

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

The Horizon Ballroom
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9:23 a.m.

COMMISSIONERS PRESENT:

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[9:23 a.m.]

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

It's a good thing the infectious diseases physicians are in town because I think an illness has just infected the -- oh, here come the rest of our Commissioners.

Okay. Let me first welcome our guests to the October MedPAC meeting. We are beginning this morning's session with our continuing work on Medicare Part D, and Rachel and Shinobu are here to present, and Shinobu is going to begin. You have the microphone.

MS. SUZUKI: Good morning. Today we will continue our discussion from the last cycle about potential changes to Part D.

Based on Commissioners' feedback at the April meeting, the discussion today will focus on the options to restructure the Part D benefit that builds on the Commission's 2016 recommendations.

Depending on your interest, we plan to work towards recommendations in the spring and are looking to you for guidance on policy direction.

1 In this presentation, we'll provide a brief
2 background on Part D and the changes that have taken place
3 since the program began in 2006.

4 We'll recap the issues the Commission has been
5 concerned about which are the impetus for today's
6 discussion. Finally, we'll go over in some detail an
7 approach to restructuring Part D.

8 Your discussion will inform us of the direction
9 of our work for next spring, and we plan to put this
10 material into a chapter in the next June report to
11 Congress.

12 Part D was created with the goal of expanding
13 beneficiary access to prescription drugs using a market-
14 based approach. The idea was to rely on competing plans
15 and allow beneficiaries to choose among a wide range of
16 plan options.

17 Plan sponsors, competing for those beneficiaries,
18 would have financial incentive and some of the commercial
19 tools to manage benefit spending.

20 Part D was structured to include Medicare's
21 subsidies, risk sharing, and late enrollment penalties to
22 encourage the creation of a new market for stand-alone

1 prescription drug plans and broad enrollment.

2 So what has changed since 2006?

3 Plans were successful at switching enrollees to
4 generics for many of the widely prevalent conditions like
5 high cholesterol.

6 By 2010, manufacturers had shifted focus on
7 specialty drugs that treat conditions with smaller patient
8 populations, such as rheumatoid arthritis and cancer.
9 These newer therapies are often very expensive.

10 Part D's benefit changed, eliminating the
11 coverage gap for some beneficiaries. Manufacturer
12 discounts were part of that change, and this discount
13 distorts market incentives and is one of the primary key
14 reasons we need to restructure Part D. And we'll come back
15 to this in a minute.

16 Another change is the expanded role of Medicare's
17 reinsurance, which is a cost-based reimbursement to plans
18 for 80 percent of the costs above the out-of-pocket
19 threshold.

20 On the right you can see the rapid growth in
21 costs above the out-of-pocket threshold, shown in orange.

22 In 2018, over 40 percent of spending was in the

1 catastrophic phase, paid mostly by Medicare. That's more
2 than double the amount in 2010, when only 20 percent of
3 spending was in the catastrophic phase. The pipeline
4 shift, Part D benefit change, and the misaligned incentives
5 have all contributed to this trend.

6 Turning to why Part D benefit needs to
7 restructured, the Commission's 2016 recommendations
8 addressed some of the same concerns we just talked about.
9 They would: strengthen financial incentives to manage
10 benefits; give plan sponsors greater flexibility to use
11 formulary tools; modify LIS cost sharing to encourage
12 generic use. But benefit design change and specialty
13 spending have worsened plan incentives, reducing incentives
14 to manage spending, and in some cases, encouraging
15 preferential formulary treatment of high-price, high-rebate
16 drugs, which increases both program costs and beneficiary
17 premiums. The focus on rebates may have affected some
18 manufacturers' pricing decisions.

19 The misaligned incentives work differently for
20 LIS and non-LIS benefits. I'll start with the non-LIS
21 benefit on the left. The figure reflects benefit for
22 brand-name drugs and biologics. The focus here will be the

1 coverage gap in the catastrophic phase above the out-of-
2 pocket threshold.

3 The coverage gap is the phase between the initial
4 coverage limit and the out-of-pocket threshold. As you can
5 see, the plan liability, shown in blue, is much lower once
6 a beneficiary reaches the ICL: 5 percent in the coverage
7 gap and 15 percent in the catastrophic phase.

8 Another thing to note is that the 70 percent
9 manufacturer discount applies only to brand-name drugs. So
10 for generics, plans are liable for a higher amount, 63
11 percent this year and 75 percent thereafter. This
12 effectively lowers brand prices relative to generics,
13 distorting the price signal which is at the core of a
14 market-based system.

15 LIS benefit, on the other hand, still has the
16 coverage gap as originally structured.

17 For LIS beneficiaries, Medicare picks up nearly
18 all of the cost sharing, including the entire costs in the
19 coverage gap. So plans have zero liability in the coverage
20 gap and just 15 percent in the catastrophic phase.

21 Based on CMS data, rebates on brand-name drugs
22 average about 30 percent. That means for some brand-name

1 drugs and biologics, the value of rebates exceeds plans'
2 costs for spending above the ICL.

3 In addition, as noted earlier, Medicare's
4 reinsurance pays for 80 percent of the costs above the out-
5 of-pocket threshold.

6 What this shows is that the current structure
7 clearly fails to provide strong incentives to push back on
8 high prices or to manage spending for high-cost
9 beneficiaries.

10 While the coverage gap discount does provide some
11 financial relief to those who use brand-name drugs and
12 biologics, it affects only a small share of spending for
13 high-cost drugs and biologics placed on specialty tiers.
14 As you may recall, plans are allowed to use specialty tiers
15 only for the most expensive products.

16 This table shows the differential impact coverage
17 gap discount has on specialty tier drugs, shown on the top,
18 and non-specialty tier drugs in the lower panel. These are
19 all major drug products with Medicare spending of at least
20 \$1 billion in 2018.

21 The second column shows the discount paid for
22 each product as a percent of total spending.

1 You can see that for specialty tier drugs,
2 coverage gap discount accounted for about 2 percent or
3 less, and this is because the discount applies to a limited
4 range of spending, as we saw earlier, between the ICL and
5 the out-of-pocket threshold, and it is also because the
6 bulk of the costs for specialty drugs are in the
7 catastrophic phase. This is shown in the last column.

8 In contrast, coverage gap discount for other
9 drugs accounted for a higher share for the selected drugs
10 shown, more than 6 percent to nearly 11 percent.

11 Another reason for low coverage gap discounts
12 among specialty tier drugs is that they don't apply to LIS
13 enrollees, but LIS enrollees, as you may recall, are the
14 majority of the beneficiaries who incur high costs.

15 What all of this shows is that, in addition to
16 distorting price signals, coverage gap discount is not an
17 effective way to offset rising prices and spending.

18 So here's the broad outline of policy ideas we
19 are continuing to explore to restructure Part D.

20 The first idea we'll discuss is eliminating the
21 coverage gap discount.

22 The second idea would equalize the basic benefit

1 for enrollees with and without the low-income subsidy.

2 The third set of ideas would restructure the
3 catastrophic benefit by adding: a new manufacturer
4 discount, cap on beneficiaries' out-of-pocket spending,
5 increased plan liability, and lower Medicare reinsurance.

6 To summarize the key points, we currently have
7 two separate benefit for LIS and non-LIS beneficiaries, and
8 that includes very little to no plan liability in the
9 coverage gap and only 15 percent above the out-of-pocket
10 threshold.

11 The restructure would eliminate the coverage gap
12 and make plans liable for a consistent 75 percent of the
13 benefit up to the out-of-pocket threshold for both LIS and
14 non-LIS beneficiaries.

15 Medicare would provide lower reinsurance in the
16 catastrophic phase, and the remainder would be a mix of
17 plan liability, which would be financed through higher
18 direct subsidy, and a new manufacturer discount.

19 We'll now go through the individual components of
20 the restructured benefit.

21 The first piece is eliminating the coverage gap
22 discount. This would increase the plan liability for

1 brand-name drugs filled by non-LIS beneficiaries from 5
2 percent to 75 percent and make plans responsible for a
3 consistent 75 percent of the benefits between the
4 deductible and the out-of-pocket threshold.

5 The policy would remove the price distortions
6 between brand and generic drugs in the coverage gap, which
7 in turn would improve plans' formulary incentives. And it
8 would also simplify the benefit structure.

9 However, this change would eliminate
10 manufacturers' contribution toward Part D's benefit costs.
11 The gap discount in 2018 totaled about \$6.9 billion. With
12 a 70 percent discount rate beginning this year, the amount
13 would be even higher.

14 DR. SCHMIDT: A second major part of the
15 restructuring would be to use the same benefit design for
16 enrollees with and without the low-income subsidy. If an
17 LIS enrollee had spending high enough to reach what's now
18 the coverage gap, their Part D plan would become
19 responsible for 75 percent of benefits, the enrollee would
20 continue to pay the nominal co-pays that are set in law,
21 and Medicare's low-income cost-sharing subsidy would pay
22 the difference between 25 percent and the co-pays. Plan

1 liability would increase in that phase of the benefit from
2 no liability to 75 percent, and Medicare's low-income cost-
3 sharing subsidy would decrease from 100 percent to a bit
4 under 25 percent.

5 We think this change would improve plan
6 incentives, particularly with respect to the decisions they
7 make about their formulary structure. Plans would have
8 stronger incentives to manage the spending of their LIS
9 enrollees. However, plan sponsors would take on additional
10 benefit spending to cover 75 percent of coverage gap
11 benefits for LIS enrollees. Medicare would subsidize about
12 three-quarters of that amount, and premiums for all
13 enrollees would increase to cover the remainder.

14 At the same time, spending for Medicare's LICs
15 would decrease and would more than offset the increase in
16 Medicare's premium subsidy. So as we equalize the LIS
17 benefit, Medicare program spending would actually go down
18 on net, and all Part D enrollees would pay somewhat higher
19 premiums. As plans become responsible for more of the LIS
20 benefit, they also would need more tools. Part of the
21 Commission's 2016 recommendation was to modify LIS co-pays
22 so that enrollees would have a greater financial incentive

1 to use lower-cost drugs when available.

2 A third major part of the restructured benefit
3 would be a new brand manufacturer discount in the
4 catastrophic phase of the benefit. This would apply to all
5 enrollees whether they receive the low-income subsidy or
6 not. That's a change from current policy.

7 One approach might be to set the new discount
8 rate so that the aggregate amount of revenue at least
9 offsets the amount that manufacturers have been paying in
10 coverage gap discounts. An alternative approach would set
11 the new discount higher to offset other costs of the
12 restructuring or to try to provide some drag on
13 manufacturer price increases.

14 This approach would offset the cost of
15 eliminating the coverage gap discount, and the cap discount
16 would apply much more directly to specialty drugs that have
17 the highest prices. Because the new discount would be
18 open-ended in the catastrophic phase, it would introduce a
19 new consideration that manufacturers would have to bear in
20 mind as they made decisions about price increases and
21 launch price.

22 Consistent with the Commission's 2016

1 recommendations, a restructured Part D could cap
2 beneficiaries' out-of-pocket spending. Today enrollees who
3 reach the catastrophic phase pay 5 percent coinsurance
4 indefinitely. Under a restructured design, Part D's basic
5 benefit would cover the 5 percent. So, for example, the
6 million or so beneficiaries who don't receive the low-
7 income subsidy and reach the out-of-pocket threshold today
8 would no longer pay any cost sharing for prescriptions in
9 the catastrophic phase. Nearly 3 million LIS enrollees
10 also reach the out-of-pocket threshold today, and they
11 currently don't pay co-payments in that phase. Instead,
12 Medicare's low-income cost-sharing subsidy pays the 5
13 percent on their behalf. Under a restructured Part D, the
14 basic benefit would cover what's now covered by Medicare's
15 extra help with cost sharing.

16 This change would provide all enrollees with more
17 complete insurance protection. But the flip side is that
18 benefit spending would be higher. Medicare's premium
19 subsidies and enrollee premiums would increase to cover the
20 new benefit. But as with Slide 12, spending for Medicare's
21 low-income cost-sharing subsidy would decrease, offsetting
22 part of the increase in Medicare's premium subsidy. On

1 net, program spending would increase, but not by as much as
2 you might expect because premiums of all Part D enrollees
3 would help to pay for the new benefit.

4 Consistent with the Commission's 2016
5 recommendations, under a restructured benefit Medicare
6 would provide less reinsurance, and plans would finance
7 more of the catastrophic spending. For example, the
8 Commission previously recommended lowering Medicare
9 reinsurance from the current 80 percent to 20 percent and
10 increasing what plans pay from 15 percent to 80 percent.

11 At the same time, Medicare's capitated payments
12 to plans would increase so that the program would continue
13 to provide the same overall premium subsidy. The program
14 would keep Part D's risk corridors in place, at least
15 during a transition period, to keep financial protections
16 for plans. And CMS would recalibrate the risk adjusters it
17 uses for capitated payments to reflect plans' higher level
18 of liability.

19 If plans were responsible for more catastrophic
20 spending, that may affect their formulary decisions. Plans
21 may be less inclined to prefer certain drugs with high
22 prices and high rebates. If more of Medicare's payments

1 were capitated instead of cost-based, plan sponsors would
2 face more financial risk. Among stand-alone plans, most
3 enrollees are in PDPs offered by very large plan sponsors,
4 and in interviews we conducted, consulting actuaries told
5 us they thought PDP sponsors have enough capital to
6 reinsure themselves. However, among MA-PDs, there are
7 smaller regional plan sponsors that may need to purchase
8 private reinsurance, which could lead to higher
9 administrative costs and premiums. It could also affect
10 whether some plan sponsors choose to enter or stay in
11 certain markets. As both large and smaller plan sponsors
12 take on more financial risk, they would also need more
13 flexibility to use formulary tools to manage benefits.

14 One question to consider is whether Medicare
15 reinsurance is still necessary. At the start of Part D,
16 this form of risk sharing helped encourage plans to enter a
17 new market. Today that market is well established, but
18 reinsurance has grown in an unintended direction.

19 To think about whether Medicare's reinsurance is
20 still necessary, we took a look at how variation in Part D
21 spending per person has changed over time compared with
22 fee-for-service medical spending. Between 2011 and 2017,

1 we found that the variation in medical benefits per person
2 remained flat, but that variation in pharmacy benefits grew
3 significantly. Median Part D spending fell nearly in half
4 over the period. At the same time, the introduction of
5 extremely high-priced drugs drove up mean spending. This
6 might suggest a continued need for some Medicare
7 reinsurance.

8 However, another thing to consider is what role
9 Medicare's reinsurance plays. When health plans purchase
10 private reinsurance, those contracts provide protection
11 against unpredictable risk that the plan will have
12 extremely high claims. Medicare's reinsurance is
13 structured very differently.

14 First, Medicare reinsures about 8 percent of Part
15 D enrollees compared to 1 to 2 percent of health plan
16 members under private reinsurance contracts.

17 Second, most Part D spending in the catastrophic
18 phase is predictable. In recent years, about 80 percent of
19 Part D catastrophic spending is attributable to enrollees
20 who also had catastrophic spending in the previous year.
21 Medicare's reinsurance is not protecting against
22 unpredictable high claims. It's providing cost-based

1 reimbursement for high-cost enrollees. In this sense, it
2 may be countering selection incentives. But CMS already
3 has risk adjusters for that purpose, and Part D also has
4 risk corridors to help protect plans from unanticipated
5 losses.

6 In order to help ensure a successful transition
7 to a restructured benefit, we would need other changes.
8 Changing from the status quo would have a lot of moving
9 parts, and policymakers may want to phase in changes over
10 time. Plan sponsors would need more formulary flexibility
11 to manage the higher plan liability. When we ask plan
12 sponsors what they think they would need, they often bring
13 up current restrictions such as having to cover all
14 protected-class drugs, not being able to limit their
15 network of specialty pharmacies, and how LIS enrollees have
16 weak financial incentives to use generics and preferred
17 drugs.

18 Under a restructured benefit, it would be
19 especially important for CMS to recalibrate risk adjusters
20 because more of Medicare's premium subsidies would be
21 capitated. There may be other ways in which to improve the
22 Part D risk adjusters.

1 In addition to reinsurance, Part D also has risk
2 corridors that protect plans at an aggregate level from
3 unanticipated losses. We may want to consider changes to
4 the risk corridors, at least on a transitional basis. One
5 option is to tighten the corridors during the transition to
6 a new benefit, giving plan sponsors more protection against
7 the risk of overall losses. Similarly, the shares of
8 unexpected losses and profits borne by plan sponsors and
9 Medicare in the corridors could be changed so that Medicare
10 bears more risk temporarily.

11 Now we'd like your questions and comments about
12 this general approach. We would also appreciate hearing
13 your perspectives about redistributing responsibility for
14 financing Part D's catastrophic phase among beneficiaries,
15 Medicare reinsurance, brand manufacturers, and plan
16 sponsors.

17 In November, Eric Rollins will bring you more
18 information about plan sponsors that have larger
19 percentages of members with the low-income subsidy and
20 their experiences in trying to manage LIS benefit spending.

21 DR. CROSSON: Well, I just want to thank you for
22 that exquisite analysis and reformulation.

1 We will start with clarifying questions from the
2 Commissioners.

3 Paul?

4 DR. PAUL GINSBURG: Yes. I thought that the
5 paper was really terrific.

6 I had a question. You concluded that the net
7 effect financially of all these changes would be a small
8 increase in program spending and beneficiary premiums?

9 DR. SCHMIDT: We weren't providing a cost
10 estimate of everything altogether. Each slide was kind of
11 discussing the puts and takes of how program spending was
12 with respect to each of the component we were going to on
13 the slide.

14 DR. PAUL GINSBURG: The reason I wanted to bring
15 up the question is I presume that there are so many
16 parameters that can be varied, such as the discount
17 percentage, the reinsurance percentage, to protect the
18 classes, that some version of this could be made budget
19 neutral or premium neutral if policymakers wanted to. Is
20 that correct?

21 DR. SCHMIDT: Yes, that's correct.

22 DR. CROSSON: Okay. Kathy?

1 MS. BUTO: Thanks a lot for this, not just the
2 chapter, but the concept, which I think is incredibly
3 elegant.

4 I had a couple questions. One is whether you did
5 an impact analysis or sort of a sensitivity or some kind of
6 analysis that the impact of beneficiaries reaching the
7 catastrophic cap, or would it be similar to the other
8 proposal that we discussed where the manufacturer discount
9 would no longer count toward reaching the cap? It feels
10 like it would be very similar to that, but I just wondered
11 if you had done that, that analysis of beneficiary impact.

12 DR. SCHMIDT: So in the 2016 recommendations, we
13 were changing the treatment of the manufacturer discount so
14 it no longer counted towards the true out-of-pocket
15 threshold.

16 MS. BUTO: Right.

17 DR. SCHMIDT: And remember it was an overall
18 package that had some things that people liked and some
19 things that people did not like, and the fact that people
20 would stay in the coverage gap longer was something that
21 folks did not particularly like but was part of the overall
22 package and something that we thought was necessary at the

1 time.

2 The nice thing about this redesign is that
3 treatment, that change in the treatment is no longer really
4 relevant.

5 MS. BUTO: Relevant, right.

6 DR. SCHMIDT: And the 25 percent cost sharing is
7 really consistent with current law. So the only question
8 is at what level the out-of-pocket cap is. Do you want it
9 to be kind of the same as what beneficiaries essentially
10 would pay under current law if you don't consider what
11 manufacturers are contributing in the coverage gap or
12 something else?

13 MS. BUTO: Okay. So, obviously, it's one
14 variable that could be -- and the other, the other question
15 I had was whether in the catastrophic cap phase whether the
16 manufacturer discount would apply to generic manufacturers
17 as well as brand name or just brand name. Had you thought
18 about that?

19 MS. SUZUKI: We only looked up brand-name drugs
20 partly because we were trying to replace the elimination of
21 coverage gap discount with a cap discount, and so we were
22 talking about the same entities.

1 MS. BUTO: Okay. Good. Thank you very much.
2 That helps.

3 DR. CROSSON: Okay. Dana, Jonathan, Pat.

4 DR. SAFRAN: Yeah. Just adding my voice to the
5 thanks for this really impressive piece of work.

6 I have two questions. One is about premium
7 increases that you'd expect. You said a little bit about
8 it here and a little bit about it in the chapter, but I
9 just wonder if you could expand a bit on what you think are
10 the likely consequences for beneficiaries in terms of
11 premium increases that might be faced as the plans start to
12 face the increased cost that you tell us are going to
13 happen because of this and that are intended here and also
14 whether there is any backstop possibilities to that in
15 terms of a cap on increases allowed with respect to
16 premiums.

17 And then I'll go to my second question.

18 MS. SUZUKI: So there are a lot of moving pieces.
19 We explicitly did not provide the overall impact because
20 it would depend on the parameters that are chosen.

21 Although one thing to note is that reinsurance is
22 already part of the premium calculation for the plans. So

1 right now, essentially, 95 percent of the cost above the
2 out-of-pocket threshold is already reflected in the premium
3 amount. So changing that distribution will not necessarily
4 lead to higher cost because I think we're now considering a
5 cap discount to pay for some of that cost.

6 The big question is, What do you do with the out-
7 of-pocket threshold, moving up or down, relative to current
8 law would affect the premium amount? Because you have 75
9 percent coverage below the threshold but a higher --
10 potentially a higher coverage above the threshold, and then
11 the low-income cost-sharing subsidy is one of the things
12 that would lead to higher premium. But we think there are
13 different ways to offset that, some of that cost, if that's
14 the policy goal.

15 DR. SAFRAN: That was very helpful.

16 My second question is also about asking you what
17 you thought about in terms of the behavioral economics
18 here, which are quite complex, will play out.

19 Early in the chapter, you highlight that
20 manufacturers had a notable shift toward specialty and
21 orphan drugs. I wonder if you've thought about whether
22 this policy shift would incentivize another type of

1 manufacturing shift, and if so, what do you hypothesize
2 that could look like?

3 DR. SCHMIDT: We'd really be speculating. There
4 are so many other factors that go into what manufacturers
5 decide to put into their pipeline and take to the market.
6 So it's the whole length of exclusivity, patent law, all of
7 those things, and obviously, reimbursement policy is one
8 important element of it. But it's just a small component.

9 But the fact that there would be this open-ended
10 discount that manufacturers would have to provide may
11 affect pricing decisions.

12 DR. SAFRAN: Thank you.

13 DR. CROSSON: Jim wants to get in.

14 DR. MATHEWS: So to go back to your first
15 question with respect to beneficiary premium increases and
16 consequences of those increases, as Shinobu said, the
17 magnitude of those increases are going to depend on the
18 parameters chosen for this redesign, but I also wanted to
19 point out that there is a longitudinal element here, that a
20 lot of the changes that we are discussing are designed to
21 get at manufacturer's pricing behavior and to increase the
22 incentives for plans to make formulary decisions over time

1 that ideally would have the impact of decreasing price
2 growth over time.

3 So to the extent that the Commission has been
4 concerned about the growth of high-price specialty drugs,
5 the growth of Medicare reinsurance spending, part of what
6 we were discussing here are changing incentives to get at
7 those rates over the long term.

8 DR. CROSSON: Okay. Jonathan?

9 DR. JAFFERY: Yeah. Thanks.

10 My question actually is along the lines of Dana's
11 second question about manufacturers' behaviors and their
12 incentives, but I'll be a little more -- I'll home in on
13 something.

14 You talk about the manufacturer's financial
15 contribution being -- let me put a number on it -- 6.9
16 billion in 2018. So is it accurate that as we're
17 estimating their contribution, that's going to be very
18 dependent on their own pricing strategies? So if they
19 double their prices, it suggests or we will calculate that
20 they're actually contributing twice as much?

21 DR. SCHMIDT: Yeah. Right, pretty much. The 6.9
22 percent was looking at claims data for 2018 and looking at

1 the value of what's described as "manufacturer discount" on
2 those claims in that year. So that was a year where it was
3 50 percent, and it's subsequently gone up to 70 percent
4 discount. So that's how we came up with the amount of
5 revenue.

6 But, yes, you're right. They have control over
7 prices.

8 DR. JAFFERY: There's something analogous here to
9 discounts that providers offer to insurance companies and
10 whatnot. We'll have to think, I guess, about how we
11 calculate different sectors' contributions based on that,
12 because that's very different than, say, what a beneficiary
13 premium is, which is an actual dollar amount.

14 All right. Okay, thanks.

15 DR. CROSSON: Okay. Pat and then Kathy.

16 MS. WANG: I wondered if you could talk a little
17 bit more about the elimination of the manufacturer discount
18 in the coverage gap. Assume that it no longer counts
19 towards the out-of-pocket threshold, and so this
20 acceleration of people reaching the reinsurance layer is
21 gone.

22 There's statements in the paper as well as in the

1 slides around the discount and the coverage gap created
2 price distortion between brand and generic. Is that a
3 statement that is made, I assume, only for brands that have
4 a generic equivalent? Because what about specialty, single
5 source? I was wondering because it still feels like
6 manufacturer discount at several layers of the benefit
7 makes sense to try to get maximum incentives running in the
8 correct direction.

9 So I wonder if you could explore that a little
10 bit more.

11 MS. SUZUKI: So I think you're correct that,
12 generally, the brand generic price distortion would be
13 brands with generic, but I would add that sometimes there
14 are therapeutic generic substitutions that are available to
15 beneficiaries. And plans may have stronger incentive
16 without the coverage gap discount to encourage more of
17 those brand substitutions that are more based on
18 therapeutic class, not just the direct generic
19 substitution, which I think plans already do.

20 MS. WANG: Do you have any sense of relative
21 proportion of those phenomena inside of the coverage gap?
22 Would a continued coverage gap discount that did not count

1 towards the out-of-pocket net be better and more productive
2 in terms of continuing to dampen price escalation than the
3 phenomenon you're describing?

4 MS. SUZUKI: I think that's a really difficult
5 question to answer, partly because some portion of those
6 brands used are probably driven by clinical needs. Some
7 portion may be due to the fact that they have hit the
8 coverage gap, and from maybe their experience, they know
9 that they're going to reach the catastrophic phase. In
10 that case, your out-of-pocket liability would be minimized
11 using the brand version of the drug.

12 So there are a mixture of things that happens in
13 the coverage gap, but we think that if there are generic
14 substitution that's available, then we want to ensure that
15 that incentive is aligned.

16 MS. WANG: Does your thinking on that change if
17 there was a manufacturer discount on generics?

18 DR. SCHMIDT: I think Kathy has raised that issue
19 in past discussions about this, and I think we had some
20 concern. This isn't true for all generic drugs, but we've
21 seen declining numbers of manufacturers for certain
22 generics. And so there was concern about if you add on top

1 of that a discount that they have to provide about the
2 viability of maintaining generic competition.

3 MS. WANG: I think that the question really is
4 more focused, not generics, generically, but there are
5 certain generics where price escalation has been just as
6 dramatic as on the brand side.

7 DR. CROSSON: Kathy?

8 MS. BUTO: I just wanted to go back to -- I guess
9 it was something somebody, maybe Dana, raised that caused
10 me to think this.

11 With a manufacturer discount that's sort of
12 unlimited in the catastrophic phase, isn't that likely to
13 stimulate higher pricing in sort of brand-name drugs; in
14 other words, similar to our recommendation of keeping
15 prices below sort of inflation, so that we would cap
16 Medicare's payment rates?

17 If you're going to require a certain discount,
18 then it seems to me the introduction prices would be --
19 there would be an incentive to really go high on those. I
20 mean, I just wonder if you've thought about that.

21 The structure, I love getting rid of the coverage
22 gap, but the structure also suggests that if there's no

1 skin in the game, then you've got, by manufacturers, before
2 the catastrophic limit that you're going to have, again,
3 more of a likelihood of high introduction prices. I just
4 wondered if you all had thought about that.

5 DR. SCHMIDT: We have talked about that
6 internally, and we've talked to other experts in the field.
7 And there's just a lot of uncertainty.

8 We hear both sides of that argument, and I'm not
9 sure that anyone knows precisely what happened. I think
10 it's going to vary from drug class to drug class, dependent
11 on competition in that class and so forth.

12 DR. CROSSON: You know, I think inherent in this
13 -- and I almost hesitate to say this -- is that there is a
14 perception that there's going to be a limit eventually to
15 how much manufacturers can keep increasing their prices.

16 Now, I think people have been saying that for a
17 long time, which is why I hesitate to say it, but I do
18 think that given the level of public outcry, one might
19 construe that while manufacturers might have an incentive
20 in the face of this change in their liability outside in
21 the catastrophic coverage arena, that they would
22 reflexively do that. But I do think there could be other

1 forces pushing against that.

2 Jon, Bruce, Amol.

3 DR. PERLIN: Well, let me add to the chorus of
4 thanks for a really thoughtful, superb chapter, and
5 discussion.

6 I have really three questions for you. The first
7 is the premise is that there's formulary management, but
8 that implies that there are substantutes. Has there been
9 any source sensitivity analysis about the degree of
10 substitutability where the costs reside if you actually
11 parse the pie of the Part D expenditures and to those
12 things with and without substitute and what that magnitude
13 is?

14 MS. SUZUKI: So CBO has looked at this a couple
15 years back, looking at selected therapeutic classes to see
16 how much Medicare could save if there were therapeutic
17 generic substitutions. My recollection is those were
18 pretty common classes of drugs.

19 And we've also independently looked at generic
20 use rate within some broad classes where we think there is
21 some mixture of direct generic substitution, therapeutic
22 generic substitution available; for example, high

1 cholesterol is one of them. High blood pressure is
2 another. Those classes where when we look at LIS enrollees
3 compared to non-LIS enrollees who do see cost-sharing
4 differential, we do see a difference in generic use rate.
5 And some of it, we have argued that are due to financial
6 incentives and due to clinical need differences.

7 DR. PERLIN: The reason I am asking that question
8 is the notion of formulary management requires, by
9 definition, formulary choices, and where those choices are
10 constrained, that limits the overall pull.

11 If I am understanding correctly, the savings
12 where there is substitution is what helps to rein in the
13 cost against entities where there's a single drug or
14 specialty drug in class.

15 With that in mind, it strikes that the points
16 that were just made about the potential risk of the
17 escalation of launch price is problematic, and I'll just
18 tee this up for the second phase of conversation. But our
19 definitions of what is a substitute, appropriate substitute
20 for a specialty drug may be particularly important.
21 Apropos of this, while certain things may be related to
22 behavior in terms of pricing, some of the specialty

1 therapies involve new technologies that may be inherently
2 more expensive. I just wonder how we get an estimate on
3 any of that to really understand how this operates.

4 DR. CROSSON: Okay. I've got Bruce and Amol, and
5 then we're going to, I think, move on to the discussion
6 please.

7 Bruce?

8 MR. PYENSON: Actually, to pick up on Jonathan
9 Perlin's comment, I opened up the June 2019 report. Table
10 2.2 has a list of the top specialty drugs, and you can
11 actually go down the list of those drugs. Many of them
12 have clear substitutes.

13 So I think that the analysis that you suggested
14 is something we could do, and in looking at that list, some
15 of these are also drugs that are probably off patent
16 already. I think the proposal would address that issue by
17 changing the plan liability in catastrophic.

18 My question, to pick up on Dana's question about
19 behavioral impacts, I think there's some wonderfully
20 complex behavioral issues here, the behavior of
21 beneficiaries, the behavior of manufacturers, but I'd like
22 to ask about the behavior of plans in response to a change

1 in structure.

2 I think you've identified some of those from a
3 formulary management standpoint. I'm wondering if there's
4 any lessons from the past on how plan behavior changes?
5 We've talked about that a little bit from what happened
6 with sequestration and Part B drugs, and I'm wondering if
7 there's any lessons from that, that might be worth looking
8 at, or other kinds of plan responses to changes in the
9 environment.

10 DR. SCHMIDT: I don't know about the example of
11 sequestration, but one thing that comes to mind is, you
12 know, there was this gradual phase-out of the coverage gap,
13 which partly was paid for by the manufacturer discount but
14 also, at least for a while, plans had increasing viability
15 that was going on. And I think one of the responses is in
16 kind of recalculating what sort of benefits to include in
17 their packages. So they previously provided more coverage
18 in the coverage gap and among enhanced benefits, and that
19 was no longer necessary and so they kind of re-evaluated
20 whether to provide that or not, you know, in addition to
21 kind of looking at the market competition to see what niche
22 to fill.

1 So there would be some response that way, I
2 suppose. I mean, I have to think through it exactly, what
3 that response would be, but I think they might envision
4 kind of changing not only what is on their -- well,
5 primarily what is on their formularies. I think that is
6 going to be the primary response. But I need to think
7 about that more, I should say.

8 DR. CROSSON: Amol.

9 DR. NAVATHE: I would also like to echo the
10 thanks for a great paper and I think some really nice
11 thinking about the design here.

12 I want to switch gears from what seemed like a
13 number of challenging questions to hopefully a softie. You
14 mentioned, toward the end of the presentation, that you had
15 talked to some plan sponsors and they had articulated this
16 challenge with, I guess, the incentive to move away from
17 generics at the beneficiary level for the non-LIS benes.

18 And so what I was wondering is, are they
19 referencing the cost-sharing -- the fact that there is
20 insurance itself and so there is a subsidy, in some sense -
21 - or is there some other aspect of the benefit that they
22 are referencing that is driving benes away from generics.

1 I wasn't sure what exactly was referenced by the plan
2 sponsors there.

3 DR. SCHMIDT: I think I am a little perplexed
4 about what exactly you interpreted. I think I was the one
5 talking about conversation with plan sponsors, and the
6 things that they mentioned to us were having to cover all
7 the protected class drugs, some concerns about LIS cost-
8 sharing and having the copay set in law and not being able
9 to move beneficiaries towards generics and preferred drugs
10 for that reason. But I am not quite following what exactly
11 else you thought I said.

12 DR. NAVATHE: So I only took note, and maybe this
13 was subsequent to that in the context of the bullet points
14 that you guys had on Slide 17, on greater flexibility in
15 formulary management. I think there was a comment that you
16 made about specifically for non-LIS beneficiaries and an
17 incentive away from generics. So that's what I was
18 referencing, but maybe I took that out of context.

19 MS. SUZUKI: One thing we were concerned about is
20 having brand-name drugs receive the gap discount and that
21 counting toward the catastrophic threshold, your out-of-
22 pocket threshold, may, at the margin, allow beneficiaries

1 to decide that taking the brand version of the drug would
2 reduce my overall out-of-pocket spending. That's one
3 possibility.

4 I think having a very low plan liability may
5 affect plans' formulary decisions and may not put as much
6 financial pressure on people who take brand-name version of
7 the drug.

8 DR. NAVATHE: Okay. Thank you.

9 DR. CROSSON: Okay. I think we are going to
10 proceed with the discussion phase now. I just have to make
11 this point and say, you know, this is a big deal. This is,
12 in many ways, to me, as important as, you know, the
13 original design and passage of Part D, in the sense that if
14 this and other changes that we have recommended, and that
15 are under discussion at the moment, take place, I think we
16 would have a reformulated and much, much better benefit for
17 beneficiaries and a better financial approach for the
18 Medicare program. So thank you again for the work.

19 I think what I'd like to do is have a discussion
20 now, point to the last slide. I would add one thing to the
21 second sub-bullet point about Medicare reinsurance and
22 that's the question that was brought up about whether we

1 want to keep reinsurance at all. I think that is
2 legitimately on the table. And so we will start with
3 Bruce.

4 MR. PYENSON: Thank you very much, and I want to
5 echo the compliments that Jay stated in the importance
6 here. I was struck by how, Shinobu, how you began the
7 discussion with a focus on the high price -- the issue of
8 high-price drugs and catastrophic, and that really flows
9 through so much of the work here, and appropriately so.

10 And I think the solution, in the direction that
11 you've outlined, would really address that issue in many
12 ways, the relief from what could be -- is often
13 unaffordable co-insurance at the 5 percent level in the
14 catastrophic zone for beneficiaries, as well as the
15 incentives for higher-priced, higher drugs to be encouraged
16 in the formulary, which is often there to, partly, to
17 reduce premium rates and enhance competitiveness among
18 plans. So I think that both of those are well addressed in
19 the proposal and I really am very happy to see those
20 developed and promoted.

21 I think there is another very important issue to
22 address in catastrophic, which is the issue of the failure

1 of biosimilars to launch in the United States. Looking at
2 the list of high-priced drugs, the billions of dollars that
3 are being covered by Part D in that area, many of those
4 drugs are considered biosimilars in other countries and are
5 being widely prescribed and widely encouraged in many
6 countries around the world but not in the U.S. And
7 changing the structure of catastrophic would be only one of
8 the solutions needed to have the U.S. come up to the level
9 of other countries.

10 I think that the issue is very important because
11 in the history of Part D, which, by and large, has been a
12 very successful program, a big part of that success has
13 been the growth of generic drugs over the last 10 years.
14 And if we are going to have room for the expensive new
15 therapies that are emerging in catastrophic we have to make
16 that shift from old, very expensive drugs, to much less
17 expensive biosimilar or biogenerics.

18 So I think some of those barriers are, I believe,
19 clearly in the kinds of work that MedPAC can do. Perhaps
20 patent law is not our area of expertise, but there are a
21 number of other issues, such as correcting the
22 misinformation about originator versus biosimilar safety

1 and efficacy for both clinicians and beneficiaries is an
2 example. The issues of even nomenclature of how drugs are
3 called and labeled. There are issues where it's a
4 misunderstanding of the shifting, even within originator
5 drugs over time, so that we ought to think about originator
6 drugs as being biosimilar to themselves. The issue of
7 international reference, where the reference for a
8 biosimilar can't be some other country's originator drug.

9 There is a whole series of issues like that that
10 are obstacles, and I think those are things we can identify
11 and quantify, to some extent, because I think it is really
12 the tip of the iceberg to a potential cost savings to
13 beneficiaries and to the Medicare program to look at the
14 existing biosimilars that are not being prescribed because
15 of the catastrophic structure. The bigger portion of the
16 iceberg is a wave of new biosimilars that can reduce
17 spending.

18 But I really want to compliment you on the solid
19 work and laying this out very systematically. I think this
20 is really key to the future of Part D.

21 DR. CROSSON: Thank you, Bruce. Paul.

22 DR. PAUL GINSBURG: Yes. I wanted to first make

1 some comments about the context of this. We got Part D as
2 a result of a longstanding debate whether Medicare drug
3 coverage should follow the single payer model, the rest of
4 Medicare, or whether it should use private plans and
5 compensation, and the decision was made to use private
6 plans and compensation. But a combination of the evolution
7 of a drug market, where so much more of the money has moved
8 into very high-cost drugs and some, perhaps, not-so-wise
9 decisions about taking additional contributions from
10 pharmaceutical companies for the ACA and then the
11 Bipartisan Budget Act of 2018, in the form of coverage gap
12 discounts, as opposed to some other place, have, for the
13 most part, you know, blunted, removed a lot of the
14 incentives that presumably the country was looking for in
15 going for private plans, to run the Medicare drug benefit.

16 So, in a sense, it is nothing that anyone did
17 particularly intentionally, but I think we are at a bit of
18 a crisis where we have really disarmed our private
19 competitive market-oriented mechanism and it can't do its
20 job anymore. So that is just the context. I think it's
21 consistent with everything you've done.

22 I'm very enthusiastic about the course you have

1 charted out for us, and I would be very intrigued in doing
2 more on reinsurance. In other words, a quick first step
3 would be taking it down from 80 percent to 20 percent.
4 That is clearly a desirable change. But I think you
5 mentioned, Rachel, that this co-insurance does not resemble
6 typical reinsurance in insurance, which is usually focused
7 on the costs of individuals who have extremely high
8 spending as opposed to a broad part of the population that
9 gets into this catastrophic range. And it might be useful
10 to think about an idea, some ideas to put in real
11 reinsurance in this program instead of what goes under the
12 name of reinsurance that have now, or might have in the
13 future.

14 DR. CROSSON: Thank you. Okay. So I see Dana,
15 Jon, David, Pat, Jaewon, and Kathy.

16 DR. SAFRAN: Thanks. Just two thoughts to add
17 into this conversation. So the first one is back on what
18 we were talking about in the last round, which is there is
19 tremendous complexity to the behavioral economics here,
20 and, you know, I couldn't help being struck as I was
21 reading the chapter at some of what you were laying out as
22 the perverse incentives that have played out, as, why

1 didn't we think of that?

2 So what I want to suggest is it would add to this
3 chapter if we had some kind of table that explicitly lays
4 out, for manufacturers, for plans, and for beneficiaries,
5 what do we think each of the main changes that you are
6 proposed create in terms of behavioral incentives. And
7 maybe even what would be the unintended consequences that
8 ought to be monitored for.

9 My second comment relates to the question I asked
10 in the question round, about premiums and increases there.
11 It does strike me, from my time in a commercial plan, that
12 it might be useful to consider one additional element here,
13 and that is to have some threshold on the allowed percent
14 increase in premiums from year to year. And, you know, in
15 Massachusetts, this was done through a policy level at the
16 state level, and to around drugs but around health care
17 costs overall, and it was placed -- the state GDP was used
18 as the percent allowed growth, and every provider and every
19 plan was held accountable to growth no more than that. And
20 it was and is a quite interesting and effective lever.

21 And I can't help but think of that as a
22 potentially important lever here, because of the pipeline

1 and the prices attached to that pipeline as something that,
2 you know, we were concerned about, all of us concerned
3 about, read about every day. And it strikes me that plans
4 ought to be playing the role of deciding what gets in and
5 at what price. And by having some limit on how much
6 overall costs can grow and premium growth caps would
7 represent a pretty important part of that limit, we might
8 put plans in a role of needing to be a really thoughtful
9 gatekeeper about what new therapies get in at what price.
10 Thanks.

11 DR. CROSSON: Thank you. Jon.

12 DR. PERLIN: Thanks. I am exceptionally aligned
13 with Dana's first point, and on page 23 you write that
14 because manufacturers would be able to estimate effects of
15 the gaps discount on the net revenues, they may still
16 increase prices to compensate for the cap discount
17 liability. And I couldn't agree more with the idea of
18 tables. In fact, my point is, just taken to its extreme, I
19 was wondering if a manufacturer would ever withhold from
20 this marketplace a particular drug so as not to be limited.
21 So some of the incentives I think maybe could be played out
22 to their logical conclusions, just as, you know, on a

1 simple financial basis. Thanks.

