

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

The Horizon Ballroom
Ronald Reagan Building
International Trade Center
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Washington, D.C. 20004

Thursday, October 8, 2015
9:44 a.m.

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DR. CROSSON: Okay. I think it's time to begin. I'd like to welcome our attendees for this morning's discussion.

Once again we are going to pick up on our continuing work on the impact of pharmaceutical costs on the Medicare program and its beneficiaries.

I'm going to make a couple of opening remarks here before we get to our presentation. I think it's fairly obvious to everyone that even since our last meeting, the issue of drug cost has become a subject of increased public awareness, both through the media and also through the injection into the American political process. As a consequence, I think there has been an increase in sensitivity and passion among all parties involved, and we're fully aware of this.

We also are concerned about the impact of drug costs on the federal treasury and on the out-of-pocket costs for our beneficiaries. But we are a nonpartisan deliberative body. We have been working on drug costs for more than a year, and we'll continue to do so. We do not

1 blow with the winds, whether those are media or political
2 winds. We approach topics through thorough research,
3 analysis, careful deliberation, and the development of
4 recommendations which are supported by facts.

5 We have a plan and a schedule. Those of you who
6 have been following our work have a pretty good idea, I
7 think, what are the issues that we have on the table
8 currently.

9 In order to think through some of those issues,
10 both with respect to Medicare Part D and Medicare Part B,
11 other issues such as the potential impact of the 340B
12 program, we need as a Commission to have a full
13 understanding of the broader world of Medicare, the
14 pharmaceutical industry, and its impact on both the
15 Medicare program and beyond so that we can then focus on
16 our mandate, and that is to deal with issues that affect
17 the Medicare program and its beneficiaries.

18 So we are going to proceed with our work plan.
19 You will see these issues that we have discussed previously
20 coming up at future meetings. But, in addition, this
21 Commission I think will be over time making suggestions and
22 potentially leading to discussion of other approaches to

1 deal with the question of the impact of Medicare costs on
2 the program, the federal treasury, and its beneficiaries.

3 In the end, as always, our work will reflect deep
4 research, thorough analysis, and careful consideration in
5 the process of developing recommendations, which I think we
6 will see later in this term and beyond. We consider this
7 problem to be of such impact that it is clearly a multi-
8 year piece of work for this Commission.

9 And with that, Rachel and Shinobu will take us
10 through the context of Medicare drug spending.

11 DR. SCHMIDT: Good morning. Our talk this
12 morning is the second of two presentations that provide
13 broader context around Medicare's payment policies for
14 drugs.

15 Last month we discussed the magnitude of Medicare
16 drug spending across all payment systems. We said that in
17 terms of the measurement concept used in CMS' national
18 health expenditure accounts -- a final purchase, retail
19 concept -- about 13 percent of Medicare spending in 2013
20 was for retail prescription drugs. When we considered a
21 broader measurement concept that also included drugs used
22 as intermediate inputs for services at hospitals, nursing

1 facilities, and so forth, about 19 percent of Medicare
2 program spending in 2013 was for drugs and pharmacy
3 services.

4 Many of you had additional questions for us, but
5 we hope that you can wait until next month's meeting for
6 answers because we've got a full agenda this morning. But,
7 briefly, let me deal out Warner's question about what the
8 19 percent looked like in 2007. The answer is that our
9 estimate was, again, 19 percent in 2007, so the proportion
10 spent on drugs did not change even as the Part D program
11 was ramping up.

12 This slide shows you how we will work our way
13 through this presentation. Let me say at the outset that
14 this is a really sprawling topic, and we are extremely
15 aware that many of you know a lot more about some of these
16 issues than we do. So for this presentation even more so
17 than others, we look to you for help in getting the details
18 and the sense of balance right in this discussion.

19 Let me also note that in the interest of time, we
20 had to condense some of the slides from your mailing
21 materials into fewer for this presentation.

22 There are two general categories of medicines

1 we'll talk about this morning. Most medicines are small-
2 molecule drugs, shown here on the upper right by aspirin.
3 Small-molecule drugs are synthesized through a chemical
4 process and can usually be manufactured at low cost. After
5 an innovator has marketed a brand-name small-molecule drug
6 for a period of time, other manufacturers may enter the
7 market and produce what are often nearly identical generic
8 versions at much lower prices. The Hatch-Waxman Act of
9 1984 laid out how and when generics may enter.

10 Biomedical science has moved toward developing
11 large-molecule biologics, depicted on the left by EPO.
12 Biologics are synthesized from living organisms or tissues,
13 they are much more complex, and they provide more targeted
14 treatments for conditions like cancers and autoimmune
15 diseases.

16 Biologics are typically injectable or infusible,
17 and they often require special handling such as
18 refrigeration. Because of their complexity, biologics cost
19 more to develop and produce, and unlike generic drugs,
20 manufacturers of biosimilars cannot make exact duplicates
21 of the reference product. Even the innovator may see small
22 changes in their own reference product as they produce it

1 over time.

2 The first biologics have been around since the
3 early 1980s, but it wasn't until 2010 that the Biologics
4 Price Competition and Innovation Act laid out a pathway to
5 approve biosimilars. The Food and Drug Administration
6 approved the first biosimilar in March 2015.

7 The federal government plays many important roles
8 in drug development. It supports biomedical research --
9 most notably through the National Institutes of Health --
10 by directly conducting studies as well as through
11 extramural awards. The government needs to ensure that new
12 drug products are safe and effective. It also provides
13 protection to innovators so that other firms can't
14 immediately jump in and compete away economic returns.
15 Otherwise, there wouldn't be much incentive to invest in
16 developing new drugs. Ultimately, though, it's also
17 important for other manufacturers to enter the market so
18 that there will be price competition. So government needs
19 to find a balance between encouraging innovation and
20 promoting entry of "me too" and generic drugs.

21 Key tools that the government uses include
22 financing and the award of temporary monopolies. The

1 government finances basic research that provides the
2 underlying knowledge base for developing drug therapies.
3 The government also uses tax credits and grants to
4 encourage private entities to conduct R&D. Most relevant
5 to the Commission, the government is a major payer for
6 biopharma products through federal programs like Medicare
7 and Medicaid.

8 Probably the most important government tool is
9 its power to award temporary monopolies. Developers first
10 apply for patents when they've found a new compound, but
11 well before they've gathered all the data they need to get
12 approval to sell it. Later in the development process, the
13 FDA grants marketing approval to sell the drug after
14 reviewing clinical studies about its safety and
15 effectiveness. So, typically, FDA approval happens well
16 into a drug's patent life, and the remaining length of
17 patent protection depends on how quickly the developer can
18 gather evidence about safety and effectiveness.
19 Additionally, the law around FDA approval provides for a
20 period of exclusivity that holds off competition from
21 generics and biosimilars. The federal government also
22 tightly controls the resale of drugs among domestic

1 purchasers and prohibits most personal importation of drugs
2 from other countries.

3 This slide is a schematic of the development
4 process for innovator drugs and biologics. Basic research
5 helps us understand the mechanisms of disease and helps
6 identify therapeutic targets such as genes and enzymes. As
7 research moves into discovery and preclinical trials,
8 developers may evaluate thousands of compounds, narrow
9 those down, and screen them for efficacy and toxicity.

10 Before developers test a compound in humans, they
11 have to file an Investigational New Drug application with
12 the FDA. If approved, clinical trials on humans proceed in
13 three phases that gradually involve larger numbers of
14 volunteers to evaluate the drug's therapeutic effectiveness
15 and side effects. Once the developer has filed a New Drug
16 Application or Biologics License Application, the FDA
17 reviews the evidence to make an approval decision.

18 Typically, there are issues to resolve such as
19 which indications have enough evidence to be listed on a
20 drug's label. Note, though, that even if a specific
21 indication isn't on a drug's label, physicians can still
22 prescribe it "off label." After the drug is on the market,

1 the developer and the FDA monitor use for additional
2 information about safety, effectiveness, and risks.

3 You can see that this process is long, and
4 relatively few compounds make it all the way to FDA
5 approval. So this process can be very costly. When
6 analysts estimate the average cost of developing a new drug
7 or biologic, they typically include the R&D costs of both
8 successes and failures. Estimates of the average cost also
9 typically include the cost of capital -- what investors
10 give up when they tie up their resources in development
11 projects. There is a lot of variation in biopharma
12 development costs, but one recent study by researchers at
13 Tufts estimated that developing an innovator drug or
14 biologic costs an average of \$2.6 billion: \$1.4 billion in
15 research and development and \$1.2 billion for the cost of
16 capital, which has been a controversial point.

17 In spite of the risk and cost associated with
18 developing medicines, many biopharma companies do not
19 appear to have had difficulty obtaining access to capital.

20 This slide shows the process for innovator drugs
21 and biologics, but there are different processes for
22 generics and biosimilars. To get a generic approved,

1 companies usually refer to the innovator's clinical trials
2 and then try to demonstrate that their product is
3 equivalent. For approval of a biosimilar, the manufacturer
4 has to demonstrate that it is highly similar to the
5 reference product through analytic studies, animal studies,
6 and clinical studies unless the FDA determines that some of
7 that process isn't necessary in a specific circumstance.
8 One estimate puts the cost of getting a generic approved at
9 \$1 to \$5 million over three to five years. Good data are
10 generally lacking for biosimilars, but one manufacturer
11 estimates that they take eight to ten years to develop at
12 an average cost of \$100 to \$200 million.

13 FDA's approval process triggers periods of
14 exclusivity, giving an innovator manufacturer temporary
15 monopoly power in setting prices. The first type is called
16 data exclusivity, during which firms that would like to
17 introduce a generic or biosimilar may not use the
18 innovator's clinical test data as part of their application
19 to the FDA. The length of this period depends on the type
20 of product: five years for new small-molecule drugs, three
21 years for new indications of a drug that's already been
22 approved, and 12 years for biologics. If a follow-on

1 manufacturer was willing to conduct their own trials and
2 pursue FDA approval, in some cases they might be able to
3 challenge an innovator's patents and introduce a competing
4 drug.

5 The second category is called market exclusivity,
6 which refers to an explicit period of protection before the
7 FDA may approve a similar product. For example, the Hatch-
8 Waxman Act of 1984 provided incentives for manufacturers to
9 introduce generics by granting the first generic producer
10 to achieve FDA approval a 180-day market exclusivity
11 period. That first generic producer might not be able to
12 charge as high a price as the brand-name drug, but the
13 market exclusivity keeps out other generic competitors for
14 a six-month period.

15 Over the past several decades, we have seen that
16 generic competition can dramatically lower prices for
17 small-molecule drugs. However, we should not expect as
18 dramatic an effect of biosimilars on the price of
19 biologics.

20 When the FDA designates a generic as "A rated,"
21 it's considered therapeutically equivalent, and in most
22 cases pharmacists can substitute the generic for the brand

1 without involving the prescriber. This ability to
2 substitute generics for brand-name drugs has led to rapid
3 downward pressure on prices. On the left is an estimate by
4 the FDA of how the average relative price of a drug is
5 affected as the number of generic manufacturers increases.

6 By comparison, producers of biosimilars face
7 substantially higher costs to bring a product to market
8 than producers of generic small-molecule drugs. The FDA
9 approved the first biosimilar product this year, and more
10 applications are under review.

11 How much of an effect might biosimilars have on
12 the prices of biologic products? The Congressional Budget
13 Office estimated that prices may be 20 percent to 40
14 percent lower than reference products, varying by product
15 and over time. Several European countries have already
16 been using biosimilars at prices 20 percent to 30 percent
17 below those of innovators. So far, Medicare's payment rate
18 for the first FDA-approved biosimilar, Novartis' Zarxio, is
19 about 3 percent lower than the payment rate for Amgen's
20 cancer drug Neupogen. However, the biosimilar has only
21 been available since September, and CMS doesn't yet have
22 average sales price data for it. Once CMS does have ASP

1 data, Medicare's payment rate is expected to go down.

2 There's a lot of variation in the number of new
3 launches of innovator drugs and biologics from year to
4 year, but generally in recent years it has been increasing.
5 One noticeable trend is that the number of orphan drugs has
6 been growing. Orphan drugs target an indication affecting
7 200,000 or fewer patients, and the government provides
8 incentives to invest in developing orphan drugs through tax
9 credits and market exclusivity.

10 New launches are not only affected by how much
11 companies invest in R&D, but also by the pace of the
12 regulatory review process. For example, the FDA has
13 developed approaches that are intended to speed up its
14 review of drugs for serious conditions that fill an unmet
15 medical need or demonstrate improvement over existing
16 therapies. Despite these newer approaches, some analysts
17 continue to have concerns that the FDA process is too
18 lengthy and expensive. Other analysts have concerns that
19 too many new launches are incremental, improvements of
20 existing drugs, instead of instead of first-in-class
21 products, or that FDA's expedited approaches and the use of
22 surrogate endpoints to evaluate effectiveness have led to a

1 review process that is too lenient.

2 Several new launches have implications for the
3 Medicare program either because of the drugs' high launch
4 prices or because a potentially large group of
5 beneficiaries may be prescribed the drug. The most notable
6 example includes hepatitis C therapies, which may lower the
7 viral load and stem the progression of disease for infected
8 patients but at prices that led to a double-digit spike in
9 Part D spending in 2014.

10 Over the past several months, the FDA has
11 approved the first of several PCSK9 inhibitors for familial
12 high cholesterol as well as a new treatment for heart
13 failure. In each of these cases, the new launches have
14 been viewed as promising therapies for serious conditions
15 but at high prices. The extent to which physicians
16 prescribe these new treatments and whether plans and PBMs
17 control dispensing will have strong implications for
18 Medicare.

19 A number of other therapies in the development
20 pipeline may also have important effects on the Medicare
21 program, including next-generation immunotherapies for
22 cancer and new compounds that aim to stall the progression

1 of Alzheimer's disease.

2 High launch prices for new drugs and biologics
3 pose enormous challenges for Medicare and other payers. On
4 the one hand, to the extent that a new therapy represents a
5 real breakthrough in treatment, access to the treatment may
6 extend a beneficiary's life or improve quality of life. On
7 the other hand, because there are few published results of
8 head-to-head trials of therapies, it can be hard to know
9 the merits, risks, and relative value of a new therapy.

10 Let's look at a couple of recent analyses that
11 put this in perspective. This chart shows trends in the
12 pricing of 58 anticancer drugs approved by the FDA between
13 1995 and 2013. Each point shows a different drug, and you
14 can tell when it was launched by looking along the
15 horizontal axis. Higher amounts on the vertical axis mean
16 that the drug had a higher price relative to its survival
17 benefits. The study found that newer drugs were not
18 necessarily associated with greater survival benefits when
19 compared with older drugs. The regression line shown above
20 suggests that after adjusting for survival benefits and
21 general inflation, launch prices for oncology drugs have
22 increased by \$8,500 per year. In other words, there has

1 been an upward trend in launch prices of cancer drugs
2 independent of additional treatment benefits.

3 Today we're at a point in time when specialty
4 drugs make up a large share of what's in the development
5 pipeline. There's no one definition of a specialty drug,
6 but generally they are expensive. Medicare Part D uses a
7 threshold of \$600 or more per month. Not all specialty
8 drugs are biologics, but biologics are often specialty
9 drugs.

10 This chart is from a study that asked the
11 question: What happens to insurance premiums as
12 beneficiaries begin to use the types of medicines that have
13 prices similar to those emerging from the development
14 pipeline? The authors assumed a simple insurance benefit
15 design where the enrollee pays out of pocket until they
16 reach a \$3,500 cap. Next they estimated what would happen
17 if a new drug became available at a price of \$100,000 per
18 treated patient. The chart shows that even if this drug is
19 used to treat a relatively narrow percent of the covered
20 population, it can have substantial effects on premiums.

21 MS. SUZUKI: There are many factors that may
22 affect drug prices. For example, on the demand side, a

1 shift from out-of-pocket to an insurance can decrease price
2 sensitivity and increase demand, and a shift from private
3 to public insurance could affect prices.

4 A consolidation in the insurance industry may
5 provide insurers with more leverage when negotiating
6 rebates and discounts with manufacturers. Discounts and
7 rebates mandated by law for certain federal programs could
8 affect both launch prices and how quickly manufacturers
9 raise prices on existing products.

10 The aging of the population can affect demand and
11 drug prices as more and more people receive their drug
12 coverage from Medicare.

13 On the supply side, a shift towards more complex
14 biopharmaceutical products, such as specialty drugs and
15 biologics, would tend to put upward pressure on prices.
16 Policies that encourage development of treatments for
17 smaller disease populations can shift the pipeline towards
18 more expensive therapies.

19 The cost of borrowing and patents and temporary
20 monopolies granted by the government can also affect
21 prices.

22 Consolidations or specialization within the

1 biopharmaceutical manufacturers can reduce competition for
2 specific therapies and increase the ability of
3 manufacturers to raise prices or launch new drugs at a
4 higher price.

5 Finally, changes in the drug supply chain can
6 affect incentives faced by individual actors as well as the
7 relative power in specific markets.

8 The next few slides will provide an overview of
9 drug supply chain, focusing on the retail slide. I will
10 briefly summarize the roles of each sector and then show,
11 using a very simplified example, how drugs and payments
12 flow through the retail supply chain.

13 Traditionally, biopharmaceutical manufacturers
14 have fallen in one of three categories: Those who
15 specialize in brand name patented products; in generic off-
16 patent products; and in biologic products. In addition,
17 manufacturers of brand name drugs also market their
18 products through direct-to-consumer advertising and
19 detailing or direct marketing by sales representatives to
20 health care providers.

21 Manufacturers set list prices that are typically
22 used as a starting point for price negotiations among the

1 different actors in the supply chain. Where to set a list
2 price depends on the availability of close substitutes,
3 expectations about the size of rebates and discounts to
4 purchasers, and prices of other products in the same
5 therapeutic class.

6 Manufacturers may negotiate rebates and discounts
7 with Pharmacy Benefit Managers, or PBMs, working on behalf
8 of health plans or employers. Manufacturers make other
9 types of payments to PBMs. For example, they commonly pay
10 a fee to PBMs for a favorable placement on their
11 formularies. What a manufacturer receives for the sales of
12 its product -- of drug products -- reflects prices,
13 discounts, and rebates that are negotiated by various
14 actors in the supply chain.

15 It is often more efficient for pharmacies to get
16 their stock through wholesalers. Wholesalers provide a
17 link between pharmaceutical manufacturers and over 60,000
18 pharmacies and outpatient dispensing outlets throughout the
19 U.S. Manufacturers can ship bulk quantities of products to
20 the relatively small number of wholesale warehouses instead
21 of shipping to thousands of individual outlets.
22 Wholesalers store the drug products and then sell and

1 deliver the products in much smaller quantities to their
2 customers. Wholesalers help smaller pharmacies by pooling
3 their purchasing power to negotiate with generic
4 manufacturers.

5 The wholesale sector is highly concentrated. In
6 2013, three companies generated about 85 to 90 percent of
7 all revenues from drug distribution in the U.S.

8 Revenues for the wholesalers typically come from
9 the spread between what they pay to purchase drugs from
10 manufacturers and what they receive in payments for the
11 sales of those drugs to the retail and non-retail
12 customers. They can also earn discounts, such as prompt
13 pay discounts and fees on services they provide to their
14 customers.

15 Retail pharmacies can be chain stores or
16 independent pharmacies, food and big box stores, and mail
17 order pharmacies. They serve about three-quarters of the
18 consumer market for prescription drugs. The remainder is
19 served by non-retail providers, including hospitals, some
20 HMOs, clinics, nursing homes, and federal facilities.

21 Pharmacies stock a wide range of single-source
22 drugs so that they are prepared to immediately fill most

1 prescriptions on demand. Because of this need, they do not
2 have much leverage to negotiate rebates or discounts with
3 manufacturers of single-source brand name drugs. For
4 multiple-source drugs, they can choose which manufacturers'
5 drugs to stock and dispense, which provides them with
6 leverage to negotiate rebates and discounts.

