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
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KATHY BUTO, MPA
ALICE COOMBS, MD
BRIAN DeBUSK, PhD
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AGENDA PAGE

P R O C E E D I N G S

[9:25 a.m.]

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

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

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

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

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

prior years.

Now, Carlos.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Before displaying the first draft recommendation,

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

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

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

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

So the draft recommendation now reads:

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

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

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

number 2.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ratings shown in Medicare Plan Finder.

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

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

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

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

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

The second draft recommendation reads:

The Secretary should:

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

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

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

As for the effect of the draft recommendation on

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

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

DR. CROSSON: Thank you, Scott.

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

DR. NERENZ: Thanks, Carlos.

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

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

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

bullet?

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

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

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

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

DR. NERENZ: Yes, yes.

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

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

MR. ZARABOZO: At the contract level.

DR. NERENZ: Yes, understand.

MR. ZARABOZO: Yeah.

DR. NERENZ: Okay. I just wanted to clarify

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

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

DR. CROSSON: Yeah.

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

[Laughter.]

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

DR. NERENZ: Yeah, that's right.

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

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

DR. NERENZ: Okay. Just making sure.

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

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

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

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

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

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

MR. ZARABOZO: Right, right, right.

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

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

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

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

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

DR. CROSSON: Thanks. Thank you.

Jon?

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

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

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

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

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

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

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

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

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

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

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

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

DR. CROSSON: Brian.

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

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

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

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

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

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

back on any technical implementation issues associated with these

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

DR. CROSSON: Pat and then Bruce.

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

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

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

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

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

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

years or --

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

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

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

MR. ZARABOZO: Yes, yes.

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

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

MS. WANG: Okay.

MR. ZARABOZO: The payments are in place already.

MS. WANG: Then starting with the 2019 bid.

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

DR. CROSSON: Bruce.

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

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

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

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

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

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

MR. ZARABOZO: Right, right. Yes.

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

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

I see Jack, Pat.

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

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

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

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

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

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

DR. CROSSON: Pat.

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

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

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

above is just really that black and white.

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

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

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

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

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

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

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

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

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

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

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

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

Okay. Dana.

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

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

DR. HOADLEY: Hawaii.

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

[Laughter.]

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

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

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

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

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

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

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

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

[Show of hands.]

DR. CROSSON: All opposed?

[No response.]

DR. CROSSON: Abstentions?

[No response.]

DR. CROSSON: It passes unanimously.

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

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

[Show of hands.]

DR. CROSSON: All opposed?

[No response.]

DR. CROSSON: Abstentions?

[No response.]

DR. CROSSON: Seeing none, it passes unanimously.

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

[Pause.]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

One part of the 2016 recommendation changes the

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

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

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

draft recommendation, which I'll put up shortly.

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

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

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

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

These distortions and incentives led us to the

current draft recommendation, which reads:

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

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

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

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

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

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

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

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

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

I will put up the draft recommendation for your discussion.

DR. CHRISTIANSON: All right. Bruce.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DR. CHRISTIANSON: Amy.

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

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

MS. BRICKER: It would be interesting.

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

MS. BRICKER: Okay. Something maybe to considering.

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

Do you think that the late enrollment penalty is

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

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

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

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

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

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

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

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

MS. BRICKER: Thank you.

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

Kathy.

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

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

MS. BUTO: Uh-huh.

DR. SCHMIDT: So there is that complication.

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

DR. SCHMIDT: Yeah.

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

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

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

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

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

MS. BUTO: Okay. Okay. Got that.

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

DR. CROSSON: Jack.

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

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

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

point to get at that question.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

mentioned at the last meeting.

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

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

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

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

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

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

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

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

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

[Laughter.]

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

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

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

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

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

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

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

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

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

DR. CROSSON: Amy.

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

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

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

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

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

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

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

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

Thanks.

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

Where are we? Rita.

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

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

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

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

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

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

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

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

DR. CROSSON: Comments?

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

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

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

Thanks.

DR. CROSSON: Jack.

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

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

DR. CROSSON: Bruce.

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

fundamentals on that.

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

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

DR. CROSSON: Dana.

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

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

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

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

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

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

The final thing, just to comment on this little

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

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

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

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

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

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

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

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

DR. CROSSON: Okay. Thank you.

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

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

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

health care itself but even beyond that.

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

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

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

[Show of hands.]

DR. CROSSON: All opposed?

[No response.]

DR. CROSSON: Abstentions?

[No response.]

DR. CROSSON: The recommendation passes unanimously.

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

time that you've spent on these difficult issues.

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

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

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

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

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

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

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

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

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

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

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

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

DR. CROSSON: Thank you.

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

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

AFTERNOON SESSION

[12:43 p.m.]

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

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

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

month.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

And with that I turn it back to Jay.

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

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

DR. MATHEWS: Not in recent memory, no.

DR. CROSSON: Warner.

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

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

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

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

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

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

MR. THOMAS: Right.

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

MR. THOMAS: Okay. Thank you.

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

MS. CAMERON: We are, yes.

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

MS. CAMERON: That is correct.

DR. MATHEWS: Okay.

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

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

MS. CAMERON: Yes.

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

DR. CROSSON: David.

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

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

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

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

DR. NERENZ: Yes. Understood.

DR. STENSLAND: So, and the market basket is

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

DR. NERENZ: Yes.

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

DR. NERENZ: Yes. Right.

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

DR. NERENZ: Yes.

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

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

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

our recommendation.

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

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

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

DR. CROSSON: Okay. Questions? Bruce.

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

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

I'd say the only information that we have

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

MR. PYENSON: [Off microphone.]

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

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

Discussion? Warner.

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

recommendation?

[Staff nod heads in affirmative.]

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

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

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

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

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

DR. CROSSON: Formulaic, yes.

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

on those whatsoever.

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

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

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

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

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

Amy.

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

DR. STENSLAND: [Nods yes.]

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

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

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

DR. CROSSON: Yes. Jack.

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

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

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

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

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

[Show of hands.]

DR. CROSSON: Opposed?

[No response.]

DR. CROSSON: Abstentions?

[No response.]

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

DR. MATHEWS: And Warner.

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

MR. THOMAS: I'm in favor.

DR. CROSSON: In favor. Thank you.

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

[Pause.]

DR. CROSSON: There will be a small hiatus.

[Pause.]

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

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

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

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

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

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

The ratio of Medicare payment rates to private

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

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

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

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

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

updates, and created the A-APM incentive payment.

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

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

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

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

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

Medicare program to reward clinicians based on value.

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

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

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

So, altogether, the draft recommendation reads:

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

Here are the implications.

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

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

payments, others a modest increase.

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

DR. CROSSON: Thank you, Kate.

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

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

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

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

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

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

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

DR. DeBUSK: Great.

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

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

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

[Laughter.]

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

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

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

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

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

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

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

DR. GINSBURG: Yeah.

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

DR. CROSSON: Clarifying questions? Kathy.

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

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

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

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

DR. CROSSON: Kathy -- Sue.

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

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

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

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

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

DR. GINSBURG: You know, another aspect of this

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

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

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

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

DR. HOADLEY: I have two questions about sort of

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

MS. BLONIARZ: You will probably want a Notice and Comment period. Yeah.

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

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

DR. HOADLEY: And would you just divert to sort

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

MR. GLASS: Right. Yes.

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

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

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

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

DR. HOADLEY: Okay. Thank you.

DR. CROSSON: Yes, Brian.

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

DR. CROSSON: Yes.

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

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

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

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

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

DR. DeBUSK: Okay. Fair enough.

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

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

Thank you.

DR. CROSSON: Alice.

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

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

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

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

MR. GLASS: At least 15 beneficiaries.

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

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

So the second line -- so all of those exempt

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

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

MS. BLONIARZ: Yeah, yeah.

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

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

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

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

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

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

DR. COOMBS: Chiropractors.

MS. BLONIARZ: -- and APs.

MR. GLASS: And also other practitioners.

MS. BLONIARZ: And other practitioners.

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

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

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

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

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

MS. BLONIARZ: Yes.

DR. CROSSON: Okay. Seeing no further questions,

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

Comments? Discussion?

[No response.]

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

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

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

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

DR. CROSSON: Alice.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[Laughter.]

DR. CROSSON: Go ahead. Sorry.

DR. COOMBS: [Speaking off microphone.]

DR. CROSSON: Paul.

DR. GINSBURG: I use different language.

[Laughter.]

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

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

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

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

DR. GINSBURG: Yeah.

DR. CROSSON: Okay. Thank you.

Comments?

David.

DR. NERENZ: Thanks.

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

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

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

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

I have concern about that.

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

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

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

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

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

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

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

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

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

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

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

DR. CROSSON: Further comments?

Rita and then Warner.

DR. REDBERG: I support the recommendations and

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

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

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

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

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

So I strongly support these recommendations.

DR. CROSSON: Warner.

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

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

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

rural areas.

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

DR. CROSSON: Let me jump in, Warner.

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

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

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

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

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

do that.

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

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

So, Kathy.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Okay. Warner?

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

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

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

DR. CROSSON: Jack.

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

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

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

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

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

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

text, Jack?

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

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

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

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

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

DR. CROSSON: Okay. All right.

[Laughter.]

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

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

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

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

DR. CROSSON: Okay. Bruce.

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

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

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

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

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

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

DR. CROSSON: Paul.

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

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

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

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

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

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

[Laughter.]

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

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

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

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

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

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

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

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

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

DR. CROSSON: Brian.

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

[Laughter.]

MS. BUTO: Be careful what you ask for.

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

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

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

DR. CROSSON: David. David and Paul.

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

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

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

DR. CROSSON: Well, good luck, Jay.

[Laughter.]

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

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

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

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

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

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

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

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

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

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

[Show of hands.]

DR. CROSSON: All opposed?

[No response.]

DR. CROSSON: Abstentions?

[No response.]

DR. CROSSON: Seeing none, it passes unanimously. And then we have the draft MIPS recommendation, its bullet points included. I'll give you a chance to read that again.

DR. SAFRAN: Can I ask a question?

DR. CROSSON: Yes, Dana.

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

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

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

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

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

[Show of hands.]

DR. CROSSON: All opposed?

[Show of hands.]

DR. CROSSON: We have two. Abstentions.

[No response.]

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

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

[Pause.]

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

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

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

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

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

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

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

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

We emphasize that our analysis is limited for two reasons.

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

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

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

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

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

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

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

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

services.

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

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

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

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

DR. CROSSON: Thank you, Dan.

Questions for Dan on the ASC recommendations?

[No response.]

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

[Show of hands.]

DR. CROSSON: All opposed?

[No response.]

DR. CROSSON: Abstentions?

[No response.]

DR. CROSSON: Seeing none, it passes unanimously.

[Dr. Coombs not present for the vote.]

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

DR. ZABINSKI: I don't know either.

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

[Show of hands.]

DR. CROSSON: Opposed?

[No response.]

DR. CROSSON: Abstentions?

[No response.]

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

[Dr. Coombs not present for the vote.]

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

MS. RAY: During this session I will summarize

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

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

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

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

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

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

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

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

determined under current law.

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

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

DR. CROSSON: Thank you, Nancy.

Questions for Nancy? Yes, Bruce.

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

MS. RAY: 2021.

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

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

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

DR. CROSSON: Go ahead. Sorry.

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

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

MR. THOMAS: Okay.

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

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

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

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

MR. THOMAS: Could change it some.

MS. RAY: Yes.

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

MS. RAY: Yes.

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

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

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

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

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

DR. MATHEWS: Or Nancy could --

MR. THOMAS: I think you just --

[Laughter.]

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

MR. THOMAS: Right.

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

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

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

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

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

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

MR. THOMAS: Right.

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

MR. THOMAS: Yep.

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

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

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

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

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

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

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

David, do you still have a point?

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

DR. CROSSON: Okay. Thank you.

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

[Show of hands.]

DR. CROSSON: All opposed?

[No response.]

DR. CROSSON: Abstentions?

[No response.]

DR. CROSSON: It passes unanimously.

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

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

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

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

So now we'll look at our indicators of payment

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

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

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

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

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

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

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

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

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

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

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

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

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

DR. CROSSON: Thank you, Kim.

Questions for Kim on hospice?

[No response.]

DR. CROSSON: Seeing none, we'll proceed to vote. All Commissioners in favor of the draft recommendation, please raise your hand.

[Show of hands.]

DR. CROSSON: All opposed?

[No response.]

DR. CROSSON: Abstentions?

[No response.]

DR. CROSSON: Seeing none, it passes unanimously.

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

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

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

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

DR. CROSSON: Okay.

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

DR. CROSSON: Thank you very much.

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

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

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

patients.

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

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

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

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

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

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

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

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

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

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

And I'll turn the voting back to Jay.

DR. CROSSON: Thank you, Carol.

Questions for Carol?

Warner.

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

DR. CARTER: Yes, I can do that.

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

So we took a two-part strategy. We used the 2008 data from the PAC PRD to get a sense about whether it was possible to predict payments based on patient characteristics. Once we proved to ourselves that we could do that, we put that data aside, and we rebuilt a model

using 2013 PAC stays.

And in our report that we issued to Congress saying that this was possible, we used those 2013 stays.

Then next year, when we were asking you to think about the level of payments, when one would go to implement the payment system, we wanted to update those estimates using the same stays, but inflating the cost and payments to 2017, to give a more accurate position sort of at the level of spending. So we used 2013 stays but estimated them up through the spending levels in the payment increases and the cost increases to 2017.

I will say just one footnote, using the PAC PRD allowed us to learn one very important thing. Even though the dataset was limited, it allowed us to model a prototype design with and without function, and in doing that, we learned that function was not the game changer. That it was okay to proceed with the design without that information and fold that in over time in the future if that was seen as a desirable thing.

So even though it was a limited set and we didn't want to use it for impacts, we learned some very important things from that study.

MR. THOMAS: And from '13 to -- you say current data. I know you updated it for kind of the trend of cost. Has there been any major utilization moves, one way or the other, or has it been pretty stable?

DR. CARTER: So I would refer to each of those things. I would not describe them as major changes of utilization from them.

MR. THOMAS: Okay, okay. Great. Thank you.

DR. CARTER: Do you guys agree with that?

[No response.]

DR. CARTER: Okay.

DR. CROSSON: Other questions?

[No response.]

DR. CROSSON: Okay. We'll proceed to the recommendation vote. You have the recommendation before you. Carol has read it. All Commissioners in favor of the recommendation, please raise your hands.

[Show of hands.[

DR. CROSSON: All opposed?

[No response.]

DR. CROSSON: Abstentions?

[No response.]

DR. CROSSON: Commissioner Wang was not present for the vote.

Okay. Carol, you're going to take us through now the SNF update?

DR. CARTER: Yes.

Let me remind you of a thumbnail sketch of this sector. In 2016, there were about 15,000 providers that furnished services to 2.3 million fee-for-service stays. About 4 percent of beneficiary used SNF services, and Medicare fee-for-service spending totaled $29.1 billion.

Reviewing the indicators of payment adequacy, we see that access to SNF services is adequate. In 2016, supply was steady. Even though covered admissions and days decreased between 2015 and 2016, these trends are consistent with the decline in inpatient hospital stays, which is a requirement for Medicare coverage, and with expanded MA enrollment and alternative payment models, which are more likely to use fewer SNF services.

Quality performance was mixed, with small changes from 2015.

Access to capital is adequate and expected to remain so. Medicare remains the provider's preferred

payer.

The Medicare margin in 2016 was 11.4 percent, and that was the 17th year in a row that the average was above 10 percent.

For efficient providers--those with relatively low cost and high quality--the average Medicare margin was 18.2 percent, and we project the 2018 margin to be 9 percent.

In considering how payments should change for 2019, the broad circumstances of this industry have not changed. Medicare SNF margins have been among the highest of any sector for over 15 years. The PPS continues to favor the provision of therapy and needs to be revised. The wide variation in Medicare margins reflects differences in patient selection, service provision, and cost control.

The Draft Recommendation reads: The Congress should eliminate the market basket update for skilled nursing facilities for fiscal years 2019 and 2020; direct the Secretary to implement a redesigned prospective payment system in fiscal year 2019 for skilled nursing facilities; and direct the Secretary to report to the Congress on the impacts of a revised PPS and make any additional

adjustments to payments needed to more closely align payments with the cost of care in fiscal year 2021.

The implementation of a revised SNF PPS would redistribute payments across conditions and narrow the differences in profitability across them. Based on their mix of patients and current practices, payments are going to shift across providers. The redistribution across providers would enable the Commission to recommend and for policy makers to implement a level of payments that is more closely aligned with the cost of care.

In terms of implications, the recommendation will decrease spending relative to current law by between $750 million and $2 billion for fiscal year 2019 and by more than $10 billion over 5 years.

The recommended changes will increase access for beneficiaries who are disadvantaged by the current payment systems, such as those who are medically complex. Given the level of Medicare margins, we expect providers to be willing and able to care for beneficiaries. The impact on individual providers will vary based on their mix of cases and their current therapy practices.

On average, payments will shift from freestanding

SNFs and for-profit SNFs to hospital-based providers and non-profit providers. As a result, the recommendation would reduce the disparities in Medicare margins across providers.

I'll put the recommendation up.

DR. CROSSON: Questions for Carol?

Yes, Bruce.

MR. PYENSON: Just a question for the next cycle. On the second bullet of the redesigned prospective payment system, I'm wondering if we could get insight into moving from a per diem to an episode-based payment that's prospective.

DR. CARTER: Well, that's actually in statute, so that would take congressional action. CMS doesn't have the authority to do that. So am I answering your question?

MR. PYENSON: Well, it's a next-cycle question. It's not part of this.

DR. CARTER: Okay. All right. We'll take it up.

DR. MATHEWS: I think what Bruce is asking is if we could start to think about --

DR. CARTER: Oh, I see.

DR. MATHEWS: -- changing the unit of payment.

DR. CARTER: Got it. Got it. Okay. Thank you, Jim.

DR. CROSSON: Okay. Seeing no other questions, the Draft Recommendation is before you. It's been read. All Commissioners in favor, please raise your hands.

[Show of hands.]

DR. CROSSON: All opposed?

[No response.]

DR. CROSSON: Abstentions?

[No response.]

DR. CROSSON: Seeing none, it passes unanimously. Thank you, Carol.

Evan, you're going to talk to us about home health.

MR. CHRISTMAN: Good afternoon. Now we're going to look at the framework as it relates to home health.

Next slide, please.

As a reminder, Medicare spent $18.1 billion on home health services in 2016. There were over 12,200 agencies, and the program provided about 6.6 million episodes to 3.4 million beneficiaries, and home health accounted for about 5 percent of total fee-for-service

spending.

Turning back to our framework, here is a summary of our indicators. Beneficiaries have good access to care; 99 percent live in an area served by home health; 86 percent live in an area with five or more.

The number of episodes decreased slightly in 2016, and the share of beneficiaries using the service also experienced a small decline.

In terms of quality, functional measures of quality improved in 2016, but the rate of adverse events such as hospitalization and emergency room use did not change significantly. Access to capital is adequate. We continue to see interest in the sector by outside investors with some outside firms buying home health agencies to expand their presence in the sector.

Margins for freestanding agencies for 2016 are projected to equal -- excuse me. Margins for 2016 equal 16.6 percent, and the marginal Medicare profit for freestanding home health agencies is 17.4 percent. And the estimated Medicare margins is 14.4 percent.

I would note that these are average margins, and our review of efficient providers success that better

performing agencies can achieve good outcomes with profit margins that are significantly higher.

Next slide, please.

Overall, our indicators are positive indicating that payments are more than adequate. Because of the consistently high margins, the Chairman's recommendation is to pursue a payment reduction of 5 percent in 2019, followed by a rebasing that would address the high margins of home health agencies.

In addition, we have noted a problem with the incentives of the home health PPS, that it uses the number of therapy visits provided in an episode to set payment. Under this system, payment increases as the number of visits rise. The Commission and others have noted that this incentive distorts decisions about care, and the higher rate of volume growth for these episodes may reflect financial incentives and not patient needs.

As a response, our recommendation will include a clause calling for the end of therapy visits as a payment factor and would make the system fully prospective by basing payment solely on patient characteristics. Implementing this second change would be budget neutral,

generally moving funds from providers that do more therapy to those that do less.

Our proposed recommendation with these components reads that Congress should reduce Medicare payments to home health agencies by 5 percent in calendar year 2019 and implement a two-year rebasing of the payment system beginning in 2020. The Congress should direct the Secretary to revise the prospective payment system to eliminate the use of therapy visits as a factor in payment determinations, concurrent with rebasing.

The impact of this change would be to lower spending by 5- to $10 billion over five years and $750 million to $2 billion in 2019. The impact to beneficiary should be limited. It should not affect provider willingness to serve beneficiaries.

Eliminating therapies of payment factor would budge-neutral as I mentioned, but redistributive. The policy would shift funds to hospital-based agencies that generally do less therapy and away from freestanding for-profit agencies, which typically do more therapy.

That completes my presentation.

DR. CROSSON: Great. Questions for Evan?

Amy.

MS. BRICKER: On the prior slide, could you clarify the impact? 750?

MR. CHRISTMAN: To $2 billion.

MS. BRICKER: Million or Billion?

MR. CHRISTMAN: Yeah, yeah.

DR. MATHEWS: 750 million to 2 billion.

MR. CHRISTMAN: I'm sorry. 750 million to 2 billion. That's what -- the 750 should have a "million" after it and the 2 should have a "billion" after.

MS. BRICKER: Gotcha. Okay. Thank you.

DR. CROSSON: Okay. Any other questions, comments, or anything else?

[No response.]

DR. CROSSON: The Draft recommendation is before you. It's been read. All Commissioners in favor of the recommendation, please raise your hands.

[Show of hands.]

DR. CROSSON: Opposed?

[No response.]

DR. CROSSON: Abstentions?

[No response.]

DR. CROSSON: It passes unanimously. Thank you.

And now we'll move on. Dana has appeared, and she's going to present the IRF recommendation.

MS. KELLEY: Last month, the Commission discussed the findings from our update analysis of inpatient rehabilitation facilities. I will review those findings and then present the Draft Recommendation for your consideration.

Just as a reminder, here is some background information on IRFs. In 2016, there were just under 1,200 IRFs. They furnished about 391,000 fee-for-service stays, at a cost to the Medicare program of $7.7 billion.

Overall, our indicators of payment adequacy are positive. Between 2015 and 2016, the supply of IRFs remained fairly steady. The number of IRF discharges per fee-for-service beneficiary grew by 1.4 percent in 2016. The average IRF occupancy rate was 65 percent, indicating that capacity was more than adequate to handle current demand for services.

To assess the quality of care in IRFs, we looked at discharge to the community and to SNFs and readmissions to the acute care hospital. We also looked at measures of

improvement in motor function and cognition. These measures have generally improved since 2011.

We then considered access to capital. Hospital-based IRFs have good access to capital through their parent institutions. Large chains also have very good access to capital. We were not able to determine the ability of other freestanding facilities to raise capital.

And finally, the aggregate 2016 margin was 13 percent. Marginal profit in 2016 was 29.8 percent.

We expect that cost growth is likely to exceed payment growth in 2017 and 2018, and so we've projected that the aggregate margin will fall to 11.9 percent in 2018.

So that brings us to the update for 2019. You'll recall that the Commission recommended that the update to IRF payments be eliminated for fiscal years 2009 through 2017. Then, as the aggregate margin neared historic highs, the Commission recommended a 5 percent reduction in the payment rate for 2018.

In the absence of legislative action, CMS has been required by statute to increase payments for each of these fiscal years. Though cost growth picked up in 2016

and margins declined somewhat, we project that aggregate payments will remain well above the costs of caring for beneficiaries in 2018. Indications, then, are much as they were last year.

So our draft recommendation for fiscal year 2019 echoes last year's recommendation. It reads: The Congress should reduce the fiscal year 2019 Medicare payment rate for inpatient rehabilitation facilities by 5 percent.

We do not expect this recommendation to have an adverse effect on Medicare beneficiaries' access to care or out-of-pocket spending. Eliminating the update for 2019 will reduce program spending by between $250 million and $750 million in 2019 and between $1 billion and $5 billion over five years. Even with a 5 percent reduction in the payment rate, we project that the aggregate margin for IRFs will remain above 5 percent.

This Draft Recommendation may increase the financial pressure on some low-margin providers, but the recommendation would be coupled with MedPAC's previous recommendation to the Secretary to expand the high-cost outlier pool. Expanding the outlier pool would reduce potential misalignments between IRF payments and costs by

redistributing payments within the IRF PPS to high-cost cases.

As you know, we've always considered that to be a short-term fix. We've also recommended and would reiterate here our recommendation that the Secretary improve payment accuracy overall and program integrity as well by reviewing IRF assessment and verifying the tool's inter-rater reliability.

So that concludes my presentation, and I'll turn it back to Jay.

DR. CROSSON: Thank you, Dana.

Questions for Dana?

[No response.]

DR. CROSSON: Seeing none, the Draft Recommendation is before you, and it's been read. All Commissioners in favor of the Draft Recommendation, please your hand.

[Show of hands.]

DR. CROSSON: All opposed?

[No response.]

DR. CROSSON: Abstentions?

[No response.]

DR. CROSSON: Seeing none, it passes unanimously.

And then the last presentation in this segment and the last update discussion is on long-term care hospitals.

Stephanie is here. Off to you.

MS. CAMERON: Thank you. Now, moving to our review of last month's LTCH presentation and your mailing materials, you'll recall that in 2016, Medicare paid LTCHs about $5.1 billion dollars for about 126,000 discharges. The average Medicare payment in 2016 was about $41,000 across all cases and $47,000 for certain qualifying cases.

In our payment adequacy analysis, we first looked at access to LTCH services. Remember that many beneficiaries live in areas without LTCHs and receive similar services in other settings. Occupancy rates across the industry have remained stable. Although the volume of LTCH services per fee-for-service beneficiary declined, this decline is in large part from the implementation of the patient-level criteria as intended by law.

Next, we considered changes in quality. We continue to rely on claims data to assess gross changes in aggregate mortality and readmissions, and since 2010, these

measures have been stable or improving.

In considering access to capital, this year availability of capital says more about the uncertainty regarding the regulations governing LTCHs, the effect of the moratorium which recently ended, and uncertainty regarding the industry's ability to comply with the new patient level criteria, than it does about the actual payment rates. The Commission expects continued industry consolidation, limited need for capital and limited growth opportunities until after the LTCH patient criteria becomes fully implemented and LTCHs adjust accordingly.

As we discussed last month, the 2016 aggregate Medicare margin was 4.1 percent across all cases. Because the implementation of the dual-payment policy began in fiscal year 2016, we calculated a pro forma margin that includes only cases that would have qualified to receive the full LTCH standard payment rate. Using the most recently available claims data, we calculated this margin to be 6.3% in 2016.

Looking ahead, we project that the 2016 LTCH margin for cases that qualify to receive the full LTCH standard payment rate will decline in 2018. We expect cost

growth to be higher than current law payment growth since updates to payments in 2017 and 2018 were reduced by PPACA-mandated adjustments equaling over one percentage point each year. Using historical levels of cost growth, we project that LTCHs' Medicare margin for qualifying cases paid under the LTCH PPS will be 4.7 percent in 2018.

With that, the draft recommendation reads:

The Secretary should eliminate the fiscal year 2019 Medicare payment update for long-term care hospitals.

Eliminating this update for 2019 will decrease federal spending relative to the current law payment update between $50 and $250 million in 2019, and by less than $1 billion over five years.

We anticipate that LTCH's can continue to provide Medicare beneficiaries with access to safe and effective care and accommodate changes in cost with no update to the payment rates for qualifying cases and LTCH's in fiscal year 2019.

And with that I turn it back to Jay.

DR. CROSSON: Thank you. Questions for Stephanie? Yes, Alice.

DR. COOMBS: These margins are without the short-

stay and the high-cost outliers?

MS. CAMERON: No. The margins do include the short-stay and the high-cost outliers. The margins we presented for 2016, both the cases the qualify, the all-case margin, and the marginal profit include all of that --

DR. COOMBS: Okay.

MS. CAMERON: -- whether or not you're a high-cost outlier or a short-stay outlier or you're just a regular LTCH, standard payment rate.

DR. COOMBS: And what about CCI cases?

MS. CAMERON: So that's where the difference comes in. So the margin I presented for qualifying cases, that was for the cases that meet the criteria or the CCI cases according to law. Those may be short-stay outliers. They could be high-cost outliers. But they just meet the criteria to be paid the LTCH standard payment rate.

Our projected margin for those cases is the 4.7 percent I presented, and that also includes all CCI cases, so it's made up of all CCI cases, regardless of whether they were just a regular, straight-up payment for the standard payment rate, or whether they were short-stay outlier, or a high-cost outlier.

DR. COOMBS: Okay, because Carol did the calculation, I think it was last month, of projections of what this looks like, combining the PPS with the non-CCI cases, right, in terms of where they would go?

MS. CAMERON: I'm not sure.

DR. COOMBS: So there's some of the LTCH cases that are in common in that bridge for the blended rate. And so what I was wondering is how this would intertwine with that.

MS. CAMERON: So we haven't looked at -- actually, we have looked at how the blended rate would affect some CCI cases, in terms of when we start doing the unified PAC payment plan that we spoke about. And, generally, while we didn't -- I don't have the exact amount wired in my head on how that would change, there was an increase, for example, for patients on ventilators. We didn't build that into the 2018 margin projection, however.

DR. CROSSON: Okay. Seeing no other questions, we will proceed to the vote. The recommendation is before you. It's been read.

All Commissioners in favor of the recommendation please raise your hands.

[Show of hands.]

DR. CROSSON: All opposed?

[No response.]

DR. CROSSON: Abstentions?

[No response.]

DR. CROSSON: Seeing none, it passes unanimously.

Thank you very much, and we will proceed to the last presentation today.

[Pause.]