2 DR. CROSSON: Okay. David and then Pat.

3 DR. GRABOWSKI: Great. Thanks. And let me just
4 agree with you, Jay. This is a really big deal. And I
5 really believe it is a first step, it is a necessary step,
6 but I don't believe it's sufficient. I think you do a
7 really nice job in the chapter and in the presentation
8 about if we are going to ask plans to take on more risk, we
9 really need to give them more tools to manage that risk.

10 And so I really like the idea of greater
11 flexibility in formulary management, and, indeed, if there
12 is going to be kind of more risk for plans, and Dana
13 mentioned unintended consequences, but we really need to
14 guard against risk selection in this kind of model.

15 And so you mentioned the idea of further
16 recalibration of the risk adjustment model, and there are
17 probably other steps we might think about in future
18 meetings around if we are going to ask these plans to take
19 on more of that risk then I'm really worried about kind of
20 increased incentives around risk selection. But I really
21 like the direction this is headed.

22 I wanted to touch on the questions you asked

1 around the catastrophic phase. Paul already touched on
2 this, but I would love to see us move towards a reinsurance
3 model that looks more like what's seen in the commercial
4 and employer health plans. It has never made sense to me -
5 - maybe it did in the early stages of Part D, how we do
6 reinsurance here -- but as the model has evolved, and you
7 made a really good case, both in the reading and in the
8 presentation, why we might want to rethink this. And I am
9 very much on board of trying to move towards much more of a
10 reinsurance model that looks like the private side.

11 Thanks.

12 DR. CROSSON: On this?

13 DR. PAUL GINSBURG: Yeah, on this. I just wanted
14 to make mention that when Part D was legislated there was a
15 lot of worry about what if we do this and nobody shows up,
16 meaning no plans show up. So a lot of things were done to
17 make sure that plans showed up, and, in fact, tons of them
18 showed up and have stayed.

19 DR. CROSSON: Pat.

20 MS. WANG: So I also want to compliment you and
21 echo the other Commissioners on just how thoughtful and how
22 much care is obvious in how you've kind of furthered the

1 discussion around here.

2 As context, I want to really endorse Bruce's
3 comments around biosimilars because I think that the work
4 here, which I agree with David wholeheartedly needs to
5 continue to evolve, is very elegant in shifting risk among
6 the current parties. The frustration is that we hope that
7 through behavioral economics it will have some impact on
8 actual prices. And I think it's speculative how much that
9 will actually happen, and so I think that Bruce's comment
10 about Medicare's role in sort of stimulating additional
11 competition on the manufacturer side is critically
12 important and will have long-range consequences for, you
13 know, the viability of the Medicare Part D benefit. I
14 think it's squarely in Medicare's playbook to sort of be
15 active here. So anything that we can do in that area is
16 important.

17 You know, one of the concerns that I want to add
18 to the questions about, you know, unforeseen consequences
19 and incentives and impacts is with the shift in risk. I do
20 have concerns about smaller plans -- okay? -- and that may
21 be a consequence that the country will deal with, that
22 everything will migrate into the dominant eight to ten that

1 are now dominating the MA market as well as the Part D
2 market. But I think we should have eyes wide open about
3 that. And that is why, to echo, I appreciate very much the
4 inclusion or the underlining of the importance of both risk
5 adjustment and, I would add, SES adjustment to that. Even
6 within the LIS population, there's different gradations of
7 LISness.

8 Specifically on the questions and the content of
9 the paper, I still would like to at least explore
10 continuing the manufacturer discount in the coverage gap.
11 And, Shinobu, I heard your concern about wanting to
12 encourage in particular therapeutic substitutions where
13 appropriate. I'm just not sure at the end of the day,
14 again, the new benefit of what outweighs what, and my
15 instinct would lean towards keeping manufacturers' skin in
16 the game at all levels of the benefit design, and certainly
17 there are many brands and increasing numbers of single-
18 source and orphan drugs for which there are no generic
19 substitutions. And it just feels like letting them out of
20 the coverage gap is -- it just doesn't seem right.

21 I'd also like to explore applying the
22 manufacturer discount to high-cost generics. It is

1 definitely -- there is a subset of generics that price
2 escalation is incredible, and they rival the cost of
3 brands, and sort of not somehow figuring out a way to put
4 them into the mix seems like a miss.

5 In terms of the cap on beneficiary spending as
6 well as Medicare's reinsurance, starting with Medicare's
7 reinsurance, the thing that concerns -- I think it's worth
8 exploring seeing whether there's a reinsurance model that
9 is similar to the commercial. You know, reinsurance for
10 drug prices is like dollar for dollar. There is no, like,
11 insurance deal when it comes to drug pricing. So I'm not
12 sure how great a solution that is actually going to prove
13 to be, and Medicare's reinsurance, which I think has to
14 stay at a minimum of 20 percent, is realistic for, I think,
15 what it would cost in the private market. It's pretty much
16 a cost pass-through.

17 I also candidly think it's important for Medicare
18 to have skin in the game so that it continues to push for
19 bigger solutions on the problem of drug pricing for
20 beneficiaries as well. I mean, I think there are pros and
21 cons that you have mentioned in the paper in terms of
22 removing beneficiary incentives, basically the problems

1 that we see with the LIS population and indifference to the
2 price of the drugs that people are taking. For good reason
3 they don't have money to pay differential co-pays, but,
4 like, beware that phenomenon when you remove price
5 sensitivity.

6 We talked about risk adjustment, and, again, I
7 really thank you for emphasizing that, and I'd throw SES in
8 there.

9 The final thing that I would say -- and, again, I
10 appreciate very much that you are going to have a separate
11 look, Eric is, on the LIS population specifically. And I
12 guess I would just as a threshold question ask whether it
13 is an automatic thing that we should be seeking to
14 standardize the non-LIS and the LIS benefit. The LIS
15 population is just different. There's zero cost sharing to
16 a couple of bucks. I mean, it's true, it's really a
17 problem. It's the same cost sharing for, you know, a
18 \$100,000 brand drug and a \$10 generic, zero, a dollar. The
19 problem is that, you know, for the population obviously
20 it's not like you can vary cost-sharing amounts, which for
21 the more middle-class, more affluent populations,
22 absolutely something that will happen. If this type of

1 proposal goes through, plans will seek ways to tier the
2 benefit, change formularies, and try to bring the
3 beneficiary into the equation more actively about which
4 drugs they choose. Those tools are completely lacking for
5 the LIS population, for good reason, and, you know, if you
6 raise their co-pays, they're just going to stop taking the
7 drug.

8 So I think that it is -- and I can tell you that
9 this is absolutely true because I know from experience.
10 It's really a dilemma, and so I would urge us maybe to step
11 back from the assumption -- like going down this pathway
12 for the restructure of Part D, it is one thing for the non-
13 LIS population. But for the LIS population, it doesn't
14 feel quite satisfying to me to sort of say let's just treat
15 it exactly the same and the plans take on all the
16 liability, because you can't give plans enough tools in the
17 world to be able to deal with the issue of the lack of
18 flexibility for the LIS population.

19 Thank you.

20 DR. CROSSON: Yeah, I just want to make one
21 comment. So, Pat, just on the point you made about
22 retaining some sort of manufacturer discount in the

1 coverage gap, I just want to be -- I think what you were
2 saying was not keep it overall, but keep one -- keep some
3 sort of one and focus it on drugs where there's no generic
4 substitution, no generic available, no commonly used
5 therapeutic substitution, and no biosimilar. Is that
6 right?

7 MS. WANG: I think that's a very fine needle to
8 thread, you know, maybe in an ideal world, but absent being
9 able to, you know, sort of cut it that fine, I would just
10 say keep it. Don't count it towards the out-of-pocket
11 threshold. It's just get the manufacturers to split the
12 cost somehow with the plans in that layer.

13 You know, I know that the theme here is you want
14 to encourage -- that it sends the wrong pricing signals and
15 so forth, but there really are a lot of single-source
16 brands that are either clinician preference or have no
17 generic substitution that are going to be at an increased
18 initial coverage limit. I just feel like the manufacturers
19 should continue to have skin in the game at every level.

20 DR. CROSSON: Okay. I just want to be clear what
21 you're saying. Amol, on this? And then Paul on the same.

22 DR. NAVATHE: Yeah, so I just wanted to pick up

1 on the last point that you made, Pat, where you -- Pat was
2 making the point that we should be mindful of sort of
3 normalizing the benefit design across LIS and non-LIS
4 beneficiaries. And the point I wanted to make there I
5 think is just worth us looking further into is at different
6 income strata we might see differential responses to
7 increases in premium versus increases in cost sharing, you
8 know, conditional participation. And if we're thinking
9 about this from the perspective of access and then, you
10 know, actual choices around filling medications, there's a
11 layer there that might actually defer quite a bit. And so
12 while I think philosophically I agree with the idea that
13 you're advancing, which is we want -- you know, regardless
14 of LIS or non-LIS, we want people to make cost-conscious
15 and cost-efficient decisions, and that would improve the
16 sustainability of the program in general. I think whether
17 a unified benefit structure actually makes sense across
18 those two strata is to me still an open question, and we
19 might want to be careful about those design elements,
20 particularly if we're going to end up raising premiums
21 across the board.

22 DR. CROSSON: Paul.

1 DR. PAUL GINSBURG: I just want to follow up on a
2 different Pat comment, the one she made in response to you,
3 Jay, it's that as far as where to be placing the
4 manufacturers' discounts. And, clearly, you know, the set
5 of drugs that are mostly in the coverage gaps and those
6 mostly in the catastrophic are different drugs. You know,
7 the catastrophic is a lot of the rare disease drugs; in the
8 coverage gap, a lot more of the chronic disease management
9 drugs. And it certainly does warrant some thought as to,
10 you know, maybe it's been imbalanced and we need to shift
11 towards more of a tax on the rare disease drugs because
12 they've been given so many advantages in the approval
13 process, et cetera. But we should be just very aware of
14 the fact that these are different drugs.

15 DR. CROSSON: Okay. So we've got Jaewon, Kathy,
16 and Larry, and Karen and -- yeah, I got you. Sorry.
17 Jaewon, then Kathy, Larry, and Karen.

18 DR. RYU: Yeah, so I think the concepts I would
19 agree with as well. I think the design is a good one. To
20 Pat's point on keeping the manufacturers somewhat involved
21 or engaged in that coverage gap, I think that resonates
22 with me.

1 One of the comments I put down was, you know, my
2 observation seems like part of the complexity of how this
3 program was created created some gamesmanship around
4 different tranches have different splits of who bears risk.
5 And the more -- just from a high-level philosophy
6 standpoint, it feels like the more we can keep consistency
7 across -- and maybe percentages themselves don't have to be
8 exactly the same, but all the actors, I think we might be
9 better off if they all have some skin in the game at each
10 tranche. And I think that kind of goes with Pat's comment
11 around the manufacturers still playing in that coverage gap
12 space if there's a way to architect it that way.

13 The second comment I had was around concentration
14 in the health plan market. In the readings, there's a
15 comment around PDP market, extremely concentrated; MA-PD
16 market, still concentrated but not as much. And I think
17 you had said that 74.5 percent would be the subsidy, but
18 now we'd convey it through capitation. I think if you
19 follow that through -- and I'm not sure, but I think it's
20 worth looking at -- that would mean the smaller plans are
21 bearing greater risk, and just sheerly from a mechanics
22 standpoint with risk-based capital requirements at

1 different state regulatory environments, there's a good
2 chance you're pushing out a lot of smaller plans simply
3 because they don't have the capital structure to support
4 staying in the business of Medicare Advantage, which I
5 think would not be a good thing. It also wouldn't be
6 consistent with other discussions we've had in this group
7 from the last cycle around how we look at five star and
8 quality measurements and the bigger multistate plans being
9 able to consolidate contracts and somewhat game the five
10 star model. And we decided that that wasn't in the best
11 interest, and this feels like a similar path we're down on.

12 And so however we could assess whether or not
13 there truly would be an unintended consequence that would
14 further concentrate the marketplace, I think that's got to
15 be part of the analysis.

16 DR. CROSSON: Okay. Kathy.

17 MS. BUTO: So I heartily support the general
18 approach, and I think beneficiaries would really welcome
19 having a simplified benefit. Right now it's very
20 complicated and hard for individuals to understand, and
21 it's certainly hard to modify their behavior to meet the
22 structure.

1 One thing I am puzzled about is I don't think
2 there is a coverage gap anymore under this proposal. Am I
3 correct in that?

4 DR. SCHMIDT: Under the proposal, correct.

5 MS. BUTO: So when people say continue the
6 discount in the coverage gap, I think they mean start the
7 discount from the very beginning all the way through the
8 catastrophic phase, which I think that's what you're
9 talking about. I think that actually is going to lead to
10 higher prices, launch prices throughout.

11 The other thing I'm not sure about -- we really
12 need Amy for this -- is to understand the dynamics of what
13 that does to the interaction between the drug plans and
14 manufacturers around rebates and their own discounts. So I
15 think it sounds right, but, on the other hand, I'm almost
16 100 percent sure it would lead to higher prices. And, two,
17 I don't know how that undermines whatever the dynamic is
18 now between manufacturers and drug plans. So I think we
19 just have to be aware of those things.

20 The other thing I would really ask that we be
21 concerned about is when we go to look at setting the
22 threshold or thinking about a threshold for the

1 catastrophic part of the benefit kicking in, that we try to
2 factor in for the non-LIS where we think drug costs are
3 really so burdensome that they really need to be attended
4 to. So we need to look at that I would say almost before
5 we do all these other calculations to figure out where just
6 logically there should be a threshold for beneficiaries
7 having to bear 25 percent of the cost, and -- because that
8 was the point of the catastrophic threshold, is to protect
9 beneficiaries.

10 I think the other policy that I agree with Pat on
11 is we should look at, at least for high-cost generics, some
12 policy there. Since the manufacturer discount in the
13 catastrophic phase is unlimited, again, we could maybe
14 address our concern about pricing by looking at those that
15 meet some threshold or where the prices seem to escalate.
16 I mean, there might be some factors we'd want to think
17 about for modifying or having different manufacturer
18 discounts depending on certain behaviors, pricing behaviors
19 that we think are important.

20 I don't know what those are, but I just feel like
21 we ought to, for restructuring the benefit, which I think
22 we are, that we ought to look at a number of factors like

1 that. But I would start with where should the threshold be
2 for beneficiaries and try to figure out what a reasonable
3 tradeoff of liability is below the threshold and above
4 among the different actors.

5 DR. CROSSON: Thank you, Kathy. Larry.

6 DR. CASALINO: Yeah, just one quick comment about
7 the use of the word "reinsurance," and this goes back to
8 what Paul said at the very beginning, and David, and you
9 mentioned, Rachel, at one point that it's not really
10 reinsurance. It's cost-based reimbursement. So I think
11 that really matters. The word "reinsurance" is used in the
12 presentation here today in two ways. In the last slide
13 here, it's used really kind of in the cost-based
14 reimbursement sense, which is kind of a novel sense,
15 really, for the word "reinsurance." And then on Slide 15,
16 for example, I think it's used more in the traditional
17 sense of, you know, reinsurance for high-cost
18 beneficiaries, say, rather than for all your cost, which is
19 cost-based reimbursement.

20 So I think it's generally -- I think you should
21 do what you can -- you're very aware of this issue, I'm
22 sure -- I know, and that the more you can do to clarify

1 that in what you do I think will really be important.
2 First of all, it's never good to use the same word for two
3 very different things. But, secondly, by doing that and by
4 using the word "reinsurance" as a synonym for cost-based
5 reimbursement, I think it really changes what the nature of
6 the debate will be, and it's giving away a lot, right?
7 Because it's like reinsurance good, cost-based
8 reimbursement bad. Right?

9 And so I think I would really try to separate
10 those two explicitly. I know the term "reinsurance" has
11 been used -- not by chance, I don't think, historically --
12 to mean really cost-based reimbursement. But this is an
13 opportunity to try to push at that a bit. I'd really
14 encourage you to try to do that and not use the same word
15 for two different things.

16 DR. CROSSON: Karen.

17 DR. DeSALVO: Thank you. This really was an
18 excellent chapter, and I found it to be very responsive to
19 some of our prior questions, so thank you for that. I also
20 want to thank you for clarifying some areas really nicely
21 like the cost-based reimbursement, reinsurance, and some of
22 the implications.

1 I want to quadruple down on Dana's point about
2 the importance of having clarify around the consequences,
3 including the unintended consequences. As I read this, I
4 did see that there was going to be likely market
5 consolidation and the implications of that for
6 beneficiaries and on drug pricing, just it would be helpful
7 to think that through.

8 The second point I wanted to raise for you all in
9 terms of tools as you start to think about formulary
10 management tools, in addition to maybe some that we've had
11 historically, we have technology available to us,
12 particularly the Office of National Coordinator and CMS
13 interoperability rules that are still not finalized, but
14 that were proposed, provide additional opportunity for more
15 seamless interface to do point-of-care decisionmaking about
16 formulary, cost of drug, not only for the clinician but
17 also for the consumer. And so as a policy matter, CMS is
18 pushing to leverage technology a number of ways, but that
19 could be an additional opportunity for the private plan.

20 DR. CROSSON: Okay. Thank you. Very good
21 comments. Excellent presentation. Again, we look forward
22 to your coming back to us with additional work, and we will

1 move on to the next presentation.

2 [Pause.]

3 DR. CROSSON: Okay. So for the second item of
4 this morning, we're going to be taking a look at some
5 potential changes to Medicare reimbursement for dialysis
6 facilities, and Nancy and Andy are here. Nancy has got the
7 microphone.

8 MS. RAY: Good morning. During today's session,
9 Andy and I will be building on work from our April 2019
10 presentation in which we discussed how the ESRD prospective
11 payment system, the PPS, pays facilities that are low
12 volume and rural and an alternative approach that may
13 better target low-volume and isolated facilities that are
14 necessary to ensure beneficiaries' access to care.

15 We seek comments from Commissioners on the
16 material presented today. This analysis is part of our
17 work to help improve the accuracy of the ESRD PPS.

18 So several factors motivated our work to develop
19 an alternative to the current low-volume and rural payment
20 adjusters.

21 First, last December and January, Commissioners
22 raised concerns about the disparity between urban and rural

1 facilities' financial performance under Medicare. What
2 really influences the Medicare margin is treatment volume.
3 The Medicare margin is decidedly lower for facilities in
4 the lowest volume quintile than facilities in the top
5 volume quintile.

6 Second, the current low-volume payment
7 adjustment, the LVPA, and rural payment adjustments do not
8 always target low-volume and isolated facilities, which are
9 critical for beneficiaries' access.

10 Lastly, the design of both adjustments does not
11 meet the Commission's principles on payments to rural
12 providers.

13 Since 2011, the ESRD PPS payment bundle includes
14 drugs and laboratory services that were previously paid
15 separately by Medicare

16 For each covered treatment that a facility
17 furnishes, its base payment rate is increased using the
18 patient-level and facility-level factors listed on the
19 slide. The current payments that are added onto the
20 adjusted base rate are also listed on the slide.

21 Today we are discussing issues with the two
22 separate facility-level adjustments for low volume and

1 rural location. Over the next year, we expect to come back
2 to you to discuss other concerns with the PPS.

3 Guiding our analysis is the very strong
4 correlation between a dialysis facility's total treatment
5 and Medicare average costs. This figure shows the 2015,
6 2016, and 2017 cost per treatment, adjusted for differences
7 in the cost of labor.

8 Facilities on the left-hand side of the figure
9 furnishing under 6,000 treatments have much higher costs
10 per treatments than facilities on the right-hand side of
11 the figure. Since 2011, when the ESRD PPS was implemented,
12 we have consistently found that cost per treatment
13 decreases as the number of treatments a facility furnishes
14 increases.

15 In 2017, about 5 percent of facilities of the
16 roughly 7,000 dialysis facilities in 2017 received the
17 LVPA, which increased facilities' base payment rate
18 substantially by 23.9 percent.

19 Eligible low-volume facilities are those that
20 furnished 4,000 treatments in each of the three years
21 before the payment year in question. The LVPA only factors
22 in the distance to the next facility if both facilities are

1 owned by the same parent organization and within five miles
2 from one another.

3 We have a couple of concerns about the LVPA's
4 design. First, some facilities are receiving the payment
5 adjustment even though they are not isolated. In 2017, 40
6 percent of LVPA facilities were located with five miles of
7 the nearest facility. An LVPA facility can be located next
8 door to another facility that could be big or small as long
9 as they are owned by different parent organizations.

10 A second concern with the low-volume adjustment
11 is that it uses only one volume threshold of 4,000
12 treatments. This so-called "cliff effect" might be
13 encouraging some facilities to limit services. And the
14 current low-volume adjustment does not address the higher
15 cost of facilities with volumes of between 4,000 and 6000
16 treatments per year that I showed you on the previous
17 slide.

18 So, in this figure, the blue bars are the
19 freestanding dialysis facilities that received the low-
20 volume payment adjustment in 2017. These facilities
21 furnished fewer than 4,000 treatments in 2014, 2015, and
22 2016.

1 The two blue bars on the left show the facilities
2 getting the adjustment that were within 5 miles of the
3 closest facilities, demonstrating that the LVPA does not
4 always target facilities necessary for ensuring access.

5 The red bars are facilities that furnished under
6 6,000 treatments in 2014, 2015, and 2016. Some of these
7 facilities, the red bar facilities, received the LVPA.
8 However, some did not qualify for the adjustment. Recall
9 the prior graph showing that facilities with 4,000 to 6,000
10 treatments have relatively high average cost per treatment.

11 So please focus on the facilities in the yellow
12 rectangle. These are both low-volume and isolated that is
13 more than 5 miles to the closest facility. Note that two-
14 thirds of facilities providing less than 6,000 treatments
15 in this yellow rectangle did not receive the LVPA. This is
16 the difference between the red and the blue bars in the
17 yellow box.

18 Moving to the 0.8 percent rural adjustment, this
19 is applied to the base rate of all facilities located in
20 rural areas. About 18 of all facilities received this
21 adjustment. Our concern here is the targeting of this
22 adjuster.

1 In 2017, about 30 percent of rural facilities
2 were located within five miles of another facility, and in
3 2017, about half of all rural facilities were higher-volume
4 facilities, furnishing more than 6,000 treatments, and had
5 lower adjusted cost per treatment than low-volume
6 facilities located in rural areas.

7 As we evaluated the ESRD low-volume and rural
8 payment adjustments and considered alternative approaches,
9 we were guided by the principles that the Commission
10 developed to evaluate rural special payments over the
11 course of several meetings and published in 2012.

12 The Commission stated that payments should be
13 targeted toward low-volume isolated providers, that the
14 magnitude of payment adjustments should be empirically
15 justified, and that the adjustments should encourage
16 provider efficiency.

17 DR. JOHNSON: Now we're going to review the low-
18 volume and isolated, or LVI, policy option that we
19 introduced in April. The LVI incorporates the Commission's
20 principle that the rural payment adjustments be targeted to
21 facilities that are both low-volume and isolated. The LVI
22 is a single adjustment that would replace the current low-

1 volume and rural payment adjustments.

2 To be eligible, first, facilities must be farther
3 than five miles from the nearest facility to be considered
4 isolated. Second, facilities must consistently exhibit a
5 low volume of treatments during each of the preceding three
6 years.

7 The LVI would expand the definition of low volume
8 to three categories. This expansion would mitigate the
9 cliff effect of the current low-volume adjustment and would
10 better account for the higher cost of relatively low-volume
11 facilities. Facilities eligible for the LVI would provide
12 fewer than 4-, 5-, or 6,000 treatments in each of the three
13 preceding years and would be assigned to the lowest
14 category for which they are eligible.

15 The next slide shows how the LVI adjustment does
16 a better job of targeting facilities that are low volume
17 and isolated and, therefore, important for maintaining
18 access to dialysis.

19 This figure shows the number of facilities
20 eligible for the current low-volume adjustment in blue and
21 the current rural adjustment in red, grouped by the number
22 of dialysis treatments provided in 2017.

1 Some facilities providing more than 4,000
2 treatments in 2017 received a low-volume adjustment because
3 eligibility is based on the three preceding years. These
4 facilities would not be eligible in the following payment
5 year.

6 The tallest red bar on the right shows that the
7 majority of facilities receiving the rural adjustment were
8 not low volume.

9 The green bars show the number of facilities that
10 would have been eligible for the LVI adjustment. In the
11 lowest treatment category, the isolation requirement would
12 have resulted in slightly fewer facilities being eligible
13 for the LVI than the current low-volume adjustment.

14 In the 4- to 5- and 5- to 6,000 treatment
15 categories, the expanded definition of low volume would
16 have resulted in more facilities being eligible for the LVI
17 than the current low-volume adjustment.

18 Among rural facilities, the LVI adjustment would
19 concentrate payments in those facilities that are low
20 volume and isolated.

21 To estimate the size of LVI category adjustment
22 factors, we conducted a regression analysis of the average

1 treatment cost in freestanding dialysis facilities. Our
2 method differs from CMS's approach which splits total
3 treatment cost across two equations -- one at the facility
4 level and one at the patient level. The text box in your
5 mailing material discusses our concern with using a two-
6 equation approach.

7 Our method uses a single facility-level
8 regression equation and included explanatory variables,
9 similar to those used in the ESRD PPS model; however, the
10 key difference is that replaced the current low-volume and
11 rural variables with the LVI category variables.

12 This table shows our estimate of the payment
13 adjustment factors for each LVI category. All estimates
14 are statistically significant.

15 The LVI Category 1 adjustment factor would
16 increase the Medicare base rate by about 31 percent. The
17 size of this adjustment is similar to our estimate of the
18 current low-volume adjustment factor, which has the same
19 volume criterion.

20 For facilities that are newly eligible for the
21 low-volume adjustment, those in LVI Category 2 or 3, the
22 Medicare base rate would increase by 27 and 19 percent,

1 respectively. These results demonstrate that there would
2 be a benefit to expanding the definition of low volume for
3 facilities that are isolated.

4 We know that the relative size of the three LVI
5 coefficients aligns with the cost and volume relationship
6 that Nancy showed you earlier. That figure is repeated
7 here.

8 In this version of the figure, the gray column
9 covers facilities that are eligible for the current low-
10 volume adjustment. However, as Nancy noted, 40 percent of
11 these facilities are located within five miles of another
12 facility and would not be eligible for the LVI adjustment.

13 The LVI adjustment would expand the definition of
14 low volume to cover additional facilities with relatively
15 low volume, as shown in the green column, as long as those
16 facilities are located farther than five miles from the
17 nearest facility.

18 We also estimated how average Medicare payment
19 rates would change for freestanding facilities by replacing
20 the LVPA and rural adjustments with the LVI category
21 adjustments. Payment rate changes depend on the facility's
22 eligibility for each of the adjustments.

1 For about 180 facilities that are eligible for
2 Category 1 LVI adjustment, payments would remain roughly
3 the same, as this adjustment would basically replace the
4 current low-volume adjustment.

5 For about 280 facilities that are eligible for
6 LVI Categories 2 and 3, payments would increase by about 18
7 percent, as these facilities are newly eligible for a low-
8 volume adjustment.

9 For about 260 facilities that are currently low
10 volume, these facilities are located within five miles of
11 another facility. Such facilities would not be eligible
12 for a low-volume adjustment and would see a payment
13 decrease of about 20 percent.

14 The current low-volume adjustment subsidizes low-
15 volume facilities that are near other facilities. One goal
16 of the LVI adjustment is to improve the value of Medicare
17 spending by supporting only low-volume facilities that are
18 essential to maintain access to dialysis care.

19 In summary, based on the Commission's rural
20 payment adjustment principles, we are concerned that the
21 current low-volume and rural adjustments poorly target
22 facilities that are both low volume and isolated.

1 We have discussed replacing the current low-
2 volume and rural adjustments with a single-payment
3 adjustment for facilities that are both low volume and
4 isolated.

5 Second, the LVI payment adjustment would consider
6 a facility's proximity to any other facility, not just
7 those under common ownership. Some facilities receiving
8 the current low-volume adjustment would not receive the LVI
9 adjustment, as they are located near other facilities.

10 Finally, the LVI adjustment would expand the
11 definition of low volume. The proposed three categories
12 are designed to mitigate the cliff effect and to account
13 for the higher treatment costs of facilities providing
14 between 4- and 6,000 treatments per year.

15 We would appreciate feedback on aspects of the
16 LVI adjustment such as whether five miles is an appropriate
17 definition for isolated facilities and whether additional
18 LVI categories are necessary.

19 Based on Commission feedback, we can develop a
20 recommendation for December that would replace current low
21 volume and rural adjustments with an LVI adjustment in the
22 ESRD PPS.

1 In the spring, we will turn out focus to other
2 aspects of the ESRD PPS, which include modeling
3 alternatives to the current patient-level adjustment
4 factors and revising the method used to estimate those
5 factors.

6 We look forward to your comments, and I'll turn
7 it back to Jay.

8 DR. CROSSON: Thank you, Nancy and Andy.

9 I'd like to start with one question myself. One
10 possible ramification of adopting the LVI recommendation
11 would be consolidation of certain facilities, let's say,
12 within five miles who don't qualify for the low-volume
13 adjustment. You could imagine market dynamic leading to
14 consolidation of those facilities.

15 This presentation is not focused on quality, but
16 could you remind me? Do we have --and what is our thoughts
17 about the relationship between -- the number of dialysis
18 procedures and quality?

19 MS. RAY: Oh, I'm sorry. The volume and quality?

20 DR. CROSSON: No, I'm sorry. Volume and quality.

21 MS. RAY: Okay. I did not quite follow that.

22 Thank you for the clarification.

1 I would have to get back. That's a very good
2 question.

3 DR. CROSSON: Okay. I'm sorry. It's not part of
4 the presentation.

5 MS. RAY: But let me just say this. In terms of
6 -- I'm just trying to triage my thoughts here. In terms of
7 CMS's Quality Incentive Program, because of the sample size
8 needed to be part of the QIP, the ESRP QIP, we may not have
9 some of the quality data for those facilities.

10 What I can do is get back to you and look at the
11 availability of QIP data and look at the availability of
12 dialysis, facility star data, to answer that question.

13 DR. CROSSON: Right. So the point I was getting
14 at is if there's going to be consolidation, good, bad,
15 what's the tradeoff? Anyway, to the certain extent we can
16 look at that, it would be great. If we can't, we can't.

17 Larry, did you want to make a point on this?

18 DR. CASALINO: Yes. It would be interesting to
19 know, I think, of the low-volume facilities that are close
20 to another facility, what is their quality? Pretty much
21 what Jay is just asking, I think.

22 But then, also, it would be interesting to know

1 the low-volume facilities that are within five miles of
2 another facility, who owns them? There are really two big
3 dialysis providers in the U.S., and we may or may not think
4 that them getting even bigger is a good thing.

5 One possibility, these are sitting near little
6 mom-and-pop dialysis facilities that have low quality, and
7 they'll disappear. And the industry will be more
8 consolidated. We may not like that, but we may think okay.

9 By the way, to really try to understand the
10 consequences of this, I think we would need to know both
11 what is the quality and also what's the ownership
12 distribution.

13 Other than that, this is a very, very lucid
14 presentation and elegant and simple solution. The
15 complexity of this seems so much less than what we were
16 just talking about. I like this one.

17 [Laughter.]

18 DR. CROSSON: Right. This is a positive comment,
19 by the way.

20 Karen, did you want to comment on this as well?

21 DR. DeSALVO: I do have something on
22 implications, but I have another point.

1 DR. CROSSON: Go ahead.

2 DR. DeSALVO: I went pretty micro on you guys on
3 this on the question of consolidation, and I wondered about
4 impact on beneficiaries who live near a state line and if
5 there are implications for closure, particularly if they
6 were dually eligible or if there are some other payment
7 considerations. And I just don't have enough knowledge to
8 know what that might mean, but maybe it's only a handful.
9 But perhaps that's an exception to the rule kind of
10 situation.

11 The other question I had, do we have any idea, by
12 the way? Do we know? Do you have a map of what we think
13 the --

14 MS. RAY: No, we don't, but we will.

15 DR. DeSALVO: Okay. And my other questions was
16 about benefits that are offered by dialysis units. So five
17 miles, I would appreciate you all getting more narrow on
18 the radius, but the question was, Do dialysis units offer
19 transportation to folks who don't have it otherwise?
20 Because in rural communities, there's unlikely to be public
21 transportation. They may not have a car or gas money or
22 even a bicycle.

1 MS. RAY: Right. So some dialysis facilities do
2 provide transportation to beneficiaries, yes. And we were
3 mindful of, you know, well, should it be 5 miles? Should
4 it be 10 miles? And given that, you know, a majority of
5 patients right now do go to the facility three times a
6 week, over time -- you know, there's the expectation that
7 home dialysis will increase, but there still will be a
8 population of incenter patients. And there is literature,
9 you know, showing that at least for certain patient
10 populations that dialysis adherence is affected by the
11 travel distance to the facility.

12 So current CMS uses that 5-mile in its low-volume
13 adjustment, and we thought it was a good starting point.

14 DR. CROSSON: Okay. Let's see. I've got --
15 Larry, we already got you. So we've got David next, and
16 then let's go Jaewon, Sue, Dana, Marge. Got it.

17 DR. GRABOWSKI: Nancy, I think you already
18 started to answer my question. I was going to ask you
19 about this 5-mile cutoff, and I know that is what CMS has
20 used. But I just was wondering if there was more empirical
21 support for why 5 miles. And, 25, to your point, strikes
22 me as too wide. I have no reason to think 5 miles is the

1 right or wrong cutoff. I'm just curious, have we, as a
2 Commission, thought about sort of looking at variation
3 around that, in travel distance, and whether 5 miles is the
4 right number?

5 MS. RAY: Again, internally, the discussion was
6 balancing the need to be consistent with the Commission's
7 principles on focusing on low volume and isolated
8 facilities, and also on patients' travel time to and from
9 the dialysis facility. We certainly could model other, you
10 know, distance thresholds, just to show the effect.

11 I can also go back and include some of the
12 literature on patient adherence and travel time in our next
13 go-around.

14 DR. GRABOWSKI: And this is just a quick -- oh, I
15 was just going to -- go ahead. Sorry.

16 DR. CROSSON: Yeah, I was just going to comment.
17 I mean, this has come up before, the issue of distance
18 versus travel time, and obviously travel time in a rural
19 setting, you know, with a highway available, versus travel
20 time in Manhattan at rush hour, those are two different
21 things.

22 I think the general -- and recognizing that, I

1 think the general thought we have had, as we have discussed
2 this previously, on this and different issues, is while,
3 you know, that's a valid consideration, actually trying to
4 craft that into some kind of law would be very difficult,
5 because travel time varies by the time of day, et cetera,
6 et cetera. So it's hard to do.

7 DR. GRABOWSKI: That makes sense that a fixed
8 road mile cutoff would be the right approach.

9 I guess the other thought -- and maybe I've taken
10 too much economics -- is there any thought that the
11 industry is going to adjust to this, in terms of their
12 decisions about how to locate and where they sort of place
13 themselves, vis-à-vis competitors, or is that something
14 that is just sort of they're fixed, or you can just sort of
15 tell me I've taken too much economics, and that's fine.

16 MS. RAY: Right. I mean, it's a complicated
17 question, and I know some of the earlier questions about
18 the potential for consolidation under the LVI. I mean, I
19 think it's a multifaceted decision about, you know, if the
20 LVI was implemented what would providers' reaction be? I
21 mean, for example, on the one hand there is a movement
22 towards more home dialysis, and we have heard a couple of

1 the larger providers announce that they may be opening
2 fewer de novo facilities in the next several years.

3 Another reaction might be for the facility
4 getting the LVPA right now, who would no longer, under this
5 policy, that facility may decide to expand their treatment
6 volume. I mean, they could be one of those providers that
7 may be limiting.

8 I think another factor in terms of really nitty-
9 gritty issues is sort of the real estate. You know, do
10 they own? Do they lease? When does the lease come due?

11 So I think it's a very multifaceted decision.

12 DR. CROSSON: Okay. Marge.

13 MS. MARJORIE GINSBURG: Thank you for this
14 report. It was clear, I could understand it all. I
15 appreciate that.

16 Just a couple of very quick questions. Have many
17 facilities closed due to insufficient payments? That's
18 question one. And sort of linked to that is, are there any
19 commercial patients? I mean, by the time people have end-
20 stage renal disease are they virtually all on Medicare, and
21 therefore there is no role for commercial insurance and
22 what they may be paying for the services, for their

1 members? So I was just curious whether there's any role
2 for commercials.

3 And then the last question is -- and this is kind
4 of related to the quality issue -- has there been any
5 evidence of inaccurate upcoding of patients? And I realize
6 this was not about the quality of the information that
7 we're getting and the legitimacy of payments, but I was
8 curious whether, in your work, you've also been looking at
9 the issue of upcoding. Thank you.

10 DR. JOHNSON: I'll address the last one and then
11 Nancy will address the first two. We haven't found issues
12 of inaccurate upcoding but there is a related diagnostic
13 coding issue, which we're going to get to in the spring,
14 the comorbid conditions that are part of the patient level
15 factors. So that's something we will come back to, but
16 it's not the same situation as what we've heard of as
17 upcoding in other sectors, like MA or PEC.

18 MS. RAY: Okay. In terms of your first two
19 questions, are patients all on Medicare? No. There are
20 some commercial patients. And the percent of commercial
21 patients, that will vary across facilities. And that would
22 probably be another factor in a facility's decision, that

1 is getting the LVPA, who wouldn't under this policy,
2 whether or not -- you know, what they would do.

3 In terms of closures, we report on that every
4 year in our adequacy analysis. That's upcoming in
5 December. We see few closures from year to year, and there
6 has been a net increase of facilities in each year.

7 DR. CROSSON: Yeah, I would add one thing, and my
8 understanding is that commercial payment rates are
9 generally in the range of four times what Medicare
10 reimburses. So while the number is small, for some
11 facilities the impact is significant.

12 MS. MARJORIE GINSBURG: [Off microphone.]

13 DR. CROSSON: Jaewon.

14 DR. RYU: Yeah. I just had a quick question
15 around, is it contemplated that this approach would be done
16 in a budget-neutral way, and if not, what is the
17 anticipated net-net impact to the program?

18 DR. JOHNSON: We would anticipate it being done
19 budget-neutral, as all updates to the ESRD PPS are
20 conducted. I think it's hard to say exactly what the
21 impact would be from this change. Roughly, the amount of
22 money going to the two current adjustments and the three

1 adjustments as we have proposed, are in the same ballpark.
2 But it also might depend on if we consider other changes to
3 the patient-level factors. All of those factors are
4 estimated jointly in one regression model, so we think that
5 it would be a small impact if it was on its own, but that
6 is sort of a counterfactual. It is not necessarily what
7 the case would be if CMS were to estimate this through
8 their own process.

9 DR. MATHEWS: But the intent here, to be clear,
10 is that this would be done in a budget-neutral manner.

11 DR. CROSSON: Sue.

12 MS. THOMPSON: Back to page 10, in the fourth
13 set of data there, what do we know about the
14 characteristics of those facilities that would be obviously
15 negatively impacted by this set of recommendations? And
16 specifically, kind of building on that question, how many
17 of these facilities are hospital-based? I mean, we assume
18 that these two big players in this business are, you know,
19 the predominant players, but how many of them, particularly
20 in rural locations, are running out of critical access
21 hospitals and are hospital-based facilities? Do we know?

22 DR. CASALINO: [Off microphone.]

1 MS. THOMPSON: I am asking, in this population of
2 all of these facilities, how many of them are hospital
3 based?

4 DR. JOHNSON: In our analysis we have looked only
5 at the freestanding facilities. We can provide more
6 information about the hospital-based facilities.

7 MS. THOMPSON: Okay.

8 MS. RAY: Also keep in mind that hospital-based
9 facilities represent 6 percent of all facilities and only 5
10 percent of all Medicare treatments.

11 MS. THOMPSON: Of all?

12 MS. RAY: Yeah, of all Medicare treatments,
13 that's correct, and that this share has been generally
14 going down over time.

15 MS. THOMPSON: And do we think that those
16 percentages play in this subset as well, in this low-volume
17 and rural set of facilities?

18 MS. RAY: Again, we will come back with you and
19 address that.

20 DR. CROSSON: Okay. Dana.

21 DR. SAFRAN: Thanks. I have a couple of
22 questions that are in the realm of trying to understand

1 home versus center-based dialysis. Is home-based dialysis
2 volume included in the volume for the centers that you're
3 describing here?

4 MS. RAY: Yes, and certain centers can just be
5 home-only facilities.

6 DR. SAFRAN: Okay.

7 MS. RAY: Correct.

8 DR. SAFRAN: Okay. And do we know anything about
9 the differences in the cost profile, you know, cost per
10 treatment for home versus center-based?

11 MS. RAY: No, we don't, and I think -- looking at
12 the data on the cost reports and trying to compare in-
13 center and home is a little bit tricky, because of the
14 relatively -- at least, you know, up until this point,
15 small sample sizes, small number of facilities that furnish
16 high enough volumes of home dialysis to, you know, utilize
17 their cost data.

18 DR. SAFRAN: Okay. So let me ask it this way.
19 Is there something that you think that is included in the
20 proposed approach to the policy revision that would be wind
21 in the sails of a moment toward more home-based dialysis?

22 DR. JOHNSON: Not specifically for home-based

1 dialysis. I guess if there was a reason for a facility to
2 locate itself farther than 5 miles from a currently
3 existing facility, there might be some benefit there, but
4 that wouldn't be specific to a home-based facility.

5 DR. SAFRAN: Okay.

6 DR. CROSSON: Jon, on this point?

7 DR. PERLIN: On this point -- and this may be
8 something that Jonathan Jaffery, as a nephrologist, can
9 illuminate. Obviously there are certain benefits for home
10 dialysis. Patient complexity and their frailty mitigates
11 against those aspirations. But I am wondering how you
12 considered the impact potentially of changing technology.
13 So, for example, there are emerging technologies that use
14 small volumes of dialysate as opposed to, you know, a
15 constant stream of purified water, et cetera, and these
16 technologies are inherently more mobile.

17 I am reminded of, you know, Clay Christensen's
18 work on innovation. Do you see this potentially inviting
19 additional development of that purposefully low-volume and
20 isolated centers by virtue of changing technology?

21 DR. JOHNSON: I don't think that's something
22 we've gotten into yet, but we can consider that further.

1 And are you thinking specifically for home dialysis being
2 mobile type technologies, or another facility-based
3 alternative?