7 The pharmacy sector is fairly concentrated among
8 large chains. In 2013, the top five dispensing pharmacies
9 accounted for about 65 percent of U.S. prescription
10 dispensing revenues. Still, independent pharmacies have
11 held on to their market shares.

12 Pharmacies make money on the spread between what
13 they pay to purchase drugs and what they receive for the
14 sales. They typically earn higher profits off of the
15 spread they get for generic drugs.

16 Pharmacy Benefit Managers administer drug
17 benefits on behalf of health plans and employers. They
18 build pharmacy networks and play a key role in negotiating
19 payment rates with pharmacies and negotiating rebates and
20 discounts with manufacturers.

21 The formulary is one of the main cost containing
22 control mechanisms to manage drug use and spending of their

1 customers. The amount of cost sharing, which drugs are
2 covered, how much members must pay for each tier, and
3 whether prior authorization is needed for a particular drug
4 are all determined in discussions between the PBM and the
5 health plan or the employer.

6 The formulary is also used to negotiate rebates
7 and discounts with manufacturers. PBMs have the greatest
8 leverage for brand name drugs with close substitutes,
9 because manufacturers typically pay rebates in exchange for
10 a favorable placement on a formulary or based on the market
11 share that the manufacturer's drug receives. Manufacturers
12 are unlikely to provide rebates or discounts on products
13 with no competition unless the PBM can make a credible
14 threat to exclude their products from coverage.

15 The market for PBM is concentrated, with about
16 three-quarters of the prescription dispensing revenues
17 accounted for by four PBMs.

18 There is a real complexity in how PBMs operate
19 and where they get their revenues. We think their revenues
20 come primarily from manufacturer rebates and fees they
21 receive for managing the drug benefit. In some cases, they
22 may take on an insurance risk and make money on the spread

1 between what they pay to the pharmacy and what they receive
2 from the payers.

3 As prescription drugs move from manufacturers to
4 wholesalers to retail pharmacies and to consumers, a
5 complex set of market transactions take place along the
6 supply chain. The type of transactions and prices paid at
7 various stages depends on whether it is a brand name drug
8 with patent protection, a brand name drug that is off-
9 patent, or a generic drug.

10 Here, I will show an example of how the payments
11 flow for a brand name drug with patent protection.
12 Although the various transactions do not necessarily take
13 place sequentially, I will go through this hypothetical
14 example, starting with the pharmacy counter.

15 In the simplified example, a PBM manages a drug
16 benefit on behalf of an insurer. The beneficiary pays a
17 monthly premium to be enrolled in the plan. The PBM and
18 pharmacy negotiated a price of \$88 for filling the
19 prescription. I will come back to the other negotiation by
20 PBM in a minute.

21 The copay amount for this drug is \$30, so the
22 beneficiary pays \$30 at the pharmacy counter. The

1 remaining \$58 is paid by the PBM.

2 The pharmacy had paid \$83 to the wholesaler to
3 stock this drug, so it makes \$5 on the sale of this drug,
4 which is the spread between what it received from the PBM
5 and the beneficiary and what it paid to the wholesaler.

6 The wholesaler had purchased this drug from the
7 manufacturer for \$80, so it makes \$3 on this drug, which is
8 the spread between what it received from the pharmacy and
9 what it paid to the manufacturer.

10 The manufacturer sold the drug to the wholesaler
11 for \$80, but since it had negotiated a rebate of \$6 with
12 the PBM, the net revenue for the sale of this drug is \$80
13 minus \$6, or \$74. Notice that the net cost to the PBM for
14 this transaction is \$58, offset by the \$6 rebate it
15 negotiated with the manufacturer, or \$52.

16 We would be happy to answer any questions or
17 provide clarification on the material presented to you
18 today. For your discussion, you may want to provide
19 comments on the material or their implications for Medicare
20 that would be relevant for policy discussions that we will
21 be having during this cycle.

22 DR. CROSSON: Thank you, Rachel and Shinobu. As

1 usual, wonderful, thoughtful, clear presentation.

2 So, we are going to do our normal thing. We are
3 going to have clarifying questions, and then after that, I
4 will ask if there are any Commissioners who would like to
5 jump out in front and start the discussion. I apologize.
6 I might have done that earlier, didn't. And then we will
7 have our discussion.

8 So, I think the centerpiece here is in view of
9 what we have had presented, as well as your understanding
10 of the work that we already have on the table, what are the
11 implications for either the existing work we have on the
12 table that we did last year that we began in September, or
13 other ideas that you have that we should consider that have
14 an impact on Medicare beneficiaries or the Medicare program
15 and the Treasury going forward, so that as we develop our
16 full program over this year and probably well into next
17 term, we have an understanding of where this Commission
18 would like to go.

19 Clarifying questions. We will start here with
20 Rita.

21 DR. REDBERG: Thanks, Rachel and Shinobu, for an
22 excellent chapter. It certainly is complex.

1 My clarifying question is just on what was page
2 seven of the mailing materials, but if you would just
3 remind us of the definition for orphan drugs, and also if
4 you could tell us if there is any tracking for how many
5 prescriptions are written. Do we know how much of that is
6 actually on-label or off-label?

7 DR. SCHMIDT: I think there is more complexity
8 than I'm able to give to the definition of orphan drugs,
9 but I think you can generally think of it as designed for
10 an indication that serves a patient population of 200,000
11 or fewer people.

12 In terms of tracking the degree to which
13 prescriptions are on-label or off-label, I'm not aware that
14 we do such a thing.

15 DR. REDBERG: I'm just wondering, do we know, for
16 example, how commonly more than 200,000 prescriptions would
17 be written.

18 DR. SCHMIDT: I don't know off the top of my
19 head. I know that there were some -- we were talking this
20 morning, there are a couple of drugs that started out as
21 orphan indications and now, I think, are used more widely
22 than was originally -- the original indications suggested.

1 DR. CROSSON: Herb.

2 MR. KUHN: So, also on Slide 7, I was curious
3 about the issue of biosimilars. So, you mentioned that the
4 European experience is 20 to 30 percent lower for
5 innovators, but Medicare's first initial is about three
6 percent. I'm assuming that, under Medicare, the referenced
7 biologic as well as the biosimilar have separate codes,
8 billing codes, is that correct?

9 DR. SCHMIDT: Well, there's just been guidance
10 out on this --

11 MR. KUHN: In the Physician Fee Schedule, they're
12 suggesting that they collapse, is that correct?

13 DR. SCHMIDT: Do you want to --

14 DR. MILLER: Not quite. Let me just parse
15 through it. Right now, the innovator drug has a separate
16 code from the biosimilars, and then what CMS was proposing
17 is that the biosimilars be put in a common code. But my
18 understanding is that the innovator continues to --

19 MR. KUHN: So the referenced biologic, the
20 innovator, would still have its own code, but the
21 biosimilars are all lumped into --

22 DR. MILLER: That's what I am saying, and I

1 believe that's correct. I could take a nod out of
2 somebody, and I just got it.

3 And, so, the second thing I would -- but, the
4 other thing you should know is what they proposed is that
5 the add-on, which, you know, the ASP-plus, which we've
6 discussed many times here, will be linked to the price of
7 the innovator, so that they're trying to neutralize the
8 incentive to the physician about which of those they use.

9 MR. KUHN: Got you.

10 DR. MILLER: That's the thought process.

11 MR. KUHN: And, I'm assuming, then, what they're
12 thinking is that creates more price competition to maybe
13 mirror what they're seeing in the European experience of
14 greater savings opportunity?

15 DR. SCHMIDT: Yes, I think that's the intent.

16 DR. MILLER: Certainly, the motivation is that
17 they believe the evidence and the argument that they're
18 making is that it creates greater head-to-head competition.

19 DR. CROSSON: Mary.

20 DR. NAYLOR: So, Slide 8. On the recent
21 approvals affecting Medicare, you mentioned -- well, first
22 of all, these are drugs that affect a large proportion of

1 Medicare beneficiaries, more than -- many more than others
2 -- heart failure, Hepatitis C, insulin -- and then those in
3 the pipeline related to Alzheimer's. So, they are higher
4 price, or most of them are in the biosimilar category.

5 Is anyone building scenarios about the
6 implications as we invest, as we have these approvals, the
7 kind of cumulative effect that this has on the Medicare
8 program in the short term? I mean, I know we have a lot to
9 learn about what Medicare's pricing ultimately will be for,
10 but I'm just wondering, is the FDA or some group taking a
11 look at the cumulative impact of recent approvals and those
12 in the pipeline?

13 DR. SCHMIDT: You know, I don't know that the FDA
14 is necessarily looking at this. In the National Health
15 Expenditure accounts, they make a projection out that's
16 actually relatively flat growth, once we get past the bump
17 over Hepatitis C spending. So, I think -- and I don't
18 think that they do their projections looking therapeutic
19 class by therapeutic class. They tend to do econometric
20 modeling and projections in that sort of approach.

21 But in the coming few years, I think they did
22 take into consideration some therapeutic classes, such as

1 the PCS canine inhibitors that are just coming out. And, I
2 believe OACT told us that one thought was that there will
3 be some degree of competition because there are two
4 products now, others in the pipeline still. So, they
5 thought that that competition might control growth in some
6 of those particular prices.

7 But, cumulatively across all of these categories,
8 no, I'm not aware of a broader effort. There are
9 individual Pharmacy Benefit Management companies that have
10 looked at particular classes of drugs just coming out, and
11 you can see some pretty shocking cost estimates for what
12 the magnitude might be. And there's just so many things
13 that we don't know yet. It's hard to have much confidence
14 in a lot of the estimates out there.

15 DR. MILLER: One clarification. Kim likes to
16 have her details straight.

17 [Laughter.]

18 DR. MILLER: She reminded me that it was not
19 proposed that the add-on be the same as the innovator, be
20 comparable between the innovator drug. That's a matter of
21 law.

22 DR. CROSSON: Kate.

1 DR. BAICKER: So, I thought Slide 17 was a really
2 helpful illustration and I had a question. I like the
3 zooming in and out -- excellent.

4 [Laughter.]

5 DR. BAICKER: That's right. Follow the bouncing
6 price.

7 [Laughter.]

8 DR. BAICKER: So, in thinking about the
9 implications of this for the potential role of competition
10 in bringing prices down, it would be helpful to know which
11 of these numbers is known to whom, you know, which, both
12 individually and in the aggregate. Who knows? Is it just
13 the parties to each transaction, or which of these numbers
14 are known to competitors who might be negotiating similar
15 transactions?

16 MS. SUZUKI: So, in the Part D setting, the
17 payments from the PBM to the pharmacy are known. Those are
18 the PD claims information. The rebates are not known.
19 Rebates are proprietary. CMS collects the information, but
20 it's not released.

21 DR. BAICKER: [Off microphone.] So CMS knows --

22 MS. SUZUKI: Right. The prices that are listed

1 for the pharmacy and wholesaler transactions and between
2 wholesaler and manufacturers, those are usually not known.
3 Those, we took, actually, from an estimate in CBO report.

4 DR. CROSSON: Okay. Clarifying questions. All
5 right, Kathy.

6 MS. BUTO: So, I have three, I think, somewhat
7 quick questions. One is the 18 percent Medicare spend that
8 includes all settings, do we know if that number has grown?
9 What's the growth rate like over the last few years? I
10 know we've recently tried to figure out how to calculate
11 that. Do we know if that's growing more rapidly now?

12 And then, secondly, is it driven more by price,
13 by volume, by the growth rate? It would be helpful to know
14 that piece of information.

15 My second question is on Slide 6, which is where
16 you talk about the patent life and data exclusivity. Do
17 you have a sense of whether patent life at the end of the
18 FDA process is longer than data exclusivity, or do they
19 coincide, that kind of issue.

20 And then the last is Slide 11, just a word about
21 how more personalized medicine, including medicine that's
22 developed in relation to an individual's genes or genetic

1 profile, what's -- I mean, do we have any experience
2 looking at the pricing of those kinds of medicines?

3 DR. SCHMIDT: On the first one, the 91 percent.
4 So that was an estimate for 2013, and actually, in response
5 to Warner from last time, I said at the start of this
6 presentation, it was also 19 percent in 2007. And so it
7 was growing at about -- I think the increase, there is a
8 slight, very slight increase, but it is growing at about
9 roughly the same rate as overall cost in other types of
10 Medicare spending.

11 MS. BUTO: Is that price driven, or did you have
12 any sense of that?

13 DR. SCHMIDT: I don't have a sense yet. We're
14 still kind of looking at that. We took that as kind of a
15 question from the last time, and we'll try and come back to
16 you with a better answer next time.

17 On the patent slide question, generally the
18 patent tends to go first when you come up with the
19 inventive idea of what a compound might be. A company or
20 whoever is the innovator will tend to patent that
21 immediately to protect it. And as we were working through
22 that development process, it takes a while to gather the

1 information to prove safety and efficacy.

2 So for that reason, the effective patent life
3 tends to be much shorter. I've seen estimates of 12 to 13
4 years, rather than the 20-year length of the actual patent.
5 That's an average, and each drug can be quite different
6 from one another. So it's hard to draw generalizations.

7 On personalized medicine, I don't know that --
8 are you going to try and -- nope. I don't know that we
9 have much experience to say a whole lot about that yet,
10 other than I guess the notion is that using more tests,
11 including information about one's DNA. That you can figure
12 out how to target specific therapies better, that's the
13 notion. Whether that actually works in practice has yet to
14 be seen. I don't know that I have a good answer for you at
15 this point.

16 DR. CROSSON: Yeah. It's a complicated issue we
17 haven't looked at because it not only impacts, potentially,
18 the cost of treatments, whatever those are, including
19 pharmaceuticals -- and that could be up or down -- but it
20 also involves the cost of doing the tests themselves and
21 what proportion of the population needs to have those tests
22 done. And many of those tests are quite expensive in their

1 own right.

2 Clarifying questions? Alice.

3 DR. COOMBS: On 9, I think it was the circulated
4 material. It actually talks about the new substances
5 launched by year, and there's been a lot of discussion
6 about antibiotics in terms of new antibiotics on the
7 market, especially with these highly resistant organisms
8 and in the hospital. I was wondering if the nonretail --
9 what does the nonretail industry look like compared to the
10 retail industry in terms of growth?

11 And also, if you were to do a pie chart between
12 the two for comparison and contrast, that might be
13 interesting because I know a lot of the discussion has been
14 around drugs that will make a difference in patient
15 outcomes within the hospital setting. So, I mean, there's
16 these new antibiotics that have been produced in the last
17 10 years specifically to address some of the resistant
18 bugs, and I am interested in knowing if innovation is very
19 -- what does innovation look like in terms of the hospital,
20 the nonretail industry. So do you have any information on
21 that kind of comparison?

22 DR. SCHMIDT: The introduction of new

1 antibiotics, you mean by --

2 DR. COOMBS: No, not just new antibiotics, but
3 what the -- what does the innovation drugs compare with the
4 retail versus the nonretail.

5 DR. SCHMIDT: Do you mean which drugs are being
6 used more as intermediate inputs compared to what's more
7 used as final product?

8 DR. COOMBS: Right.

9 DR. SCHMIDT: I don't have a good answer to that.
10 A lot of the -- I guess it would be things that
11 are used in surgeries, for example --

12 DR. COOMBS: Right, right.

13 DR. SCHMIDT: -- anesthetics and that sort of
14 thing. We don't -- I guess it's conceivable that we could
15 look to claims information to try and understand what those
16 are. I don't have that information at my fingertips,
17 though.

18 DR. COOMBS: And then the other question I had,
19 like a lot of the administered drugs in the clinical
20 setting, someone comes in to get a drug administered just
21 for observation to see if they have a reaction, and then
22 there's associated cost with monitoring that has to occur.

1 For instance, someone has something like methotrexate, and
2 they have to have a series of tests to check their liver
3 function and things like that. Have we looked at the costs
4 associated with drugs that are not necessarily the cost of
5 the drugs themselves? So we're looking at drug pricing,
6 but I'm wondering if the associated cost of some of these
7 medication -- the innovation drugs, the associated cost may
8 be also a cost driver. That 19 percent only includes --

9 DR. SCHMIDT: That's right. It includes the
10 pharmacy costs --

11 DR. COOMBS: Right.

12 DR. SCHMIDT: -- as well as the cost of the drug
13 themselves, but not any other services associated with
14 that. So I do not have a number for you, but yes, that's a
15 valid point.

16 MS. UCCELLO: So a quick question regarding the
17 payments for manufacturers to PBMs. Are the terms "rebate"
18 and "fee" interchangeable, or does "fee" really mean
19 something else? "Fee," for some reason, just seems a
20 little worse to me. In terms of just this formulary
21 administration, why are they paying that?

22 MS. SUZUKI: So my understanding is that

1 sometimes there is a service fee because PBMs administer
2 formularies, and they may offer rebates or discounts, and
3 I'm not sure how to clearly distinguish between the
4 different names that are attached to them. Rebates and
5 discounts may look like a fee if it's attached to the
6 volume of prescriptions that are dispensed. So I think
7 there's a little bit of gray area, and maybe it's just that
8 we don't have a clear understanding.

9 DR. MILLER: I remember when we were talking
10 about this internally, and it's to the first point and
11 maybe just one more sentence on it. There is a role that
12 they play with smaller pharmacies where they administer
13 their -- can you rerun that, that point?

14

15 MS. SUZUKI: So this is the wholesaler point?

16 DR. MILLER: I remember we had a conversation on
17 it, and I was trying to recover what we got out of it, but
18 let's just move on. We'll talk and see if we can get this
19 straight.

20 DR. NERENZ: Yeah. A quick question on slide 5,
21 please. I am interested in these drops along the way,
22 particularly from 250 to 5, and I'm just curious. In the

1 middle of the slide where it has 5 compounds, is that
2 literally the number at Phase 2, or for example, is it that
3 it's 5 that survive to the far end of this series of 250
4 that start? Or on the other hand, are there only 5
5 compounds that even enter the clinical trial sequence out
6 of 250 that were there, just to the left? Where exactly is
7 that drop from 250 to 5?

8 DR. SCHIMDT: And let me say these are suggestive
9 number that I took from a combination of sources, including
10 the GAO study on this, but it's to notionally give you an
11 idea that there are literally thousands of potential
12 compounds that are being evaluated during the preclinical
13 phase.

14 And then let's see. So I think probably it gets
15 to about five compounds that start into human trials that
16 pass the IND approval. So the percent of those that go
17 from Phase 1 to Phase 2, they make it -- about 70 percent
18 of those compounds make it.

19 And then it quickly drops off here. So going
20 from Phase 2 to Phase 3, contingent on getting to Phase 2,
21 about 33 percent of those make it on to Phase 3.

22 DR. NERENZ: Okay. That's very helpful. So the

1 main drop from 250 to 5 is even at the point of beginning -
2 -

3 DR. SCHMIDT: Right.

4 DR. NERENZ: -- a Phase 1 trial. It's not during
5 the clinical trial sequence.

6 Dr. SCHMIDT: Correct.

7 DR. NERENZ: Thank you.

8 DR. CROSSON: Jack.

9 DR. HOADLEY: I have a couple of questions that
10 may not be things that you necessarily need to answer right
11 now, but when one was -- Kathy picked up in terms of the
12 patent terms, and it seems like it might be useful to have
13 a schematic that sort of relates the length of the patent,
14 the exclusivity periods, and I know you talked about how
15 many years. I don't know if there's any data that would
16 show sort of a distribution of how many drugs got how many
17 years of actual monopoly, exclusivity on the market, but it
18 seems like that would be useful to sort of add to the
19 context. And maybe some of those data are not available.
20 You have clarified some of it in response to Kathy's
21 question.