DR. CROSSON: Okay. Today's final presentation returns us to policy discussions. We've finished with the update process for this year. And the first issue we're going to take on is, in fact, a mandated report, actually an extension of a mandated report on the effects of the Hospital Readmissions Reduction Program. As many of the Commissioners know, there has been some reports in the literature, even in the popular press, about this issue. And so Craig and Jeff are going to present us with the requirements of the mandated presentation, but extend that into this set of other questions.

Craig, it looks like you're going to start.

MR. LISK: Yes, I am. Good afternoon. This

session is the first discussion of a congressionally mandated report on the Hospital Readmissions Reduction Program. This report is due in June of this year.

First, some background on how increased awareness of excess hospital readmissions led the Congress to enacting the Hospital Readmissions Reduction Program.

In 2008, the Commission was concerned that a lack of care coordination and poor transitions between acute and post-acute settings resulted in more readmissions than were necessary. There was a belief that the care transitions could be improved and readmissions reduced, but hospitals did not have a financial incentive to improve care that occurred outside of their walls. To create a financial incentive to better coordinate care and reduce readmissions, the Commission recommended publicly reporting readmission rates and reducing payments to hospitals with relatively high readmission rates. Following the commission report there were several articles suggesting readmission rates were higher than they needed to be. Then, in 2009, CMS started to publicly report hospital readmission rates. in 2010, Congress enacted the Hospital Readmission Reduction Program, and in 2013, hospitals with

above average readmission rates during 2010 to 2012 had their hospital inpatient payments reduced.

Following the passage of the program, readmission rates declined. Several pieces of data suggest that the program was a key contributor to the decline in readmissions. First, surveyed hospital administrators report that they increased their efforts to reduce readmissions due to the program. Second, readmissions declined on a raw and a risk-adjusted basis. Third, the declines in readmission rates were faster for conditions covered by the program than for other conditions. Fourth, a study that compared reductions at hospital affected by the policy found that their rates declined faster than rates at critical access hospitals that were not covered by the policy. Therefore, the evidence is strong that the program was at least partially responsible for the decline in readmissions.

However, in recent years some researchers have raised some concerns about the policy. One concern is that patients may not be readmitted, but still cared for in the hospital under observation status. The concern was that care patterns and care coordination were not really

improving, but patients that used to be admitted as inpatients were just being held as observation patients at the hospital. In other words, did hospitals just substitute observation care for inpatient admissions rather than truly improve care?

A second concern is that changes in risk-adjusted readmissions primarily reflect coding changes, rather than a real improvement in care. A third concern is that necessary readmissions were not occurring, resulting in higher mortality for some heart failure patients. There is limited evidence of this, but it did receive attention in the popular press.

That brings us to the mandate for this study. In the 21st Century Cures Act, the Congress required that MedPAC examine if reduced readmissions are related to changes in outpatient and emergency services furnished.

In this report we examine relationships between the change in readmissions and three things: changes in observation stays, changes in ED visits, and changes in mortality during the stay and the 30-day period following discharge.

Our mandate is to examine the effect of the

Hospital Readmission Reduction Program. Therefore, we start by looking at all admissions that are covered under the CMS readmission measures. These are admissions for beneficiaries age 65 and older, enrolled in fee-for-service Medicare with certain exclusions, such as left against medical advice or beneficiary that had a prior admission for the same diagnosis within 30 days.

As we discussed in your paper, there was a big drop in admissions per capita suggesting that the profile of patients admitted changed over time. Therefore, risk adjustment is important to capture this change. Therefore, we use a clinical categorical model of risk of readmissions developed by 3M. However, because risk adjustment is imperfect, we also present raw readmission rates, measuring the rates prior to risk adjustment.

Finally, because there are many concurrent factors affecting readmissions and mortality, we want to look at more than simple time trends. Therefore, we also look at correlations between changes in readmissions and changes in other variables of interest.

So we will start by presenting raw readmission rates.

The red line at the top of this slide is the all-cause readmission rates without any risk adjustment. We see a downward trend in readmissions. This is reassuring, especially given that the number of initial admissions also declined during this time frame.

Second, we turn to the green double line. This is the trend in unplanned readmissions. The line has the same slope as the red line, but is slightly lower because it excludes certain planned readmissions to the hospital such as scheduled surgery, maintenance chemotherapy, or rehabilitation. These are the readmissions captured in CMS's readmission measures.

Third as a crosscheck on the data. We also looked at changes in potentially preventable admissions. This is a 3M measure that only looks at readmissions that appear to be clinically related to the initial admission. The level of these readmissions is lower due to more exclusions.

However, the main point is that across all three measures readmission rates are declining and the slope of the trend lines are similar.

From here on out we will focus on unplanned

readmissions, the type covered by the policy.

This slide shows the decline in raw readmissions for five specific types of services covered by the readmissions policy through 2016, and there are two main points to this graphic. First, notice that all of the lines are trending downward. That is good. Second, notice that the green line represents all conditions, including those not covered by the policy. The slope of the green line is not quite as steep as the other lines. This indicates that raw readmission rates were declining slightly faster for conditions covered by the policy than for other conditions.

So far, we have just showed you the raw readmission rates. Now, we switch to risk adjusted rates.

In your mailing materials, we discussed why we believe patient complexity among those admitted has increased over time. Therefore, risk adjustment is important. And the main point to this slide is that risk adjusted rates are declining and that the slope of the lines is a little steeper than we saw for the raw readmission rates on the previous slide.

We state in your paper that we think the increase

in patient complexity reported on the claims at least partially reflects the admitted patients becoming more difficult. We do not think it is all coding. The reasons are, first, admissions per capita declined by 17 percent. We expect that it is the easier cases that are no longer being admitted to the hospital. Second, when we look at the data, we see that there are fewer one-day stays. This is consistent with the incentives that occurred when the Recovery Audit Contractors started to deny payments for short stays in 2010. The activities of the RACs, which were concurrent with the program, could have resulted in some short stay patients, who are less severely ill, being shifted to observation.

While we are saying that it appears that patients being admitted to the hospitals are sicker on average, we are not saying that there is no change in coding. Part of the change in reported complexity could have been due to changes in coding.

Now let's shift our focus to our mandate. Are observation and ED visits acting as substitutes for inpatient care?

This slide examines per capita changes in use of

inpatient care, observation care, and ED services. These are per capita numbers for all Medicare beneficiaries over age 65, not just those readmitted. The green line shows declines in initial admissions -- that's where we saw a 17 percent decline -- the red line increases in ED visits -- as we discussed in your mailing -- and the orange line increases in observation stays. As we discussed in your mailing, observation and ED visits increased broadly. That means that the rate of increase for patients without a prior admission to the hospital was similar to the rate of increase after a discharge for patients admitted to the hospital. Another way to look at this is to examine the share of all ED visits that took place after a hospital discharge, and this share was the same in 2010 and 2016.

Now we shift to looking only at care received after an admission. The top green line shows that risk-adjusted readmission rates are going down. The red line shows that risk-adjusted ED rates are going up for those recently discharged, with a big jump in 2012. We are not sure of the cause of the jump in 2012, but it may have partially been due to the RAC program, which reduced initial admissions and encouraged substituting ED care for

inpatient admissions. It also could have been partially due to the readmission program. Finally, the orange line shows that observation care was steadily increasing over this time.

So next we try to see if there is a correlation between declines in readmissions and increases in ED visits and observation stays. This slide shows that hospitals with bigger declines in readmissions were slightly more likely to have larger increases in observation and ED visits. This suggests that to some degree ED visits and observation visits can substitute for readmissions. But the correlation is relatively weak and the reduction in readmissions only explains about 3 percent of the variation in changes in ED and observation rates. So there may be some effect, but it appears that the readmission program is not the main driver behind the ED and observation growth.

So another way to look at this is to examine changes in readmission rates, observation stays, and ED visits for the conditions covered by the program and for those not covered. The first set of bars looks at conditions covered by the program. The green bar shows that these conditions had a 2.9 percentage point drop in

readmissions from 2010 to 2016, which was much larger than the 1.3 percentage point drop for conditions not covered by the program.

But now if we look at change in use of observation, the orange bars, and ED, the red bars, we see that the change in use of these services was almost identical for conditions covered and not covered under the program. If we were to expect hospitals were using observation and ED settings to avoid readmission penalties, we would expect to see larger increases in use of observation and ED for conditions covered by the program, but we do not.

Jeff?

DR. STENSLAND: All now. Now we're going to shift gears to talk about mortality. We are presenting data on mortality because a recent article raised a concern that the readmission program may be causing mortality rates to rise. We do not find any evidence of this, and will walk you slowly through the data.

First we look at raw mortality rates, and I want you to start by looking at the sold green line in the middle of the graphic. That is the raw mortality rate

across all admissions. Note that the readmission rate climbed up slightly from 2010 to 2015, and that increase could be due to the 17 percent drop in initial admissions. As easier cases are no longer admitted to the hospital, patient complexity increases, and we would expect increase in the raw, meaning not risk-adjusted, mortality. Given the decline in initial admissions we see, increasing raw mortality rates should not be unexpected.

What is surprising is the blue and orange lines at the top of the paper. The blue line shows raw pneumonia mortality rates declining, the orange line shows raw AMI rates declining. The declines in pneumonia and AMI mortality have not received much attention, but what has received a significant amount of attention is the red line. It shows a slight increase in raw mortality for heart failure patients. Because this coincides with the time frame of the readmission program, one study raised questions whether the program has somehow contributed to the increase in heart failure mortality. The concern is that hospitals are turning away necessary readmissions to avoid the readmission penalty.

But taken together, the data show large mortality

declines for two HRRP conditions, two readmission conditions, and a small increase for one. This is not consistent with the readmission program causing an increase in mortality.

Of course, this is just raw rates. We should also look at the risk-adjusted rates to see how mortality rates look after adjusting for patient severity.

When we look at risk-adjusted rates we see all five conditions showing a decline in mortality, and this could be due to better care, or it could be due to increase in coding of comorbidities, or both. We expect that at least some of the change in risk adjusted mortality is real, given the big drop in initial admissions. Therefore, we think at least some of the improvement in mortality across the conditions covered by the Readmission Reduction Program appears to be real.

Nevertheless, risk adjustment is imperfect, so we want another method for looking to see if changes in readmissions are associated with changes in mortality.

This graphic looks at the correlation between changes in readmissions and changes in mortality from 2010 to 2016. Each green dot represents a hospital. The yellow

dotted line represents a linear regression line, and we see that the correlation is weak but the positive slope is reassuring. The positive slope tells us that falling readmission rates are associated with falling mortality rates.

Now the slide here only looks at the relationship for risk-adjusted mortality of heart failure patients, but we examined the other correlation and found that the positive correlation holds for all five conditions covered by the readmission policy. It also holds when looking at either risk-adjusted or the raw rates.

The bottom line is that the data we have suggest that declines in readmissions are not causing increases in mortality.

The positive clinical outcomes we have seen in terms of reduced readmissions and reduced mortality, now we now shift to looking at costs.

We computed what the cost of readmissions would have been if the 2016 readmission rates were still as high as they had been in 2010. We found that the Medicare program spent $2.28 billion less on readmissions in 2016 than it would have if readmission rates had not declined.

The program did spend a bit more on observation visits and ED visits, but these costs are relatively small. On average, the payment for an observation stay is about 1/5th the payment for a readmission, and the payment for an ED visit is about 1/20th the payment for a readmission.

The bottom line is that the changes in use of post-acute services resulted in Medicare spending being reduced in 2016 by about $2 billion.

So the data we have presented suggests a few things. First, readmissions declined. Second, while observation stays increased, they did not fully offset the decrease in readmissions. Third, while ED visits also increased, those increases appear to largely be due to factors other than the readmission program. And fourth, in addition, all of the evidence we examined suggests that the readmission program did not result in increased mortality.

Now while the program is not perfect, it has appeared to generate some benefits for patients and taxpayers. Patients benefit by not having to endure as many readmissions. Patients spend less time in the hospital and appeared to have at least equal outcomes. Second, the readmissions program is a contributing factor

to the $2 billion reduction in spending on readmissions. This will help extend the financial viability of the Medicare trust fund.

As I said, the program is not perfect. In the past, we've discussed how the program could be improved. We outline some of those options such as fixing the payment penalty formula in your mailing materials, and we'll discuss those changes further when we discuss potential changes overall to hospital incentive programs in the spring.

Now I'll turn it back to Jay for your discussion.

DR. CROSSON: Craig and Jeff, thank you very much. This is really excellent work -- dense but fascinating. Thank you.

So we're now open for clarifying questions. I see David first, Jon.

DR. NERENZ: Thanks. Just to fill me in in a little more detail, let's start with the first bullet here about the program has reduced readmissions. If we could then flip to Slide 12? There are a couple others we could do, but let's see that one. Top line. This is risk-adjusted unplanned readmissions, probably a good precise

measure. I see no program effect there whatsoever. Readmissions were coming down before the program. The slope continues at exactly the same rate. I see no program effect. And we could point to three other graphs that have essentially the same pattern. What am I missing here?

DR. STENSLAND: Let's look back to the four points we've made. I think some people have said, "Look, it's just a downward slope, there's lots of downward slopes."

But I think first if we go out and we talk to people and they say, "We've actually done things to try to reduce readmissions," and they say it's due to the program. And then we go and we talk to the pharmacist who says they're doing pharmacy reconciling medications before discharging the patient, and they weren't discharging before, so there's at least some stories of things happening.

I think the second thing that we had was that there was actually a decline in the raw -- in the risk-adjusted readmission rate, so we don't think it's just a coding thing.

The third thing is we see a steeper drop for the

readmission rates that are in the program than the ones not in the program. So if you compare across the two different groups, you see that difference there. And I think if you also look at the Ibrahim study where they compared it, what happened to the readmission rate reductions for hospitals that are affected by the program and the critical access hospitals that are not affected by the program, the hospitals that are affected by the program had a steeper drop in their readmission rates than the other ones.

So you have all of those different pieces of information that are all lining up together, suggesting it's doing something.

DR. NERENZ: Okay. Maybe we can get into this more in Round 2. I just wanted to know if there was a statistical test or something that I was missing that was actually making that point from those graphs.

DR. CROSSON: Okay. Let's see. I had Jon, Pat, Bruce, David.

DR. COOMBS: Jay, can I ask a question on this [off microphone]?

DR. CROSSON: On that, yes, Alice.

DR. COOMBS: Jeff, you said that the possibility

of a different -- like a larger cohort of not as sick patients in this DRG classification might have resulted in some of that decline early on? I guess the severity of illness for the DRG, did you say something along those lines?

DR. STENSLAND: Right. So if we look at what was happening at the same point in time as the readmission reduction program took place, at the same point in time there was the RAC program, and what the RAC program did was it told -- for certain cases, the RAC auditors were coming in and saying this didn't really need to be an admission; therefore, we're not going to pay you. And they were really focusing on these short-stay cases.

And so what we believe happened is if you look at the data you see a decline in the short-stay cases, and you see those short-stay cases tended to have very low readmission rates. Okay? So when you get rid of those short-stay cases, we think the remaining cases are more difficult cases that would tend to have higher readmission rates. So if anything, the readmission rates at least in those kind of 2010-2014 period would probably maybe have been a greater improvement than you would expect just by

looking at the raw rates because the people got more difficult.

DR. COOMBS: So you're saying there was softer diagnosis for the DRG in the large cohort of the early -- say early on, if you had a diluted, in terms of severity of illness, for that DRG, you're seeing those patients not being -- the readmission is not impacted -- I mean is actually looking better than what it really is.

DR. STENSLAND: For the early years before the RAC program, yeah.

DR. COOMBS: Yes, yes.

DR. CHRISTIANSON: Thanks for this paper. There's certainly a lot of discussion that I feel about this. So you said this is due in June.

DR. STENSLAND: Yes.

DR. CHRISTIANSON: Will we be seeing another version at some other time then?

DR. STENSLAND: I guess that's depending on how much additional information comes out of this discussion. It's possible.

DR. CHRISTIANSON: I would say it depends on how much additional information comes out of the field in part

two. In fact, I think I just sent you another paper last week. I mean, it would really understate things to say that this has become a cottage industry among health services researchers.

[Laughter.]

DR. CHRISTIANSON: And I expect that we're going to continue to see things. So my question is: Did you have plans to sort of, you know, keep us abreast of the new stuff that comes out, and then at some point you just lock the door and say, "That's as far as we can go"? And if so, what's that point?

DR. STENSLAND: I think we can do that one of two ways. You know, we could keep you abreast and put things in the paper before it goes out for your final review. If you think it's actually worthy of all your time to have another session, that's possible also. But that's kind of a hierarchy of the importance of --

DR. CHRISTIANSON: There's so much going on, I just don't want us to release a paper that could be more updated but wasn't because we just have some rule that says we can't do it after such-and-such a date. So we should talk about this.

Pat, you're next.

MS. WANG: I just wondered, on Slide 18, obviously the effectiveness of the program is good for beneficiaries avoiding unnecessary care. It's really good. On Slide 18, though, which tries to kind of get at some sort of cost ROI, I guess you could say, has there -- is it feasible or has there been an attempt to look at the total cost of care for beneficiaries who may have been in the cohort of those who avoided unnecessary readmissions, whether that is increased care at home, you know, physician visits to the home? Both medical care as well as maybe what you would call administrative costs, sending a pharm tech to bedside to do a medication reconciliation before somebody goes home? You know, doing more with social workers or care coordinators once the person does go home? I just wonder whether -- I just wonder whether there is any usefulness in looking at a total cost of care, including the use of, you know, certain post-acute-care resources. Even if it came out to be even, which I doubt, it's still a good thing. But this is part of the picture, so -- I know that this was the mandate, but I was just curious what you think of it, even, and is it worth looking at?

DR. STENSLAND: I think that would be interesting. I'm reluctant to say that we could do it well. At least when I think of -- at least I think there's one kind of working paper that Jon sent, but that looked at the extra costs of these people in the hospital that was charged to them. You know, was there more stuff charged to them in the hospital? But I think a lot of the things they're doing are not stuff that you actually have a charge for in the hospital. So it's hard to track those costs. Like if they have somebody that's setting up a follow-up appointment with the primary care physician as part of the discharge planning, or if they're having that pharmacist I talk about doing a reconciliation of the medication and they have a Pharm.D. doing it and maybe just a nurse was doing it before, it's hard to figure out how we would get data on how much that stuff is costing. I think this number is probably an upper bound because you're going to have some of those other costs.

MS. BUTO: What about post-acute, Jeff [off microphone]?

DR. STENSLAND: We could look at higher post-acute if we could come up with a good counterfactual of who

are these people that would have been readmitted. I don't think we could do a good job of that between now and whenever we hand out our June paper.

DR. CHRISTIANSON: Okay. Bruce, I think you're next.

MR. PYENSON: Thank you. A really terrific paper.

I noticed on page 6 of the drug cartels, the majority of hospitals, 81 percent, will have a penalty, but the penalties are small. And I was curious about if you had thoughts about the impact of the penalty since the penalties we're talking about are relatively small, if there's any scale effect there, you know, maybe -- so the implication is if we doubled the penalty or tripled the penalty, maybe the results would be even better, or not. That's one question.

And a related question on the penalty is that the -- I think there was some discussion -- this is on page 11 -- on the socioeconomic status, hospitals who have more poor patients would -- the recommendation, I think, from 2013 that Congress did mandate a peer grouping. And my question about the penalty there is -- it seemed to me the

penalty would go down for hospitals with more poor patients. Would it go up for hospitals with fewer poor patients so that the average stayed the same?

DR. STENSLAND: Yes.

MR. PYENSON: And on the first question, whether you have thoughts on the scale of the penalty.

DR. STENSLAND: When we've talked before, I think we've talked about not increasing the size of the penalty per readmission but actually decreasing the penalty for readmission by removing what I call the "multiplier," because now the penalty is really large for one extra readmission, and part of the thought we had discussed back, I think, in 2012, 2013, when we talked about this before, was taking the readmission penalty and expanding it to all conditions, but then having a smaller penalty for each readmission and make the size of the penalty more equivalent to the cost of that extra readmission. Right now the size of the penalty can be, you know, anywhere from five times the cost of the initial admission in a heart failure case to 25 times the cost of the initial admission in the case of hip and knee. So I think, if anything, especially in the hip and knee cases, the size of the

penalty for one excess readmission is probably too large, not too small.

DR. CROSSON: Okay. Let's see. David next, and then I see Sue, Dana, and Jack.

DR. GRABOWSKI: Great. Thanks for this chapter. I enjoyed it a lot. Could we look at Slide 9?

So when you say "all conditions" here, do you mean all other conditions not included within the HRP? Or does that include all readmissions?

MR. LISK: That includes all.

DR. GRABOWSKI: All. So this was an issue I had, and I promise it's a question, but why not compare the HRP conditions against all other conditions as your comparison group? That's what most researchers in the literature have done. You have those great parallel trends in the pre-period, and you can see the impact. That really gets at David's question earlier. What's the real impact of HRP here? I think you could show that. Why were you reticent in the chapter to do that? I kept waiting for you to show me the effect of the program, and you ever did, and it's sort of -- you took us most of the way there. You have the data. Why not show us the effect of the HRP? Why is that

not --

MR. LISK: I mean, that's what this slide is showing, so this is showing -- this slide's showing that. It's showing -- we're showing like all readmissions, but this is showing the same thing in terms of what that slide would be there.

DR. GRABOWSKI: If you go to Slide 10, you could do this for all of -- you could do this for op stays. You could do it for ED. You could do it for coding.

MR. LISK: Sure.

DR. GRABOWSKI: I think that would be a great way to sort of frame the chapter. And if you showed that for each of these steps, you could actually show kind of what was the true effect here, both intended and unintended, of the HRP. I would find that more convincing than some of the arguments that were made.

DR. CROSSON: Okay. Thank you. Sue.

DR. REDBERG: Jay, can I 00

DR. CROSSON: Oh, I'm sorry. Rita.

DR. REDBERG: On this slide, we're talking about a difference of a hundredth of a percentage point here? It's between 0.013 -- zero point --

MR. LISK: That's actually -- that's percentage point change and that's actually -- it's 1.3 percentage points. The labeling got -- yeah.

DR. STENSLAND: The labeling is wrong because --

DR. REDBERG: Okay.

DR. STENSLAND: The labeling says percentage points, but it's really in decimal points. So, yeah.

MR. LISK: It's really in decimal points, so that's -- it's 1.3 percentage points and 2.9 percentage points.

DR. CROSSON: Sharp eyes. We got sharp eyes here. Sue.

MS. THOMPSON: I'm going back to the questions in the discussion around post-acute and considering -- causes me to wonder a bit about total knees now being removed from the inpatient only category and what impact that will have on all of this. And is there an opportunity ahead of the game to think about how to structure watching that? Granted, you know, it will be the lower-risk patient that will be going to the outpatient setting. Nevertheless, there's going to be some readmissions, and I just have some curiosity about it. Have you thought at all about that,

Jeff?

DR. STENSLAND: I haven't thought about it, but it's a great idea, because I think there's a real danger that the readmission program will stop the movement to the outpatient basis, because the penalty for an excess readmission on the hip and knee is so huge, you might be reluctant to move your hips and knees to an outpatient basis where the easy cases go over there and you end up having high readmission rate and pay the huge penalty. That's a really good point.

MS. THOMPSON: Yeah, prospectively, I think it's one for us to keep our eye on.

DR. CROSSON: Brian, on this.

DR. DeBUSK: To that point, though, if I do a knee on an outpatient basis, I don't have an initial admission to trigger the readmission, do I?

DR. STENSLAND: No, you don't have an initial admission to trigger the readmission, so you're safe on that one. But the question then, what does it do to your rate?

DR. DeBUSK: But if an outpatient knee comes back to me and I admit the patient, I don't have a readmission.

I have an admission.

DR. STENSLAND: Right.

DR. DeBUSK: So I should -- maybe I'm missing something, but I think I'd be okay, wouldn't I?

MR. LISK: It's more the issue of the cases that remain.

DR. DeBUSK: Oh, you'll get -- sicker patients will be the inpatients and then you'll have to risk-adjust for those patients.

DR. STENSLAND: Yes, so I think the real question is: Can the risk adjuster fully account for how much sicker the patients that are still going to be inpatient? If the risk adjuster was perfect, we got no problem.

DR. DeBUSK: On a number of fronts.

MR. LISK: The other issue with hip and knee is the multiplier, and actually, it actually has a relatively low readmission rate. But, actually, in percentage terms, it had one of the biggest declines in readmission rates, probably because of the steeper penalty that they would be receiving.

DR. DeBUSK: That was to Bruce's earlier point. Could increasing the penalties actually improve the

performance of the program? Bruce, I don't mean to put words in your mouth. Was that what you were --

MR. PYENSON: Those were my words [off microphone].

DR. CHRISTIANSON: Well, Bruce, Brian; Brian, Bruce.

[Laughter.]

DR. CROSSON: So far not today. I did do a Paul-David thing, but that's okay. Sue, you're good? Dana.

DR. SAFRAN: So I was wondering whether you tried at all to tease out the effect of ACOs which launched in the midst of your observation period here. And it seems like a good thing to do if you haven't. I really like David's idea of, you know, doing that comparison of the conditions that were not covered by the program and the conditions that were. Once you introduce the ACOs, they have the incentive to reduce all readmissions, so you could look at sort of the interaction of these things. I think it's worth looking at to try to really get at the impact of the program. But the ACO program's certainly rowing in the same direction, so it would be, I think, instructive.

DR. CROSSON: Okay. Jack?

DR. HOADLEY: I'm jumping from methodology questions to process questions. First of all, I was trying to remember the 2013 recommendation -- or improvement suggestions, were those formal recommendations or were they more general?

DR. STENSLAND: They were more general policy options. There was no vote.

DR. HOADLEY: Okay. And then when you say on the last slide potential improvements and then we'll discuss in the spring, is that within the context of this report that we would talk about these improvements? Or is this more going into a more general outside of the context of this report? What do you have kind mind? And did you have in mind formal recommendations?

DR. STENSLAND: We started this in the fall where Ledia came up and led the discussion on the hospital value improvement program where we talked about shifting from these individual silos of different programs into one combined program where you would combine the readmission and mortality and maybe patient experience, and you have all these things creating a single score and then a single adjusted rather than multiple adjusters, which sometimes

can overlap. And while that discussion is going on, there will be some discussion of how maybe to evaluate readmissions or incent readmissions differently than we're doing right now.

DR. HOADLEY: So the report that specifically responds to this mandate would not be all that stuff, it would be just basically the analytical work that you're doing here.

DR. STENSLAND: Right.

DR. CROSSON: The intent here, as I understand it, is, assuming that we have general support, this would be the discussion leading to the final mandated report, and then other issues we can take -- if we decide we want to take on, we could take on subsequently.

Okay. So I see no further questions, so let's proceed to the discussion and comment period, and I think Rita is going to lead off.

DR. REDBERG: Thanks, and thanks for an excellent chapter and mailing materials. It's a very complex issue, and I think you summarized the literature well. It just leaves me with a slightly different conclusion, though, because I think it's really hard to know what's going on

here.

It's all observational data. There are questions about temporal trends, other programs going on. I mean, clearly there were good things that happened with the readmissions penalty. Hospitals all started outpatient programs, pharmacists, nurse to call the patient, but then clearly, there were other things going on. And some things are just not preventable, and it may have created perverse incentives not to readmit patients. We don't know.

Also, there were other questions that you mentioned about Ibrahim and the coding issue and whether what we were seeing was a change in coding severity and not an improvement in risk-adjusted mortality.

I don't know what -- the real savings because I think, as Pat said, there were big, bigger -- you know, we were looking at 1-, 2 billion in admissions, but there are a lot of costs of heart failure in the programs and other things.

Last week, when I was in the hall of the hospital, one of the heart failure cardiologists had just come back from rounding, and they said to me -- I said, "How are you doing?" and they said, "Oh, it's so

discouraging seeing so many heart failure patients now getting all these unnecessary procedures," and that's not usually what the other -- mostly, she was talking about ventricular assist devices, which is sort of not covered in here. But Medicare pays a lot of money -- I don't know -- 60-, 70,000 for these beds. And they used to be used for people that were very sick as a bridge to transplant, but now there is this destination therapy, which essentially the idea is that you put them in people with heart failure, and then they go out the rest of their lives with them.

The data is very unclear what the tradeoffs are. This is a pretty invasive device that you're now attached to. It has a lot of problems with thrombosis and pump and all of that.

But the other issue, there was a very interesting trial presented at the American Heart meetings in November on shared decision-making, and it turned out that a lot of people, as happens, getting these devices really didn't have an idea of what they were in for before they signed up for it, and their families didn't know. And it's quite a commitment for not just the patient but their family because it requires a lot of care.

This was a randomized trial they presented, the people that had what they called shared decision-making had a much lower rate of accepting the beds, which, by the way, also happen to be, as I said, very expensive.

We've had other studies where we know defibrillators, which again is very expensive, can be a life-saving intervention, but are overused. We know that the study published in JAMA a few years ago suggested like 25 percent of defibrillators that Medicare was paying for were outside of the cardiology guidelines, and now there's talk about maybe changing the guidelines.

Clearly, I think if our goal is to improve the care of patients with heart failure and to improve value, there are other places we could look that I think would have more bang for the buck and working more on this readmissions, which to me I feel like we've gotten a lot of the benefit from it, and there are much bigger pockets in all the people getting, for example, beds and defibrillators, particularly near end of life, that don't have the benefit of shared decision-making and may not have chosen to go that way.

So I just think we might start looking at other

avenues if we're trying to improve care for our heart failure patients.

DR. CROSSON: Thank you, Rita.

I just want to be clear on one point. I think I understand, and I think I agree with what you're saying. But I just want to be clear. You're not implying, I don't think, that the increased use of ventricular assist devices as an outpatient is a result of the hospital readmission program.

DR. REDBERG: I wasn't linking those at all.

I think at least what this cardiologist --

DR. CROSSON: Right.

DR. REDBERG: There's the draw of technology, and they are reimbursed very well.