4 DR. PERLIN: You know, small-volume facility-
5 based, because the technology is inherently less complex.
6 The patients are equally complex, but the ability to
7 distribute, you know, it's kind of like the micromole
8 analogy that Christensen writes about, where you may be
9 able to distribute -- still manage the frailties of
10 patients in a way that you can't do at home, yet disperse
11 the technology in a way that the historical approach has
12 not allowed.

13 DR. DeSALVO: Just on this point, one model of
14 this might be to have dialysis available in a tractor
15 trailer that is moved around from location to location.
16 And that would beg the question of, what does 5 miles mean
17 if you're moving from one big box store to another, to do
18 dialysis, or whatever that's going to be, one faith-based
19 organization on the weekend to do dialysis, and how does
20 the 5 miles, et cetera, get into that?

21 I think you're probably, not right away -- this
22 is not a near-term issue, but if we're going to fix the

1 policy it might make sense to think about some of the
2 innovations that are being thought of to help reach hard-
3 to-reach populations.

4 DR. CROSSON: Okay. We're going to move on to
5 the discussion. Oh, sorry. Larry.

6 DR. CASALINO: So I understand that there needs
7 to be a hard cutoff for what low-volume means, because you
8 have to be low-volume and isolated. And when I first read
9 it I thought three categories of low-volume makes sense.
10 But then thinking about this some more, you have to have
11 the hard cutoff, like 6,000, whatever, for low-volume, but
12 below that, do you think it's better to make two categories
13 below that, two more categories, or use a continuous
14 standard for pay?

15 I ask that because I remember years ago being at
16 a major medical center interviewing some of the top
17 executives, and it was a time when a lot of attention was
18 being paid to leapfrog volume standards for cardiac
19 surgery. And they were joking that -- this was in
20 February, and they were joking in December of the previous
21 year, they were just one short of the volume standard for
22 cardiac surgery. And the CEO nodded to another director

1 and said, "You know, Dr. So-and-So here volunteered to have
2 his chest cracked open so we could hit the standard."

3 So the less of that, the better, it seems to me.
4 So is there a reason it couldn't be done continuous below
5 the hard cap at the top?

6 DR. JOHNSON: So we heard this comment last time
7 as well, and I think where we got to in this time, you
8 know, we spent a lot of time getting our data together to
9 run some models, but I think the current requirement is to
10 identify consistently low-volume facilities, and the
11 easiest way to do that is to apply a cap in each year. If
12 you were to conduct a continuous adjustment, I think you
13 would have to contemplate some averaging across years, or a
14 total volume across the three years.

15 And we looked at some of the low-volume
16 facilities and saw some new facilities who had low volumes,
17 still sort of low-volume, and then really high volume. And
18 those facilities would have met an averaging criteria but
19 they fall out in our criteria. And those types of
20 facilities are not the ones that we are trying to target
21 here.

22 So I think there is room for some more discussion

1 but we just didn't quite go straight to considering a
2 continuous function, but we would certainly welcome more
3 comments on that.

4 DR. CASALINO: To be clear, there would be one
5 cutoff. If you were below X, 6,000, you would be in the
6 low-volume, but then below that there's the way you get
7 paid, instead of having two categories it would be
8 continuous. And I was just asking if that would be
9 possible or if you think it would be better.

10 DR. JOHNSON: We can certainly think about that.

11 DR. CROSSON: Okay. We'll move on to the
12 discussion. Jonathan?

13 DR. JAFFERY: Yeah. Thanks, Jay, and thanks to
14 both of you. This was a great presentation and great
15 chapter, and I think, you know, despite some of the
16 conversation earlier that, you know, this seems so simple
17 compared to the previous one. I think as we get into this
18 clearly there is more and more complexity.

19 And I really appreciate, this is a unique,
20 complex patient population, right? They have an intensive
21 therapy that is ongoing, that requires, at least in in-
22 center hemodialysis, three times a week, half-a-day

1 treatment. It's 7 percent of the Medicare budget, or
2 something along those lines. So it continues to be an
3 important topic.

4 I wanted to spend just a couple of seconds giving
5 everyone a little bit of context thinking about how
6 treatments have changed over time. There was a point,
7 decades ago, where there was more home dialysis,
8 particularly peritoneal dialysis, and this starts to speak
9 to changes in technology that allow other opportunities.

10 Over time, various drivers -- economic,
11 demographic, educational -- resulted in more dialysis units
12 opening up, and then that created an opportunity for more
13 in-center hemodialysis. And then, over time, that becomes
14 a bit of a cycle, where fellows are less experienced with -
15 - again, this was traditionally more peritoneal dialysis,
16 but home dialysis overall, which then makes them more
17 comfortable with offering patients preferentially in-center
18 hemodialysis. And now you have a cycle where it's mainly
19 in-center hemodialysis.

20 So I think, you know, Nancy, you said this
21 several times and others have commented about the changes
22 that we're seeing that maybe incenting more home dialysis,

1 whether that is through payment policy or complex
2 technologies like home dialysis units, or home dialysis
3 technologies that get simpler to use, or maybe even simple
4 technologies like how do we have mobile dialysis units,
5 which I know some places have actually tried to look at.

6 So I think regardless, we're going to need to
7 keep paying attention to this. Some of the things that
8 we're talking about here, that people have mentioned, feel
9 like they're somewhat arbitrary, in terms of 5 miles versus
10 10 miles, even if directionally they make sense, but I
11 think we are really going to have to keep an eye on things
12 as they evolve, as they inevitably will, because of all
13 these changing factors.

14 So that said, I think that adding simplicity to
15 this and targeting it towards the places where we think the
16 policy adjustments or the payment adjustments were intended
17 is laudable, and so I really support trying to move in this
18 direction of a more targeted and simple payment approach.

19 I think the idea of thinking about proximity to
20 all facilities rather than just the ones that are
21 individually owned aligns with our goals and incentives as
22 well.

1 In terms of the five-mile thing, again, probably
2 a little bit perhaps arbitrary. I think not changing the
3 current standard makes sense. And I do agree with what
4 others have said that the 25 miles may not seem like a far
5 distance for certain things, but when we think about what
6 people have to do to travel three times a week, you know --
7 so I've taken care of dialysis patients for a couple
8 decades now in both Vermont and Wisconsin, and people may
9 recall that sometimes there's snow in those places, and at
10 least one of those places has mountains. So it can be
11 pretty hard for people to get through winding mountainous
12 roads in the snow. And we do get into -- it's not
13 impossible to get into some emergency situations that
14 people can't get to treatment sometimes. So making that
15 easier makes some sense.

16 And then, finally, I think avoiding cliffs is a
17 good idea, not only for the reason that you mentioned about
18 incentives for facilities to do things that might limit
19 beneficiary access with that cliff, but also, as you've
20 shown, there's evidence that facilities greater than 4,000
21 treatments a year have some -- are not covering their
22 facility costs with their per treatment cost, and I think

1 it just aligns with our goals of private pay providers
2 adequately.

3 Thanks.

4 DR. CROSSON: Thank you, Jonathan. Further
5 discussion? I see Kathy and Dana and Amol.

6 MS. BUTO: I want to support the recommendations
7 and moving in this direction, but Jonathan and Dana's
8 comments just prompted me to want to mention one thing from
9 history, and that is, there was a time when there was a
10 real spike in the use of home dialysis, and the reason for
11 the spike, it turned out, is we were paying reasonable
12 charges for home dialysis that were so high -- I don't know
13 if it was twice as high as the in-facility rate, but it was
14 pretty high -- to the point where the home dialysis
15 provider was able to offer free medical assistance to come
16 to your home and help you with home dialysis.

17 We proceeded to try to put a cap at the in-
18 facility rate and found ourselves in court. I think
19 eventually what happened, I think we lost that case. I
20 testified, and I remember the judge was not too sympathetic
21 because these patients are very sick, and if you can keep
22 them at home with an assistant, you know, it sounded very

1 appealing to him. But we got a change in the law.

2 So I'm just saying as we look at the issue of how
3 do you promote more home dialysis, I think it bears more
4 work to look at, you know, what are the obstacles and what
5 might we do from a policy perspective that won't really
6 distort the incentives in a way that promotes more home
7 dialysis where possible.

8 DR. CROSSON: Thank you. Dana.

9 DR. SAFRAN: Yeah, I'm fully supportive of the
10 direction that you're moving here. I really like it. And
11 I have three comments to offer.

12 One is building on this issue of home dialysis
13 and Jonathan's add to that around just innovation. I'd
14 like us to really think about how we can structure this in
15 ways that promote innovations and doing the very best for
16 quality of life for beneficiaries who need dialysis. This
17 is just a monumental impact to people's quality of life,
18 and so whatever we can do to promote home dialysis where
19 that's safe and, you know, can be done effectively without
20 huge cost implications seems really important.

21 Second is that I was thinking on similar lines to
22 what Larry suggested, which is I love that you're trying to

1 address the cliff, but I fear that we've now got three. So
2 I'd love to see a smoothing of that to incentives, and I
3 hear your point that, you know, you don't want to average
4 across three years and then, you know, be paying for low
5 volume when you don't actually have low volume anymore. So
6 I do take that point and recognize we have to address that.
7 But let's think about an approach that won't give us three
8 cliffs rather than one.

9 And then the last is I know you mentioned that
10 there actually is a quality incentive program for this
11 field and that you're going to come back and be talking
12 about that later. So I don't think I've learned about that
13 program yet and will be interested in it and think it will
14 be really important to think about it again with respect to
15 home- versus center-based dialysis and how we can learn, if
16 we don't already know, the differences in quality but also
17 just making sure that we are building into that quality
18 program the same kind of principles that we've been
19 systematically building into all of the quality programs
20 that we touch. So I'm looking forward to seeing what the
21 proposals will be there.

22 Thanks.

1 DR. CROSSON: Thank you, Dana. Amol.

2 DR. NAVATHE: Thanks for this great work, and I
3 certainly echo a lot of the comments made before.

4 I think in some sense I feel like it's helpful to
5 take a step back as we're thinking about why we have this
6 program in the first place around isolated, low-volume
7 facilities. I think it's framed in some sense around the
8 additional costs of providing dialysis services in lower-
9 volume facilities.

10 If we take a step further back from that, I think
11 it's about access, and in some sense you can think about an
12 analogy here being kind of like the critical access
13 hospital. And so what struck me is we might want to be
14 thinking quite carefully about this access pieces or
15 perhaps a little bit more deliberately about the access
16 piece. Again, in some sense, you know, our goal here is to
17 match supply with demand or try to induce a matching of
18 supply with demand such that we're getting to the right
19 point from an access perspective. And while we do -- and I
20 think I would certainly endorse this approach over what we
21 have now. I think it's a step in the right direction. We
22 do want to try to address some pieces of, you know, sort of

1 gaming that could happen where facilities could be shopping
2 up essentially to get access to these subsidies in essence.

3 I think it's worth trying to understand how, you
4 know, the sort of five-mile radius piece, but kind of what
5 is the market, local market for ESRD services. How do
6 patients actually flow? And, you know, we used MedPAC
7 markets as part of the analysis. I think it might be worth
8 taking a step back and understanding how that sort of
9 natural structure of ESRD services looks from a geographic
10 perspective. And then in that context, either in those
11 markets or the other markets that we're using here, MSAs,
12 MedPAC markets, otherwise, thinking about other metrics of
13 access. So, you know, ESRD patients to, quote, ESRD beds,
14 you know, in some sense, or other capacity to utilization
15 type of metrics. Because one thing that struck me is there
16 was kind of an assumption, I think, made. On page 10 of
17 the paper, we had Figure 2 shows that some LVPA facilities
18 were located near other facilities, suggesting that they
19 may not have been essential for ensuring access to care.
20 And I think sort of borrowing David's point about having
21 learned some economics, I think we would assume to some
22 extent that suppliers are responding to the need and,

1 therefore, are locating themselves where there is volume.
2 That may not be perfectly the case when you have these
3 regulated prices, and so there may be some distortions.
4 But I think we should directly look at access metrics as a
5 way to ensure that what we're doing is actually creating
6 greater alignment around access.

7 DR. CROSSON: Thank you, Amol. Larry.

8 DR. CASALINO: So, again I'm generally very
9 supportive and I like the clarity of what you've done.
10 Just one more question about the low volume but close to
11 another facility. We talked earlier about possible effects
12 on consolidation and asked what's the quality of the low
13 volume but not isolated, because you imply in what you
14 wrote that if they're low volume but not isolated, they
15 should just merge maybe. And if they're low quality, the
16 low volume and not isolated, that might be a good solution.

17 But I do think we need to think about the effects
18 on competition and hat that can mean for access, quality,
19 transportation. So let's suppose there's a low volume not
20 isolated that's just kind of okay for quality, and then
21 there's a high-volume corporate place nearby, and the
22 little guy goes out of business. What effect will that

1 have, for example, on the offering of transportation, for
2 example, from the big facility that's the only place left?
3 Because I think that is a decision point or a point of
4 competition that families and the dialysis patients care
5 about. Is there transportation available? For
6 emergencies, as Jonathan was -- my mother was on dialysis
7 for ten years, so I kind of got to see this in action. So,
8 on the one hand, there's the emergency, my God, the person
9 can't get dialyzed at all. But there's also the driving
10 home from dialysis. You don't really feel so good after
11 dialysis, and if there's not someone to drive you home,
12 you're driving yourself, you know, that matters. And some
13 people might prefer if there's transportation.

14 My sense is -- and, Jonathan, you probably know
15 better -- that most places do offer transportation in some
16 way or another, but it's not that great if you have to wait
17 three hours after your dialysis to get the transportation.
18 So I'm just asking, think about if we cut competition,
19 there's only one left, does that matter or not? And I
20 don't have the answer to that.

21 DR. CROSSON: Kathy.

22 MS. BUTO: Nancy or Jonathan, I don't know if you

1 know, but I think the U.S. is the only country that deals
2 with dialysis as an industry the way we do, with a lot of
3 in-center facilities versus other options. And I wondered,
4 as we look at this broader question of access, whether
5 there's some work that could be done to look at what other
6 at least OECD countries are doing in that regard. And I
7 assume you know already. But my understanding is that we
8 are the only country that has this extensive network of in-
9 center dialysis. Maybe I'm wrong.

10 DR. JAFFERY: Well, I haven't looked at this in a
11 while, and maybe you guys know more. But I don't know how
12 they're distributed in other countries, but most other
13 countries, as I recall -- and, again, it's been a while
14 since I looked at it -- were more in-center than not, with
15 a few exceptions. I think Mexico stands out as a place
16 that always did a lot of peritoneal dialysis, but --

17 MS. BUTO: Yeah, I was thinking of other
18 alternatives like mobile units and so on. But --

19 DR. JAFFERY: I don't know about things like
20 mobile units.

21 DR. CROSSON: Okay. I wasn't sure what you were
22 saying. I thought you were implying that in many countries

1 it's done in acute-care hospitals or outpatient --

2 MS. BUTO: I think that's also true.

3 DR. CROSSON: Yeah.

4 MS. BUTO: In other words, I think we're -- I
5 could be wrong, but I think we're the only one that has a
6 big for-profit industry like this, and that others have
7 smaller community-based and other options, and I thought
8 some mobile units as well, more home dialysis, et cetera.

9 DR. JAFFERY: You know, I think there are a
10 number of dynamics in other countries where you don't have
11 -- it's not as common for people as they get older with
12 multiple complex chronic conditions to necessarily either
13 be offered or receive dialysis, and it's a different
14 dynamic than we have here, of course. And I just don't
15 know exactly, but what I do know, though, is that one of
16 the two large dialysis organizations is based in another
17 country, in Europe, so that suggests that there's some
18 market there for it.

19 Can I make one other comment?

20 DR. CROSSON: Yeah.

21 DR. JAFFERY: I think it would be really
22 interesting to come back to this quality discussion, and I

1 know that's not for today, but, you know, thinking about
2 certainly wanting to have the quality measures line up with
3 our overall philosophy and be consistent with what we do in
4 other areas and other sectors that Medicare pays for, but
5 also thinking about some of the unique factors that might
6 not be captured here, I'm thinking about -- especially with
7 these shifts towards home dialysis, I'm thinking about what
8 that really means for quality of life for people in terms
9 of traveling, not just transportation to individual units,
10 but, you know, we're talking a lot about this population as
11 being very fragile and frail, and certainly we want to be
12 considerate of that. But I think we also want to remember
13 that there are a lot of people who still work and still
14 travel and want to be able to do those things. And a lot
15 of time and effort has gone into trying to facilitate
16 travel for people on in-center dialysis, which may be
17 something that is easier to do if you're doing it yourself
18 and you can get the supplies appropriately, there's ways to
19 do it.

20 So I think we want to think a lot about what
21 those quality metrics mean in terms of not only outcomes
22 and cost but really patients' quality of life.

1 DR. CROSSON: Okay. Thank you for this excellent
2 work, and I think we have supplied you with some additional
3 food for thought, and we'll be seeing you again.

4 That ends this topic, and we now have time for a
5 public comment period. If there are any of our guests who
6 wish to make a comment on the matters before the Commission
7 this morning, please come forward to the microphone.

8 [No response.]

9 DR. CROSSON: Seeing none, we are adjourned until
10 1:45.

11 [Whereupon, at 11:56 a.m., the meeting was
12 recessed, to reconvene at 1:45 p.m. this same day.]

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1 MR. O'DONNELL: I'm just going to go down the
2 row.

3 Jaewon, you asked for more information regarding
4 the decline in primary care physicians' billing.

5 And, Bruce, you provided several suggestions to
6 improve our volume analysis.

7 Before we get into these topics, Carolyn will
8 provide some context on how these changes fit into our
9 payment adequacy framework.

10 MS. SAN SOUCIE: Today's presentation is
11 regarding updates to the methods used to assess the
12 adequacy of Medicare payments for physicians and other
13 health professional services.

14 The updates you see today will be included in our
15 December presentation. Every year, we use the following
16 factors to assess payment adequacy for physicians and other
17 health professionals: beneficiaries' access to care,
18 quality, and Medicare payments and providers' costs.

19 Today we will be presenting updates to our
20 methods of calculating the first factor: beneficiaries'
21 access to care. Although there are additional indicators
22 of beneficiaries' access to care, including the

1 Commission's annual beneficiary access survey, we have
2 updates on two indicators in this presentation. First, we
3 will discuss the supply of providers. Second, we will
4 update our analysis of volume of services.

5 Regarding supply of providers, we have an updated
6 estimate of the number of hospitalists billing the Medicare
7 program.

8 To begin, I will define the hospitalist specialty
9 as well as give its role today. Then I will contextualize
10 trends we see in the number of hospitalists with trends
11 related to primary care within the Medicare program.

12 Hospitalists are physicians whose primary focus
13 is the general medical care of hospitalized patients.

14 The first program utilizing a hospitalist model
15 of care in the United States was implemented in Minnesota
16 in the 1990s. Several factors influenced the creation of
17 the program, including previously inefficient use of
18 physician time and delays in discharging patients.

19 The model departs from the historical practice of
20 primary care physicians, or PCPs, rounding in hospitals.
21 Instead, it relies on hospitalists to monitor the progress
22 and tend to the needs of hospital inpatients, while primary

1 care physicians focus on office-based care. The use of
2 hospitalists quickly spread throughout the country, and
3 they now serve a prominent role in inpatient care.

4 Many factors may influence residents' or
5 physicians' decisions to become hospitalists. Namely,
6 hospitalists' training, salary, and schedule may be
7 influential in that decision-making.

8 Regarding training, most hospitalists are board-
9 certified in internal medicine, and no additional sub-
10 specialization is necessary to practice hospital medicine.

11 Concerning salary, hospitalists earn
12 substantially more than primary care physicians on average.
13 One survey found that in 2018, hospitalists earned about
14 \$36,000 more per year than PCPs. Median compensation is
15 about 243,000 dollars for PCPs and 278,000 dollars for
16 hospitalists.

17 Lastly, hospitalists' schedules often consists of
18 working for several consecutive days and then having the
19 same amount of time off. For example, one common schedule
20 is to work 12-hour shifts for seven consecutive days and
21 then have seven days off. This type of scheduling, which
22 does not involve being on call, may be attractive to many

1 new physicians. Young physicians may increasingly choose
2 to become hospitalists because doing so requires no extra
3 medical education, increases their salaries, and may
4 provide a more favorable work-life balance.

5 However, this is a potential cause for concern
6 because hospitalists are drawn from the same physician
7 specialty that constitutes a large share of the primary
8 care supply: internal medicine.

9 Indeed, recent data from a survey of third-year
10 internal medicine residents suggest that the share of
11 residents who plan on practicing general internal medicine
12 has declined substantially over time.

13 Meanwhile, the share who plan on becoming a
14 hospitalist has increased. Because general internal
15 medicine physicians constitute a substantial share of
16 primary care physicians, a shift away from general internal
17 medicine could affect the supply of PCPs.

18 From 2002 to 2018, the share of third-year
19 internal medicine residents who plan on practicing in
20 general internal medicine declined from 23 to 11 percent,
21 while the share who plan on becoming hospitalists increased
22 from 9 to 19 percent. The share who planned to

1 subspecialize remained relatively flat in comparison.

2 I'd like to also note that although it is not
3 reflected in the figure, the percentage of respondents who
4 were unsure of what they wanted to practice increased
5 during this time as well.

6 In its annual assessment of payment adequacy, the
7 Commission tracks the number of clinicians who bill the fee
8 schedule as an indirect measure of access to care.
9 Historically, the Commission has tracked the number of
10 physicians who bill the fee schedule in two groups --
11 primary care physicians and other specialties.

12 The Commission defines PCPs as those who billed a
13 plurality of their fee schedule-allowed charges under one
14 of four specialties -- internal medicine, family practice,
15 geriatrics, or pediatrics -- and includes all other
16 physicians in the "other specialties" category.

17 Because CMS had not established a specialty code
18 for hospitalists prior to 2017 and most hospitalists are
19 board- certified in internal medicine, the Commission
20 counted nearly all hospitalists in its count of PCPs
21 because they self-designated as internal medicine.

22 Including hospitalists in the count of primary

1 care physicians could be problematic because the services
2 they furnish do not meet the criteria that are commonly
3 used to define primary care.

4 Beginning in the second quarter of 2017, CMS
5 introduced a separate specialty code for hospitalists.
6 Before then, hospitalists self-identified under other
7 specialties.

8 Because of concerns about how the increasing
9 number of hospitalists affects the supply of primary care
10 physicians, we sought to better understand the number of
11 hospitalists who bill Medicare and the services they bill.

12 We used the introduction of the hospitalist
13 specialty code in 2017 to more fully understand the billing
14 patterns of hospitalists and to establish a methodology to
15 retrospectively identify hospitalists in claims data.

16 We used that information to separate our estimate
17 of hospitalists from our PCP count going back through 2010.

18 We developed the methodology, as explained in
19 your mailing materials, and are happy to answer any
20 questions you may have afterwards.

21 Using the billing patterns of self-identified
22 hospitalists in 2017, we estimated the number of

1 hospitalists over several years. From 2010 to 2017, the
2 number of hospitalists who billed Medicare grew from about
3 32,000 to 48,000.

4 We found that the number of hospitalists who
5 billed the fee schedule increased steadily over the last
6 several years. Specifically, there was an average growth
7 rate of 5.9 percent per year.

8 Now Brian will go over how this estimate of
9 hospitalists affects our count of PCPs used for payment
10 adequacy.

11 MR. O'DONNELL: So this next figure shows the
12 effect of excluding hospitalists from our annual counts of
13 PCPs.

14 The dotted blue line represents the counts we've
15 published in our annual March reports.

16 The solid green line shows the count of PCPs
17 after excluding hospitalists.

18 From 2010 to 2017, we estimate that about one in
19 five physicians the Commission has historically considered
20 to be a PCP were actually hospitalists.

21 While the data from the previous slide suggests
22 that a smaller number of PCPs billed Medicare than we

1 previously estimated, it does not change our past
2 conclusions that beneficiaries maintained adequate access
3 to care.

4 For example, the Commission's annual beneficiary
5 survey has found that beneficiaries have been less likely
6 to wait longer than they wanted for routine care compared
7 to those with private insurance.

8 The survey has also not indicated large changes
9 in the share of beneficiaries who had trouble accessing
10 PCPs, and beneficiary access to PCPs has remained as good
11 as or better than individuals aged 55 to 64 with private
12 insurance.

13 While the absolute differences in PCP counts does
14 not indicate an access issue, the slower growth in PCPs
15 after excluding hospitalists underscores the Commission's
16 concern about the future supply of PCPs.

17 To demonstrate this, we will now look at the same
18 data we've been discussing in the last two slides, but now
19 we'll focus on growth rates and not absolute levels.

20 The blue bars in this figure represent the annual
21 percent change in the number of PCPs that we've published
22 in our annual March reports.

1 The green bars show how the annual percent in the
2 number of PCPs change after we excluded hospitalists.

3 As you can see, after excluding hospitalists, the
4 growth in the number of PCPs billing the fee schedule is
5 much slower, with a flat or declining trend in recent
6 years.

7 The staff will return to you in November with an
8 update on our ongoing work on the pipeline of PCPs.

9 Switching gears a bit, I'll now discuss the
10 updates we plan to make to the Commission's fee schedule
11 volume analysis, and just a reminder of how this all fits
12 together, the volume analysis is another way in which we
13 measure access to care.

14 The Commission's traditional volume analysis took
15 into account the number of services beneficiaries received
16 and their complexity, as measured by relative value units,
17 or RVUs.

18 We used volume trends to measure access to care,
19 with increasing volume suggesting sufficient access.

20 We've also used volume trends to help determine
21 the drivers of spending increases.

22 However, our volume measure was sensitive to

1 shifts in the site of service. This means that our measure
2 of volume could go up or down based simply on where
3 services were performed. For example, shifts from
4 physician offices to hospital outpatient departments,
5 HOPDs, have resulted in negative volume trends because RVUs
6 disappear from our volume analysis when such shifts occur.

7 These negative volume trends do not indicate
8 access issues but are instead an artifact of technical
9 differences in how Medicare accounts for practice expense
10 costs across settings.

11 This slide gives an example of how RVUs disappear
12 from our volume analysis when they shift and a site of
13 service occurs.

14 The left-hand bar represents a CT scan that is
15 performed in a physician office.

16 The right-hand bar represents a CT scan performed
17 in an HOPD.

18 As you can see, the number of RVUs that would be
19 included in our volume analysis declines by about 60
20 percent when the same service is performed in an HOPD
21 instead of a physician office, nearly all of which is due
22 to a decline in practice expense RVUs, the green bars.

1 To address the site of service problem, we will
2 replace our traditional volume analysis with two new
3 analyses. The first new analysis will measure access to
4 care and is the number of beneficiary encounters with
5 clinicians.

6 Encounters do not take into account the number or
7 complexity of services per encounter and are less sensitive
8 to shifts in the site of service. For example, we would
9 count an office visit as one encounter, regardless of where
10 it was performed.

11 The second new analysis measures spending and
12 relies on allowed charges, which are the payment amounts
13 specified under the fee schedule. Total allowed charges
14 are a function of the number of services billed, the RVUs
15 for those services, and other factors, such as the
16 conversion factor.

17 The Commission tracks a similar metric for HOPD
18 spending. Using similar metrics for both fee schedule and
19 HOPD spending could allow us to better understand global
20 spending trends for clinician services, as clinician
21 services continue to shift to the HOPD.

22 I'll now walk through two examples of our new

1 measures of access and spending.

2 This table shows the number encounters per
3 beneficiary, stratified by type of clinician. From 2013 to
4 2017, the number of encounters per beneficiary increased
5 modestly from 20.4 to 21.1, suggesting stable access to
6 care.

7 However, the patterns by type of clinician
8 suggest shifts occurred beneath these top line numbers.
9 For example, the number of encounters per beneficiary with
10 PCPs fell by about 3 percent per year, while encounters
11 with APRNs and PAs grew dramatically, by about 13 percent
12 per year.

13 The decline for PCPs occurred across a broad
14 range of services, is consistent with previous Commission
15 analyses, and suggests that APRNs and PAs could be billing
16 many services once billed by PCPs.

17 This next slide is an example of the type of
18 analysis we plan on including for allowed charges. We will
19 continue to examine growth rates by type of service, as we
20 have done in the past, only now it will be growth in
21 allowed charges per beneficiary. For example, allowed
22 charges grew by an overall average of 1.6 percent from 2016

1 to 2017, but growth rates varied between different service
2 categories.

3 Differences between categories reflect a number
4 of factors that we will discuss in the update chapter, such
5 as differential growth rates in service use and policy
6 changes.

7 In the March chapter, we plan on updating this
8 analysis with 2018 data and including the table from your
9 mailing materials that breaks down allowed charges by the
10 more granular type of service categories.

11 This last slide reiterates a few of the topics we
12 covered today. While we now estimate that a smaller number
13 of PCPs billed Medicare than we previously thought, this
14 does not change past conclusions that beneficiaries
15 maintained adequate access to care.

16 However, because the number of hospitalists has
17 grown rapidly, netting them out of our count of PCPs
18 reveals a flat or declining trend in PCPs in recent years.
19 This trend reinforces the Commission's concern about the
20 future pipeline of PCPs.

21 The staff is also seeking feedback on all the
22 planned methodological changes we discussed today, and on

1 the policy front, staff will return to you in November with
2 an update on our ongoing work on the pipeline of PCPs.

3 With that, I look forward to your comments, and I
4 turn it back to Jay.

5 DR. CROSSON: Okay. Thank you, Brian, Kevin,
6 Carolyn.

7 We are now open for clarifying questions.

8 Sue?

9 MS. THOMPSON: Thank you.

10 Yeah, it's Table 9 in our reading. It was just
11 the previous slide. One more. Who are the other
12 practitioners?

13 MR. O'DONNELL: So the biggest group amongst that
14 is PTs, so PTs, OTs, are the two biggest groups in the
15 other practitioners category.

16 MS. THOMPSON: So back to the APRNs and PAs --
17 and we've had this conversation in other discussions around
18 primary care and what's happening -- a 13 percent increase
19 is pretty amazing. Remind us what the compensation
20 difference is for the same level of service delivered by an
21 APRN versus as physician.

22 MR. O'DONNELL: Right. So from a salary

1 perspective, the average APRN might make around \$110,000 a
2 year, and PCPs make on average about \$240,000. So that's
3 the salary differential.

4 And then from the Medicare perspective, if APRNs
5 and PAs bill directly, they're paid 85 percent of the fee
6 schedule and not 100 percent.

7 MS. THOMPSON: Thank you.

8 DR. CROSSON: Other questions?

9 Pat and then Marge, Jonathan, Dana.

10 MS. WANG: How do urgent care centers bill, and
11 would they be reflected? Would an internist in an urgent
12 care center show up in the billing for primary care
13 physicians?

14 MR. O'DONNELL: Right. So if there's a primary
15 care physician, based on our definition, if it's in an
16 urgent care center, they would show up in this category, in
17 the PCP category, but if the APRN delivered the service in
18 the urgent care center, it would appear under the APRN row.

19 When we break it out, we can break it out by
20 place of service as well, which would be another chart, and
21 then there, we could see the breakout of specifically all
22 services performed in the urgent care center, if you wanted

1 to see that.

2 DR. CROSSON: Okay. Marge.

3 MS. MARJORIE GINSBURG: A couple questions which
4 I'll just group together. Is this the first time that
5 MedPAC has looked at statistics having to do with
6 hospitalists? Or has this come up before?

7 MR. O'DONNELL: So to my knowledge, it's the
8 first time we've done this deep of a dive on it, and I'll
9 look to people who have been here longer that know it. But
10 I think that's the answer.

11 MS. MARJORIE GINSBURG: And so related to that,
12 does Medicare have a separate payment structure for
13 hospitalists than it does for PCPs?

14 MR. O'DONNELL: No. So the payment doesn't
15 differ based on whether you're a hospitalist or whether
16 you're a PCP. I think the thing that's new for us is that
17 there's a new specialty code in 2017 so we can identify
18 hospitalists in the claims data much more easily.

19 MS. MARJORIE GINSBURG: Okay. And this report,
20 the one we read, devotes a lot of space to discussion of
21 hospitalists' work, but the information being presented to
22 us really doesn't -- in terms of what we're looking at for

1 policy recommendations doesn't talk about hospitalists at
2 all. So this is just background to understanding where the
3 trajectory is for PCPs? That's the sole purpose for
4 including a lot of information about hospitalists? I just
5 wanted to make sure I was reading this correctly.

6 MR. O'DONNELL: That is right. We didn't want
7 you to get scared when you look to November or December and
8 you saw a big decline in PCPs. We wanted to give you some
9 background on hospitalists since we haven't talked about it
10 that much to say just to give you kind of a warning, this
11 is coming in December with our normal update process.

12 MS. MARJORIE GINSBURG: Thank you.

13 DR. CROSSON: Jonathan.

14 DR. JAFFERY: Yeah, thanks. Great report.

15 On Slide 5 you show the survey result from the
16 American College of Physicians in-training exam, and I
17 wondered if you've thought about looking for other sources
18 of data to figure out what people actually do become, so
19 this is what they're planning. And, in particular, I'm
20 thinking about longer term, not even just a year after
21 finishing residency but -- this probably wouldn't impact
22 the general internal medicine line as much, but thinking

1 about hospitalists -- people that go and become
2 hospitalists for a year or two and then actually go back
3 and do a fellowship in some specialized -- it may be a not
4 insignificant percent, and it might make us think about
5 longer-term things in terms of workforce.

6 MR. O'DONNELL: Yeah, and that's a great point
7 because I think the churn in hospitalists is probably a
8 little bit greater than the churn in PCPs. And so we've
9 seen that in the literature a little bit, and I think that
10 we don't have a great data source right now, but thinking
11 about this kind of on a going-forward basis is that now
12 that we've identified hospitalists in the Medicare data, we
13 can then track them to see, you know, how long they stick
14 with being a hospitalists versus subspecializing or
15 whatnot.

16 DR. CROSSON: Okay. Dana.

17 DR. SAFRAN: Yeah, so really interesting work. I
18 have two related questions and both sort of under the
19 heading of I'm struggling with this idea that, you know, we
20 have either a pretty significant substitution of
21 hospitalists for PCPs in terms of the pipeline or I think
22 you used the figure that, you know, one in five clinicians

1 that we thought was a PCP actually is a hospitalist, so 20
2 percent fewer PCPs than we thought. And yet the survey's
3 telling us that hasn't introduced access problems. So I'm
4 struggling with that a little bit. And so I'm wondering
5 two things. One is are there some ways that we can look to
6 see with the growth that we've had in hospitalists while
7 we're losing PCPs, let's take for a minute at face value
8 that we aren't creating a PCP access problem, and we'll
9 come back to that. We're getting a whole new class of
10 physicians. What's the evidence for the value in the
11 dollar that we're paying for this whole new cohort of
12 physicians? Has it so significantly contributed to
13 improved hospital safety, you know, hospital outcomes,
14 simply added costs, helped hospitals do better discharge
15 planning? What do we know about, you know, what's the
16 value coming with this tradeoff that we now understand that
17 we're making? That's the first question.

18 Second question is if we want to go a little bit
19 beyond the survey data, I wonder if we could look at some
20 longitudinal data from claims to see -- and maybe it would
21 be hard to go back far enough, but just see whether for the
22 E&M codes that typically would be seeing a PCP, do we start

1 seeing them going somewhere else? Or are they just more
2 concentrated with fewer PCPs? You know, so what's
3 happening with Medicare beneficiaries' visits that have
4 historically been to PCPs? Are they still going to PCPs,
5 or are they going to specialists? Are we seeing fewer of
6 those visits? Kind of what's happen so we can triangulate
7 a little bit that data point that tells us we don't have
8 access problems.

9 MR. O'DONNELL: Right, so starting with the first
10 one, I think the value proposition -- and I'll look to the
11 hospital CEOs here -- is that when the hospitalist field
12 first came about in the late 1990s, you know, so there were
13 studies looking at, you know, hospitalist care versus care
14 of a PCP. And I think it happened in the context of
15 managed care and DRGs. And so I think the conclusions of
16 the literature are that, you know, it reduced costs for
17 hospitalists -- or for hospitals, rather, primarily by
18 reducing the length of stay, and that the quality and
19 patient satisfaction were kind of held level. And so those
20 are the thumbnail sketches that I have in my brain, and we
21 can dig more, but those are kind of the basic points.

22 And then on the E&M codes that you mentioned that

1 are declining for PCPs, you know, we don't have great data
2 on where NPs and PAs are practicing, but, you know, we
3 showed a graph in, I think, the June 2019 report that the
4 number of office visits, NPs and PAs, are performing
5 increased by 184 percent over the last seven years, and
6 that PCPs have declined by about 16 percent over that same
7 time frame. And so I'm not saying that all the NPs and PAs
8 are primary care, because they're certainly not, but I
9 think, you know, with certitude a good chunk of that
10 increase are office visits with NPs and PAs that PCPs might
11 have performed in the past.

12 DR. CROSSON: Kathy.

13 MS. BUTO: So I really want to follow up on some
14 of Dana's points here. I don't know that we know what the
15 -- assuming that hospitalists do deliver some value, that
16 we know what the right percentage of total general
17 internists going into hospitalist care would be. So I
18 think we do need to know more about sort of the value they
19 deliver.

20 I'm also curious to know if we know anything
21 about why they make more money because I'm assuming there's
22 some association with value. I can think of other reasons

1 why they might be attracted to being a hospitalist versus
2 being a PCP in the traditional sense because they also get
3 to work with a team of people that you may or may not have
4 access to outside. You've got hospital resources. There
5 are a number of things that bring along a certain level of
6 sort of prestige and association with a larger entity.

7 So I think we need a better understanding of the
8 hospitalist, but I'd be interested to know what else we
9 know about their impact on quality and why they're making
10 more money. Are they being paid on the fee schedule, do
11 you know, Brian, or whether they're being paid on salary or
12 some combination?

13 MR. O'DONNELL: Right, and I just want to make
14 clear that, you know, what's the right mixture of general
15 internist versus hospitalist. We were staying completely
16 away from that. We're just looking at the data. But in
17 terms of the salary, it's really a hospital-level decision
18 because when you look at the -- the best information we
19 have is that, you know, hospitalists are subsidized quite
20 heavily by hospitals, and so, you know, maybe a thumbnail
21 sketch, \$100,000, \$125,000 per year per FTE are subsidized.
22 So hospitalists are not living off of their own

1 professional fees billing.

2 And so I think that, you know, when I've talked
3 to folks in the field, they said, look, you know, they're
4 valuable to us for holding down costs in the inpatient. We
5 task them with quality improvement, you know, reducing
6 infections and things of that nature.

7 MS. BUTO: I think that's something we need to
8 think about in terms of PCPs and why they're not happy with
9 the compensation arrangement that we offer them.

10 I also wanted to mention -- somebody asked the
11 question about teasing out different kinds of physician
12 services and different specialties, and one of the bedrock
13 decisions that was made with the physician fee schedule was
14 that there is no specialty differential. So if you're a
15 surgeon providing E&M services, you get paid the same as if
16 you were a hospitalist providing that same service. So I
17 think it would be very hard to tease apart by specialty
18 what's going on there. But there may be greater detail
19 than when I was familiar with it.

20 DR. CROSSON: Larry.

21 DR. DeSALVO: Can I -- I just want to make a
22 response to Kathy's comment, if I could, that in addition

1 to what Brian articulated, which I think there's a lot of
2 head nodding around the table, I think that you pretty well
3 got that exactly right. There's also a little bit of a
4 supply and demand that happened that hospitals really and
5 academic health centers also wanted hospitalists. For
6 example, in the academic health center environment, as
7 graduate medical education work hours changed, it was more
8 important to have physicians that could be devoted to the
9 inpatient setting to make rounds in a timely fashion so
10 that residents didn't have to stay too long as another
11 example or supervision of fellows. So all these things
12 came together at once, and there was a demand for the
13 specialty, and so we all had to pay higher prices for
14 salary to accommodate that and it just set the level. But
15 it does make me wonder if our numbers on salary for primary
16 care then also will get reset if we pull these out, pull
17 out the hospitalists.

18 DR. CROSSON: On this point as well?

19 DR. RYU: Yeah, I'm glad you raised the demand-
20 supply issue because I think that's what's driving a lot of
21 this. If you think about a hospitalist staffing model,
22 it's a 24/7 model, and so -- versus primary care which --

1 DR. DeSALVO: It's 24/7.

2 DR. RYU: Which is hidden 24/7.

3 [Laughter.]

4 DR. RYU: But I think that's one factor. And as
5 far as the value -- and I would turn to -- I don't know if,
6 Dave or even Larry, you might be more familiar with a lot
7 of the data, but I know there was a lot of work done on the
8 value of hospitalist programs coming out of David Meltzer
9 and the University of Chicago back in the '90s, lower
10 length of stay being the big cost driver for hospitals.
11 It's efficiency of throughput. There's also a consistency
12 of medical education versus if you have every primary care
13 doc admitting their own patients, you know, that's a pretty
14 disparate field that you're dealing with. It becomes
15 really tough even driving will initiatives, consistency of
16 practice, if you use something like sepsis protocols as an
17 example, getting, you know, 150 different admitting primary
18 care physicians to do the same thing on that is a lot tough
19 than getting a team of 15 hospitalists to do the same
20 thing. So I think there are a lot of underpinnings around
21 what's driving, you know, those changes.

22 DR. CROSSON: Larry

1 DR. CASALINO: Oh, I think I'll wait till the
2 next round.

3 DR. CROSSON: All right. Further questions?

4 [No response.]

5 DR. CROSSON: Seeing none, we'll move on to the
6 discussion, and we had Karen first and then Paul are going
7 to open.

8 DR. DeSALVO: It was a jump ball. Everybody
9 wants to talk about physician workforce -- well, since I am
10 general internist.

11 [Laughter.]

12 DR. DeSALVO: Yeah, I just want to thank you guys
13 for the chapter and clearly for going to ground to the
14 field to really understand the history and what it's like
15 in the practice environment. I think that this is, though
16 a little bit academic, important because it helps us
17 understand how the scope of practice and the delegation of
18 responsibilities is evolving, especially for people with
19 significant chronic disease who are the ones that, you
20 know, we want to make sure are getting access to really
21 good preventive care, and it helps us start to think
22 upstream more.