22 On slide 4 -- and this may not be available, but

1 we talk about the federal government role in research. Is
2 there any reliable data on what share of the R&D ends up
3 coming from federal sources versus industry sources and so
4 forth? It's obviously not an easy question because a lot
5 of those things get very commingled, but if there's any
6 studies that have tried to answer that, that would be
7 probably useful to see.

8 On slide 7, the graphic you put here I think is
9 really helpful in terms of showing as you get more
10 manufacturers, the price comes down. It seems like there's
11 another graphic that I think I've seen that also would be
12 useful, which is the period of time involved. I believe I
13 remember seeing from INS the notion that the time period --
14 and it may be in conjunction with the number of
15 manufacturers, but the time period, once the generic
16 competition is allowed and once the 180 days has become
17 more compressed in recent years than it had been in the
18 past. And so I don't know if that's still true or if
19 there's been some variation over time, but the sense of how
20 quickly we get to these, you know, 23 percent or 6 percent
21 kind of price points, it seems like it would be helpful.

22 On slide 9, this looks at the particular example

1 from oncology drugs. The other thing that strikes me is
2 this study that was out I think earlier this year on the MS
3 drugs where it showed that price increases for older drugs
4 rose at a similar rate to the new entrants, and so it seems
5 like that's a useful piece. I don't know if that's unique
6 to MS. I don't know if we have any way to know that
7 because there is one study done that addressed the MS side,
8 but this is sort of going to whether prices relate to life
9 year gained and sort of a time thing. But another
10 interesting question is what's happening with old drug
11 prices in conjunction with new.

12 And then on slide 10, was that particular study
13 in a Medicare context, or was that in a broader --

14 DR. SCHMIDT: This was a broader context.

15 DR. HOADLEY: A broader context. So it does seem
16 like the Medicare picture could end up looking different
17 between the reinsurance.

18 DR. SCHMIDT: Absolutely, it would.

19 DR. HOADLEY: And so we thought about it as total
20 costs, government plus everybody else, that might work.

21 And then my last comment relates on slide 15.
22 It's sort of a little better sense of the role of mail

1 order. I know in Medicare, it's still pretty small. I
2 don't have a sense of how much of the pharmacy -- total
3 pharmacy sales are on mail versus retail, and it might be
4 an interesting context, and how much that differs from what
5 Medicare is seeing is something we might want to think
6 about down the road.

7 DR. CROSSON: Warner.

8 MR. THOMAS: So on your slide 17, first of all, I
9 think it's a great analysis, and I think it's very helpful
10 to understand the flow of dollars. Do you have any idea of
11 the -- and I guess the question on the relative dollars
12 that you're using, are those the estimated margins that
13 each of those components of the chain, chain of payments?

14 MS. SUZUKI: So this is a hypothetical example,
15 but I took the example from a CBO report that did use some
16 actual data to estimate the average for a single-source
17 drug. So it's not completely a made-up number, but it is a
18 hypothetical example.

19 [Laughter.]

20 MR. THOMAS: I'll think about that for a minute.
21 I thought that was "yes" or "no."

22 DR. MILLER: That was masterful.

1 DR. CROSSON: Shinobu, have you thought about
2 running for political office?

3 [Laughter.]

4 MR. THOMAS: I'm going to take that as a "no."

5 DR. CHRISTIANSON: The question was about
6 margins, though, too. These aren't margins, right?

7 MR. THOMAS: Well, okay. So I guess I was -- I
8 mean, if you look at it, I guess I was taking the net
9 revenue as kind of the net that they were taking. You're
10 right. It would not necessarily be the margin.

11 So I guess the follow-up question would be do we
12 have any idea of what the margins are in each of those
13 components of this supply chain process, from the PBM to
14 the manufacturer, because one of the things we do in all of
15 our update factors on the provider side is we're constantly
16 looking at margins and margins of efficient providers, and
17 I wonder if we do that in the drug area.

18 DR. MILLER: So you've asked this question also
19 in other meetings, and we have some -- I don't know that we
20 have the same or we're going to have the same kind of data
21 that we bring to the update discussions, but we've been
22 trying to acquire some other data and work on this question

1 that you've actually raised a couple of times.

2 So it's not as masterful as Shinobu, but not yet.

3 But we are looking at this.

4 MR. THOMAS: I just didn't know, being publicly
5 traded, if we even have any idea from the publicly traded
6 data of what the margins are. It's just a general
7 question.

8 The second question is on the concentration of
9 pharmacy benefit managers and the wholesalers. I mean, you
10 identify that for PBMs or 75 percent of the dispensing
11 revenues and three of the wholesalers are 85 to 90 percent.
12 I mean, do we have any idea how that compares to other
13 components of the dollars distributed in health care, just
14 how that concentration compares to other components in the
15 Medicare system?

16 DR. SCHMIDT: Well, I guess I should say no, but
17 --

18 MR. THOMAS: It just may be something we want to
19 think about. I mean, it just seems like it's a relatively
20 --

21 DR. SCHMIDT: It does seem like there's growing
22 concentration across, for example, insurers.

1 MR. THOMAS: Right.

2 DR. SCHMIDT: And there's been a lot of merger
3 and acquisition activity in many of these sectors, and as
4 one side tends to merge and join forces, it seems like the
5 others do as well --

6 MR. THOMAS: Right.

7 DR. SCHMIDT: -- whether that's to help in their
8 negotiating leverage or what.

9 MR. THOMAS: And I know there's been some
10 discussion of that in other parts of the industry lately,
11 but it just seemed to me like this is pretty
12 disproportionate to a lot of the other components of the
13 industry, and just how does that impact the Medicare
14 beneficiary, I think that would be the question. So those
15 are just a couple of questions that I think could be
16 interesting, especially as I think this is a very helpful
17 understanding to understand how the dollar is going to pass
18 through. I think if we understood more about what the
19 total dollars are -- and this is one hypothetical on one
20 drug -- do we understand what that total component of
21 spending looks like for Medicare? For all of the Medicare
22 dollars that roll through these areas, that may be helpful

1 or instructive in the future.

2 DR. CROSSON: One more clarifying question?

3 DR. HOADLEY: I was going to follow up on
4 Warner's comment. The other thing to observe is that --
5 you can even see it on the examples on the slides here that
6 there is overlap between the PBM industry and the pharmacy
7 industry, and what you don't see here is there's also
8 overlap between the PBM industry and the insurance. A
9 number of the insurance companies have in-house PBM. So if
10 we get to thinking about those things, that's just a --

11 DR. CROSSON: Okay. So we have about 45 minutes
12 left, and what I'd like to do, again, is have a discussion
13 here about what you as Commissioners see the implications
14 being of this information as well as other information that
15 we've had before with respect to our program going forward
16 to deal with the question of whether the Medicare program
17 is paying appropriately for pharmaceuticals, Part B or Part
18 D, and whether or not the impact of pharmaceutical cost on
19 beneficiaries is appropriate, and to entertain any ideas,
20 either comment on work we're already doing or entertain
21 additional ideas that we should be considering as our work
22 progresses.

1 So are there any Commissioners who would like to
2 jump out and lead the discussion? I see, one, Bill Hall
3 and Jack, and then we'll proceed in order. Jack, we're
4 getting towards the edge of this, but Bill, Jack, and Rita,
5 and then we'll proceed longitudinally.

6 DR. HALL: This has been a very good report, and
7 I've learned a lot from this and some of the implications.

8 I have two points that I would like to make, and
9 I guess they both have to do with the components of
10 pricing, following up on Warner's comments and maybe also
11 Kate's about what do we know about the unknown.

12 From a clinical standpoint, the decision to use
13 biologics and the complexity of monitoring biologics is
14 immense. It's a total change from any other kind of drug
15 therapy that's ever been there, certainly through my
16 career.

17 Some of the hidden costs that affect the Medicare
18 program -- and I'll say why it affects the Medicare program
19 in a minute -- are that the monitoring is really extensive.
20 And maybe we need to have a little deeper dive on what the
21 kind of hidden costs are of using these drugs, particularly
22 in terms of specialties, medical subspecialties that use

1 them, and laboratory tests, and just sort of human capital
2 that has to go into managing patients with this. This is
3 not like aspirin -- not that aspirin is a safe drug either.

4 One thing that I've noticed -- and going through
5 these data brought this to the fore -- there has been a
6 tremendous uptick in direct-to-consumer advertising for
7 biologics, and my impression is or maybe my bias is that
8 for the first time in direct-to-consumer advertising it
9 really features a lot of older actors. So this brings it
10 more into the Medicare sphere, and, in fact, the clinical
11 use of these drugs. And if you pay just a little bit of
12 attention to these ads, I would defy you to really
13 understand what is being said in these sound bites. It's
14 sort of like the used car market when they say the
15 monitoring and all the things that are necessary.

16 So there are a lot of components to pricing that
17 go into this, and I think we have to understand that
18 biologics are very, very important. We should use them
19 appropriately. But it is not just the usual components of
20 cost. I think we might want to get a little deeper dive on
21 that.

22 And the other -- I don't know if this is even

1 possible to do -- is looking at the consumer and out-of-
2 pocket costs. I wonder if there's any way of getting any
3 kind of a handle as to whether there is, in fact, an impact
4 on the utilization of these drugs by Medicare recipients.
5 We know the burden falls a great deal on Part D and on the
6 Treasury, but I -- and one of the things I'd like to have
7 us understand is are people actually being deprived,
8 Medicare recipients, of these drugs because of out-of-
9 pocket costs? I have not seen those data at all.

10 So those are just two points about trying to
11 understand both the pricing and what the implications are
12 in the future for managing these perhaps very important
13 adjuncts to our medical therapy.

14 DR. CROSSON: So, Bill, I think all of the ideas
15 that you have brought up are appropriate. I think
16 certainly as we mentioned, the impact on beneficiaries and
17 out-of-pocket costs is a big one there.

18 I think Alice brought up in addition the notion
19 of, what do we want to call it, follow-on costs but
20 additional costs with certain classes of drugs, and I think
21 that's legitimate.

22 I think the issue of advertising per se, which I

1 know is being looked at, is something that we could look
2 at. I think we need to understand, you know, whether or
3 not that is something that we as a Commission can and
4 should attempt to effect. But we'll take that under
5 consideration.

6 DR. HALL: My point wasn't that we have to get
7 into the nitty-gritty of this, but it's just an example of
8 the complexity involved in the administration of these
9 drugs and management of the patients. It's unprecedented
10 in terms of the direct-to-consumer advertising. And the
11 complexities are, if you really try to understand those
12 ads, it's pretty difficult. For most doctors it's pretty
13 difficult.

14 DR. CROSSON: Thank you.

15 DR. COOMBS: I just wanted to echo what Bill has
16 said. When I asked the question about the monitoring,
17 there are two entities that I can think of right off the
18 bat. One is the new oral anticoagulants that don't require
19 serial testing. In that situation, you might have some
20 examples of where innovation has taken place which actually
21 replace a lot of the resources necessary for monitoring,
22 and that's one case.

1 On the other side, for rheumatoid arthritis there
2 are three new biologics that have come out that are
3 competing with methotrexate, and so what does the resource
4 input look like in that entity? And I think, you know, we
5 are talking about Medicare spending, but it's huge,
6 especially with the anticoagulation in patients with atrial
7 fibrillation and things like that because the Medicare
8 population has such a large number of patients who are in
9 atrial fibrillation, and you're looking at their risk
10 stratification as to who might need it. Not everyone needs
11 it, we know that. But I think those are the other
12 unanticipated costs that Medicare spending on drug costs,
13 pricing, entail. Thanks.

14 DR. CROSSON: On Bill's points?

15 MR. ARMSTRONG: So just briefly to build on
16 Bill's point, and in particular -- and we may come back to
17 this later, but the view of the beneficiary that you kind
18 of brought into this, I think part of our work going
19 forward would really benefit by thinking about -- it's sort
20 of analogous to the supply side/demand side around pricing.
21 I mean, our issue is costs, right? And if you put yourself
22 in exam room or in the shoes of a beneficiary and think

1 about what are all of those variables that influence the
2 likelihood that they should or will want to or ultimately
3 will get prescribed a drug, because there's a lot of them.
4 It's advertising. It's out-of-pocket costs or other
5 benefits. It's clinical advice. It's shared
6 decisionmaking. It's a handful of other things. And then,
7 of course, it's also the supply side that will influence
8 that as well.

9 But so far our analysis hasn't really given us a
10 chance to sit in the shoes of the beneficiary and look at
11 all the variables, many of which we could influence through
12 payment policy, that ultimately have an impact on the cost
13 to the beneficiary.

14 So, anyway, I just want to slip that in there as,
15 I think going forward, a point of view we ought to bring
16 into this whole conversation.

17 DR. CROSSON: Others on Bill's points?

18 DR. NAYLOR: I support what Bill has said in
19 terms of trying to get a handle on the costs and Alice on
20 the monitoring cost. I think that this is a new dimension
21 as we're thinking about impact on the program.

22 I'm also thinking that in the classes of drugs

1 that have recent -- biologics that have recently been
2 approved, and I don't know how we can do this, but whether
3 or not we can begin to drill down on what is the evidence
4 from the testing of those drugs that apply to the Medicare
5 population. And so, you know, how many of those enrolled
6 in the clinical trials were 75 and older, 80 and older, et
7 cetera, particularly as it relates to thinking about one of
8 the options that we've talked about, which is coverage with
9 evidence. And so how much of the evidence exists, if we
10 could have one or two cases to help us to know whether or
11 not these drugs should be used for this population.

12 I totally agree on the impact on beneficiaries
13 and the notion of taking one or two of those newly approved
14 classifications of drugs to think about a simulation model
15 - I don't know if we could do it -- that would say what
16 will be the impact over the next ten years, even if it's
17 just to one class, but what impact will it have on the
18 beneficiary? [off microphone] On the costs.

19 DR. CROSSON: Okay. Further elaboration on
20 Bill's points?

21 DR. HOADLEY: I do like the points that have just
22 been discussed, and it does occur to me that on the

1 discussion I heard the other day on the PCSK9 drugs that,
2 you know, where they're initially being approved with an
3 indication of familial cholesterol problems, there's a
4 question of figuring out who those patients are and what
5 testing is needed to identify that they're that. And so,
6 you know, this is coming up in a very immediate context.

7 I thought this was a great discussion of some
8 very complicated issues and trying to put it in context,
9 and, you know, I think part of what we're learning is that
10 the issue of the next several years is a lot about the
11 pipeline of these new drugs, very expensive new drugs, a
12 lot of biologicals, a lot of other products that are, you
13 know, both for smaller-scale diseases, some of the cancers,
14 but also now with new cholesterol drugs and some of the
15 other categories you highlighted that are going to really
16 mean that we're dealing with high-cost drugs, which just
17 makes it a somewhat different flavor to some of the issues.
18 It's not that the issues of chronic multiple-drug use
19 aren't equally important, but I think what we're seeing
20 here is some of these additional issues. And I think it
21 gives us some context to go back to the things that we
22 discussed so well last year in those very good chapters on

1 the Part B drugs and the issues of least costly
2 alternatives and 106 percent of average sale price and the
3 oncology bundling and the 340B. And I think, you know,
4 there's a lot of interest here, I think, around the table
5 in trying to get to a point where we can reach some
6 conclusions on some recommendations around that, and I
7 think what this does is help to give us some context for
8 that.

9 One of the particular items that I'm struck by is
10 some of the coding issues around the biosimilars. I mean,
11 that's clearly one of the things that could have a
12 potential to help fix some things, and I know we commented
13 on that on the physician proposed rule. But part of our
14 comment there was whether there's an ability to go even
15 further with common coding across the innovator drug and
16 the biosimilars, and that could potentially put more price
17 pressure on. I think, you know, that's some of the lessons
18 of what we're hearing today in terms of things. And I
19 think then down the road, you know, maybe not -- because we
20 haven't discussed as much -- are some of the issues around,
21 you know, what do the launch prices of these drugs look
22 like? What transparency do we have in terms of how those

1 prices are set? Which raises some of the issues like the
2 value-based pricing approaches. You know, that drug that a
3 lot of manufacturers are now saying, well, we're pricing
4 that drug given its great value to society, so maybe that's
5 the point to say, okay, let's only give you that revenue if
6 the value is truly going to be achieved. And so that's at
7 least one of those value-based pricing approaches that you
8 can kind of talk about. I think those are going to be
9 harder to think through and not something we're going to do
10 in the short term, but I think those are issues on the Part
11 B drug side that we want to do on the Part D side.

12 Again, I think the fact that there are a lot of
13 costly new drugs that fall under Part D raised issues, and
14 we had our chapter last year on the risk structure, and I
15 think, again, this helps to give us the context for that
16 discussion of, you know, what adjustments should we make
17 there. Again, as I've said before, I'd like to keep the
18 sort of out-of-pocket cost side of that in the picture
19 because the 5 percent that beneficiaries continue to pay,
20 you know, when they are in the catastrophic range for these
21 expensive drugs adds up to a lot of money. There are
22 similar issues on Part B, but those are, you know, somewhat

1 mitigated by supplemental coverage. Part D it's all on the
2 consumer to continue to pay that 5 percent of the cost. So
3 as we think about the reinsurance and risk corridors, you
4 know, we want to make sure to do that.

5 I also think, again, my sort of parallel to the
6 Part B side is when we think about as new prices come on --
7 new drugs come on with these high prices, especially the
8 ones that are true single-source in the category, is there
9 -- what is the right role for the government to try to
10 address those kinds of prices? So it's one thing when at
11 least for hepatitis C or the PCSK9s for cholesterol, they
12 at least look like they're multiple products, so there is
13 some ability for the Part D plans to negotiate. If we get,
14 you know, the next drug that comes on the market is truly
15 only coming out of one manufacturer and it's the only drug
16 to address Alzheimer's or whatever the next breakthrough
17 is, then we're going to have something where the leverage
18 is all on the manufacturer side, and we really should be
19 anticipating how to make sure we can exercise some greater
20 pricing leverage at that point.

21 So that's what I see as sort of our agenda on
22 this.

1 DR. CROSSON: And a healthy-looking agenda that
2 is.

3 [Laughter.]

4 DR. CROSSON: Jack, let me just ask you one
5 question, because, you know, I have been thinking about
6 this value-based pricing idea. I've seen a lot of things
7 written about it, including some from the industry itself.
8 Did I hear you say you think that applies only to Part B
9 and not to Part D, or am I wrong?

10 DR. HOADLEY: I say it about Part B in terms of
11 given the structure of Part D and that most of the pricing
12 is handled by the plans, there may be questions there of
13 whether plans could do such a thing, or there might be
14 questions, if we're talking about this true, you know, no
15 competitor kind of drug where that would be the kind of
16 thing that if we introduced some kind of government role in
17 negotiation, it could be along those lines. So I just see
18 it's more directly a place for it on the B side.

19 DR. CROSSON: Directly. Yeah, got it. Okay. I
20 agree with that.

21 Follow-on to Jack's points?

22 DR. COOMBS: So, Jack, I was just curious. What

1 kind of leverage would exist for a savior drug that comes
2 out? What kind of strategies could be implemented?

3 DR. HOADLEY: You know, it's hard. I mean,
4 there's been some interesting ideas having to do with some
5 legal mechanisms that are out there. They haven't
6 typically been used in the drug world. There are patent-
7 type things. Some of it may more be bully pulpit. I mean,
8 there were examples on the antibiotic side some years ago
9 when we had all the concerns about the bioterrorism of
10 whether the government could -- and there were some
11 discussions, as I understand it, that happened, and then
12 the manufacturer made some decisions. You know, some of it
13 may go to sort of cost-effectiveness kinds of things.
14 We've seen analyses saying, you know, what's the right sort
15 of level. I mean, I know those are things that politically
16 can be challenging, but, you know, should we be looking at
17 drugs? What we don't have in a simple way is a lever, so
18 what we'd really be trying to do is think about how would
19 you create that leverage? I mean, it is not obvious, but,
20 you know, what's happened in the private sector in the
21 hepatitis C, after there were competitors, is a company
22 like Express Scripts would come on and say, you know, if

1 you'll give us price concessions, we'll open up this drug
2 with less hoops to go through. And so there are some of
3 those kinds of things. We can say, you know, if the
4 default is to allow this drug but only under limited
5 circumstances, make it more available if there's a lower
6 price. So those are the kinds of tradeoffs you have to
7 start thinking about. But it's hard. We have to think
8 hard about how to do that.