DR. CROSSON: Yes.

DR. REDBERG: They're profitable for the hospital.

DR. CROSSON: No, I understand that.

DR. REDBERG: I don't think it's related to readmissions.

DR. CROSSON: I just want to be clear.

Okay. So where are we? Discussion. Brian --

I'm sorry. Let's move down this way. We got almost everybody. Sue, do you want to start?

MS. THOMPSON: Well, I think this was a wonderful chapter to end the day's discussion, and I want to build on the question that was raised. I think it was Dana who asked about taking a look at ACOs to see if there's any correlation to improving and reducing readmissions.

Actually, I think this discussion relates nicely to our chapter on MIPS and transforming or making recommendations that works to transform our health care system to move from fee-for-service to value.

Improving quality or reducing readmissions is not a solo opportunity. It really is a team sport, and having come from a hospital background in my past life, you don't reduce hospital readmissions without the support particularly of your specialty community and especially in the five diagnoses that are reviewed. So I think this just underscores the importance of the recommendations we've made earlier today, and I thoroughly enjoyed this topic. So thank you for your good work here.

DR. CROSSON: Thank you.

David.

DR. GRABOWSKI: Yes. Thanks again for the chapter.

The Hospital Readmissions Reduction Program has a very blunt policy, and the good news is that blunt policies often have their intended effect. The bad news is they often have lots of unintended effects.

And I think it's important here that we figure out both of those. Is it truly reducing admissions? And two, does it have any unintended consequences, whether that be coding changes or increased mortality, ED, ob stay? So I think we should continue to look in all of those dimensions.

There is a robust literature, as Jon noted, on all of those issues. I think, however, that MedPAC, given the data that we have access to and sort of the framework that we can apply to this, I think we can actually sort of put this all on sort of a common framework and take a close look at these issues.

I will say again that I think it's really important when we're framing each of these issue, both examining the intended effect but also all these unintended effects, that we compare those HRP conditions against other

conditions over time.

I think we should do that for the decline in readmissions. I also think we should look at the coding issues. I think that's very important.

I found the Ibrahim paper very compelling and interesting, and I agree with the bullet that you had up earlier. Coding may explain some of the effect. I don't think it explains all of the effect, and so I hope that maybe we could put a bound on how much of the readmissions effect is due to coding and how much is due to truly a decrease in readmissions.

And I think also looking at mortality, I think my read on the mortality work, including your work on this, suggests -- I don't think we've seen a big mortality effect associated with the HRP.

And then finally, looking at ob stays and ED visits, I think that's really important too. So I look forward to your work on this going forward.

Thanks.

DR. CROSSON: Brian.

DR. DeBUSK: I would also like to thank you both on a very well-written chapter. It was a good read.

You mentioned this in the paper, and I realized that this isn't going to be an integral part of the report coming up this summer, but developing out and reusing this concept of peer grouping, I mean, I think there's a lot of power. We almost let risk adjustment get away from us because when you tell me that something is risk adjusted, I have no idea. I mean, is it age? Is it gender? Is it full HCCs? It sort of proliferated the different techniques.

I think we have an opportunity here with SDS showing up in so many things. We mentioned it in the VVP earlier today as well. I think now getting a standard treatment where maybe we peer group into quintiles or deciles, but it's all tied, say, to SSI percentage, the more off the shelf we can make it and the more facile we can become with using it in all the different programs, I think it will be a huge benefit for us. So I hope we develop it out and continue to test it and see it appear in lots of different analysis areas.

DR. CROSSON: Okay. Warner.

MR. THOMAS: I think this was very informative as well.

I just think having the proper incentive here for hospitals to be doing the right thing and to not readmit is a great direction. I think we're seeing changes in readmission. I guess we got to continue to determine whether these are causal or not, but it's not having a negative impact from a mortality perspective, according to the data. So I would just encourage us to keep pushing programs like this forward.

DR. CROSSON: David.

DR. NERENZ: Yeah. Thanks.

Just to build a little bit on my question -- and I guess I'll express is now as a caution -- I really look forward to this, and I think the work done here is really important and really good. But in every one of these line graphs I looked at, I was impressed by the fact that the trend line started coming down all the way to the left side of the graph, and what my eye was impressed with was more just the continuation rather than a change, and so I guess I feel cautious in saying the program had certain effects because they certainly don't jump out of the graph visually. And since we only have a few time points, I don't think we have statistical tests about changing the

trend line. I wish we did. That's usually how you try to do it.

I would be curious about what those trends look like further back in time, just again to enrich that line, but maybe it's very expensive or impossible to do that.

So I guess all I can say is caution, and even on your point about the target conditions declining less than the others, that's -- what was that? Slide 9? Well, there's that. The differences are not that great. We don't say what were these lines doing before 2010. Were they converging any -- were these lines moving in the same direction, anyway? I guess it seems uncertain.

And then just to echo Dana's point that there are other things happening in the environment. You got ACO initiatives in the environment. You've got other things happening in the environment. So I'm not disputing the numbers, but to say just as a clear unqualified conclusion, the program reduced readmissions, I'm not so sure.

DR. CROSSON: Okay. Bruce.

MR. PYENSON: I think this was a terrific study, and I'd like to give you, the fellow Commissioners, my perspective on this, which is this is trends that we don't

often see in looking at the data. So something good is going on here.

And I don't want to take apart something that's fundamentally good and unusual to try to tease out exactly what happened in South Dakota versus what happened in Missouri. So I think as programs go, this was implemented and the outcomes are successful. Guess what? In the real world, you're probably never going to know all the determinants of what happens.

So I think the work -- I just don't want this to become an academic exercise and MedPAC to become involved in the cottage industry of publishing. So congratulations on terrific work.

DR. CROSSON: Jon, on this?

DR. CHRISTIANSON: Kind of on this, I guess, yeah, and on what David and David said.

So it is an interesting question. Most of the time, MedPAC is a consumer of research, and that's kind of what we're doing here, except we're also contributing our own data. And I think, David, you kind of suggested we should continue to do this kind of stuff going forward, and then, David, you said we need to have more timeline here to

really get a sense of what's going on. We need to back but also track it forward, both of which suggest that we do contribute to the cottage industry.

So I think we need to kind of make a decision about what we want to do here, and I think part of the reason -- so this was mandated. When I looked at it, I thought, "Wow. Why?" Maybe we kind of did something to get it mandated, but it's something we should have done, anyway. Sometimes the mandated stuff is stuff that we are less happy with, but I think we should be really happy we did this mandated report.

And this is really important stuff. Just a little anecdote, I just finished five days of executive education, four to six hours a day with a group of doctors, about 30 doctors, and we had a whole section on measurement. So I walked through the readmission measure and whether it was good or bad. I'll tell you, they all hate it. Every one of them hate measurement, and they hate the readmission, but they love the paper that said there was probably or there could have been a relationship between mortality and readmission. They all knew about that paper, and they took that like it was gold, right?

So the kind of stuff you're doing is a real benefit, I think, to the field to be able to sort through everything that you're seeing that's going on here and try to sort of provide some context for us also.

I'm kind of leaning in the we need to continue to do this for a little bit, even though it's not normally what we do and even though it won't be mandated in the future. I think there's going to be so much stuff coming out, and there's going to be continued need to put it in context, and I think that's what you were saying too, David, is that we have a context we can put it in. So I hope we do, even though it's kind of out of the norm for us.

MR. PYENSON: So are we going to apply for a clinical trial grant?

[Laughter.]

DR. CHRISTIANSON: Well, you can sign me on as a consultant if you'll do the work.

DR. CROSSON: Jim, you may want to comment on this. I mean, generally speaking we do our work. We publish our reports to Congress. We send letters to CMS, and we let it go at that. I mean, that's where we stand.

It's possible that this particular situation and the value of this research, as Jon is pointing out, might suggest that we do a little more than we normally do. That's something that we're considering doing.

DR. CHRISTIANSON: We did jump into this sort of discussion around cross-subsidies of pay -- Medicare payment and kind of try to put a new perspective on that and publish that, go into the Journal and then you publish that. And this might be another kind of example of that sort of topic where some clarification is useful.

DR. CROSSON: Okay. Alice and then Dana and Paul.

DR. COOMBS: So I read the Ibrahim article, but I also read the Gupta article too.

I just want to say something about -- we kind of broaches this, what, 2013? And back then, I talked about experiences that we were having in the community with this readmission that was correlated with the shuttle effect, and that would be that the patient would have a high-intensity procedure and then would go to a rehab, a post-acute care, and then within a short period of time would find themselves on the door steps of community hospitals.

So they're not being necessarily readmitted back to the parent institution -- and how that's tracked. It's almost like a shuttle because it's very hard to get back into the elite tertiary center when it's a post-operative complication and it doesn't involve some of the more initial interventional kind of procedures.

I think this is not unique, and I was wondering if we could look at the readmissions and whether or not the readmissions were -- and I think you can do this to the parent institution of the original admission, because I do think that there's something at work here. It can't be that I've seen this multiple times and no one is being aware of it.

Now, two things can be in operation. One is that because there's no continuity of care, there might be a lower threshold to readmit that patient back to the secondary institution where they arrive on the doorsteps, because they're usually coming from a place like -- they might be coming from an IRF, and the IRF says this patient has to go somewhere. They find themselves in the emergency room, and something must be done with this newfound symptom. So that's a piece of it.

It may be that if the patient actually went back to the parent institution that they may have an e-visit, but they may not necessarily be admitted to that facility because there's continuity of care. Hopefully, there's some kind of coordination with the service.

The particular institution that I am referring to is a highly integrated system, one of the largest in the country, on the East Coast. So it's not necessarily that these places are not ACOs and these are advanced -- the Cadillac model of an APM or ACO. So I think that that piece has always bothered me when it comes to that.

Initially, when we had the discussion, Jeff and Craig, I thought that all-cause readmission would be a problem because of the randomness of how some hospitals have a proclivity to have certain diagnoses, whereas other hospitals might be more pulmonary, and so that I was concerned about that skewed population that some hospitals may have with DRGs versus others.

That will be another interesting piece because I read the summary of how many hospitals are subject to the readmission penalty, and I think it's nearly 3,000 or something close to that. I should check my data before I

quote that, but I think it's a large number that is subject to the readmission penalty and looking at how that looks under the umbrella because it could tell us something about just the whole notion of coordinated care.

DR. CROSSON: Thank you.

Dana.

DR. SAFRAN: So just a couple of thoughts, I guess. I hear, particularly in David's comments, a kind of skepticism about whether the policy has worked, and I guess as I think about that, certainly some of the analyses that we've suggested and follow up to here will help us tease that out. You know, I think there's something in this picture that, yeah, up on the screen, that helps us get at that.

But one of the comments I wanted to make was that from a qualitative perspective, I have no question in my mind that this set of policies has changed the way hospitals are thinking about care and behaving and the work that they're doing.

So then it comes to the question of, you know, if it's true that it was already declining, and, you know, that the trend hasn't really changed, then I think the

question becomes, why not? Why aren't all the things that all these institutions are trying not working?

And so there I would just add a couple of points from my own experience. One is a hospital that's in our network that in order to reduce CHF readmissions – and they had a quite high rate when all this started -- hired a caseworker to call every CHF member post discharge, every single day, and then only wean off that daily phone call until they started to feel secure that that patient sort of understood what they needed to do to take care of themselves, et cetera. And they got their CHF readmissions to zero and kept them there. So that's one observation that, you know, I see for sure folks are working on this.

I also see, in our data, that before 2010, rates were high and undifferentiated. Everybody's rates were high, which makes sense to me because nobody was shining a light on it and nobody was really working on it. After 2010, you start to see some differentiation. You start to see some perhaps best practices emerging.

So I guess I wanted to inject that into this conversation because I don't have any skepticism myself that these policies have changed behavior. How well they

are -- how effective the interventions are is a different question. And the last thing I'll say, because I know this comes up often, is -- and I don't think it's all about SES, because, in fact, in our market some of the organizations, some of the hospitals that have the most socioeconomically vulnerable populations made the biggest improvements, because they took a serious look at who is our population and what would it take to reduce readmissions, and they started to do those things. Not every hospital that serves a low SES population did that, and therefore not everyone was so successful. But I've heard stories of the same from other markets, from Warner's market.

So I just wanted to inject those few thoughts. Thanks.

DR. CROSSON: Thank you, Dana. Paul.

DR. GINSBURG: Yeah, and I went and reread the mandate which you had in the paper, and the mandate does call for a research study, as we discussed. And I think that's fine because there are some real advantages that the MedPAC staff and Commissioners have in doing this. For one thing, the staff knows the Medicare data so much better than most researchers publishing in the academic

literature.

But it brought the question to my mind, is that even though they didn't ask for any policy advice as to how to improve the readmissions program, should we contemplate giving them some advice?

DR. CROSSON: We have that scheduled separately?

DR. MATHEWS: Yeah, we do.

DR. CROSSON: Yeah. So, again, this is a little bit of a function of segmenting the work here. So we're kind of viewing this as the mandated report, although we've added on the mortality piece. But then there's additional work anticipated in the spring to begin a broader question on that topic, which is how could it be improved.

DR. GINSBURG: Yeah, I think there are a lot of -- you know, Bruce mentioned the issue of calibrating the penalties. I've always thought that -- been interested in changes so that the incentives to reduce readmissions don't fall only on the hospitals with poor performance, that we have some incentives for the hospitals with the average performance, or maybe even somewhat better-than-average performance, so that they can reduce their readmissions as well.

DR. CROSSON: Okay. Good discussion. Now I want -- David.

DR. NERENZ: Just very quickly, I won't belabor it. I think, Dana, I think you and I basically agree and I just want to, perhaps, for the group and get it on the record. I'm not against this program in any way. I'd love to see this work. I'd love to see huge drops in readmission. I'm not a fan of readmissions. But I just want us to draw conclusions that are driven directly from the data we have in front of us, and if the trend lines don't seem to be moving, I'm worried. I'd like to see them move more than I'm seeing.

And just to follow on your point a little bit, what I would accept, absolutely, although we don't have data on it in the report, is how much money and time hospitals are spending on this issue. But that's part of my concern. I want that money to be spent effectively, and that time to be spent effectively, because it's being spent here. It's not being spent on something else.

And so that's part of my concern about, you know, wanting to see more dramatic effects here, is that if there's a lot of people spinning their wheels and not

getting powerful effects, that's not a good thing.

MR. LISK: Just to say, on the trend line, is that to say actually that the trend line is steeper since the program went into effect from the short time before period that we have here, and we didn't go back before that. If we went back before that, from other data we had, it was not as steep. In fact, I think it was flat going back before 2008, but I'd have to go back and confirm that.

The other thing is that actually we saw the steepest decline in 2016, from 2015 to 2016. So just to say is that there actually -- even though it's harder to see, there was reductions going on before that, but --

DR. NERENZ: No, I did notice that.

[Overlapping speakers.]

DR. NERENZ: I'm just surprised you didn't remark on that, you know, what's going on there, because it --

DR. CROSSON: Okay. Okay. All right. Paul and then Jack.

DR. GINSBURG: Just to follow up on David, in a sense, you know, conceptually, when we have things like ACOs and bundled payments, a readmission program is a very second-tier program, in a sense. We'd rather focus on the

big picture, on overall quality, on overall spending. And, in a sense, you know, the readmission program probably was conceived long before that, and was a -- you know, let's focus on this thing that we can measure very well. Because we can get the hospitals to pay lots of attention to it, and as you said, maybe that's not for the better. But I guess that's just the reality of the world we live in, that we'll bite off something easy, succeed with it, and that's probably okay as long as it doesn't have major long-term diversion of energy from higher potential activities.

DR. CROSSON: Jack.

DR. HOADLEY: Yeah. I was just going to observe, I mean, given some of this last round of discussion, I mean, some of -- you cite some of the qualitative -- a couple of qualitative sites sort of early on in setting the stage, but, you know, the kinds of things that Dana's talking about could be bought in, in a discussion of these results, at the end, more some of the broader kinds of things that we've been talking about here, in terms of how much you can draw this conclusion, how much there's multiple things going on. I mean, making sure -- on the one hand we want to present the statistical analysis very

cleanly, but then in talking about what we learned from it, what we take away from it, I think what you've got here is a number of ideas for how to set that in a context. That, I think, will just make the discussion all the stronger.

DR. CROSSON: Okay. So I think there's two ways we could proceed here, and it has to do with whether or not we feel we've had an adequate discussion and input, and whether the product, the final product would be a lot better if we, let's say in April, went over this again, versus having the staff take the input -- and I'm looking a little bit at you, David, because I think you had the most thorough comments in this direction -- have the staff take the input about how to express the data mill a little differently, add data. You know, in some cases make it, you know, clearer, maybe expand that curve, if that -- backwards, if that's important, in terms of looking at trends. But, you know, fundamentally, make a set of improvements in the final report that would satisfy the discussion here, or whether people think we need to have another presentation in April with that data, before the report is finalized.

So -- because I'm sort of --

MS. BUTO: What was the first option, Jay? Sorry.

[Laughter.]

MS. BUTO: I thought that was the first option, April and --

DR. CROSSON: It's 4:30, Kathy. No, that's fine. The first option would say, in terms of the mandated report, not all of our work on readmissions policy, but in terms of the mandated report, where we're done with that discussion, we've made our comments, we will now trust the staff and verify, because we'll get a chance to look at the next version of that and have input into that, or whether we have such a concern about the data that we want the data to be brought back and presented again in April, or March, rather -- I'm sorry -- March or April. March. March. April. March. March or April, before the report is finalized.

Dana, Jack, Bruce.

DR. SAFRAN: I guess my point of view of that is it's not that we have so much concern but there were so many ideas and suggestions here, including, you know, further methods work, that for us to land sort of all on

the same page about what do we know about this -- I mean, this is a very important policy intervention. And so I think it is helpful to come back and have a substantive discussion about the revised piece and not just all read it and think our own thoughts about it.

DR. CROSSON: Jack.

DR. HOADLEY: I would just, to some degree, just leave it to the discretion of Jim and the staff. If the thing evolves -- like if there's -- and Jon was talking earlier, you know, there's all this literature. Well, if some significant new articles come out that, or if you get some significant new results that feel like they need, you know, our input, you know, that's a good excuse. I think Dana's point could be fine too. I mean, if there's enough evolution in sort of how you frame the conclusion, or maybe you bring us just the conclusion, ask us to talk about a conclusion section or a discussion section without necessarily going back through all the data, I mean, it seems like there are some options sort of in between.

DR. CROSSON: Oh, my gosh. I thought there were only two.

DR. CHRISTIANSON: So I heard concerns about do

we have enough data to reach conclusions, but I also heard some concerns about the conclusions that were reached --

DR. CROSSON: Yes.

DR. CHRISTIANSON: -- and those are the ones that would suggest to me that we probably need to come back.

DR. CROSSON: Okay. I'm seeing a semi bobble-headed consensus that we would like to --

MR. PYENSON: I think the report is wonderful as it is and I'd leave it to the discretion of the staff and Jim to push it through.

DR. CROSSON: Okay. We've got double bobble-heading. Okay. This is why I'm bringing the question up, because I sort of sensed we were split in this. Let's try this. Let's do a straw poll. This is not a vote. This is just a straw poll. All those who would suggest that we leave it to the staff to take these suggestions and rework it and then provide us with a reworked final report that we would then provide input into, that's going to be Option A. Option B is we come back in March or April, depending on the schedule, and we do it as a committee of the whole. That would be Option B.

So Option A, can I see a straw poll for -- oh,

I'm sorry.

DR. MATHEWS: Can I offer an Option C?

[Laughter.]

DR. MATHEWS: And it's a variation of Option A.

DR. CROSSON: Okay.

DR. MATHEWS: You know, I understand you guys having, you know, grave reservations about giving the staff broad latitude here, and if I were in your position I would have those same reservations. But in addition to accommodating the discussion here, and keeping track of any developments in the literature that come out over the next six to eight weeks, which is literally the timeline we're talking about to close this out, we could also go back and revisit some of the display issues here, and, you know, particularly with respect to differentiating trends for the conditions subject to the HHRP versus all other conditions, make that clear. And we can see if there are any additional analytic work that we can do in response to this conversation. And if we do determine any significant differences in our findings, interpretation, or message, we could commit to coming back to you in April to have that discussion.

But if we did all of that, incorporate your discussion, make sure all of your thoughts are accommodated, and we didn't find anything that takes us off of what we've presented here today, we would reserve the option of not coming back in April and instead giving you a memorandum, here's what we did. And so basically giving us the toggle to come back.

DR. CHRISTIANSON: So let me just say something, to add on to that. But ultimately, as a Commission, the decision we're making on this mandated report is whether that one or two sentences we agree with -- did it have the effect that was intended, in this, and then you brought up the mortality.

So that's what we have to be comfortable with. And so all of the other stuff is great, but ultimately, when we approve the report, we're really approving that conclusion, whatever it is. So think about that when you think about what you want to do.

MS. BUTO: And I guess I'm wondering why we are -- I mean, we usually go through two or three rounds on a number of important issues. This one's Round One. Are we short of time? Didn't we just buy ourselves a bunch of

time by really doing a fantastic job on updates? I'm just wondering why we won't allow ourselves to go ahead and schedule that now. Are we concerned about the amount of work for June?

DR. MATHEWS: We do currently have a full schedule and, you know, we would need -- and coming back to this discussion in April is currently contemplated in our agenda for the spring. And so we can definitely come back. The question is we've got a number of other competing issues and a limited, you know, amount of time. And the question would be given, you know, work that we want to get in front of you on low-value care, this cycle, given work that we are trying to put into the calendar to follow up on the fee schedule work that we're presenting tomorrow, you know, we want to come back later with a more primary care-focused policy option for you, the question is given the competing demands, does this, here and now, rate a decision to come back definitively in April.

DR. CROSSON: Okay. I think I know what's going to happen here, but I'm going to do it anyway.

MR. PYENSON: Can we narrow this to two choices, because I'm confused.

DR. CROSSON: Well, Jim is making a distinction between simply saying that the report would be reworked and sent out, and the report might be reworked or might be brought back, depending on staff discretion, judgment on that issue, as opposed to the specific content issues.

So let's try this again. So A is we give the staff complete discretion to take the input today, write the report, we're done. B is we definitely want it to come back to be reworked at the March or April meeting, before the report is finalized. And C is we give the staff discretion to rework it, but also discretion to determine whether or not it comes back or not, based upon changes that might take place or further staff discussion.

DR. GINSBURG: Can I suggest dropping A in favor of C? Isn't that the way we usually work it?

DR. CROSSON: Drop A --

DR. GINSBURG: -- in favor of C. Make B and C the only options.

DR. CROSSON: Okay. Yeah, okay. Does B become A now, or does B --

[Laughter.]

DR. HOADLEY: Just call them B and C.

DR. CROSSON: All right. I'm okay with that. So we now have option B, which is -- I've forgotten.

[Overlapping speakers.]

DR. CROSSON: We bring it back automatically or we give staff discretion in terms of whether to bring it back or not. Is everybody clear on that except me? Okay.

So all in favor of Option B, please raise your hands.

[Show of hands.]

DR. CROSSON: Okay. Well that's --

[Overlapping speakers off microphone.]

DR. CROSSON: Mandatory coming back. Okay, we've got three.

Staff discretion as to whether to bring it back or not.

[Show of hands.]

DR. CROSSON: That follows, that carries, and that's what we'll do.

MR. LISK: I appreciate your faith in the staff.

DR. CROSSON: Okay. Okay. Well, thanks very much, Jeff and Craig. I guess I was surprised. Okay.

[Laughter.]

DR. CROSSON: So we have completed the work for today. Thank you, everybody. It's been exhilarating, to say the least.

So now we have time for public comment period. Anyone who would like to come up and address the Commission, please stand at the microphone. Sharon, in a minute I'm going to ask you who you are, and what organization you come from. You know the rules. Two minutes for your remarks. And let me just wait and see if anybody else is heading up. I don't want them to get in your way.

Okay, Sharon, we're off and running.

MS. McILRATH: All right. I'm Sharon McIlrath with the American Medical Association. So I wanted to talk a little bit about MIPS. I don't think it's a surprise to anyone here that we did not support the VVP for the reasons that David Nerenz and Dr. Coombs laid out. We do agree that there are problems with MIPS -- the complexity, a lot of methodological issues. Some of those methodological issues are going to have to be resolved even if you went with the VVP.

So where we are is that we would like to fix it

rather than kill it, and partly that's because we don't like sending sort of shifting messages to the physicians. It's kind of like, you know, are they going to invest in building an infrastructure on shifting ground.

There's a problem that is coming up and that needs to be resolved quickly. We don't think that it is political viable to think that you're going to go up there and get the Hill to kill MIPS. We had -- the medical profession came together and agreed on a very restricted sort of policy. The intent is to sort of pause the program briefly and to stop a couple of hammers that are going to come down in 2020 -- well, 2019 for the performance year.

So those are that the -- it's not just a question of what the size of the threshold for -- the performance threshold is. It's that it has to be the mean or the median, which at CMS was once interpreted as 50 percent of the people have to fail. And in addition to that, you can't do what they did in the VBM, which was to have a range and only the people at both ends were winners or losers. Now, anybody on one side of that threshold loses and on the other side of that threshold they win.

So then the other issue is the cost measures.

The cost measures that are in the VBM are -- they're irrelevant for a lot of physicians. They have a lot of flaws. And we're working with CMS and a contractor to try to come up with some good cost episodes. That's taking time. It won't be ready in 2019, so we don't want that weight to go up to 30 percent.

My concern is that if you say that nothing other than repeal will do, are you going to then, you know, say, well, if we want to pause the program and at least fix what's there and prevent the worst outcomes from happening, that you don't want to do that.

DR. CROSSON: Thank you, Sharon.

Okay. So we are adjourned until 8:00 a.m. tomorrow morning [off microphone].

[Whereupon, at 4:39 p.m., the meeting was recessed, to reconvene at 8:00 a.m. on Friday, January 12, 2018.]

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
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AGENDA PAGE

P R O C E E D I N G S

[8:10 a.m.]

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

specific questions, we are happy to take them. The goal today is, like the unified PAC PSS report, to approve to forward the report in its entirety to Congress.

Through the 21st Century Cures Act of 2016, Congress mandated MedPAC to provide a report by March 15, 2018, answering three questions. As a reminder, the first question was what telehealth services are covered under the Medicare fee-for-service program. The second addressed what telehealth services do commercial health plans cover. And the third addressed how telehealth services covered by commercial health plans might be incorporated into the Medicare fee-for-service program. To complete our work and deliver it in March, we are back here today to have you review the entirety of our findings and gather your final thoughts.

Telehealth services encompass a variety of clinical services, technologies, and modalities. Per your request and for the sake of our discussion and Medicare focus, we have narrowed the telehealth down to three forms: direct to consumer, or DTC; provider to provider, or PTP; and remote patient monitoring, or RPM. For your reference, on the slide and in your mailing materials you can find

further explanation.

In June 2016 the Commission concluded that existing evidence on the efficacy of telehealth was mixed and that the incentive for using telehealth services differed among the various types of payment systems. In addition to Medicare, we know that several government programs cover telehealth services, but to varying degrees. In addition, to date, 35 states have passed telehealth parity laws requiring commercial insurers to cover certain telehealth services equal to in-person services.

Across commercial and government payers, the most common physician services used via telehealth were basic office visits and mental health services.

Under the physician fee schedule, the use of telehealth services was low in 2016. This low use was also reported by the DOD and those commercial plans we interviewed as part of answering Question 2 of the mandate.

While use was low, the growth in telehealth use has been rapid. Between 2014 and 2016, the number of telehealth visits per 1,000 beneficiaries increased 79 percent among Medicare beneficiaries. The most rapidly growing services were for subsequent nursing care,

psychotherapy, and pharmacy management. Keep in mind that one factor in this rapid growth is that the base use in 2014 was extremely low. While advocates say that the growth being shown in use is a good sign and indicates there should be expanded access, critics cite the increased growth as a warning that telehealth services may supplement, rather than replace, in-person services, which would ultimately lead to costs increases if growth is sustained.

In attempting to answer the question if telehealth is a supplement or a substitute, we used Medicare data to assess E&M claims and found that, after controlling for patient risk score, telehealth users and non-telehealth users had equal numbers of in-person E&M claims in 2016; however, telehealth users had an additional 1.6 telehealth E&M claims. This suggests that telehealth E&M claims might be supplemental.

In addressing mandate issue one, we looked at Medicare coverage of telehealth across all sectors with a focus on the physician fee schedule. We found that under risk-bearing entities such as MA and ACOs, flexible coverage of telehealth exists. We also found that flexible

coverage exists for fee-for-service coverage other than the physician fee schedule. Lastly, we found that Medicare coverage of telehealth is most constrained under the physician fee schedule and is the focus of the mandated report.

The most flexibility to use telehealth in the Medicare program occurs in the Medicare Advantage ACOs. Under MA, payments to plans are capitated and plan coverage must include telehealth services covered under fee-for-service Medicare. Plans also have the flexibility to finance the coverage of additional telehealth services through a supplemental premium or through their rebate dollars, and those added telehealth costs may not be built into the plan bid. Under CMMI, organizations selected for several programs have waivers to use telehealth services beyond the limits of PFS coverage. While outside the scope of the mandate, the Commission has expressed support for expansion of flexibility for these entities. You can refer to your mailing materials for a more detailed discussion of this.

Among the other fee-for-service systems, telehealth is contemplated as a fixed payment for a

beneficiary episode. In these cases, the physicians have the flexibility to use telehealth as they see appropriately to achieve higher quality or more effective care while being held at risk if the cost exceeds the fixed payment. Within these areas and with their current payment structure, we believe enough flexibility exists and, therefore, it is not a focus of the rest of our analysis.