1 You know, the academic world has been dealing
2 with this change, as you say, since the '90s. We started
3 our hospital medicine program at Charity Hospital in the
4 late '90s, and it grew out of all the things that we just
5 discussed in terms of driving the need for change. And the
6 field has not only evolved so far that hospitalists have a
7 special certification and now their own code and with CMS,
8 but it's already starting to come back around, and some of
9 the original hospital medicine experts like David Meltzer,
10 who was just mentioned, are beginning to build models that
11 are outside of the site of care of the hospital and in the
12 home, recognizing that the care of particularly people with
13 significant, multiple comorbidities and chronic disease and
14 challenges with some of their social determinants of health
15 sometimes are better served not only by a person who's got
16 experience in comfort with high-acuity patients, like a
17 hospital medicine physician, but also it's better for the
18 person in the home. So that the whole term "hospitalist"
19 is actually starting to be called into question of they
20 don't just practice in that environment any longer and that
21 they're also in the post-acute environment.

22 And, in fact, in some places for a while there

1 was a splintering in the academic departments hospital
2 medicine having its own section separate and apart from the
3 ambulatory part of general internal medicine. In some
4 places they're beginning to merge back together again in
5 recognition of the fact that it's not site of care that
6 defines the work; it has a little more to do with acuity of
7 care and some of the interest on the part of folks.

8 I wanted to call out for your future thinking not
9 only is this a topic of conversation in literally every
10 department of medicine meeting that ever happens anywhere
11 in an academic health center, but also in every hospital
12 executive board meeting. So this is an important topic of
13 do we have the right supply and are people working in the
14 right place to serve the beneficiaries where they have the
15 most need.

16 It's also of interest to the professional
17 societies who have done a lot of work on looking at
18 pipeline and looking at the impact of choices of practice
19 for our trainees, and that has culminated in a panel that's
20 being sat by the National Academy of Medicine looking at
21 the future of primary care -- again, not in a negative way,
22 but just trying to understand what is the future scope of

1 practice if there are hospitalists taking care of inpatient
2 medicine, what does that -- how do we define what it means
3 to be the first point of contact and the other descriptions
4 that we have for primary care? So that will be, you know,
5 18 to 24 months, but there will be a lot of work, I would
6 imagine, that will go into pulling literature and bringing
7 people to the table to think about not only what does the
8 future work look like, but then what does the workforce
9 need to look like and train for to get there? So I wanted
10 to make sure that I raised that.

11 I just had a couple of things that I wanted to
12 mention, that one I go back to a lot, which is the way we
13 define access to care correctly. And it's even less about
14 how we assess it, is it the right instrument, the right
15 survey tool? Are we getting appropriate -- you know, are
16 we getting a good response rate from the sampling, but also
17 is our goal right? So if, you know, still upwards of 25
18 percent of beneficiaries say they're having trouble getting
19 access to care -- if I remember, that's about the number --
20 is that where we would want beneficiaries to be? Or do we
21 want it to be 100 percent of beneficiaries have the kind of
22 access to care that they want? So just thinking about what

1 that goal looks like, even as we feel like the pipeline for
2 primary care might be a little tenuous, is that going to
3 get worse? Is it ever going to get better? Is there
4 anything we could do to actually see that all of our
5 grandmas and grandpas and ourselves have access to care
6 when and where it matters?

7 I think that kind of brings me to the second
8 point I want to make, which is around outcomes. Access to
9 care is sort of a proximate -- not proximate. It's
10 probably a lagging indicator, as Jay has said, and so it
11 may be a little too late when we know that we don't have
12 enough folks in the pipeline.

13 On the other hand, outcomes might also be kind of
14 a lagging indicator, but it might be -- given all the
15 discussion about dividing scope of practice, so if primary
16 care physicians are more in the outpatient setting or doing
17 more home visits or whatever, and hospitalists are also
18 doing home visits but also in the hospital, the point is
19 not so much who's doing -- how many FTE are doing the
20 service, but are the beneficiaries getting outcomes that we
21 want them to have? And that gets to part of our
22 conversation we're going to have in the next session. Are

1 we looking for ambulatory care sensitive conditions being
2 well treated? Is that the way we would want to track on if
3 we've got a strong primary care infrastructure? It could
4 also be broader than that and thinking about how we're just
5 trying to help the system organize itself not to a certain
6 number of a certain type of doctor, if you will, but to a
7 team that can address the needs of the beneficiary in the
8 right place at the right time with the right kind of tools.
9 And the more we move towards global payments, whether it's
10 just for primary care or for, you know, a population, the
11 more flexibility local institutions, local practices, local
12 communities will have to figure out what's the right mix
13 and, you know, based on a whole bunch of local conditions,
14 but it may very well be that there's more interest in
15 leveraging technology or asynchronous visits or team
16 members rather than purely primary care physicians.

17 So I just want us to be cautious about
18 overdefining who does the work but really thinking about
19 what the outcomes might be in the long term.

20 I just maybe also wanted to emphasize that last
21 point a little bit from personal experience, which is that
22 having practiced medicine for 25 years, the most delightful

1 time of that was when we were in a global budget and
2 building patient-centered medical homes with teams because
3 we were really focused on prevention and on identifying
4 gaps in services, thinking about social determinants, going
5 to people's homes, doing all these things that you want the
6 system to do, but you don't have to necessarily pay for the
7 piece, you really -- if you pay for the out and give some
8 flexibility to that team with accountability and
9 transparency, there can be a lot more innovation inside to
10 really meet the needs of the beneficiaries.

11 So I think that the data teasing out is really
12 important. I'm all in. But I also think we've got to
13 figure out how we focus as much as possible on the
14 outcomes, and that the pipeline -- like what the primary
15 care is going to be doing in ten years might look really
16 different than what we do today. And so I just want to be
17 cautious about overly prescribing what we want to build for
18 a future that we don't quite know what it looks like.

19 DR. CROSSON: Thank you, Karen. Paul.

20 DR. PAUL GINSBURG: Yes, I really enjoyed your
21 presentation and paper, and, you know, I think your
22 analysis of that hospitalist is very solid. And it brought

1 a couple of thoughts to me. One is how difficult it is to
2 assess adequacy of access by capping people, because, you
3 know, basically we were wrong -- you know, we were
4 overstating the trend of PCP counts until we got the
5 specialty code for hospitalists and we were able to fix it.
6 We don't know how many other things are going to be
7 problematic.

8 Also, the question is, you know, very sharp rise
9 in nurse practitioners, physician assistants -- what is it,
10 about half of them, you know, some good proportion of them
11 go to primary care. So it's very difficult to assess, you
12 know, what does that mean? Does this mean that, you know,
13 we have a shortage and this is making do, or is it, hey,
14 this is a movement towards efficiency. They don't cost as
15 much. If they're doing the rights that are consistent with
16 their skill level, this is really a change we can be proud
17 of. We don't know. So again, it comes back to just
18 counting people, how difficult it is to get a meaningful
19 assessment.

20 And finally, there are the productivity issues,
21 you know, that older physicians talk about what it was like
22 when they practiced primary care, the number of hours they

1 used to practice compared to today's physicians, at least
2 younger ones. So, in a sense, this is really big. You
3 know, if we're going from 60 hours to 40 hours a week, you
4 know, that could overwhelm changes in counts of physicians.
5 So it's going to be problematic.

6 I think, you know, the surveys are useful, but I
7 think we have to just continue to look for different places
8 for evidence that whether access is adequate or not,
9 because, you know, many people, including me, have been
10 since baffled. You know, we basically have frozen
11 physician payment rates for a long period of time, and we
12 don't see any change in access. Now maybe we were just
13 paying too much or maybe we're not seeing problems.

14 So, anyway, it's just respect for the daunting
15 challenge that Congress has charged us with each year.

16 DR. CROSSON: Thank you, Paul. So we are going
17 to go into the discussion phase. Now we've got two
18 proposals that I hope we can address. I haven't heard any
19 opposition so far, but just to be clear, in terms of the
20 data we're going to use in the future, that we're going to
21 carve out hospitalists, and then in terms of the volume
22 analysis we're going to split out encounters and allowed

1 charges. So to the extent that people agree or don't agree
2 with that, that's fine. If you want to make other
3 comments, that's fine too.

4 So, okay. Jon first, Pat, David, Jonathan, Sue,
5 Jaewon, Larry, Kathy, and Bruce.

6 DR. PERLIN: Well, let me --

7 DR. CROSSON: I thought this was a slam dunk.

8 DR. PERLIN: The first is easy. I agree with the
9 recommendations.

10 Now let me make a comment. Beyond that, I agree
11 substantially with the comments of Karen and Paul, in terms
12 of their comments.

13 You know, the stated purpose of this section is
14 adequacy of Medicare payments for physicians, and behind
15 that, really, the ultimate purpose is the assurance of
16 adequacy of access, particularly to primary care, for all
17 the reasons that have been so well stated.

18 But beyond that sort of nominal purpose of
19 primary care adequacy, we have got a bonus in this. We got
20 a bonus in the sense that we look not only into the
21 changing distribution of care, in primary care, but the
22 changing nature of care in the hospital. And I think both

1 are tremendously important questions to the integrated care
2 of Medicare beneficiaries, for the reasons particularly
3 that Karen mentioned, in terms of how we figure out what
4 kind of care mechanisms work best to promote the best
5 clinical, financial, and, fundamentally, integrated
6 outcomes.

7 So just two suggestions. First, I think Paul
8 made a brilliant observation here, that, you know, we are
9 comfortable with our impression of adequacy of access, and
10 there are at least two hypotheses. One is that access
11 remains adequate, or, two, that we're not sensitive to
12 changes in access. And I think we have to be particularly
13 attentive to that second proposition.

14 I think that beyond, you know, sort of a Boolean
15 choice between access, no access, that there are shades of
16 gray in amongst some -- I've shared the story of, you know,
17 being the fortunate son of an elderly father, a 94-year-
18 old, who has nominal access to open Medicare practices but
19 also, as a retired physician reports, that they're sort of
20 parsing the day into how many complex patients, older
21 individuals, Medicare beneficiaries, they are balancing
22 with potentially simpler commercially insured, et cetera.

1 And so I think we have to find ways, as Dana
2 alluded to in her earlier comments, whether using claims
3 data, whether going into other health services research --
4 and I appreciate the challenges of our survey -- but a
5 number of ways to really get a finer grain on access and
6 associating that, also, with the outcomes, particularly in
7 things that may be sensitive to integrate continuity of
8 care. That's point one.

9 Point two is the bonus that you've opened up
10 through this work, which is that from 2017 you have insight
11 through a code on care that's rendered by hospitalists,
12 just parenthetically. You know, the quality actually are
13 pretty good that the upsides of hospital medicine are, you
14 know, more consistency, reduction in negative variation,
15 better in-hospital outcomes. Some of the downsides are the
16 fragmentation, discontinuities, because different people
17 are, of course, providing the care inside and outside.

18 But putting that aside, I thought your table on
19 page 16, about the distribution of workload amongst
20 different practitioners was particularly insightful,
21 because I would posit that there is an analog to that in
22 the inpatient environment, that the work is parsed amongst

1 different practitioners.

2 First, a hospitalist is not a hospitalist. There
3 are hospitalists that are internal medicine. There are
4 hospitalists that are critical care. There are
5 hospitalists that are cardiologist. Not necessarily
6 germane to our group, there are what we call deck docs, or
7 obstetrical hospitalists, and as we learned earlier today,
8 the new term SNFists, in extended care environment. And so
9 I think we need to get another level of detail on the type
10 of clinician.

11 The other dimension of that is, of course, not
12 all of the care is being rendered by physicians. In fact,
13 it's a team-based world. And we need to understand the
14 effect on beneficiaries of multiple providers, I think in
15 the same way that we entertain the identification of non-
16 physician care providers in the ambulatory environment in a
17 prior meeting. I would argue that we get a deeper
18 understanding of that, not as academic exercises but, you
19 know, really toward the broader questions, how do we assure
20 the financial sustainability, sustainability of the
21 Medicare program, and how do we assure the access to high-
22 quality care?

1 Thanks.

2 DR. CROSSON: On Jon's first point, I just want
3 to make a contribution here, and that has to do with an
4 additional problem that we've had over time in the
5 analysis, and that's the unevenness of distribution of
6 access, geographically. And it is, part in part a function
7 of, you know, unless we had a gigantic, gigantic survey,
8 the resolving power, depending on how you broke it up
9 locally, would be beyond the scope.

10 But I do remember, you know, a decade ago, when
11 we had a discussion similar to this, the previous chairman,
12 Glenn Hackbarth, remarking that while the adequacy seemed
13 good overall, in central Oregon, where he lived, it was
14 very difficult to find an internist, and that was a decade
15 ago.

16 So there is an issue about, I think, about
17 pockets of problems that it's hard to get to with even the
18 very large survey that we do.

19 Okay. So Pat.

20 MS. WANG: I'll try to be quick here. So it's
21 great conversation that goes so far beyond the
22 congressional mandate that we have, which Paul pointed out

1 is struggling to sort of like fit all of this back into
2 that shoe.

3 But, you know, I think that some of the comments
4 here go to sort of if you look at the cup half full or half
5 empty, like let's fill the cup up with what are the
6 different ways that people are getting primary care?
7 What's emerging? What do we want to encourage as we think,
8 and make sure that we are cognizant of all of that. The
9 cup half empty is like we had discount of primary care
10 physicians -- we've got to take this slice out.

11 I asked the question before about urgent care
12 because I wonder whether there's another slice in there,
13 both for folks who are billing E&M codes that look like
14 primary care, as well as APRNs and PAs are working in
15 urgent care setting, which, you know, are kind of like
16 they're lumpily distributed around the country but where
17 they exist in concentration. That's not primary care, and
18 it's not emergency room care exactly, but it's something in
19 between, and I wonder whether there's another slice that
20 needs to be taken out of the cup. I don't know. That's
21 why I asked the question before.

22 But it's not going to get us to the right answer

1 by continuing to slice out what used to be in the count of
2 primary care, so I think that Paul and Karen's comments
3 about trying to understand what beneficiaries need, and
4 keep a very open mind about ways to meet that need, we have
5 to be very flexible.

6 DR. CROSSON: Thank you, Pat. David.

7 DR. GRABOWSKI: Thanks. So first I'll start with
8 saying I'm also supportive of the recommendations, and
9 thank you for this great work.

10 I'm going to echo Karen and Paul as well in
11 saying that volume is a really noisy way to measure access,
12 and I think we know that and we have other indicators. I
13 think what bothers us in picking up, Jon, on your comment
14 is that I don't know that we feel like we really are
15 capturing access with the survey, and so how do we do that?
16 And I'd like to give a couple of ideas towards maybe
17 putting a couple more tools in our kit here that we could
18 think about measuring access.

19 So beyond just the survey, I think some
20 qualitative work, so more focus group-oriented work. I
21 know we've done some of that. Could we do more directed
22 around this issue? I suggested last year, and I don't know

1 that it went anywhere so I'll suggest it -- I'll keep
2 suggesting it until you tell me it's a bad idea -- but I'd
3 like the idea of audit studies. I know that won't get at
4 all the different access issues, but at least seeing, you
5 know, to the example, Jon, of your parent, and, you know,
6 is there a panel that would take on, you know, calling
7 around. We might not be able to determine whether could
8 get an appointment as quickly as they want, but at least we
9 could figure out whether or not they could get on a
10 particular panel.

11 And so there are some creative ways, maybe, from
12 a research perspective, that we could enrich our
13 understanding of access. And so I'd like for us to think
14 about that going forward. Thanks.

15 DR. MATHEWS: And just one quick response there.
16 In the past we have sometimes selected the cities where we
17 conduct our annual focus groups, in light of media accounts
18 of specific access problems. So we'll go to Albuquerque,
19 we'll go to, you know, Indianapolis, if there had been
20 substantial media or press coverage that beneficiaries were
21 having trouble. So we do use that in a qualitative way to
22 fill in the survey. Again, it's not exhaustive, it's very

1 limited, but we are very cognizant of how this fits into
2 our access assessment.

3 DR. GRABOWSKI: Yeah, and just to respond to
4 that, I think that's great and we want to continue to do
5 that, and it's most definitely a complement to the types of
6 analyses, like the count of physicians, like the survey
7 that we do. So I think that we need to look at all of
8 these metrics and can we do more on the qualitative side to
9 sort of expand our knowledge base.

10 DR. CROSSON: Sue.

11 MS. THOMPSON: I'll be quick as well. I'm in
12 agreement with the recommendations -- I will go on record -
13 - and then I just have a few comments. I mean, certainly
14 one of the tangential learnings from this was obviously all
15 this discussion we're having about hospital medicine. And
16 I'm pleased very much with this work, in terms of pulling
17 out the hospital medicine component of what we understand
18 to be primary care.

19 But just a couple of comments about other
20 dynamics going on in that arena. It is a supply and
21 demand, and this is an expensive element to running a
22 hospital. It has become standard of care, and that spreads

1 into rural communities where physician recruitment is very
2 difficult. And so one of the observations I have made, and
3 continue to observe growing, is the role nurse
4 practitioners are playing in the hospital medicine field.
5 And we are seeing rural hospitals staff their hospital
6 medicine program with nurse pracs, and having a physician
7 oversee that.

8 So there's another dynamic going on here in terms
9 of we think nurse practitioners are going to continue to
10 maybe be the backfill to what we understand to be primary
11 care, while they're pulled into some of this specialty
12 work, and in this discussion, hospital medicine, I think is
13 worthy of paying attention to. Also, because of the
14 expense associated with staffing a 7x24 hospital medicine
15 program, nurse practitioners are attractive to hospitals.

16 And there's another new dynamic that we are
17 beginning to take advantage of, and that's a telemedicine
18 program of hospital medicine. So there are a lot of moving
19 parts in this discussion, and I recognize I've gotten way
20 outside the shoe of access of primary care, but I think
21 it's a complicated set of dynamics we've got going on here.
22 And to just think back 15, 20 years, most of the hospitals

1 I worked with, I mean, we were thinking about putting
2 hospital medicine programs together. Today, critical
3 access hospitals are being moved to take on hospital
4 medicine for purposes of retaining their primary care doc,
5 so they don't have to cover the hospital.

6 So it's a substantial aspect, but I think it's an
7 important one. I think it does drive improvement in
8 quality, but I can't substantiate that with evidence today
9 without some refresh. So I just think this is a
10 conversation we need to continue to have.

11 DR. CROSSON: Thank you, Sue. Jaewon.

12 DR. RYU: Yeah, so I maybe going outside the shoe
13 here too, but the recommendations, I also agree. I think
14 they are spot on.

15 The only comment I wanted to make around this
16 notion of access, because I think, like many of the
17 comments here, and I'm one of them as well, it just defies
18 logic to think that it hasn't impacted access. But then
19 when I think about what are the leading indicators that
20 might suggest that access has been detrimentally impacted,
21 I heard some of the comments, you know, maybe it's
22 geographic pockets where access isn't what it should be.

1 Maybe there's some measures of ambulatory-sensitive
2 conditions.

3 But the other one I think we need to look at is
4 the impact on other payer classes. So Medicaid, I think,
5 is the one that I would look at. It would be interesting
6 to see if Medicaid members or beneficiaries have seen a
7 deterioration in their perceptions of access. Because when
8 I think about how a typical practice might work -- and I
9 think this gets back to Jon's comments -- I think the first
10 cracks in the wall won't be Medicare. It's unlikely to be
11 commercial because of the payer rates. The first cracks in
12 the wall, if access is a problem, will show up in Medicaid.
13 That's the segment of the population that a lot of
14 practices will start to triage out, and close off their
15 panels too.

16 And so I think that might be a clue to look at,
17 you know, what the perceptions have done in that
18 environment.

19 DR. CROSSON: Interesting. Thank you.
20 Interesting idea. Kathy.

21 MS. BUTO: So I don't totally support the
22 recommendation, and the one I don't support totally is the

1 first one, which is to merge hospitalists in with other
2 specialties. And the reason I don't support that is I
3 think even though we definitely want to be able to separate
4 them in terms of our analysis, I think for all the reasons
5 that people have already stated, I think it's important for
6 us to keep our eye on the role they are playing in care
7 coordination inside and outside the hospital for high-risk
8 patients who have been hospitalized. And from what I
9 gather, it is even now going into post-acute settings.

10 So I'd hate to lose them in that other specialty
11 bucket which tends to be -- I hope there are no other
12 specialties sitting around the table, but we tend to
13 denigrate that third bucket of specialties that, if you
14 look at some of the areas of growth in services or
15 ancillary services that might not be considered critical,
16 some of those specialties are implicated. And I'd hate to
17 have us assume that hospitalists are somehow associated
18 with unnecessary services. From what I'm hearing, they do
19 play an important role, maybe not everywhere, but they are
20 sought after.

21 So they also are providing primary care. For
22 that reason, I think we ought to keep our eyes on them in

1 the evolving role, along with nurse practitioners and
2 physician assistants.

3 Secondly, I'm trying to understand -- and I think
4 this analysis helps us understand better -- declining
5 interest on the part of physicians becoming PCPs. So we've
6 touched on it in talking about hospitalists. I think
7 another element is what we're beginning to see in terms of
8 primary care physicians opting out of Medicare.

9 So there are elements we should be looking at to
10 determine if there's sort of a threshold or a canary in the
11 coal mine for a threshold, when we really get concerned,
12 either geographically, for some areas, or just in a more
13 general sense. But there are a number of things going on -
14 - movement to hospitalists, some opt-outs, some pockets of
15 access problems. The question is, what's going on? So I
16 think it can help us, in a broader sense, look at access.

17 Thank you.

18 DR. CROSSON: Thank you, Kathy.

19 Larry?

20 DR. CASALINO: Yeah. First of all, in terms of
21 measuring access, I agree with what others have said. Just
22 relying on the survey may not be enough. Focus groups is a

1 good idea. I don't know if it would be legal or
2 politically wise for MedPAC to do Secret Shopper kind of
3 phone calls like Karen Rose did, but that would be a way of
4 getting at things.

5 I think another possible measure is health care
6 fragmentation. There's ways to measure fragmentation from
7 claims data now, and if you believe that if there's less
8 primary care or there's fewer primary care physicians,
9 they're more rushed, whatever, at least more fragmentation,
10 which is a reasonable hypothesis, then you'd expect to see
11 fragmentation go up as primary care physicians go down. So
12 that could be looked at pretty cheaply.

13 I'd also look at the growth of urgent care. I
14 think that, in my mind, every urgent care visit, pretty
15 much, is a failure of primary care, of primary care access.

16 You could also say, for slightly different
17 reasons, ambulatory care and ED visits. I think if you see
18 urgent care going up, you see ambulatory care and ED visits
19 going up. I think you can think there's less primary care
20 access.

21 Looking at units -- I agree with the
22 recommendations, by the way. I should say that straight

1 up, but looking at units of service for primary care as a
2 measure of access -- other people have mentioned this -- if
3 physicians started doing more on the phone, for example, or
4 by telemedicine, however you want to define it, and less in
5 person and you couldn't measure that, it would look like
6 less service. But it wouldn't necessarily be the case.

7 I also agree. I don't know if it's within
8 MedPAC's scope to look at Medicaid, which I can tell you
9 from experience, that will be the first thing that goes for
10 practices is cutting out Medicaid, seeing Medicaid
11 patients.

12 But maybe you already do this. Looking at dual
13 eligibles, I think, would be of some use.

14 Then in terms of the supply of physicians, we had
15 a little discussion earlier today about if primary care
16 physicians aren't spending an hour or two a day of doing to
17 the hospital and back and rounding in the hospital on one
18 or two patients, could they see more patients? We actually
19 see, in the numbers here, fewer encounters with primary
20 care physicians per beneficiary per year. So it's not
21 obvious that that's happening in terms of hospitals
22 indirectly increasing the supply of primary care services.

1 I think that it's already been mentioned with
2 physician assistants and nurse practitioners. There's
3 probably a fair amount of billing done not in their name,
4 but under the physician's name. But without being able to
5 measure that, it's hard to know the contribution of PAs and
6 NPs to primary care supply.

7 But I will say -- this may have been mentioned --
8 I think we're going to see fewer and dramatically fewer
9 physician assistants and nurse practitioners working in
10 primary care. They're working pretty much in every
11 specialty now, and just counting encounters with NPs and
12 PAs, without knowing whether they were primary care-based,
13 is not going to contribute to understanding the supply of
14 primary care services.

15 Long term, I think there's a tremendous -- I
16 think we are getting behind the curve. We had the one
17 graph that showed a 50 percent drop over not very many
18 years in the number of general internal medicine residents
19 planning to do primary care. Fifty percent is a lot,
20 particularly in the last year or two, it looked like. I
21 don't know if that's a blip, or if it were to continue like
22 that, it would be very dramatic. So I think that's a worry

1 about supply and then also what I mentioned about the NPs
2 and PAs going into subspecialties.

3 And then just two extremely quick points to
4 finish, in terms of the volume measurement as a way of
5 measuring access, I think that's fine, but it is a little
6 tricky to interpret. In one graph that you had, imaging
7 increased by far the least, not very much at all. So do I
8 interpret that as a lack of supply of imaging, or do I
9 interpret it as physicians are actually getting better at
10 not ordering unnecessary imaging? So it can be a little
11 tricky interpreting volume. That's not a reason not to do
12 it, but I think it needs to be given in context.

13 The last thing I would just caution is be careful
14 with percentages versus absolute numbers. A 13 percent
15 increase in encounters for nurse practitioners and
16 physician assistants over the last few years, average a
17 year, that sounds pretty impressive, but actually over
18 three years, the increase in absolute numbers was 1.1 to
19 1.8. Looked at in those terms, it's not as impressive as
20 the percentage terms.

21 Also, it was mentioned 16 percent versus 84
22 percent. I can't remember exactly what that was. I think

1 one was NPs and PAs; the other was primary care physicians.
2 Again, given the very different denominators that we're
3 looking at, it's misleading, I think, to try to compare 16
4 to 84 percent. I'd always try to look at absolute numbers
5 and absolute differences as well as percentages.

6 DR. CROSSON: Okay. Dana and then Bruce. I'm
7 sorry. I wasn't keeping up with the list. So Bruce, Paul,
8 and then Dana.

9 MR. PYENSON: Thank you very much. I support the
10 recommendations, though I would ask consideration for an
11 RVU work unit-based metric taking out the practice expense
12 and the medical professional liability piece. It might be
13 useful or just another metric to test for consistency.

14 I think on the broader issue of the ultimate
15 chapter and the tasks we have, some recognition of the
16 changing nature of physician employment would be helpful.

17 I think much of what we do, perhaps even the
18 physician fee schedule, has an underlying assumption of
19 individual physicians who are self-employed or working in
20 small groups, and that is an assumption that may affect the
21 way we look at health care more broadly.

22 For example, a self-employed physician may have

1 different behaviors with respect to how they think about
2 answering emails and phone calls because they're building a
3 panel of patients, if you will, a business that's going to
4 persist for years. Whereas an employed physician who
5 doesn't get paid for that may have a different view of how
6 they work.

7 So it seems on the one hand almost easier to
8 think about physician practices in the same way that we
9 think about the financial indicators for adequacy of
10 hospitals or adequacy of other enterprises by looking at
11 whether there's adequate capital and other financial
12 metrics. How are the publicly traded outlooks? How is
13 that perceived?

14 So just some ideas on the broader topic to
15 recognize the changes, I think, all the Commissioners have
16 spoken to from our adequacy analysis.

17 DR. CROSSON: Thank you, Bruce.

18 Paul?

19 DR. PAUL GINSBURG: This is my second time, so
20 let me --

21 DR. CROSSON: Oh, okay. Dana?

22 DR. SAFRAN: Thank you.

1 So I guess I wanted to make two comments about
2 this was a great discussion, and I think the opportunity
3 that I see in front of us is really to leverage a workforce
4 that we didn't fully know we had. But in listening to a
5 lot of the comments of my colleagues, I see two things in
6 particular that I wanted to call out.

7 One is the opportunity to really in a formal and
8 very purposeful way integrate what happens for a patient in
9 the hospital back out to their primary care physician in
10 the community has been a gap forever. It's one that ACOs
11 are, I think, working to close, but I think it would be
12 good to harness the workforce that we have in hospitalists
13 to really formalize that and make it an expectation that
14 when a patient has been hospitalized that doctor to doctor
15 can really connect the dots for that patient and what is
16 needed for their care, even if they're not in an ACO, so
17 that that doesn't fall through the cracks.

18 The other is I was really struck by what Karen
19 was sharing about kind of seeing hospitalists as people
20 trained in internal medicine but who are really comfortable
21 with the high acuity and complexity, and thinking about
22 Jonathan's comments about his dad, remembering my own

1 experiences with my dad who passed away in 2012, but during
2 a several-month illness said that his primary care doctor
3 told him he could no longer take care of him because he was
4 too complicated.

5 So harnessing this idea of hospitalists as part
6 of the primary care workforce, though, I definitely support
7 segmenting them out so we don't lose track.

8 Doing what we can do to potentially promote this
9 idea that maybe they are really useful workforce, not just
10 when patients are in the hospital but when our
11 beneficiaries are complex and need a clinician who can look
12 after them as a primary care physician outside of the
13 hospital and is comfortable with that complexity and high
14 acuity.

15 So thanks.

16 DR. CROSSON: Thank you, Dana.

17 Paul?

18 DR. JAFFERY: Jay?

19 DR. CROSSON: On her point?

20 DR. JAFFERY: Yeah, it's sort of related to that.

21 I'll be very quick.

22 Thinking about the idea of people being

1 comfortable with their hospital training, then becoming
2 hospitalists, on Slide 4, you talk about the factors that
3 might influence decisions to become hospitalists.

4 The one thing that I don't think we heard come
5 out would really fall in that training, that first bucket,
6 the training one, which is that hospitalists or internal
7 medicine residents train largely in hospitals and are
8 comfortable in that role. I think it's just important for
9 us to call that out and think about it, maybe not so much
10 for this report specifically but going back to last month
11 in our conversations about graduate medical education
12 funding. It's something we should think about, how these
13 things track.

14 DR. CROSSON: Okay. Paul?

15 DR. PAUL GINSBURG: I just wanted to mention that
16 for our March reports on beneficiary access, the context
17 may have changed substantially because of the proposed rule
18 for the Medicare fee schedule that CMS has issued, and the
19 Commission has commented very favorably on a very
20 substantial increase in relative payments for outpatient
21 ambulatory evaluation management services. Of course, this
22 won't go into effect until, I guess, next year, and we'll

1 know this in November.

2 But the interesting thing is that it's probably
3 the most striking policy over a long period of time that's
4 specifically relevant to this issue of access to primary
5 care.

6 DR. CROSSON: Thank you, Paul.

7 Good discussion. Thank you, Brian and Carolyn
8 and Kevin. Thanks for coming back, Kevin.

9 [Laughter.]

10 DR. CROSSON: We'll move on to the next
11 discussion. Thank you.

12 [Pause.]

13 DR. CROSSON: Okay. We're going to move on to
14 the last presentation for the day. That has to do with the
15 continued discussion on the development of population-based
16 outcome measures, specifically avoidable hospitalizations
17 and avoidable emergency room visits.

18 Ledia is going to present. You have the mic.

19 MS. TABOR: Good afternoon. Today I'll present
20 background and analysis on two population-based outcome
21 measures -- avoidable hospitalizations and ED visits.

22 Consistent with the Commission's principles,

1 these measures are patient-oriented, encourage coordination
2 across providers and time, and promote relevant change in
3 the nature of the delivery system.

4 After the presentation, we would like your
5 feedback on next steps for our work with these measures.

6 The Commission's goal for quality measurement is
7 to use a small set of population-based outcome, patient
8 experience, and value measures to assess the quality of
9 care and create aligned incentives across different
10 populations such as beneficiaries enrolled in Medicare
11 Advantage plans, accountable care organizations, and fee-
12 for-service in defined market areas.

13 Today we'll talk about the use of avoidable
14 hospitalizations and ED visits as concepts that could be
15 translated into claims-based outcome measures to compare
16 quality of care for fee-for-service populations, given the
17 adverse patient impact and high cost of these events.

18 We contracted with RTI International to define
19 uniform avoidable hospitalizations and ED visits measure
20 specifications.

21 Hospitals are important to the delivery system
22 and are necessary to diagnosis and treat the sick and

1 injured. However, hospital stays can pose risks to
2 patients, particularly the elderly.

3 The inpatient environment itself can lead to a
4 reduction in elderly patients' independence as they cope
5 with functional loss that can stem from extended bed rest
6 or delirium.

7 Adverse events during the hospital stay also
8 represent a risk, including hospital-associated infections,
9 medication errors, and pressure ulcers.

10 Similarly, EDs are not the ideal venue for
11 treatment of non-urgent acute conditions and management of
12 chronic conditions because non-urgent utilization detracts
13 from ED resources for providing emergency and lifesaving
14 care.

15 Also, clinicians in the ED typically lack a
16 relationship with the patient and are unfamiliar with the
17 patient's baseline state.

18 Conceptually, avoidable hospitalizations and ED
19 visits may result from inadequate access to ambulatory care
20 or inadequate coordination of care received and as such may
21 reflect the effectiveness of the ambulatory care system.

22 Avoidable hospitalizations and ED visit measures

1 based on administrative data, if properly calibrated, can
2 be useful indicators of potentially high- or low-quality
3 care.

4 In practice, not every avoidable hospitalization
5 or ED visit can be avoided, but they can demonstrative
6 relatively quality.

7 We defined avoidable hospitalizations using
8 existing measures of ambulatory care sensitive conditions
9 that are currently used in the Medicare program. For
10 avoidable ED visits, we applied the same set of conditions
11 as used in defining avoidable hospitalizations and
12 incorporated other acute conditions from additional
13 research because there are less comprehensive existing
14 measures currently used in Medicare.

15 Two categories of ambulatory care-sensitive
16 conditions are counted in the measure definitions; first,
17 chronic conditions including diabetes, chronic obstructive
18 pulmonary disease, asthma, hypertension, and heart failure;
19 second, acute conditions including bacterial pneumonia,
20 urinary tract infections, cellulitis, and pressure ulcers.
21 The ED visits'
22 definition of avoidable conditions also includes upper

1 respiratory infection, otitis, rhinitis, influenza, and
2 non-specific back pain.

3 The measures assume that not every
4 hospitalization or ED visit tied to these conditions can be
5 avoided, but they can be used as relative markers of
6 quality.

7 Our definition of avoidable hospitalizations
8 included both inpatient admissions and observation stays.
9 From a patient's perspective, an observation stay in a
10 hospital is similar to an admission.

11 Our measure of avoidable ED visits consisted only
12 of ED visits that did not result in an admission or
13 observation stay.

14 Now that we have defined the two population-based
15 measures, I will walk through some of our analysis,
16 calculating measure results for the fee-for-service
17 population using 2017 claims data.

18 In 2017, about 4 percent of fee-for-service
19 beneficiaries had at least one avoidable hospitalization
20 while roughly 7 percent experienced an avoidable ED visit.
21 Nationally, the average rate of total observed avoidable
22 hospitalizations was 50.5 per 1,000 fee-for-service

1 beneficiaries, and the average rate of total avoidable ED
2 visits was 94.3 per 1,000 fee-for-service beneficiaries.

3 Avoidable hospitalizations due to chronic
4 conditions contributed more than avoidable hospitalizations
5 for acute conditions. This trend was reversed with
6 avoidable ED visits, with more avoidable ED visits for
7 acute conditions than chronic conditions.

8 For quality improvement, it is important for the
9 Medicare program to understand the nature of variation and
10 avoidable hospitalizations and ED visit rates across local
11 health care markets and the degree to which it reflects
12 genuine differences in quality versus differences in
13 underlying patient risk. Calculated at the local market
14 area level, comparatively high risk-adjusted rates of
15 avoidable hospitalizations and ED visits can be used to
16 identify opportunities for improvement in an area's
17 ambulatory care systems, even though not every
18 hospitalization or ED visit can be prevented.

19 In the risk adjustment model, we controlled for
20 patient demographic characteristics such as age and gender
21 and clinical conditions primarily based on HCCs. Consistent
22 with the Commission's principles for quality measurement,

1 we did not adjust for social risk factors in the risk
2 adjustment model itself to avoid masking disparities in
3 care.

4 To understand the nature of variation in
5 avoidable hospitalizations and ED visits across local
6 health care markets, we calculated risk standardized rates
7 of avoidable hospitalizations and ED visits for two
8 different types of market areas.

9 First, MedPAC has previously defined a set of
10 about 1,200 MedPAC market areas that are designed to
11 reflect local health care markets. The average fee-for-
12 service population in each MedPAC market area is about
13 25,000 beneficiaries.

14 We can reliably measure avoidable
15 hospitalizations and ED visit rates for most fee-for-
16 service beneficiaries in these larger areas. However, the
17 values may not be actionable for ambulatory care systems,
18 so we also calculated avoidable hospitalizations and ED
19 visit rates for more narrowly defined hospital service
20 areas.

21 There are about 3,400 Dartmouth-defined HSAs
22 comprising zip codes whose residents receive more of their

1 hospitalizations in that area. There are about three times
2 the number of HSAs than MedPAC market areas. The average
3 fee-for-service population in each HSA is about 10,000
4 beneficiaries.

5 This slide shows the distribution of percentiles
6 of performance for the MedPAC market areas. The MedPAC
7 market area at the 90th percentile of avoidable
8 hospitalizations had a rate that was 1.8 times the MedPAC
9 market area at the 10th percentile.

10 The MedPAC market area at the 90th percentile of
11 avoidable ED visits had a rate that was 2 times the MedPAC
12 market area at the 10th percentile. This variation in
13 performance signals opportunities for improvement.

14 Comparatively high or low risk-adjusted rates of
15 avoidable hospitalizations and ED visits can be used to
16 identify opportunities for improvement or best practices in
17 an area's ambulatory care systems.

18 To further understand the nature of variation in
19 avoidable hospitalizations and ED visit rates across MedPAC
20 market areas, we looked profiles of the MedPAC market areas
21 at selected percentiles of avoidable hospitalizations.

22 The Seattle MedPAC market area could be

1 considered a relatively high-performing area because its
2 rate on the avoidable hospitalizations measure -- the green
3 square -- is relatively high performing, and its rate on
4 the avoidable ED visit measure -- the orange triangle -- is
5 also high performing.

6 One of the rural Nebraska MedPAC market areas
7 could be considered a relatively average performing
8 ambulatory care system on both measures.

9 A rural Arkansas MedPAC market area could be
10 considered a relatively low performing ambulatory care
11 system because of its low performance on both measures.

12 MedPAC market areas may have relatively high
13 performance on one measure and not pm the other.

14 For example, a MedPAC market area in rural Ohio
15 is a relatively high performer on the avoidable
16 hospitalization measure, but low performing on the
17 avoidable ED visits measure.

18 By contrast, the Greenville, North Carolina,
19 MedPAC market area is a relatively low performing market
20 area on the avoidable hospitalizations measure, but a
21 higher performing MedPAC market area on the avoidable ED
22 visits measures.

1 I'll now switch to discussing results for the
2 more narrow HSAs.

3 This slide shows the distribution of percentiles
4 of performance on the measures of avoidable
5 hospitalizations and ED visits across HSAs.

6 The HSA at the 90th percentile of avoidable
7 hospitalizations performance had a rate that was 1.9 times
8 the HSA at the 10th percentile. The HSA at the 90th
9 percentile of avoidable ED visits performance had a rate
10 that 2.4 times the HSA in the 10th percentile of
11 performance. This variation in performance across HSAs
12 signals opportunities for improvement like the MedPAC
13 market areas.

14 HSAs are more representative of ambulatory care
15 systems than the larger MedPAC market areas. So
16 policymakers, providers, and beneficiaries may find it
17 beneficial to see the performance of HSAs compared to other
18 contiguous HSAs.

19 To further understand the nature of variation in
20 rates across contiguous HSAs, we selected one MedPAC market
21 area (Northern Virginia) and compared the rates of the 12
22 HSAs within that market area to each other.

1 For the Northern Virginia market area, the mean
2 risk-adjusted rate of avoidable hospitalizations is about
3 50 per 1,000 beneficiaries, and the rate of avoidable ED
4 visits is about 90 per 1,000 beneficiaries.

5 There are HSAs that are relatively high-
6 performing, low-performing, or average on both measures,
7 while other HSAs have relatively better performance on one
8 measure than the other. For example, HSAs 2 and 5 are
9 relatively high performing with both avoidable
10 hospitalizations -- the green squares -- and ED visits --
11 the orange triangles -- having rates below the means.

12 HSA 7 is relatively low performing with both
13 avoidable hospitalizations and ED visits rates above the
14 Northern Virginia mean.

15 HSA 10 is a relatively average performer on both
16 measures.

17 The other areas have about the same level of
18 performance on the measures or may be higher or lower
19 performing on one of the measures.

20 In summary, we developed uniform, claims-based,
21 risk-adjusted measures of avoidable hospitalizations and ED
22 visits. We compared the quality of care for fee-for-

1 service beneficiaries across two different local market
2 areas.

3 Overall, the variation in risk-standardized rates
4 of avoidable hospitalizations and ED visits for both the
5 MedPAC market areas and the HSAs signals opportunity to
6 improve the quality of care for fee-for-service ambulatory
7 care, especially in those areas with comparatively low
8 performance for both avoidable hospitalizations and ED
9 visits.

10 We plan to report out fee-for-service avoidable
11 hospitalizations and ED visit results as a part of the
12 physician update in the March reports to the Congress

13 This brings us to your discussion. We would your
14 input on potential next steps for our work including
15 analyzing areas that are both relatively high performing
16 and low performing to identify factors that affect
17 performance.

18 For example, we could analyze common factors
19 across high-performing HSAs that may lead to better
20 preventive care, such as higher rates of primary care
21 clinicians per capita and ACOs in the area that have
22 incentives to improve preventive care and lower

1 hospitalizations and ED visits.

2 The goal of this analysis would be to identify
3 best practices that may lead to higher performing
4 ambulatory care systems, which could help inform Commission
5 discussion on a variety of different topics.

6 As a part of this work, we would include areas
7 with a higher proportion of patients with social risk
8 factors that achieve relatively high performance. We know
9 that social risk factors can affect measure performance, so
10 effective technical assistance should be targeted to the
11 low-performing areas.

12 We can also continue to explore using these
13 measures to compare the quality of care across fee-for-
14 service, ACOs, and MA.