9 DR. COOMBS: I was just thinking about the
10 diagram that we have in terms of each of those components
11 and what kind of leverage could be implemented in each of
12 the components within the diagram.

13 MS. BUTO: So one possible approach, Alice, would
14 be -- it kind of gets back to this coverage with evidence
15 development for a new blockbuster that you could combine
16 something like -- this is just off the top of my head --
17 something like value-based pricing or risk sharing on the
18 part of the government with the manufacturer that requires
19 evidence that shows that it delivers what it promises. I
20 mean, there are a number of things like that and other
21 countries have tried it.

22 So I do think that the Commission longer term --

1 obviously, it requires some research -- needs to look at
2 this issue of how the government can be a more proactive
3 participant in that area.

4 The other thought that occurred in that same
5 realm is, you know, Medicare doesn't proactively say X is a
6 huge Medicare problem, we want to invite companies to work
7 with us and NIH, or whatever. So are there some
8 possibilities for a collaboration amongst the key
9 government players with the industry to identify and
10 potentially share in the risk, but also share in the
11 profits from some new drug where -- and there was a program
12 like this at NIH -- I don't know if it still exists --
13 where NIH and the companies did share -- there was some
14 royalty arrangement. But I do not think it is widespread.
15 So I think we could longer term, as we look at this issue
16 over a couple of years, could look at things like that.

17 I just wanted to raise the question and I think
18 it's related to Jack's earlier point that, you know, it's
19 helpful to us in looking at the whole array of things that
20 are available in Medicare to really make an effort through
21 our research to identify what are the key problems we see.
22 Is it these first launch blockbuster drugs and the pricing

1 of those? I think we all agree there is a problem with the
2 reimbursement mechanism for Part B, and we've begun to
3 address that this year. Is it a category of drugs that we
4 think maybe some special solutions need to be addressed?
5 We started looking at oncology last year. That's the kind
6 of thing I know we'll be talking about. Or do we think
7 that, you know, there is just a lack of -- once a drug gets
8 approved in Medicare, it's just sort of "Katy, bar the
9 door," anything can happen and costs just go up?

10 So I think it's important for us to do that, and
11 I would really like to see a little bit of research on --
12 and I know there's research out there -- what the failures
13 have been in Medicare, because they've looked at
14 competitive bidding for Part B drugs, and it didn't work
15 for a variety of reasons. I do not fully understand those,
16 but it would be helpful for us as a Commission to
17 understand why that didn't work. Coverage with evidence
18 development, they've tried a couple of times, I think with
19 a prostate cancer drug. I do not know if we think it's
20 successful. What happened with LCA -- and we've gone over
21 that ground a little bit, but, you know, what are the
22 issues there that need to be addressed.

1 So I think at least understanding some of those
2 issues and maybe even some of the risk sharing that's gone
3 on with drugs in other countries to get more accountability
4 and shared responsibility, is there something we can learn
5 from that? So, again, I think most of these are longer-
6 term not this-year issues, but if we can get a better
7 definition on what we want to solve and then really apply
8 ourselves to what are the mechanisms available.

9 DR. CROSSON: Kathy, I think it entirely makes
10 sense to look at things that have been tried and not
11 worked, because, you know, as they say -- I forget the --
12 but, you don't want to make the same mistake twice, because
13 then you are truly a fool.

14 You know, one wrinkle on the coverage with
15 evidence development that I've heard, and I'm not sure if
16 this is a good idea or not, but taking a look at the
17 difference between effectiveness and efficacy. In other
18 words, the drugs generally are licensed based on their use
19 in a relatively small population of patients. It provides
20 evidence about how effective the drug is, and sometimes,
21 once the drug is launched and is actually used broadly, it
22 may have the same effect, it may have a better effect or a

1 lesser effect, and that's just one wrinkle on the same sort
2 of idea. So, I think as we look at that, we should think
3 about permutations of things that have been tried before,
4 as well.

5 Okay. So, Kate.

6 DR. BAICKER: Just synthesizing what Jack and
7 Kathy have brought together, it seems like the policy
8 levers at our disposal going forward are thinking about how
9 we're paying, you know, in Part B, how Part D is
10 structured, what's covered, what's not covered, and all of
11 those decisions can be made through the lens of are we
12 promoting the right incentives to get the right drugs to
13 the right patient at the lowest price possible, and that's
14 about competition among all of these entities, it's about
15 evidence on appropriateness of use, and that is going to
16 play out -- it's going to manifest differently in Part B
17 and Part D because the different ways that we purchase.
18 But the principle that we want people competing to deliver
19 the right drug at the lowest price available to our covered
20 population is the lens through which I would interpret all
21 of those nitty-gritty decisions that we're going to have to
22 work through.

1 DR. CROSSON: Yes, and in fact, I think, as I
2 heard what Kathy said, I heard it almost the same way. Are
3 there sub -- put it in the marketplace term. Are there
4 sub-markets that we're talking about? You know, we're
5 talking about, for example, the market when there's a
6 single-source drug and how that changes and how it's paid
7 for. We're talking about the market when there are
8 multiple competitor drugs. We're talking about, more
9 recently, a kind of degraded market where a drug that's
10 been in existence for a long period of time now only has
11 one manufacturer, and then that company is acquired and
12 then there is a new price situation with respect to that
13 drug. And then we're also talking, at least qualitatively,
14 about the essence of a new market related to biosimilars.
15 Maybe it's not qualitatively different, but it is
16 quantitatively different, for example, because of the
17 amount of money it takes in order to develop these drugs.

18 And, so, I think that sense of understanding the
19 problem, as you put it, understanding the nature of the
20 market as it exists for that category of drugs is a very
21 helpful thing -- thought -- on this.

22 DR. SAMITT: You know, what's remarkable to me as

1 we look at Slide 17 -- this is very helpful -- is there's
2 another lever on here, and I mentioned this at the last
3 meeting, that we're not even discussing, which is the
4 prescribing practitioner. And, we struggle with how do we
5 have leverage, how do we have influence at every level
6 here. But, I think the reality is, is that if we can also
7 intensify our focus on the accountable practitioner that is
8 going to make the appropriate trade-off decisions about
9 whether a new drug is really efficacious and whether it
10 actually has a positive effect on a beneficiary's health
11 over other costly alternatives like surgeries or
12 hospitalizations, that if we can intensify the
13 accountability at the practitioner level, that will be, in
14 many respects, in my experience, the greatest leverage of
15 all.

16 The organizations that I come from, as we look at
17 Slide 17, we would develop our own sub-formulary that was
18 narrower even than the PBM's formulary, because we had
19 determined that several of the things even in the formulary
20 were not as effective as either prior alternatives or other
21 treatment sources.

22 So, I think continuing on our mission to really

1 shift accountability in many respects to the provider
2 sector is going to be very powerful and we should not
3 exclude that from our discussions about influencing drug
4 cost.

5 DR. CROSSON: I completely agree, and I think
6 although it's mind-bendingly complicated to think about,
7 the notion of looking at the incorporation of Part D into
8 the development of delivery system and payment changes and
9 risk-bearing entities, so that you have risk-bearing
10 entities, like I did in my professional career, who are
11 handling not only the costs of Part A and Part B -- I'm
12 sorry, A and B, including the cost of Part B drugs, but
13 also potentially at risk for and potentially rewarded for
14 the management of Part D costs, which we can't do right
15 now, but thinking about how to do that would follow the
16 general trend of delivery system reform and payment reform
17 that we're thinking about, and I think --

18 DR. SAMITT: And one of the other suggestions
19 we've made before, which may be a good entre into testing
20 out this space, is in the ACO world. You know, do we
21 factor in and do we have ACOs focus on Part D expenditures
22 in addition to A and B, and is that a good way to begin to

1 test enhanced provider accountability for total drug spend.

2 DR. CROSSON: A much clearer way of saying what I
3 was trying to say.

4 DR. SAMITT: Oh, sorry.

5 [Laughter.]

6 DR. CROSSON: Okay. Further on on these -- Jon.

7 DR. CHRISTIANSON: No, not on these --

8 DR. CROSSON: No, no. Jack, on your own stuff.

9 DR. HOADLEY: Yeah, I wanted to comment on
10 Craig's thought. I mean, I think -- and you were picking
11 some of this up, Jay -- I mean, there's really three
12 settings where that plays out very differently. One is
13 Part B, where we've already got the issues like the 106
14 percent that says, we're actually offering you an incentive
15 to use the higher-cost drug, and we've talked about that.

16 There's Part D for the stand-alone, for the
17 people in traditional Medicare, where we've really
18 separated, and so the Part D plan has no relationship to
19 the provider and the ability to sort of leverage that idea
20 -- and that's where you get into the ACOs or other kinds of
21 ways to try to begin to bring them together.

22 And then you do have the Medicare Advantage,

1 where at least the Part D plan is inside the Medicare
2 Advantage plan, although they're sort of financially a bit
3 separated. But presumably, and maybe something that we
4 could learn more about, is within the context of MA, are
5 they doing more -- because there's some evidence that
6 suggests there's not that much of a difference. There is
7 some difference in generic use that Shinobu and Rachel have
8 seen and some differences in a few other ways. But the
9 overall sort of spending levels and things -- but that's
10 separate from sort of the appropriateness of the
11 prescribing and sort of getting the right drug. And, so,
12 maybe there's something to be learned somewhere out of the
13 MA PD side to see whether that greater potential for
14 integration is actually paying off.

15 DR. SAMITT: And what I would counter with is,
16 and I've mentioned this before as it pertains to MA PD
17 analysis or MA analysis in general, is not all MA plans are
18 the same.

19 DR. HOADLEY: Yeah.

20 DR. SAMITT: So, there's a danger in sort of
21 averaging the performance of drug utilization in MA, and
22 maybe we want to actually look at whether the distinction

1 between provider-sponsored MA plans and not, or do we see
2 pearls of opportunity within a subset of MA that can give
3 us some guidance on drug utilization and where the
4 opportunities could be.

5 DR. HOADLEY: Yeah, I think that's a great point,
6 and it's something I've thought about, as well, is it
7 really does matter what kind of MA plan you're talking
8 about.

9 DR. CROSSON: Okay. Rita.

10 DR. REDBERG: Thanks.

11 DR. CROSSON: You've been patiently waiting.

12 DR. REDBERG: There's been a rich discussion. I
13 just wanted to make a few points. You know, it's not just
14 specialty drugs and biosimilars that are expensive, but
15 it's of great concern, I think, to our beneficiaries that
16 the generics are going up in price, too, and drugs that
17 have been around for hundreds of years, like colchicine for
18 gout has gone a 500 percent increase. You know, albuterol
19 inhalers, which are all off-patent generics, have undergone
20 increase. And a lot of generics that used to have multiple
21 sources are now single sources and that has had the --
22 given the companies an opportunity for price increases.

1 And, so, there are certainly a lot of pressures on drug
2 costs that all affect the Medicare program and
3 beneficiaries.

4 On the other part, I guess on Slide 9, we had
5 that nice slide on oncology drugs. Per license year gain
6 has increased -- the price has increased over time. But
7 that also reminds me, and you can see it a little bit in
8 those -- how many have circles, which meant the trial
9 showed overall survival, as opposed to just progression-
10 free survival. JAMA Internal Medicine published a study in
11 June looking at oncology drugs and the increasing use of
12 surrogate markers and that very few of them are actually
13 validated and show an increase in survival.

14 So, there's a concern that not just are these
15 drugs getting more costly, but the evidentiary standard
16 that they actually improve patient survival is dropping,
17 because there's more and more progression-free survival and
18 modeling studies, and with the increased emphasis on faster
19 approvals, it means that we're not getting data, and
20 oftentimes the overall survival data never comes, or when
21 it comes, it doesn't actually affect provider prescription
22 behavior.

1 So, from our beneficiary point of view, I think
2 we need to think about what are we spending and what are we
3 getting, and there's a lot of concern we're spending a lot
4 more and we're getting a lot less in terms of improved
5 survival and even improved quality of life.

6 Also, looking at the research costs and what's
7 driving it, I think there was an op-ed in the Washington
8 Post last week from a former editor of the New England
9 Journal noting a few points that a lot of the research and
10 development costs actually are -- at NIH, they are federal
11 government. A lot of the good drug ideas are started at
12 the NIH funding, and then drug companies buy them at the
13 point when they are, you know, much further down the line
14 and clearly looking more promising. And that companies are
15 spending more on advertising than they are on research and
16 development, and she cited a study from York University.

17 But, certainly, when I am at the gym and see the
18 ads now for chemotherapy drugs and biosimilars, I just
19 think it doesn't seem appropriate to me that that would be
20 a direct-to-consumer ad. You know, that is really a
21 discussion, it seems to me, that a doctor should have with
22 their patient and not someone should say, oh, I --

1 So, I wanted to get back to the idea, and someone
2 else already mentioned it, of least costly alternative
3 policy that we talked about a year ago, because it was
4 effective. And the idea that a single payment rate is set
5 for a group of products with similar health effects makes a
6 lot of sense, because when I look at, again, from the
7 beneficiary point of view, the future of the program, I
8 mean, there was an article in the New York Times recently
9 from Robert Pear suggesting a 50 percent increase in
10 premiums. I think we're all concerned about the effect on
11 premiums. And, so, you know, certainly, this huge price
12 pressure on drug costs and question of value seems to be
13 addressed by Medicare paying a similar amount for something
14 with a similar benefit.

15 And, I have to say, not just for drugs, but I
16 think about for other things, you know, for similar
17 effects. And, I'll just, my personal story. I recently
18 had to have the colorectal cancer screening, and I used our
19 electronic record to message my primary care provider and
20 say, just send me this fecal testing kit, and I never had
21 to lose a minute from work. I'm sure that fecal testing,
22 according to the U.S. Preventive Services Task Force, it's

1 equally effective, the same health effects as colonoscopy.
2 I mean, not just was it easier for me, but it's a lot less
3 costly for the system.

4 I'm not a Medicare beneficiary, but for Medicare,
5 I think we need to think about the idea that for similar
6 health effects, Medicare should consider offering the least
7 costly alternative. That's not to say people can't opt to
8 purchase a more costly alternative, but I think we should
9 think about what's the responsibility of the program as
10 opposed to the individual beneficiary, and I think we have
11 to think about the future of the program and the incredible
12 pressures on the program, the trust fund, the federal debt,
13 and in terms of value.

14 So, I would like us to get back to the discussion
15 of least costly alternative, because it seems to me it's
16 like a win-win.

17 DR. CROSSON: Okay. Follow-on to Rita's points?
18 Warner.

19 MR. THOMAS: I would just agree. I think it's
20 something that with our concept that we believe in site
21 neutral, to me, this is a very similar concept to site
22 neutral. I know we addressed this last year. It just

1 seemed to stop. But, I would really encourage us as a
2 Commission to take this up with a serious conversation.

3 And, also, evolving into just thinking or
4 understanding what are the pros and cons of evolving long
5 term to a Medicare fee schedule for drugs versus an average
6 price, you know, plus a certain markup. There's very few,
7 if any, other areas in the Medicare payment system that do
8 not have this type of payment methodology, and I think we
9 just need to evaluate that and think about the pros and
10 cons of what that would mean for the security of the
11 program and for the beneficiaries of the Medicare program.

12 DR. CROSSON: Thank you, Warner. You make a good
13 point. Some have observed, and I think we are acutely
14 aware here at the Commission, that for the most part,
15 particularly when we deal with the updates, we are dealing
16 with Medicare as a price setter, for all the warts and
17 difficulties that come from that.

18 In the case of pharmaceuticals, for the most
19 part, we're dealing with Medicare as a price taker, and
20 it's different, and it's different for reasons that are
21 historical and based on Congressional intent and all the
22 rest of that. But, your point that it is different is very

1 valid.

2 Okay. Jon.

3 DR. CHRISTIANSON: I just wanted to go back to
4 Scott's comment and say how much I think it's important for
5 us to keep our eye on how all of this affects the
6 beneficiary.

7 I have a question for Mark, I think. Hello.

8 DR. MILLER: I wasn't bothering anybody.

9 [Laughter.]

10 DR. CHRISTIANSON: No, you weren't. So, when we
11 -- we have our payment update discussion coming up. We
12 have data from -- survey data from beneficiaries about
13 access. Is that a survey that we field ourselves, and do
14 we have questions in there about financial access relative
15 to pharmaceuticals? I just don't remember whether we put
16 that in.

17 DR. MILLER: Yeah. I'm going to look first. So,
18 here's what we do, and I probably can't do this as well as
19 the person who's in charge of it. We have a contractor
20 administer a telephone survey to beneficiaries, and we've
21 done that because we found on the provider side response
22 rates are really poor and somewhat variable, and so we

1 found the beneficiary stuff more effective.

2 Mostly, those questions are fairly consistent
3 from year to year about can you get an appointment in this
4 amount of time for these kinds of things. We sometimes add
5 additional questions to it. There's cost, which not a
6 giant issue for this. But, it has mixed success.
7 Sometimes response rates, or how clear the question is
8 understood.

9 And this is all leading to another point, which
10 is we also, as a matter of course every year, do focus
11 groups with beneficiaries and with providers, usually in
12 three marketplaces, and there, we do do special interest
13 types of questions. And if there is something here you'd
14 like us to pursue, I'm willing to consider either or both
15 of those vehicles to --

16 DR. CHRISTIANSON: Well, I think it's worth
17 thinking about, because I think if we really want to find
18 out how this is affecting the beneficiary, we should ask
19 them, and think about how we might ask them. And I think
20 this is, I think we all agree, not an issue that is going
21 to go away anytime soon. It's going to get bigger for
22 Medicare. And, so, even if we haven't done it in the past,

1 that maybe starting to establish a baseline and move
2 forward.

3 Now, that's all easy to say and it's all, you
4 know, things that the staff would have to come back to us
5 with in terms of the suggestions and cost of the survey and
6 all that sort of stuff.

7 DR. MILLER: I want to be very clear here. I
8 think we can start fashioning some questions. I don't
9 think the add-on cost to what I'm talking to prohibit our
10 ability to do that. And, so, you should assume that we're
11 going to look at this, based on what you said.

12 DR. CROSSON: Okay. Can I see hands for folks
13 who would like to make additional points, other than those
14 they've already made or have been made? Scott, and David.

15 MR. ARMSTRONG: This is probably building on
16 comments that have already been made and may not have that
17 much, but it just really strikes me that as we go forward,
18 a lot of our discussion today in particular has been
19 focused on the price of drugs and how they get set and how
20 they get inflated and all that kind of thing. And I think
21 that's interesting, and yet I sit here realizing when I
22 take responsibility for the overall cost of pharmaceuticals

1 to the Medicare program, price is just one component part
2 in this whole thing.

3 I actually realize I don't have a particularly
4 good handle on how powerful a lever price is relative to
5 some of the other variables.

6 In listening to Rita, for example, I know we
7 spend too much on a per-unit price basis, but is it
8 overwhelmed by how much utilization that's inappropriate or
9 how much we're using the wrong drug or a more expensive
10 alternative than the drug we should be using?

11 So I say that I think that would have a real
12 bearing on policy interventions, we might imagine, and so I
13 say that asking, is there some way to know more about that?

14 Craig's point is a great one, and in other areas
15 of the Medicare program, we will often ask, is there some
16 way of comparing fee-for-service experience with experience
17 in ASOs or in MA plans? So maybe that is an avenue for
18 getting a little more insight into how we would answer that
19 question.