Under the PFS where telelehealth is most constrained, there is a limited set of telehealth services on a fee-for-service basis that are restricted based on originating locations, geographies, and modalities. You can find much more detail of this in your mailing materials. CMS largely determines which fee schedule service codes are covered as telehealth services, and I'd like to highlight that since our September presentation, Medicare now permits remote patient monitoring as one of the approved telehealth modalities, but remote patient monitoring must still occur under the same restraints as the other telehealth services. There is one exception of all of these rules which is a variety of management codes where services are bundled together, and in telehealth it's considered part of the covered services that may be used to

deliver care under these codes at the physician's discretion.

MR. GAUMER: The Congress also asked us to evaluate the extent to which commercial insurance plans cover telehealth. We sampled a large group of diverse plans and interviewed over a dozen insurers. We found that most plans covered some telehealth services, but few did so comprehensively. There was wide variation in coverage, but basic physician visits and mental health visits were among the most common types of services covered. Plans covered telehealth in urban and rural areas. Cost-sharing levels varied by plan and service type.

Plans often used pilot programs to test telehealth services before implementing them more broadly.

Plan representatives consistently stated that cost reduction was not their primary rationale for covering telehealth services. But, instead, their aim was to respond to employer demand and to compete with other insurers.

In terms of outcomes, plans reported low levels of use, as we've said, that access and convenience had been expanded, and that only one insurer noted cost reductions.

In response to the third question of the mandate concerning how to incorporate commercial coverage into Medicare, the Commission has several points about doing so being complicated and how it should be approached differently.

Overall, plans do not offer a clear and homogenous model for Medicare to follow.

Plans appear to consider cost reduction as a secondary rationale, but cost is a critical piece of Medicare coverage decisionmaking.

While plans have a variety of tools at their disposal to control volume incentives and any potential misuse, under the fee schedule taxpayers are not indemnified against this incentive, and telehealth may be more vulnerable to misuse.

Plan cost sharing varied widely, while under the fee schedule Medigap policies often shield beneficiaries from cost sharing.

In general, plans use pilot programs to test telehealth coverage, while Medicare to date hasn't tested telehealth to the same degree.

Therefore, the Commission recommends that

policymakers exercise caution in further incorporating telehealth services into the fee schedule.

In an effort to simultaneously exercise caution and advance the Medicare program, the Commission recommends that policymakers use the following three principles to guide the evaluation of individual telehealth services for their potential incorporation into the program. While a given telehealth service may not demonstrate evidence of all three principles, a service should strike a balance between these three.

The first principle is reducing costs, the second principle is expanding access, and the third principle is improving the quality of care.

Based on the Commission's discussion, we developed several illustrative examples of how the principles can be applied to telehealth services that were commonly used by commercial plans. I will walk through three of these examples, which demonstrate: first, a telehealth service where the evidence of balancing the principles is clear; a second where the evidence of balance is less clear; and, third, where the evidence of balance is unclear.

The first example is telestroke services. These are currently covered by the fee schedule in rural areas, but policymakers could consider expanding telestroke to urban areas.

By applying the three principles, we believe that telestroke is likely to increase program costs, by increasing the number of these consults that are occurring. However, cost increases may be mitigated by this service's low risk of misuse and its potential to reduce long-term disability.

Telestroke may improve timely access to neurologists. In terms of quality, health systems cite reductions in mortality and disability from their telestroke programs.

Therefore, because the evidence of the principles is fairly clear and balanced, policymakers may decide to consider telestroke services for incorporation into Medicare.

The second example are tele-mental health services, which are currently covered under the fee schedule in rural areas, but policymakers similarly could consider to expand these services to urban areas or to the

patient's residence.

Program costs are likely to increase because roughly 30 percent of beneficiaries report a mental health condition.

This service would expand access to mental health clinicians, which the AHRQ reported being in short supply last year.

The evidence that these services improve quality is less concrete.

Due to the expectations for cost increases and the gaps in the evidence of quality improvement, the overall evidence of balanced principles is less clear for tele-mental health services. Policymakers may need to use their best judgment and could pair implementation of this service with utilization control policies or with other oversight.

DTC services are not covered under the fee schedule, but Medicare could consider covering them in urban and rural areas.

DTC may significantly increase costs because these services would be available to all beneficiaries, are used for routine care, are vulnerable to misuse, and

Medigap policies shield beneficiaries from cost-sharing responsibility.

DTC would expand access and convenience significantly.

There is potential for DTC to improve quality, but the evidence of this is unclear to date.

Therefore, due to the potential for cost increases and the lack of evidence of quality improvement, the evidence of balanced principles is unclear for DTC. Therefore, policymakers could consider testing this service within CMMI.

Over the course of this analysis, we have found that Medicare covers telehealth services in several areas of the program. Coverage is more constrained in the fee schedule. Commercial plan coverage varied and was motivated by the demands of employers and competition rather than cost reduction. Commercial plan coverage as a whole is not a clear and consistent model for Medicare. And due to the lack of commercial homogeneity and the fact that under the fee schedule cost increases will be passed along to taxpayers, we identified three policy principles that policymakers can use to evaluate individual telehealth

services. When telehealth services demonstrate evidence of balancing these principles, policymakers could consider incorporating them. When the evidence is unclear, policymakers could consider testing the service more thoroughly through CMMI.

Okay. This concludes our presentation and our work in this area, and we will now pass this off to Jay, who will walk you through the Q&A and then the vote.

DR. CROSSON: Thank you so much. Nice work. Really appreciate it. Let's do clarifying questions. Sue.

MS. THOMPSON: Thank you, Zach, Amy, everybody. On page 45 of the reading material and I think on one of the slides as well, in the direct-to-consumer analysis, you cite a very large increase in cost on Table 8. And then on Slide 5, telehealth utilization, we talk about number of claims for telehealth and non-telehealth users. What's the assumption behind claims? I mean, is the assumption that the claim for a telehealth encounter is equal to a claim if a beneficiary goes to an office visit? I mean, are we just measuring claim to claim, or are we quantifying by dollars this big increase in cost?

MR. GAUMER: We're thinking of, you know, the

utilization, 0.3 percent of beneficiaries. That's on a beneficiary basis. That's our assessment of the utilization. But, generally, we think of this on a claim level.

MS. THOMPSON: Has there been any analysis of the difference in intensity of service when I pick up the phone or get on my iPhone and have an encounter because I have a sore throat and I need something to get to work tomorrow, as opposed to if I go to an office visit and all of the ancillary services that might be added to that claim?

MR. GAUMER: So we haven't dived into the different codes that are appearing on these claims in addition to just the telehealth code. We've looked to see that, you know, maybe a basic E&M code, a physician visit, if it's paired with mental health services and other types of things. We have looked to see what other things have been the second-most likely condition or service to appear on the claim, but we haven't compared the broad scope of services appearing on claims of telehealth versus other office visit claims. So that's something we haven't done yet.

MS. THOMPSON: Okay, which was a wonderful segue

to my next question, which relates to mental health, and if 30 percent of beneficiaries have some diagnosis that relates to mental health. And our assumption is that if we open up telehealth, the costs will go up. Well, have we thought about the impact that we might have on improving the beneficiary's quality of life and adherence to their medication protocols and activities of daily living if their underlying depression was addressed? I mean, I'm curious to know if we're connecting those dots.

MR. GAUMER: I think what you're seeing especially on Slide -- let me flip here, on Slide 15, when we say that the evidence of quality improvement is less clear or it's limited, I think we just haven't seen specific evidence in the literature or in our own work that we would have a definitive improvement in outcomes if this -- if tele-mental health services were made more widely available.

That doesn't discount what you're saying, and that's why here we've said potential for improvement. I think it is clear that there's great potential for improvement, but we haven't seen definitive evidence of this, and that's where we were trying to go.

MS. THOMPSON: Thank you, Zach.

DR. CROSSON: Jon, on this topic. Then I'll call on Jack.

DR. CHRISTIANSON: Yeah, I appreciated that you put in there, too, that it's not like everybody that wants to get care will necessarily be able to get care. We've talked a lot about shortages in mental health care professionals as well. So that might somewhat limit what we would hope would be a positive effect of this.

DR. CROSSON: Paul and then Jack.

DR. GINSBURG: Yeah, I was going to raise the same thing about the constrained supply of mental health services, which are, you know, extremely constrained in Medicare. And another possibility, I call it "crowd-outs." In a sense, maybe rather than a big increase in supply, maybe there's little increase in supply, and the result is that some beneficiaries getting mental health services would no longer have them because the supply is diverted into tele-mental health. I don't know if you've thought about that.

MR. GAUMER: So the point that Paul and Jon both

made here was something that has come up in our work in the past, and since the last round we've incorporated some ideas about these things into the draft. So hopefully we've reflected what your thoughts are.

DR. CROSSON: Jack.

DR. HOADLEY: So on the comparison and the examples on Slides 15 and 16, I thought I was clear when I read in the paper, but as I sort of go through what you put here, I'm struggling to sort of see what's the level of difference that puts the tele-mental health one at sort of this category of less clear evidence and the DTC as unclear evidence. You talk about, you know, both have potential for misuse and increased cost; both have some ability to expand access; both have potential for improvement in quality. But I was struggling to remember what you're really seeing is the key difference here.

MR. GAUMER: The difference here, I think, quality is both unclear and there's great potential for the quality improvement. The difference that I see between the two is that the potential for cost increase is higher for DTC based upon the fact that you've got this applying to a much larger population of people. It's routine services

that anyone is likely to use as opposed to in tele-mental health services, yes, they're available to everybody, but we're seeing that as somewhat of a smaller pool of beneficiaries just because, you know, the research tells us that 30 percent of beneficiaries have a mental health condition, you know, it's probably higher than that. The pool of potential users is probably higher. But we're just seeing a difference in cost.

DR. HOADLEY: Okay. Thank you.

DR. MATHEWS: And if I could jump into this as well, I agree with everything Zach said. I would also point out that in mental health we do have a lot of evidence of, you know, potentially constrained access, a lot of which is related to the supply. But we do not have similar evidence of access problems with respect to garden variety face-to-face E&M. So that's another reason why we would, you know, think there is a potentially greater rationale to increase access to mental health services through telehealth than there is for standard direct-to-consumer kinds of interventions.

DR. HOADLEY: And I assume on any of these distinctions, if more research appears, I mean, it might

push us one way or the other, either development of issues over time, like changes in the availability of mental health providers. But even just studying some of these things would give us a chance to push it up or down in the --

DR. MATHEWS: That's exactly right.

And the other general thing to keep in mind here is that as part of our assessment of the landscape, we have found that utilization of telehealth tends to be very low across the board. Medicare, commercial payers, Medicaid -- I think GAO came out with an evaluation of DoD use of telehealth, and it's again in the same low single-digit rates of utilization. So a lot of the evidence just isn't there, which is why we've come down on the side of here are some principles that you should use to determine whether or not you want to expand coverage rather than definitive statements saying yes, you should expand coverage for this service in this way.

DR. HOADLEY: Thank you. That's helpful.

DR. CROSSON: Rita and then Bruce.

DR. REDBERG: I think I'll wait until Round 2.

DR. CROSSON: Then Bruce and Warner.

MR. PYENSON: Thank you very much.

I think a lot of the focus here has been on potential impact on the physician fee schedule, but it strikes me that at least some of what we're talking about is more connected with the underlying infrastructure that Medicare and others don't pay for through a physician fee schedule that they would pay as part of a DRG or case rate or something like that.

To what extent is this an issue that is best handled through things like licensure? So, for example, probably emergency rooms require running water. It's not something Medicare pays for separately.

When it comes to telestroke or other emergency room kinds of things, I think there's requirements -- and it may vary by state, but access to certain kinds of services to be considered a stroke center or even top-rated emergency room.

So I'm wondering where you draw the line on some of these services.

MR. GAUMER: So I think we can talk to telestroke and licensure. We did a little looking around at the qualifications criteria for stroke centers, and what we

found is that generally the Joint Commission, JCAHO, when they're accrediting stroke centers, what they'll say is that a stroke center does not have to have telemedicine in place, but it can. The critical component for the stroke centers is that they must be 24/7 and have access around the clock. They can use the telemedicine instead of in-person care if they choose. So it's not a requirement that the stroke center have telemedicine, but they can use it.

We are seeing kind of an opening the door in the licensure world. They are opening the door to telehealth but not requiring that telestroke or telehealth be a part of the process.

MR. PYENSON: Just a follow-up question. In the telestroke example -- forgive me if this was in the material, whether the stroke centers have moved to that because it's more efficient than other ways or not.

MR. GAUMER: That, I'd say we don't have a good sense of.

Do you --

MS. PHILLIPS: Count.

MR. GAUMER: Yeah. And the coming of this is a little unclear to us as well. We're looking at what the

Joint Commission does now, but I'm not sure if that happened five years ago or last year.

DR. CROSSON: I think I see Rita and Kathy on this point.

DR. REDBERG: Just on this, because I had forgotten until you said that. In the telestroke session, which you considered to have the better evidence, I saw that UVA, for example, said it was better, but I didn't see actual references that were kind of -- I like to see references.

MR. GAUMER: Sure, sure.

DR. REDBERG: Were there studies that also said it was better?

MR. GAUMER: Yeah. There's been a bunch of studies on telestroke specifically. That's probably where the research is most robust, and so we can put some of that in there.

DR. REDBERG: And the idea is then they are diagnosing remotely, but someone is on hand to treat that wouldn't have felt comfortable treating was the impression I got without the remote diagnosis.

MR. GAUMER: Yeah.

And do you want to talk about the ambulance stuff?

We've seen telestroke happening out of ambulances as well in some markets, and it seems like that might be kind of a new frontier for telestroke in general. So you've got an EMT on one end and not just -- you know, maybe a standard physician in a rural ER connecting with an neurologist. It's happening with nurses and EMTs as well.

DR. REDBERG: That sounds great.

MS. BUTO: Bruce, back to you point, I thought what you were trying to get at -- and correct me if I'm wrong -- is don't hospitals, stroke centers have flexibility to use telestroke methodologies, and I think as the paper, I thought, pretty well laid out with DRGs and MA payments, there's a lot of flexibility to do that kind of substitution.

But I think the question here is really whether the physician involved remotely gets paid, and so I think even though the stroke center -- and correct me if I'm wrong, that this is where you were headed -- may have flexibility and licensing and so on and may somewhat dictate what services they can offer or have available or

substitute.

The question is still whether the physician on the other end of that gets paid.

MR. PYENSON: Well, sometimes maybe the physician at the other end is not going to know whether the patient is Medicare-eligible or not or which carrier, so this is different. It might be a service requirement that the hospital has to do this, has to make it available just like they have to have 24-hour access. The physician in that case doesn't know whether they're going to get paid or not.

MS. BUTO: I'm sorry. I just meant I thought that the question we were trying to address as a Commission was whether this service ought to be legitimately and clearly covered by Medicare for physicians, so that a statement is made that for telestroke, anyway, that meets these criteria, the physician should get a payment or the consulting stroke expert ought to get some sort of payment. So I misunderstood where you were going with that. Sorry.

MR. PYENSON: I think I was going there.

DR. CROSSON: Okay. Alice, on this point?

DR. COOMBS: Yeah. I just wanted to say -- as a stroke center -- and it forms clinical affiliations with

surrounding hospitals whereby the strokes -- as a stroke center, it has people on call 24/7, makes itself available for the radiologic interpretation of the CT scan. As soon as it's done in the community hospital. Someone reads it remotely, and they say, "Oh, this is a problem. There's no hemorrhage. We can drop TPA and ship the patient to the center." So it's a whole arborization of services that are incurred.

But the stroke center usually doesn't have a requirement that you know what the payment structure is like. It could be no insurance at all. So it depends on where you're located, but the requirement to be a stroke center, it doesn't have anything to do with geography. It is the resources that the facility says, "I have these resources. We need this to serve our community." So it can vary anywhere in the country. There's some places where it's available because the resources of the tertiary center has the availability of those resources, and they're on for 24/7 but not just for one entity, but for many. And the small hospital might be one that says we would like to tie into this, and we want a clinical affiliation. And so they would have to be able to have the connection in terms

of being able to have someone to do a CT really quickly and be able to be available to say, "Okay. Administer TPA," that kind of thing.

The variation in the clinical infrastructure changes, depending on where you are. So there's not a mandate. There is a need to meet community needs so people will rise to that occasion based on the resources that they have.

DR. CROSSON: Okay. Warner.

MR. THOMAS: I guess one question I have is it seems like you're making an assumption. You're concerned about the increase in utilization and cost. I mean, what do we do today to impact utilization just in offices? Why do you think this is more susceptible to a cost run-up or utilization challenge than just general visits, which there is really on control of today?

MR. GAUMER: I think the argument that's made for this, for this being higher potential for misuse, is the concept of convenience and just having more access, easier access, especially with DTC where you can pick up your telephone, connect with your physician's office.

I think generally there's concern that some folks

will just overuse this service or that providers will connect with patients maybe when they're not needing the service. So that's what I'd say.

There are some things in place in the Medicare program, some limitations for just standard office visits that do apply to telehealth. For example -- and I'll be very general here, and the physician crowd over here will probably say I'm wrong to a certain degree. But you cannot have more than one office visit, just a standard office visit per day under Medicare. There's a limitation on that. So the same limitation applies to telehealth currently and would, if they just decided to expand this to urban.

So I don't know if that answers your question completely, but the convenience thing is why, the fear.

MR. THOMAS: So is there a concern that someone will essentially have a telehealth visit and still have an office visit or -- or it sounds like really the concern is multiple -- just multiple telehealth visits, you know, potentially even same day or, you know, just that a potential recipient, Medicare recipient may just try to over-utilize from that perspective. Is that the thinking?

MR. GAUMER: I think that there is that, and there is concern that folks may do both, in person and the televisit, have a televisit. The problem may or may not be solved. Therefore, the patient may have to go in and see the doc face-to-face. That's the other side of the concern. So it may generate other visits is the argument.

DR. CROSSON: Pat.

MS. WANG: Going back to the discussion of telestroke, because each of these modalities is really very different, I think, but going back to telestroke, I have the impression that telestroke is, borne out by your paper, used by many, in many different areas beyond rural, and I guess if the question on the table for telestroke is physician fee schedule payment as Kathy articulated, is there evidence that the current lack of physician fee schedule payment for telehealth consults outside of these rural areas has constrained the availability of use of that service?

MR. GAUMER: I think we have not heard that from beneficiary groups. We didn't hear that, I think, in the beneficiary focus groups that we did. So we have not seen or heard that argument.

MS. WANG: I guess what I'm getting at is for different kinds of telehealth services, there are different ways of obtaining those services, other than fee schedule billing. Sometimes they are contractual arrangements with a vendor type of entity that will supply, and so it's a different payment mechanisms, perhaps.

So on telestroke in particular, which I think everybody recognizes is quite valuable and important, I just am curious whether in an urban area, for example, hospitals or others, ambulances that are employing telestroke effectively have complained or feel like, well, if we don't get physician fee schedule, specific payment for telehealth, we have to stop doing this, or we would make it more -- it seems like it's happening somehow.

MS. PHILLIPS: Yeah. Everyone we talked to said they were implementing these programs irregardless if they were going to get payment from Medicare or insurance companies. Some said they were starting to get commercial payments. Some said as long as they had a certain number of telestroke visits a month, it paid for itself in the other savings. And so people are saying this is something they believe in to do, regardless of if they were going to

get payment. No one expressed that they were going to stop if they didn't get payment in the next year or anything like that.

DR. CROSSON: Paul.

DR. GINSBURG: I wouldn't be surprised if the telestroke centers have to compensate the neurologist. So if the neurologist is not getting payment from Medicare, the center does it, but as they're saying, it's worth it.

DR. CROSSON: Warner.

MR. THOMAS: Just on this comment or on this issue. So we have 65 hospitals on a telestroke network. We get whatever minimal payment from Medicare. It's an amazing service that I think people need to -- I would encourage you to look at this more because essentially what happens here is if someone doesn't get this TPA or gets it inappropriately, as you know, that's pretty bad, and if they don't get the TPA, essentially the cost of the program with a negative outcome on that stroke is significant.

So I would really just encourage us to make sure we fully understand that before we kind of pass judgment on these programs because they're critically important. I mean, I'm sure you see it in your area, so --

DR. CROSSON: Okay. Jack, Pat, and we're going to have to move on to the discussion soon.

DR. HOADLEY: Yeah. I was looking at the conclusion on implications for policymaking, and I think I've got this right. Where you talk about CMMI testing, that's something that wouldn't require any kind of statutory measure. They've got the full authority to do that.

With the other areas -- so for something like telestroke, if somebody wanted to read this and say, well, we really need to move forward and broaden the telestroke coverage, to just do that would take a statutory adjustment?

MR. GAUMER: Yes. It's written into statute now that rural-originating sites are permitted and urban is not. So they would have to change law.

DR. HOADLEY: And do you anticipate or did you think about any way that Congress could sort of write something more along the lines of our principles, give CMS authority to add things if it met a set of principles that might look something like what we're setting? Is that also a possibility?

MR. GAUMER: I imagine it could be.

DR. HOADLEY: Yeah. Okay.

DR. CROSSON: Pat.

[No response.]

DR. CROSSON: Okay. So what I'd like to do now is have a round, and we are a little behind, but nevertheless, I think this is the opportunity to give final thoughts to the authors here who are going to prepare this report for delivery to Congress in March.

So we'll start with Brian.

DR. DeBUSK: Well, first of all, congratulations on a really well-written report. I mean, it's a good read, very informative.

On Chart 3 -- and I promise this isn't a Round 1 question. It's a legitimate Round 2. I held it for that reason. You know, the third part of our mandate speaks to ways in which telehealth services covered under private insurance plans might be incorporated into the Medicare fee-for-service program. I love the research that we've done, that you've done, and I really like the examples. You have a table on page 45 that actually lays those examples out.

I realize this homework assignment has to be turned in real soon. So I was even nervous about even mentioning this, but did we stop just a little bit short of what they may be asking for? And this is an honest question. This isn't rhetorical.

I almost wonder if they wanted us to be a little bit more prescriptive in saying here's a pool of things -- not just telestroke, for example -- here are a pool of things that we consider very low risk that maybe you should encourage CMS to adopt, again, along the lines that you've done. But did we pull up and stop just a little bit short of giving them something? Is there a risk that a policymaker could read this and say, "So what am I supposed to do?"

DR. MATHEWS: So, Brian, if you don't mind, I'll take a stab at answering that. If anyone has to take the fall for misinterpreting congressional intent, it should be me rather than the staff.

But you are correct. In addition to the statutory language of the mandate, there was a sense of the Congress language underneath the mandate that said exactly what you're saying. There was a presumption that Medicare

should be doing more telehealth, and MedPAC should look for ways to try and facilitate the importation of commercial practices into Medicare.

The problem that we found ourselves facing was that when we looked at private plans coverage -- and I think we looked at 48 different plans offered by 40 different managed care and commercial payer entities -- beyond things like face-to-face -- or the equivalent of face-to-face visits, the telehealth equivalent of E&M visits, we found a lot of heterogeneity in terms of what types of modalities private plans covered, limitations that they would impose on the use, a lot of heterogeneity in terms of cost sharing that they would impose. Some had cost sharing equivalent to face-to-face visits. Others said, "You're going to pay full freight for the intervention. Feel free to use." And the motivations for private-sector coverage were different than what might motivate the Medicare program.

I'll get to the punchline here. We did not find a very clear-cut set of examples that could be imported lock, stock, and barrel into the Medicare program, and so we felt the best we could was come up with a set of

principles so that if something out in the environment did have potential to be brought into Medicare, here is a structure by which you would be able to evaluate that.

DR. DeBUSK: First of all, thank you. That's perfect. So what we're really saying is that we can't -- we've answered the question as best we can because Mandate 3 says it's within the context of what we see in commercial -- or private insurance plans or commercial plans. Perhaps then if they re-ask the question for MedPAC to develop a road map for telemedicine adoption, that would be maybe step two.

DR. MATHEWS: Potentially, yes.

DR. CROSSON: Kathy and then Jack.

MS. BUTO: Just two things. One is just kind of an observation. The cost, access, and quality criteria are really good ones, the principles that you've laid out. But I did notice that under cost, most of our examples are cost increasing. So, yes, we ought to consider cost or it ought to be considered, but I think what you're acknowledging here is that a lot of telemedicine is about increasing access through other means rather than reducing costs by some kind of substitution.

So the impression I didn't want to leave in the report is that cost reduction should be an important criterion for moving forward on telehealth because I think -- my recollection of the history of this has always been it was an effort to figure out how to improve access for services that were critical.

So, yes, we ought to look for cost reducing, but that's not the compelling issue, and you do lead with cost as the criterion. So that's sort of what got me thinking about this.

The other thing is -- and I think I brought this up last time -- I think we acknowledge that MA plans, along with hospitals under DRGs, should have greater flexibility because of the fixed payment to use telehealth services. And I think the stroke example was a good one where many hospitals are doing that.

But I keep seeing in the text references to either in terms of, quote-unquote, expansion of telehealth in MA plan coverage, that either it'll be done through a supplemental or potentially included in the original bid. I think they have as much flexibility as a hospital does under DRGs to substitute whenever they want to. That

doesn't really come across. So if that's what we -- if we're clear about that, I think we need to be clear about that, because our narrative really just goes into there are these two avenues, and I think an important other avenue is they're MA plans. The idea was to allow them the flexibility, because they're accountable for quality and access, to make these substitutions. So if we could weave that in a bit more, I think it would be a stronger message.

And then I guess the last thing -- and this is a point Paul mentioned at some point -- is I actually think we are teetering on the edge of a couple of recommendations, Jim, and one of them is around telestroke. And you sort of point out that, you know, this is not an area that's really subject to a lot of abuse. Yes, there's always the issue of, well, gosh -- Warner mentioned this -- hospitals are already doing this. Why should Medicare pay extra? Well, I think Medicare's responsibility is to pay for services that it ought to be paying for.

So I would just raise that question of aren't we just teetering on that one and then, you know, anything else in the flexibility area could be stated strongly in a recommendation that, whether it's MA plans or two-sided

risk ACOs, where we really feel strongly there ought to be the kind of flexibility, urban and rural, to use these services. I see that we're there in the narrative, but we don't go that last step, as Brian was saying, of going ahead and, you know, making the recommendations.

So just a couple of thoughts.

DR. CROSSON: Thank you. Jack.

DR. HOADLEY: I was going to play directly off of what this discussion has been, but it also relates to the question I asked. But in the very last paragraph in the chapter under implications, you know, we make some statements. We talk about the cost, quality, and access, and we say when the evidence is sufficiently compelling, policymakers should consider implementing these services. So that's the amount to which we get up to that edge.

But I wonder if that sentence could be followed with a "for example." I mean, we're not presumably going to move to a formal recommendation because we haven't gone through the procedural stuff to do that. But we could take it one step closer to that edge, to use Kathy's phrase, by saying, "for example, telestroke," blah, blah, blah, you know, "seems to meet this." We still don't have to say

"should." We could still say "could." But we could put -- and the other one that has clear evidence we haven't been talking about today, but, you know, if we felt like -- or maybe the telestroke is the cleanest one, but using that as an example there. And then, similarly, you know, maybe in the next sentence or two beyond that, it talks about the CMMI should consider -- and there we do so say "should" -- conduct more testing. Again, maybe even just building in one or two of those examples to make it a little more concrete and come a little closer to being instructive, even while phrasing it in terms of "for example" so we're not sort of at that bold pace level.

DR. CROSSON: Could I just see the hands here again? Because I think I missed -- I've got Pat, Paul, Alice, Bruce, Warner, Rita, David. Okay. Let's go down that way and come back up this way.

MS. WANG: Sort of picking up on Kathy's point about cost, I think that the -- what we're really talking about here is cost effectiveness. So in a capitated environment, in an MA plan, within a DRG system, telehealth has tremendous -- telehealth in general has tremendous potential to improve quality outcomes, beneficiary

experience. The issue, I think, that we're afraid of is that it will be cost inflationary without an offsetting benefit in improvement in outcomes, effectiveness, quality of life, et cetera. We don't want to create a low-value telehealth benefit, right? That's what people are concerned about. So that's why I feel like in the -- certainly in the more sort of global budget environment, whether it's an ACO kind of situation or an MA situation or a DRG, there is less concern because, by definition, there are constraints. And so what we're really talking about here is fee-for-service.

I would just encourage us to think about -- and so to echo the point, in an environment when somebody is at risk for needing to show sort of an ROI on using a different modality that may cost something, you know, it has to result in a better outcome, basically, to continue doing it.

And my question earlier about telestroke and the availability of telestroke was not to say that I don't think it's valuable. I think it's very valuable. The question is kind of don't fix it if it ain't broke. If folks are feeling like it's worthwhile to do it, even

without a private fee-for-service or a physician fee-for-service payment on the other end, they've already kind of figured out because it results in a more cost-effective approach to treating stroke.

So I would urge us to kind of maybe -- it's not specifically reducing cost. You know, I talk a lot about total cost of care. I know that's difficult to get at in a fee-for-service environment, but I do think that that is kind of the measure that we should be using.

DR. CROSSON: Paul.

DR. GINSBURG: Yes. First, let me repeat this. This is a really good report. I thought it was very focused and very nuanced and very thorough.

I think one of the main contributions the report has is showing how the experience of commercial insurers is far less relevant in this sphere than it might often be for Medicare because the employer's motivations are different, including keeping people at the work site saving them time, doesn't come up here.

I also felt, as I stated before, that I think there is some opportunities to be a little more forceful in the policy recommendation area without taking a formal

vote. I actually thought that I really was concerned about Medicare Advantage being constrained by having to put this in as a supplemental benefit. And the possible principle that we could propose is that where a service appears to have potential to reduce costs, that should clearly be in the bid, not as a supplement, and that supplements should be reserved for things where it looks predominantly to increase patients' convenience, because that could be seen as something extra.

And we probably can't get into it, but, you know, the notion that legislation says that you can be paid for telestroke in a rural area and not an urban area, Medicare has to get away from this type of micromanagement. So kind of a broad theme is that, you know, if this is going to be a very nuanced area, some services are going to be worthwhile, some are not. This just has to be delegated to CMS to work through.