15 Thank you, and I'll turn it back to Jay.

16 DR. CROSSON: Thank you, Ledia. Excellent.

17 Let's have clarifying questions. We'll start
18 with Marge.

19 MS. MARJORIE GINSBURG: This is very exciting
20 work, and it's wonderful to really start focusing on
21 something that has such a need.

22 The goal is to look at all three types of

1 services -- MAs, ACOs, and fee-for-service. All the
2 information presented here looks like it's just on the fee-
3 for-service world. Is that because they were the easiest
4 ones to pull and until you get a thumbs up from us you
5 weren't going to try to figure this out for the ACO and MA
6 world?

7 MS. TABOR: That's a great question. So the
8 analysis that we presented here today includes fee-for-
9 service plus ACO beneficiaries, so it's the global fee-for-
10 service. And you're right, we did just kind of want to
11 start off -- I think the biggest goal that I had in mind
12 was creating uniform measures because we don't have those.
13 So now we have those. We tested them out on fee-for-
14 service. They seemed to work well. Now if you all would
15 like, we can go forward and kind of try to do ACO and MA.
16 I will say it's not going to be easy, particularly with MA
17 because of the encounter data not being as complete as we
18 would like it to be, and then also we'd have to look at
19 kind of coding differences between the populations. So I
20 think we can kind of keep exploring it, and this was a good
21 first step.

22 DR. CROSSON: Thank you, Marge. Larry.

1 DR. CASALINO: Yeah, just a question about what
2 you called in the report a weak correlation. By the way, I
3 thought it was a great report, and I love ambulatory care
4 sensitive admissions. Now I don't really want to
5 participate in --

6 MS. TABOR: Yeah, right.

7 [Laughter.]

8 DR. CASALINO: But you point out that there's a
9 weak correlation, and the graph seemed to show that. But I
10 wonder if there's one thing that's a little bit of a
11 problem for that analysis, and maybe it needs a little
12 deeper digging.

13 If I understand correctly, so if there's an
14 ambulatory credit sensitive hospitalization that happened,
15 you know, first someone comes into the ED, it's an
16 ambulatory care sensitive ED visit, then they get
17 hospitalized. You're counting ambulatory care sensitive
18 hospitalization but not the ambulatory care sensitive ED
19 visit.

20 MS. TABOR: Right.

21 DR. CASALINO: And that makes sense from a point
22 of view of not double counting, I think. But if you want

1 to talk about correlations, the more ambulatory care
2 sensitive hospitalizations they are, assuming that most if
3 not all of them are associated with ambulatory care
4 sensitive ED visits, the fewer ambulatory care sensitive ED
5 visits there will be, if I'm thinking about that correctly.
6 So that would weaken the correlation, I think, and so it
7 might be interesting to try to look at the correlation if
8 you count all the ambulatory care sensitive
9 hospitalizations and all the ambulatory care sensitive ED
10 visits and see if the correlation is higher. I suspect it
11 would be.

12 MS. TABOR: Yeah, I did not look at that, but
13 that's an interesting idea.

14 DR. CASALINO: And I think that's not true,
15 though. I mean, I think that actually makes a difference.

16 MS. TABOR: Right.

17 DR. CASALINO: Because I would actually expect
18 them to be fairly highly correlated, and it's a little bit
19 of a mystery to me why they aren't. That might explain
20 part of it least.

21 MS. TABOR: Yeah, that's a good point. We can
22 look at that.

1 DR. CROSSON: Dana.

2 DR. SAFRAN: Exciting work, glad that you are
3 undertaking it, and it feels like it could be a long road.
4 So it's good to take the first step -- right? -- as the
5 saying goes. A couple of thoughts, one sort of where Larry
6 was going. Because we know that such a high percentage of
7 emergency room care by other algorithms is coded as
8 unnecessary and so much of admissions comes through the
9 emergency room, it does seem important to just get a read
10 on how much of these emergency room visits are turning into
11 admissions. So that's one thought.

12 The second thought is on Slide 12, I think it
13 was, where you showed the MSA view, I think I get with your
14 benchmarks, your two different benchmarks there, that
15 actually these paired data points don't tell that different
16 of a story from the story we saw a couple slides before it.

17 MS. TABOR: Right.

18 DR. SAFRAN: But on the face of it, it looks like
19 it tells a really different story, so I would just flag
20 that and say like the y axis that you used before around
21 percentile -- what did you use? -- percentiles of
22 performance is probably a helpful way to look at that, just

1 so we can get a better sense of how tightly these things
2 are related.

3 I wondered two things. One is do you already
4 know sample size needed for reliable measurement here?

5 MS. TABOR: Right, so based on some previous
6 work, we used a minimum sample size of 1,000 beneficiaries,
7 and we're actually working with the same contract team to
8 see how much smaller we can go.

9 DR. SAFRAN: Yeah.

10 MS. TABOR: So we did kind of -- so we'll have
11 more information, I guess, when we come back, but 1,000 was
12 our reliability standard.

13 DR. SAFRAN: And does 1,000 get you 0.7
14 reliability at the --

15 MS. TABOR: I don't want to say a number yet --

16 DR. SAFRAN: -- you're looking at?

17 MS. TABOR: -- because, again, we're still
18 working on it.

19 DR. SAFRAN: Okay.

20 MS. TABOR: We felt kind of confident enough with
21 the 1,000 just based on our kind of back-of-the-envelope
22 stuff, but as far as getting an actual reliability metric,

1 we'll come back to you.

2 DR. SAFRAN: Okay. The reason I want us to keep
3 that in our sights is at some point you probably want to
4 move this measure from, I'll call it, surveillance measure
5 to an accountability measure. And I think we're going to
6 be challenged with that. I mean, anything that has
7 potentially avoidable is always a hard sell with those who
8 are being held accountable for it if you can't prove that
9 it was avoidable. But just getting a handle on the sample
10 size, it seems important.

11 Then my last question was -- what? Oh, avoidable
12 ED, when I looked at your list, I wondered how often do we
13 think that the beneficiary would kind of know that -- like
14 if they understand the distinction between like what you
15 need an emergency room for and what you don't, how often
16 they would actually think this is potentially an emergency?
17 Like the unspecified back pain or however you described
18 that, you know, somebody could think they're having a heart
19 attack and go off to the emergency room. It turns out it
20 was, you know, just unspecified back pain. But I just -- I
21 wondered if you've looked at the ED measure through that
22 lens of, you know, whether the beneficiary could actually

1 think there is an emergency here and should we be trying to
2 parse that out from the avoidability or at least keep --
3 even if we lump it in, know which segment of avoidable ED
4 visits may not be avoidable based on what a person thinks
5 is the level of care that they need.

6 MS. TABOR: Yeah, that's a good point. I will
7 say that patient preference definitely plays a role in
8 this, and the literature talks about that. And I'm not a
9 clinician, so I kind of, you know, won't get into what
10 truly is preventable or not, but I think this is just kind
11 of a good sense of this could be potentially preventable,
12 knowing that not everything can actually be avoidable.

13 DR. CROSSON: Karen, do you want to come in on
14 this?

15 DR. DeSALVO: Maybe just to make a -- to this
16 accountability point, I could easily see how if everyone
17 were -- if all clinicians were held accountable for
18 avoidable ED admissions, you could go down a pathway pretty
19 clear where there'd be contested diagnostic codes based
20 upon what the ER put in or the hospital, and that could
21 create some -- the opposite, of coordination of care and
22 communication, and so just being careful about exactly

1 making sure the measures are right and that we're threading
2 that needle well, so we're creating teams and partnership
3 and not a battle on the front line.

4 DR. CROSSON: You know, I know from -- in the
5 insurance world in terms of coverage, thinking about this,
6 it's often better to look at the presenting complaint than
7 it is to look at what the diagnosis at the end is. That
8 gets to the question of what the beneficiary thought they
9 might be having a heart attack or whatever. I don't know
10 how accessible that information is.

11 DR. DeSALVO: Yeah, I was going to ask that
12 question about which codes these are, and not to be very
13 negative late in the afternoon, but you could also see a
14 world in which there was some gaming of documentation, to
15 document things that were --

16 MS. TABOR: Absolutely.

17 DR. DeSALVO: -- different than maybe the
18 presentation just so that you didn't get dinged with
19 avoidable admissions.

20 DR. CROSSON: Okay. David.

21 DR. GRABOWSKI: Great. Thanks, Ledia, for this
22 work. I think it's shaping up really well.

1 I wanted to ask about the ambulatory care
2 sensitive condition. Similar to Larry, I've worked with
3 those, and we like them. One thing, however, you know,
4 we've gotten -- when we've obtained these really
5 interesting results, we've then gone and run the model on
6 all hospitalizations and gotten the same result. And so
7 this speaks to Karen's issues and others that these
8 measures aren't maybe picking up quite what they think --
9 what we think they should be. And so I just wanted to ask,
10 have you looked at all sort of conditions and whether those
11 results look kind of different across markets? Or are
12 these sort of ambulatory care sensitive hospitalizations --
13 we haven't looked at ED visits in our work. Maybe others
14 have. But at least in our work, the hospitalizations seem
15 to be pretty well correlated with overall hospitalizations.
16 Is that true here?

17 MS. TABOR: They are correlated. I haven't
18 looked at them kind of market by market, but just on a
19 national level, there's a correlation between both the
20 hospitalizations and the ED visits, and that would be, I
21 think, an interesting kind of follow-up piece to do of
22 looking at just risk-adjusted total admissions in a market

1 area versus these avoidable and do the same for ED.

2 DR. GRABOWSKI: Yeah, and then it --

3 MS. TABOR: We can come back to you on that.

4 DR. GRABOWSKI: Oh, sorry. Go --

5 MS. TABOR: I was going to say we can come back
6 to you on that.

7 DR. GRABOWSKI: Yeah, and I think it may get you
8 out of some of these issues Karen just raised about coding
9 and other things, just to look overall. I realize there's
10 something very nice, and I agree with Dana, you don't want
11 to use the word "potentially avoidable," but there's some -
12 - I find something very maybe simple about just using all
13 hospitalizations.

14 My other question was about competing events, and
15 in addition to ED visits and hospitalizations, we hear a
16 lot about observation stays, and is that something that's
17 important in this context?

18 Then I guess the other competing event is
19 obviously mortality, and can you look at these rates
20 without thinking about those other competing events?

21 MS. TABOR: So we purposely actually did consider
22 the observation stays, and we included those in the

1 avoidable hospitalizations. So if you -- they're in there,
2 yeah. And I think in general we're trying to do that with
3 all of our quality measures just because, again, from the
4 beneficiary perspective, they're an admission.

5 And then your second point about mortality is
6 that we -- I haven't looked at them kind of all together,
7 but you'd think that we'd need kind of a full set of
8 outcome measures, which, depending on the accountability
9 program, could or could not include mortality.

10 DR. GRABOWSKI: Thanks.

11 DR. CROSSON: Okay. Thank you. Sue.

12 MS. THOMPSON: Thank you, and thank you, Ledia.
13 I, too, am excited about this conversation. In relation to
14 the question that Marge began with in terms of fee-for-
15 service, ACO, MA, by very nature of being an accountable
16 care organization, ACOs are astutely aware of what their
17 emergency department utilization rates are or what their
18 admission rates are and work to obviously reduce those and
19 provide the right care to the right patient at the right
20 time.

21 I'm curious. In the absence of some organized
22 system of care or an ACO, who's the accountable party for

1 ED utilization or an unnecessary admission? Have we
2 thought about that in the context of the broader fee-for-
3 service world?

4 MS. TABOR: I guess I would kind of turn that
5 over to you guys too.

6 I mean, one, I will say that, in principle, when
7 the Commission discussed the Voluntary Value Program, which
8 could replace MIPS, that one of the measures we talked
9 about using as an accountability for a large physician
10 group would be these two measures. I think we haven't
11 tested it out that way yet, but that's one direction this
12 could take.

13 DR. CROSSON: That would have been my answer as
14 well.

15 DR. MATHEWS: And another way to think about it
16 would be if there already is accountable entities, ACOs
17 that make plans, you could use the ambient fee-for-service
18 performance on these measures as a benchmark against which
19 their performance is assessed. So the rewards and
20 penalties aren't necessarily applied to a random collection
21 of fee-for-service provider, but is the accountable entity
22 doing sufficiently better to warrant a bonus, something

1 like that.

2 DR. DeSALVO: I also think that, probably, it
3 could -- potentially, it could encourage more team-based
4 care in the primary care environment. So these models like
5 global primary care payment that are being experimented
6 with by CMI or Medical Homes, they wouldn't necessarily
7 have to be part of a larger organization.

8 MS. THOMPSON: That's what I was going to say in
9 Round 2, but that's good.

10 [Laughter.]

11 DR. CROSSON: Round leakage.

12 Okay. Pat?

13 MS. WANG: I think it's more of a Round 2 comment
14 too.

15 DR. CROSSON: Round 2. Okay, honesty. Okay.

16 [Laughter.]

17 DR. CROSSON: Bruce?

18 MR. PYENSON: I want to pick up on David's Round
19 2 comment.

20 [Laughter.]

21 MR. PYENSON: Just on Slide 11, if we could go to
22 the numbers here, I think the background here, the average

1 admits per thousand in the Medicare population is perhaps
2 350 or something.

3 MS. TABOR: Yeah. I would adjust those. Yeah.

4 MR. PYENSON: I'm sorry? Oh. But something just
5 to put it in context.

6 So we're talking about at the 50th percentile a
7 pretty big chunk of at least the national average
8 admissions. Is that the right interpretation?

9 MS. TABOR: I guess I haven't thought about it
10 with percentiles, but I have thought about it with
11 percentages. So about 18 percent of fee-for-service
12 beneficiaries have a hospitalization a year and about 4
13 percent have an avoidable hospitalization, so that's about
14 a third.

15 MR. PYENSON: But the 18 percent, it includes
16 more than one hospitalization, perhaps, probably?

17 MS. TABOR: Correct, correct.

18 MR. PYENSON: So your number was about a third?

19 MS. TABOR: About a third, yeah.

20 MR. PYENSON: A third. I mean, this is a big
21 deal, right?

22 MS. TABOR: Yeah.

1 MR. PYENSON: Another question, we're calling
2 these "avoidable hospitalizations," and others have said
3 "ambulatory care-sensitive admissions." It strikes me
4 there's other categories of avoidable admissions.

5 MS. TABOR: It's really just nomenclature. So
6 AHRQ has used this term, "ambulatory care-sensitive
7 conditions." 3M used "potentially preventable." NCQA uses
8 "potential complications." So we just kind of picked a
9 nomenclature of "avoidable" and stuck with it.

10 MR. PYENSON: But there's also like "preference-
11 sensitive," like someone gets back surgery or hip surgery,
12 and that was the preference of the doctor or patient versus
13 --

14 MS. TABOR: Right. I would say that's different,
15 though, because I don't think we necessarily included any
16 preference-sensitive conditions, other than you preferred
17 to go to the ED and you went.

18 MR. PYENSON: In terms of when we think about
19 regions that have low hospitalization rates, overall that
20 could reflect preference-sensitive as well as other -- as
21 the ambulatory care-sensitive.

22 DR. CASALINO: [Speaking off microphone.]

1 MS. TABOR: Right.

2 DR. CASALINO: Ambulatory care-sensitive in
3 total.

4 MR. PYENSON: Yeah. In total.

5 MS. BUTO: [Speaking off microphone.]

6 MR. PYENSON: As Kathy said, read.

7 My view is the same as David's that they're all
8 correlated, the lower admission, lower readmissions, low
9 preference-sensitive admissions, lower ambulatory care-
10 sensitive admissions."

11 I'm wondering if that kind of lining those up
12 would be -- if the data holds or the hypothesis holds.
13 What do you think?

14 MS. TABOR: We haven't looked at it that way, but
15 I think it would be interesting. So we can do that as a
16 follow-up step.

17 MR. PYENSON: Thank you.

18 DR. CROSSON: Marge, question?

19 MS. MARJORIE GINSBURG: So for unnecessary ER
20 visits, would it make a difference if, in fact, the patient
21 called their doctor and the doctor said go to the ER,
22 mainly because they didn't have any openings in their

1 appointment that day, and they basically wanted to get off
2 the call? So is there any way at all of tracking that, and
3 would that make a difference?

4 MS. TABOR: In our current world of the data we
5 have available to us, we wouldn't be able to make those
6 distinctions.

7 DR. CROSSON: Okay.

8 UNIDENTIFIED: [Speaking off microphone.]

9 DR. CROSSON: All right. You've taken a long
10 lead off of first base, I can see. Yes.

11 UNIDENTIFIED: [Speaking off microphone.]

12 DR. CROSSON: Yes. Go ahead.

13 DR. DeSALVO: I'm sorry. No, I'm not going to
14 steal your thunder. Never do that.

15 I just wondered if you have the level of data to
16 know what kind -- what the code was of the clinician, the
17 doctor that admitted them. So you could look at whether
18 the hospital was staffed by a hospitalist or the primary
19 care physician had to come in and do the admission. I'm
20 just trying to figure out this weirdness where sometimes
21 people are not admitted, you know, in some communities
22 where there's more ED visits than hospital. And it might

1 have something to do with who's actually --

2 MS. TABOR: Doing the admitting?

3 DR. DeSALVO: -- literally on call or --

4 MS. TABOR: Yeah. That is an increasing question
5 that I'd have to look into some more.

6 DR. CROSSON: Okay. So we are now at the
7 discussion phase, and Amol will begin.

8 DR. NAVATHE: So, Ledia, as always, thank you for
9 a clear, concise presentation and paper.

10 I think as we kind of put focus on these two
11 measures, my sense is, the way you kind of put them forward
12 as consistent with Commission priorities, I think, makes a
13 lot of sense. I think we generally, of course, want to
14 support transparent, simple measures that can be commonly
15 measured across different types of programs, and I think
16 that makes a lot of sense.

17 The other thing I'll say is that as somebody who
18 works with these types of measures quite a bit, there's
19 obviously no such thing as a perfect measure, and so, at
20 some point, we're going to have to pull the trigger and say
21 this is a measure we want to use and double down on.

22 I think it's also nice that there's alignment

1 between these measures and other measures that we see in
2 other programs, including ACO programs and more recently
3 primary care first and the direct contracting for Medicare.
4 So I think that alignment is beneficiary because it means
5 that it's less jarring to the extent that we propose this
6 in order to get it adopted to providers who are actually
7 operating in various models in a kind of longitudinal
8 sense.

9 I do think it's worth pausing on the nomenclature
10 a little bit, and we should think about it because I think
11 it does have a psychological impact on how people think
12 about the measure. So the distinction between ambulatory
13 care-sensitive and avoidable is actually pretty different
14 in terms of what we're telling people it means. So that's
15 worth visiting.

16 I think there's a couple other pieces that I
17 would highlight and perhaps some suggestions that build
18 upon what other Commissioners have already started to, I
19 think, get at in terms of exploring the value, the validity
20 of the measure in a kind of broader sense.

21 So the one observation, I think, that's important
22 to think about is to the extent that we're using this as a

1 measure of the performance of the ambulatory care system
2 within a market, then to me, it seems like the conceptual
3 framing there is we should have a common performance across
4 both measures. So if we have a well-functioning ambulatory
5 system, then we should both get lower avoidable ED and
6 lower avoidable hospitalizations.

7 I think the observation -- so I think it was on
8 Slide 10, for example -- that you have specific HSAs or
9 markets where there's discordance between the two is
10 potentially a problematic piece.

11 I think Larry pointed out important potential
12 "fix" on it, but I think that also perhaps brings a
13 convergence of the measures because if we are including
14 avoidable ED within hospitalization, then I think, in some
15 sense, the difference between them starts to blend. The
16 correlation will certainly go up, but then the distinction
17 also goes away.

18 So one thought is, Should we be thinking about
19 this as avoidable ambulatory care-sensitive events or
20 something like that as a way to unify the two and have a
21 measure which is more likely, presumably, to be consistent?

22 I could imagine again being in the room with one

1 of our hospital administrators or primary care physician
2 practices and them saying, "So the same infrastructure is
3 leading me to perform the top quartile of one measure and
4 then the bottom quartile, and we're doing the same stuff
5 for both of them." So I think we want to try to avoid that
6 discordance because that could, I think, be particularly
7 pernicious to the success of the measure from an engagement
8 by an adoption.

9 DR. CASALINO: [Speaking off microphone.]

10 DR. NAVATHE: I'm sorry?

11 DR. CASALINO: [Speaking off microphone.]

12 DR. NAVATHE: Unify them, making it an ambulatory
13 care-sensitive events measure, encompassing both pieces of
14 it.

15 In terms of other things that one could do or we
16 could do here to sort of build some validity around the
17 measure, we have done work on other measures, like
18 readmissions measures, where we see really big swings in
19 longitudinal variation.

20 For example, I was observing here that we're
21 using 2017 data. When we looked at the readmissions
22 measure -- this is a few years ago -- we saw that hospitals

1 could go from bottom quartile to top quartile year to year,
2 and there was actually a pretty large share of them that
3 were bouncing around. It's very unlikely that big
4 infrastructure is changing so much year to year, such that
5 we would see that volatility.

6 So I think one thing we could do here is look at
7 the longitudinal variation within markets and see how much
8 we're seeing. If we're seeing a lot of variation, I think
9 that would kind of raise a question of how valid it is.

10 Another question is thinking about this notion,
11 and I think Bruce was getting at this, which was kind of
12 practice style, preference style within a market, and can
13 we do something to actually account for it?

14 If we were to do this at the provider level, we
15 could actually try to control for the sort of market style
16 in some sense by looking at everybody else outside, except
17 for them in the market, and using that as a variable to
18 control for. So that might be a way to try to get away
19 from just capturing purely practice style and trying to
20 actually understand what performance is looking like. That
21 would be hard to do at the market level, easier to do at
22 the provider level, as we get there.

1 The other thing we could do is look within
2 condition here. I think we have a set of conditions, and
3 ensuring that we have validity within condition would also,
4 I think, build a case that consolidated across condition
5 measure also makes sense.

6 The two last suggestions -- and then I'll close
7 here -- to the extent that we decided we wanted to use the
8 word "avoidable," I think it would behoove us to do some
9 deeper work to see what proportion of these ambulatory
10 care-sensitive condition admissions are actually avoidable.
11 That would mean getting access to clinical data or doing
12 some sort of deep dive, so to speak, charge review type of
13 work in perhaps a selective fashion to really try to elicit
14 that. Otherwise, I think it's hard for us to push to call
15 it "avoidable."

16 And the last piece, I would say I support a lot
17 of -- I think the general construct, of course, of the
18 measure/measures, that follow-on analyses that you have
19 outlined as next steps, I think, make a lot of sense and in
20 particular would support the idea that to the extent that
21 there are unified markets where we're seeing high
22 performance, that there are lessons we can take around the

1 capabilities of those markets, the practice patterns,
2 composition of the types of providers that are in those
3 markets. I think we could actually learn a lot there, and
4 I think that sort of positive deviance analysis could be
5 very helpful as we start to think about translating this
6 into technical support and more tactical sorts of
7 recommendations.

8 DR. CROSSON: Thank you, Amol.

9 I just want to make a comment. First, I think I
10 like the direction you've taken with respect to the
11 ambulatory-sensitive one. I think for a lot of different
12 reasons, it avoids some opposition which occurs
13 reflexively.

14 The notion of combining the two under a
15 terminology of "ambulatory-sensitive events," the first
16 question I had in mind is, Are there other events other
17 than hospitalization or ER visits that you would think
18 might or should be included in that? Maybe you can just
19 think about that because, I mean, I don't know, but I would
20 imagine that there are some.

21 DR. PERLIN: Drug-drug interactions from
22 different providers.

1 DR. CROSSON: That's certainly one.

2 DR. NAVATHE: Yes. I think that's a great point,
3 and I don't have an answer off the cuff for you. But I
4 think I'll put my thinking cap on and get back to you.

5 DR. CROSSON: Yes, Jim.

6 DR. MATHEWS: Yes. When we kicked this around
7 internally, we also were struck by the fact that
8 performance within an area was not consistent on two
9 measures that ostensibly reflected the adequacy of the
10 ambulatory care infrastructure.

11 Again, this is kind of developmental work. We're
12 just kind of figuring it out, but one of the things we
13 talked about pursuing when we start doing case studies, if
14 that's what we end up doing, is things like does the supply
15 of urgent care centers in an area represent a safety valve
16 that could keep patients from showing up at the emergency
17 department, while still showing up at fairly high rates in
18 the hospital inpatient setting.

19 So there are things we still want to pursue here,
20 but the ideas that have been expressed here are extremely
21 helpful in that regard.

22 DR. CROSSON: I'm sorry to interrupt, but I just

1 want to make one more comment on top of Jim's there. And
2 it has to do with potential explanations, not for the
3 divergent examples here, but for the convergent one on the
4 left, which is Seattle.

5 Now, I think in addition to looking at ACOs,
6 looking, if it's possible, more broadly at the presence of
7 integrated delivery systems of various types would be
8 useful, whether they're ACOs or not, because I know Seattle
9 is one of the most concentrated markets for that model of
10 care. And that could explain not anything to do with the
11 divergent markets but the convergence and the quality, the
12 relative high performance on both measures.

13 Okay. I'm sorry. Let's go. Pat, Jon, Dana,
14 Larry.

15 MS. WANG: So I'll slide into Round 2 with what I
16 was going to ask in Round 1.

17 I just want to confirm that what you're
18 describing here as avoidable or whatever calling admissions
19 includes avoidable readmissions.

20 MS. TABOR: We only count it based on the initial
21 admission.

22 MS. WANG: Okay.

1 MS. TABOR: So if you are readmitted, you only
2 get once, and that was a question that we thought about
3 with measure developers and just picked away.

4 MS. WANG: Okay. Because that is, obviously,
5 like already an area of deep examination and opinion.

6 MS. TABOR: Right.

7 MS. WANG: I don't know. Maybe there's a way to
8 reconcile that these things either are alike or not alike
9 because the description of the events as ambulatory care-
10 sensitive, I really appreciate what you said, your
11 suggestion about this.

12 I am uneasy, though, that it's really all about
13 ambulatory care. I do think that there are a lot of other
14 things going on here. It's very complex. Everybody around
15 the table has sort of acknowledged that, but there are many
16 truths going on at the same time. I mean, there are, in
17 most states, actually prudent layperson laws that require
18 insurance companies to pay for avoidable emergency room
19 care if the patient thought that it was an emergency and
20 that they were in imminent danger of severe injury, death,
21 blah-blah-blah.

22 So the concept that people were talking about

1 before the subjectivity about what brings somebody to the
2 ER and maybe get treated and released from the provider's
3 perspective is that's a prudent layperson. The person
4 actually thought they needed it. I'm not sure what having
5 the greater ambulatory care system in the world would do to
6 avoid that.

7 Another sort of set of cognitive, dissonance
8 truths is that from a hospital perspective, what we're
9 calling an "avoidable admission" is medically necessary.
10 So from their perspective -- the person walks into the ER.
11 They don't have any contact with them. They've never seen
12 them before. They admit them. It's medically necessarily.
13 So to kind of characterize that as something that could
14 have been avoided, it goes to the question of "What does
15 that mean, 'Who's accountable for that?'" I think that, in
16 that regard, we do have to be kind of -- I think the work
17 is really, really important, and the refinements that
18 people have suggested in sort of reconciling the data and
19 so forth is great.

20 But I think that we should be careful about
21 rushing to like we're going to use this to reward and
22 punish across provider sectors, across payment systems.

1 Just hesitate a little bit on that because when you talk
2 about avoidable and the sufficiency of an ambulatory care
3 system to prevent much of what you have displayed here, I
4 think people would say, "Look this is beyond me." It's
5 housing. It's food. It's people's fears. It's their
6 psychology.

7 They may have the greatest relationship with
8 their PCP in the world, and the PCP might be fantastic, but
9 a PCP will say, "I can't stop my patient from going to the
10 emergency room. She just likes to go to the emergency
11 room." It sounds weird, but it's true. I mean, people go
12 to the emergency room for really strange reasons, and I
13 don't think it's a very simple -- I think it's hard to pin
14 that all no sufficiency or deficiency of an ambulatory care
15 infrastructure.

16 The other sort of thing that I know you mentioned
17 and I think is critically important is, at some point,
18 looking at socioeconomic status, and to the extent that we
19 are looking at sufficiency and influence of ambulatory care
20 infrastructure, I just wonder whether an additional factor
21 in that adjustment or look would be sort of the
22 distribution of health profession shortage areas, which if

1 there are still legitimate designations, sort of our
2 markers of areas where there is insufficient physician
3 supply, that might help explain or not maybe some of the
4 incidents and the utilization that you see.

5 The final thing is just a small one. When you do
6 get to looking at Medicare Advantage, which in the Star
7 system is held to an all-cause readmission rate -- and
8 there is reward and punishment around that, and it's true
9 that it's plan to plan. But plans in New York City are
10 compared to plans in Seattle in terms of their success or
11 failure at that metric. But when you get there, I think
12 this measure specification changed recently. So I think
13 it's still on display to include denials, which is very
14 important because what you don't want to be capturing is
15 what looks like a great rate because of payer practices
16 around denials. So just put it on your radar screen.

17 Thanks.

18 DR. CROSSON: Thank you, Pat. Jon.

19 DR. PERLIN: Well, thanks. This is really an
20 important line of inquiry and thank you for a really
21 thoughtful review. I want to identify with Pat's and
22 previous speakers' comments on a number of areas.

1 I, too, would agree that this is directional but
2 not diagnostic, and I think, Pat, you said it really well,
3 is that this probably reflects more about integrity of the
4 overall infrastructure than just, you know, sort of
5 ambulatory services, but that would be a large part of it.

6 I can't help but wonder how social determinants -
7 - geographic, urban, rural -- and patient behavioral
8 factors play into the differences in utilization, as well
9 different sort of characteristics about how people access
10 care in different environments. Having the privilege of
11 being in a large distributed system across numerous states,
12 the infrastructure so very different but so, too, are the
13 behaviors about when and how people seek care. I have to
14 just say that New York and Florida have more income than
15 Florida and parts of Georgia. And, you know, it's pretty
16 well demonstrated in a variety of metrics.

17 I do think this does relate to our prior
18 conversation, though, and I wonder about this as a bit of a
19 referendum or another piece of data on primary care
20 infrastructure access sufficiency.

21 I, too, had noted, you know, Jim, the question
22 about whether urgent care centers do, in these instances,

1 provide somewhat of a safety valve. We talked previously
2 about whether they were concentrated in more commercial
3 areas, but, in fact, in areas where they may exist in
4 Medicare populations is a very important question.

5 I think we have to have, you know, some
6 sensitivity to the patient behavioral factors that actually
7 were really well reported, by you, and the comparison of ER
8 versus urgent care center utilization. If you recall, for
9 just nominally the same conditions, patients who presented
10 to emergency rooms, if I recall the numbers, had -- what
11 was it? -- 3.41 comorbidities compared to urgent care
12 presentations, for the nominal same condition, 2.0
13 comorbidities. So there was some sort of self-selection
14 about when and how people accessed care.

15 So putting it all together, along with maybe a
16 final comment on, you know, our confidence in the
17 definition of what, in fact, is avoidable, you know,
18 particularly along the lines, as I just mentioned, if you
19 have a bunch of comorbidities -- you know, diabetes, heart
20 failure, hypertension, coronary artery disease, and a cough
21 -- you may have a real different sensitivity for access
22 than if you have, you know, a cough and the absence of

1 those comorbidities.

2 So to your sort of three questions there, yes, I
3 think continue the analysis and begin to understand, you
4 know, what is, in fact, just not directional but
5 diagnostic.

6 I think the second question may be premature. I
7 think it's difficult to say at this juncture what are the
8 best practices until we understand what the features are
9 that really lead to the utilization, though that line of
10 inquiry may inform the former. And I think it is worth
11 looking at other payment models to understand what it is
12 that makes a more robust infrastructure.

13 Thanks.

14 DR. CROSSON: Okay. Thank you. Dana. I'm
15 sorry. No, Jonathan, were you in line?

16 DR. JAFFERY: I thought I was.

17 DR. CROSSON: Okay, well, we may have gotten your
18 name wrong.

19 [Laughter.]

20 DR. JAFFERY: I'll be Jay.

21 DR. CROSSON: Okay. Can one of you change your
22 name?

1 [Laughter.]

2 DR. CROSSON: Jonathan and then Dana.

3 DR. JAFFERY: Thanks. Ledia, thanks. I really
4 appreciate you diving into what obviously could be a long-
5 term thing.

6 So, you know, I think it's great to try and get
7 to things that we can compare across the ACOs, MA, and
8 traditional fee-for-service. So even though it can clearly
9 be a big lift, this is good work.

10 I think, you know, you are asking, in the first
11 bullet point, about different ways to identify factors that
12 affect performance, and one thing that came to mind is
13 that, you know, there's some stuff in the literature about,
14 thinking about ACOs in particular, about physician-led ACOs
15 versus ACOs that include hospitals. Various conclusions
16 have been drawn and I think some of our own work here maybe
17 doesn't totally align with.

18 But in any event, that might be an interesting
19 thing to look at, when one of the proposals or hypotheses
20 has been that ACOs that include hospitals aren't incentive
21 to avoid these kinds of things, because they get paid this
22 way. So that's something to think about.

1 I think also the point about combining events to
2 get at some of the divergent issues is interesting, and I
3 do wonder about if the absolute numbers, for example, the
4 absolute number of ED visits might overshadow things. I
5 mean, if you look at the MedPAC market area there are more
6 ED visits in the 10 percentile than there are avoidable
7 hospitalizations in the 90th. And so that would be
8 something to have to think through.

9 And then, finally, just in the report you talk
10 about some of the -- you have a description of some of the
11 negatives of avoidable events, and one thing that isn't
12 there, that I think might be -- you might be able to
13 quantify that and would be good to try to report on more in
14 general, is what the cost is to beneficiaries. We talk
15 about the cost of the system and the life impact to the
16 beneficiary but there are some quantifiable costs to
17 beneficiaries that it would be nice to try and avoid.

18 So thanks.

19 DR. CROSSON: Thank you. Dana.

20 DR. SAFRAN: Great. Thanks. So late in the day
21 this may be an idea that makes no sense at all, or it may
22 be so obvious that we'll think, like, why didn't we think

1 of this before? We want to compare across these different
2 major system approaches that we have, and I'm wondering, as
3 I sit here, knowing that ultimately where we'll want to go
4 with this is having the providers that work in these
5 systems act on the information, and, therefore, likely be
6 accountable, I'm wondering if we're starting in a place
7 that's too hard.

8 That is, we've talked quite a bit in the last
9 hour about how challenging it will be, even if we change
10 the nomenclature, to get from measures that really were
11 uncertain whether something was avoidable or not, and
12 whether the source of the avoidability, if it was, is care
13 versus other things. And I'm wondering, why not start
14 actually with some of the accountability measures that we
15 have today and use those to measure across systems?

16 Now I know when we've talked about it before, the
17 data from the Medicare Advantage system, or, to some
18 extent, the rate limiter hike, so, all right, well, so
19 let's start with the measures of accountability in the
20 Medicare Advantage system and work our way out from there
21 and say, if we compare ACOs and the broader fee-for-service
22 system, absent ACOs, to Medicare Advantage performance on

1 things like 30-day readmissions, or the other things where
2 we feel more confident in the underlying data from Medicare
3 Advantage because they're being held accountable, might
4 that be our best path for comparing across these three
5 pieces of the system, because once we have an answer then -
6 - well, first, we've already got validated measures that
7 are accepted and being used for accountability, and second,
8 we know how to point to where the action needs to happen.

9 So I hope that's a helpful thought, and if it's
10 not then we can just set it aside and keep working on new
11 measures.

12 Thanks.

13 DR. CROSSON: Thank you, Dana. Larry and then
14 Bruce.

15 DR. CASALINO: Thank you. I just want to come
16 back to the 1,000-beneficiary level, that you said if you
17 have 1,000 beneficiaries you can get reliable measures. I
18 think, you know, that is incredibly valuable information,
19 you know, if true, and if you can really strongly support
20 that, that really ought to be published, because it has
21 implications for all kinds of programs, all kinds of
22 accountability programs, all kinds of research. So I

1 didn't want that to get lost.

2 It would be worth looking at that year over year
3 too. So if you have 1,000 beneficiaries, minimum, how
4 correlated is the performance over a period of several
5 years? So that would be one point, which I really think is
6 important, actually. I wouldn't just let that go.

7 The second thing is, just want to talk about
8 whatever this is as a measure. Well, first of all, this,
9 as a measure, I really haven't listened to discussion -- or
10 to say it even more strongly, I think emphasizing the
11 disjunction between ED and hospitalization really is a
12 mistake, for the reason I just said. Every hospitalization
13 is going to reduce the ED, if you count it the way you're
14 counting it, and that doesn't make sense.

15 There are also problems with counting them both,
16 as Amol pointed out, and I think the composite measure
17 would solve that problem. Actually, presenting all three
18 ways of doing it could be useful.

19 I think that it would be useful -- Bruce kind of
20 was, again -- it would be useful within the tables, that
21 you showed us in the report, I think to show not just rates
22 of ambulatory care sensitive admission, but also -- and let

1 me just, by the way, I think it needs to be emphasized that
2 when we say ambulatory care sensitive or potentially
3 avoidable, we're not saying every one is avoidable. We're
4 saying on average they are somewhat avoidable. And so, you
5 know, you're comparing people on average to other people on
6 average. You're not saying you should avoid every one of
7 these. And providers' instinctive responses are going to
8 be, "Oh, you're saying I can avoid every one of these."
9 That's not true. That needs to be emphasized, I think.

10 But it would be good, I think, to show in tables
11 rates of ambulatory care sensitive admissions, overall
12 rates of hospitalization, 30-day readmissions. It would be
13 very illuminating, I think, to see those.

14 I do want to just say a little bit about
15 ambulatory care sensitive admissions to hospitalizations or
16 ED visits as a measure. We've had some discussions, like
17 the kind of things Pat was saying, I think, all true about,
18 you know, why these things might not be avoidable and all
19 the other factors that could come in. But you can say that
20 about a lot of performance measures, except for the ones
21 that are so dinky that they don't, in my opinion, mean
22 anything, like did you counsel your patients about stopping

1 smoking, or did you ask them if they smoked?

2 And, to me, one of the attractive things about
3 ambulatory care sensitive admissions is that is a global
4 measure, I think, to some extent, of how a system is taking
5 care of its patients. True, there are always problems with
6 it, and maybe the problems are enough not to use this as a
7 measure, but then I'm not so sure that the problems with
8 this are worse than with other measures that are being used
9 a lot. So I think everything has to be comparative.

10 And I would say, also, that, yes, if someone has
11 crushing substernal chest pain they are probably not going
12 to call their primary care physician and ask them should
13 they go to the emergency room, and that's fine. But most
14 emergency room visits are not for that, and I would argue
15 that if a system of care and a primary care physician have
16 proved their value to their patients, they will call their
17 primary care physician first, if they really think that
18 it's worth it, not if they have substernal chest pain but
19 if they have a cough or back pain or whatever.

20 So I'm not entirely sympathetic to the argument,
21 "Oh, my patients just do whatever they want. I can't stop
22 them from going to the emergency room when they want to."

1 There's something to that.

2 And the last thing I'll say is in terms of trying
3 to -- not too much has been said about it today but quite a
4 bit in the report -- trying to compare high performers
5 versus low performers, in terms of what makes them high and
6 low, I think we have had some people here say that's not
7 worth it right now because the measures aren't good enough.
8 But just assuming that it is for the moment, I don't know
9 if that much would come out of looking at this at a
10 geographic level, even a relatively small geographic level.

11 You know, Dartmouth didn't have, in my opinion, a
12 whole lot of luck explaining the geographic variation they
13 found in utilization by market level characteristics. I
14 think it is probably worth looking at social deprivation
15 indexes you suggested, things like that. But it probably
16 would be better done at the provider organization level,
17 like a hospital system in an area or whatever. In a lot of
18 those you would have enough beneficiaries.

19 There is a way of kind of systematically doing
20 that qualitatively that is pretty rigorous, and Betsy
21 Bradley used it and got a qualitative study published in
22 JAMA using it. I don't want to bore people with that right

1 now but I'd be happy to talk to you offline. It's
2 something that would be well within MedPAC's capability at
3 a quite reasonable cost. If you're measuring at the
4 provider system level I think it would be a good thing to
5 do.

6 Just the last thing I wanted to say, actually,
7 about this 1,000 beneficiaries, assuming that is the
8 number, what does that say then about MedPAC's principle of
9 not adjusting for SES in risk adjustment formulas but using
10 strata, and where would you be able to -- how would that
11 affect the ability to compare performance within
12 socioeconomic strata?

13 DR. CROSSON: Some data sets it would and in
14 others it wouldn't.

15 DR. CASALINO: Yeah.

16 DR. CROSSON: Bruce and then Kathy and then
17 Jaewon.

18 MR. PYENSON: Well, thank you very much. Ledia,
19 as you know, I'm enthusiastic about this work. I'm
20 actually not in favor of the first two bullets but perhaps
21 for reasons other than questioning the validity of the
22 metrics. I suspect what we'll find is what others have

1 found, which is it's incredibly hard to figure out how or
2 why particular regions accomplish what they do, partly
3 because there's lots and lots of different routes and
4 partly because it's more determined by the local culture,
5 defined very broadly.

6 And so I think others have certainly explored
7 that, and this is a well-worn area of research. There's
8 lots of different tools out there. 3M has its tool.
9 Dartmouth Atlas, you know, you go back 20 years, this is a
10 very well-worn area and I think incredibly valuable. But
11 what it identifies, I think, is that so many of the
12 determinants of health care are not medical, and I think
13 it's a mistake to try to medicalize population-level
14 outcomes such as we're talking about here.

15 And, in particular, I was happy to see mentioned
16 in the report the negative outcomes associated with
17 admissions such as delirium and debilitation, which are
18 mentioned but are not often measured. We tend to measure
19 things we can medicalize -- drug-drug interactions or
20 wrong-side surgeries or hospital-acquired infections. To
21 the extent we can measure any of them, they are well-
22 defined medical phenomena. But things like debilitation or

1 the effects of delirium post-admissions are perhaps not
2 what we normally think of as medical phenomena or medical
3 acute events, so are often not measured on a population
4 basis but maybe much, much more important than we think.
5 So I was very glad to see your mention of those in the
6 report.