20 But that also comes back to the point of view of
21 how our beneficiaries' care gets managed. In particular,
22 when I was saying I feel like we're taking a big global

1 look at how this works and we need to come at it in a more
2 personalized level, it's not just so much the out-of-pocket
3 cost for the beneficiary, but it's again to a point Craig
4 made earlier. It is, what are the variables that influence
5 the clinical decisions that end up actually in a
6 prescription? Because that is how you spend the money.
7 It's a lot more things than just the price per unit of
8 service, and that just may offer some more insight into
9 again where we might intervene.

10 I wish I could tell you what I thought were more
11 powerful ways of intervening, but honestly, I don't have
12 great insight into that.

13 DR. CROSSON: Scott, I think that's a great point
14 -- a great set of points actually. Not only does it change
15 the paradigm of our thinking, which I think you're right
16 about, but it also I think changes our conceptualization of
17 what some potential solutions should be because some of --
18 it's like the notion of if you have a hammer, everything is
19 a nail. We are the Medicare Payment Advisory Commission.
20 So we think about prices.

21 But in fact, as you say, it's more than cost,
22 it's more than price, and it's more than prices of

1 individual drugs. But as you start thinking about
2 potential solutions to that problem, it begins to move you
3 away from what I might call centralized solutions to
4 decentralized solutions, one of which is this question that
5 Craig brought up as well.

6 Thanks. One other brief point I wanted to make,
7 and that is our conversation also just presumes -- I think
8 it's true. We spend too much on drugs, and I think we need
9 to get better control over it.

10 But there is a real return on our investment in
11 drug costs, and we don't have any mechanism for judging the
12 quality of our drug utilization, to kind of use a phrase we
13 used in other -- we judge the quality of skilled nursing
14 care and the quality of hospital care. It just makes me
15 wonder: Is there some way for us to kind of bring that
16 question in as another variable in judging is the spend the
17 right spend for the Medicare program?

18 DR. CROSSON: Very good.

19 On this point, Bill?

20 MR. GRADISON: Yes.

21 DR. CROSSON: Yeah.

22 MR. GRADISON: Briefly, it's a conceptual point,

1 but I think it picks directly up on what Scott said.

2 I'm interested from a conceptual point of view in
3 observations we have made earlier that may relate to this.
4 Specifically, we have commented about the increased
5 incidence in the Medicare population of certain conditions
6 like diabetes, obesity, high cholesterol, high blood
7 pressure, and so forth. And I'm really thinking about how
8 that matches up with where these drugs are being used. In
9 other words, the benefits -- to the extent that a lot of
10 this new ammunition for dealing with conditions -- not
11 solving them, but dealing with them so people can survive
12 with diabetes when they couldn't before is an example -- to
13 the extent these are focused on where the greater problems
14 are for the population we're responsible for, to me this
15 question of price, while not unimportant, gets scaled down
16 a little bit. In other words, if we're having some
17 societal success at aiming at the right targets, let's keep
18 that in mind and in context.

19 DR. CROSSON: Thank you, Bill.

20 Warner, are you on the same point? All right.
21 So I think David was -- oh, it was Jack? Did I miss it?

22 DR. HOADLEY: On the same point.

1 DR. CROSSON: Same point.

2 DR. HOADLEY: Yeah. I think part of why we've
3 sort of moved a bit more into price is the current pipeline
4 and the emergence of a lot of these expensive drugs,
5 although they again interact with volume because, again,
6 the cholesterol -- the new cholesterol drugs is a great
7 example. If they are used for their narrowest indications,
8 A, that may be the most appropriate use, and that means the
9 total cost won't be such a burden to the program. If they
10 become the replacement for statins for the broad
11 population, despite perhaps the lack of clinical evidence
12 why that's appropriate, then that's big.

13 The other comment I was going to make is I think
14 when Part D was created, medication therapy management
15 programs was a big part of the focus on how we would
16 address proper use, and we've had reports from the staff
17 repeatedly on those programs. The record has not -- they
18 don't have much to show for results, and I think maybe it's
19 part of the point of going back, and maybe we stop looking
20 at those and say, "That just isn't working. Is there a
21 different way?" And maybe that does get back into the
22 previous conversation about how do we get the Part D plans

1 better linked with the prescribers and other kinds of ways
2 to think about how to address volume.

3 DR. CROSSON: We have pretty much exhausted our
4 time. David was next and then Mary, and then I think we're
5 going to move on.

6 DR. NERENZ: I think this will be quick. I was
7 just going to extend on Craig and Rita's comments both, and
8 this is about the prescriber and some of the decisions.

9 In two specific domains, CMS has already stepped
10 across a line about measuring efficiency as part of an
11 overall quality measurement program, which then leads to
12 financial incentives. And I wonder if there's territory we
13 could explore here in that general area under some label,
14 say, like prescribing wisely. That if we're thinking about
15 what levers are there, well, there are levers that involve
16 measurement of certain quality parameters or efficiency
17 parameters and then linking those to financial incentives.

18 Now, I almost cringe when I make this statement
19 myself because there are technical difficulties. There are
20 exceptions. There are changing guidelines. Yes. Yes, all
21 that. But just the point being if we're struggling to know
22 what some of the levers might be, I think this is domain we

1 could at least look at and perhaps some carefully crafted
2 things might emerge.

3 DR. CROSSON: Thank you.

4 Mary, last word.

5 DR. NAYLOR: Just very briefly, this conversation
6 has also helped me to rethink the role of beneficiary
7 because we have been talking about it in the context of the
8 person that's paying the \$30 copay on an \$88 cost of drug.
9 And I think paying attention to opportunities around
10 engagement and shared decision-making, the work that we did
11 in terms of high-value cancer care and the recommendation
12 that patients know the risks and the benefits and the
13 costs, they come out with different sets of decisions about
14 use.

15 So I think this in addition to all of the
16 recommendations around coverage, least costly alternative,
17 all of that, we really should look very substantially at
18 the opportunity we have now with a population that's really
19 ripe to get them fully engaged in the decision.

20 DR. CROSSON: Thank you, Mary, and thank you to
21 all the Commissioners. This was a very robust discussion,
22 and I think it's going to be very helpful to Mark and the

1 staff and all the rest of us as we move along.

2 We've now come to the end of the morning period,
3 and we have an opportunity for public comment. Could I see
4 if there are any individuals who would like to make a
5 comment. Please step to the microphone.

6 [No response.]

7 DR. CROSSON: Seeing none, we are adjourned, and
8 we will reconvene at 12:45.

9 [Whereupon, at 11:33 a.m., the meeting was
10 recessed, to reconvene at 12:45 p.m. this same day.]

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1 expect that CMS will issue implementing regulations for all
2 of these policies.

3 This slide shows the difference in Medicare's
4 payment rate for APM clinicians and non-APM clinicians. It
5 is a stylized example, so you should just think of the
6 provider billing a constant amount of services over time.

7 From 2015 through 2019, both groups of clinicians
8 receive the same update -- 0.5 percent per year. From 2020
9 through 2025, there is no update. But clinicians who are
10 qualifying APM participants would receive 5 percent in a
11 lump sum payment each year from 2019 to 2024. And you can
12 see that in the orange bars on the graph.

13 Starting in 2026, clinicians who are qualifying
14 APM participants would receive a 0.75 percent update per
15 year. Non-APM clinicians would receive updates of 0.25
16 percent per year. And these updates are in perpetuity.

17 I mentioned two slides ago that clinicians who
18 are not eligible for the APM incentive payment are subject
19 to a separate payment adjustment that provides increases
20 and decreases based on their performance.

21 The MIPS has four components: quality, resource
22 use, meaningful use of eHR -- or electronic health records

1 -- and clinical practice improvement activities. The MIPS
2 consolidates the three separate payment adjustments that
3 clinicians are currently subject to: the physician quality
4 reporting system, meaningful use of electronic health
5 records, and the value-based payment modifier. But the
6 measures used in those programs are retained for use in the
7 MIPS. For example, the MIPS will use the PQRS quality
8 measures.

9 The maximum adjustment factor for MIPS is set in
10 statute, rising to 9 percent in 2022 and later. A scaling
11 factor can also increase the effective upward adjustment
12 above these limits, and there is an additional
13 appropriation for exceptional performance. Finally, the
14 MIPS is linked to the alternative payment models provision
15 because eligible APMs must have comparable quality measures
16 to MIPS.

17 I first want to talk about some concerns that
18 arise regarding the MIPS. First is the challenge posed by
19 assessing clinician performance at the individual level.
20 The MIPS, like the current value modifier, is designed to
21 produce an individual-level payment adjustment. But many
22 quality and resource use measures are not reliable at the

1 individual clinician level, and it is a particular
2 challenge for outcomes measures. Based on CMS' experience
3 to date with individual-level payment adjustments, most
4 clinicians will likely look average, and the Medicare
5 program will only be able to reliably identify persistent
6 outliers.

7 The structure of the MIPS itself also raises
8 additional concerns. The PQRS reporting system presently
9 has hundreds of measures, some of which assess only
10 processes of care and are poorly linked to outcomes. MIPS
11 would combine PQRS with the value modified, eHR meaningful
12 use, and add additional criteria. The resulting system is
13 likely to be overly complex and further burden both
14 providers and CMS, and because the MIPS directly implicates
15 APMs through the requirement for APMs to have comparable
16 quality measures, it could pose a barrier to APMs' ability
17 to use a more meaningful measurement system.

18 Now I'm going to talk about the APM path, and
19 we're going to spend the rest of the presentation on this
20 topic.

21 Clinicians who participate in eligible APMs
22 qualify for the 5 percent incentive payment from 2019 to

1 2024 and receive a higher update starting in 2026. And
2 they're also excluded from the MIPS. MACRA establishes
3 rules for eligible APMs, as well as the required level of
4 participation in an eligible APM for a clinician to receive
5 the 5 percent incentive payment.

6 The first question is: What is an APM? The pool
7 of APMs are all models under the Center for Medicare &
8 Medicaid Innovation (except for innovation awards), models
9 tested under the pre-existing Medicare demonstration
10 authority, a demonstration required by law, and the
11 Medicare shared savings program.

12 Then there is statutory language that further
13 winnows down the number of APMs that can qualify clinicians
14 for the incentive payment. They must meet three criteria
15 on the left side: they must use certified eHR technology;
16 they must have comparable quality measures to MIPS; and
17 they must either bear financial risk above a nominal amount
18 or be a medical home that has been certified for expansion
19 by the Office of the Actuary. And I'll note here that that
20 certification has not occurred.

21 A key takeaway is that not all APMs will be
22 eligible APMs for which clinicians can receive the

1 incentive payment. They will need to meet the criteria set
2 out in the law, and presently, very few models are likely
3 to do so.

4 A clinician will qualify to receive the incentive
5 payment if they have a specified share of their revenue in
6 one of these eligible APMs. So I want to draw your
7 attention to the dates on the screen. They are corrected
8 from your handouts, and those of you in the audience can
9 get a corrected version on our website.

10 The share is set in statute, and it is a bright
11 line. If the clinician meets it, they receive the
12 incentive payment. CMS also has the discretion to make
13 this calculation based on the number of beneficiaries
14 (versus the amount of revenue). Any revenue from Medicare
15 Advantage is not considered for either the numerator or the
16 denominator in the calculation. And there's also an option
17 for an all-payer calculation, and I can address that on
18 question.

19 If the clinician meets that threshold that I just
20 discussed, they receive the 5 percent incentive payment.
21 The incentive payment applies to their professional
22 services payment and is made in a lump sum. CMS shall

1 establish a process for making payments to APM participants
2 that do not receive fee-for-service -- for example, an ACO
3 receiving a capitation payment. The additional payment
4 incentive does not count as spending for APMs that compare
5 actual spending against a spending benchmark. In other
6 words, the additional money would not cause an APM to
7 exceed its financial targets.

8 So I'm going to turn to David to talk about some
9 of the implications.

10 MR. GLASS: Thank you, Kate.

11 Kate has just laid out what the statute says
12 about MIPS and APMs. CMS will now have to implement the
13 law. It will have to go through the rulemaking process and
14 have things specified probably by 2016 in order to allow
15 time for practitioners to form APMs and sign up, because
16 2018 is the base year for the APM bonuses which start in
17 2019. So CMS just issued a request for information on MIPS
18 and APMs last week, and rulemaking will follow.

19 One of the key implementation issues CMS will
20 have to address is what spending is the APM responsible
21 for. Remember, it has to be at risk for something,
22 presumably the difference between expected and actual

1 spending. But what spending will that be? The spectrum
2 would seem to range from spending only for the services the
3 APM clinicians bill for at one end to total Part A and Part
4 B spending for a beneficiary for the year at the other end.
5 It could also be something in between such as spending in a
6 bundle for some period -- for example, all services around
7 a hip replacement for 30 days post discharge.

8 Another issue CMS will have to address is rules
9 for attributing clinicians and beneficiaries and, hence,
10 their spending to APMs. Also, as Kate has discussed, CMS
11 will have to decide what quality comparable to MIPS means.
12 And, finally, what is risk above a nominal amount? We are
13 not going to go into this last issue at length but, however
14 defined, at a minimum one would need to be able to measure
15 changes in spending if an APM is at risk.

16 In the next few slides, we are going to look at
17 the first question and use it as an organizing principle
18 for thinking about the issues that an APM program would
19 face.

20 Decisions about the scope of an APM's
21 responsibility for spending will have an important
22 influence on how the program works. First, let's look at

1 an APM that is only responsible for the spending its
2 clinicians bill for. Here are some of the characteristics
3 of the APM that would follow.

4 First, it is likely the clinician would only be
5 in one APM because the APM is defined around clinician
6 billings. In contrast, a beneficiary is likely to be in
7 several APMs -- for example, one with her cardiologist and
8 one with her primary care provider.

9
10 One issue with this model is that an APM is
11 unlikely to have sufficient "n" to reliably measure changes
12 in spending or quality, and by that I mean it will not have
13 enough attributed beneficiaries or cases for CMS to
14 determine if there is a meaningful difference between
15 actual and expected spending. Because APMs have to be at
16 risk, this is a problem.

17 Because the APM is only responsible for its own
18 billings, it has no incentive to coordinate care or control
19 total spending. Spending on an unneeded hospital
20 admission, for example, would have no impact on the APM's
21 performance, so why control it?

22 Finally, there would also be no incentive to

1 improve quality outcomes. There may be many quality
2 measures, but the APM would not likely have responsibility
3 for a defined population so it could not have
4 responsibility for population outcomes or an incentive to
5 change them.

6 An APM defined as responsible for spending around
7 a bundle of services presents a different picture. In this
8 case, a clinician could be in multiple APMs, each
9 responsible for a different bundle of care. Beneficiaries
10 also could be in multiple bundles, hence, in multiple APMs.
11 In this case, there may be a sufficient number of
12 beneficiaries or cases in an APM to reliably measure
13 change, but that could vary widely among the APMs.

14 There may be some incentive to coordinate care
15 within the bundle but not necessarily outside of it. There
16 also would be some incentive to control spending within the
17 bundle but not to control the number of bundles or total
18 spending. Finally, the last goal concerns improving
19 quality outcomes. The Commission has emphasized outcomes
20 over process measures. Most outcomes are population
21 outcomes. Only an APM with responsibility for all spending
22 could be measured on population outcomes because it would

1 have an attributed population. If some sort of
2 intermediate outcomes were defined, then the bundled APM
3 could have some incentive to improve them as well.

4 Finally, let's look at an APM responsible for all
5 of a beneficiary's spending for Part A and Part B over the
6 course of a year. If the logic of attribution were similar
7 to that used in ACOs, the clinician would be in one APM if
8 that physician's claims were used to attribute
9 beneficiaries to APMs. Some specialties, if they were not
10 used for attribution, could be in multiple APMs.

11 A beneficiary would be in one APM almost by
12 definition. The APM would likely have sufficient "n" or
13 could be required to. In the Medicare shared savings
14 program, for example, a minimum of 5,000 attributed
15 beneficiaries is required for each ACO. Because the APM
16 would be at risk for total spending, we would expect it to
17 have strong incentives for coordinating care, controlling
18 total cost, and improving outcomes.

19 So far we have discussed each of the three models
20 separately, and that has been complex enough. However, the
21 legislation leaves open the possibility that these models
22 could all exist at once, and that makes things even more

1 complex as we will show on the next few slides.

2 So here we have APM-1 with Clinician A in it and
3 beneficiary B1. So in this case, the spending for
4 Beneficiary 1 comes through APM-1 and goes to Clinician A.
5 So in this case, that seems pretty clear.

6 But now let's add another APM, APM-2. Clinician
7 A is also a participant in APM-2 as is Clinician B, and
8 they share revenues for beneficiary B2. Sorting out how
9 revenues are shared is important to determine if Clinician
10 A, for example, has enough of his revenue coming through
11 APMS to clear the threshold.

12 Similarly, having APMS responsible for different
13 scopes of spending will complicate the program. We start
14 out with APM-1 responsible for all A and B spending for
15 beneficiaries B1, B2, and B3 -- not vitamins.

16 [Laughter.]

17 MR. GLASS: We now add APM-2 responsible for a
18 payment bundle and B2 and B3 use that bundle, and then
19 let's add one more. Let's add B3 responsible for its own
20 billing, and that has a relationship with B3 as well. If
21 all three APMS have a relationship to the beneficiary --
22 B3, for example -- how would the share of revenues of each

1 clinicians be counted? How are savings or losses shared?
2 And what if a clinician is in multiple APMs? These
3 complexities would not only make the administration of the
4 program difficult, they could lead to unintended incentives
5 for the clinicians and other providers. They might also
6 confuse and mystify the beneficiary to the extent that the
7 beneficiary is aware of APMs at all.

8 In summary, there are now two payment paths going
9 forward for clinicians. There are APMs and the bonuses and
10 higher updates that path includes. And there is the path
11 for clinicians who do not qualify as being APM
12 participants. Those clinicians continue in fee-for-
13 service, but with no APM bonus and lower updates. They are
14 also subject to MIPS, which has the possibility of fairly
15 large payment adjustments depending on performance.

16 Because of the bonuses and higher updates, there
17 will be strong interest among clinicians to be considered
18 qualified APM participants and, thus, pressure to include
19 many models as eligible APMs. But if APMs are not
20 responsible for total spending, incentives for care
21 coordination will be diluted, and the complexity of the
22 program could increase.

1 So one way of looking at this is focusing on some
2 key questions.

3 First, how can MIPS be defined to minimize the
4 burden on providers and CMS and to emphasize outcomes of
5 interest to beneficiaries in the program? There may be
6 many clinicians in MIPS if APMs are defined to have strong
7 incentives. Simply combining all the measures and the
8 three current quality and value measurement systems into
9 one may result in an overbuilt system, placing a lot of
10 burden on providers and with too much emphasis on process
11 measures. Is there a better way to go?

12 Second, should APMs be required to lower costs
13 and increase quality? This seems like a good idea, but the
14 legislation does not require it. And simply having a low
15 level of risk may not do it. For example, if I get a 5
16 percent bonus and I have a 1 percent risk, I might not work
17 too hard to control spending. Also, if put at sufficient
18 risk, APMs would have to be large enough to measure their
19 performance and to absorb those.

20 Third, CMS will have to strike a balance between
21 the scope of spending for APMs and having as many APMs as
22 possible. There will be pressure to expand the number and

1 variety of APMs, but there should also be a concern that it
2 might be better to have fewer, more robust APMs that can
3 take on risk.

4 Finally, if you think it's important to get
5 clinicians to participate in APMs, should APMs be given
6 additional tools, such as regulatory relief from things
7 such as the three-day rule or the ability to share savings
8 with beneficiaries? This might make it a stronger model
9 and increase the incentive to be in APMs and out of MIPS
10 fee-for-service.