DR. CROSSON: Thank you. Dana.

DR. SAFRAN: So one of the things that strikes me is a kind of irony about worrying about the cost inflationary nature of this, and that's deserved. We worry about it, too, on the commercial side, and we've had some

conversations about that along the process here. But as we think about all of the things that are introduced as new treatments, new technologies in Medicare all the time, there's a part of this conversation that's making me think, you know, why are we thinking about this one so differently from all the other things that get added year after year that we know are going to be cost inflationary?

And so there are things that are different about this, and, you know, in one case we think it could improve access, and/or it could create a substitution effect that, frankly, with the rest of what we've been talking about over the last two days, we want to encourage, you know, calling to mind a clinician calls it "breaking the tyranny of the office visit," right? Or, you know, just building-centered care, right? Moving away from that, we want to encourage it.

So I guess for me I'd like to see us find a way to encourage that these modalities could improve access and quality, including quality of life. We have to be mindful of cost, and that we should, therefore, be monitoring those three elements that you frame up as principles as these are implemented to be sure that it's having the desired effect.

But this kind of treatment of it as something that we have to be afraid of introducing because it could be cost inflationary, I understand; but, on the other hand, we don't do that with anything else.

DR. CROSSON: Okay. Alice is next.

DR. COOMBS: First of all, it's an excellent report, and I think, Zach, Amy, and Andrew, you guys got it right. And, Amy, you said something that was really important in that this progression of telestroke, the availability of it is proceeding because of the need to meet community needs. And I think that's the most important piece of this, is that hospitals, community hospitals, providers are actually already there, and I think we're not in the infancy of this whole process with telestroke. We're actually far along. And because of that, I really feel that it's part of the duty of the institution to help meet the needs of the community, and they're doing it already.

So I think we're right at the right place. I wouldn't go any farther with a starter recommendation. I would wait to see what other literature there is along the lines of the distribution of telestroke centers. We know

geographically, I think, there are so many studies that look at the Stroke Belt, and if you looked at the Stroke Belt and telestroke didn't go with the Stroke Belt, then you'd say, okay, there's some major problems with access. But that would be one thing that CMMI could do, is actually look at the distribution and determine whether or not the demand is adequate -- the supply is adequate for the demand.

But I think you guys got it right. This is a really difficult field because the potential for dire consequences is enormous, and I've seen people who've gotten tPA, the $11,000 drug, and actually have a hemorrhagic event whereby they went from maybe being cadaveric in an arm and a leg and all of a sudden they're in a severe vegetative state because of a bleed on top of that. So it requires a lot of expertise. No way in the world would I ever want it to be expanded beyond what the clinical services are available to really make sure it's a good program. But, you know, there's 800,000 strokes a year, and, you know, it's the leading cause of death amongst beneficiaries. But I think right now people are trying to get to the place where they develop a good stroke

service, and I think this is one of the areas where it's really important that we stay right there in terms of studying the supply and demand.

So I think that I like the report. I like where it is. I do not think that MAs should get a special inclusion of this in their bids. I think that that's part of the duty of a plan.

DR. CROSSON: Okay. Coming up this way -- I'm sorry, Bruce. I didn't see your hand.

MR. PYENSON: Thank you. I like the report as it is and would suggest a couple of thoughts for the next cycle if the Commissioners agree with pursuing this.

I'm concerned that some elements of what we think of as telehealth are really pretty old technology, and I can remember companies selling transtelephonic EKG services in the 1980s, and if you think of the pace of technology change and what that would mean for price and cost, so the venture capital that's pouring into telehealth perhaps looks at office visit fees, but envisions servicing that with physicians without a practice expense, or maybe even without a malpractice expense.

So the trade-off with telehealth, since we're

jumping heavily into a fast-moving new technology structure, should be a dramatically reduced set of fees for many of the services. So I think -- that's my hypothesis, but I think if that's the sort of direction we're going in, I think that deserves a look in the next cycle. But I'm very happy with the report as it stands.

DR. CROSSON: Thank you. I think I saw Warner first.

MR. THOMAS: Yeah, I think it's a really important topic, and I think it does a good job in the report. I would just encourage us -- and I agree with many of Dana's comments that, I mean, this is a technology that is critically important for access. I feel like we're having a little bit of the Blockbuster-Netflix discussion here, and so, you know, I think if a patient is taken care of via telemedicine and they're satisfied and taken care of, they're probably not going to get in the car and go down to the physician's office.

So I think we need to facilitate and support this, and I think especially in rural areas or -- and I'll tell you, there's relative urban areas that don't have appropriate stroke capability. And to be able to connect

with the appropriate people, going to Alice's point, has a significant positive impact on patients.

So I would encourage us to facilitate and accelerate this and support this. It may have some short-term cost impact. I'm not sure. But I think this is something we should bet on, and it's a potential service that could really help beneficiaries and I believe over time can have a cost reduction impact. But I don't think that should necessarily be the leading indicator for whether we add every single service. I think this is just something that will facilitate better access to care, and, frankly, the reason we have a lot of cost issues in the program is because people don't have timely, appropriate, preventative access to care and then we deal with things on the back end. So I think this may help mitigate some of those issues.

DR. CROSSON: Thank you. Rita.

DR. REDBERG: Thank you. I first want to compliment you. The report was really excellent. It's a very complex area and you really, I think, had a great organization and clearly put a lot of work and talked to a lot of people.

I will say, though, I don't agree -- I mean, I don't think our problem in Medicare about cost is all because of not access, and I actually think a lot of our access indicators are really good. I think a lot more of our problems are related to fee for service and inappropriate services. You know, I want access to things that are helping our beneficiaries. But fee for service, you know, paying for things that have never been shown to help our beneficiaries and are harming them is, I think, what's really driving up our costs.

And when Bruce mentions that venture capital is pouring into telehealth, one has to think that they're seeing a lot of money from Medicare coming into this area and that, you know, should raise some red flags, I think.

You know, I think you laid it out very nicely in terms of the evidence, and as we were talking about with telestroke, if there's good evidence that's great, but I think having Medicare coverage get out ahead of the evidence is going to be something that we're going to regret, and it's very -- it's always hard to pull back once Medicare has started paying for things. So I don't think the argument that, well, we pay for everything else so

let's start paying for this is a good reason to start doing things. I think we should apply the, you know, principles of, is this going to improve our beneficiaries' health.

And because as you laid out very carefully, telehealth is a lot of different things, and, you know, some of them -- it really depends on what the alternative is. You know, if the alternative is something that, you know, this person wouldn't have gotten care and this is going to be an improvement, that's great. But if that's not what the alternative is, or it's an add-on or it's not useful, that is not a good thing, and we really need to have the evidence.

If we just start paying, particularly as you laid out in a fee for service system, we're not going to get the evidence and we're going to end up, you know, with something that may not be good at all for beneficiaries, and clearly is going to be very costly. That's different in a capitated system, and I think we were talking about that, where then, you know, you are going to be focused on outcomes and what you're putting in and what you're getting out.

And the last thing I just wanted to say is, you

know, for some -- I mean, maybe I'm old-fashioned but some things are better face-to-face, and particularly for our elderly patients. I mean, I don't know that everyone -- there are people, if you're -- certainly if you're an employee, you're going to work, you're rushing around. You'd rather go, you know, have a phone call if that's the -- going through a place in offices, and lots of people do that, and I don't think this -- but there also is value for a face-to-face visit, and, you know, I don't -- I think there is potential for telehealth, and great potential in circumstances. But I think the way you laid it out in the chapter, in terms of the evidence and looking at the type of systems, is really the way to go.

DR. CROSSON: Okay. David.

DR. GRABOWSKI: Great. Thanks. Once again, this was a great chapter. Zach, I wanted to pick up on a word you used, "convenience," because I actually think in fee for service convenience is both telehealth's greatest selling point but also its greatest challenge, in that for certain service it can really open up the floodgates. And for that reason, I really like the framework you've set up. We want to think about -- not just think about cost. We

also want to think about cost in the context of quality and access. It's really a value construct.

And I think we want to cover telehealth in fee for service, in those instances where there's high value, and obviously not in those instances where there's not value there. And I think that's a very simple construct, and I think that's what you were trying to get at with the framework, of thinking about not just spending but spending in the context of quality and access. In a kind of ACO risk-based framework or in MA, let them cover it, but in fee for service, I think we want to be really thoughtful here about the evidence and what it says in terms of value. Thanks.

DR. CROSSON: Thank you. Sue and then Jon.

MS. THOMPSON: I'll be quick. Again, thank you. The report frequently cites lack of evidence. It's tough to study something that we have been so restricting. So I just strongly support the chapter. I strongly support continuing to work with CMMI to study what we can. This has great application in our value-based environments. And so, you know, go forward, do great work with us.

DR. CROSSON: Thank you. Jon.

DR. CHRISTIANSON: Yeah, I agree with Alice and Sue, and I think the chapter is where it should be right now, and that we are where we should be.

I do have a question in terms of the framework, to follow up what you said. So in describing the framework you used phrases like "incorporating in the Medicare program," that the chapter is all about -- mostly about coverage. So I'm not sure whether incorporating in the Medicare program in your framework means finding ways to cover or whether it means something else.

And then the framework starts out by saying telehealth should reduce costs, and so forth. Is what we're looking for in the framework what telehealth should do in these areas or what coverage for telehealth should be about for Medicare? And I think those are very different things, and so I think when we think about this framework we need to be careful in terms of laying this out. I believe that if somebody gets to this point in the chapter their mind is going to be about coverage.

DR. CROSSON: Okay. Thank you. Good discussion. I'm not going to try to summarize it. I think we're not heading towards a point decision here. You've got good

support for the report. I think you've had a number of suggestions for maybe some added emphasis, and we will look forward to your final report. Thank you so much.

DR. MATHEWS: Do you want a show of hands vote for the report?

DR. CROSSON: If you'd like. Yeah. So, sorry. This is not a formal vote but sometimes when we do reports, Jim reminded me, we do an informal show of hands for support for the report, so I'd like to do that now.

All Commissioners supporting the report as it will be revised please raise your hand.

[Show of hands.]

DR. CROSSON: Thank you. All opposed?

[No response.]

DR. CROSSON: Abstentions?

[No response.]

DR. CROSSON: We have unanimous support for the report. Thanks very much Andrew, Amy, Zach. We will head on to the next topic.

[Pause.]

Okay. I think we can move forward with the next presentation and discussion. We're going to come back to

our discussion which has been going on for a number of years now, with respect to the fee schedule, particularly with respect to balance among specialties. And Ariel and Kevin are here to take us through that discussion.

MR. WINTER: Good morning. Today, we will be talking about rebalancing Medicare's physician fee schedule towards ambulatory evaluation and management services. This is a follow-up to a presentation we gave at the November meeting, and we expect to include this work as a chapter in the June report.

During your discussion at the November meeting, it became clear that are dealing -- we are trying to address two separate issues. The first issue is that the fee schedule underprices ambulatory E&M services relative to other services. An example of an ambulatory E&M service is an office or outpatient visit. Today we will be discussing a policy option to increase payment rates for these services when they are provided by any clinician.

The second issue relates to primary care, and concerns about whether the fee schedule is well-designed to support primary care services and clinicians. We will describe a policy option there for a special payment for

primary care clinicians. If you are interested in pursuing this option, we could develop it further in future meetings.

I want to note up front that we modeled the impact of each policy option in isolation. We did not model the combined effects of both options.

Our work on these issues is part of a broader agenda on clinician payment policy. Yesterday, as well as last month, we presented our annual assessment of payment adequacy for physician and other health professional services, and you approved an update recommendation for 2019. Yesterday, you also approved a recommendation to repeal MIPS and establish a new voluntary value program.

We have also done work on advanced alternative payment models and ACOs, which will be presented right after this session.

The fee schedule underprices ambulatory E&M services relative to other services. Payment rates for clinician work are based on estimates of the relative amount of time and intensity required for each service. E&M services are labor intensive. A clinician takes the patient's history, examines the patient, engages in medical

decision-making, and so forth. These activities do not lend themselves to reductions in the time it takes to provide the visit.

By contrast, the time needed for other services, such as procedures, often declines over time due to productivity gains and changes in clinical practice and technology. Ideally, the prices for these services would also be reduced to reflect these efficiency gains.

Because the fee schedule is budget neutral, a reduction in the prices of these services would raise prices for ambulatory E&M visits. But this two-step sequence often does not occur, which means that payment rates for ambulatory E&M visits are too low relative to other services. The Commission has called this problem "passive devaluation."

This slide illustrates the extent to which certain services have become overpriced. We hired a contractor in 2014, to compare the actual number of hours worked with the number of hours assumed in the fee schedule for services provided by clinicians in four practice groups: cardiology, family practice, orthopedics, and urology. If a physician actually worked 10 hours per day,

but the fee schedule assumed that the services provided by that physician take 15 hours, this difference implies that the time estimates in the fee schedule are too high.

The contractor's study found that the hours assumed in the fee schedule exceeded actual hours worked for physicians in all four practices. However, the discrepancy was much greater for the practices that focus on procedures, which suggests that the services they provide may be based on inflated time estimates. For example, the hours assumed in the fee schedule were 24 percent higher than actual hours worked for family practice, but 64 percent higher in cardiology, and 92 percent higher in orthopedics.

Since 2008, CMS has reviewed many potentially mispriced codes, but we believe the process has not been sufficient. Although the review process has been going on for several years, many services have not yet been reviewed. These unreviewed services account for 35% of fee schedule spending. Even for services that CMS reviewed and reduced their work RVUs, the RVUs did not decline as much as might be expected, given the decline in the amount of time that it takes to provide the services.

From 2008 to 2016, CMS decreased the work RVUs, the time estimates, or both, for 607 services. The time estimates for these services decreased by an average of 18 percent, but the work RVUs decreased by an average of 9 percent. A potential explanation for this disparity is that decreases in time were partially offset by increases in intensity.

Prior incremental efforts to address the relative underpricing of ambulatory E&M services have not succeeded in rebalancing the fee schedule. Therefore, the Commission may wish to consider more significant changes.

Based on your discussion from the November meeting, we are presenting an option to increase payment rates for ambulatory E&M and psychiatric services by 10 percent when they are billed by any clinician, regardless of specialty. This option recognizes that many specialties provide ambulatory E&M services and are affected by the underpricing of these services.

This option would increase total spending for these services by about $2.7 billion. To maintain budget neutrality, payment rates for all other services would be reduced by 4.5 percent.

The E&M services included in a payment rate increase are E&M codes for office visits, home visits, and visits to patients in long-term care settings; chronic care management and transitional care management codes; and Welcome to Medicare visits and annual wellness visits.

The payment increase would also apply to psychiatric services, which include psychiatric diagnostic evaluation and psychotherapy. We included these services because of concerns about beneficiaries' access to behavioral health care. Also, the psychotherapy codes are based on the amount of time spent with a patient, which makes it difficult to improve productivity.

A question for you to discuss is whether we should include Welcome to Medicare and annual wellness visits in the payment increase. Both Choosing Wisely and the U.S. Preventive Services Task Force recommended against annual general health checkups.

In addition, we have heard from ACOs and physicians in our focus groups that third-party companies sometimes provide annual wellness visits to beneficiaries, during which they recommend unnecessary tests. Also, the beneficiary's primary care clinician is unable to bill for

a wellness visit during that year if a third-party company has already billed Medicare for one for the same patient.

We modeled the net effect of a 10 percent increase to payment rates for ambulatory E&M and psychiatric services, and a 4.5 percent decrease to the rates for all other services to maintain budget neutrality, and here we show the specialties that would have the greatest net increase in their fee schedule payments.

The top three specialties are licensed clinical social workers, which would have payment rates going up by 10 percent, clinical psychologist, by 8 percent, and endocrinology, which would increase by 6.5 percent.

It's important to note that LCSWs are paid 75 percent of the full fee schedule amount.

In the last row, you will see internal medicine, which would have a net increase of only 2 percent. That is because this specialty performs a lot of services other than ambulatory E&M, and the rates for those services would drop by 4.5 percent.

Later on, we'll talk about a targeted payment to support primary care clinicians, and this table does not show the effects of such a payment.

We also looked at which specialties would account for the largest share of the total payment increase across all specialties, and this is shown in the second column. Internal medicine would account for 18 percent of the total increase, or $493 million, and family practice would account for about 16 percent of the total increase, $423 million. Taken together, all the primary care specialties would account for 45 percent of the total increase, or $1.2 billion.

Several specialties, not shown on this slide, would experience payment reductions of more than 4 percent because they provide very few E&M or psychiatric services, and these include radiology, pathology, physical therapy, and occupational therapy.

Up until now, we've been talking about an option to increase payment rates for ambulatory E&M and psychiatric services when they are billed by any clinician, regardless of specialty, and now we're going to switch gears and talk about another topic, primary care.

The fee schedule is not well-designed to support primary care because it is oriented towards discrete, face-to-face services, while a major component of primary care

is ongoing, non-face-to-face care coordination. Another issue is that the nature of fee-for-service payment allows specialties that focus on procedures to more easily increase the volume of services they provide than primary care clinicians, who tend to focus on E&M services. This is because it's easier to achieve productivity improvements for procedures than for E&M services.

As we've discussed before, compensation for primary care physicians is substantially less than for other specialties, which could deter medical school graduates and residents from pursuing primary care careers, and the pipeline of future primary care physicians appears to be shrinking. The share of third-year internal medicine residents who planned to practice primary care dropped from 54 percent in 1998 to 21.5 percent in the 2009-2011 academic years. We note in your paper that multiple factors influence physicians' specialty choices, but income differences among specialties have an especially strong influence.

The Commission has been working on primary care issues for several years, and this slide lists our key recommendations in this area. In 2008, for example, we

recommended that Congress create a budget-neutral bonus for primary care services, and this eventually became the Primary Care Incentive Payment program, or PCIP. In 2015, we recommended that Congress establish a per-beneficiary payment for primary care clinicians to replace the PCIP, which ended in 2015.

An option for you to consider is whether to establish a special, targeted payment for primary care clinicians to address the concerns that we've outlined, namely, that the fee schedule does not adequately support care coordination activities, if compensation for primary care is much less than other specialties, and the pipeline of future primary care physicians is shrinking. This special payment would be on top of the 10 percent increase in payments for ambulatory E&M and psychiatric services billed by all clinicians.

This is an issue that we could work on and flesh out during future meetings. There would be several important design issues to consider. How should eligibility for a special payment be determined? Options include the specialty designation, the share of payments that they derive from ambulatory E&M services, or both. Should

clinicians from specialties besides primary care be eligible for a special payment? How much money should be allocated to a special payment, and where should the funding come from?

One option would be to use the $500 million per year from the MIPS exceptional performance bonus, which would be available if MIPS were repealed. But keep in mind that this money is scheduled to expire after six years. Another option is an across-the-board payment reduction for non-ambulatory E&M services.

Another important question is how to distribute a special payment for primary care. One option is to distribute it based on the number of eligible E&M services billed by a primary care clinician. This would be easier for CMS to administer, but it would reward clinicians who provide more discrete visits. Another option is to distribute it based on the number of beneficiaries attributed to each clinician, consistent with our recommendation from 2015. However, a per-beneficiary payment does raise questions about how to attribute patients to primary care clinicians, and whether the payment would need to be risk adjusted.

We've raised several design questions in the last few slides, and the answers to those questions would affect any future modeling that we might do. But to illustrate the potential impact of a special payment for primary care clinicians, we used a fairly simple scenario, which is similar to the PCIP program. We assumed that the special payment would be equal to a 10 percent increase for ambulatory E&M services, and it would be provided to primary care clinicians who derive at least 60 percent of their fee schedule revenue from ambulatory E&M services. In this scenario, the special payment would total $1 billion and would be paid to about 220,000 clinicians.

To maintain budget neutrality, payment rates for services other than ambulatory E&M services, such as procedures, imaging, and tests, would be reduced by 1.7 percent. This reduction would be smaller if the add-on were partially funded with $500 million from the MIPS exceptional performance bonus.

During your discussion, we'd like to get your feedback on the two policy options that we talked about. And this concludes our presentation, and we'd be happy to take any questions.

DR. CHRISTIANSON: [Presiding.] Amy.

MS. BRICKER: Really quick clarification on Slide 9, the chart that lists the specialties. Which specialty is nurse practitioner and physician assistant?

MR. WINTER: They're listed on the slide. Are you asking for clarification about what subspecialties might be within those?

MS. BRICKER: Well, nurse practitioner is just a license. What is the --

MR. WINTER: Okay. So these are self-designated by the clinician when they enroll with Medicare, so they are self-reported by the clinician.

MS. BRICKER: So this nurse practitioner could be working in the cardiology office --

MR. WINTER: Yes.

MS. BRICKER: -- or could be working in the family practice office.

MR. WINTER: Yes. Yes, absolutely. Yes.

MS. BRICKER: Okay.

MR. WINTER: Yeah, and the same with physician assistant, same thing with internal medicine, and any of the other clinicians who are listed here. And that's one

of the weaknesses of relying on this specialty designation. It's reported by the clinician when they enroll with Medicare. There's no requirement for them to update it if they change their practice patterns.

DR. REDBERG: So we don't know how many nurse practitioners are working in primary care as opposed to specialties or others.

MR. WINTER: So AHRQ did a report in 2010 where they estimated that about 43 percent of PAs focused on primary care and about 52 percent of NPs focus on primary care. And if you look at a mix of services they provide, NPs about three-quarters of their fee schedule payments are for ambulatory E&M, which, you know, may or may not be primary care, and for PAs it's lower. It's something like in the 50 percent range.

DR. CHRISTIANSON: And I think Alice, you wanted to get in on this question too?

DR. COOMBS: Yes. I was going to go straight to the slide, and the reason, Ariel, is because this piece is a really difficult complex and I want you to tell me, can you decipher between "Incident to" billing, because some of these individuals are working under the direction of a

physician.

MR. WINTER: Right.

DR. COOMBS: Now, they are salaried but yet the office is billing under Medicare and what they -- this increase that we see doesn't reflect what actually they get. It's that they may be working under primary care physicians. Right?

MR. WINTER: You are correct that if a service is provided by an NP or a PA, but it's billed by the physician as an "Incident to" service, that it would show up -- it would be attributed to that physicians and not to the NP or PA. So we have no ability to discern, based on claims, whether the service was provided "Incident to", and we have suggested to CMS, more than once, that they change the claim to add a modifier so that we would be able to distinguish between "Incident to" and other services.

DR. COOMBS: So this, depending on states, because some states allow MPs and PAs to work without collaboration or supervision, and that's okay, but this graph is artificially maybe lower or higher for any of these entities without us being able to appreciate that specific.

MR. WINTER: I would say it doesn't fully capture the number of services being provided by MPs or PAs, and a portion of those are being billed under the physician's identifier.

DR. CHRISTIANSON: Sorry to interrupt. I need to see some hands. I've got Brian on the list. Okay. So then I've got Pat and Paul. Go ahead, Brian.

DR. DeBUSK: Ariel, I just wanted to follow up on something too. When you were commenting on Chart 9, again, just to make sure I understand this, you know, there is a weakness here in that they designate their primary specialty when they enroll in Medicare, and there's a weakness there in that it isn't necessarily accurate or properly updated. But there's actually a second weakness here in that we treat nurse practitioners and PAs as a specialty. I mean, it's really a structural issue in the data and how the data -- I mean, it's not just a matter of, oh, we need to keep up with how they designate better. We actually need to change the way that designation is done, in that you almost need to say this is my specialty and then within that specialty I am a physician or I am a PA or I am a nurse practitioner. It's almost like you designate

to a specialty, and -- okay, I just wanted to make sure that, at least in my mind, how the world should work is correct, because that would be a really bad thing.

MR. WINTER: Yes. That level of detail or refinement would be helpful for us as analysts.

DR. DeBUSK: Okay. And then to build on Alice's point, we've been talking about "Incident to" services. That is a separate but somewhat related data integrity issue, and I don't think -- and to go back to Chart 9 as a clarifying question -- 9? I don't have my glasses.

Oh, that didn't help. Chart 5 is a --

[Laughter.]

DR. DeBUSK: I need to really get my prescription worked on.

Back to Chart 5, the fact that "Incident to" services to occur, I don't think that gets us a pass to say, "Oh. Well, we can't trust these numbers," and I don't think we're saying that at all.

And "Incident to" may distort some of these numbers, but you see extenders used in all of these professions. And I don't know that we can definitively say that they're disproportionately used in any one.

So it's fair to say that there is some contamination there, but it's spread across the spectrum of specialties. It isn't just something that's lumped onto one specialty.

DR. HAYES: Can I just clarify? On this particular project, we did not allow "Incident to" billing to kind of contaminate the data. In other words, we did require a separation of the practitioner from the volume of services, from the time spent.

DR. DeBUSK: Well, that's, first of all, excellent. I mean, that's great.

But if the claim comes through and it has the physician's NPI, but the actual work was done by the PA or nurse practitioner but it's billed "Incident to", can we even tell the difference? I don't know that we can see that in the data, can we?

MR. WINTER: We can't.

DR. DeBUSK: Okay.

MR. WINTER: And in addition to our strong suggestion to CMS that they change the claim to reflect that, OIG has made the same recommendation because of program integrity issues as you raised. We're not the only

ones saying this.

DR. DeBUSK: Okay. Not to belabor this, but if you notice, every public meeting, we have a data integrity issue, and I think making claims smarter may need to be a chapter someday. That's my plug.

MR. WINTER: That's a good point.

DR. CHRISTIANSON: Good point.

MR. WINTER: If I could just clarify something about this table, the policy option we're trying to model here is would an increase in ambulatory and psychiatric services, regardless of the specialty that billed for the service, it would not apply to certain specialties but not others. And what we're trying to do here is to show you the impact by specialty because we know there have been concerns about certain kinds of specialties perhaps being under -- having lower compensation or perhaps access concerns or pipeline concerns. That's why we're showing you by specialty. The intent here is not to have the policy applied differently by specialty.

DR. DeBUSK: Well, a corollary to that -- and again, I promise I'll get off this issue -- if we go back, for example, and change -- let's say we do try to do a

designation for nurse practitioners or PAs. We're going to have to either assume their primary care or not, won't we? Because we won't have the luxury of knowing their specialty. I guess we'd have to base it on their E&M codes, wouldn't we?

MR. WINTER: Right. One thing you could do --

DR. DeBUSK: Okay.

MR. WINTER: -- which is what PCIP did is to base it on the share of their fee schedule revenue that are derived from ambulatory E&M as a proxy.

DR. DeBUSK: You are a couple steps ahead of me. Thank you.

MR. WINTER: And the same issue would apply to internal medicine because many internal medicine physicians so specialize.

DR. CHRISTIANSON: Okay. So I've got Pat, Paul, and Kathy.

Thank you, Brian. I think we've got a new -- besides your points, I think we have a new potential MedPAC principle, so how the world should be according to Brian. It's very good.

[Laughter.]

DR. DeBUSK: It should be right there with paying similar --

DR. CHRISTIANSON: Yeah, I think so.

DR. DeBUSK: -- for similar rates.

DR. CROSSON: It's right up there with that. Yeah.

MS. WANG: Staying on Slide 9, can you remind me why some of the cognitive specialties like neurology don't show up on this list?

MR. WINTER: So I will look up in a second what their specific impact was.

So what we think of as cognitive specialties, they're doing -- yes, they're doing ambulatory E&M, but they're also doing other services. They're doing inpatient E&M. They're doing procedures, imaging, and test some of them, and so those services would be reduced by 4.5 percent, the rates for those services.

For some services, you're getting an increase. Other services, it's a decrease. And so for certain specialties, the net effect is not large, and if you will give me a moment, I'll just quickly look up -- do you want me to look up neurology, or was that just an example?

MS. WANG: Don't take the time of the group. We can follow that up later.

Also, I understand that Slide 9 is just showing sort of like this is what it would look like and this is how it falls down by specialty, but you did a good job, I think, elsewhere in the material about talking about the concerns around primary care physician shortages, pipeline, et cetera, et cetera.

Do we have evidence that the non-physician specialties that sort of fall out in this analysis is having a lift in compensation or in similar shortage situations? Applications to PA school, for example, are through the roof. I'm just curious about --

MR. WINTER: As you pointed out, there's been an increase in NP and PA students, and there's been an increase, fairly substantial, in the number of NPs and PAs treating Medicare beneficiaries. So it went up from, I think, 3.3 per thousand beneficiaries in 2014 to 3.9 per thousand beneficiaries or 3.6 per thousand beneficiaries in 2016. So there was a marked increase.

DR. CROSSON: Okay. Paul.

DR. GINSBURG: Actually, most of what I want to

say was covered by others, but I just wanted to make sure we come back later to -- the full payment of a physician fee under "Incident to", I think is a growing problem, and I guess that's what you meant by the program integrity issue. I think it's really worth some of our attention.

DR. CROSSON: Let's see. I've got Kathy, Warner, and Jack.

MS. BUTO: I just wondered whether we have kind of walked away from the top-down approach and gone to the 10 percent add-on as a way of sort of short-circuiting or cutting through, cutting to the chaise, if you will, and raising payments for E&M services, because I thought you did a really good job of explaining how that would begin to really address underpricing of services. So I'd be curious just to know that.

DR. MATHEWS: Kathy, can you refresh my memory as to what you're referring to by top down?

MS. BUTO: This is the approach that's laid out where we look at the changes in time related to procedures, and there's a growing disparity between primary care or E&M services and other procedural. And I think you called it the top down. Am I getting that wrong?

DR. HAYES: No. That's correct.

MS. BUTO: Maybe you can explain it better than I can.

DR. HAYES: This slide is an illustration of how the top-down approach would work. We would have information on what the fee schedule estimates as the total amount of time worked for all services furnished during a given time period, and then we would compare that to hours worked, actual hours worked for the same individual, for the same individual, for the same physician, nurse practitioner, PA, whoever it would be. And you would sort of compare the two, and that would be an indication of where in the fee schedule there might be problems. And it would require a more focused look on the specific services that went into accumulating into the fee-for-service time and the hours worked that are shown, but it would give you a starting point. The issue is that we've got 7,000 or so codes in the fee schedule, and it kind of becomes a question of where do you start. And so that's what this kind of thing is meant to do.