7 So in summing it up, I think we have some really,
8 really valuable work here, and it's really population-
9 based. It's not medical. It's population, and it's system
10 outcomes. And I think if we recognize it as that, then we
11 can make a lot of progress.

12 DR. CROSSON: Thank you, Bruce. Kathy.

13 MS. BUTO: So I've been struggling with this area
14 because although we are sort of taking this up, and the
15 work here is excellent, under the overall rubric of sort of
16 how did we come up with population-based measures that are
17 useful in looking at quality incentive programs, this feels
18 to me a lot like -- well, it feels like we are really just
19 looking at the adverse outcomes of not having good quality,
20 as opposed to how do you actually, step-wise, get to
21 measures that reward quality. So we're looking at outcomes
22 that really would come about because we think quality is

1 not there, whether or not the measures are good ones or
2 need to be refined.

3 I guess I'd feel better about this if we were
4 sort of on the road to looking at some of these ambulatory
5 sensitive conditions or avoidable ED visits or whatever in
6 relation to some of the conditions that you were talking
7 about in the chapter, like COPD, I guess diabetes,
8 cellulitis, et cetera, mental health conditions, that, yes,
9 we'd like to avoid. But I think what we really want to get
10 after here is how do you reward good practice? So can we
11 get to it by starting with these are things we don't want
12 to happen but we really want to get to a place where we can
13 identify and reward practice that is setting a standard or
14 meeting a new patient standard that needs to be met.

15 And so it's an issue I always have with these
16 negative parameters or measures for judging quality, is we
17 still haven't gotten to how do we actually incent the kind
18 of practice that we want to?

19 So I would just say that as we go down the road
20 if we can think about that, sort of the positive side of
21 good practice, not just the negative outcomes that we don't
22 want to happen. I think that would be a great way to think

1 longer term about this area.

2 DR. CROSSON: So, Kathy, I don't want to pin you
3 down and say what do you think those might be, but I would
4 ask you to think about it.

5 Sometimes, not always but sometimes the positive
6 is, of course, the reciprocal of the negative. So, for
7 example, rather than measuring the number or the length of
8 hospitalization for a patient with diabetes in a year, you
9 could also measure the number of -- we have toyed with this
10 in the past in some ways, you know, when we were talking
11 about healthy days at home. So you could get to this same
12 place by measuring -- I'm just making this up, but
13 measuring, you know, the number of days -- of healthy days
14 at home for a diabetic, which, of course, in many ways it's
15 a reciprocal of being in the hospital.

16 MS. BUTO: Healthy days at home I thought was a
17 really good place to start going down that road. I know
18 from work that was done in the short time I was at CBO that
19 diabetes is a root cause condition that drives a lot of
20 cost in Medicare. We never talk about it. We don't talk
21 about it here at MedPAC. There should be something we can
22 do proactively to promote a better reward system to reward

1 good treatment of people with diabetes or early detection
2 or whatever it is. I don't know what it is. Healthy days
3 at home I thought was a really good start.

4 DR. CROSSON: Okay. Thanks. On this point?

5 DR. SAFRAN: Just picking up on Dana's comment
6 earlier about there are -- in the Medicare Advantage Stars
7 program, medication adherence for diabetes medications as
8 well as others, and outcomes measures like blood sugar
9 control, it is absolutely one of the Star measures, and
10 those are outcomes measures that are very pinpointed in the
11 direction that you describe. So it might be a good place
12 to look.

13 DR. CROSSON: On this point as well?

14 DR. PERLIN: Yeah. Thanks. I think this point
15 actually connects with Bruce's point in terms of being a
16 sort of population which means sort of integrity of the
17 system. I think that's the first piece. So some of those
18 markers may not be individual markers.

19 That said, something we haven't talked about, you
20 know, when I had the privilege of running the VA system,
21 one of the things we looked at was patient functional
22 status. You know, this so transcended whether the

1 patient's blood pressure was 120/80, but, you know, could
2 she carry groceries from car to kitchen? Could she drive?
3 Was she ambulatory? You know, days free of pain, et
4 cetera.

5 To me, as we move forward in terms of thinking
6 about both the integrity of the system, writ large, on the
7 success of a health care system with respect to the
8 individual, I think we need to begin thinking about
9 different sorts of measures like that.

10 Thanks.

11 DR. CROSSON: Thank you. Okay. On this point as
12 well?

13 DR. GRABOWSKI: Jon, how did you measure that in
14 the VA relative -- it would be interesting to try to learn
15 from those lessons. We have obviously provider-reported
16 functional status in long-term-care settings. I don't
17 think we believe that. It would be interesting to --

18 DR. PERLIN: Yeah, it was patient-reported on the
19 SF-12, and because the population was more akin to dual
20 eligibles with floor effects there was an SF-12v to take
21 account for the general lowering. What was really
22 remarkable and gratifying was to see policy changes over

1 time correlate with not just increases in longevity at
2 lower cost but actual improvements in function.

3 DR. GRABOWSKI: And you surveyed them every time
4 they touched the health care system or annually or what?

5 DR. PERLIN: There was a sample that was done
6 annually. It may not be the same individual. It was
7 really sort of a population or other marker of system
8 integrity.

9 DR. CROSSON: Okay. Jaewon.

10 DR. RYU: Yeah, thanks, Ledia. I like the
11 direction of the measure, and I think it's exactly right.
12 I love the analysis. I do feel a little bit conflicted
13 because I think there's a natural tension and a balance
14 question as I start thinking this through.

15 I think the measure itself -- and maybe this gets
16 to Bruce's point a little bit -- by virtue of it being a
17 population-based measure, it's really a statement on the
18 overall ambulatory environment and infrastructure that's
19 out there. And as a result of that, it feels very
20 multifactorial as far as what feeds into success or lack of
21 success on the measure. And I do -- you know, maybe it's
22 true for most population-based measures. The one that

1 comes to mind is even readmissions to some degree is
2 measuring an entire system. It takes a village to avoid a
3 readmission. It takes a village to make sure that
4 ambulatory sensitive ED or hospital stays in that
5 ambulatory arena. And I think this ultimately to me gets
6 to Sue's earlier point around who's accountable or who's
7 responsible. This is why I love Amol's concept of
8 combining the ED and the hospital, but I also struggle with
9 it because if you look at ambulatory sensitive ED and you
10 ask the question who's accountable or who was in the last
11 position to have done something about it, I think that's
12 probably the primary care doc.

13 But if you then look at ambulatory sensitive
14 hospital and you ask the same question, who was in the last
15 position to be able to do something about it, I think it's
16 the ED physician because most of these are coming through
17 them and getting admitted. So I do think there's still a
18 value in bifurcating those, although maybe you also put
19 them together for simplicity's sake.

20 I don't know the right answer to that, but that's
21 why this area feels a little bit conflicted to me, but I
22 think we're trying to do drive a population-based measure

1 which is sort of a look at a system. But at the end of the
2 day, some actor should be accountable for it, and those two
3 things wend, at least in my head, in two slightly different
4 spots.

5 DR. CROSSON: Karen, on this or just in line?

6 DR. DeSALVO: Just I guess on this, to say that
7 to me part of the point is to catalyze shared
8 accountability, and I think that's why it's worth
9 continuing to think about this and all of the potential
10 actors and drivers, including the social determinants and
11 the public health infrastructure, because that is --
12 ultimately those are the supports that we want for
13 beneficiaries.

14 So I hear you, but I also think this is kind of
15 the point for me, is to find something that would bring
16 everyone to the table for shared accountability.

17 DR. CROSSON: Okay. Amol, you started. You can
18 wrap.

19 DR. NAVATHE: So Karen gave me a perfect segue
20 because I think at the end of the day we are interested in
21 system integrity. We are interested in how -- you know,
22 not just the primary care doctor or not just the

1 specialist, not just an NP, not just the ED, can actually
2 help to improve these outcomes. And I think picking up
3 also one thing that Larry said, you know, the idea that we
4 think about patient preference or we think about social
5 determinants of health, and we take a view perhaps that,
6 okay, this measure will vary certainly by those levels of
7 those kinds of variables, and to then turn around and say,
8 well, in that case if I have a bunch of patients who just
9 prefer to go to the ED, I should not be held accountable
10 for that.

11 I think that's actually going the wrong
12 direction, and if we've learned from what integrated
13 delivery systems have done, the Kaisers of the world, I
14 think we've learned that by setting up infrastructure and
15 creating patient-centered services, we can affect these
16 population outcomes and we can educate patients that going
17 to the ED is not necessarily the most, one, beneficial but
18 probably rewarding even for their own personal goals
19 pattern. And if we don't start to think about
20 accountability, if we don't think about measuring, we don't
21 advance and put some oomph behind it, I think we're
22 actually doing a disservice for our populations who have

1 challenges with social determinants of health and, you
2 know, other sources of morbidities and comorbidities.

3 So I think it's just maybe a little bit of a sort
4 of re-upping of things. This is really important, and
5 we're not going to get to a perfect measure, but I think
6 it's really important that we keep this in focus, that we
7 do need to advance population-based measures that cut
8 across conditions, that try to capture how we're doing it
9 in an aggregate level; and that if we can use those
10 conditions very well, we can actually catalyze system
11 transformation, which is what we're really after here.

12 DR. CROSSON: Okay. Well said. Thank you.

13 We've come to the end of this discussion. Thank
14 you, Ledia, for getting us going here. Very nicely done.

15 We now have the opportunity for public comment.
16 If there are any of our guests who would like to make a
17 comment on the business before the Commission this
18 afternoon, please come to the microphone

19 [No response.]

20 DR. CROSSON: Seeing no one at the microphone,
21 we're adjourned until 8:30 tomorrow morning.

22 [Whereupon, at 4:20 p.m., the meeting was

1 recessed, to adjourn at 8:30 a.m. on Friday, October 4,
2 2019.]

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MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, October 4, 2019
8:30 a.m.

COMMISSIONERS PRESENT:

FRANCIS J. CROSSON, MD, Chair
PAUL GINSBURG, PhD, Vice Chair
KATHY BUTO, MPA
LAWRENCE P. CASALINO, MD, PhD
KAREN B. DeSALVO, MD, MPH, Msc
MARJORIE E. GINSBURG, BSN, MPH
DAVID GRABOWSKI, PhD
JONATHAN B. JAFFERY, MD, MS, MMM
AMOL S. NAVATHE, MD, PhD
JONATHAN PERLIN, MD, PhD, MSHA
BRUCE PYENSON, FSA, MAAA
JAEWON RYU, MD, JD
DANA GELB SAFRAN, ScD
WARNER THOMAS, MBA
SUSAN THOMPSON, MS, RN
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P R O C E E D I N G S

[8:30 a.m.]

1
2
3 DR. CROSSON: Okay. I'd like to welcome our
4 guests to this morning session of the October MedPAC
5 meeting. We have two items on the agenda this morning, and
6 the first one, Carol and Carolyn will be here as part of
7 our ongoing work on the unified PAC PPS and specifically
8 will be looking at some policy options.

9 Carol, you are going to start.

10 DR. CARTER: Yeah, I'm going to start.

11 Good morning, everyone. Over the coming year, we
12 plan to continue our work on a unified payment system for
13 post-acute care by considering how to align the benefits
14 and cost sharing across all PAC.

15 Carolyn and I will outline possible changes to
16 benefits and cost sharing that could be made, and we would
17 like to get your input on three key design decisions.

18 I wanted to step back for a second and remind
19 everybody about the context for PAC reform.

20 Our work and that done by others has found that
21 many similar patients are treated in the four settings, but
22 payments can differ substantially because Medicare uses

1 separate payment systems for each.

2 Given the lack of clear guidelines about who
3 needs PAC, where that care would be best provided, and how
4 much care would result in the best outcomes has resulted in
5 per capita program spending that varies more than for any
6 other service.

7 Setting-specific patient assessments and outcome
8 measures make it difficult to compare patients, their
9 costs, and outcomes across settings.

10 Another concern was the shortcomings in the
11 current designs of the current payment systems warrant
12 correction. Providers can vary their payments with their
13 coding and therapy practices.

14 Finally, Medicare's payments for PAC are high
15 relative to the cost of care. For about a decade, the
16 Commission has recommended to the Congress to lower or not
17 update payments to PAC providers.

18 Over the past 5 years, the Commission has
19 examined the design, implementation issues, and a value
20 incentive program for a unified payment system.

21 We recommended design features of a unified
22 payment system that uses a stay or, in the case of home

1 health care, an episode of care, and estimated the impacts
2 and redistribution of payments. We examined paying for
3 sequential stays and paying for an episode of sequential
4 PAC stays.

5 Regarding implementation issues, the Commission
6 recommended lowering the level of payments and having a
7 multiyear transition. Until a unified payment system was
8 implemented, the Commission recommended blending PAC PPS
9 rates with setting specific rates to begin to realize some
10 of the benefits of the redistribution that would occur.

11 We also outlined an approach to align the
12 regulations so that providers face similar requirements and
13 their associated costs.

14 And as we discussed last month, we've developed
15 uniform outcome measures and plan to develop an
16 illustrative design of a value incentive program for all
17 PAC providers.

18 Our presentation today will go over aligned
19 benefit and cost sharing across PAC. This is another
20 important implementation issue associated with our ongoing
21 work on a PAC PPS.

22 The goal of a unified payment system is to pay

1 similar rates for similar patients, regardless of where the
2 beneficiary is treated.

3 Payments and regulatory requirements would be
4 aligned so that distinctions between settings would become
5 less meaningful.

6 When payments and regulatory requirements are
7 aligned, cost sharing and benefits need to be aligned so
8 that beneficiaries have the same coverage and face the same
9 cost sharing

10 Aligned benefits and cost sharing would remove
11 financial considerations from beneficiaries have in
12 affecting their decision-making about where to get their
13 care.

14 The current benefits and cost sharing differ
15 considerably by setting, and on the left are the key
16 differences, whether a prior hospital stay is required, if
17 there are limits to coverage, whether the beneficiary is
18 responsible for the inpatient deductible if they are
19 admitted from the community, and the daily copayments that
20 apply.

21 When beneficiaries use home health care, there
22 are no limits to benefits and there is no cost sharing.

1 If a beneficiary uses a SNF, the stay is covered
2 only if there was a three-day prior hospital stay and
3 coverage ends after 100 days. Copayments are assessed
4 beginning on day 21 of the stay.

5 Finally, when a beneficiary uses an IRF or an
6 LTCH, a prior hospital stay is not required, but then the
7 beneficiary is liable for the inpatient deductible, and
8 coverage ends after the lifetime reserve days have been
9 used. Copayments begin on day 61 of the combined hospital
10 and IRF or LTCH stay.

11 So, given these differences, beneficiaries may
12 base their decisions about where to get their care on
13 coverage or cost sharing considerations.

14 There are three changes that could be made to
15 align benefits and cost sharing that we will go through
16 today.

17 On the benefit side, policymakers could align the
18 requirements for a prior hospital stay and the limits on
19 the days covered by the program.

20 On the cost sharing side, the copayments could be
21 aligned.

22 Our work on a unified payment system considers

1 IRFs and LTCHs as PAC providers. As such, the inpatient
2 hospital requirements would be replaced with the uniform
3 benefits and cost sharing for all PAC providers. Aligned
4 benefits and cost sharing would reinforce the concept of a
5 PAC provider and be consistent with a unified payment
6 system.

7 Turning to the prior hospitalization requirement,
8 before we discuss that, I wanted to show you the share of
9 stays that have a prior hospital stay. Most institutional
10 PAC stays have one, while the majority of home health stays
11 do not. So a uniform requirement for a prior hospital stay
12 would disproportionately affect home health care users
13 since the majority of them are admitted from the community.

14 To align benefits, policymakers could require a
15 prior hospitalization for all coverage of all post-acute
16 care or could eliminate the current requirement that SNF
17 users now face.

18 If a hospitalization were required, just as we
19 saw, this would affect the coverage for a minority of IRF
20 and LTCH users but the majority of home health care users.
21 This would lower program spending associated with the
22 community-admitted users.

1 Alternatively, policymakers could eliminate the
2 prior hospitalization requirement. This would increase
3 coverage for SNF users. Because Medicare payments are
4 higher than those made by other payers, nursing homes would
5 have a financial incentive to qualify their long-stay
6 residents as Medicare-covered short stays. As a result,
7 removing the requirements for a prior hospital stay is
8 likely to substantially increase program spending.

9 Another benefit to align is the number of days
10 covered by the program, either by establishing a uniform
11 limit or eliminating the various existing ones. Remember
12 that the unified payment system would be a stay-based
13 design, so payments would not vary by length of stay. So
14 what we're considering here is how to align the benefits or
15 coverage.

16 Establishing a uniform day limit would eliminate
17 the open-ended coverage for home health care and would
18 align the current limits that vary across the institutional
19 PAC settings.

20 Alternatively, policymakers could eliminate the
21 existing limits on coverage. This would retain the open-
22 ended coverage for home health care and would extend

1 coverage for the small share of beneficiaries with long
2 institutional stays.

3 And now Carolyn will talk about aligning the cost
4 sharing.

5 MS. SAN SOUCIE: First I will go over PAC cost
6 sharing in 2017, and then I will go over elements to
7 include in the design of a per-stay copayment for aligned
8 post-acute care cost sharing.

9 In total, beneficiaries who used PAC services
10 were liable for \$5.2 billion in cost sharing in 2017. This
11 is equal to approximately 9 percent of Medicare PAC
12 spending in that year. Home health care made up slightly
13 less than three-quarters of PAC stays, yet these users paid
14 no cost sharing for those services. Those stays are not
15 represented in this figure.

16 SNF stays made up about one-quarter of PAC stays
17 but accounted for almost the entirety of PAC cost sharing,
18 close to 93 percent.

19 In comparison, cost sharing associated with LTCH
20 stays was about 6 percent of total PAC cost sharing, while
21 that associated with IRF stays was about 2 percent.

22 The 5.2 billion in PAC cost sharing represented

1 on the previous slide was mostly incurred through daily
2 copayments. However, the requirements for daily copayments
3 vary widely by setting, and additionally, the majority of
4 stays do not incur any cost sharing through daily
5 copayments or otherwise.

6 In order to align cost sharing for PAC, we will
7 be modeling a per-stay copayment. In this case, a
8 beneficiary would be responsible for a copayment for each
9 PAC stay. If a beneficiary transitioned between providers
10 or was recertified for an additional home health episode,
11 the beneficiary would be responsible for separate
12 copayments for each stay.

13 This is consistent with, but goes further than,
14 the Commission's 2011 recommendation for community-admitted
15 home health users.

16 Additionally, this would be consistent with cost
17 sharing in other parts of the Medicare program.

18 In 2017, more than three-quarters of all PAC
19 stays did not incur any beneficiary cost sharing, driven by
20 the volume of home health episodes. Ten percent of stays
21 incurred cost sharing above \$1,600, and 1 percent of stays
22 incurred about \$11,000 in cost sharing. These numbers

1 represent beneficiary cost sharing liability and does not
2 reflect what the beneficiary actually paid. Supplemental
3 coverage may have reduced beneficiary out-of-pocket
4 spending.

5 Because home health makes up the majority of
6 post-acute care, a copayment assessed for each PAC stay
7 will result in a considerable redistribution of cost
8 sharing from the minority of stays that currently incurs
9 cost sharing to the bulk of PAC stays that incurs none.

10 Now let's look at the per-stay cost sharing by
11 setting, where the variation in cost sharing across PAC
12 settings is quite substantial.

13 The graph in the upper left-hand corner is the
14 same as the one on the previous screen. This is showing
15 the distribution of cost sharing across all PAC stays.

16 The graph in the upper right-hand corner shows
17 the distribution of cost sharing for SNF stays. Over half
18 of SNF stays incurred about \$1,000 in cost sharing, while
19 10 percent incurred close to \$7,500.

20 The graph in the lower right-hand corner shows
21 the distribution of cost sharing for LTCH stays, where more
22 than half did not incur any cost sharing. Ten percent of

1 LTCH stays incurred over \$7,500 in cost sharing, similar to
2 top decile of SNF stays. However, the most expensive LTCH
3 stays were much more expensive than those in any other
4 setting.

5 Lastly, the graph in the lower left-hand corner
6 shows the distribution of cost sharing for IRF stays. Over
7 three-quarters of IRF stays incurred no cost sharing.

8 The implementation of a per-stay copayment will
9 result in a large redistribution of cost sharing for all of
10 these stays.

11 Per-stay copayments could either be the same
12 across all PAC settings, or different by setting.

13 A uniform copayment would fully align PAC cost-
14 sharing. Because payments for home health care would be
15 adjusted downward under the PAC PPS, a uniform copayment
16 would result in home health users being liable for a higher
17 share of the total payment for a stay than would users of
18 institutional PAC. However, this would eliminate the
19 incentive some beneficiaries currently have to base where
20 they receive their PAC on financial considerations.

21 Alternatively, a copayment could be different
22 across PAC. In this case, one lower copayment amount would

1 be assessed when home health care is used, and a higher
2 amount would be assessed when institutional post-acute care
3 is used. This two-tiered approach would result in
4 considerably lower copayments for beneficiaries treated by
5 home health agencies compared with those treated in
6 institutional PAC settings. However, it would retain cost
7 sharing differences by setting, thereby undermining one of
8 the goals of aligned cost sharing. As a result, it may
9 encourage beneficiaries to base their decisions on
10 financial considerations, choosing the use of less costly
11 services.

12 Policymakers will need to decide on the
13 importance of having a uniform cost sharing amount that
14 removes financial considerations from where beneficiaries
15 get their PAC.

16 Regardless of if copayments were to vary for home
17 health and institutional stays, policymakers would need to
18 establish the share of a stay's payment that would be the
19 beneficiary's responsibility.

20 For example, in previous benefit design work, the
21 Commission modeled a home health copayment of \$150, which
22 approximated 5 percent of program spending on home health

1 episodes. We could use the same approach and model a
2 copayment that equaled 5 percent of program spending for
3 PAC, or we could consider an amount that represents a
4 higher percentage, more in line with the current levels of
5 aggregate cost-sharing requirements for PAC, which is about
6 9 percent.

7 Additionally, we could consider an amount that
8 represents a percentage that would be in line with cost
9 sharing of other program services. For example, 20 percent
10 would be identical to the cost sharing required for Part B
11 services. While a larger percentage may discourage the use
12 of unnecessary PAC, it also could discourage the use of
13 needed services.

14 In summary, a unified PAC PPS will align payments
15 across PAC providers. Consistent with that, differences in
16 the regulatory requirements for PAC providers will narrow.

17 Accordingly, beneficiaries should have the same
18 benefits and face the same cost sharing regardless of where
19 they receive post-acute care.

20 In the spring, we will model some illustrative
21 benefit designs and cost sharing based off of your guidance
22 in the discussion that follows.

1 There are three areas that we seek guidance on.
2 The first, should a prior hospital stay be required for
3 covering any PAC use? A prior hospital stay could be
4 required only for covering institutional PAC, or the
5 requirement could be eliminated.

6 The second question that we seek guidance on is
7 whether there should be a uniform day limit on coverage or
8 should the current limits be eliminated.

9 Lastly, we would like your feedback on the
10 implementation of a per-stay copayment. Should the
11 copayments be the same for all PAC stays, or would the
12 copayments be proportional to the average PAC PPS payments?

13 We look forward to your discussion, and with
14 that, we'll turn it back to Paul.

15 DR. PAUL GINSBURG: Thank you, Carolyn.

16 This has been really helpful and clear in
17 presenting the issues.

18 As a context, we have a vintage 1965 cost sharing
19 system for most post-acute care, and it's been amazing how
20 it's been ignored over the decades, and by pursuing the PAC
21 PPS, it just forces attention to these issues because,
22 obviously, you have to have something more uniform than you

1 have today.

2 So let me begin by asking for clarifying
3 questions.

4 Yes. Marge and then Jonathan and Amol.

5 MS. MARJORIE GINSBURG: Great. Thank you. Good
6 work.

7 I used to work in home care many, many years ago,
8 and the thing that most surprises me about all this is the
9 -- it sounds like there's virtually no difference in the
10 services offered at the institutional PACs, not counting
11 home care, and the idea that patients can decide then which
12 institutional PAC they want to go to based on how close it
13 is, whether there's copays, I have to say really surprises
14 me.

15 I actually thought these organizations, these
16 entities were set up because they met very specific needs
17 of patients. Somebody would qualify for a SNF, but they
18 wouldn't qualify for a long-term institution.

19 So could you give me more about the background,
20 and why did these things all merge in concept? But somehow
21 these are not specific entities that serve specific
22 purposes.

1 DR. CARTER: So this work assumes that when the
2 patients are similar they will receive similar payments.
3 We recognize that home health has different services
4 because there's no facility, and that's recognized in the
5 payment system, setting a much lower payment for home
6 health, like one-sixth. And so we're recognizing that the
7 services are different in home health and the payment
8 reflects that.

9 What we're saying is let's take a patient -- I
10 was just talking with Kathy about this before the meeting -
11 - let's take a patient who is recovering from hip
12 replacement. They can go home, with home health, on a
13 part-time and intermittent basis, or they may go to a SNF,
14 and if they qualify for intensive therapy they may go to an
15 IRF. There is an example of a patient who might look
16 similar, in terms of their clinical characteristics, but
17 may be treated in very different settings.

18 So I don't think we've said that the services are
19 the same, and, in fact, our payments reflect that they're
20 not the same. What we're saying is that we are hoping that
21 the risk adjuster captures differences across the patients,
22 and when those are different the payments will be

1 different.

2 MS. MARJORIE GINSBURG: So just to make sure I'm
3 clear on this. Since patients don't get into any of these
4 programs without a referral from the physician -- they
5 don't get home care, they don't go anywhere -- physicians
6 simply don't discriminate? Nobody discriminates between
7 the appropriateness of the patient's particular needs and
8 the virtue that particular settings -- I mean, it just -- I
9 feel like I've just dropped in from outer space. I missed
10 something in the last 30 years, as I got out of home care.
11 But suddenly everything feels like it's just been merged
12 into one pot called PAC, and that baffles me still.

13 I mean, I wonder whether there's some background
14 here about when disease settings all start. Have they
15 always been -- has it always been so fluid about where
16 patients go after the hospital, or from the community, that
17 it really is often up to the patient to decide where they
18 want to get services? Isn't there something wrong with
19 this picture here?

20 DR. CARTER: I guess I would say that
21 beneficiaries most often want to go home when they can, and
22 some patients don't have either the family support or able

1 and willing caregivers at home to do that. And so there
2 you might see a patient that looks really identical, but
3 they've ended up in an institutional setting because they
4 can't go home.

5 I think that there's been a lot of work. We've
6 done a little bit but there's also literature about PAC
7 placement, and I think that there are all kinds of factors
8 that go into that decision, and some of it are clinical
9 care needs. Sometimes it's availability of a bed.
10 Sometimes it's proximity to where, you know, your daughter
11 lives. I mean, it's a whole constellation of things.

12 Dana and I, before this PAC PPS work got started,
13 we did a lot of work looking at the overlap between IRFs
14 and SNFs, and I think I've said this before, we talked to
15 the directors of five or six stroke centers around the
16 country and they were all very clear about where they sent
17 stroke patients. The problem was they completely disagreed
18 with each other. And I think it had to do with how good
19 was the SNF in your market, and could that SNF handle the
20 complexity of that patient. And if there wasn't a SNF with
21 an available bed in the market, those patients went to
22 IRFs. Now that's not a clinical discrimination. That's

1 sort of the lay of the marketplace.

2 So I don't think you've landed in from outer
3 space. I think we recognize that -- and even in the
4 discussion we talked about, in terms of regulatory
5 requirements, we know that the regulatory requirements for
6 home health are going to be a little different, right,
7 because if there's no facility and there are all kinds of
8 things that come with having a facility that you don't need
9 to regulate. But things like physician oversight and the
10 training and the skill level of your staffing probably
11 should be the same, or similar.

12 And so we're trying to have some nuanced approach
13 to when differences in home health care are warranted and
14 when they're not.

15 DR. CROSSON: Kathy.

16 MS. BUTO: Marge, I realized in your question how
17 much of a gap there is between the early work on PAC PPS,
18 which has been going on for some years, and your sort of
19 landing from outer space recently, on the Commission. And
20 so I think part of your question is, are these patients
21 really totally interchangeable and are these facilities
22 interchangeable.

1 And I think we've been approaching it, with
2 Carol's guidance and help, as where they are, the payments
3 should be pretty much the same. They shouldn't differ by
4 weird characteristics of the way the facility has been
5 structured under some regulatory rules that were designed
6 in 1965.

7 Where they're not -- say vent patients, stroke
8 patients, different kinds of patients, community-
9 originating home health patients -- the payments will be
10 different but it will be really based on the patient's
11 condition rather than what facility or type of PAC you sort
12 of land in.

13 So I think it was really more an issue of where
14 they're similar, the differences in payment were so stark
15 from one place to another, and I think that's a lot of what
16 this tries to address. Where they're different, I hope we
17 preserve the ability to provide specialized care for the
18 patients who really need it. So I think that's really just
19 -- because, you know, this whole system has been evolving
20 under the Commission that that nuance may have escaped you.

21 DR. CROSSON: Jonathan.

22 DR. JAFFERY: Yes. Thanks. First of all, this

1 is great, and as Paul said, this really pulls together how
2 something that I think we're all excited about coming up
3 with some more aligned payment system, and when you start
4 to do it, it calls out what are those issues.

5 I have two or three questions, and the first one
6 sort of follows up a little bit on what Marge was starting,
7 but I don't think you came in from outer space. You may
8 have dropped into outer space --

9 [Laughter.]

10 DR. JAFFERY: -- talking about U.S. health
11 policy.

12 So is there some data we know about beneficiary
13 preference in choosing, in terms of price sensitivity?
14 Because a number of things -- none of the questions sort of
15 speak to that and how that might change behavior, and do we
16 know anything about that in particular?

17 DR. CARTER: We haven't looked at that yet, and,
18 of course, you have the whole backdrop of supplemental,
19 which is, you know, immunizing many beneficiaries from first-
20 dollar coverage. But if you would like we can look into
21 that a little bit. We have not explored that yet.

22 DR. JAFFERY: Okay.

1 DR. GRABOWSKI: Can I say something on that? We
2 actually have a paper where we are able to exploit the
3 CAHPS data and we know who has supplemental and who
4 doesn't, and we use that to predict, then, out in the full
5 set of Medicare claims, and so we have a predictive model.
6 And beneficiaries are very responsive. Those without
7 supplemental, there's a huge spike at day 20, and those
8 with supplemental there's a much smaller spike. So there
9 is quite a bit of responsiveness to the cost-sharing.

10 I'll also say that, well, that could mean these
11 discharges are premature or overdue, and when we sort of
12 push on that, many of these beneficiaries are being
13 discharged home, many of them home without home health
14 care, there's no increase in readmissions or mortality. So
15 that leads us to conclude this overdue and there's a lot of
16 waste here. We could see, you know, much earlier discharge
17 for many of these patients. And it leads me to wonder --
18 and I could say more in round two -- this is just kicking
19 in at day 21. Imagine a cost-sharing arrangement that's
20 much earlier in the stay.

21 DR. JAFFERY: You know, that's interesting.
22 That's helpful. So that's discharge from the SNF, not

1 choosing the initial --

2 DR. GRABOWSKI: No, no, no, and we don't really
3 have cost-sharing there, right, to help us.

4 DR. JAFFERY: Right. Great. Okay.

5 So thinking about the three-day waiver, you
6 talked in the report about how in 1988 and 1989 the
7 spending doubled, but then, now we haven't really seen any
8 big changes with some of these others, particular with
9 ACOs, being able to utilize the three-day waiver. Do you
10 have any sense of why that would be so different now?

11 DR. CARTER: Why there hasn't been such
12 responsiveness when providers are given the option to waive
13 the three-day requirement?

14 DR. JAFFERY: Yeah. It sounds like in 1988 it
15 was pretty dramatic.

16 DR. CARTER: Yeah.

17 DR. JAFFERY: In a single year it doubled and
18 then they repealed.

19 DR. CARTER: Right, but some of that could have
20 been nursing home patients being requalified, which is
21 different than kind of initial PAC decision, if you will.
22 I mean, I think ACOs and BPCI participants are using the

1 prior hospital stays as speed bumps. So even if they can
2 take advantage of the waiver, many are not, and it's for
3 the same reasons that there are requirements in place.
4 Well, I mean, I think there are a couple of reasons. One
5 is the prior hospital stay was really a way for the
6 program, back in '65, to reinforce, this is a continuation
7 of a post-hospital extended services benefit. That was the
8 way post-acute care was seen.

9 DR. JAFFERY: Okay. That's interesting. I mean,
10 we've been trying to implement it, and we haven't
11 implemented it, and there are challenges to doing it
12 robustly. But that's helpful.

13 And the last question has to do with the idea of
14 eliminating day limits on SNF stays. And do you have any
15 sense if that would have any impact, and if so, what on
16 Medicaid spending?

17 DR. CARTER: That's a good question. I haven't
18 looked at that. I know that very few, something like 3
19 percent of SNF stays go more than 100 days, and less than 1
20 percent of IRF stays and less than 1 percent of LTCH stays.
21 Something like at the 99th percentile the length of stay is
22 280 days. And so if you think those might be Medicaid, you

1 know, not all beneficiaries are poor but it would impact
2 what the Medicaid program, you know, exposure for -- if the
3 program is now paying for that, yeah, so that would go
4 down.

5 Now, of course, we know that lots of Medicaid
6 programs that, in theory, pay for what's not covered by
7 Medicare, but that isn't always true. So the coverage is
8 uneven, I would say.

9 DR. CROSSON: Great. Amol.

10 DR. NAVATHE: So my question is really a
11 continuation of this last thread, which is if we looked at
12 Slide 13, for example, for duals specifically, would it
13 look different, because of the reasons that you were
14 saying, that there's variation in how much follow-through
15 there is on the Medicaid side?

16 DR. CARTER: It probably would. We haven't
17 looked at it, but we could come back with that.

18 DR. NAVATHE: Seemingly, as a population we
19 continually care about, it would be nice to see that.

20 DR. CROSSON: Dana.

21 DR. SAFRAN: Thank you. A couple of questions
22 for you. One is -- and I'll hold for round 2 but I am

1 struggling with just how far do we want to go in making the
2 beneficiary side equivalent, and so that's sort of the
3 theme under which my questions are coming from.

4 First question is, for the three types of PAC
5 care that do not currently require a hospital stay, do we
6 know what percentage of the time a hospital stay occurs for
7 those? So for home health, for example, I'm assuming it's
8 very, very rare. You know, I'm thinking about your --

9 DR. CARTER: I think your question is that slide.

10 DR. SAFRAN: Okay. Yep. Okay. Thank you.

11 Sorry, I missed that slide.

12 DR. CARTER: That's okay.

13 DR. SAFRAN: Okay. And then a second question
14 is, when you were talking about the possible equalizing of
15 the copayments, whether it's done on a per diem or episode
16 basis, it was up on the screen and it was in the paper in
17 percentage terms, but is that how you imagine that it would
18 actually be done, percentage of the underlying cost as
19 opposed to a dollar amount?

20 MS. SAN SOUCIE: So the slide you're talking
21 about with the percentages, we would use the weighted
22 average of the payment, of the average PAC payment for the

1 stay, and then calculate a fixed percentage of that, so it
2 would come out to a set dollar amount that it would be. In
3 the home health work that they did, or in the 2012 work
4 that they did to assess a home health copayment, it was a
5 set \$150, but it equaled about 5 percent of the average
6 home health payment. Does that make sense?

7 DR. SAFRAN: I think it does. Let me just make
8 sure I'm getting it. So the beneficiary would understand
9 ahead of time, this is the dollar amount that's required
10 for this setting. This is the dollar amount that's
11 required for this other setting.

12 MS. SAN SOUCIE: Yeah. So if the average PAC
13 payment was \$5,000 and you were doing 10 percent of that,
14 it would be \$500, and that would be set for everyone.

15 DR. SAFRAN: Great. Got that. Thank you.

16 DR. CASALINO: [Off microphone.]

17 MS. SAN SOUCIE: If it was per stay it would not
18 depend on the length of stay, correct.

19 DR. SAFRAN: Okay. I'm going to hold the rest
20 for second round.

21 DR. CROSSON: Okay. Pat.

22 MS. WANG: Thank you for laying this out so

1 clearly.

2 Focusing on the three institutional settings and
3 putting home health to the side for a minute, the vast
4 majority -- and this focuses on the requirement for prior
5 hospital stay -- the vast majority of the stays in IRF and
6 LTCH are preceded by a hospital stay, which maybe we could
7 speculate is because an IRF and an LTCH are themselves
8 hospitals, and so the medical diagnosis and complexity of
9 the patient, you know, would more naturally follow from a
10 prior hospital stay.

11 I'm wondering if you can share more thoughts
12 about SNF, because there was a reference in the paper to, I
13 guess during a demonstration period there was an assessment
14 that if the three-day stay requirement were to be lifted,
15 spending would increase dramatically, or did increase
16 dramatically. That's also described on the slide.

17 Can you speculate about why that is so different,
18 why that would be different than the other institutional
19 IRF, LTCH stays? If you eliminated the three-day prior
20 stay requirement for SNF, why would spending increase
21 dramatically?

22 DR. CARTER: So what you're referring to is what

1 actually happened when catastrophic got rid of the prior
2 hospitalization requirement, and I will say that there were
3 other coverage changes made at the same time. So that
4 doubling of use and spending isn't just the lifting of the
5 three-day hospital stay requirement.

6 But I do think this has to do with long-stay
7 patients requalifying for covered Part A stays, which is
8 obviously very different from the IRF and LTCH situation,
9 where you don't have the same facility treating both types
10 of long-stay and short-stay patients. So I think that's at
11 least one big factor that's going on here.

12 MS. WANG: Do you think that the phenomenon of
13 requalifying folks for a Medicare SNF stay would increase,
14 versus today where maybe folks from a nursing home are
15 admitted for some reason or another and then come back and
16 restart their SNF benefit? Because that does, I think,
17 happen today.

18 DR. CARTER: Yeah, I'm sorry. I didn't quite
19 catch what the question was.

20 MS. WANG: The question is, if you eliminated the
21 three-day inpatient stay for SNF, would the thing that you
22 just described, the fear that patients would be requalified

1 and kind of cycled through the SNF benefit more frequently,
2 would occur more than it does today? Because today, if
3 somebody is living in a nursing home and they're admitted
4 to the hospital and then they come back to the nursing home
5 they are actually restarting their SNF benefit. You know,
6 it's a very important factor.

7 Can you say more about what you think would
8 actually happen, because this is sort of a behavioral
9 assumption here, that, you know, more people would be --
10 that SNF spending would increase if you removed that
11 little, you know, sort of --

12 DR. CARTER: Right. So I'm thinking -- so
13 patients qualify for the SNF care because of those prior
14 hospital stay requirements. If that's lifted then
15 beneficiaries that are in SNF would only need to meet the
16 other coverage requirements for SNF, which is you need a
17 skilled service, which can be either skilled nursing or a
18 skilled therapy service. And so that could be quite easy
19 for nursing home patients to qualify, given kind of the bar
20 they would have to get over, if you will. So I think the
21 other requirements for SNF care would, I think, fairly
22 straightforward to meet for many nursing home residents.

1 MS. WANG: Okay. Thank you.

2 DR. CROSSON: Larry and then Kathy and Jaewon.

3 DR. CASALINO: You may have just answered what I
4 was about to ask.

5 I still remember when I was first in practice as
6 a young physician, the first time I saw a patient who I
7 thought I can avoid a hospitalization if I can get this
8 person into a skilled nursing facility for a few days, and
9 when I was told I couldn't do that, I was flabbergasted.

10 So I think from a physician point of view -- and
11 you see this with ACO complaints -- the necessity for a
12 three-day hospitalization really gets in the way.

13 Are you saying that you think if the three-day
14 period of hospitalization requirement was taken away --
15 you're not saying it would be fraud by requalification
16 within SNFs. It's just the bar would be so low to
17 requalify?

18 DR. CARTER: Well, I think you'd have to decide
19 on sort of what would be the coverage and benefit
20 requirements for institutional PAC providers.

21 Right now, the IRF requirements and LTCH
22 requirements to meet coverage are very different, and

1 LTCHs, you need to have an average length of stay in that
2 institution. The IRF requirements are you're expected to
3 be able to tolerate and benefit from intensive therapy,
4 which is often translated into three hours of therapy.

5 Under a PAC PPS, we're thinking there's going to
6 be some uniform coverage delineation that's probably not
7 going to be those things, but that would need to be decided
8 about what is going to be the uniform coverage and benefit.

9 One of the big differences also, IRFs and LTCHs
10 are already hospitals, and so the idea that they need to go
11 to a hospital for care, I mean, it just happens less
12 frequently because they're already hospitals. They have
13 the nursing, the 24/7. They can identify when a patient is
14 dehydrated and manage that patient, whereas SNFs don't have
15 that kind of coverage.

16 DR. CASALINO: I'm sorry. I'm still not sure I
17 understand. It sounds like you don't see a way around
18 eliminating the three-day requirement because you think
19 there would just be too much requalification of patients
20 within SNFs?

21 DR. CARTER: No, I'm not saying that. No. I'm
22 just trying to talk through what the options would be.

1 I think you could either eliminate it or you
2 could make it uniform, and that would be a really big
3 change for the home health users.

4 DR. CASALINO: Do you see any other options?

5 DR. CARTER: Well, we had on the slide you could
6 require it just for institutional and not for home health,
7 and that would be -- that is going away from aligning
8 benefits that we thought should be aligned under a PAC PPS.

9 But if you thought that the change to requiring a
10 hospitalization for home health, which would eliminate
11 coverage for two-thirds of home health, was too big a step,
12 then you might do a sort of two-tiered requirement. That
13 was on the slide, and that's something that you guys can
14 talk about.

15 DR. CASALINO: I'm sorry. Just one last time.
16 But the reason not to eliminate it, is there any reason not
17 to eliminate it besides the fact that it would be so easy
18 for so many SNF patients to get kind of requalified -- or
19 long-stay patients -- I'm sorry -- to get requalified as
20 SNF patients?

21 DR. CARTER: Right, right. I guess it depends on
22 what you think post-acute care is. If you think it's post-

1 hospital, then that sort of implies there was a hospital
2 stay, but we have a situation now where that's not true.
3 And so you might want to think, well, why don't we live up
4 to the term or have different requirements.