11 Another way of looking at this, of thinking about
12 these issues, is to consider a hypothetical model for an
13 APM and how the program would look as a result. We have
14 based this model loosely on ACOs to illustrate some of the
15 issues we have just discussed. In this model, the APM
16 would be at risk for total spending, have sufficient
17 numbers, have ability to share savings with beneficiaries,
18 be given regulatory relief, and have a single entity to
19 assume risk. Under this construct, the beneficiary would
20 be in one APM per year, and the clinician would be in one
21 APM if his claims were used for attribution. So this is
22 not a suggested definition but, rather, an example to

1 illustrate the issues.

2 We look forward to your discussion.

3 DR. CROSSON: Okay. Kate, David, thank you very
4 much.

5 This opens a new chapter in MedPAC's work. It
6 actually is derivative of two extremes of work that the
7 Commission has been doing for quite a long time. One is in
8 the area of delivery system and payment reform. I think
9 many of you are aware that the accountable care
10 organization idea itself had at least part of its genesis
11 here at the Commission, because I think a longstanding
12 belief that some -- not all, but some of the complexities
13 that we deal with, particularly in fee-for-service
14 Medicare, can be more effectively addressed by more
15 integrated delivery systems and particularly by methods of
16 payment, such as David and Kate have suggested, which
17 combine responsibility for larger areas than just the
18 services delivered by one individual to one patient.

19 It also follows from the recommendation that I
20 think is almost a decade old that the sustainable growth
21 rate formula with respect to physician payment and Medicare
22 fee-for-service was an ineffective incentive and needed to

1 be replaced.

2 So I think it's appropriate for the Commission
3 now to take on this work, and our goal here, first of all,
4 is to understand this better, to understand the intent of
5 the legislation, but also to assist CMS and others, to the
6 extent that we can, in thinking the best pathway through
7 because I think, long term, the Commission as well as many
8 other interests within the health care delivery system and
9 payment system have an interest in this direction being
10 successful. And it's quite complicated as you can just
11 see. How it's implemented, how the rules are created, I
12 think will go a long way to determining whether it sets out
13 on a path of success or not.

14 So this is a preliminary discussion that we're
15 going to have. I think our purpose here today is to try to
16 understand what's been presented and, to the extent that we
17 can, what lies behind it, and to get some preliminary ideas
18 from the Commission about how we should be thinking about
19 this, so that as we design issues to be brought here over
20 this term, we pick those which are the most likely to be
21 impactful and around which we can reach the greatest level
22 of consensus.

1 So that's our goal, and we'll start as we usually
2 do with clarifying questions. We will start here with
3 Kathy and go down this way.

4 MS. BUTO: Kate and David, thank you for this
5 presentation. This is really complicated stuff.

6 So I had several questions that are just a
7 threshold. One was how much leeway the statute gives. I
8 understand that the updates are all in this, probably in
9 the statute, and they've been scored and everything thing
10 else. But how much leeway does the statute give vis-a-vis
11 the complexity of the MIPS themselves? Because the
12 complexity there leads to the complexity of the APMs. So
13 that was question one: How much leeway?

14 Question two is it looked to me from slide 9 as
15 if the physician meets the percentage APM participation or
16 involvement required to get the bonus, that that was
17 regardless of whether or not the APM met any quality
18 standards. It's just the APM had to have the quality
19 standards, but there's no quality component to it other
20 than that, right?

21 MR. GLASS: Yeah. That is correct.

22 MS. BUTO: Okay.

1 And then, thirdly, I got confused about an APM
2 that was going to take risk for A and B vis-a-vis the ACO,
3 and I guess I imagine that it was possible to be double
4 paying for shared savings to the physician in the update
5 and then also to the ACO, which would then in turn share
6 some of those savings with the physician. So those are the
7 three questions.

8 MR. GLASS: I'll just take the last one.

9 So if an ACO were qualified to be an APM and
10 became an APM, they would get -- they could still be
11 eligible for shared savings, and as you said, the
12 practitioners in it would be getting their 5 percent bonus,
13 assuming they were beyond the threshold.

14 But the 5 percent bonus doesn't go into the
15 calculation of the shared savings. So, in some sense, they
16 wouldn't be being paid double for that.

17 MS. BLONJARZ: And I can answer your first
18 question. So what the legislation does with respect to
19 MIPS is it basically removes the kind of three separate
20 payment adjustors, but it does retain all the measures and
21 kind of the processes for PQRS, the value modifier, which
22 uses the PQRS measures, meaningful use.

1 There is a new category of clinical practice
2 improvement activities and then also the resource use, and
3 I think CMS is reading that very strictly, kind of planning
4 to keep all those mechanisms going and merging them into
5 kind of one adjustment.

6 It would be up to them to decide how much leeway
7 they have under the statute to depart from that, but it
8 seems to be their intent from the RFI.

9 DR. SAMITT: So my questions are in the same
10 line, and I would turn to the slide 3 because I could use
11 some help understanding this as well.

12 I am trying to understand the compare and
13 contrast of an APM versus a MIPS provider. So let's take a
14 hypothetical situation. In 2022, let's assume the APM here
15 is a qualified ACO, and the MIPS is a MIPS provider. But
16 in 2022, there is eligibility for a 9 percent in the best-
17 case-scenario adjustor. So if I am an equally high-
18 performing ACO as an APM versus a MIPS provider, in which
19 scenario will I be rewarded more appropriately for being a
20 highly accountable, high-performing clinician? How does it
21 all add up in those two settings?

22 MS. BLONIARZ: I think it would depend on the

1 level of risk that the APM is bearing and then also how the
2 APM entity is kind of transmitting the risk it faces down
3 to the clinician. That's going to be another key piece of
4 it.

5 I think you have brought up another point, which
6 is that people will be in one or the other.

7 DR. SAMITT: Right.

8 MS. BLONJARZ: They can't be in both. So if they
9 are in an eligible APM, they are not in the MIPS and vice
10 versa. What I don't know is whether there will be kind of
11 a lot of switching back and forth year by year based on how
12 advantageous it may be, but I think the statute was written
13 that people would only be in one or the other. But that
14 determination happens every year, so people could go from
15 one to the other and back.

16 DR. SAMITT: I think it would be helpful to see
17 even average modeling of what it would look like between
18 the two scenarios because even the 9 percent -- so the 9
19 percent would be supplemental to what's listed in green
20 here, and then it puts in question, if I am a provider,
21 would I prefer to be in MIPS, or would I prefer to be in
22 APM? That's not clear to me from the math right now.

1 I am assuming we would want people to prefer to
2 be in an APM, but the methodology isn't clear that it would
3 incent that.

4 MR. GLASS: Yeah. And there would be the
5 uncertainty if you were in MIPS of whether you're going to
6 be getting 9 percent or losing 9 percent, and you'd have to
7 have that in the calculus. And then in the ACO or the APM
8 in this, the question would be you'd get the 5 percent on
9 your professional services, but then you'd also be eligible
10 for shared savings on the entire spend. And how that would
11 work out, hard to know.

12 DR. MILLER: I just want to say, you used the
13 word "modeling," and I started to break out in a sweat.

14 [Laughter.]

15 DR. MILLER: I was actually surprised how cool
16 you two remained.

17 I don't know that we would -- yeah, okay. What I
18 think we could do, though, is potentially give you sort of
19 hypotheticals like this -- yeah. And if that's what you're
20 talking about, I think we could knock that out, but
21 simulating like what might happen here, I don't think we
22 would have the capability. There's too much uncertainty.

1 DR. SAMITT: Yeah Just confidence intervals is
2 all that I'd want to see. Modeling isn't necessary.

3 DR. CROSSON: On this point?

4 DR. NERENZ: Exactly on this point, just in the
5 text, it says the MIPS applies to clinicians who do not
6 qualify. It doesn't say anything about choice or
7 preference. Is there a feature of choice or preference?

8 MS. BLONIARZ: That's a good point.

9 So CMS is going to determine whether the APMs,
10 kind of in that big, broad category at the top here, will
11 determine whether they are eligible APMs. I do not know
12 how they will do that, whether they will ask the APMs to
13 come forward with an application, whether they will say
14 things that look like this model are considered eligible
15 APMs. But once that process happens, all of the clinicians
16 that are a part of that APM, like, for example, for an ACO,
17 all of the physicians that are part of that ACO would then
18 get into the next stage where they would look at how much
19 revenue they had going through the APM.

20 MR. GLASS: But the physicians or practitioners
21 would have the choice of wanting to be in the ACO or the
22 APM or not, so that they would choose "I am in this APM" or

1 "I am in five APMs," whatever it is, and then CMS would
2 make its calculation.

3 DR. NERENZ: I was just going to say, because
4 your question implied that physicians could choose which
5 track they wanted to be in, and I'm just trying to clarify
6 that they don't really have that specific choice.

7 MR. GLASS: They can choose to try to be in the
8 ACM.

9 DR. NERENZ: I understand.

10 DR. CROSSON: Alice.

11 DR. COOMBS: I was curious. If you're an APM
12 during that period 2019 to 2024, you don't have -- you have
13 the same quality parameters, but you don't have any kind of
14 grade. You don't have a report card. No report card for
15 those, right, in the APMs?

16 MS. BLONJARZ: There's no kind of quality
17 resource use evaluation, yeah.

18 DR. COOMBS: And so with the others who are the
19 non-APMs, there are still quality benchmarks that are
20 occurring during that time period, right?

21 MS. BLONJARZ: There are. Yeah, I should just
22 clarify that.

1 The eligible APM will have to have some criteria,
2 so they'll have to have some kind of -- their payments will
3 have to be based on some kind of quality measures
4 comparable to MIPS, so there's something there.

5 DR. COOMBS: Right.

6 MS. BLONJARZ: But the Medicare program is not
7 evaluating that group of APM clinicians.

8 DR. COOMBS: Right. So you get a waive with a 5
9 percent bonus and no grade, whereas the other group that's
10 the parallel group, the non-APM, is it being evaluated with
11 the 0.5 -- no update, zero update, right? So it's like a
12 two-tier system that is occurring simultaneously with the
13 APMS on one side receiving the 5 percent bonus. The
14 evaluation of the quality parameters are there, but you
15 don't get a grade. And then you get a zero percent update
16 on the other side, and that's just it, right?

17 MS. BLONJARZ: Yeah. But there's also that
18 upward and downward adjustment on the non-APM side.

19 DR. COOMBS: Okay.

20 MS. BLONJARZ: Right.

21 And I think I would just say that on the APM
22 side, there is some kind of quality assessment going on.

1 It's just the Medicare program is not defining what that
2 is.

3 DR. COOMBS: Right.

4 MR. GLASS: Also, it's at the APM level, not the
5 individual patient.

6 DR. COOMBS: Right. So it is reliance on the APM
7 to be the governance of that process.

8 And then --

9 DR. MILLER: I think there is some clarification.

10 DR. CROSSON: Well, I may be making a different
11 point.

12 So, Kate, am I right that the APM would develop a
13 quality measurement and improvement process, and that that
14 would get certified somehow? CMS would say that's
15 comparable to the MIPS criteria? But then after that, it's
16 all internal; is that right?

17 MS. BLONJARZ: Something like that.

18 [Laughter.]

19 MS. BLONJARZ: So what I'll say is I don't know
20 that CMS has said how they're going to determine whether
21 something is comparable to the MIPS quality or not. I
22 don't know at what level of detail they are going to be

1 looking at that.

2 MR. GLASS: And beyond that, the APM in order to
3 get, say, that it was a shared savings sort of arrangement,
4 there could be quality --

5 DR. CROSSON: Additional.

6 MR. GLASS: Yeah.

7 DR. MILLER: The thing I wanted to -- I wasn't
8 quite sure whether we came away with this, that in a sense,
9 you can have a conversation about how the performance of
10 the APM is judged. Did it save money? Did improve
11 quality? And then if there's some shared saving action
12 there, that's one thought.

13 Then there's another thought, which is does a
14 person who is in the APM get the 5 percent, and I think the
15 conversation about quality's role there is the conversation
16 you were having.

17 DR. COOMBS: Right, right.

18 DR. MILLER: Okay. I just want to be sure you
19 were squared away there.

20 DR. COOMBS: I understand that.

21 DR. MILLER: Okay.

22 DR. COOMBS: So the next piece of the puzzle, is

1 there any way that you could get an automatic acceptance
2 letter into college, the college of APM that receives the 5
3 percent bonus, when you get funneled through this funnel?
4 Would you say that if you're part of the CMMI, are you
5 guaranteed it? What I really want to know is, what
6 percentage of all of those robust CMMI programs would
7 qualify for the 5 percent bonus? Do we have any knowledge
8 of that?

9 MS. BLONJARZ: I think right now, there's
10 probably very few.

11 In the paper, we talked a little bit about the
12 number of models currently under CMMI that have shared
13 savings and losses. There's not that many. There's --

14 DR. COOMBS: Well, the reason why I say that, we
15 have the Pioneer, and we know that there was some attrition
16 with that, and so it makes a big difference if you have a
17 really, really small -- when you say few, really small
18 number, and during that period, between 2019 and 2024, you
19 just have so few providers that are qualified. That begins
20 problematic in terms of whether or not there is a
21 disincentive to take on a higher risk, even with the MIPS
22 in terms of behavior response to being rejected from

1 college.

2

3 MR. GLASS: Right. That's why the definition of
4 risk above a nominal amount because --

5 DR. COOMBS: Right.

6 MR. GLASS: It's very important because there are
7 very few right now.

8 DR. MILLER: And I'll just say there's a Round 1
9 thing that we're still in here, and I want to make sure
10 that the -- and then we can get to what do you want to do.
11 Do you want to make it rigorous? Do you want to make it
12 less rigorous?

13 I also want to make sure that the public
14 understands what Kate just said. There's three
15 requirements for APMs -- to be ineligible APM. Sorry.
16 We're still waiting to see how that's all going to play
17 out. So the answer of how many is really unknown, but the
18 second part of her question is, if you take a layman's look
19 at what's out there, it doesn't look like a lot qualified
20 right at the moment. And I'd just like to make sure that
21 the public follows all of that.

22 Sorry. Back to whoever is up.

1 DR. CROSSON: And having said that, I think there
2 is the realization here, I think, behind this approach that
3 it's not designed to essentially work well with what exists
4 right now because what exists right now isn't getting us
5 necessarily to where you want to be, that part of this, the
6 incentives here in this APM creation, is to start providers
7 moving forward to realize that they are going to have to
8 change some of their organizational structural and other
9 relationships in order to get to where they need to be.

10 MS. UCCELLO: So we keep talking about this APM
11 like it's an ACO type of arrangement, but it seems like
12 that's not the only way to do it. And it seems like from
13 this chart, you could just be part of a bundled payment
14 program. How could you not be in more than one of these
15 kinds of things if that kind of program or whatever is
16 included in this? And you could see a particular clinician
17 getting a share of his or her income from that particular
18 program, but then also being involved in some other kind of
19 program, and you've got to add all that stuff up.

20 So I don't know how this works, or is that the
21 issue?

22 DR. CROSSON: Kate is going to emphasize that

1 there are -- having said that, there are these three
2 criteria that need to be met, and some payment models right
3 now, I don't know that they would meet those three criteria
4 that are on slide number 8, right?

5 MS. BLONJARZ: That's right.

6 And the other point I would make is the second
7 step of the evaluation, which is does the clinician have
8 enough revenue in these types of models. So for a bundle,
9 a clinician may only have a small share of their revenue in
10 that model.

11 [Pause.]

12 DR. CROSSON: David.

13 DR. NERENZ: Can you put Slide 15 up, please? I
14 just want to make sure I'm clear what point you want us to
15 take away from this, and I'm not sure I yet understand the
16 problem.

17 MR. GLASS: This is very much going to Cori's
18 question.

19 DR. NERENZ: Okay. Well, let me try to
20 paraphrase and then explain why I don't yet see the
21 problem. Let's assume that the two APMS are approved,
22 valid, they're okay APMS. Clinician A -- and the arrows

1 are dollar streams, right? Dollar flows?

2 MR. GLASS: Correct

3 DR. NERENZ: Okay. Clinician A gets two dollar
4 flows, and presumably they are going through APMs, so they
5 count. They're good dollars. Then that total amount is
6 compared against some larger revenue pool to see if you
7 meet the 25 or 50 or 75 percent.

8 MR. GLASS: Correct.

9 Dr. NERENZ: Okay. We're good so far.
10 Clinician B gets one dollar flow, and that's compared
11 against some larger total. So what's the problem?

12 MR. GLASS: Well, the problem will be in figuring
13 out how to share the revenues coming from Beneficiary 2,
14 for example, and --

15 DR. NERENZ: But why do you have to do that? If
16 each one of those dollar flows counts as legit, the unit of
17 counting is the clinician, not the beneficiary.

18 MR. GLASS: Right.

19 DR. NERENZ: I just want --

20 MR. GLASS: Except that somehow the beneficiary
21 has to be attributed to one of these APMs in order for the
22 dollars to flow through the APM.

1 DR. NERENZ: Well --

2 MR. GLASS: So there's this matter of
3 attribution, is the first complication.

4 DR. NERENZ: Beneficiaries aren't attributed to
5 bundled payment, for example. They're just -- they're in
6 it or they're --

7 MR. GLASS: Right, they're defined to be in it.

8 DR. NERENZ: Okay. So it seems to me the key
9 issue is just -- does any dollar flow through? But I'm not
10 sure why we worry about whether a beneficiary has dollars
11 running in different directions. I don't understand why
12 that's a problem.

13 DR. MILLER: Is it possible that you're talking
14 about two different things? Are you talking about whether
15 they qualify for the 5 percent or whether how --

16 DR. NERENZ: Yes.

17 DR. MILLER: -- split savings -- yeah, so across
18 the 5 percent, David, just stay with me.

19 DR. NERENZ: Yeah.

20 DR. MILLER: I hate to do this live. I think you
21 may have a point. You know, it's like I'm in enough APMS
22 and my percentage of revenue qualify to get the 5 percent.

1 DR. NERENZ: Right.

2 DR. MILLER: But what I think David is answering,
3 possibly, is, all right, a second question is: If these
4 APMs were successful or unsuccessful, how would you
5 hierarchically decide how to allocate the savings?

6 DR. NERENZ: Well, and I realize -- I don't want
7 to get into Phase 2, but at least as it's currently
8 written, it doesn't matter if they're successful or not.

9 DR. MILLER: Agreed. But I think David is
10 raising this point of, like, you're still going to want to
11 evaluate how APMs perform and how savings get shared as a
12 separate statement from the 5 percent.

13 MR. GLASS: Right.

14 DR. MILLER: Are we in the same place, David?

15 MR. GLASS: Yes. But, also, I think it's a
16 perfectly valid point, yeah, if you can define which
17 beneficiaries you're sharing revenue -- you know, the
18 revenues are coming from and how they're going through APMs
19 and who's billing for them and all that and keep all that
20 straight, then, yes, you can then figure out for Clinician
21 A whether he has enough revenue coming through APMs
22 compared to his total to meet the 25 percent or 50 percent

1 --

2 DR. NERENZ: Right.

3 MR. GLASS: We're just showing that that can get
4 -- you know, you'd have to keep track of a lot of things
5 going on.

6 DR. NERENZ: Okay, fine. I just wanted to make
7 sure I wasn't missing something else.

8 MR. GLASS: No, no. That's fine.

9 DR. NERENZ: Okay.

10 DR. CROSSON: Clarifying questions?

11 DR. HOADLEY: So I'm still wrestling with the
12 question that I guess Craig started on this notion of how
13 the clinician joins or is attributed to, and it sounds like
14 as you've gone on to talk about more of these, that a lot
15 of these, they're just in because they're doing these
16 things, and some -- but in some of these, it may be more of
17 a I have to actually sign up to be part of it. And I --

18 MR. GLASS: I think they have to sign up to be --

19 DR. HOADLEY: For any of these, back on that
20 other slide --

21 MR. GLASS: Yeah, I think the clinician has to
22 say, "I am in this APM." So they have to--

1 DR. HOADLEY: And any of the subunits --

2 MR. GLASS: They're going to have to do it on,
3 you know, taxpayer identifier numbers and the whole --

4 DR. HOADLEY: So whether we're on a bundled
5 payment thing or a demonstration or an ACO, those are all
6 things where the physician would have to have actively
7 opted; they're just not in it because it's something maybe
8 their larger practice is just part of?