DR. CROSSON: Just to remind people, that's in distinction -- terminology is a little cumbersome. That's

in distinction to what we have called "bottom up," and bottom up would be sort of time-in-motion studies, sending somebody around to actually find out on a sample basis how long it takes to do a colonoscopy, et cetera, et cetera.

MS. BUTO: Right. What I was trying to get at, Jay, was really have we walked away from that approach and moved to this 10 percent add-on to E&M services for all specialties as sort of a proxy and then reducing. To me, it's sort of the issue of more of a rough-cut approach versus one that's based on the actual data that reflects the time in performing these services, so I'm just curious.

MR. WINTER: I think there's a -- I'll let Paul speak to this, and then I'll jump in.

DR. GINSBURG: Actually, I was going to say this is a major issue I was going to get into in Round 2 --

MS. BUTO: Okay.

DR. GINSBURG: -- is that have we failed year after year with the bottom-up approaches that now we have to contemplate what some other countries have done and do it top down.

MS. BUTO: Right. But I think they've gone yet another step. Am I wrong? The 10 percent is your latest

version of that, which is sort of an across-the-board, not a specific look at the differences in time so much as just an across-the-board increase for E&M services and then a reduction.

DR. GINSBURG: That's how I interpret it, but Ariel --

MR. WINTER: Yes. Yeah, I think you're correct. This would reflect a policy judgment that because of many years of MedPAC and others making recommendations about ways to improve the process and the data by which services are valued and frustration that the system process and the data have not improved and therefore there are still big differences, there's still a significant relative underpayment of E&M, ambulatory E&M relative to other services, that there needs to be a different approach, sort of a mechanical adjustment to make up for many years of -- make up for this underpricing.

So, ideally, the process by which we've -- the process -- the change that we've recommended over the last decade-plus would have addressed a lot of the over-valuations that we've been seeing. But we think the process has not been sufficient. The data are not there,

and so we're making sort of a -- we're suggesting a mechanical adjustment.

But you could still -- we still -- I mean, one way to look at it is that going forward, you still want to do the things that we've been recommending, like a top-down approach, improving the data, improving the process, because you still need to maintain the entire system.

DR. CROSSON: Kathy, I just want to be clear. Is what you're asking why not take the top-down data, which is the data that we have? Because we found out that it's too difficult and too expensive to do it bottom up, and I think that's still a question, but that's the issue.

Why not sort of take a numerical approach based upon the ratios, et cetera, et cetera? Is that the point?

MS. BUTO: That's exactly what I was --

DR. CROSSON: Yeah. Got it. Okay, thanks.

Warner.

MR. THOMAS: I just had a question, a little different angle. Did we consider or look at the opportunity to expand primary care-specific training options, GME slot specifically around primary care? I mean, I know we have capped those for many years, but the

idea to just target this specific area?

MR. WINTER: It's something we talked about in our 2008 chapter. We made a recommendation for a bonus for primary care clinicians. We talked about some ideas for targeting GME and IME dollars to improve the supply of primary care; for example, targeting some of those dollars to primary care residencies specifically. And there's some other ideas along those lines, but we have not really discussed it since that 2008 report.

MR. THOMAS: And I guess based on what we know, was there any work done in -- I mean, I know this is really focused primarily on the economics and the payment, and I think there's -- I guess the question is do we -- did we do any work on pipeline as part of this? Do we have any knowledge of kind of what that looks like?

MR. WINTER: Yeah. We talked about that in the chapter in terms of the change in the number of family medicine residents --

MR. THOMAS: Right, right.

MR. WINTER: -- and internal medicine residents, and then we provided some data on percent, the decline in the percent of internal medicine residents who say they

intend to pursue a primary care career.

MR. THOMAS: And I guess that kind of gets back to my point of is there a way to think about that being targeted specifically because, as we know, folks that are in internal medicine, they can go in a lot of different directions. So this idea of targeting -- so is there -- do we have a handle on what that exact number looks like of primary care-only slots?

MR. WINTER: Oh, in terms of residency slots? I'd have to look into that.

DR. CHRISTIANSON: So since we made our recommendation in 2008, of course, there's been a major IOM report on graduate medical education, and it had some recommendations about how the Medicare funding for it should be redone. We probably want to try to build off of that or use it as a starting place if we decided to go down this path.

DR. CROSSON: Okay. Jack.

DR. HOADLEY: So I had a question on Slide 14 where you illustrate the special payment, and I'm just trying to make sure I understand these numbers.

So you get 220,000 eligible clinicians by this

definition, and that's -- as I read this, that's people who meet two criteria. One is they've got a designated primary care, and second, that they meet the 60 percent payments from the eligible services.

Do you have numbers on how many meet one but not both of those criteria? So either they're getting 60 percent from eligible services, but they're not primary care, or vice versa?

MR. WINTER: I feel like we had some of that information for the November meeting. I don't recall it, but I can get back to you with that.

DR. HOADLEY: Yeah. It would just be a helpful context to understand, if you wanted to loosen that either way, what kind of set of people were you talking about.

The other question I had was you talk in the chapter about making the assumption and modeling the 10 percent increase that it would apply to all charges, including beneficiary cost sharing, but that that's potentially a design decision. What tradeoffs did you have in mind particularly in terms of the beneficiary cost sharing?

MR. WINTER: So if you include the beneficiary

cost sharing, there's more revenue to the clinicians. That's sort of one upside.

A downside is if this payment were separated from a visit, a separately billed visit, and the beneficiary just got a bill in the mail for 20 bucks, 100 bucks, because their clinician was getting a monthly payment from a Medicare program, they might be confused. They might wonder what's this about, "I didn't see the clinician last month." So there's going to be some confusion.

And we've heard about this issue coming up with the chronic care management codes, which are billed on a monthly basis and are not linked to a specific visit, and the beneficiaries have been confused when they get a bill in the mail for the coinsurance for that. So that would be a downside.

Another downside could be why should we ask the beneficiary to pay more to address this issue with primary care.

DR. HOADLEY: Thank you.

DR. CROSSON: Alice? I'm sorry. I thought I saw your hand.

DR. COOMBS: I just had a question about the

percentage of primary care patients as being an index of being a primary care physician, and so my concern is obviously that someone can be an FTE that's .4 versus a .3, and they could have 100 percent of their patients in primary care. But in terms of them meeting access needs in a given community, it's problematic.

And then the other question is you have a very productive -- you know, as mentioned yesterday, you have a very productive neurologist, who's seen as much primary care. Maybe he has a multiple sclerosis patient where he coordinates the primary care, and when you do absolute percentages, it becomes problematic. And that the volume of, say, someone who is not necessarily designated family practice or internal medicine might be doing more primary care because of the sheer number of patients that they're seeing.

MR. WINTER: Yeah. We've looked at different points both for the November meeting and for our 2008 chapter. We can talk about a 40 percent threshold, 50, 60, 75, and if you lower the threshold, then more clinicians are going to be eligible, which means you're spending more money.

DR. COOMBS: Well, I wasn't thinking about lowering the threshold. I was having an "or" in there for a very productive person. So if you were to say whatever percentage one should decide, then there should be an "or" this person is actually doing above and beyond the call of duty of procurement, which merits some kind of accountability to us paying attention to them as well.

MR. WINTER: So are you suggesting more like an absolute number of beneficiaries seen, an absolute number of ambulatory E&M visits?

DR. COOMBS: Yeah. So if you took the average number of a panel for internals, say 1,000, 1,500 patients, and if you said this is the average expectation in terms of how many patients correlate that with ours, then you might come up with an absolute number that says, okay, this is a reasonable amount of primary care patients that should be as a part of it. And you could use the percentage, but you could also use an absolute "or" as well.

DR. CROSSON: Okay. I've got Bruce and Dana and then Pat.

Bruce.

MR. PYENSON: Thank you. I've got a question

related to Slide 5. In the decade since RBRVS, as I think you've pointed out, there have been various solutions to the issue we've identify of the disconnect between primary care and specialists or, as we're perhaps characterizing it, E&M, ambulatory E&M and procedures. So I think each of those was perhaps an attempt to make the relativities here look similar, and over time it fell out of sync for I think the reasons you've described as the ability for procedures to take less time.

So my question is: Can you estimate how long the 10 percent fix would last before we're back in this situation?

MR. WINTER: Yeah. It's really hard to say. I think part of it depends on whether there are improvements in the data and the process for updating and validating the RVUs. If there are no changes, then the effect of that 10 percent increase is going to, I think, wear off over time. If there are improvements, then you may see a greater -- a similar relativity across types of services and specialties that persist. I think it really depends on where the process goes from here.

DR. CROSSON: Dana.

DR. SAFRAN: Thanks. My question relates to the added payment, not the 10 percent, and I guess I'm trying to understand whether the added payment -- the fundamental goal of the added payment is to further ensure the adequacy of payment for primary care. And if that's the goal, my reading, anyway, of what you're showing on Slide 5 is that even with the balance issues that we have -- could you put Slide 5 back? -- that in family medicine, for example, payment was actually more than adequate to time being spent.

So I question it from that perspective. If the goal of the added payment is to encourage primary care to do added services -- care coordination and so forth -- I think the evidence is really weak coming out of the patient-centered medical home research, that doing that is very effective, that those added payments -- so I'm not going to make a Round 2 comment about what I, therefore, think about it, but I just am asking the question about whether -- which of those things is your goal for this added payment?

MR. WINTER: I think that's really a question for you all to think about, to put the ball back in your court.

But, you know, is the goal here -- we laid out a variety of concerns, and we think that a special payment for primary care could address some or all of these concerns, the issue of how there's a mismatch between a fee-for-service payment and the need for ongoing, non-face-to-face care coordination, issues of compensation disparities, issues of the future pipeline of primary care clinicians. And it's really a judgment call as to whether a special additional payment for primary care could address one or all of these concerns, or whether some other options should be pursued. We're laying this out here for your discussion, and as you know, the Commission is on record with the 2015 recommendation that there should be a per beneficiary payment, but that was three years ago, and you might want to reconsider that, particularly in the light of the first policy option that we're raising, which is a new direction for the Commission, potentially new direction.

DR. CROSSON: So it is up to -- that's why we're having the discussion. It is up to the Commission. You know, but thinking back to 2015, to may be a very little reductionist, I think the concern here was -- or is, or was at the time, anyway, that we think there's a fair

likelihood that the pipeline for primary care physicians -- now, it gets very tricky because I think we've included in this other providers of primary care services, and I think the question of whether there's a shortage or not is a good one. But I think if you look at the pipeline for family practice doctors and internal medicine physicians practicing internal medicine and the decrement that's occurred in the last decade or so, and you project that forward in a pipeline that may be seven to nine years long, there's a good possibility that if we don't act or make a suggestion to change that, that we could find a situation in a few years where a significant number of Medicare beneficiaries who want to see a physician for primary care services are unable to do that because they're not there. That's about as close to the problem statement as I can get.

Now, the solution for that is, of course, difficult, right?

MR. WINTER: If I could provide one more piece of background about the 2015 per beneficiary recommendation, at the time the PCIP, which was a 10 percent increase for primary care, was about the expire, and the Commission

believed that letting it expire without replacing it with anything would send the wrong signal to primary care clinicians. And that was coupled with an intent to try to move away from fee-for-service payment towards a broader type of payment for primary care.

DR. CROSSON: Thank you. Pat.

MS. WANG: Going to Slide 14, this kind of puts the additional screen of 60 percent of payments from eligible services, 220,000 eligible clinicians. Do we have this information broken down by the categories in Slide 9, what specialties, what type of clinician to see who's in that 220,000? Is that available?

MR. WINTER: I'd have to go back and look at the November meeting materials, but I can --

MS. WANG: Was it in there? Okay.

MR. WINTER: I believe there was something very similar to that in there, the distribution by specialty. You're going to see the larger specialties, like internal medicine and family medicine are going to represent the bulk of the clinicians who get the additional payment.

MS. WANG: Okay, but in addition, all clinician types, which was helpful to see in Slide 9 --

MR. WINTER: You mean the specialties we showed?

MS. WANG: Yeah, physician and non-physician.

MR. WINTER: Yes, sure. We can do that.

MS. WANG: Okay, who was in there.

The other question I had was: Is Slide 14 related to the information in Table 3 on page 21 in the report? There's a table, primary care practitioners and certain other specialties derive much of their fee schedule payments from ambulatory E&M, and then there's a column. So does this Table 14 then exclude geriatricians? Geriatricians are not represented in the 220,000 eligible clinicians? They don't have 60 percent of their payments, according to this table.

MR. WINTER: Right, so the table on page 21, Table 3, is showing the average percent. So there's a distribution around that average.

MS. WANG: Okay.

MR. WINTER: So geriatric medicine, across the entire specialty they derive 56 percent of their revenue from ambulatory E&M, but there are many geriatricians who get more than 60 percent and, therefore, would qualify for this additional payment.

MS. WANG: It would be so helpful to see this cohort of -- if we move from with this approach, it would be so helpful to see this 220,000 broken down into the same categories as Table 9.

MR. WINTER: Absolutely, we can do that.

MS. WANG: Thank you.

DR. CROSSON: Okay. I think we're going to move forward now to the discussion, try to move this issue forward a little bit, see where we think we should go. And Paul and then Kathy are going to -- have asked to begin the discussion.

DR. GINSBURG: Yes, well, I thought that this document that you sent made real progress since November by making the distinction between dealing with the distortion that affects all E&M services versus the particular issues that where fee-for-service payment is not very suitable for a lot of current contemporary primary care activities.

But, Ariel, your answer to Dana's question made me wonder if you really believe what you wrote, but we can get back to that later.

DR. CROSSON: Okay. But I think we need to give Dana a chance to answer while he's thinking. Go ahead,

Paul.

DR. GINSBURG: Sure. So in a sense, I think the key thing is the distinction. You know, I think the -- you didn't get into why only outpatient services, and I started thinking of some reasons, but better that you stated them than I come up with something.

So when we get to the shortcomings of inpatient payment for primary care, I think some of these shortcomings do affect some of the other cognitive specialties who have the same issues in care coordination and non-face-to-face visits. And there really are a range of ways to address these primary care issues beyond RVS changes. And one thing that I'd like us to look into and if you have or haven't talked to Bob Berenson, his ideas about coming up with new codes suitable for primary care, he's told me he thinks it can solve a lot of some of these fee-for-service shortcomings for primary care.

I do have concerns, as many others have, about, you know, a per physician payment for primary care in this non-HMO, non-organized environment, with problems for attribution and, as Dana mentioned, you know, the lack of encouraging results from the patient-centered medical home

demonstrations.

DR. CROSSON: Okay. I apologize. You all look confused, so, Ariel, do you want to respond?

MR. WINTER: I believe everything I wrote.

[Laughter.]

MR. WINTER: But this is -- it's not just my document. It's, you know, the combined efforts of Kevin and Jim and other staff as well. But I think what we were trying to get at is react to the feedback we got at the last meeting, where there was both an interest in addressing the undervaluation, underpricing of specifically ambulatory E&M, but also addressing issues and concerns about primary care. And so we tried to separate those two concerns into separate policy options.

With regards to the second one, which I think is what you're referring to, Paul, in my response to Dana's questions, if you provide more payment, it's going to address to some extent the compensation disparities, particularly if private sector -- if commercial payers and plans follow suit. It's not going to, you know, completely equalize compensation. I don't think that's the goal. But it should help improve the disparities or reduce the

disparities.

In terms of coordination and improving care management, I think that depends on whether you want to impose any requirements, in terms of practice requirements, and the evidence about practice requirements on improving care coordination is mixed. We noted that in our 2015 chapter. And so that's probably the best response I can make.

DR. GINSBURG: You were really talking about Option 2 when you were answering Dana.

MR. WINTER: Yes, I --

DR. GINSBURG: I was afraid you were abandoning Option 1.

MR. WINTER: And I'm not abandoning either option.

DR. CROSSON: Okay. Kathy.

MS. BUTO: So I think I expressed some concerns at the last meeting, and I continue to have them. Let me just say, as I think about this issue, I think we're all trying to grapple with, first of all, recognizing that we believe -- I think you correctly say in the preamble or beginning of the report, the chapter, that E&M -- that

primary care is undercompensated and underpaid for services rendered. You lay out, I think very well, some of the problems, so the underpricing of primary care or E&M services, which I think you make a compelling case for; secondly, the issues of income disparity and concern about the future supply of physicians; thirdly, you talk about the important role of primary care. I think this is a goal, actually, that we are somehow trying to strive for, making primary care more of a central, more powerful role in the Medicare sort of fee-for-service system, that it actually gets both the compensation and kind of the authority it should to do better on managing fee-for-service patients.

So if I start with the problem set, underpricing of primary care, back to the issue of the 10 percent and then the across-the-board cut, I really like better the old top-down or the top-down approach that you proposed as an alternative to bottom-up, which is more numerically based, as Jay was articulating. And the reason for that is that's something that MedPAC -- that doesn't rely on MedPAC coming back every five years and recommending a 5 percent or a 10

percent increase, sort of Bruce's question of how often would we need to be doing this.

If it's numerically based, it ought to have some momentum of its own that continues to rebase the system, if you will, and so that to me has some real power to it.

On the issue of income disparity -- and I think this gets partly -- we're trying to partly address this in the primary care special add-on section. I looked at the various options and think that a 10 percent increase in income, Medicare income, is not going to make much of a difference. I don't think it gets to the problem we're concerned about, which is the supply of primary care physicians or practitioners down the road.

So that leads me to the question of, you know, what would -- and I do have some thoughts about that. I think you laid out very well that some of the other concerns that physicians in training have are things like medical school debt. Maybe we should look at a flat payment that helps to compensate for medical school debt related to primary care for Medicare. If you want to come into Medicare and you're willing to have, you know, a patient panel that represents 60 percent of your practice,

we will help you to some extent with your medical debt. Maybe we ought to look at those kinds of issues rather than trying to use the fee schedule as the vehicle for, you know, ensuring a supply for the future. I don't know.

The last thing, which is the issue of are we hoping that enhancing payments for primary care will actually improve coordination of care and management of patients, I don't think either of these options really does that. So that leads me to ask the question: Should we be thinking more about that issue? I don't know what Bob Berenson's coding changes would be, but maybe that's -- I'm assuming they're more bundled, they're more -- no?

DR. GINSBURG: [off microphone].

DR. CROSSON: Microphone, Paul.

DR. GINSBURG: I think some of them are codes for additional services that are not paid for today.

MS. BUTO: Okay. So there may be a way to work with those and maybe add to them. But it just strikes me that the area that we hope we're getting to, which is to have more authority, more accountability, and more management, the primary care physician, and then I guess more of a relationship between the primary care physician

and the patient over time. We're not getting at that, and it just strikes me that the current codes for coordination of care and chronic care management don't get there either.

So that's an area that I hope we'll try to build into this in some way. But bottom line, I'm worried that, because of our collective frustration with what's happening with primary care and E&M, that MedPAC is trying to in a sense take over the responsibility that should be CMS' of updating and making these adjustments, rebasing and so on, the idea that every so many years we might have to recommend another adjustment of 10 percent or 5 percent. I'm hoping that it doesn't rely on us to do that, that there's something that we can recommend systematically that should be done much more automatically by the agency. And maybe it involves taking some of that authority that was delegated to RUC back. Having been involved in the original delegation, I mean, maybe it's time to take another look at what would that look like. Would that mean that CMS would need to develop its own structure for updating, for looking at overpriced procedures, et cetera? I don't think we talk about that. But we're sort of wrestling with this is the world we're living in, we

haven't seen any progress, let's go ahead and make some bold changes. I get that. I just don't feel like that's -- I don't feel comfortable with that right now.

DR. CROSSON: Okay. So let's open up the discussion. We'll start down there with David.

DR. HOADLEY: Jay?

DR. CROSSON: Sorry?

DR. HOADLEY: Could you speak to where we're sort of trying to head with this procedurally? Are we trying to get to the point of some recommendations at the March and April meetings for the June report? Are we still just envisioning an array of options of the sort that the way this is currently structured?

DR. MATHEWS: Yes, so this particular presentation, again, tries to separate the two policy options that got conflated a little bit at the November meeting, and what we're trying to do at this point is, now that they have been separated, gauge the Commission's interest in pursuing the mechanical fee schedule rebalancing option, and if so, that's something that we could continue to model and come back to you. And then as a companion piece of that, we're putting some markers down

as to how we might proceed on the related path of improving payments for primary care physicians.

So I don't think we are aiming towards bold-faced recommendations this cycle. I think we would package this up in an informational chapter in our June report. You'll recall we tend to do this when we are in a policy development phase. We'll have an informational thing in June first, and then we could come back, depending on the specificity of your guidance and interests here, in the fall of this year, this upcoming fall, to, you know, develop more specific draft recommendations if that's where you end up.

DR. HOADLEY: That's helpful because otherwise it would seem like we need to really push to where we're --

DR. CROSSON: Yeah, and I wish we could, honestly, Jack. I'm not sure how many years we've had this discussion. From my perspective, there's, you know, kind of a core problem. I described it five minutes ago. I'm not going to repeat it. We're looking for a solution. We had one a few years ago. Congress adopted it; then they let it sunset. We came back and said let's do it again but do it better, and it has not been enacted. So we still

have, I think, a significant problem facing the Medicare program and beneficiaries coming forward. The solution space, though, is complicated. No matter how you kind of try to dice it, there's a problem associated with it.

You know, just based on the questions so far today, I don't think we're going to nail anything, you know, in the next however many minutes we talk about it. So this clearly is going to be, I think, a chapter for June that kind of lists our deliberations, you know, the pros and cons of different ideas, but I really hope that we can find the time, you know, during the next cycle to come up with a solution we can all agree on. Otherwise, I think we've probably not done our job.

David?

DR. NERENZ: Okay, thanks. I'll try to be brief here. First of all, let me just echo Paul's thank you for the changes from the last time we looked at this. I think they're really good. The two things specifically separating ambulatory E&M and primary care, recognizing they're not synonymous terms, I really appreciate that. I was going to say it if Paul didn't say it, but he beat me to do it. That's good.

And also, I think, opening the door to discussion that not everything on the E&M side should receive the same treatment, and you gave us one example, and I'll get back to that in a second. So, first of all, thank you for that.

A few things, concerns, but I think are all addressable as this moves forward. First of all, just the issue that a 10 percent uptick is not going to completely solve the problem of the pay disparities. It's too bad Craig is not here. You know, two years ago he was absolutely eloquent on this point, so I'll try to rephrase what he said. You know, what we're going to do here is take a $250,000 pay gap and turn it into a $247,000 pay gap. And it doesn't mean that the thing shouldn't be done. It just means that other things have to be considered and addressed at the same time if ultimately we're talking about people's choice, for example, to go under primary care.

There's a literature on that. There are other practice dissatisfiers, and I think we could probably say even more about those, and then perhaps talk about, in the section of this, not on primary care, what might be done. You know, just as an example, when we think about, you

know, why there's not been much uptake of some of the chronic care codes or perhaps why there hasn't been much behavior change in some of these demos, you know, if you look at the regulations of what doctors are asked to report and certify and attest to, you know, to bill for $20 like care coordination code, you know, it's expensive, and there seems to be evidence that those barriers, those burdens, are the take-up of those codes.

Well, I think we could extend the concept and say, you know, what burdens or what requirements does Medicare impose in either the domain of ambulatory E&M or primary care, or their overlap, that perhaps could be relieved? It's not a money issue but it still is in the domain of payment.

I do -- I was going to link with Dana on this. She stepped out. And I was going to borrow her term from a few minutes ago about the tyranny of the office visit. You know, I am a little concerned about the proposal here focusing on face-to-face office visits when I think it is important to look at better ways to compensate physicians for work done the other way. I just read something, a recent study in Health Affairs primary care physicians now

spending only half their time actually seeing patients face-to-face. The rest of the time is spent in backroom things. Again, it doesn't mean this is bad, but it just means that it focuses on one part, and perhaps a shrinking part. So it's perhaps a little bit behind, but, you know, it just means that we should be thinking about those other things and how do we address those, recognizing, as Dana pointed out, recent evidence that it's not easy. You know, we've tried some things and they haven't worked all that well.

Okay. Last two things. I did mention last time we talked about this, I used the phrase it's a "blunt instrument" that we're talking about here, and I just want to repeat that concern. You know, we've taken the domain of physician practice, divided it into two big chunks, and say, okay, we're going to pay more for everything on one side, we're going to pay less for everything on the other side, and I was concerned about that a month or two ago and I'm still concerned about it.

But you've actually opened the door to that. On the bottom of Slide 8, you asked us the question, you know, what about, say, the annual wellness visit. Should that be

in or not? I would say no, based on as you described it. But I think I would just extend that concept and say we really ought to look carefully and say, well, it's not all ambulatory E&M that should get the update, nor should it be everything on the other side that should go down. Now we have to think through what are then the criteria. You know, but we've been down this path before. When we did the site-neutral recommendations in 2012 and 2013, there was a finite list of codes that met an explicit list of criteria, and we said these are the things to which the policy would apply, but other things that are sort of like them, we don't apply. So I'd like to have us work through that here.

And then the last thing. I'll use the term "collateral damage" here. It's a familiar term in the military context. What it means is you try to attack a target but in the course of doing that innocent bystanders are harmed. I see that here and I hope we can figure out a way to avoid it.

Page 24, and then you mentioned it briefly in the presentation, physical therapists, occupational therapists, you have their pay reduced 4.5 percent. It doesn't seem to

me that we have any evidence in front of us that they're overpaid or that, you know, their work is, you know, somehow, you know, become more efficient. They're face-to-face. It's very time-dependent, but it's billed as a procedure.

So I don't think we should be hurting innocent bystanders, and I have the same concern about a procedure like colonoscopy. You know, for the appropriate people it's a lifesaving procedure. Should that payment go down 4.5 percent? I don't know. So if we could just be more fine-grained in carrying this forward I think it would be better.

DR. CROSSON: David, thank you. I think your concerns about lack of uptake of the care coordination and chronic care management codes is a good one for us to keep in mind as we start thinking about solutions, because, you know, a few years ago that seemed like, you know, it was going to be a good solution. And I thought you did a nice job channeling Craig. The only concern I had was that you weren't loud enough.

DR. NERENZ: I could try it again but I think everybody heard it.

DR. CROSSON: Okay. Amy.

MS. BRICKER: So just to echo a few things that I've heard so far. I was, too, left with the question of, you know, if the average salary is $230,000 and so now you're given a $20,000 increase, does that then, you know, result in more people entering the field? It's a nice gesture, but I'm not sure that it actually gets to the question at hand, which is, you know, this decline of practitioners entering the field. I like where Kathy was going. I think that's interesting. That would send a stronger message.

And have we spent -- do we feel like we've spent adequate time with med students to understand why they are selecting the fields that they are, and would something like Kathy's suggestion sway them one way or the other? I think that would be an interesting survey or feedback, and if there are other things that might sway those decisions I think also it would be quite interesting.

DR. CROSSON: Rita.

DR. REDBERG: I thought the chapter was excellent and I liked the separation. I really wanted to make the sort of bigger philosophical sort of comment on the

Medicare world as it should be. You know, to me, I feel we can make these changes but a lot of the problem is in fee for service Medicare, because we're just rewarding -- you know, even with these change, we're rewarding procedures. We're not rewarding, necessarily, things that patients value, and that I see sort of rebalancing primary care as part of what we were talking about yesterday, and moving towards alternative payment models, voluntary value program, because I think in that model we will do much better at the balance between primary care and specialty.

And I feel like a lot of times, you know, we spend a lot of time rebalancing and the problem is really that the fee for service system is broken and it's very hard to, you know, make changes in the system and that we should be spending more of our energy talking about the alternative payment models that we're trying to move towards, which I think would be better for beneficiaries, better for the program and for physicians.

DR. CROSSON: Thank you. That's a good point, and I think, to a certain degree, that was the notion inherent in trying to move away from the 10 percent add-on to a per-beneficiary payment, although it's kind of a tiny

change in that direction.

Yeah, Brian.

DR. DeBUSK: Well, first of all, congratulations on a very well-written chapter. I'm really excited to see us not treating this as a choice now and saying let's look at the 10 percent payment and let's look at an additional special payment. So I like the all-of-the-above approach.

Just to build on something that Jay was talking about earlier, his concern about the future of primary care physicians. I would argue that the pipeline is collapsing now, and part of that is being masked by nurse practitioners and PAs. And I would urge us to all watch the literature closely, particularly on the number of tests and other procedures done by the extenders, because we may be trading a $260,000 primary care physician for a $100,000 extender, who may be ordering hundreds of thousands of dollars of additional tests and misdiagnosis.

So we may be experiencing a more detrimental effect than we even anticipate. And I know the reading materials we're talking about, how the shortfall in PCPs per thousand beneficiaries was being filled by these extenders. So I think we should watch the literature

closely, because I think, you know, we may be pennywise and pound foolish.

The other thing that I want to talk about, and these are little bit more technical issues, I really like the top-down approach as a way to identify potentially misvalued codes. I think the frustration there is that we probably can't analytically solve that problem. I think, at best, we can just identify the codes, because you've got 7,000 CPT codes that are spread across all these different specialties. And I know you guys can do some pretty complex regressions but I don't think you're ready to regress every specialty across 7,000 codes and say adjust this code up, adjust this code down. So I think the top-down approach is a wonderful approach but it's probably more of a weather vane to point us toward the misvalued areas, more so than it is an analytic base to come up with a numeric solution to exactly how much to adjust a particular work RVU.