5 DR. CROSSON: Kathy?

6 MS. BUTO: So I was wondering. To me, the issue
7 of whether we should consider a lower copay level for home
8 health versus the institutional providers somewhat turns on
9 the question of whether the institutional provider patients
10 set is really interchangeable with home health patients.
11 In other words, would they be probably sensitive and choose
12 home health because there's a lower copay?

13 My sense is that there's some overlap between
14 home health patients and institutional patients but not
15 total. In fact, I think you were saying in our
16 conversation before that two-thirds come from the community
17 to home health.

18 So I think in making a judgment about
19 differentiating or not somewhat depends on whether you
20 think setting the home health copay is going to really drag
21 patients from institutional settings or not. I just wonder
22 if we can try to look at that question a little more

1 specifically and in that look at who's coming from the
2 community and for what reason because that may influence
3 whether we think there should be a lower copay if we don't
4 think there's much overlap, for example, because you've
5 already decided that the payments ought to be lower.

6 So I just lay that out and ask the question of
7 what do we know about that overlap that would help us make
8 that decision.

9 DR. CARTER: Well, we do know a little bit about
10 the use of PAC with alternative payment models, and so
11 there has been some substitution of home health for SNF
12 use.

13 I mean, Amol, maybe you can talk about in the
14 BPCI, that has been definitely lower, shorter SNF stays but
15 also not using SNF and replacing with home health. I'd
16 have to go back and look at the evaluations to know kind of
17 what that estimate is.

18 I think we've seen similar but smaller effects
19 from ACOs.

20 DR. CROSSON: On this point?

21 DR. NAVATHE: Yeah. Just as an example, in CJR
22 for hips and knees, our pre-participation rate of sending

1 patients to SNFs was about 60 percent and post was about 25
2 percent. That switch happened virtually overnight.

3 MS. BUTO: And was influenced by the copay?

4 DR. NAVATHE: No.

5 MS. BUTO: Okay. I'm just trying to understand.

6 DR. NAVATHE: No. Influenced by the payment
7 model.

8 MS. BUTO: Okay. Anyway, I just think it helps
9 us to decide whether lowering the copay for home health
10 would make a huge difference and would create some kind of
11 a perverse incentive or not to know that sense of
12 interchangeability.

13 The second question I have is we've been talking
14 about the three-day prior hospitalization stay. In a
15 sense, I agree with at least what you were laying out,
16 Carol, which is we've always thought that pretty much
17 guarantees that SNF stays are post-acute care, at least it
18 strongly suggests.

19 If you eliminate it, we may get more sort of
20 community recommendations or admissions that are less
21 clearly post-acute, so that's an issue.

22 I wondered. For IRF and LTCH, there's an

1 inpatient deductible. Had you thought about applying a
2 deductible across all settings, or would you consider that
3 too big a barrier to access? Because it's already there
4 for IRF and LTCH. Is a deductible something like that kind
5 of constraint?

6 DR. CASALINO: Deductible and no three-day
7 requirement?

8 MS. BUTO: Right. Deductible instead of a three-
9 day requirement and a deductible for home health, instead
10 of the structure that we have now.

11 MS. SAN SOUCIE: We thought that the current
12 situation in IRF and LTCH, the majority of -- or a big
13 proportion of patients who are paying cost sharing are
14 paying the inpatient deductible. That's that \$1,300 you
15 see on the bottom left- and right-hand corners. And so we
16 thought that was similar to kind of a per-state copayment.
17 That's the amount they're paying for the care, and so we
18 see them as kind of similar, but we would apply the per-
19 state copayment. So you would just pay the cost sharing
20 once and not have additional amounts on top of that.

21 MS. BUTO: So you're thinking of it more as a
22 per-stay copayment rather than any kind of constraint on

1 who's using the institutional care in that case. Okay.

2 DR. CARTER: But that might influence, then,
3 whether you thought there should be different copayments
4 for institutional. If you're thinking, oh, copayments are
5 kind of like deductibles, first, you've got a copay that's
6 for every stay. It's not dissimilar from a deductible.

7 MS. BUTO: Right.

8 DR. CARTER: So if you wanted a speed bump for
9 institutional, you might have a higher copay. But that
10 undermines the idea of having a uniform copay.

11 MS. BUTO: Interchangeable, yeah.

12 DR. CARTER: So that's just something for you
13 guys to think about.

14 MS. BUTO: That's helpful. Thank you.

15 DR. CROSSON: Okay. I've got Jaewon, Karen,
16 Warner, and Bruce, and then I think we need to move on to
17 the discussion. Questions? Jaewon.

18 DR. RYU: Sure. Thank you.

19 I had a question about the supplemental coverage.
20 On Slide 15, the 9 percent current aggregate cost sharing,
21 is that net of the supplemental coverage kicking it? It's
22 not?

1 DR. CARTER: It's not. So that's sort of what
2 the bene is liable for, and that's a hard thing for us to
3 get at, actually, as sort of what really was.

4 DR. RYU: So maybe the next question I was going
5 to ask might be the tough thing for us to get at, but do we
6 know what percentage of that 9 percent in the aggregate is
7 covered under supplemental coverage?

8 DR. CARTER: We don't. There was a table in the
9 mailing materials about sort of 80 percent of beneficiaries
10 have supplemental. At least for the Medigap plans, most
11 Medigap plans cover the PAC cost sharing, and that's where
12 most benes are enrolled in the plans that have the cost
13 sharing. But that's only a third of beneficiaries.

14 We know very little, I think, about the employer
15 landscape in terms of what the supplemental policies look
16 like.

17 DR. RYU: Okay. Thank you.

18 DR. CROSSON: Karen?

19 DR. DeSALVO: Thank you.

20 I have a question about the community admissions
21 to SNF in particular, not the other two institutional post-
22 acute care environments, and I wondered if you all had

1 looked at modeling the total cost of care for beneficiaries
2 who could have gone through a community admission to SNF
3 and avoided a three-day hospitalization potentially, if
4 there's a way to look at it. I don't know how you might do
5 that, based on acuity, but clinically, you might see a
6 person and say, "I want them to go to SNF, but I need to
7 admit them for three days in order to get them there."

8 So I just wonder from a total cost of care, there
9 would be savings even if we might spend more on SNF and if
10 there's a way to model that out, potentially.

11 DR. CARTER: We could think about that.

12 I know when we were looking at -- and it wasn't
13 the work that we did. It was many years ago when Zach was
14 here, and he looked at counting observation time towards
15 the three-day requirement, and then the Commission had a
16 recommendation that patients would have to have one
17 midnight, but two of the days in observation. We can
18 relook at that work to see how many stays was that and what
19 would the effect have been.

20 To look at trying to match patients that maybe
21 went that route, that's probably beyond the scope of this
22 project, anyway.

1 DR. DeSALVO: Maybe there's some lessons inside
2 the ACO work that could be learned from that.

3 MS. THOMPSON: Perhaps. And that was really
4 where I was going to go in my comments in the second round,
5 but to your point, we're one of the ACOs that actually has
6 taken substantial advantage of three-day waivers. And with
7 that, I happened to pull some of our own statistics on
8 next-gen beneficiary number of 110,000 lives in our ACO.

9 We have very much used the three-day waiver with
10 no increase in utilization of SNF. It stayed at 7 percent
11 for the first three years in that contract.

12 So you could, I think, extrapolate in our savings
13 something that could correlate, I think, maybe roughly, but
14 a lot of our savings in this next-gen contract have been
15 around reducing utilization of SNF.

16 DR. CROSSON: Thank you.

17 Paul, on that point?

18 DR. PAUL GINSBURG: Yeah. I just want to
19 reinforce you're talking about highly managed environments.
20 So we wouldn't want to infer this outside of the managed
21 environments.

22 DR. CROSSON: Okay. Warner?

1 MR. THOMAS: Actually, my question relates
2 actually directly to Sue's comment. Do we have data that
3 we can compare utilization and post-acute providers between
4 the ACO world and what's happening there and/or even MA and
5 the traditional fee-for-service Medicare? Do we have data
6 that we can compare that utilization? Is there anything we
7 can learn from that, just given my understanding is the
8 utilization of post-acute in the managed area is
9 significant different? I don't know if we have anything
10 there.

11 DR. MATHEWS: Yeah. Warner, we have some work
12 that we are currently developing getting to that specific
13 question in a very granular way. How does the utilization
14 of post-acute services in the ACO environment differ from
15 ambient fee-for-service in those market where they exist?

16 There's some literature out there that has made
17 some general assertions about those differences, and we're
18 kind of digging pretty deep. And we hope to roll this out
19 a bit later in the fall.

20 DR. GRABOWSKI: I just want to answer the other
21 part of his question on Medicare Advantage. There's also
22 some papers, and they all suggest MA utilization of PAC is

1 way below fee-for-service, and some of that is probably
2 selection. But a lot of that is just greater management of
3 the patient.

4 DR. CROSSON: Amol and Pat, on this point, do you
5 want to make a point?

6 DR. NAVATHE: Yeah. On this point, we've been
7 looking at some of the ACO PAC, ACO bundles overlap PAC, a
8 bunch of these different areas. What we can see is that
9 ACOs definitely use infrastructure in different ways to
10 perhaps rationalize post-acute care use, and so we can see
11 they even do things like use post-discharge visits as ways
12 to reduce home health utilization. There certainly seems
13 to be the SNF home health margin that Carol alluded to
14 earlier, which is a significant one. We see a little bit
15 less action on IRF just because it's less common in
16 general. So SNF is definitely the main margin.

17 I think the short answer is yes. There's
18 definitely activity on that.

19 MS. WANG: I just wanted to underscore Paul's
20 point. MA plans will absolutely admit directly into a SNF
21 but very much monitor length of stay and utilization. It
22 is very much a managed event.

1 DR. CROSSON: Okay. Bruce, last question.

2 MR. PYENSON: Was there any information that was
3 useful to this from the extension of hospitalization at
4 home programs? I think there's folks who are exploring SNF
5 at home.

6 DR. CARTER: That's a good idea. We can look
7 into that. Thank you.

8 DR. CROSSON: Okay. We'll move on now to the
9 discussion. Put Slide 16 back on.

10 Just to reiterate, these are the policy
11 directions that Carol and Carolyn are seeking input on to
12 help them bring forward a set of recommendations that we
13 can consider. So I'd like to ask that the discussion in
14 general be directed towards that end, and David is going to
15 start.

16 DR. GRABOWSKI: Great. Well, thanks again,
17 Carolyn and Carol, for that great presentation. This is an
18 area that's, I think, bothered me for a long time, and I'm
19 glad. You shed a lot of light on this.

20 As Paul said in his introductory remarks, as we
21 began Round 1, this is really a 1965 vintage model of cost
22 sharing. It's incredibly outdated, and not only do we have

1 the chance to harmonize cost sharing across the sectors,
2 but also, in many ways, modernize it.

3 It makes no sense to me that we have no cost
4 sharing in home health, this cost sharing that kicks in on
5 day 21 in skilled nursing facilities, and then kind of a
6 more traditional deductible, and then copayments later in
7 the stay for IRF and LTCH.

8 I think going forward, I'll say at the outset I'm
9 supportive of trying to unify the cost sharing across the
10 four sectors.

11 I think we're going to do that, and we're also
12 going to think about cost sharing as a way to encourage
13 appropriate use of post-acute care. I think we first have
14 to take on the elephant in the room, and that's just the
15 role of supplemental in this marketplace.

16 Far too many beneficiaries are protected from the
17 costs of post-acute care. Obviously, that's money that the
18 program is not spending. That's money that's coming from
19 outside, so we're not charging the trust fund. But we're
20 not kind of using cost sharing the way, I think, a lot of
21 economists think about it as a way to sort of encourage
22 more appropriate utilization, as somebody said yesterday,

1 to give patients some skin in the game.

2 I really think we need to reform supplemental
3 here, whether that's disallowing the Medigap plans from
4 having first dollar coverage. We actually force
5 beneficiaries to spend out-of-pocket up front, or the other
6 idea you have is charging beneficiaries with those
7 supplemental policies more. I don't know that I have
8 strong thoughts on either of those, but I don't think we're
9 going to get as far as we want with this if supplemental is
10 standing in the way. I very much think that's a first step
11 in this agenda.

12 The second point, I wanted to sort of go through
13 your questions that you outlined. This issue of a prior
14 hospital stay, I am a believer that if we do away with the
15 three-day rule or some prior hospital stay, whether it's
16 three days or less -- and I'm going to come back to that
17 point in a moment -- I do think that's a big of opening the
18 flood gates for those long-stay nursing home residents. I
19 do think skilled nursing facilities will immediately
20 qualify a lot of individuals for therapy care, for SNF
21 stays, and we would see a huge increase in spending.

22 I do believe we need to put some sort of

1 guardrails in place.

2 I like the idea of a prior hospital stay, of
3 requiring a prior hospital stay. I don't think we can do
4 it for home health, just given the large percentage of home
5 health episodes currently that don't have a prior hospital
6 stay. Requiring a prior hospital stay would basically
7 decimate that industry. I mean, as we saw, what, 65
8 percent of episodes currently are community based.

9 So I think although I'm a huge proponent of being
10 as unified as possible and as uniform as possible across
11 the four settings, I don't think we can do that here. I
12 think we can only apply this prior hospital stay
13 requirement on the institutional side. That would be first
14 best. If that wouldn't work, come second best would be
15 placing a requirement directly on long-stay nursing home
16 residents, to say once you've been admitted as a long-stay
17 nursing home resident you have to have some sort of
18 hospital stay in order to qualify for SNF, and not placing
19 the same burden on the IRFs and LTCHs.

20 I wanted to make one other point about this
21 before going to the second question, and you raised in the
22 chapter -- I don't think it came up in the presentation --

1 whether in calculating the three-day rule we could use ob
2 stays or any sort of days. I like the idea of using ob
3 stays, and I think we could -- and I'm not even certain
4 three days is the right limit anymore. That's another
5 limit policy that we came up with a long time ago when, you
6 know, the average length of hospital stay was much longer.
7 I do believe we could probably rethink the length of stay,
8 and I do think allowing kind of those observation days to
9 count against that limit would be a good idea as well.

10 The second question, and this may be a point
11 where I'm not understanding this, but under a stay-based
12 model I don't think we need a uniform limit on the number
13 of days covered. I just like the idea that you're covering
14 kind of a stay. Very few kind of beneficiaries, as you
15 noted already, are getting out to that 100 days anyway in a
16 SNF. We do see, in home health episodes, multiple
17 episodes. I don't know that we need to sort of limit this
18 if we're paying on a stay. I don't believe that there
19 needs to be that limit in place.

20 The final issue is how to structure the
21 copayment, and, Kathy, I very much appreciate your comment
22 about unintended consequences here. If we make it too high

1 in one setting are we sort of, especially in home health,
2 are we then potentially directing individuals into higher-
3 cost institutional PAC?

4 I'd like the idea of imposing a copayment or some
5 sort of cost sharing on all four of the settings, but doing
6 it on a proportional basis, where it's not a fix dollar
7 limit but rather some sort of proportional amount, where,
8 in an absolute sense, you're paying less for home health
9 than for the institutional PAC, but in a proportional sense
10 or relative sense you're paying that same share of the
11 overall bill. I think if you impose a fixed amount you're
12 really distorting behavior and really directing individuals
13 towards the institutional setting.

14 So, once again, this is great work, and I'm very
15 excited we're going down this path, and not only the
16 unified payment but also the opportunity maybe to take on
17 cost-sharing, which has been an area long in need of some
18 attention. So thanks.

19 DR. CROSSON: Thank you, David. Very clear. I
20 see Jon, Amol, Jonathan, Kathy, Dana, Bruce, Pat, Marge.

21 DR. PERLIN: Thank you, Carol and Carolyn, for
22 really terrific work, and obviously provocative of great

1 discussion afterwards. What I appreciate about your work
2 is that it is motivated by our first principle which is
3 right care in the right place, in this instance, for the
4 right length of time.

5 You know, I just can't help but think of the last
6 couple of weeks when my daughter is studying for her LSATs
7 and they wonder what the heck has that go to do, and these
8 logic tests of which one doesn't fit. So the one that
9 doesn't fit for me is the home health, and I think -- I'm
10 very akin to David on this one in terms of thinking about
11 what we need to think about differently for home health in
12 terms of the right care at the right place at the right
13 time.

14 You know, if a patient doesn't need to come into
15 an institutional setting after a joint procedure, a total
16 joint replacement, as an example, why, in heaven's name,
17 would you put them in an institutional setting, you know,
18 with all of the concomitant risks of institutionalization,
19 disorientation from environment, infection, and everything
20 else? It seems like a sort of perverse incentive.

21 Ditto as we think of two points Karen has made a
22 number of times, that as the care model changes, more of

1 the care is given in the community. Why would you bring a
2 patient in the hospital if they need an IV infusion that
3 could be delivered at home, again, without the sort of
4 nosocomial infection risk or wound care, or any number of
5 other settings?

6 So I recall what got us to the constraints around
7 home health, but why should it be hardest to use the least
8 expensive setting of the entire set of settings?

9 I also think that the application of arbitrary
10 hospitalization -- to David's points about the changing
11 length of stay, obs, et cetera -- creates a countervailing
12 pressure. If you have a patient you're worried about, you
13 know, that they need home health, what are you going to do?
14 You're going to drive up the use of hospitalization, and I
15 don't care how tightly we stipulate it, you know, you can
16 find reasons that a patient has a justifiable
17 hospitalization. When we think about the cost I think we
18 have to look not only in the bucket of the post-acute but
19 also in the bucket of the pushback that, you know, would
20 occur in a countervailing manner on the acute side as well,
21 were that required.

22 So given these issues, in terms of your specific

1 questions, one, you know, I don't see that the copay should
2 be the same. It should be lower for the least expensive
3 setting. I think David's suggestion of proportionality
4 actually comes right out of economics and it makes sense as
5 well. Certainly you shouldn't discourage the least-
6 expensive, least-disorienting and potentially most
7 clinically attractive setting when possible.

8 Next, something we didn't talk about, although I
9 know we have in the past, is that we have to get to a
10 uniform set of quality measures in terms of clinical
11 outcomes across all the settings. In this regard, that
12 would include home health.

13 And finally, I think a principle is right of
14 symmetry in general, save for the obvious difference
15 between institutional and non-institutional care, and in
16 terms of the coverage limit, for the reasons David
17 mentioned, and that may solve itself. So just in terms of
18 this issue, then, of the three day, I don't think we have
19 the evidence. I think there are a lot of changing facts in
20 terms of length of stay and potentially countervailing
21 pressures, and that's the one that deserves further study.
22 Thanks.

1 DR. CROSSON: Thank you. Thank you, Jon. Amol.

2 DR. NAVATHE: So thanks, Carol and Carolyn, for
3 taking this topic on and really distilling it, I think,
4 into some really concrete areas for us to engage upon, so
5 thank you for that.

6 So I have a couple of sort of more well-defined
7 comments and then a broader one. The first one kind of
8 picks up on what David was suggesting regarding the
9 supplemental coverage piece, and I would maybe suggest
10 thinking about presenting this information in a slightly
11 different way, which is if we can get our hands on it it
12 would be nice to be able to look at essentially income
13 level of patient, or of beneficiary, and see what cost-
14 sharing they're likely to face, based on the distribution
15 of how supplemental coverage is not uniformly distributed
16 across income distribution, as well as the interaction with
17 potential Medicaid benefits. And I think that would be a
18 rich thing for us to be able to look at, to think about
19 where this cost-sharing is really going to bite and who it
20 is going to bite for. And so I just wanted to make that
21 one suggestion.

22 The second piece is I think we -- I want to

1 commend you guys in thinking about this from a copay-only
2 structure. I think that makes a lot of sense. I think in
3 the literature and in the work that we have done, we kind
4 of ostensibly know, at this point, that individuals tend
5 not to really understand deductibles and coinsurance very
6 well, but they tend to understand copays.

7 And so to the extent that we're putting a cost-
8 sharing structure, particularly one, for example, for home
9 health where it has never existed before, it would be nice
10 to lead with something that people intuitively understand,
11 as opposed to something that we would expect them to be
12 educated about. So I thought that was very nice.

13 My broader point is I think what we should be --
14 the frame that we should be taking -- I think this picks up
15 on what Jon was just saying -- is we should be thinking
16 about what the value of these services are. I think
17 traditionally the way insurance has worked is we have said
18 we should have copays that are proportional to the cost of
19 the service, or to the payments being made. And so we have
20 said if there's a very high cost service we should have a
21 larger cost share, or at least dollar amount larger cost
22 share, and for a lower-cost services we have lower cost

1 share.

2 And I think as we are going through this journey
3 of thinking about ACOs and bundles and MA, just a shift
4 toward value, then I think that should also apply to the
5 beneficiary, from the perspective of what we expect them to
6 contribute. And if there are services that are
7 particularly high value then we would want low cost sharing
8 for those, because that means that they are likely to get a
9 lot of value and benefit, and, in fact, decrease cost in
10 the system down the road.

11 And so if we take it down to the -- try to make
12 it pragmatic, I think what we start to think about is,
13 well, so how high-value is IRF care and SNF care and home
14 health? And I think what we'll quickly realize is that it
15 depends a lot, of course, on clinical scenario. There is
16 this question of is institutional PAC a substitute for
17 short-term acute stays, short-term hospitals? I think in
18 some cases there is a sense that, yes, that may be the
19 case, and, in fact, we can drive length of stay down, for
20 example, in a hospitalization, or maybe even avert a
21 hospitalization altogether, because of SNF and IRF care.

22 For home health I think it also helps clarify,

1 because much of what's done in the home health setting
2 actually is helping patients either improve quality of life
3 or in potentially averting a hospitalization or an acute
4 event. And so I think if we use that frame we have to
5 understand that there's quite a bit of variability and this
6 is not an easy one-to-one kind of mapping. But I think we
7 can start to think about it in this frame and say, well, as
8 we go through each of these pieces, do we want a prior
9 hospital stay? I think, in some sense, because of the
10 tight link between the short-term acute hospital and
11 institutional PAC, it suggests that probably there should
12 be some requirement, but at the same time we probably don't
13 want it to be as stringent as it has historically been. So
14 kind of doubling down on what Jon and David have said.

15 In terms of the uniform day limit, I think the
16 suggestion would be, for example, for home health that it
17 may be a mistake to have a day limit, because there is very
18 unlikely to be, at some point, at day 100 or whatever, that
19 the subsequent home health is going to suddenly stop being
20 of value, from a quality of life for from keeping people
21 out of the institutional setting. And so I think that's
22 kind of a rational implication.

1 And then uniform copayment, I think because the
2 value of these services likely vary, it implies that
3 probably a uniform copayment doesn't make a lot of sense,
4 and we probably need to think about how it's proportional
5 to the value of the services being provided, presumably
6 thinking, you know, that services in an institutional
7 setting have perhaps a lot more value, because otherwise
8 people would get a lot sicker and have worse events.

9 So that's kind of the framing that I wanted to
10 bring to this that might help clarify. The parting thought
11 on it is that I guess in some sense we're stuck with
12 thinking about this as average value, because it may be
13 very hard to rationalize this, given that different
14 clinical scenarios may actually be quite different, and
15 that's attention, I think, that we are probably always
16 going to feel.

17 DR. CROSSON: Thank you, Amol. Jonathan?

18 DR. JAFFERY: Yeah. Thank you. I will try to be
19 brief. I'm in agreement with what the others have said. I
20 just want to emphasize maybe one or two points.

21 I think in terms of thinking about the copayment,
22 you know, I think we've started to talk more about this

1 principle of thinking about what is the care model we want
2 to put out there, and if we believe that there's some
3 benefit to trying to get people to be spending more time
4 closer to independent at home, I think that we don't want
5 to limit ourselves or push ourselves to try to do things
6 that would incent away from the home health. So whether
7 that's a difference between a facility-based and home
8 health type of copayment, or as others have suggested, a
9 proportional one, despite the fact that it gets away from a
10 completely uniform thing I think that makes sense.

11 In terms of the prior hospital stay, I think this
12 is one I'm still -- before coming to the meeting and doing
13 the reading I was really struggling with this, and I was
14 really hoping that after an hour and a half of discussion I
15 would have some moment of clarity, and it hasn't happened.
16 And I appreciate that, you know, thinking about 1988 -- and
17 I appreciate what Paul said, because, you know, it's a
18 different environment in managed care with MA. But we now
19 have two-thirds of beneficiaries in either MA or ACOs,
20 which have a variable amount of tight management between
21 the two, but still, that's a bit of a difference.

22 And so, you know, I think you're hearing from a

1 lot of the doctors and nurses in the room that there is
2 some discomfort with the clinical side of this, in addition
3 to not understanding all the payment and behavioral
4 influence.

5 So I think I would just end with that. I'm not
6 sure that I have a really strong feeling yet about what the
7 right direction is, or know enough, and so Jon's final
8 point about this particular topic probably needs a little
9 bit more thought and work within the Commission is
10 something I would really support.

11 DR. CROSSON: Thank you, Jonathan. Kathy.

12 MS. BUTO: I want to thank you for taking up some
13 of the toughest issues in post-acute care unified PAC. I
14 think these are tough.

15 I don't have any problem with the first one,
16 requiring prior hospital stay, even for home health. I
17 would not just fall back on, well, that's not who they are
18 right now. Well, that's because it's never been required.
19 But before we went there I'd really like to know more about
20 the community-admitted patients to home health. So it may
21 be that I'm wrong about that, but I honestly think this was
22 designed as a post-acute benefit, it was intended to be

1 short term, to follow up on hospitalization and recovery
2 from either surgery or some clinical treatment, and was
3 never intended to be just a benefit for people who are at
4 home.

5 Now having said that, for home health there are
6 other requirements, and what I think we'd have to think
7 about, if we went this route, would we want to loosen up on
8 things like homebound and so on? I think those are as
9 constraining to use of the benefit as anything else, the
10 fact that you can only travel to religious ceremonies and
11 so on. Your ability to -- it almost implies you're very
12 frail, instead of that you are able to return home and
13 rehab there. There is a contraction sort of embedded in
14 that.

15 So I would just say, qualified, I think if it as
16 a post-acute benefit that's never properly been, I guess,
17 overseen, in a way, or properly provided, but I think we'd
18 need to know more about the community-admitted patients.

19 On uniform days, until David said it I thought,
20 wow, he's right. If this is a per-episode basis, we don't
21 tell inpatient hospitals how long the benefit will last
22 because they're paid a specific per-episode payment for

1 each admission. I don't see why we'd want to have, or
2 need, a day limit in this case, unless I'm missing
3 something.

4 And on the third one, having listened to the
5 conversation, again, I think there's an issue of how much
6 real interchangeability is there with patients. I think in
7 the conversation there's a little bit of a contradiction
8 between the goal of unified PAC, which is to make the site,
9 or not have the site be attractive because of the structure
10 and cost sharing, and to try to make these benefits more
11 available for choice, given the patient could benefit in
12 any number of settings.

13 And an underlying theme I'm hearing that maybe we
14 should try to skew cost sharing to favor home health. I'm
15 really torn about that, so on that one I initially thought
16 a two-tiered copayment would make sense, with home health
17 being lower. Again, particularly if there isn't a lot of
18 likelihood that institutional patients are going to migrate
19 to home health, just because the copay is cheaper, that
20 strikes me as an okay thing to do, because home health is a
21 much more cost-effective benefit.

22 But I'm still thinking about that and I don't

1 like the idea of trying to mix signals to create incentive
2 to take home health, even when you'd be better off in an
3 institutional setting. So I want to make sure we don't go
4 too far in that direction. But it strikes me that the copay
5 should be lower for home health.

6 DR. CROSSON: Thank you, Kathy.

7 Dana?

8 DR. SAFRAN: Thank you.

9 I add my thanks for your taking on this complex
10 issue. I've been struggling with it, and this conversation
11 has been helpful. And your answers to the questions I had
12 before were also helpful.

13 I think that I'll start by saying Marge's
14 comments at the beginning really to me underscore the
15 magnitude of the communication challenge we have in front
16 of us if we go this path because this would be a monumental
17 change. And beneficiaries as well as the people hoping to
18 organize their care would need to really understand what
19 we're doing and why.

20 The second thing is that part of why I've been
21 struggling -- and I think it's sort of come out in a lot of
22 comments in the last 20 minutes or so -- is that on the

1 provider side, I really understand trying to equalize
2 payment for patients who are clinically the same,
3 regardless of which setting. But I don't think that's the
4 same as saying that we're indifferent about which setting
5 patients receive their care in or that these different
6 settings are good and do well, the same things. So that's
7 part of why I'm struggling with how far do we actually go.

8 It makes sense for a given patient who could be
9 treated in any of these settings, let's pay the same,
10 regardless of which setting. That makes total sense to me.

11 It doesn't make sense to me necessarily, then, on
12 the flip side to align our payment approach, cost sharing
13 approach for the patient so that the incentives about which
14 setting they go to are the same. So that's where I'm
15 struggling a bit.

16 I think, in essence, I land a bit where Jonathan
17 Perlin was. I didn't disagree with anything you said,
18 Jonathan.

19 [Laughter.]

20 DR. SAFRAN: But that home health feels different
21 here, and part of why I think it feels different to me is
22 that -- and you said it, Carolyn, in answer to a question

1 before. There are social factors that enter for a given
2 patient with a given clinical profile. There are then
3 other factors, mostly social ones, that decide like is it
4 this setting or that setting. And that says to me that we
5 should think carefully about how far we go in neutralizing
6 or equalizing the way that cost sharing is between
7 institutional versus home health settings.

8 So on your specific questions, prior hospital
9 stay, I would say absolutely would not want to see us
10 impose one for home health care. Inducing that much more
11 hospital care really makes me very uncomfortable, unless
12 we're thinking that we would, on the flip side, just be
13 dis-incentivizing that much more home health care. And
14 that doesn't seem like a good idea either. So I'd say no
15 there.

16 And I don't know about -- I think all the smart
17 things have already been put on the table about is it
18 really helping us to have a hospital requirement for SNF or
19 to the two-thirds of beneficiaries who are already in
20 managed arrangement kind of almost start to take care of
21 that for us. So I don't know for the institutional whether
22 we need that.

1 Uniform limit on days covered, I don't know that
2 I'd go to uniform for some of the reasons that I have been
3 spelling out, particularly wanting to preserve home health
4 as a benefit that people take advantage of, if it can keep
5 them out of higher-cost settings for longer. But I do
6 think that having some kind of cap on the benefits across
7 all of the settings -- and maybe it's at a dollar amount --
8 is a good thing to do.

9 Uniform copayment. Now that I understand that --
10 and this goes to Amol's point. Part of my worry in my
11 question before was I thought payments were going to be on
12 a percentage basis based on that provider, like
13 coinsurance, and that would be terrible. So I loved your
14 answer that these are flat-dollar amounts, and it doesn't
15 actually matter which provider type.

16 So I do like the idea of uniform copayments, and
17 since the underlying costs are going to be different, I
18 could be okay with the same percent, regardless of which
19 setting.

20 So let me stop there. Thanks.

21 DR. CROSSON: Thank you, Dana.

22 Bruce?

1 MR. PYENSON: Thank you very much.

2 I was struck by something I think David was
3 suggesting, which is that the hospital requirement for SNF
4 might be waived if someone came from the community but
5 would not be waived if someone was a nursing home resident.
6 That would seem to help solve some of the concerns.

7 On the prior hospital stay required just to
8 connect to the discussion yesterday, I think yesterday we
9 heard that 20 percent of hospital admissions are
10 potentially avoidable because they're ambulatory care-
11 sensitive.

12 There's other categories of avoidable
13 hospitalizations, such as preference, sense of admissions
14 that are there. So the prior hospital stay required seems
15 connected to another archaic issue left over from the
16 1960s, which is the failure to recognize that today we have
17 relatively good objective criteria for when a
18 hospitalization is necessary. That seems connected to a
19 solution on this hospital required, prior hospitalization
20 required.

21 I'm wondering if looking for objective criteria
22 on SNF required or home health required would be a

1 worthwhile venture. I know there's been some frustration
2 in that, but give where we are with data and the advance of
3 medical knowledge and outcomes, I'd suggest that a
4 utilization management approach be adopted for many to
5 these services and would point out that there are similar
6 kinds of criteria that have been used for things, for
7 example, in DME to get a hospital bed or to get a motorized
8 wheelchair. So I think that would help solve some of the
9 concerns we have, and there seems to be enough interest,
10 enough importance, and enough money in post-acute care to
11 justify the development of those.

12 DR. CROSSON: Thank you.

13 Kathy, do you want to comment on that?

14 MS. BUTO: Yeah. Some of my comments about prior
15 hospitalization are a holdover from the catastrophic
16 experience where -- and other experiences where if you lift
17 a requirement that had its intent sort of associated with a
18 particular kind of benefit, you will see a huge surge and
19 increase in utilization.

20 I also know that utilization management tools are
21 very difficult to deploy and are very budget dependent. So
22 I would never rely on utilization management to try to

1 manage this benefit. I just wanted to say that because I
2 think, administratively, it's very hard to do, to manage
3 something where you sort of open the door and there's a
4 huge potential beneficiary population involved and then try
5 to manage it kind of after the fact. So I think that's
6 just really tough to do.

7 DR. CROSSON: Let me just be clear. At the level
8 of CMS, we've already heard that for MA plans and ACOs in
9 terms of managing --

10 MS. BUTO: Right. I'm talking about -- yeah.

11 DR. CROSSON: Yeah, right.

12 MS. BUTO: As I understand it, MA and ACOs can
13 waive the three-day stay now and are doing so.

14 DR. CROSSON: Among other ways to manage
15 utilization.

16 MS. BUTO: Yeah, right.

17 DR. CASALINO: Jay, may I ask a clarifying
18 question about this?

19 DR. CROSSON: Yeah.

20 DR. CASALINO: And then I have some comments for
21 later.

22 Kathy just said we'd get a huge surge if we took

1 the three days away.

2 MS. BUTO: That's my --

3 DR. CASALINO: Yes. And I saw Amol and David
4 nodding.

5 But I haven't heard you guys say that. You said
6 that you think that some of the doubling or whatever it
7 was, when the three-day requirement was removed, was from
8 SNFs requalifying patients. Do we know how much there was
9 of just people being admitted straight to SNFs from the
10 community?

11 There seems to be a little bit of an unspoken
12 assumption here that people kind of like to go into SNFs,
13 and I'm not --

14 [Laughter.]

15 DR. CASALINO: I'm not sure that that's really
16 true.

17 So do we have any data on that? I don't think we
18 should just assume. This is not like you can get an MRI of
19 your knee the first time you sprain it. This is going SNF,
20 which is not the most pleasant environment in most cases.
21 I'm trying to separate the two.

22 DR. CARTER: So why don't we go back, because

1 there were two or three payers that looked at the effect of
2 catastrophic.

3 Now, of course, there were many things going on
4 at the same time besides the three-day, and so I'll see
5 whether those papers tried to tease that apart and whether
6 they looked at the use of community admits versus the
7 nursing home residents. And we'll see what there is there.

8 DR. CASALINO: It is an important question,
9 right?

10 DR. CARTER: Yes, I agree.

11 DR. CASALINO: Because there could be some kind
12 of barriers put in place to SNFs requalifying perhaps.

13 DR. CARTER: Mm-hmm.

14 DR. CASALINO: Now, if the idea of people going
15 directly into SNFs from the community and that there be a
16 huge surge, inappropriate surge in that is incorrect. That
17 matters.

18 DR. CARTER: Yes, I agree. Yeah.

19 DR. CROSSON: Okay. We have Pat, Marge, Paul,
20 Warner, and Larry. And we have exhausted our time for this
21 discussion.

22 MS. WANG: So I will be quick.

1 DR. CROSSON: I'm going to beg conciseness.

2 MS. WANG: So I'm just going to go.

3 For the three questions that you have here, in
4 the first one, I would say do nothing. I would leave the
5 requirement in for SNF with the caveat of maybe looking at
6 the average short stay today and sort of maybe making some
7 recommendations of modifying the three-day to something
8 else.

9 I would not put a requirement for an inpatient
10 stay to be a requirement for another inpatient stay, which
11 is LTCH and IRF. It's not a problem today. Don't fix it
12 if it ain't broke.

13 I'm with Kathy in trying to understand more about
14 home health and the community it knitted. When I listened
15 to the conversation, I know that I myself, this particular
16 treatment modality is something that seems like has a much
17 broader range of what is being done and for what reason. I
18 would think it would be very helpful to learn more about
19 that.

20 On the second one, uniform limit on days covered,
21 I take the point that David raised. My only concern is
22 that when a state-based payment is developed that there be

1 some sort of outlier for length of stay so that we don't
2 create disincentives to keep people who need to stay for
3 100 days. I mean, those poor people. After that, today,
4 after that limit is exhausted, there's no place for them to
5 go. There is no insurance that is going to cover them. So
6 that's a tough situation to be in.

7 On the third, for copayment, I think I agree with
8 my colleagues here. I have the most confusion around home
9 health. It does seem like it should be lower, but I would
10 benefit at least from understanding more about the nature
11 of the services there.

12 On the prior hospital stay, the reason that -- I
13 think it would be helpful to learn more as you dig up the
14 old research. The one thing that I would say that I like
15 about the way the system works now is that it is an extra
16 benefit to join a managed system, whether it's an ACO or an
17 MA plan, and clinicians should understand that when they're
18 counseling their patients. And maybe it creates an
19 indirect incentive to boost participation in value-based
20 managed Medicare as opposed to flat-out fee-for-service.

21 So, in a way, we are differentiating the benefit
22 as between MAP-niched environments and straight out fee-

1 for-service, and I like that.

2 DR. CROSSON: Thank you, Pat.

3 Marge?

4 MS. MARJORIE GINSBURG: I will also try to be
5 quick.

6 I'm beginning to think that maybe PAC, it's time
7 to put that term to rest. We've been focusing everything
8 around acute care, as if that is the centerpiece of health
9 care, which it probably is, but regardless, we're trying to
10 move that away from being the center of health care.

11 So my first suggestion is we change PACs to
12 community-based care. We move the LTCHs over to the
13 hospital, acute care. I'm not sure what to do with IRFs,
14 but the rest is community-based care, so that's my one
15 point.

16 The other is right on home care, and I do speak
17 from some experience with this. Home care is a preventive
18 service. the reason why so many people get it, not
19 counting those that came directly from the hospital, is
20 they've got a medical need that can be addressed in the
21 home, and this is, in part, to keep them healthier, to keep
22 them out of hospitals.

1 I don't think we want to do anything to
2 discourage that, except maybe put a limit on the number of
3 days. I would not put any cost sharing on patients for
4 home care because my fear is they would then turn it down.
5 I don't need that.

6 The doctor says you need to go into the hospital.
7 You go to the hospital. Even you go to the SNF. But if he
8 says you need home care and if there's anything about it
9 that patients are feeling uneasy about, they can turn it
10 down. And if they're paying a piece of it, I worry that
11 they will turn it down, and I think of it more in terms of
12 that category of prevention that we now provide for free
13 for seniors to get their preventive exam once a year. To
14 me, that's really how we should be looking at home care.

15 We do have to put some more boundaries around it
16 because it's gone wild, but I think we can do that without
17 any cost burdens on the patients.

18 Thank you.

19 DR. CROSSON: Thank you, Marge.

20 Paul?

21 DR. PAUL GINSBURG: Sure. I think it's terrific
22 that we've had this discussion, which has forced us to

1 really grapple with this ignored-for-years cost sharing
2 structure, and I think that's going to be a real benefit of
3 having pursued PAC PPS.

4 Just one thing on the home health. Marge, I
5 think when you have zero cost sharing, then you get fraud,
6 and that's been our experience with home health. I know
7 the virtue of not having any barriers for something that
8 might be preventive, but when you go to the extreme of
9 having no cost sharing, then you're just opening yourself
10 up to fraud.

11 MS. MARJORIE GINSBURG: It's not the patients
12 that are committing fraud.

13 DR. PAUL GINSBURG: I know. But you want the
14 patients to block the fraud.

15 MS. MARJORIE GINSBURG: And do we really think
16 that they --

17 DR. PAUL GINSBURG: I mean, I'm going to have to
18 pay \$10 a day for this? Get out of here.

19 DR. CROSSON: Okay, all right. Let's not have a
20 debate on honesty. Go ahead.

21 DR. PAUL GINSBURG: Yeah. But, actually, the
22 final thing I want to say is that I'm really glad that

1 David brought up this issue of having some redesign of
2 supplemental coverage to be consistent with the best cost
3 sharing approach we can come up with, and I think we want
4 to do this in other areas too.

5 When we look for better ACO models, ones that
6 engage beneficiaries, there's likely to be a supplemental
7 coverage component to that, so that the supplemental
8 coverage doesn't block all attempts to engage
9 beneficiaries.

10 DR. CROSSON: Thank you, Paul.

11 Warner?

12 MR. THOMAS: I think it's great work, and it's a
13 tough situation.

14 I think the idea of prior hospitalization, I
15 think for me works with the institution, though I would not
16 do that around home health. That's just my view. I agree
17 with Marge that I think it's -- and Jonathan actually as
18 well. I think it's a totally different situation.

19 I think if you want to look to unified payments,
20 I would go back to the word I know you guys have done and
21 looking at it along diagnosis and looking at the type of
22 care and trying to align along diagnosis, regardless of

1 whether you're in an IRF, a SNF, or an LTCH.

2 I think we do that in hospitals, in acute care
3 hospitals all the time. It's based upon the type of
4 diagnosis, and you're paid appropriately for that
5 diagnosis, regardless of kind of where you sit in the
6 hospital. I think we could look at the same thing in post-
7 acute.

8 I think going back to the limit, I would put a
9 limit on home health, but I wouldn't make it an absolute.
10 I would have different milestones where you need additional
11 review and approval because there is overutilization in
12 this area, and we know there's a view.

13 I think many times, going back to Marge's point,
14 it's needed, but having the right review process would be
15 important.

16 I would like to encourage us. Whatever is
17 learned from the information in the ACO or the MA world, I
18 think we ought to be looking at that and trying to apply
19 here because I think there is lower utilization in those
20 areas. It would be interesting to see if you can prove it
21 out, but I think there's a lot to learn that could be
22 applied to this area.

1 The final piece -- and this is maybe a little off
2 topic, but in the home health area, we haven't talked a lot
3 about how digital and telemedicine is going to play in this
4 world, and I think that is a big opportunity and probably
5 going to be a very complex topic. There's going to be more
6 and more digital home monitoring that's going to play out
7 in home health world, and today it will all be out-of-
8 pocket or retail-oriented. But I do think there's going to
9 be opportunities to save other costs by doing those types
10 of things to try to keep people in the home.

