on the last of these
19 policy issues, and I've talked in some previous years about
20 some of these. I do worry about the potential for
21 confusion at the beneficiary level, just like the letters
22 were confusing, you know, what happens if you try to do

1 certain things in a voluntary designation of a primary
2 source of care, like Dana was talking about, might be fine.
3 But, you know, what happens as you start to move into --
4 even putting the Medigap issues aside, you start to move
5 into something that looks more like a network, even if it's
6 more like a PPO-ish kind of network where you're going to
7 tilt people toward -- encourage the preferred providers,
8 but not restrict -- and I sort of go to Jon's comment. At
9 that point should we just be saying before you get to that,
10 we should just encourage these organizations to shift into
11 the MA world rather than have something that sort of acts
12 like MA and the beneficiary hasn't really had a full
13 selection of it with all the consequences weighed out? I
14 want to move carefully, you know, if we try to look in that
15 direction.

16 DR. CROSSON: Bruce.

17 MR. PYENSON: Thank you. Terrific paper. I
18 noted your useful definition of the counterfactual as how
19 much would these beneficiaries cost in the absence of the
20 ACO, and that's a really useful concept. However, I'd urge
21 us to think that given the popularity of ACOs, it might
22 make sense to have the benchmark deliberately below that

1 because ACOs appear to bring so much value to the
2 organizations that are participating in them. And there
3 could be other features that encourage that such as some of
4 the network opportunities others have mentioned.

5 DR. CROSSON: Comments? Warner.

6 MR. THOMAS: I would encourage us in the chapter
7 to be -- to me, the way I look at this is you either
8 believe in the ACO model and trying to go to more value-
9 based type of payments or not. And if you don't, then it
10 means you believe in the fee-for-service model and you
11 think that's the right solution. So, to me, I think if we
12 believe in value and we believe in moving to more proactive
13 and preventative care, then I think we should be clear
14 about that in this writeup.

15 I do think the comment around engagement of
16 patients and how we try to build relationships is
17 important. It's hard to coordinate care, as you indicated,
18 David, without someone knowing that they're part of
19 something and understanding that they've got a relationship
20 with this primary care physician and a team. So I do think
21 that building that information out is critically important.

22 The other comment I would make is that there's

1 significant expense that goes into building the
2 infrastructure to make these organizations work. I think
3 comments around that and I think celebrating versus --
4 celebrating the organizations that are doing this I think
5 would be a very positive thing, because I think they're
6 trying to drive the payment model in the right direction.

7 I do think moving towards more first-dollar
8 sharing is a positive thing, and I think we'll get more
9 organizations on board. And I think continuing to evolve
10 the 1+ model to try to move people to two-sided risk is
11 critically important. I think part of that will be
12 availability of information and ability to engage patients,
13 which I think those are going to be two very critical
14 aspects to get organizations comfortable moving there.

15 I hear Jack's comments on, you know, this being
16 MA-like, but the reality is that if we don't change the
17 payment model, then we shouldn't sit here and complain
18 about the cost of the program. And if we're concerned
19 about the cost of the program, we've got to change the
20 payment model. And that is going to require change on the
21 beneficiaries' part as well, but I think you'll find the
22 quality of results here are positive. It would be nice to

1 have consistent quality results across all the payment
2 mechanisms so we could really do a true comparison. So I
3 think that should be part of our comments as well.

4 But I think, generally, patients that are more
5 engaged and are more aligned in their care are generally
6 happier and feel more connected to their system, and I
7 think we'll find that as we build that connectivity with
8 patients with these organizations.

9 DR. CROSSON: Sue -- David, go ahead.

10 DR. GRABOWSKI: I just wanted to come back to the
11 quality issue again and echo kind of Dana's recommendation
12 that we bring in some of those data that we have using the
13 MedPAC quality assessment framework, but applying it to
14 these different models. I think that could be really
15 useful and help kind of educate potential stakeholders on
16 this transition and what it means. Given Ledia has already
17 done some of that work, I think that could be a real value-
18 add to this chapter.

19 Thanks.

20 DR. CROSSON: Sue.

21 MS. THOMPSON: Three points.

22 On the benchmarking, for those low-cost providers

1 that are in that lowest quartile, we want to keep those
2 providers at the table and sharing how they became low-cost
3 providers. So I think assuming their quality is where it
4 needs to be, we need to understand what's driving that
5 performance, and what we can do to keep those folks
6 participating I think is important.

7 Secondly, on the attribution, personal
8 experience, having come from the Pioneer world and moving
9 into the NextGen world, we moved from a 25 percent churn
10 when it was a retrospective attribution to most recently a
11 4 percent churn. And we're roughly managing around 80,000
12 Medicare lives in NextGen. It wasn't that large in
13 Pioneer, but I think it's worth taking a deep look at, how
14 do we -- because what we need to do, to Warner's point, is
15 to maintain -- develop, first of all, and maintain
16 relationships with these beneficiaries. That's the only
17 way I think we're going to be successful in meeting the
18 goals.

19 And last, but not least, you know, to the
20 organizations who are participating, I tell you, the shared
21 savings is not going to cover the reduction in top-line
22 revenue they have left on the table in order to move to a

1 transformed care delivery model. We believe this is a fee-
2 for-service system that is broken. We believe that the
3 payers are no longer going to participate in a payment
4 model that's going to reward us in fee-for-service. We
5 believe we're moving to a value-based payment model. In
6 order to do that, we have to invest in these care
7 capabilities to be successful.

8 So I again would underscore Warner's
9 recommendation to celebrate these organizations that have
10 been bold enough to take on that kind of work.

11 DR. CROSSON: Okay. It's a very good discussion.
12 This is a biological block from my perspective, a set of
13 building blocks. I think we've moved these issues along
14 that are on the slide there, and I think that will be
15 helpful.