The other thing -- and again, these are more technical issues but they're in the weeds -- I think it was Bruce who mentioned, or who asked the question about, well, if we make a one-time change to say that TCM, CCM, and

ambulatory E&M codes, what's to prevent the distortions from not occurring, or passive devaluation from occurring again? I hope we can explore the idea of using separate conversion factors. You know, the RBRVS used separate conversion factors for a few years, but it was really around a designation of primary care versus the procedural specialties.

In this case, what we would do is we would separate them out into a subset of E&M, TCM, CCM type codes. So really what you'd be doing is segregating based on code, not based on specialty. But if we did it that way, and used separate conversion factors, it wouldn't interfere with the underlying RUC process. So, you know, you wouldn't -- I mean, there's an obstacle that's being addressed, but you'd also have independent control of how you want to manage payments for what we would consider primary care-associated services versus other procedures. And again, I know that's a very technical issue but I think that would be an interesting way to get control, on an ongoing basis, without having to go back and try to argue work RVUs for, you know, 99213 or something like that, because I think that gets us into the weeds in a hurry.

And then, really, the final issue is I really like this idea of a separate payment to people who are designated primary care. I think doing it on a per-member, per-month basis is a great idea, and I also do think that it needs to have some type of risk adjustment, say like a CPC+ type risk adjustment, where you're trying it to HCCs but maybe you're breaking it into quartiles or quintiles. I like that too, because -- just one other plug -- I still want to get all these fee for service beneficiaries fully coded, because I think there's benefit to knowing more about them, plus as you recalibrate the model each year, you're actually reducing the need for that coding intensity adjustment, or at least part of that coding intensity adjustment as well.

So there's benefit on both sides to getting these patients properly coded, and if this is another step toward that, so be it. Thanks.

DR. CROSSON: Some good points coming up here. Sue.

DR. THOMPSON: I'll be quick. I just -- Jay, I thought your comments outlining this problem were right on the money and I appreciate that. An unintended

consequence, and to build on Brian's comments about the fact that we do have ARNPs and PAs filling these roles, especially in rural parts of our country, I'm not quite so pessimistic about what the data may show as we study that, but I think it is wise for us to keep an eye on what's happening with quality and cost as it relates to panels of patients that are being cared for by extenders. And I think we're going to be asking that question so it's a good time for us to get ahead of that.

And then last but not least, I don't know that we've gotten this into the discussion today but we have 56 percent of psychiatrists in this country that actually take Medicare, and I'm not sure that a 10 percent boost in their $200,000 average income is going to change their idea about -- and I think we talk about psychiatry whether we're in telehealth, or -- it seems like every discussion we reference the grim shortage of behavioral health. And in the context of our country, I think that's worth including in this discussion and thought going forward as we work on this chapter.

DR. CROSSON: Thank you. Jon.

DR. CHRISTIANSON: Yeah. I also have three

comments. I guess one is I agree with Paul. I think separating the chapter in the way that you've done it is good and I think we can see that in the discussion here. I think it's helped the discussion.

I think Jay's problem statement isn't in the chapter. So, yeah, if the problem is there's not going to be enough primary care physicians in the future and the goal is to increase the number of primary care physicians, we need to be pretty explicit about that in the chapter. There are a few set of allusions to if we increase payment rates maybe that will affect the choice of specialty, and I think David's comment about, you know, channeling Craig I think is right.

So I think Kathy is also right. I think if the problem statement is as Jay has articulated, the chapter needs to be redone and we need to think about, from what we know at least from behavioral economics, give them money up front to repay their cost of going to medical school and we're going to get a lot more primary care physicians than depending on a trickle-down theory of a very small increase in payment, which will increase your income maybe over time, sometime in the future, while you're trying to pay

down your medical school debt for the first 20 years before that sort of really makes a material difference.

And then, finally, to something I say all the time, when we have this discussion, so I might as well say it again, since I know what I want to say, so there's no guarantee at all anymore, in the world of primary care physician employment, that increasing the payment for primary care services is going to trickle down into higher incomes for primary care physicians, because that payment will go to organizations, and organizations will decide what to do with it, and it's additional revenue and maybe it'll go to invest in the newest cardiac procedure, because that's going to generate more retained earnings, if it's a nonprofit organization or if it's a profit organization.

So thinking that we're going to, even with a materially large increase in primary care service payment, that's going to all turn into magically primary care income is not necessarily going to happen. And then the other part of that is -- getting back to Brian's comment -- there is a market for primary care out there, and if I'm a -- we're pushing ACOs, we like ACOs, if I'm managing an ACO, my problem is how do I provide primary care services more

efficiently for my population. So back to what Sue was kind of saying, more and more we're seeing these kinds of organizations turn to advanced practice nurses and others to do this. And we actually have quite a bit of data about what's happening in retail clinics, which are increasingly becoming owned by and part of these organizations, and that is the practitioners in those organizations are more and more getting into chronic illness management. So, you know, they're located in drugstores makes all the sense in the world. You can buy your drugs for your chronic illness, while you're there seeing the advanced practice nurse.

So what's my point? My point is that there is a market here, a labor market here, in which, for many services, owners and managers of ACOs are going to see advanced practice nurses as close substitutes, and that is going to depress incomes for primary care physicians, and that is the way it is. So we are sort of thinking about a small change in payment as the way to sort of counteract what I think is a major shift in the market and how we think about primary care, and I don't think that will be successful.

So if we want to increase the number of primary care physicians in the future, I think we have to go back further upstream and talk about educational subsidies and things like that.

DR. CROSSON: Thank you. Pat.

DR. WANG: I appreciate and want to thank you for the additional work that you did modeling the top down, et cetera, et cetera, because I think that what it demonstrated to me anyway is that that's a very kind of overly broad and crude approach, you know, that doesn't really get at the problem statement that was just discussed here, and that -- because it involves clinician types that are not in short supply, it includes specialties that may or may not be providing primary care, it seems not to include others. So, you know, the issue of undervalued services, I do kind of think that as frustrating as it has been, finding other approaches, bottom up, to address that is very important.

I do think that we need to be clear, as a Commission, of what exactly we are trying to -- as we iterate this conversation -- what we are trying to address, and I do endorse trying to come up with, if you call it

top-down or, you know, lateral or something like that, to address very specifically the issue of increasing the supply and practice presence of primary care clinicians, about whom we have concerns about pipeline, primary care physicians who, in particular, specialize in the care of older adults, and, you know, that includes geriatricians. It's not exclusive to geriatricians but I don't want to leave them out of the mix, because, to me, you know, all care of older adults aspires to the quality of board-certified geriatricians, period, end of story.

And there's, you know, lots of great primary care delivered by other primary care specialties, but I don't want to lose sight of that, and that's why, you know, I look for them in all of these analyses. Are they popping up to the top of the list? And the fact that they're not, you know, suggest that the approach is a little too blunderbuss.

I think that if the concern also is, you know, sort of clinician types shortage pipeline, particular focus on care of older adults, because this is a Medicare program, we do slide into lots of other areas and medical education training, medical school debt. Frankly, you

could get as far as to think about whether the training of physicians is equipping our entire physician workforce for the realities of how care is delivered today, which is increasingly population-based, increasingly team-based, et cetera.

So I would encourage us to -- I think the top-down, the 10 percent, as well as per-beneficiary are very important exercises to look through, but for me, you know, just seeing the -- sort of the results of the 10 percent bump approach, as well as the 10 percent screen of certain percentages -- I wouldn't really take that approach further, personally, and I think that we should focus on how you correct undervalued codes through the system so that it's self-perpetuating, and then focus in a very targeted way on Jay's problem statement.

DR. CROSSON: Dana.

DR. SAFRAN: Thanks. I do really appreciate the way this chapter split things out. I think we're hearing how that's benefitted our discussion.

I think Jon's comments captured a lot of what I'm thinking because I think that so much of primary care payment now is driven by the organizations that primary

care physicians increasingly are a part of. That I'm finding myself struggling with how this lever that we're -- or set of two levers that we're trying to use is actually going to accomplish what we want to accomplish.

So that led me to think about payment adequacy in sort of three categories. Are we trying to accomplish better equity? Are we trying to accomplish better supply and in so doing assure access, or are we trying to be sure that payment is aligned with value and what we think is valued?

I guess on all three counts, I am finding both of these approaches coming up short. It maybe helps the most with equity, but then there's that challenge about how payment actually gets shaped by the organizations providers are a part of. So I struggle with whether it even accomplished that, but maybe it's not a bad idea for that.

On the supply piece, I am extremely skeptical that anything we could do with either of these, the 10 percent or the lump sum, is going to accomplish some of what, Jay, you outlined as our problem statement.

I do say that in our market, as ACOs really took hold and in particular in a payment model that Blue Cross

has championed, we saw a huge increase in both the valuing of primary care by organizations that knew they couldn't be successful on either the quality incentives or the resource use incentives without really strong primary care. So we saw tremendous investment in primary care, both through compensation models, but also in the kinds of infrastructure enhancements for primary care, and we saw our state starting to get primary care providers coming from other states.

So that's in my thinking as I consider what are the real levers that are going to increase supply, and I also -- I really liked Kathy's suggestion about medical school debt because I've been removed for a while from that literature and that line of inquiry about what shapes people's decisions about their career, but back when I was closer to it and the little bit that I still interact with medical students, it seems like it's an awful lot to do with the kind of esteem that they believe they'll be held in by the profession and what their mentors are pushing them and encouraging them to do coupled with a concern about their ability to make a living that will pay off this debt. So I did like that idea a lot.

Then finally, I really feel that the added per-member payments are not going to really get us anything on any of these goals. That it wouldn't help us with supply. It wouldn't get us better care for the reasons I was indicating before from the evidence.

I'm concerned about spending that money and not really getting a return on it for any of our goals. So those are some thoughts.

DR. CROSSON: Thank you.

Jack.

DR. HOADLEY: So again, thank you for what you've put together in this chapter, and I'm glad that we're not trying to get ourselves to a recommendation in the next two meetings because I don't think we'd get there.

And I guess I'll focus on a few things where I feel like I need more information or I need more help in thinking about either literally data or maybe, in some cases, it's our continued conversation about these things.

One of them is the whole issue of primary care, specialty designations, codes, and going back to some of the questions from the data about we're identifying these physicians based on a specialty that they may have

designated at some point historically, and if that becomes a channel to how we're paying, the accuracy of that definitely becomes a concern.

And that then spills into the sort of, well, who is really delivering primary care, and what do we mean by it, and these notions that we've talked about so often. While lots of people are getting their primary care from a family physician or something like that, sort of the classic mode, others who have a cardiac history may really be getting their primary care from a cardiologist or a diabetic, from an endocrinologist or whatever, and do we understand that well enough to be able to actually draw that conclusion. And that's, of course, the notion of percentage of services that are E&M and some of that stuff.

Another area is this whole NP/PA role, and I'm hearing some very different perspectives on whether there are challenges in that. I'm hearing data perspectives. Just the "Incident to", the question of how many of these NPs and PAs are actually doing specialty care and where we're going to wrap the up in any kind of payment adjustment, and from a workforce perspective, are we concerned about or are we happy about the notion that NPs and PAs may become the

dominant providers of the classic primary care? And I think the more we can get some sense of that built into this, that feeds into this.

The per-beneficiary payment, I mean, Dana was just raising issues about that. I think of some of the specific issues like the attribution and this notion of which patients are you really getting this for that we've struggled with so often, the psych services, is any of this really addressing this, is this part of this issue, or is this really a separate issue? Should we be dealing both with the adequate payment for psych services and the adequate supply of people to deliver those services through some completely different mechanism or is it for the moment, we were sort of piggybacking it on this, which could work?

And then last, I hope we don't forget the cost-sharing angles on this. I do think, to Ariel's comment earlier, if we do go in some kind of a per-beneficiary direction, this notion that you get billed for cost sharing sort of out of the blue for something that's very nebulous doesn't make a lot of sense, and yeah, it may get picked up on a supplemental coverage, and so at some point, people

won't necessarily notice it. But that seems problematic.

If we're just correcting the fee schedule -- and that means that cost sharing is going up for primary care services -- well, it would have been up had the fee schedule not gotten out of this line, so that's not much of a problem. But I just want to flag that we should continue to pay attention to sort of where that plays out.

So that's a list of things where I feel like I need help before I can draw a better conclusion.

DR. CROSSON: Okay. Alice and then Bruce, and then we'll move on.

DR. COOMBS: So I won't echo everything that's been said so far, which is a lot, but I want to piggyback on Kathy and Brian and Warner and Jon on the whole thing with the workforce.

Dana, you talked about supply and equity, income disparities, but this key piece, when I came on in 2012, I went to Glen and I said, "Glen, we've got to deal with GME because it's really an important piece for primary care." And at the end of this coming near six years -- you know, we did it in 2010. I think we should go back to that. The Institute of Medicine, as Jon has said, has done a piece on

this in terms of how we fund GME. It's really important.

And there's been some analysis, Dana, that actually looked at -- it's not just how much you get paid as a primary care doctor. It is also this whole notion of who is your mentor while you're training in medical school. You get someone in internal medicine that's frustrated because of the pay, I think this is what that's for.

I think that giving everyone across the board a 10 percent increase, on Slide No. 9, we probably shouldn't show that slide again until we get some of the questions answered that Jack and many people around the table have spoken about because this whole notion of how specialties are kind of conflated with nurse practitioners versus PAs -- and there's actually been several studies in "Health Affairs" that say that the migration of mid-levels from rural areas into urban areas, they want to go to the same place physicians want to go. And they want to practice in specialties that are similar to what physicians have. There's two articles, one with PAs specifically and one with advanced nurse practitioners. So I think that's really important.

So we have to have a multi-prong approach. One

is to deal specifically with the supply and medical school decision-making with the students and all of the factors that influence them, which is the sum total experience.

The other thing I want to mention is that I think that we do get a different type of practitioner, rapidly turnover in field with internal medicine and family practice in terms of mid-levels. It's a very different kind of provider that's how there, and I can only say my experience is the ICU doctor being called to the emergency room. When I see PA who says, "I got five consults, and I did a CT, angiogram, and I did this," to me I'm like, "Well, what about this patient who has an obvious acute appendicitis?"

There's a different type of thought process from a physician who is seasoned, a primary care physician who has been seasoned, and it has a lot to do with experience, but it also has a lot to do with just the sheer fact of training and the intensity of training.

I'm saying that we don't have enough data in this area of cost. I think, Brian, you hit it -- and so did Sue -- about this whole notion saying they're equivalent to physicians, and I think that this is an area that we're

going to enter in.

And I haven't seen any studies yet that actually look at cost per APRNs, cost per independent practicing PAs, or even cost for aggregates of mid-levels who are working together in comparison to -- and risk-adjusted and looking at the type of patients that are being cared for.

I think that this thing of ACGME is really important, and I just want just for us to focus on that at some point going forward.

DR. DeBUSK: May I build on that?

DR. CROSSON: Yes.

DR. DeBUSK: Just briefly.

I really appreciate what you are saying there, particularly about the culture of medical schools. I worry that when you take a prospective primary care physician and you dump them into a medical school where the person on their left is going to become a cardiologist and the person on the right is going to become an orthopedic surgeon, I think it creates a culture where it is hard to do, to do primary care. And I think we need to go back and look at institutions. What are the characteristics as we address the pipeline? What are the characteristics of institutions

that produce higher rates of primary care physicians?

I mean, there are schools out there that have 70, 75, 80 percent rates of primary care conversion. One of the challenges is a lot of those are DO schools, and now that the DO residencies are being harmonized, ACGME and AOA are being harmonized, I suspect you're going to see DOs begin to specialize at allopathic rates.

We talk about these pipeline issues, but I think there's some medical school cultural issues. I loved what Kathy and Jon were talking about, about addressing student debt and some of the other behavioral economic issues, but I think there's a whole -- and maybe it's a whole separate chapter on pipeline, but it needs to look at the culture of medical schools, and it needs to look at the threats on the horizon because I think what you're seeing is -- the primary care pipeline crashed. I think it crashed years ago, and I think it's been backfilled by nurse practitioners, PAs, and DOs. And I think all of those have some issues now that we're going to need to address because I think there will be a snap effect. Once we realize what's happened, it's going to be too late. We're going to be 10 years out from fixing the pipeline.

DR. CROSSON: Okay. Bruce, last comment.

MR. PYENSON: I hate to add to Jack's list, but one issue that I would welcome some help in is whether the disparity is that primary care is paid too little or specialists are paid too much.

But I would like to, second point, support Brian's idea of a separate conversion factor, and if we think about a longer-term solution, I think we can find very strong evidence that productivity increases over time for procedures. So rather than coming back every couple of years to fix that, that should be built into the fee schedule, perhaps through the conversion factors, so some real technical issues there.

MR. THOMAS: Jay, may I make one quick one?

DR. CROSSON: Last one, yeah.

MR. THOMAS: I just would echo Kathy and Jon's comments around pipeline. I think the idea of the loan repayment probably has the quickest impact, and it's something that would be more immediate. Some of these others are going to be long term, but I think if we could look at the GME primary care-only slots coupled with loan repayment, I think we would have some immediate impact.

And I would encourage us to try to expedite some of those ideas.

DR. CROSSON: Okay. Very good discussion. It would come as no surprise to anybody that we have more work to do on this topic, and so we look forward to further analyses, suggestions, and ultimately coming to some conclusions.

Thank you very much, Ariel, Kevin. Appreciate it.

We will now move on to the last presentation and discussion for the meeting.

[Pause.]

DR. CROSSON: Okay. So our last presentation and discussion is a status report on ACOs, Medicare ACOs specifically, and we've got David, Sydney, and Jeff here. Sydney, are you going to begin? Go ahead.

MS. McCLENDON: Good morning. In this session we'll be discussing the status of Medicare's Accountable Care Organizations, or ACOs. Before we begin, I'd like to thank Ledia Tabor for her help with this presentation.

I'll begin today by giving some brief background on Medicare's ACOs and an overview of the status of ongoing

and completed ACO programs. From there we'll look at quality and financial performance in 2016. I'll then turn it over to David to further discuss the net savings results, potential concerns when creating and rebasing benchmarks, and some policy issues for your consideration.

So what are ACOs?

ACOs are groups of health care providers who have agreed to be held accountable for the cost and quality of care for a group of beneficiaries. If the ACO does well on cost and quality measures, it is rewarded with shared savings.

Medicare's ACOs were created with a goal to improve quality and slow Medicare spending growth by rewarding efficient and high-quality providers for better coordinating their beneficiaries' care.

There are three basic concepts at the core of ACOs, though individual ACOs and ACO models vary somewhat in the details.

The first is the composition of the ACO group. ACOs can be composed of whatever health care providers they choose, which can include primary care clinicians, hospitals, or specialty practices, as long as they have the

minimum number of beneficiaries attributed to them as required by their model.

To attribute beneficiaries to an ACO, CMS looks at beneficiary service use. If an ACO is responsible for a plurality of a beneficiary's evaluation and management services in a year, the beneficiary is attributed to that ACO. Starting in 2017, beneficiaries also have the option to voluntarily align themselves with MSSP ACOs. And when attribution happens depends on the ACO model. Some ACOs have beneficiaries attributed to them prospectively, at the beginning of the performance year, while others have beneficiaries attributed to them retrospectively, at the end of the year.

To judge ACO financial success, CMS creates benchmarks. The benchmark is an estimate of expected Medicare Part A and B spending for an ACO's beneficiaries, and at the end of the year CMS assesses whether spending was above or below the benchmark. The majority of Medicare's ACOs are in one-sided risk arrangements where they earn shared savings if spending is below the benchmark, but are not responsible for losses if spending is above it. ACOs can also choose two-sided arrangements

where they earn shared savings yet are responsible for shared losses.

Medicare has multiple ongoing and completed ACO models, which are listed here, and more detailed information on these models can be found in your mailing materials. But I'd like to highlight a few things here.

First, the Medicare Shared Savings Program includes three tracks and is a permanent part of Medicare. Track 1 is a one-sided model, while Tracks 2 and 3 are two-sided models. And about 90 percent of MSSP ACOs are in Track 1.

The rest of the ACO programs are demonstrations, and most of these are two-sided models.

The first of these demonstrations was the Pioneer ACO demonstration, which began in 2012 and ended in 2016. The Pioneer ACO model was the foundation for the Next Generation ACO demonstration, which began in 2016.

There's also the ESRD Seamless Care Organizations, or ESCOs, that began in 2016. ESCOs differ from the other ACO models in that they are only comprised of ESRD beneficiaries on dialysis, so they are often responsible for fewer beneficiaries that are also higher

cost.

So CMS has recently begun releasing the number of participating ACOs for a few of the models in 2018, but for our presentation today we will be focusing on performance year 2017 and earlier.

As you can see from the chart, the number of Medicare ACOs has been growing since 2012. If you look to the far right bar, which highlights the number of ACOs in 2017, you can see that MSSP Track 1, a one-sided model, contained the largest number of ACOs at 438, although the number of ACOs in MSSP Track 2 and 3 grew to 42 in 2017. The number of NextGen ACOs and ESCOs also grew in 2017, to 44 and 37.

And as the number of ACOs continues to grow, so does the number of beneficiaries attributed to them. In 2017, there were approximately 10.5 million beneficiaries attributed to ACOs, or about a third of the beneficiaries in fee-for-service.

So a goal of ACOs is that providers come together voluntarily to give coordinated, high-quality care to their Medicare patients. And CMS has defined a set of about 30 measures to evaluate ACO quality.

In each ACO's first performance year, they are only scored on whether they report quality information. In the second and future years of the ACO, each ACO's performance is converted to a quality score, and that overall quality score affects the ACO's ability to earn shared savings payments.

We find that ACOs meet the reporting requirements and have relatively consistent and high overall quality scores. Across the models, overall quality scores for individual ACOs ranged from 76 to 100 percent in 2016.

However, in all ACO models, more than half of the quality measures used are process measures, like influenza vaccination rates and medication reconciliation. These measures are inconsistent with the Commission's principles that Medicare quality programs should include small sets of population-based measures such as outcomes, patient experience, and value measures.

Where data were available, we looked specifically at results for patient experience and outcome measures. We found that ACOs are maintaining at least average results. For example, MSSP ACOs had slightly higher performance on readmission rates compared to fee-for-service readmission

rates, while ESCO patient experience results are around the national average for dialysis facilities.

In addition to being judged on the quality of care they provide, ACOs are judged on their financial performance, and on this slide we have financial performance by ACO model for 2016.

The first bar for each ACO model is what we'll call "savings" and is displayed in green. We calculated this savings value by subtracting actual expenditures for the year from the CMS-computed benchmark. Overall, actual spending for beneficiaries in MSSP Track 1, MSSP Tracks 2 and 3, Pioneer and the NextGen demonstrations was less than the benchmark, constituting a savings for the program.

The second bar for each ACO model, which is displayed in red, shows the amount of shared savings CMS paid to ACOs, and the white bars show the shared losses that CMS recouped from ACOs in two-sided risk arrangements. Because shared savings payments are money paid out by CMS, we've displayed them as a loss to the program.

So when you combine these three values, meaning the savings relative to the benchmark, the shared savings payments, and shared losses, we obtained a net savings

value for each program, which is shown in blue.

For MSSP Track 1, which is comprised of ACOs in one-sided risk arrangements, CMS paid out more in shared savings than what ACOs reduced relative to their benchmarks. This resulted in a net loss to the program of 0.1 percent. MSSP Tracks 2 and 3, the Pioneer and the NextGen demonstrations, which are all two-sided arrangements, resulted in net savings of 0.7 percent and 1.2 percent. These findings are not surprising given that two-sided ACOs by design will not cost the program additional money because CMS can recoup losses from these ACOs.

It's also worth noting that NextGen's net savings may appear higher than would be expected based on the values displayed in green, red, and white. And this is due to an ACO-specific reduction to the benchmark, called the "discount," that occurs for all NextGen ACOs and generates additional savings for Medicare.

Now, you may remember from our October 2016 presentation on ACOs that we provided analysis showing service use in an ACO's market area was the best predictor of ACO success, with ACOs in high-use areas generating

larger savings than ACOs in low-use areas. And we've continued to explore the relationship between savings and service use in a preliminary analysis of the 2016 MSSP data.

For this analysis, we first price-adjusted the ACO benchmarks so that they could serve as a proxy for an ACO's historical service use. We then separated the ACOs into quintiles based on the adjusted benchmarks. So ACOs with the lowest adjusted benchmarks were placed in the first quintile, while ACOs with the highest adjusted benchmarks were placed in the fifth quintile.

On the chart we've displayed the percentage of ACOs in each quintile that received shared savings. You can see that as the average price-adjusted benchmark increased, more ACOs earned shared savings payments, and this is consistent with the hypothesis that efficient ACOs may have a harder time generating savings, while initially less efficient ACOs may have unnecessary service use to cut. Part of this unnecessary service use appears to be utilization of post-acute care, and some studies have found that ACOs are beginning to reduce PAC. Taken together, these findings indicate that ACOs with high historical

service use, especially high PAC use, may have an advantage in generating savings.

Now we'll take a look at the financial performance of a slightly different ACO program, the ESCOs. Overall, ESCOs are responsible for fewer beneficiaries than other ACO models, but because they focus on a high-cost population, ESRD beneficiaries on dialysis, their benchmarks per beneficiary are about nine times higher.

All 13 ESCOs in 2016 reduced spending for their beneficiaries relative to the benchmark, and even when factoring in the resulting shared savings payments, they generated a net savings of 1.7 percent for the program.

The higher savings percentage for ESCOs relative to the other ACO programs could potentially be explained by more frequent beneficiary contact with their providers. ESRD beneficiaries see their providers more regularly, which could create more opportunities for providers to better coordinate their beneficiaries' care and decrease unnecessary utilization.

Now I'll turn it over to David to further discuss the ACO net savings results.

MR. GLASS: Thank you, Sydney.

A key question is whether or not ACOs are saving money for the Medicare program.

As Sydney just discussed, relative to the CMS benchmarks, the one-sided MSSP, which has by far the most ACOs, had a small loss, and two-sided models had gains ranging from 0.4 percent to 1.7 percent of Part A and B spending for their attributed beneficiaries.

However, some have argued that the CMS benchmarks are not the right measure for savings. That is, they are not necessarily a good estimate of what spending would have been in the absence of the ACOs.

Therefore, we looked at what other researchers have found. For example, McWilliams and colleagues found savings of 0.7 percent for MSSP and 1.2 percent for Pioneer. And the Office of the Actuary at CMS found savings of 1.2 percent for MSSP and 2.1 percent for Pioneer.

The bottom line is all agree that ACOs model with two-sided risk show greater savings than models at one-sided risk, and savings are in the 0 to 2 percent range.

But the other studies find that MSSP ACOs are reducing program spending by a small amount and the

benchmarks do not. Does that mean that the benchmarks should be rethought?

Well, we would say that benchmarks should not be rethought simply because they do not match some estimate of what spending would have been without the ACO. This is because benchmarks are intended to create incentives and incorporate policy goals, not strictly to represent the counterfactual. The question is, rather, what policy goals should be incorporated into the benchmarks?

One goal, for example, could be equity within a market. In other words, should an efficient ACO have a lower benchmark than an inefficient ACO? Or should they face similar benchmarks?

Another goal could be equity across markets. As Sydney has just pointed out, the most important factor for achieving shared savings is the service use in the ACO's market. Higher service use is associated with greater savings. Should a goal be to make it easier for ACOs in low-use markets to meet their benchmarks?

Another goal might be equity over time. It may become more difficult to achieve savings as benchmarks are rebased to reflect past success.

Current ACO models are taking different approaches to these issues. For example, the Next Generation demonstration explicitly includes factors for efficiency within a region and for efficiency across regions when calculating its discount. The higher the efficiency, the lower the discount, thus the easier for the ACO to keep spending below the benchmark.

MSSP is blending historical performance and regional fee-for-service spending when rebasing benchmarks to address equity within a market and over time.

A separate issue that we have found in a preliminary analysis is that beneficiaries who move in and out of ACOs seem to have systematically different levels of spending growth. This could have implications for setting benchmarks and for estimating savings from ACO programs.

With these finding in mind, we would like to know which policy questions you might want us to pursue. Here are some possible issues for your consideration.

First, how should quality assessment change to be more consistent with our quality principles? This could be particularly important as we move beyond MIPS to a voluntary value program so that the two will align.

Second, in general, how should benchmarks be set to correctly incentivize ACOs and keep them in the program long term? For example, already efficient two-sided ACOs may find it difficult to generate savings, so should benchmarks be adjusted to account for that?

Also, how can we better encourage ACOs to take on two-sided risk? We could explore, for example, how Track 1+ is doing and consider approaches such as asymmetric risk corridors.

Finally, should voluntary alignment be encouraged to stabilize attribution? That is, in light of our findings on differential spending growth for beneficiaries moving in and out of ACOs, would it be helpful for beneficiaries to designate a primary clinician in addition to claims based attribution? And how can that be encouraged?

So we look forward to your views on these issues and would be happy to answer questions on the status of ACOs.

DR. CROSSON: Okay. Thank you very much. This is both an update and I think also an opportunity for us to discuss policy issues of further changes to the ACO model.

So let's do clarifying questions. We'll start with Warner.

MR. THOMAS: Thanks for the information. Sometimes I know the benchmarks continue to move. I mean, have we looked at by any of these different tracks, whether it be NextGen or Pioneer or MSSP, the different tracks, the trend over time compared to just traditional, you know, Medicare trend?

MR. GLASS: Well, we haven't looked at that explicitly. There is a trend that's really a nationwide trend in MSSP that's reflected in the benchmarks as they go from year one to year two to year three. So they're set for the first year on historical and then that's trended forward by the national increase. So, in other words, it should look pretty similar, but we could certainly look and see if that is, in fact, what happened.

MR. THOMAS: And I understand they're benchmark -- I mean, and I think that's part of the issue is the benchmark continues to move. I think what I'm trying to figure out -- and it's hard to ascertain from the information -- is, you know, if Medicare trend is -- I'm just making up numbers -- 4 percent overall for the program, is the trend on ACOs 4? Is it 5? Is it 3? Is it

2? Like, what is it in aggregate? And I think that's what I'm trying to understand, because I think, you know, what happens is we -- you know, we keep looking at the benchmarks and the savings paid out and what-not, and I think at the end of the day the question to me is: Is the trend different over time? And I don't think you can look at it one period of time. I think you need to look at it over multiple years. I'm just trying to get a handle on where that is.