11 And the last comment I'd make -- and I didn't
12 really see the information here, but it would be
13 interesting to look at acute care cost during the same 12-
14 or 24-month period while somebody is in post-acute to see
15 if there's any differential in acute care cost while folks
16 are in these different modalities and try to understand is
17 there any relation to a reduction in the acute care cost by
18 utilization of certain services.

19 Maybe that's been done. I'm not sure, but there
20 might be some learnings there or reasons that we would want
21 to focus on certain post-acute disciplines versus others if
22 it has a material impact on acute care cost, so just a

1 couple other thoughts.

2 DR. CROSSON: Thank you, Warner.

3 Larry, last comment.

4 DR. CASALINO: Briefly going from the third to
5 the first, I think a uniform copayment, there's been some
6 discussion of that, but speaking specifically about home
7 health -- and let's say it was a per-stay payment for home
8 health that was maybe lower for other places based
9 proportionately on the cost. It's attractive in a way, but
10 I think there are two problems. If it is very high, it's
11 going to discourage people. If it's per-stay, it's going
12 to have to cover the whole cost, potentially, or some kind
13 of average from a week of home health to six months of home
14 health. So it could be really an obstacle, that kind of
15 per-stay copayment, to people who really just need a week
16 or so of help and that would be paying very much for that
17 compared to someone who needs six months of help and be
18 paying the same amount. I think that is a little bit of an
19 obstacle.

20 The other side of the coin is once you've made
21 your per-stay copayment, then there's really no incentive
22 to stop with the home health, which can be nice to have

1 because it helps in lots of ways, and even if you don't
2 really need it anymore, it's nice.

3 That's not really true with the three
4 institutional sides. Most people don't really want to stay
5 in an institution, but they might want to keep up with home
6 health as long as they could. So I do see some problems
7 with per-stay for the home health.

8 Home health seems to be what we're all mostly
9 talking about because it is the problem in trying to make
10 something unified, I think. There probably should be some
11 kind of limit on days. I'm not sure that that's a separate
12 issue from the issue of how you actually pay. I think we
13 all agree that it shouldn't be free forever to get home
14 health.

15 I've already addressed, I think, from a clinician
16 point of view, the three-day stay for SNFs is hard for
17 doctors to understand. I think that Bruce and maybe a
18 couple of other people since have mentioned that maybe the
19 idea of eliminating that for community-based patients but
20 doing something a little different to try to prevent
21 nursing homes from qualifying people for that
22 inappropriately would be something to look at, although I

1 suppose the argument could be made that that's really
2 discriminating against people who are in SNFs already. Why
3 should they be treated differently from someone in the
4 community?

5 DR. CROSSON: Thank you, Larry.

6 Good discussion. Carol, Carolyn, you've got
7 plenty of material to take back and cogitate on, which is
8 what we're here for. So thank you for that. Thank you for
9 the good work, as usual.

10 MS. BUTO: Jay, could you remind us, or maybe
11 Carol could, what the timing of unified PAC was in the
12 legislation?

13 DR. CROSSON: Carol, could you answer that?

14 DR. CARTER: I'm sorry. The question?

15 MS. BUTO: The timing of the introduction or
16 adoption --

17 DR. CARTER: Oh, so there's no actual requirement
18 in the legislation. There are just requirements for
19 reports.

20 MS. BUTO: And our last report is this year --

21 DR. CARTER: No. Our report is in like 2022.

22 DR. CROSSON: Okay. Now we will proceed with the

1 final presentation and discussion for the October meeting,
2 and we are going to be looking at the issue of an aggregate
3 cap, the aggregate cap for the hospice benefit, and Kim is
4 here to present, all by herself. Go ahead.

5 MS. NEUMAN: Good morning. We're going to
6 discuss Medicare's hospice payment and explore a policy
7 option to modify the hospice aggregate cap, as a way to
8 potentially increase equity across providers, improve
9 payment accuracy, and generate savings for taxpayer and the
10 Medicare program.

11 The presentation is going to have three parts.
12 First, we'll discuss background on hospice and the hospice
13 payment system, then we'll discuss the hospice aggregate
14 cap and how the cap works, and finally we'll explore a
15 policy option to wage adjust and reduce the cap.

16 So, first a reminder about the hospice benefit.
17 Hospice provides palliative and supportive services for
18 patients who have a life expectancy of six months or less
19 if the disease runs its normal course. There is no limit
20 on how long a patient can be in hospice as long as a
21 physician certifies that the patient continues to meet this
22 criteria.

1 In 2017, Medicare spent \$17.9 billion on hospice,
2 and Medicare pays a daily rate for hospice care. This rate
3 is paid regardless of whether the patient received services
4 on particular day.

5 There are four levels of care. Routine home care
6 is the most common level, accounting for 98 percent of
7 days. The other three levels of care offer more intensive
8 services to manage a crisis or special situations.

9 Over the years, the Commission has expressed a
10 number of concerns about the hospice payment system.
11 First, the Commission has found that the aggregate level of
12 payment for hospice substantially exceeds cost. The
13 Commission recommended a 2 percent reduction to fiscal year
14 2020 base rates. That recommendation was not taken up and
15 instead the hospice annual was a 2.6 percent increase for
16 2020.

17 Second, there's been concern that the payment
18 system has been out of balance by level of care, with
19 routine home care overpaid and the other three levels of
20 care underpaid.

21 Third, the Commission has been concerned for many
22 years that long stays in hospice are profitable. Until

1 2016, routine home care was paid a uniform daily rate.
2 Because hospices furnish more services at the beginning and
3 end of an episode and less in the middle, this has meant
4 that long stays in hospice have been more profitable than
5 short stays, and these profit opportunities associated with
6 long stays have led to substantial for-profit entry in the
7 sector.

8 Finally, hospices with disproportionately long
9 stays that exceed the aggregate cap -- something we will
10 talk more about shortly -- have strong margins.

11 CMS' changes in 2016 to restructure routine home
12 care payment rates and in 2020 to rebalance payment rates
13 by level of care are improvements, but the aggregate level
14 of payments for routine home care remains above cost and
15 long stays remain profitable.

16 When the hospice benefit was first created,
17 Congress included an aggregate cap to ensure that the
18 legislation creating the new benefit saved money. This cap
19 limits the total payments a hospice provider can receive in
20 a year. The cap is an aggregate limit on payments, not a
21 patient-level limit. If a provider's total payments
22 exceed the number of patients served by the provider,

1 multiplied by the cap amount, the provider must repay the
2 excess to Medicare.

3 The cap was set at \$6,500 initially and has been
4 increased annually for inflation. Currently, as of fiscal
5 year 2020, the cap is about \$29,965. The cap is not wage
6 adjusted.

7 As we'll see shortly, the hospice cap affects
8 providers that have disproportionately long stays. So this
9 next chart is a reminder of what hospice length of stay
10 looks like for the overall hospice population nationally.

11 On average, hospice length of stay among
12 decedents was 87.8 days in 2016. Many hospice decedents
13 have short stays. Fifty percent have stays of 18 days or
14 less. Some patients, though, have long stays. Thirteen
15 percent of decedents had stays of 180 days or more in 2016.

16 So here's an illustration of how the hospice cap
17 calculation works. This is a hypothetical example of a
18 hospice with a mix of patients with disproportionately long
19 stays compared to the national data that we just looked at.

20 This is a hospice with 20 patients, half with
21 stays of 30 days and half with stays of 300 days each. To
22 determine whether the hospice exceeds the cap we compare

1 the provider's total payments, in the left box, to the
2 aggregate cap amount, in the right box. So let's look at
3 the provider's total payments on the left.

4 For patients with a length of stay of 30 days,
5 the hospice was paid about \$5,600 per patient, and for
6 patients with a length of stay of 300 days, the hospice was
7 paid roughly \$46,000 per patient. Adding it all up, the
8 hospice was paid in total \$520,000 for the 20 patients.

9 In the right box, we have the calculation of
10 aggregate cap, which is just the number of patients, 20,
11 multiplied by the cap amount in 2016 of about \$27,800,
12 which yields an aggregate cap of about \$556,000.

13 And so when we compare the left, the provider's
14 payments, to the right, the cap, we see that this hospice,
15 with half of its patients with 300-day stays, would be
16 under the cap.

17 So now let's look at some statistics on hospices
18 that are above the cap. In 2016, we estimate that about
19 12.7 percent of hospices exceeded the cap. Payments in
20 excess of the cap were equivalent to about 1 percent of
21 total payments to all hospice providers. Margins for
22 above-cap hospices would have been very high without the

1 cap -- we estimate about 20 percent. After the return of
2 cap overpayments, above-cap hospices' margins were still
3 strong, at 12.6 percent.

4 In terms of characteristics, above-cap hospices
5 have substantially longer stays and higher live discharge
6 rates than other hospices. They are also
7 disproportionately for-profit, freestanding, urban, small,
8 and recent entrants to the Medicare program.

9 So next let's talk about wage adjustment.
10 Hospice payments are wage adjusted but the aggregate cap is
11 not, and because the cap is not wage adjusted it is
12 stricter in some areas of the country than others. For
13 example, for a provider with a wage index of 1, the
14 aggregate cap in 2016 was equivalent to an average length
15 of stay of routine home care of about 173 days. However,
16 it was equivalent to a shorter average length of stay in
17 areas with a higher wage index and a longer average length
18 of stay in areas with a lower wage index.

19 And so this means that providers with the same
20 utilization patterns in two areas of the country could fall
21 on opposite sides of the cap, due to wage index
22 differences. And we do see more hospices in high-wage

1 index areas exceed the cap than those in low-wage index
2 areas. About 20 percent of hospices with a wage index above
3 1 exceeded the cap in 2016, compared to 9 percent of
4 hospices with a wage index below 1.

5 In light of all of this, the Commission could
6 consider a policy option to wage adjust and reduce the cap.
7 Wage adjustment could improve the equity of the cap across
8 providers. Reducing the cap could improve payment accuracy
9 and reduce excess payments to providers with
10 disproportionately long stay and high margins. To the
11 extent that some providers have entered the hospice sector
12 pursuing a strategy focusing on long stays, this could also
13 lessen the attractiveness of that business model. Also,
14 reducing the cap could generate savings for taxpayers and
15 the Part A trust fund, which could help address the
16 Commission's concern about the aggregate level of payments.

17 So we conducted a simulation to explore the
18 potential effects of a policy that would wage adjust and
19 reduce the cap. We simulated a 20 percent reduction to the
20 cap. This figure is illustrative. Other amounts could be
21 considered. The simulation uses 2016 data and assumes no
22 utilization changes. Because the 2016 data does not

1 reflect CMS' 2020 rebasing, we simulated the rebasing
2 before simulating the effect of the policies to modify the
3 cap.

4 So I'm going to summarize what we find when we
5 simulate the policy option. There is more detail in your
6 paper.

7 Overall, the share of hospices exceeding the cap
8 increases, but many hospices would remain well below the
9 cap. Under the policy option, we estimate that about 26
10 percent of hospices would have exceeded the cap in 2016.
11 This estimate is based on constant 2016 utilization and
12 does not reflect the possibility that some providers might
13 adjust their admissions patterns so that they don't exceed
14 the cap. And as you'll see on the next slide, these
15 hospices that exceed the cap are those that have the longer
16 stays.

17 At the same time, many hospices would remain
18 below the cap. For example, in our simulation half of
19 hospices would have been 41 percent or more below the cap
20 under the policy option.

21 So this next chart shows the simulated effect of
22 the cap policy option on payments to providers in 2016.

1 Overall, our simulation estimates that total payments would
2 decline 3.2 percent in 2016. As you can see in this chart,
3 the reduction payments occurs among hospices with the
4 longest stay and the highest margins. Those are the
5 hospices on the bottom two lines of the chart. The other
6 hospices, on the three lines above the bottom two, there's
7 virtually no effect.

8 So when we look at the effects of the policy to
9 modify the cap by provider characteristics, what we find is
10 that the effect by category of hospice depends on the
11 prevalence of providers in that category with
12 disproportionately long stays. So as a category, for-
13 profits and freestanding hospices would experience reduced
14 payments. We find little effect on nonprofits and
15 hospital-based hospices, provider categories with the
16 lowest margins.

17 In summary, wage adjusting and reducing the
18 hospice cap is an immediate targeted step that could be
19 considered to improve equity across providers, increase
20 payment accuracy and reduce excess payments for providers
21 with disproportionately long stays and high margins, and
22 likely generate savings for taxpayers and the Part A trust

1 fund.

2 We expect that beneficiaries would continue to
3 have good access to hospice care, many providers would
4 remain substantially below the cap, and to the extent that
5 some providers have entered the sector to pursue strategies
6 focusing on long stays, it would lessen the attractiveness
7 of that business model.

8 So that concludes the presentation. I look
9 forward to your discussion and would be glad to answer any
10 questions. It would be helpful to get your feedback on the
11 policy option to modify the cap and whether you would like
12 to consider developing it further into a potential
13 recommendation for further consideration in December.

14 DR. PAUL GINSBURG: [Presiding.] Thank you very
15 much, Kim. Let's start with clarifying questions for Kim.
16 Yeah, Larry.

17 DR. CASALINO: Yeah, Kim, very nice work. Very
18 clear, and this really makes a lot of sense to me.

19 Two quick questions. One is, one of the
20 characteristics of the hospices that had the highest profit
21 margins and a disproportionate number of long stays was
22 that they were small. That's not what I would have -- I

1 don't know much about this area but that is not what I
2 would have predicted. Do you have any sense of who these
3 small ones are, and why they fit into this disproportionate
4 long-stay category?

5 MS. NEUMAN: Well, the hospices that exceed the
6 cap, as you know, are small, and they have a bit of a
7 different patient mix. They have fewer non-cancer patients
8 and more patients with -- I'm sorry, fewer cancer patients
9 and more patients with non-cancer diagnoses. And then,
10 within any diagnosis category, they have longer stays
11 within those categories. So it's both their mix of
12 patients is different and then they have long stays for any
13 type of patient.

14 DR. CASALINO: And physicians have to refer. Do
15 you have a sense of who the physicians are that are
16 referring them, compared to physicians who are referring to
17 different types of hospices?

18 MS. NEUMAN: We have not looked at the referring
19 physicians.

20 DR. CASALINO: Okay. And the second question I
21 had was, the 18-day median for hospice stays I think
22 probably is way too short, right? I mean, my main idea

1 about hospice is that most physicians refer too late, not
2 too soon, right?

3 So have modeled, or could you model -- if that
4 increased to a more appropriate number, whatever that
5 number might be, but it's probably a lot longer than 18,
6 maybe multiples of 18, would that be likely to be putting
7 many hospices -- and everything else stays the same, say --
8 would that be likely to be putting many hospices over the
9 cap?

10 So just conceptually, we'd like to not have
11 hospices have too many disproportionately long stays that
12 are unnecessary, but we would like them to have more stays
13 that are of an appropriate length, and what would be the
14 effect if that happened? We want to, quote/unquote, punish
15 the one but not the other, right?

16 MS. NEUMAN: Right. And you can see on this
17 slide here, where we did the sort of hypothetical example,
18 we put half of these hospice patients at 30 days. So there
19 were no 2-day or 3-day stays, which is actually a big chunk
20 of what happens in hospice. So it's kind of the sentiment
21 that you were just expressing. You could play with this
22 and try other kinds of numbers, but that was kind of the

1 thinking here is to bring the shorter stays up.

2 DR. PAUL GINSBURG: Jon.

3 DR. PERLIN: This is really just an extension of
4 Larry's question. In terms of understanding what drives
5 the longer length of stay at the smaller hospices, I just
6 want to understand what you know about their locations. Do
7 we know if they are more isolated, either being rural or
8 in, you know, sort of urban areas that may be lower income
9 and bereft of SNFs for alternatives?

10 MS. NEUMAN: So hospices that exceed the cap are
11 located more in urban areas than rural areas. There is
12 geographic concentration. It happens in more states than
13 others, and it tends to happen more in the southern coast,
14 I would say, is where we see more access cap hospices.

15 DR. PERLIN: The question I'm trying to tease out
16 is what is it being a substitute for? I mean, because
17 clearly you don't go to a post-acute care by choice. You
18 don't go to a hospice by choice. So these are individuals,
19 then, that have some sort of care dependence, say, and
20 need, and yet our working assumption is that they're not
21 really who we are thinking of as the most appropriate of
22 hospice patients. So I'm just trying to get at this

1 question, what piece of infrastructure is it that they're
2 not accessing?

3 MS. NEUMAN: We hear anecdotally that sometimes,
4 for certain patients, certain providers may view it as a
5 substitute for long-term care or other kinds of supports,
6 but I can't speak to it broadly, just anecdotally.

7 DR. CROSSON: [Presiding.] Kim, I apologize.
8 I'm just jumping in here. But maybe for the benefit of
9 some of the other newer Commissioners you might talk about
10 the changes in diagnoses that have occurred over the last
11 decade or so, in terms of who is going into hospice,
12 particularly for the longer term.

13 MS. NEUMAN: So there has been a big shift over
14 the last 15 or more years in terms of patients in hospice.
15 It used to be that it was largely cancer patients, but we
16 have shifted over time to a mix that is majority non-cancer
17 on diagnoses, and, in general, probably is more reflective
18 of the overall decedent population than solely the cancer
19 model that existed.

20 DR. CROSSON: With a particular emphasis on
21 chronic neurologic disease -- would that be fair to say?

22 MS. NEUMAN: The largest sort of big category now

1 is chronic neurologic disease.

2 DR. CROSSON: Thank you.

3 DR. RYU: Do we attribute that to anything in
4 particular? Is that just better education for the care
5 delivery system around types of patients that might benefit
6 from hospice, or is it a different mix of beneficiary
7 disease burden? Do we know what is driving that?

8 MS. NEUMAN: I think it's a combination of
9 things. I think there is a better understanding that
10 hospice is appropriate for a range of patients, so I think
11 that that is certainly part of it. And I think that, as
12 well, this group of patients has longer stays and so they
13 are an attractive group from a business model perspective.

14 Mr. Cassidy. [Off microphone.]

15 MS. NEUMAN: Substantially. Substantially
16 longer.

17 DR. CROSSON: Okay. Dana.

18 DR. SAFRAN: So that last bit was actually very,
19 very helpful, so thank you for that.

20 I guess if you could go back to Slide 6. You
21 know, what you told us and shared in the written materials
22 about the policy is this applies to people expected to live

1 less than 180 days, or half a year, and for the most part
2 that's what we see. I mean, I don't know if 13 percent
3 beyond 180 days is what you'd expect by chance, in a
4 population, you know, that clinically you are assessed to
5 live, you know, less than 180 days. But it doesn't
6 probably look like it's that far off.

7 So coming at this fairly new to the topic, does
8 leave me wondering whether we really need a sort of
9 systematic policy solution like a wage index, or whether we
10 need a solution that addresses sort of bad actors,
11 specifically. So I just wonder kind of if you could speak
12 to that a little bit, of why you've come to sort of the
13 policy lever tool that would go across as opposed to kind
14 of -- it sounds like you kind of can identify specific
15 entities that are bad actors, and is oversight of those
16 maybe a better approach here?

17 MS. NEUMAN: So there's two pieces to the policy
18 option. One is the wage index, as you mentioned, which
19 puts everybody on equal footing.

20 And then the second piece is that we see certain
21 providers whose distribution looks quite different from
22 this, and so what the cap does is it reduces payments to

1 providers whose distribution looks dramatically different
2 from this. And so, in a way, it is sort of a blunt
3 targeted approach, and it effectively does not affect the
4 vast majority of providers. It would just hone in.

5 DR. CROSSON: Okay. Questions? Amol.

6 DR. NAVATHE: So, on Slide 13 and then, I think,
7 Table 7 in the paper, I just want to make sure I'm
8 understanding correctly. The simulated effect is the
9 percent change, correct? It's not the net margin that we
10 would end up seeing? So, if I'm understanding that
11 correctly, I just want to confirm that the lowest quintile
12 group of hospices here would end up with a negative margin.
13 If they start with a negative margin, they would end up
14 with a negative margin.

15 MS. NEUMAN: Right. They're at minus 5.4
16 percent, and the policy does not affect their payments.

17 DR. NAVATHE: Okay. Thank you. I'll save my
18 comments for later.

19 DR. CROSSON: Karen?

20 DR. DeSALVO: Thank you.

21 Kim, two questions. One is about whether you can
22 tell anything about the actual clinical services being

1 delivered not only in that tale of the longer stay but in
2 some of the newer diagnoses, particularly related to
3 palliative care, because clinical practice has changed a
4 lot in the last decade as well as referral patterns to
5 treat people, not just that's a hospice service, but that
6 there's also a palliative care side. I'm just wondering if
7 there's something to tease out that some of those providers
8 are delivering a different kind of service, and maybe
9 that's the reason for the longer length of stay.

10 MS. NEUMAN: So the data that we have for hospice
11 is we know how many nurse visits they get, how many aide
12 visits, social worker visits, physician visits, those kinds
13 of things. So it's been a while since we've looked at the
14 difference for cap versus non-cap in those services, but
15 the last time we looked at it, we didn't see that big of a
16 difference.

17 To the extent that there's different kinds of
18 palliative care that's being provided, that's sort of not
19 those kind of tangible things like nurse visits, aide
20 visits. We don't have a window on that.

21 DR. DeSALVO: Okay. I'm just thinking that, for
22 example, there may be some service providers that are doing

1 more procedures, paracentesis or thoracentesis, ways to
2 palliate symptoms, and that prolongs life, compared with a
3 hospice model from the past that would be more about you're
4 right at the end of life. And this is going to be more
5 true comfort care and family support.

6 It may or may not be relevant, but I think part
7 of the reason to ask is both of these ideas that we -- we
8 want people to get both palliative and hospice and not just
9 go in for hospice, so raising the floor but also
10 recognizing that there's got to be some upper limit of
11 what's realistic, but trying to understand if there's
12 something different about clinical practice.

13 The other question I had was about tradeoffs,
14 which has kind of come up in what Jon Perlin said. Is
15 there something of value to understand a comparator
16 population? Where even if there is a very long hospice,
17 hospice stay, the alternative would have been a series of
18 inpatient admissions or other admissions that -- just
19 thinking from a cost, not even so much about quality and
20 quality of life, but that we should be taking into account.

21 Part of the reason I'm asking is, again, we want
22 to encourage right type of care at the right time when the

1 beneficiary chooses that, and so we wouldn't want to dampen
2 what seems to be an appreciation for the opportunity of
3 palliative and hospice care by squishing it too much, to
4 use a technical term, and to understand again globally that
5 there is a little bit of an extra cost, 12 percent, but on
6 the other hand, what we're gaining for beneficiary quality
7 of life and total cost of care is greater than in one
8 particular area and then take a strategy that's more
9 targeted.

10 So what I'm asking, is it possible to kind of do
11 a comparator population and say if there wasn't 180 or 300
12 days of hospice stay, what would that potentially have
13 looked like in terms of inpatient admissions to do
14 something similar?

15 MS. NEUMAN: So there's some literature on that
16 end. The Commission has sponsored research looking at the
17 effect of hospice on Medicare expenditures, and it's tricky
18 methodologically to say what would have happened in the
19 counterfactual, they weren't in hospice.

20 But what the evidence suggests is that for
21 patients in the first month or two right before death,
22 hospice saves money. When stays are longer, there's a

1 point where the savings turns to extra cost, and the study
2 that the Commission sponsored found that in aggregate, the
3 evidence suggests that overall the net of the savings and
4 the cost haven't -- there's not evidence overall that it's
5 saved, even though it saves for particular patients.

6 One other thing, just one comment, just to sort
7 of put this in context, while the cap was thought of at the
8 beginning of the legislation as a means of generating
9 savings, today when we look at the data, it's functioning
10 kind of differently. It's functioning almost as a payment
11 accuracy tool. It's honing in on providers that would have
12 the highest margins, and it's pulling back some of those
13 payments. So that's kind of more the spirit of the
14 presentation here of whether we want to go further down
15 that road of using it in a payment accuracy kind of
16 context.

17 DR. CROSSON: Okay. Thank you.

18 Amol?

19 DR. NAVATHE: I apologize for being confused
20 about this, but on this slide, the simulated effect, is
21 that a percent change, or is that a percentage point
22 change?

1 For example, for highest quintile, would their
2 margin, simulated margin, be zero, or would it be 15 minus
3 15 percent of 15?

4 MS. NEUMAN: Their payments would go down by 15
5 percent.

6 DR. NAVATHE: Percentage point. Okay.

7 MS. NEUMAN: So if they didn't change their cost,
8 which we would never make that assumption -- that's why we
9 didn't simulate a margin because we don't want to assume
10 what's going to happen to their costs. We just are saying
11 what's happening to their payments.

12 If they didn't change their cost, it would be you
13 could add those two together.

14 DR. NAVATHE: Right, okay. Got it. Thank you.

15 DR. CROSSON: Okay. So we'll move on to the
16 discussion. We can put the last slide on, Kim, 16.

17 What Kim is asking for here is people's
18 perspective on the two policy options, wage adjustment,
19 geographic wage adjustment, and then in addition, reduction
20 of the cap for the purposes that she described fairly
21 recently to target certain facilities and certain patterns
22 of marketplace behavior.

1 Then, also, I think a qualitative sense from the
2 Commission is to what degree do we believe that these
3 things should be changed, and should we move forward in
4 this cycle to recommendations?

5 Okay. And Paul is going to begin.

6 DR. PAUL GINSBURG: Yeah. Thank you.

7 I want to express my enthusiastic support for
8 both of the recommendations. I was particularly influenced
9 as far as lowering the overall cap your comments about the
10 fact that the few hospices that have this that are
11 constrained by the cap or closed by it, their patterns look
12 very different from the bulk of hospices. It's not just
13 that they have a little higher all throughout the
14 distribution, but as you say, they are very different. I
15 very much doubt these are the innovators and the pioneers -
16 - or not the pioneers in a good sense -- in the industry.

17 So I think that lowering the cap would serve a
18 function of reducing abuse.

19 DR. CROSSON: Thank you.

20 David, Jon, Sue. David, Jon, Sue.

21 DR. GRABOWSKI: I'm also enthusiastic about both
22 of these recommendations, both -- wage adjusting seems like

1 a complete no-brainer that we're disproportionately
2 penalizing. That makes no sense to me. I like the idea of
3 lowering the cap.

4 The only addition I would make here in the
5 chapter, you mentioned the problem of live discharges. I
6 really think that needs to be monitored because we can
7 imagine hospices that are nearing the cap beginning to
8 discharge more and more patients in order to keep them
9 below that, so just monitoring those rates. And I don't
10 know if that's a quality measure, if that's some sort of
11 trigger for penalties, but something around live
12 discharges, that needs to be monitored alongside the
13 average length of use.

14 Thanks.

15 DR. CROSSON: Jon?

16 DR. PERLIN: I'm really challenged in this area,
17 and I still feel like I don't personally have enough
18 information to understand exactly the problem we're trying
19 to solve.

20 Don't get me wrong. If there are high outlier
21 entities that are abusing the intended purpose, that is an
22 issue.

1 A table that's missing for me is a table that
2 shows not the distribution, not the length of stay by
3 decedent, but a table with length of stay by institution
4 and the sort of deep dive into what the characteristics of
5 the patient and the environment around that institution are
6 to be able to get at that.

7 I'm really glad, Jay, that you brought up the
8 comments about the types of patients and the change and the
9 diagnoses over time because, clearly, I think of chronic
10 neurologic disease. Obviously, we think about dementing
11 illnesses and frankly the burgeoning population there and
12 clearly a large a substantial needs for the Medicare
13 program and its beneficiaries.

14 I hate to do things that maybe discourage into
15 the appropriate use while trying to solve the inappropriate
16 use. I'm reminded of Jack Rowe's work at Aetna, where the
17 uptake of hospice was low until they offered intervention
18 to patients who would be appropriate for hospice, which is
19 that they could revert back into general care. That
20 questions the fundamental philosophical underpinning of the
21 structure of our particular Medicare benefit.

22 But I think one would have to look to the

1 evidence and say, "Gee, I wonder if that as a premise
2 itself shouldn't be under some degree of discussion," and
3 that what we want is not only efficiency but the best
4 possible care. So I just offer that out because I think it
5 makes this question.

6 When I look at this in my hat as a health care
7 administrator, it strikes me as indirect, getting at it
8 through wage, though David, as an economist, may be able to
9 comment to me that's absolutely the right approach.

10 I wonder if retrospectively there isn't an
11 appropriate reclassification of patients if, in fact, this
12 is serving as a substitute. Not all hospices -- there are
13 a variety of hospice services, but something akin to re-
14 class as home health or something else where a population
15 that has that, so that you can just rectify that in
16 reverse.

17 Final point, given the obvious inability in not
18 the instances of potential abuse of the system but,
19 frankly, the reality that sometimes even the best
20 clinicians can't estimate accurately the length of
21 remaining life.

22 Thanks.

1 DR. CROSSON: Thank you, Jon.

2 Sue?

3 MS. THOMPSON: I too am really challenged by this
4 chapter because of the importance that palliative care as
5 well as hospice plays in doing the right things for
6 patients. I think some of the most important work that we
7 do in the Medicare program and I think the advancement, as
8 described by Karen, in terms of more intervention on the
9 palliative side is improving the quality of life.

10 My mother with pancreatic cancer lived an
11 additional six months pain free because of a stent that was
12 placed. So I'm a huge advocate of the work, and she lived
13 longer than six months with a diagnosis of pancreatic
14 cancer. There's very good work that goes on here.

15 At the same time, what I really struggle with are
16 the bad actors in this arena, which are making it very,
17 very difficult for organizations that are practicing
18 ethically and professionally, and I'm all about MedPAC
19 going after policies that will address abuse of -- and
20 playing with their panels of patients and avoiding taking
21 on cancer diagnoses and abusing the system, and that's a
22 fine balance.

1 This obviously is the question that's on the
2 table, but I'm quite supportive of continuing this work,
3 Kim, and I thank you for bringing it forward.

4 DR. CROSSON: Thank you. Thank you, Sue.
5 Larry. Larry, then Bruce.

6 DR. CASALINO: Yeah. I agree that wage
7 adjustment is a no-brainer. I think that's why we haven't
8 been talking about it very much. So that makes sense for
9 sure.

10 Having read this and for most of the discussion,
11 I also thought that the cap seemed like a good idea, but a
12 couple things concern me. One is it seems like these are
13 bad actors, but we could be wrong. Maybe they specialize
14 in care of ALS or something, and so they have lots of very
15 long-stay patients but appropriately. That seems unlikely,
16 but it might be nice to be a little more sure about that if
17 we can be.

18 If it's bad actors, I think then the question is,
19 What's the best remedy? Is a cap going to really get them
20 very effectively and not get other people that it shouldn't
21 get so much, or is it realistic to think that Medicare can
22 actually police the bad actors? And if that was done well

1 -- and I'm saying this is realistic to believe that -- then
2 would there still be a need for the cap? So I think those
3 questions could use a little bit more work.

4 I just say as a technical point, the table Amol
5 kept referring to, I had kind of the same problems. That
6 last column is a little hard to understand. Do we make it
7 that they had a 15 percent margin and now they have a minus
8 15 percent margin, or is it just that they're losing 15
9 percent of their payments? I think a lot of people might
10 be confused by that. So that could probably be just made
11 more explicit because that's going to be a table that would
12 get a lot of attention, potentially.

13 DR. CROSSON: Okay. Bruce?

14 MR. PYENSON: I support the policy option for
15 both the wage adjustment and the reduction in the cap.

16 I'd remind fellow Commissioners that our
17 recommendation for last year was perhaps less refined. We
18 called for an overall cut in hospice reimbursement because
19 of the high profitability of the industry overall, though
20 recognizing that there were hospices that were losing money
21 and others that were making a lot of money.

22 So, looking at Slide 13, I think this is a more

1 refined policy option than we've already recommended, and I
2 think fairer for the stability of the industry.

3 So I hear the concerns, but in the past, this
4 seems to be an improvement over what we've recommended in
5 the past. So I'm very comfortable with them.

6 DR. CROSSON: Thank you, Bruce.

7 Dana?

8 DR. SAFRAN: Thanks. This is difficult. So the
9 thing I want to underscore is the importance of continuing
10 this work. You know, end-of-life care for this population,
11 both in terms of cost and the impact on quality of life is
12 probably one of the most things that we can focus on.

13 I'm mostly supportive of the two policy levers
14 you've suggested here. The one thing I would just like us
15 to be really careful about before we say the wage index is
16 a no-brainer is that it wouldn't be expected to have
17 unintended consequences on the wages set for hospice
18 workers, and, therefore, the ability to attract the quality
19 and training of workers that are currently serving there.

20 So I don't pretend to understand the wage index
21 implications well enough to know whether that's a
22 possibility, but I would just ask you to look at that

1 before we pull the trigger on recommending that.

2 Otherwise, I'm comfortable with these but I
3 really want to kind of continue to underscore that I think
4 our most important policy lever here could be figuring out
5 how we identify those who are sort of systematically
6 abusing this benefit, and address that. Jonathan's idea of
7 retrospective is important, and certainly the point about
8 having a table in this that really calls out what you seem
9 to indicate, Kim, is a distribution that you can see at the
10 site level and how different the distributions look for
11 some entities versus for others I think is important.

12 I wonder whether some of the qualitative work
13 that the staff often does, of actually going out and
14 talking to folks might be useful here. You know, go talk
15 to some of the entities that look like bad actors, and go
16 talk to some of the actors that look like really good ones,
17 and maybe that would be helpful.

18 But I want us to keep our focus on the fact that
19 as, I think Larry was the first of us to say it, one of the
20 biggest problems across the board is getting people into
21 hospice sooner, and so I don't want us to make moves that
22 will undercut the progress that's being made there.

1 Thanks.

2 DR. CROSSON: Kim -- sorry, so Kathy and Warner.
3 Kim, could you just basically briefly describe how the
4 applicable wage index is set here?

5 MS. NEUMAN: Sure. So we use the hospital wage
6 index, and so right now it is used to adjust the payments
7 that the hospice providers receive. So a provider in
8 Manhattan is going to get a higher payment rate than a
9 provider in a rural area. But the cap amount is the same
10 amount. So that would be the only place where we would be
11 adding it.

12 DR. PAUL GINSBURG: So if a hospice wanted to
13 raise the wages of its employees it would have no effect on
14 the wage index.

15 MS. NEUMAN: Correct.

16 DR. CROSSON: Okay. Amol.

17 DR. NAVATHE: So thanks for this great work. I
18 also am supportive, I think, of the changes, generally
19 speaking, and of continuing this line of work. Thanks for
20 that clarification, Jay, on the wage index part, because I
21 thought that was very helpful.

22 Two points. I think one thing is just looking at

1 the table on Slide 13 again, I'm struck that there's the
2 negative margins on the low side as well, and I think you
3 made comment in the paper that the cost structure is this
4 new cost structure. And so it made me sort of think about
5 to the extent that we would follow Jon's recommendation,
6 for example, to look at the environment and the
7 characteristics of the patients of the highest quintile
8 outliers, it might also make sense to look at the lowest
9 quintile, essentially, to try to understand what the
10 characteristics are there and if they're intrinsic with the
11 patients or settings or intrinsically different from
12 others, given that right now they have a negative margin,
13 and so the incentives there are obviously different.

14 And then, accordingly, this hasn't been included
15 in the scope of what we've talked about here, but if this
16 work on wage index and cap should also be pared with some
17 further recommendations on rebalancing the fee structure to
18 more closely emulate the new cost structure, which is not
19 part of the CMS updates that are upcoming. So I just
20 wanted to see if we could add that to our scope of
21 thinking.

22 DR. CROSSON: Thank you, Amol. Kathy, and then

1 Warner and Karen.

2 MS. BUTO: Yeah, I support both recommendations.
3 I just have a quick question, which is, is any of this
4 possible to be done administratively or does it require
5 legislation?

6 MS. NEUMAN: The cap is written into statute, so
7 it would have to be modified.

8 MS. BUTO: The wage index could be done -- wage
9 indexing the cap is also implicated by legislation?

10 MS. NEUMAN: The statute says \$6,500, and then it
11 has an inflation factor in it. So I'm not clear if they
12 could wage adjust on their own.

13 DR. CROSSON: Okay. Warner.

14 MR. THOMAS: This may be a little bit off-topic
15 but it just seems -- and I was reflecting on this
16 conversation, the one we had on post-acute, and, you know,
17 it seems like when we're trying to create payment policies
18 that have broad implications that we constantly kind of
19 bump up to it's because of bad actors. And so then we're
20 trying to make kind of broad payment changes.

21 And I don't know what sits in the purview of
22 MedPAC or not around the situation of, you know,

1 significant outliers. But I just wonder at some point
2 should we be taking up the discussion around significant
3 outliers and how that should be addressed, and should there
4 be, you know, a much more detailed review on entities that
5 are in the -- decide if it's the top or bottom 10 percent,
6 or whatever the number is, about a much more significant
7 review. Because I think we keep trying to have broad
8 policies here, and whether it's home health, which we were
9 just talking about, that, you know, we want to put
10 utilization caps because there's a lot of overutilization,
11 but there's lots and lots of organizations that are doing
12 it right that that can be impacted.

13 And I worry about the same thing with hospice. I
14 mean, we're going to put a policy in that, you know,
15 frankly, may impact the bad actors, but going to David's
16 point, there might be the discharge right before the cap
17 and then readmission after.

18 And so it's just more of a question. I don't
19 know whether it sits in the -- where that sits in the
20 agenda of MedPAC, but it just strikes me, in some of our
21 conversations we're trying to put things in that have broad
22 implications, but we're really trying to deal with, you

1 know, a small percentage of organizations that are not
2 adhering to the policies appropriately.

3 DR. CROSSON: Thank you, Warner. Karen.

4 DR. DeSALVO: That's a good segue, because that
5 would be my hope is that we don't create such a broad
6 policy that we disincentivize people getting into
7 palliative care and hospice when it's right for them, and
8 that they don't get the kind of, you know, quality of life
9 that we want them to have. And this famous, you know,
10 Slide 13, you might even read it like that. You know, if
11 the -- again, not understanding all the patients that fall
12 into the bucket, but maybe people are getting in too late,
13 and what we really want to do is try to keep encouraging
14 that to improve.

15 And so, again, I don't know if that's the purview
16 of MedPAC, but in addition to the things that you've
17 recommended, which I am generally supportive of and I
18 certainly would like to see us continue this work, but it
19 would be -- if it's possible to think about a more targeted
20 strategy, to Bruce's point, rather than sort of a broad
21 approach. This is more finessed, and I appreciate that,
22 but maybe we could get an option that was even more

1 finessed, that looked at outliers, as opposed to trying to
2 maybe send a negative message and disincentivize the whole
3 care opportunity.

4 DR. CROSSON: Okay. Thank you, Karen, thank you,
5 Kim, and thank you to the rest of the Commission for the
6 good discussion.

7 I'll just bring up one topic and that's that
8 several Commissioners have commented on not the issue of
9 the hospice benefit per se as it exists, but perhaps as it
10 should exist, with more of a consideration for palliative
11 care. And I think in the paper, Kim, I think you wrote, as
12 I remember, an example of where that's beginning to take
13 place.

14 And I just want to make sure that nothing that
15 we've said here with respect to these recommendations is in
16 any way antithetical to that set of developments, which is,
17 I think, late now and important. It needs to have moved
18 forward more quickly.

19 So at that rate I think you've had some good
20 information provided to you, and thank you again for the
21 presentation.

22 DR. CROSSON: We now have an opportunity for

1 public comment period. If there are any of our guests who
2 wish to make a comment about the issues before the
3 Commission this morning, please come forward to the
4 microphone. I'll give you an instruction in one second.

5 So please identify yourself and any organization
6 that you are part of or speaking for, and we'd ask you to
7 confine your remarks to two minutes. And when this light
8 comes back on, the two minutes will have expired.

9 MS. ACS: Thank you. Good morning. My name is
10 Annie Acs. I am the Director of Health Policy and
11 Innovation with NHPCO. That's the National Hospice and
12 Palliative Care Organization. On behalf of our President
13 and CEO, Edo Banach, I'd like to offer comments on the
14 proposed policy options regarding modifications to the
15 hospice aggregate cap under the Medicare hospice benefit.

16 NHPCO is the largest membership organization
17 representing the entire spectrum of not-for-profit and for-
18 profit hospice and palliative care programs and
19 professionals in the U.S., comprised of almost 4,000
20 hospice locations with more than 57,000 hospice staff and
21 volunteers, as well as 46 state organizations. NHPCO is
22 committed to improving end-of-life care and expanding

1 access to hospice care, with the goal of creating an
2 environment in which individuals and families facing
3 serious illness, death, and grief will experience the best
4 that humankind can offer.

5 With this in mind, we would like to submit the
6 following comments to MedPAC today.

7 As stated today, the original intent of the
8 aggregate cap was to ensure savings to Medicare when the
9 benefit was first established. The outstanding question is
10 whether Medicare has achieved any savings since the cap was
11 first introduced. Without this understanding, it is
12 unclear whether reducing the cap by 20 percent would impact
13 spending positively or negatively. We cannot support
14 proposed changes until we understand whether the cap
15 currently functions to produce savings for Medicare.

16 The vast majority of hospice providers do not
17 exceed the annual aggregate cap limits. We are concerned
18 about the unintended consequences of reducing the aggregate
19 cap limit by 20 percent and the wage indexing of the cap on
20 beneficiary access and quality of care delivered by hospice
21 providers, especially to those who are located in
22 underserved areas and across the nation, including rural

1 areas.

2 We would like to work with MedPAC to further
3 analyze the impact of wage adjusting the cap and possibly
4 indexing the cap based on quality. Any proposed policy
5 change to the hospice benefit, including modifications to
6 the aggregate cap limit, must be first tested to determine
7 the extent to which beneficiary access to high-quality care
8 is hindered.

9 On behalf of NHPCO, I thank you for your service.
10 We continue to offer our assistance to MedPAC in your
11 important role in advising Congress.

12 DR. CROSSON: Thank you for your comments.

13 Seeing no one further at the microphone, we are
14 adjourned until November 7th.

15 [Whereupon, at 11:05 a.m., the meeting was
16 adjourned.]

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