16 I do think there's a larger question here that
17 we're eventually going to have to grapple with, because I
18 feel the same as Warner and Sue and others around the table
19 here that this is the right direction for the Medicare
20 program. I also think that, you know, MedPAC specifically
21 has somewhat of a special responsibility in this area since
22 ACOs literally came out from this body. So I think we have

1 a responsibility not just to monitor it and do periodic
2 status reports, but to take a very hard look at why it has
3 not been as robust. You know, there are savings here.
4 These are small percentages but large dollars. The quality
5 is moving in the right direction. I think that's terrific.

6 But I also don't think that it's as robust as
7 what I intuitively think we could be seeing if we had, you
8 know, some significant changes, and here again we may have
9 to, you know, over time become a little bit more -- a
10 little bit bolder.

11 Some of the things that I would like to see us
12 take a look at, if we can do it, are: What's the
13 difference between Medicare ACOs and how they're doing and
14 commercial ACOs? Are there things that we could learn for
15 the Medicare program there?

16 I think that -- and I think Paul brought this up
17 to a certain extent, but I think the role of specialists in
18 all this is critical. I don't see how an ACO over time is
19 going to be successful if a small group of primary care
20 physicians has one set of incentives and the specialists
21 that are necessary to care for the patients have a
22 different set of incentives. I realize how difficult that

1 is, but I think we need to think about it. We need to
2 explore it. Paul suggested one idea. I hope we can find
3 more comprehensive ones as well.

4 Pat's gone now, but sometime ago she brought up
5 the question of the role of hospitals, and, similarly, I
6 have had for a long time a question of, you know, if we
7 have hospitals with one set of motivations and incentives,
8 you know, to fill up beds, but we're working with a group
9 of physicians, no matter how large that is, and we're
10 asking them to take a different set of motivations and
11 incentives, how that's going to work. And this is a very
12 large and very complicated and very difficult question.
13 But I do think down the line, if this is going to be
14 successful, the role of hospitals needs to be thought
15 through. And the payment changes that Sue suggested, that
16 I completely agree with, need to somehow involve hospitals
17 down the line, or essentially we're just sending a bunch of
18 physicians to batter their heads against the wall.

19 You know, and then I think this whole issue of
20 beneficiary engagement and this issue of the boundaries
21 then between more sophisticated ACOs and how they're paid
22 through more sophisticated mechanisms and what that means

1 for MA or for MA-like organizations, because I know, I can
2 tell you those proposals are going to be brought forward
3 very aggressively in the coming year. I think we need to
4 think about that and what our position is and whether we
5 think this is part of the solution or not.

6 So from my own perspective, because I think it's
7 important for the Medicare program and because I think we
8 have a special responsibility, for me this is very high on
9 my own priority list, and I hope that as we carve out time,
10 you know, heading into and through the next set of
11 sessions, we will begin to take this on, you know, from
12 some of the more detail-level issues which we've discussed
13 today to some of the more global issues. And I can tell
14 you they're going to be tough and difficult and
15 controversial to deal with, but I think if we don't do
16 that, we're not fulfilling our responsibility.

17 Having said that, the January meeting has come to
18 a close. Thank you, Sydney, David, and Jeff, for the
19 presentation. Good work.

20 We now have time for a public comment period. If
21 there are any members of our audience that would like to
22 come up and make a comment, please come to the microphone.

1 [Pause.]

2 DR. CROSSON: We have one individual. Let's let
3 people clear out a bit. I don't want our speakers to be
4 trampled as they try to speak.

5 So I'll ask you in a minute to identify yourself
6 and any organization that you represent. I would point out
7 that there are other opportunities to provide input. This
8 is one. Direct contact with the staff of MedPAC is another
9 one. And I'd ask you to confine your comments to two
10 minutes, and when this light comes back on, that will have
11 expired.

12 MS. BRENNAN: Okay, great. Thank you. My name
13 is Allison Brennan and I'm with the National Association of
14 ACOs.

15 So it was a great discussion today and I just
16 wanted to make two comments. One is on the performance of
17 two-sided models versus one-sided ACOs. I think as we're
18 having this discussion it's really important to keep in
19 mind that ACOs won't move into two-sided models unless they
20 see success in one-sided models. And I think from an
21 organizational perspective that really makes. You're
22 probably not going to take on risk if you haven't seen

1 savings. You wouldn't have enough confidence to move into
2 that two-sided model.

3 And one of the ways that we can help support ACOs
4 so that they are successful in a one-sided model and have
5 that confidence is to make certain program changes. We
6 talked about the benchmarking today. I think that really
7 warrants further exploration. There are a couple of issues
8 related to that -- risk adjustment and how ACOs are treated
9 with risk adjustment, in comparison to other programs in
10 Medicare and Medicare Advantage. ACOs have a much more
11 difficult time and limits with risk adjustment.

12 Also, with the benchmarking we're trying to move
13 ACOs to compare them more to their region, as their
14 benchmarks are reset, but there are a couple of flaws with
15 how CMS is doing that. One of the flaws is that they leave
16 the ACO beneficiaries in the regional population. So when
17 you have an ACO that comprises a large market share, you're
18 not really comparing the ACO to its region. You're still
19 comparing the ACO just to itself and its historical
20 performance.

21 There are other benchmarking issues. Obviously
22 with two minutes we won't get into them. But I do think it

1 would be great to have you take a closer look at some of
2 those issues. Thank you.

3 DR. CROSSON: Thank you very much. Seeing no one
4 else at the microphone, we are adjourned until our March
5 meeting. Safe travels, everyone. Stay healthy too.

6 [Whereupon, at 11:59 a.m., the meeting was
7 adjourned.]

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