MR. GLASS: We can see if we can compute that. Jeff?

MR. THOMAS: Because if you look at Table 5 in the chapter -- and I understand the population of ACOs keeps changing, but the actual spending from '12 to '13 through '16 keeps dropping. But my guess is that that's because the population of ACOs is different. So it would be nice to know for ones that are in in '16 and were also in in '12, would did that look like? You know, just kind of consistently through.

MR. GLASS: Yeah, we can --

MR. THOMAS: I'm just trying to get a handle on what that trend, the overall trend for total cost in, looks

like comparatively.

DR. CROSSON: I think I saw Brian.

DR. DeBUSK: First of all, really well-written chapter, great information. I had a question on page 13, and you alluded to this at the end of your presentation, but I really want to just set myself up for a Round 2 comment. But I won't get there, I promise.

Your last bullet point, when you talk about the benchmarks and the fact that, again, you know, beneficiaries entering the ACO versus those leaving, that does introduce a bias in the benchmark -- or I guess in the cost of the beneficiary. And are we -- when you suggest this in that bullet, are we proposing to use basically a numerical solution to an underlying attribution problem? Can you speak to -- would you rather try to just solve the attribution issue and not have to face this potentially difficult numeric correction?

MR. GLASS: This is why we brought up this question of the voluntary alignment, where a beneficiary says this is my primary care provider, and if that provider is in the ACO, then the beneficiary is attributed to that ACO.

And you can play that out in various ways. You can say that that's going to trump any attribution based on use, and you could have it just keep going until the beneficiary changes that.

DR. DeBUSK: Well, in keeping this as a pure Round 1 question, let me ask you a slightly different way. If we as a Commission come up short and can't agree on a better attribution mechanism and we just sort of throw this problem over the fence and say, well, you know, "Sydney, David, and Jeff, figure out how to adjust for this numerically," how comfortable are you with making that numeric adjustment?

MR. GLASS: Well, if you make it Jeff, how do you do it, then I'm perfectly comfortable with it. Yeah.

[Laughter.]

MR. GLASS: But there are a lot of subtleties involved. Are you doing prospective, retrospective attribution? Do we have enough data to really estimate what it is? Is it different for physician-only ACOs, or is it ones with hospitals? There are a lot of things that might enter into it.

DR. DeBUSK: So you are comfortable doing the

numeric adjustment?

MR. GLASS: I'm not too comfortable, but Jeff might be.

DR. STENSLAND: I think I'm moderately comfortable, and I have a little bit of hope that the problem we're talking about is a lot less severe when you have prospective adjustment. So if you're getting attributed by your visit this year to the doctor and that attributes to who you are going to be aligned with next year, that's less of a problem.

The problem of the mixing of the attribution and the spending is more severe when the attribution is happening at the same year as the spending.

DR. DeBUSK: So the retrospective attribution is more problematic than prospective attribution?

DR. STENSLAND: Yes.

MR. GLASS: That's what he's saying.

DR. DeBUSK: Okay. So if you get 18 opinions out of 17 people on how to do attribution, you're still okay as long as it's prospective. You can do the adjustment.

DR. STENSLAND: I think something could be done or we could -- maybe even a perspective, maybe just live

with it.

DR. DeBUSK: Okay.

DR. CROSSON: Thank you.

David.

DR. GRABOWSKI: Great. Thanks for a great chapter.

I wanted to ask you about that first bullet. I guess this connected a couple of dots for me. I know how MedPAC thinks about quality assessment. I guess I knew how the ACOs were being assessed, and I just had never thought about that, that they weren't being assessed in a way that was consistent with MedPAC principles. Have you gone back and sort of thought about what that would have meant, how they've actually fared given -- if you had applied this sort of MedPAC framework historically?

MR. GLASS: Yeah. That's why we talked -- can you turn to the slide on quality? That's why we're talking about the third bullet on population-based outcome and patient experience measures. They're at least average, and some are --

DR. GRABOWSKI: But you haven't gone back and sort of actually looked at sort of payments or anything

like that and said that --

MR. GLASS: About what?

DR. GRABOWSKI: Or just how they've been assessed and who would have been -- who wouldn't have been -- who wouldn't have qualified, I guess, for a payment.

MR. GLASS: Oh, I see. Yeah.

DR. GRABOWSKI: Yeah. No, we haven't done that.

DR. CROSSON: On that Dana?

DR. SAFRAN: Yes.

DR. CROSSON: Yeah.

DR. SAFRAN: I had a similar question about -- you know, in Appendix A, you list out all the ACO measures. Have you actually looked to see what performance in the different programs, different ACO programs looks like on those measures compared to fee-for-service?

MR. GLASS: I can turn that over to Ledia who I think has actually done that.

MS. TABOR: So in the process measures, we haven't, because we don't have a good comparison point, since for MA its plan to report it and for fee-for-service we don't have the clinical data to be able to do it.

We did look at readmissions because we have the

fee-for-service results for that, and ACOs were slightly better, so about 14.7, at least for MSSPs, compared to about the 15 percent that we learned yesterday. And patient experience is around the national average.

There's some of the ambulatory care sensitive condition measures that we couldn't compare because CMS kind of changed the way they reported out the results. They did publicly report the results, but -- and not in a way that's comparable over time.

DR. SAFRAN: But you can compare the ACO programs to each other in terms of performance on those.

MS. TABOR: Right. And they were all pretty consistent because, again, a lot of those process measures are kind of topped out.

DR. SAFRAN: Yeah.

MS. TABOR: So there wasn't much variability between the programs.

DR. CROSSON: Okay. Questions. I see Jack.

DR. HOADLEY: Yeah. Can you just explain again the next-gen discount sort of what's both the -- how does that work, and what's also the logic that's going on with that?

MR. GLASS: I'm glad you asked that question.

DR. HOADLEY: Gee --

[Laughter.]

MR. GLASS: So I didn't know if we wanted to get into this level of detail or not.

So the next-gen, there is an ACO-specific reduction to the benchmark, and it could range from .5 percent to 4.5 percent, the standard discount being 3 percent. And the discount varies based on ACO's quality. So the discount could be zero if you're, I guess, perfect on quality or minus -- well, no, it's the other way around. Minus 1 is if you're really good on quality. It's minus 1.

The efficiency relative to region is plus or minus 1 percent. So you look at the ACOs risk-adjusted benchmark relative to fee-for-service spending, risk-adjusted in the region, and if you're more efficient, you get -- let's see. Which is it? A lesser discount. And again, efficiency relative to the nation, the same thing.

So you can work your discount down to .5 percent. If you're really good on quality, you're efficient relative to the region, and you're efficient relative to the nation. So if you have a smaller discount, then that means your

benchmark essentially is bigger.

DR. HOADLEY: So therefore harder to --

MR. GLASS: Easier --

DR. HOADLEY: Right.

MR. GLASS: So that's how it works, and it's an interesting way to do it. It has some good features, if we think that -- if you think it's good to give ACOs that are more efficient some leg up.

DR. HOADLEY: Okay. Thank you.

DR. CROSSON: Questions. Bruce and then Warner, and then we'll move on.

MR. PYENSON: Thank you very much.

I've got a question that gets at the viability of the ACO programs.

Table 1 in the materials shows a remarkable popularity of ACOs over time. There's no shortage of interest in organizations becoming ACOs, and that's increasing. I was struck, the 10 million figure that you showed today is, as I said, about a third of fee-for-service beneficiaries. That's just huge in just a couple of years, so lots of organizations want to do this, but it's hard to see.

Apparently, they're not doing it because of the shared savings, because the shared savings seems rather modest.

Now, perhaps there's the belief that they'll get lots of shared savings in the future, but the evidence is that shared savings from most organizations are thin. What do you think is going -- the contrast there? I can see the popularity if shared savings were substantial.

MR. GLASS: Yeah. Well, a couple of years ago, we went and talked to ACOs and tried to figure out what's going on, and a lot of them just thought that they didn't want to be left out of the move away from fee-for-service to value, and that this was a good way to get into it, particularly the Track 1, which is one-sided. You don't have a chance at a loss.

Then as MACRA comes into effect and the A-APM bonus of 5 percent if you're -- for the clinicians who are in ACOs and have a sufficient number of people, blah-blah, as that comes in, a lot of people don't want to be left out of that. So that's going to provide another impetus, and some of them really are achieving lots of shared savings. And they're going to continue to want to be in it.

But the Track 1+ model, which is just starting in 2018, has attracted, I think, 55 ACOs into that, just in the first year -- and Warner, for example, now as a proud owner of a Track 1+ ACO, and perhaps he can explain what the attraction is to that model. But it does get you -- it's considered an advanced APM model, so the clinicians in it will get the 5 percent. There's a chance of shared savings, and it's asymmetric in the sense that the shared savings rate is 50 percent, and the shared loss rate is 30 percent. So -- and it also has a small cap on total losses, 4 percent of the benchmark, or if it's all physician, then maybe a rural hospital thrown in, then it's 8 percent of the practice's revenue. So that one has a lot of attraction to it, I think.

MR. PYENSON: SO that's all Medicare kind of issues.

MR. GLASS: Right.

MR. PYENSON: Do you think there's attractions behind Medicare?

MR. GLASS: Oh, for sure, I think what I meant to say, the first part is not being left out of value-based purchasing, and the move away from fee-for-service holds

not just for Medicare, but also for commercial. And there is -- I forget how many -- 700 or something commercial.

MR. PYENSON: Most states have about 780 or something like that.

MR. GLASS: Yeah, yeah. A commercial variance of ACOs, and there are all sorts of different designs for that.

DR. CROSSON: Jack, on this?

DR. HOADLEY: Related to where Bruce started out, of the 10.5 million beneficiaries, how many of them are in two-sided?

MR. GLASS: [Speaking off microphone.]

MS. McCLENDON: Yes. So there were about 9 million overall in the MSSP program. So that 10.5, 9 million were MSSP, and like most of those are Track 1 still. So it's really a good chunk of them are still --

DR. HOADLEY: So the share that are in the two-sided, less qualifying as A-APM, is still pretty small?

MS. McCLENDON: Yeah.

MR. GLASS: Yeah. That's before the Track 1+ came in. Yeah.

DR. HOADLEY: Do we know how many beneficiaries

are represented in Track 1+ yet? Too early?

MR. GLASS: I don't think we have the number.

MS. McCLENDON: No. CMS gave an overall number for how many beneficiaries are going to be in all of MSSP when they have started really seeing this first wave of who is going to be in MSSP in 2018, but they haven't broken it out yet by track.

MR. GLASS: On the table back there, we have the fast facts from the MSSP.

DR. CROSSON: Warner.

MR. THOMAS: Do you have any thoughts or is there any comments around the different ways to engage patients in the different types of models and the impact that that had on outcomes or any feedback you got as you were talking to the ACOs and on ways to do things differently there and engaging patients, or do you see any correlation to how patients are engaged, results, or anything like that?

MR. GLASS: I mean, that was a real, I guess, sore point at the very beginning of all the ACO business was do you even tell the beneficiaries they're in the ACO. First, they sent out a letter, and that managed to confuse approximately everybody. And they quit sending out the

letter saying, "Congratulations. You're now in an ACO," because no one knew what it meant.

So this has been a big issue because people said, "Well, how can we help coordinate their care if we can really only see the patient once?" I think that's something that no one has quite figured out yet.

What they are doing is making sure people come in for annual wellness visits because they don't have any cost to the beneficiary, and they help people get attributed to the ACO. Well, Rita is not here, but she might question whether those are particularly helpful.

DR. CROSSON: Questions. Sue.

MS. THOMPSON: You've alluded to it, but are you leaning towards recommending prospective attribution versus retrospective attribution, or do you have any comment on that?

MR. GLASS: Well, I think the Commission has come out several times in favor of prospective attribution in our comment letters. I don't think we ever put it in a bold-faced recommendation or not.

We've written -- I don't know -- five comment letters on ACOs over the years, and we've often said

prospective seems to be a much better bet than retrospective, and the new Track 1+ is prospective, as is I think Track 3 in the MSSP. So there is a move -- and of course, next-gen. So there is a move towards prospective.

DR. CROSSON: But we could very well in the next set of sessions, if we come to some conclusions -- we could very well come up with a set of bold-faced recommendations.

Yeah. Bruce.

MR. PYENSON: I thought your attention in the report to the churn issue and how that distorts makes it difficult to set benchmarks, the applicability of benchmarks, where patients who come in or leave. And I wonder if you have a directional solution, so the suggestions for dealing with that.

MR. GLASS: Well, I may turn it to Jeff for thoughts on that.

I would say the fact that the churn is pretty high, I think has been concerning for many people, and can you really coordinate care for people if they're moving in and out of the lot? Just the initial thinking behind the ACO design was you take historical spending for this group of beneficiaries or for beneficiaries in these practices.

Then you trend it forward, and that's going to work great because people are loyal to their doctors and stay there. And then it turns out attribution is not quite working out that way. So there's two approaches to it. One, you change how you do attribution, and the other is you try to make some numeric adjustment for in and out. And Jeff, I think addressed that.

DR. STENSLAND: Yeah. I think when we look at it, at least with MSSP in our preliminary results, you tend to underestimate the performance of the MSSP due to the fact that when people get attributed to you, they get attributed because they're actually coming to see you. And if they're coming to see you, it's kind of an indicator that maybe they're going to need some care.

So there is this problem that is not going to be picked up -- all that is not going to be picked up with the risk adjustor either.

That would imply to me that if we moved -- and we haven't done the prospective yet, though I think your organization did some analysis with the Pioneer, that it wouldn't be as large of an effect. And I think the magnitude of the effect might be fairly small, like it

might even be less than a 1 percent effect, which could just be kind of like this -- you know, this little benchmark adjustment they have in next-gen.

So I'm not sure if the problem, if it's prospective alignment, it would be so large that it would need to be addressed. We might just say that you are going to maybe have to overcome a little bit of this. It might ding you three- or four-tenths of 1 percent, but you're going to have to overcome that.

DR. CROSSON: Okay. Go ahead, Brian.

DR. DeBUSK: A question on the prospective alignment. I understand what you're saying that it reduces the magnitude of the difference, but isn't that just because it falls back on the law of averages? I mean, the idea is that a few people will -- you know, there's still this high churn, and the fact is a few people come in, a lot of people come in, a lot of people come out, and I'm really just falling back on the fact that there's sort of a nominal person that I can start with, with prospective attribution. I mean, is that a fair statement?

DR. STENSLAND: I may have not followed it, but I think it more just has to do with you are measuring

spending say in 2014, and that 2014 spending is just going to be more correlated with whether you had that office visit in 2014 and whether you had it in 2013.

DR. DeBUSK: Agreed. But what I'm saying is let's say that I'm looking at the 100 percent, and 15 percent churn in, 15 percent churn out, well, that's 30 percent of my base shifting in a year.

DR. STENSLAND: Right.

DR. DeBUSK: Prospective attribution isn't really fixing anything. What it's really doing is it's sort of using a plug number. It's using an average to blend that. We weren't really fixing anything as much as we're mathematically smoothing over a problem because those biases in theory should average out if my base isn't changing. Is that --

DR. STENSLAND: Right.

DR. DeBUSK: Okay.

DR. STENSLAND: Yeah, because you're going to have a lot of people that you're responsible for that you didn't see that year.

DR. DeBUSK: Right, right.

DR. STENSLAND: So you're relying on the fact

that those aren't disproportionately swinging one way or the other.

DR. DeBUSK: You're coasting off the ones that are going away, and you're taking a hit on the ones that come in, but it's averaging out because you're prospective.

DR. STENSLAND: Right.

DR. DeBUSK: Again, I'm going to get close to a Round 2, and then I'm going to stop. I promise. I won't do Round 2.

But Bruce and you were just having a conversation about is this an issue of prospective attribution versus retrospective or is this an issue of adjusting the numeric benchmark. I would ask the question: Have we looked at addressing ways to address the underlying churn? Because that's really -- that would really fix the bigger issue, and to that point -- and again, not Round 2, because I'll do Round 2, but is this -- do we need to incorporate some type of beneficiary engagement mechanism that creates maybe a financial incentive to stay within the ACO and a financial penalty if you leave the ACO? Is it time to give ACOs a beneficiary engagement mechanism?

DR. STENSLAND: And that, again -- the Commission

has also addressed that in the past, that if there are shared savings, why aren't they shared with the beneficiary as well? And through that sort of thing where you have lower cost sharing if you see someone in the ACO or not. So that's been contemplated, and we can certainly look at that again.

DR. CROSSON: Okay. I think we're going to proceed to the discussion.

Let me just point we have run over -- I'd like to try to get us done by noon because people are going to have travel issues to deal with pretty soon. Paul is going to start the discussion. Then we'll have a discussion. I have a few remarks I'll make towards the end.

Paul?

DR. GINSBURG: Okay. This is a very valuable paper. I'm particularly pleased that you clarified the benchmark versus counterfactual issues and assessing it. I think we all benefit from that.

On the policy priorities, I think to me the areas I think most fruitful would be doing more work on benchmarks. You know, you've covered a lot in the Round 1 discussion. One other factor is just thinking about,

again, the business case for investing in doing better, that this was the problem in just pure, you know, rebasing to new historical data, an option to stay at the older historical data for some time, which I gather Dana's plan did initially. She might have something interesting to say.

And then the attribution alignment issue, I think that's very important. I'd like us to perhaps consider network models where the beneficiaries share in the savings, they have incentives to use physicians that the ACO puts in a network around the ACO as opposed to other physicians, and this is a way of involving specialists more in ACOs, which would help us on APM, advanced APMs, if they did.

Sorry about my voice.

DR. CROSSON: Thank you. Okay. So let's have a discussion. I will press for conciseness. Issues, people who want to comment? We'll start with Jon.

DR. CHRISTIANSON: Yeah, just a quick comment as we move along to all of these suggestions that we've heard. Just to think about it, at what point do we say, you know, it looks like an MA plan, it quacks like an MA plan, why

isn't it an MA plan? You know, so it gets us back to, I think, the discussion of what exactly were we trying to accomplish? Were ACOs going to be the sort of gateways to moving more providers in MA plans? Or did they have distinct features that we valued that were separate from MA plans? Because most of what I hear about next steps has to do with moving them towards looking more like an MA plan.

DR. CROSSON: And, in fact, there is a proposal I've looked at recently by a physician organization to do just that, to sort of pick up on the old PSO concept, Kathy, that we've talked about and move certain types of ACOs into risk-bearing arrangements similar to MA plans.

DR. CHRISTIANSON: And there are people, organizations, in that business to try to help you take the next steps.

DR. CROSSON: Right. Dana.

DR. SAFRAN: Yeah, so my brief answer on all of the policy issues there is yes, that we should be looking at all those things. On the quality piece, I would think it would be valuable in the paper, even if it does go in an appendix, to not just list out the ACO measures but to show the analysis, Ledia, that you said you've done, and

wherever we have it, to have the fee-for-service comparison data, because I think keeping our eye on how quality is going in these programs is really important.

The issue of benchmarks has been so incredibly important that I think we have to look at that. Particularly given what NextGen is doing with the rebalancing and everything, really anything we can do to really understand how that is succeeding or not at keeping the more efficient providers in and encouraging those that aren't efficient to perform better, you know, that feels like the Holy Grail. So that seems really important to understand.

On the issue of taking on two-sided risk, you know, my two cents on that is that it's very hard to get organizations off of one-sided risk if that's where they start. But I do think a policy treatment of that question is very, very important, particularly in light of the numbers that you showed us of, you know, where the bulk of ACOs are and how weakly they are performing compared to the others.

And a definite yes on encouraging voluntary alignment. I think, you know, you had -- I forget if it

was in this paper or another one -- a statistic that 97 percent of Medicare beneficiaries report having a regular source of care. So it's not that our beneficiaries don't have someone they would identify, and so just asking them to tell us who that is, and perhaps considering, you know, cost-sharing benefits if they do that and stay within their network, though I know there are some Medigap products -- we had the first one -- that try to help ACOs in that way, and members.

So, anyway, yes, on all of that.

DR. CROSSON: Paul -- Jack.

DR. HOADLEY: Actually, Jay, I meant to ask -- you said something about eventually moving towards recommendations. Like I asked on the last one, is the assumption for this year that we're just at a discussion chapter again?

DR. CROSSON: That's correct.

DR. HOADLEY: So I'll focus on the last of these policy issues, and I've talked in some previous years about some of these. I do worry about the potential for confusion at the beneficiary level, just like the letters were confusing, you know, what happens if you try to do

certain things in a voluntary designation of a primary source of care, like Dana was talking about, might be fine. But, you know, what happens as you start to move into -- even putting the Medigap issues aside, you start to move into something that looks more like a network, even if it's more like a PPO-ish kind of network where you're going to tilt people toward -- encourage the preferred providers, but not restrict -- and I sort of go to Jon's comment. At that point should we just be saying before you get to that, we should just encourage these organizations to shift into the MA world rather than have something that sort of acts like MA and the beneficiary hasn't really had a full selection of it with all the consequences weighed out? I want to move carefully, you know, if we try to look in that direction.

DR. CROSSON: Bruce.

MR. PYENSON: Thank you. Terrific paper. I noted your useful definition of the counterfactual as how much would these beneficiaries cost in the absence of the ACO, and that's a really useful concept. However, I'd urge us to think that given the popularity of ACOs, it might make sense to have the benchmark deliberately below that

because ACOs appear to bring so much value to the organizations that are participating in them. And there could be other features that encourage that such as some of the network opportunities others have mentioned.

DR. CROSSON: Comments? Warner.

MR. THOMAS: I would encourage us in the chapter to be -- to me, the way I look at this is you either believe in the ACO model and trying to go to more value-based type of payments or not. And if you don't, then it means you believe in the fee-for-service model and you think that's the right solution. So, to me, I think if we believe in value and we believe in moving to more proactive and preventative care, then I think we should be clear about that in this writeup.

I do think the comment around engagement of patients and how we try to build relationships is important. It's hard to coordinate care, as you indicated, David, without someone knowing that they're part of something and understanding that they've got a relationship with this primary care physician and a team. So I do think that building that information out is critically important.

The other comment I would make is that there's

significant expense that goes into building the infrastructure to make these organizations work. I think comments around that and I think celebrating versus -- celebrating the organizations that are doing this I think would be a very positive thing, because I think they're trying to drive the payment model in the right direction.

I do think moving towards more first-dollar sharing is a positive thing, and I think we'll get more organizations on board. And I think continuing to evolve the 1+ model to try to move people to two-sided risk is critically important. I think part of that will be availability of information and ability to engage patients, which I think those are going to be two very critical aspects to get organizations comfortable moving there.

I hear Jack's comments on, you know, this being MA-like, but the reality is that if we don't change the payment model, then we shouldn't sit here and complain about the cost of the program. And if we're concerned about the cost of the program, we've got to change the payment model. And that is going to require change on the beneficiaries' part as well, but I think you'll find the quality of results here are positive. It would be nice to

have consistent quality results across all the payment mechanisms so we could really do a true comparison. So I think that should be part of our comments as well.

But I think, generally, patients that are more engaged and are more aligned in their care are generally happier and feel more connected to their system, and I think we'll find that as we build that connectivity with patients with these organizations.

DR. CROSSON: Sue -- David, go ahead.

DR. GRABOWSKI: I just wanted to come back to the quality issue again and echo kind of Dana's recommendation that we bring in some of those data that we have using the MedPAC quality assessment framework, but applying it to these different models. I think that could be really useful and help kind of educate potential stakeholders on this transition and what it means. Given Ledia has already done some of that work, I think that could be a real value-add to this chapter.

Thanks.

DR. CROSSON: Sue.

MS. THOMPSON: Three points.

On the benchmarking, for those low-cost providers

that are in that lowest quartile, we want to keep those providers at the table and sharing how they became low-cost providers. So I think assuming their quality is where it needs to be, we need to understand what's driving that performance, and what we can do to keep those folks participating I think is important.

Secondly, on the attribution, personal experience, having come from the Pioneer world and moving into the NextGen world, we moved from a 25 percent churn when it was a retrospective attribution to most recently a 4 percent churn. And we're roughly managing around 80,000 Medicare lives in NextGen. It wasn't that large in Pioneer, but I think it's worth taking a deep look at, how do we -- because what we need to do, to Warner's point, is to maintain -- develop, first of all, and maintain relationships with these beneficiaries. That's the only way I think we're going to be successful in meeting the goals.

And last, but not least, you know, to the organizations who are participating, I tell you, the shared savings is not going to cover the reduction in top-line revenue they have left on the table in order to move to a

transformed care delivery model. We believe this is a fee-for-service system that is broken. We believe that the payers are no longer going to participate in a payment model that's going to reward us in fee-for-service. We believe we're moving to a value-based payment model. In order to do that, we have to invest in these care capabilities to be successful.

So I again would underscore Warner's recommendation to celebrate these organizations that have been bold enough to take on that kind of work.

DR. CROSSON: Okay. It's a very good discussion. This is a biological block from my perspective, a set of building blocks. I think we've moved these issues along that are on the slide there, and I think that will be helpful.

I do think there's a larger question here that we're eventually going to have to grapple with, because I feel the same as Warner and Sue and others around the table here that this is the right direction for the Medicare program. I also think that, you know, MedPAC specifically has somewhat of a special responsibility in this area since ACOs literally came out from this body. So I think we have

a responsibility not just to monitor it and do periodic status reports, but to take a very hard look at why it has not been as robust. You know, there are savings here. These are small percentages but large dollars. The quality is moving in the right direction. I think that's terrific.

But I also don't think that it's as robust as what I intuitively think we could be seeing if we had, you know, some significant changes, and here again we may have to, you know, over time become a little bit more -- a little bit bolder.

Some of the things that I would like to see us take a look at, if we can do it, are: What's the difference between Medicare ACOs and how they're doing and commercial ACOs? Are there things that we could learn for the Medicare program there?

I think that -- and I think Paul brought this up to a certain extent, but I think the role of specialists in all this is critical. I don't see how an ACO over time is going to be successful if a small group of primary care physicians has one set of incentives and the specialists that are necessary to care for the patients have a different set of incentives. I realize how difficult that

is, but I think we need to think about it. We need to explore it. Paul suggested one idea. I hope we can find more comprehensive ones as well.

Pat's gone now, but sometime ago she brought up the question of the role of hospitals, and, similarly, I have had for a long time a question of, you know, if we have hospitals with one set of motivations and incentives, you know, to fill up beds, but we're working with a group of physicians, no matter how large that is, and we're asking them to take a different set of motivations and incentives, how that's going to work. And this is a very large and very complicated and very difficult question. But I do think down the line, if this is going to be successful, the role of hospitals needs to be thought through. And the payment changes that Sue suggested, that I completely agree with, need to somehow involve hospitals down the line, or essentially we're just sending a bunch of physicians to batter their heads against the wall.

You know, and then I think this whole issue of beneficiary engagement and this issue of the boundaries then between more sophisticated ACOs and how they're paid through more sophisticated mechanisms and what that means

for MA or for MA-like organizations, because I know, I can tell you those proposals are going to be brought forward very aggressively in the coming year. I think we need to think about that and what our position is and whether we think this is part of the solution or not.

So from my own perspective, because I think it's important for the Medicare program and because I think we have a special responsibility, for me this is very high on my own priority list, and I hope that as we carve out time, you know, heading into and through the next set of sessions, we will begin to take this on, you know, from some of the more detail-level issues which we've discussed today to some of the more global issues. And I can tell you they're going to be tough and difficult and controversial to deal with, but I think if we don't do that, we're not fulfilling our responsibility.

Having said that, the January meeting has come to a close. Thank you, Sydney, David, and Jeff, for the presentation. Good work.

We now have time for a public comment period. If there are any members of our audience that would like to come up and make a comment, please come to the microphone.

[Pause.]

DR. CROSSON: We have one individual. Let's let people clear out a bit. I don't want our speakers to be trampled as they try to speak.

So I'll ask you in a minute to identify yourself and any organization that you represent. I would point out that there are other opportunities to provide input. This is one. Direct contact with the staff of MedPAC is another one. And I'd ask you to confine your comments to two minutes, and when this light comes back on, that will have expired.

MS. BRENNAN: Okay, great. Thank you. My name is Allison Brennan and I'm with the National Association of ACOs.

So it was a great discussion today and I just wanted to make two comments. One is on the performance of two-sided models versus one-sided ACOs. I think as we're having this discussion it's really important to keep in mind that ACOs won't move into two-sided models unless they see success in one-sided models. And I think from an organizational perspective that really makes. You're probably not going to take on risk if you haven't seen

savings. You wouldn't have enough confidence to move into that two-sided model.

And one of the ways that we can help support ACOs so that they are successful in a one-sided model and have that confidence is to make certain program changes. We talked about the benchmarking today. I think that really warrants further exploration. There are a couple of issues related to that -- risk adjustment and how ACOs are treated with risk adjustment, in comparison to other programs in Medicare and Medicare Advantage. ACOs have a much more difficult time and limits with risk adjustment.

Also, with the benchmarking we're trying to move ACOs to compare them more to their region, as their benchmarks are reset, but there are a couple of flaws with how CMS is doing that. One of the flaws is that they leave the ACO beneficiaries in the regional population. So when you have an ACO that comprises a large market share, you're not really comparing the ACO to its region. You're still comparing the ACO just to itself and its historical performance.

There are other benchmarking issues. Obviously with two minutes we won't get into them. But I do think it

would be great to have you take a closer look at some of those issues. Thank you.

DR. CROSSON: Thank you very much. Seeing no one else at the microphone, we are adjourned until our March meeting. Safe travels, everyone. Stay healthy too.

[Whereupon, at 11:59 a.m., the meeting was adjourned.]