9 MR. GLASS: Well, if their practice is in it --

10 DR. HOADLEY: It might be done at that level

11 MR. GLASS: Yeah, and it's done at the taxpayer
12 identification number level, then that would be sufficient
13 probably

14 DR. CROSSON: So now I'm getting a little
15 confused.

16 [Laughter.]

17 DR. HOADLEY: That's why we're clarifying.

18 DR. CROSSON: We're talking about the money to
19 the physician flowing through the APM. Is that right? Is
20 --

21 MR. GLASS: That's the way the statute is
22 written. I mean, it says --

1 DR. CROSSON: So the APM --

2 MR. GLASS: -- it has to go through the --

3 DR. CROSSON: -- is not just a payment model.

4 It's an entity. Is that the implication of that?

5 MR. GLASS: Right, yes. I think that's correct.

6 I mean, the way it's written, it says the revenue has to go

7 through the APM to be counted in order for them to qualify

8 as a participant in APMs. Do you see what I'm saying?

9 DR. CROSSON: I do.

10 [Laughter.]

11 DR. CROSSON: I think it changes things. Okay.

12 MR. GLASS: Okay.

13 DR. MILLER: I mean, it can be a passive

14 transaction. So once again --

15 MR. GLASS: The APM is not paying the physician.

16 DR. MILLER: Is that clear?

17 [Laughter.]

18 DR. CROSSON: Then I think we need to parse the

19 word "through." Have we got a definition of the word

20 "through"?

21 MR. GLASS: So think about how an ACO works now.

22 I can sign up to be in this ACO as, you know, a

1 practitioner, a clinician. I can sign up to be part of
2 this ACO, and I'm under the taxpayer identifier number that
3 the MSSP ACOs --

4 [Laughter.]

5 MR. GLASS: At any rate -- but the checks come
6 from CMS directly to me in payment. My fee-for-service
7 revenue comes directly from CMS.

8 DR. CROSSON: Right.

9 MR. GLASS: In the current ACO, MSSP ACOs. So
10 think of it as that. The check is coming from -- the fee-
11 for-service revenue check comes directly to the clinician,
12 but in the sense that the clinician is part of the ACO, and
13 in this case the patient is attributed to the ACO, then the
14 money is coming through the ACO. And that's -- I'm
15 reasoning by analogy, given that that's the case in ACOs, I
16 assume it's something like that.

17 DR. MILLER: So half of my -- I'm in -- actually,
18 let's keep it real simple. The reason we keep going
19 through an ACO, Cori, is because --

20 DR. CROSSON: We know where it is.

21 DR. MILLER: Let's say all of my patients are
22 attributed to an ACO, just to keep it simple. But CMS is

1 paying me on a fee-for-service basis. But because each of
2 those beneficiaries, all of my business, was in an ACO, all
3 of it would have flowed through an ACO and qualify, I would
4 be 100 percent by that definition, and I would qualify as
5 being in an APM and getting a 5 percent on that, you know,
6 total book of business.

7 DR. CROSSON: The actual flow of money or the
8 credit for the flow of money?

9 DR. MILLER: I would say credit in that sense.

10 DR. CROSSON: Right, okay. All right.

11 MS. BLONJARZ: Let me just clarify. So in the
12 statute, it says "through an eligible APM entity," and
13 it's, like, What does that mean? And I think that that
14 will be subject to rulemaking. I think that we have a
15 relatively good sense of what that could mean in the ACO
16 context because money is coming from the fee-for-service
17 Medicare stream, but it's kind of part of an ACO
18 arrangement between the Medicare program and the provider.
19 But beyond that, I would say we will have to see how CMS
20 defines it.

21 DR. CROSSON: Right.

22 DR. SAMITT: Can I take on one --

1 DR. CROSSON: Can you save us here?

2 DR. SAMITT: No, that's impossible at this point.

3 [Laughter.]

4 DR. SAMITT: So what if not 100 percent but 60
5 percent of my services qualify as an APM? Do I get the 5
6 percent bonus on 100 percent of the services that I provide
7 or only the 60 percent that is linked to APM?

8 MS. BLONJARZ: You would get it on 100 percent of
9 your professional services. You would get it in 2019 and
10 2020, 2021 and 2022. You would not get a payment in 2023
11 based on this slide, because at that point it's a 75
12 percent threshold.

13 DR. SAMITT: I understand. Okay.

14 DR. CROSSON: Where are we? Jack?

15 DR. HOADLEY: I have two others that I think are
16 simpler. On Slide 8, you talked very briefly about the
17 medical home that meets the expansion criteria as this
18 other path and said that that hasn't happened yet. Do we
19 know anything more about that? Is it that nobody has tried
20 to make it happen? Is it standards that are hard to meet?

21 MS. BLONJARZ: So the criteria that I'm talking
22 about is the one that was established in PPACA when the

1 Center for Medicare & Medicaid Innovation was established
2 that basically says any model under CMMI can be expanded
3 nationally if it is shown to improve outcomes without
4 increasing cost or lower cost without hurting outcomes.
5 Only one CMMI project has gotten that certification. It's
6 the Pioneer ACOs.

7 So CMMI has a whole bunch of other medical home
8 demos. They haven't reached that criteria yet.

9 DR. HOADLEY: So it's the whole demo that's going
10 to get certified or not get certified.

11 MS. BLONJARZ: I think that's probably right,
12 yeah.

13 DR. HOADLEY: And my other question was on 9
14 where you talk about MA revenue not being part of the
15 calculation, and I guess that's logical in the sense that
16 this isn't directing MA payments. But I'm trying to think
17 about how that plays out for -- obviously, if a particular
18 clinician is completely in the HMO, doesn't matter. But
19 some clinician who might have 75 percent of their work,
20 this would be out of the numerator and the denominator?

21 [Ms. Bloniarz and Mr. Glass nodding.]

22 DR. HOADLEY: And so all of these judgments would

1 be made on, say, that 25 percent of their business, and
2 then whether 75 percent of that meets the criteria and so
3 forth. Okay.

4 DR. CROSSON: Okay. I want to make sure we have
5 some time to actually discuss directions, so let's move
6 ahead with the clarifying questions, and I ask for, despite
7 the complexity, as much brevity in questions and answers as
8 is humanly possible.

9 MS. THOMPSON: A simple question. I thought you
10 did a great job, Kate and David. Thank you for this.

11 Back to page 8, if we would define the universe
12 of eligible candidates to be considered to become an APM,
13 does it only include those that you've identified in those
14 four bubbles going into -- so what is --

15 MS. BLONIARZ: That's right.

16 MS. THOMPSON: I think that's an important point.
17 So what's the line in the sand in terms of date that I or
18 an organization as a physician I'm a part of, do I have to
19 be in a model or in an ACO or bundled payment project? I
20 think that is important. So can you talk a little bit
21 about that?

22 MS. BLONIARZ: Yeah, so it is only these four

1 pathways, and the first one, Medicare demonstration
2 authority, that actually has been superseded by the CMMI
3 process. And, you know, demonstrations are required by
4 law. There have been some, you know, through the years,
5 like one-off demonstrations. But I would say that
6 currently the way to get new models in is likely going to
7 be through CMMI.

8 DR. CROSSON: Very good question, and so the
9 derivative question is, Do we anticipate that CMMI or CMS
10 has the capacity to put enough models out, assuming we got
11 a robust response to this by physicians across the country?
12 Or are there going to be physicians who want to do this but
13 can't?

14 MS. BLONJARZ: Yeah, I think that's an open
15 question. I should also mention there's another kind of
16 input into this process, which is a physician-focused
17 payment models, technical advisory committee. That is a
18 committee that is just now standing up, and appointed by
19 GAO and staffed by ASPE. They will also come up with
20 models, but the models that they come up with would then
21 also have to go through the CMMI process to get into the
22 bucket of potentially eligible APMs.

1 DR. CROSSON: Got it. Thank you.

2 MS. THOMPSON: The second part to my question,
3 because in your criteria that you list, the risk above a
4 nominal amount or a medical home --

5 MR. GLASS: That meets the expansion criteria.

6 MS. THOMPSON: I'm sorry.

7 MR. GLASS: The medical home that meets the
8 expansion criteria, not just any medical home.

9 MS. THOMPSON: Not just a stand-alone medical
10 home that meets -- okay. That's important, too. Thank
11 you.

12 DR. MILLER: And the only thing I was going to
13 say about Jay's question, I mean, a question that when we
14 discuss this in the second round and move on over time is
15 how expansive, how many models, versus focus, and I think
16 that's something that the Commission could say that could
17 help the environment sort of define what it's actually
18 looking at here.

19 DR. REDBERG: Two quick questions. On the
20 mailing material, on page 8, when you're talking about how
21 MA is not part of the determination, it says that CMS is
22 doing a study to look at the feasibility of alternative

1 payment models and it will be out next year. Do we have
2 any information or timing?

3 MS. BLONJARZ: No, we haven't heard anything more
4 about it.

5 MR. GLASS: Well, the legislation requires that
6 it be done by some specific date. Do you remember?

7 DR. MILLER: We can look that up and get back
8 [off microphone].

9 DR. REDBERG: Sure. On maybe page 9 of the
10 presentation, clinicians can qualify for the APM if 25
11 percent of spending, say, in 2018 and 2019 is part of the -
12 - are in an eligible APM. But the 5 percent bonus would be
13 applied to all of your Medicare payment, not just the 25
14 percent that was in the APM.

15 MS. BLONJARZ: It says -- "professional services
16 revenue" is the term in the statute. But, yeah, all of it.

17 DR. REDBERG: That's interesting. Okay.

18 DR. CROSSON: I'm sorry. I missed Jon coming
19 around this way.

20 DR. CHRISTIANSON: On Slide 9, that slide, the
21 bullet point about MA revenue not part -- what was the
22 thinking, what's your understanding of the thinking behind

1 that?

2 MR. GLASS: Well, it's a fee-for-service program,
3 I think is the thinking. So they're interested in your
4 fee-for-service revenue, and that's where you're getting --
5 the bonus is a percent of fee-for-service revenue, and I
6 guess that's the thinking, is that they're interested in
7 how much of your fee-for-service revenue is under one of
8 these arrangements, not of your --

9 DR. CHRISTIANSON: Okay. I was thinking they
10 would be interested in how much of your total revenue as a
11 provider would be subject --

12 MR. GLASS: Well, that goes to the all-payer
13 calculation option would include MA as well as commercial
14 payers.

15 DR. MILLER: It would include MA or it's possible
16 that it does that? Is that defined?

17 MR. GLASS: Possible? Well, I haven't read the
18 rules yet, yeah.

19 DR. MILLER: Right.

20 MR. KUHN: Yeah, kind of going on with this issue
21 of the narrowing of the narrowing of the number of APMS out
22 there. So, in addition, maybe a smaller number, but it

1 could leave large geographic areas in the country without
2 even that option available to clinicians. Is that
3 contemplated in the statute? And is there any backup for
4 that should that occur?

5 MS. BLONIARZ: There are a couple of provisions
6 that are, you know, directing CMS and the committee to
7 look, you know, more closely at models that would work for
8 smaller areas, HPSA areas, underserved areas, and then
9 there's also, I think, technical assistance money for them
10 as well.

11 MR. KUHN: Thank you.

12 DR. NAYLOR: Thanks. I got to read this two or
13 three times before I began to know that this conversation
14 was important. So I --

15 [Laughter.]

16 DR. CROSSON: Oh, sorry.

17 DR. NAYLOR: This starts with all models in CMMI
18 so basics. Not all models are equally successful in the
19 demo, and so was there any qualifier in -- I didn't see it.
20 The language says "all." So if bundled payments -- all of
21 them are in regardless, and then applying those three
22 criteria.

1 MS. BLONJARZ: Yeah, there's one exclusion, and
2 that's for the innovation advisers. Those are not really
3 models. Those are payments to individuals. So that's out.
4 But everything else -

5 DR. NAYLOR: Everything else is in.

6 And, secondly, given the interest in the
7 Commission's emphasis on primary care and clinicians who
8 provide primary care, anything in the MACRA legislation
9 related to MIPS or APMS -- what do you call them? -- that
10 pays attention to primary care clinicians?

11

12 MS. BLONJARZ: Let me get back to you. Let me
13 look.

14 DR. NAYLOR: Thank you.

15 MR. ARMSTRONG: Jay, you can decide this may, you
16 know, verge on a Round 2 question, but at the risk -- I'm
17 trying to avoid getting lost in a lot of the specificity on
18 what the heck is an APM and so forth and trying to remind
19 myself what was actually the policy goal here other than
20 just replacing SGR -- which is not a bad thing. But it
21 looks like -- so here's my question: Am I reading this
22 right, that there seemed to be strong incentives created

1 for being part of an APM through which some payment would
2 be made? But there's nothing specific about what the real
3 goal is, like lower costs or better quality or better
4 health outcomes or whatever else you might be looking for.
5 Is that correct? And is that really a part of the work
6 that we would expect to unfold going forward?

7 DR. MILLER: [off microphone].

8 [Laughter.]

9 MR. GLASS: I think that's a very reasonable
10 question, and there isn't a requirement that they save
11 money or improve quality or anything like that, so it does
12 raise -- I think it raises that very question.

13 DR. MILLER: In fairness to the process, I think
14 -- and my most direct answer is I don't know. You know,
15 I'm not in the room in the end in all of that, but, you
16 know, my sense is some of their intent was to take a look
17 at MIPS. What they're saying is in a sense I'm going to
18 start to fix this dollar, and you're going to have to, you
19 know, compete with one another in order to get it. And it
20 can go down or up, which in theory from an incentive point
21 of view might get a clinician to start to say, well, maybe
22 I want to be in one of these APMs.

1 And you move over to the APM, but there's a
2 push/pull in the sense, you know, maybe 9 percent, you
3 know, says it dampens the incentive. But if we are one of
4 the people it's not getting at, then maybe the incentive's
5 there. So there's a pull with the 5 percent.

6 Now, the APM itself, that's where it just didn't
7 seem as rigorous as you might have thought, although there
8 is this real key sentence and definition which hasn't been
9 defined. And I don't even know what the term of art is,
10 but substantially about nominal --

11 DR. CROSSON: Nominal amount.

12 DR. MILLER: Yeah, or -- I should have read this
13 before I came into the room. But that -- and I think there
14 was some sense that these models would create some kind of
15 incentives along these lines in the sense of there are
16 quality linkages between MIPS and this and some sense of
17 risk. But exactly how rigorously that gets defined is the
18 complexity.

19 MR. ARMSTRONG: Yeah, so that's kind of how --

20 DR. MILLER: I think they were trying to move
21 people, you know --

22 MR. ARMSTRONG: You know, it's almost like we're

1 starting to -- this contemplates creating a structure
2 through which at some point, once it gets going, you can
3 begin to really pay much more attention to, well, what are
4 the real outcomes that we're trying to drive toward? So I
5 guess I [off microphone].

6 DR. CROSSON: Bill, go ahead.

7 MR. GRADISON: Is my understanding correct that
8 this would cover PAs and advanced practice nurses?

9 MS. BLONJARZ: It would, yeah.

10 MR. GRADISON: And how would it apply in broad
11 principle? Let's say an advanced practice nurse who in the
12 course of a year may work for moving around the country for
13 10 different organizations.

14 MS. BLONJARZ: So if they are billing directly,
15 it would be like -- if they were billing the Medicare
16 program directly, it would be like any other.

17 MR. GRADISON: No, but if they're paid for, let's
18 say, by hospitals, they are going where there's a -- they
19 may be travelers. They may go in where there's -- cover
20 vacations or a strike or health care emergency or
21 something. They move around the country.

22 Conceptually, they have multiple employers.

1 That's all, paid by the hospital.

2 MS. BLONIARZ: Yeah. I'm not sure I could speak
3 to how --

4 MR. GRADISON: Well, it may be too small a
5 question. I've been trying to figure out particularly how
6 this applies to non-physicians, and we'll talk more about
7 that later, I guess.

8 DR. CROSSON: Warner.

9 MR. THOMAS: As I was reading this -- and maybe I
10 missed it -- do we have an idea in these different payment
11 models what percentage of the Medicare population is
12 covered in these models today? And if we kind of broke it
13 down and looked at how many folks or how much of revenue is
14 in a bundle, how much are in the Medicare shared savings or
15 ACO program, do we --

16 MS. BLONIARZ: Definitely get something like
17 that.

18 MR. THOMAS: I'm just curious as to whether -- is
19 it 10 percent today? Is it already at 25? I mean, I think
20 if you -- you generally think about this as probably -- I
21 don't know. Are there maybe 25 to 30 percent of
22 organizations or systems that are kind of moving down this

1 road? I'm just trying to get an idea of how big a
2 modification this would be. It looks pretty material from
3 where they are today. I'm just curious.

4 DR. CROSSON: Okay. So here's what I think we
5 might want to do with the half hour or so we have
6 remaining. We've had a nice discussion, very nice
7 presentation, and I think we've surfaced a lot of the --
8 either apparent problems or contradictions or just simply
9 lack of understanding about either the intent or where
10 things are going to go, which is fine, and that's the
11 situation that often takes place when there's legislation
12 and the statute and before the rules are written.

13 This is our first run at this. It seems to me
14 that one thing we might do here is, having heard all this,
15 begin a discussion of what characteristics we would like to
16 see in APMs, particularly, but in MIPS implementation, if
17 you want, but I think particularly in APMs.

18 David started this. David and Kate started this
19 with the slide they had showing one suggested model. Mark
20 suggested that one issue we take a look at is capacity.
21 What do we think? Where should we be going? Should this
22 be a small number of robust entities who can prove the

1 point for X number of years, or do we really think that
2 somehow we need to make this opportunity available broadly
3 across the country? That's one question, but there are
4 others.

5 So let's talk about what should be. Kate and
6 David and Mark might want to comment as we make these
7 suggestions, whether the suggestion fits within the
8 existing language of the statute or not, and that might be
9 helpful.

10 So who would like to lead off on this one? I see
11 Craig, David, Mary, and Herb -- and Jon. Oh, and Kathy as
12 well. Okay. All right. Enough of that. We've gone this
13 way too many times, so, Jon, I'm going to start with you,
14 and then we're going to go this way.

15 DR. CHRISTIANSON: All right. So I think we've
16 all -- the Commission has always taken a stance that we
17 should encourage people to be enrolled in MA plans and
18 providers to be participating in MA plans. Is there
19 anything in this that you see that would discourage
20 clinicians from choosing to be part of an MA plan instead
21 of one of these APMS?

22 MR. GLASS: I thought we were kind of neutral

1 between an MA or not, but anyway, I don't think there would
2 be any reason for them not to want to also participate in
3 MA plans. But I haven't thought it through, but I haven't
4 -- I can't think of anything.

5 DR. MILLER: I have to say I hadn't thought about
6 the problem that way. I keep thinking of the -- and
7 perhaps incorrectly, Jon -- as the MA, you end up following
8 the patient. If the patient chooses their way into MA,
9 then as a provider -- it's not quite like that. I get
10 that.

11 I think I'd have to think about this a little
12 bit.

13 DR. CROSSON: On this point, Kathy?

14 MS. BUTO: My question was almost the same as
15 Jon's, only I wondered whether this program was actually
16 going to slow the physicians that find this attractive as
17 an alternative to Medicare Advantage.

18 It is speculation at this point because it
19 depends on how they define it and scope it. It could also,
20 because it's so complex, that physician will say, "Hey,
21 Medicare Advantage, much better approach to managing care.
22 It is looking simpler, and I like what that looks like."

1 So it could go either way, but I don't think they are
2 unrelated. I think this program could become more
3 attractive and skew where physicians choose to go.

4 DR. CROSSON: And I've seen that, at least
5 anecdotally, in medical groups who have tried some of the
6 existing ACO models and have moved away towards MA. So I
7 think you're right. So let's proceed this way. Who wants
8 to go? Sue?

9 MS. THOMPSON: You're looking for principles too?

10 DR. CROSSON: Principles, principles.

11 MS. THOMPSON: Well, on page 14, I think you have
12 outlined principles, and that is, however, we should work
13 to coordinate care and reduce total spend while improving
14 quality, which the triple aim. And my thought would be,
15 coming at the top of the funnel again, any of those
16 projects, whether it's MSSP or Pioneer, those are the
17 metrics that we have been held to in those projects. So it
18 would strike me that those would be operating principles to
19 think about as recommendations are formed.

20 DR. MILLER: You used the word "total" there,
21 which I took to mean for A/B, but the entire patient's --
22 almost a population-based concept.

1 MS. THOMPSON: Absolutely.

2 DR. MILLER: I mean, people's reactions to that,
3 I think would be very helpful, and it begins to draw some
4 lines around there.

5 DR. SAMITT: And D.

6 DR. CROSSON: It is similar to the model on page
7 19 as well.

8 MS. THOMPSON: And the only other piece is
9 attention to the regulatory relief and the waivers that
10 have been available to -- particularly in the Pioneer to
11 help make this happen and make it possible to do the work
12 that's required to be done.

13 DR. REDBERG: So just to build on what Sue said
14 and I think what Scott said earlier, I think of the options
15 you outlined, Option 3 certain encompasses what we think
16 of, I think, as the goals of the program to improve quality
17 and coordinate care and reduce total spending. And I think
18 it's important, you know, as these rules are being written
19 to keep these goals in mind and to write pretty specific
20 and rigorous rules because, hopefully, we have learned from
21 SGR, this is what we're trying to replace and improve. I
22 think SGR, of course, had good intentions too, but I think

1 it suffered from a lack of rigorous definitions and maybe
2 not looking at the big picture.

3 That's why I look looking at beneficiaries' A and
4 B spending. To me, SGR was trying to control spending but
5 only looked at updates and didn't look at volume. So it
6 missed a whole -- and why we had 20 years of negative
7 updates -- or however many years it was. And so I think
8 it's important that we be very rigorous going forward and
9 really learn from the past and keep our goals in mind when
10 rules are being written.

11 DR. CROSSON: Herb?

12 MR. KUHN: So for me, I kind of laid it out in
13 three buckets. So the first one is program
14 vulnerabilities, as we look at this, to make sure that
15 we're looking at the incentives to avoid poor care,
16 underservice, fraud and gaming, different things like that,
17 so just the overall program vulnerabilities that we would
18 normally look at when you stand up any kind of program.

19 The second is really kind of the big bucket and
20 what many folks have talked about already here, is the
21 workability of this system. I mean, we've seen a lot a lot
22 of Medicare systems, and this is the single most complex

1 one I've ever seen as we go into this thing.

2 But for me, the key here is that data inputs are
3 available to providers in CMS and as close to real time as
4 possible that can facilitate both not only billing, but
5 assessment of the program and maintenance of the program as
6 we go forward.

7 And then I think even beyond that, we've talked a
8 little bit about it here, but this whole set of quality
9 measures. And I think one of you said it when you were
10 talking about the overview. We all know that the quality
11 system is overbuilt that's out there. How do we take this
12 as a chance to kind of take a mulligan and kind of do it
13 over and get the real measures that are out there that are
14 focused probably on outcomes and quality measures that are
15 aligned with resource use measures as well and get that
16 alignment and get it right as we move forward, so kind of
17 just the overall workability?

18 And then the final bucket I'd put it in is the
19 end game, and the end game to me is to make sure that we
20 maintain access and we maintain high quality. And then I
21 would add a third part of that, and that is equity and
22 really equity for clinicians because we've got to make sure

1 that this is going to work for them.

2 DR. CROSSON: Herb, in terms of workability,
3 where does that take you on scale?

4 MR. KUHN: That's a good question. I don't know
5 yet. I want to think that one through a little bit more
6 because if you look at these -- and the one example where
7 you have multiple ones, might in a geographic area --
8 people might be in things that are out there. I think a
9 little bit back to like the old days when CMS used to do
10 demonstrations, and they used to look at parts of the
11 country where there was not something there already
12 because, one, they wanted to maintain the integrity of the
13 program, so that they could have an honest intervention
14 group versus the control group that are out there. And I
15 think about the ACE dem, the Acute Care Episode demo. They
16 searched and searched around the country and said, "Okay.
17 Finally, we can put this in Oklahoma and Texas where we
18 don't have overlap of different areas that are out there."

19 So in scale, I am really thinking about this
20 overlap as where we go forward, so I want to think through
21 that scale thing a little bit more because it's going to be
22 a tough one.

1 DR. CROSSON: Thanks.

2 Mary?

3 DR. NAYLOR: So these are building on others, but
4 I think that there is a real need for clarity of goals. I
5 mean transparency and clarity of goals. This was to be
6 SGR's replacement for payment to really advance and assure
7 that clinicians deliver all of the things that Herb is
8 talking about, and it seems to me to be a path to -- this
9 is my interpretation -- to create entities and encourage
10 people to move into those entities, and I'm not sure that
11 those are aligned.

12 I think the idea of simplicity, in any way that
13 we can, to enable the implementation of this to be really a
14 simple path.

15 Equity, I also think is important for the
16 clinicians and across fee-for-service and MA.

17 Value, I think that putting into funnel programs
18 or models that have not yet been proven or, in some cases,
19 have been proven not to be working doesn't make sense to me
20 to get ultimately to high-value care.

21 And certainly placing a real priority on the
22 quality of the goals, why we exist, for the beneficiaries'

1 outcomes, and so really a payment model that drives towards
2 that.

3 And accountability, I mean the accountability
4 here is individuals. It's teams. It's systems, and I'm
5 unclear about how this payment model is getting us to that
6 shared accountability of the individual, the team, and the
7 clinician.

8 DR. CROSSON: Well said and quickly said.

9 Scott?

10 MR. ARMSTRONG: So three quick points. First, I
11 agree with Mary.

12 [Laughter.]

13 MR. ARMSTRONG: Second, if I were to answer your
14 question directly, I'd pretty much answer it the way the
15 slide up there answers it.

16 But third, I feel like what I'd want to do is --
17 particularly since this is through a lens of payment policy
18 for the Medicare program -- is kind of lay out the
19 continuum from fee-for-service to MA and all the different
20 things in between. You've got ACOs, and you've got
21 bundles, and you've got DRGs, and ask how do you want --
22 what's the goal you want to design this to relative to all

1 the other payment policy that you have out there? What's
2 kind of the place you want it to be, given the broader
3 goals that we -- and accountability we have for the
4 Medicare program? And I feel like, to Mary's point, I'm
5 just not sure what that is and how it would fit in that
6 context.

7 Thanks.

8 DR. CROSSON: Bill.

9 MR. GRADISON: Herb used the program "program
10 vulnerabilities." My way of thinking about this is very
11 similar, using the term "possible unintended consequences."
12 I've jotted down just two or three that came immediately to
13 my mind.

14 One is the risk of regulatory capture where
15 specialist groups propose and get accepted as standards,
16 whatever the current standard of care is, which doesn't
17 really change anything, but it might get them the 5
18 percent.

19 The second is the possible effect of this new
20 venture in accelerating retirements, especially of older
21 physicians and particularly of primary care physicians. I
22 could see some people looking at this and saying it's time

1 to move on at a time when we might like them to continue in
2 practice.

3 And another example -- and I'm just not trying to
4 be too long. I always try to make my point that there are
5 a lot of possibilities here, and this has already been
6 cited by MedPAC in a comment to CMS earlier. And that is
7 the possibility that costs would increase because of the
8 emphasis in the criteria on inputs, inputs unrelated to
9 outcomes.

10 DR. CROSSON: Right.

11 MR. GRADISON: So you do more inputs and you get
12 credit for it, but you move your costs up and move the
13 needle on quality. I'm not saying these things would
14 happen, but I think sometimes with something like this,
15 it's not a bad idea to look at the worst-case possibilities
16 and use that as one test.

17 DR. CROSSON: Thank you, Bill.

18 Kate?

19 DR. BAICKER: So building briefly on both what
20 Scott and Bill and Herb were saying, it seems like the goal
21 is to create a system that moves more care into models that
22 are rewarding higher quality, better value, and away from

1 models that are just fee-for-service without any incentive
2 to modulate quantity and maintain quality.

3 And there are so many moving parts that I imagine
4 it is impossible to hang any real numbers on the
5 implications of turning those dials, but I am trying to
6 think through, and I think it would be helpful to have some
7 broad breast-stroke, qualitative framework about here are
8 the dials that are most likely to move physicians from one
9 model to the other; here are the dials that are most likely
10 to change behavior within those models.

11 And I can imagine if you pick one set of options
12 for all of these, you end up in a model where everybody
13 gets 5 percent, and nothing changes. And on the other end
14 of the spectrum, you could make choices such that people
15 are aggressively taking on more risk and delivering higher
16 value, more focused care, and thinking about which of these
17 is pushing in which direction, how powerful a lever it is,
18 both to move people between models and to change behavior
19 within the models. It would help me think through how they
20 play out together.

21 What you have produced already is incredibly
22 helpful in getting our arms around what the levers are, and

1 now I want to think through, in a broad brush-stroke way,
2 which set seems like the right ones to try to focus on
3 deployment.

4 DR. CROSSON: Warner.

5 MR. THOMAS: So it appears to me, as I look at
6 this, that a couple of comments. One is it seems we ought
7 to be moving more to global payments and not just focused
8 on bundles, and I would just encourage us to consider that
9 in our comments because if you just look at the bundled
10 payments, it really doesn't look at the impact of
11 utilization or avoidable care.

12 So I would just really encourage us in our
13 comments to think about this in the model you are talking
14 about in an ACO or an MSSP program versus a bundled program
15 because of the opportunity to have avoidable care.

16 The other thing that I would comment on is,
17 personally agreeing with my other Commissioners, the idea
18 of having bonus payments that are not tied to some sort of
19 quality initiative or cost reduction to me just seems it
20 would be challenging to agree with. And I would agree with
21 Herb. If we could look at this as an opportunity to
22 simplify and create better alignment in the quality

1 measures, I think this is a great opportunity to do that.

2 The comment around the clinicians being in one
3 APM, I would concur, especially from a primary care
4 perspective. That would make sense. I think that that
5 could be problematic in some specialties that are more
6 referral oriented, but they may need to be in multiple APMs
7 for this to work.

8 I would agree that beneficiaries need to be in
9 one. Primary care need to be in one because of the
10 attribution to one APM versus another, but specialists,
11 specialty referral oriented, that could be an issue.

12 My last comment would be on Medicare Advantage.
13 I think excluding Medicare Advantage in this calculation is
14 a mistake because, frankly, if you can get systems that are
15 taking risk in Medicare Advantage, that will benefit the
16 traditional Medicare population, anyway, because the
17 programs that are put together in Medicare risk usually are
18 applied to the traditional Medicare population as well. So
19 I would just encourage us to think about, as we think about
20 the calculation of 50 or 75 percent, especially in areas
21 that have tremendous Medicare Advantage penetration. I
22 think that's something that should be a consideration.

1 MR. GLASS: There's just one issue on that.
2 People have pointed out that, but the Medicare Advantage
3 plan would also have to be paying on something other than
4 straight fee-for-service to be counted.

5 MR. THOMAS: Right. So my comment would be only
6 include Medicare Advantage if the provider is taking risk,
7 you know, global payment or some type of model like that,
8 or some type of risk arrangement around global payment in
9 Medicare Advantage, not a fee-for-service arrangement
10 through Medicare Advantage. So I would just -- I would
11 think about if they were in a risk or partial risk
12 arrangement with the MA plan.

13 DR. CROSSON: Okay, thanks.

14 DR. HALL: So I think I'm starting to get it now.
15 I'd like to just put this into context of what I know of
16 MedPAC and some of our recent and not so recent history.

17 For the last 15 years or so, a recurrent theme
18 and emphasis in MedPAC among all the other things is that
19 we were trying to do something about SGR. And we finally
20 did it. We finally were able to contribute to finding a
21 way to repeal SGR. But remember, at the time we did that,
22 we put together kind of a manifesto of -- some of it looked

1 at pay-fors, but the other said what is our dream, and the
2 dream, I think, in that document was that we were not going
3 to be prejudicial per se against fee-for-service, but we
4 thought the only way that we could move forward eventually
5 throughout the country was probably to incentivize people
6 to move from fee-for-service to be more in aggregate groups
7 as much as possible.

8 And so MedPAC suggested the incentive plan,
9 right? That we were going to -- the pay-for included a
10 reduction over a number of years for specialists and a
11 slight payment update for primary care physicians, with the
12 idea being that we would make the environment much more
13 attractive to physicians to think about being in organized
14 systems.

15 Now, I don't think the discussion that we're
16 having now was very much different than 15 years ago when
17 people said Medicare Advantage, that sounds like communism,
18 or what's going on here? It was new.

19 So what we're now doing is continuing this
20 process that maybe we had some role in establishing, and
21 that is to say, it looks good on paper, but the
22 complexities involved are just absolutely enormous and

1 mind-boggling to change physician behavior by mandate.

2 So I look upon this as a further step in looking
3 at models -- ACOs were one of those models, and this is in
4 a sense another one -- with the laudable goals of trying to
5 reduce complexity, that look at quality, access to care,
6 all the things that have been mantras for us for a long
7 period of time.

8 So my feeling is that we can of most help to CMS
9 and to anyone else who is listening to us -- and this
10 discussion has been rich in that environment, and we look
11 at this as another progression and just an experiment,
12 really, to see how we're going to move to the Holy Grail,
13 which is a unified payment system that meets a lot of the
14 goals that are important to our beneficiaries.

15 So we might be able to be of most help to CMS if
16 the distillate of the conversation we've had today and at
17 future meetings would really point out what have we
18 possibly learned from our own experience in looking at how
19 you implement models that alter the payment systems for
20 physicians, and out of that we might be able to distill,
21 you know, 12 or 20 or whatever number of principles that
22 CMS should take into account before we launch into

1 something else and find out that we were doomed to failure
2 by virtue of not thinking about our ultimate goal.

3 So I think we're on the right path. I just don't
4 know where it's heading right now.

5 DR. CROSSON: Did Yogi Berra say that?

6 [Laughter.]

7 [Comments off microphone.]

8 DR. HOADLEY: So I don't want to repeat some of
9 the kinds of themes that people have already talked about,
10 but I wanted to mention three that I really haven't heard
11 come up so specifically. One is along the same lines of
12 clarity and complexity. One of the things I worry about is
13 we'll get to a point where the clinician is going to look
14 at this and not really know whether they're going to end up
15 being eligible for this or not. And so I can see some
16 paths by which that wouldn't be a problem, so I just think
17 that's something to keep in mind, is to make sure that the
18 people who are affected financially by this can understand
19 -- it goes back to those discussions about can I choose to
20 be in or out and are these things that are kind of passive.

21 The second point is sort of where the beneficiary
22 fits into all of this, and in some ways, the best outcome

1 might be if the beneficiary doesn't have to know that any
2 of this is going on except maybe their care is getting
3 better and they're getting better quality or something like
4 that. But I think that -- I'd like to make sure as we talk
5 about things like the Option 3 where the beneficiary would
6 only be in one of these things, are we now talking about
7 same discussion we've had in the past about ACOs? Are we
8 talking about something where the beneficiary now needs to
9 enroll or accept or, you know, something? And that could
10 be very confusing. So we just need to make sure, again,
11 it's going to be clear to -- and whether there's any
12 financial impact to the beneficiary. I assume that they
13 don't pay because these extra payments are just over and
14 above the physician, they're not linked to particular
15 beneficiaries, that that's not going to affect co-
16 insurance. So that part's okay.

17 MR. GLASS: Until they get to having different
18 updates.

19 DR. HOADLEY: On the underlying fees, right. So,
20 I mean, just trying -- making sure we're thinking about
21 whatever impact or lack of impact there is on beneficiary.

22 And, third -- and I know you said somewhere in

1 the paper that you're going to come back to us with more
2 about whether and how drugs might fit into this, and
3 obviously to link that to this morning's discussion.
4 That's a big part of what we're hoping the clinicians are
5 paying more attention to, is the prescribing. And so I
6 look forward to that future topic.

7 DR. MILLER: I'm trying to track on a couple of
8 things that are happening in the room. I could take some
9 of your comments as -- and you didn't say this; this is why
10 I'm trying to tease it out of you, you know, particularly
11 if you want to make sure that there's a connection to the
12 beneficiary, and then you threw drugs in at the end. Could
13 I be interpreting that as bigger versus smaller in terms of
14 what the model looks like, that you're looking for more of
15 a population base to this, or not?

16 DR. HOADLEY: I'm not going that far. I'm just
17 trying to say these are implications that I want to
18 understand to be able to make that judgment at some point
19 in the future.

20 DR. MILLER: I just wanted to [off microphone].

21 DR. NERENZ: Let me emphasize a little bit, but
22 let me start with the idea of the policy goal and take it

1 in a particular direction.

2 The thing was passed presumably to encourage
3 people into alternative payment models, and my signal for
4 that is this 5 percent feature of that track. That seems
5 to be a reason -- it signals to me that that was the
6 desired track.

7 Because it's structured as a two-track system --
8 and at least so far I don't see any choice element to it.
9 If you qualify for APM, you are in APM. That's your -- but
10 that's my --

11 DR. BAICKER: [off microphone].

12 DR. NERENZ: Okay. So the way the regs are
13 written is going to strongly determine how many physicians
14 end up in one track or another. In fact, they almost
15 entirely determine it. I can see even within the language
16 in the legislation regulations being written so it's
17 relatively easy to be in the APM track. A lot of doctors
18 in the APM track, 5 percent bonus. But I could also see
19 the regulations being written so it's really hard to be in
20 that track. Very few in that track, everybody in the MIPS
21 track. So it just seems like it's going to make a lot of
22 difference, and that balance as a desired endpoint would be

1 something it would seem like we would want to talk about.

2 Now, then the fine point within that -- and,
3 Mark, you mentioned it in your example and, Kate, you
4 mentioned it. The APM characteristics are described here
5 at the level of the entity or the program. They're not
6 described at the level of the way the payment is
7 experienced by the individual clinician.

8 So we could end up in a situation where a lot of
9 physicians are in the APM track getting the 5 percent
10 bonus, but almost every single dollar they get is an
11 absolutely traditional, utterly unchanged, unvarnished fee-
12 for-service dollar like nothing ever changed. And to me
13 that's not a desirable end result of that, that I would
14 then suggest that as this moves forward, whether it's our
15 opinion, in the regulations, whatnot, to the extent
16 possible, given the language, this should be about
17 alternative payment as experienced by the physician, not
18 necessarily as a characteristic of the program.

19 Now, how exactly to do that is not so clear, but
20 somehow this ought to be moving in the direction of
21 meaningful, direct-to-the-physician alternative payment if
22 that indeed is the policy goal.

1 DR. CROSSON: I mean, I -- you may want to
2 comment. I mean, I think the inclusion of the criteria for
3 substantial risk seems like it wouldn't work -- right? --
4 unless that was somehow translated down to the physicians.

5 DR. NERENZ: Well, two things. At least the
6 language in our chapter does not say that, but maybe it's
7 hidden. But, also, we have programs right now that are
8 being described as alternative payment, pay for value, with
9 percent up-down in the range of a half percent, 1 percent,
10 2 percent. And if those count and then you qualify for a 5
11 percent up, then I think we ought to have a question: Is
12 that a good idea?

13 DR. CROSSON: Or is that substantial risk?

14 DR. NERENZ: Or is that what Congress wanted to
15 do?

16 DR. CROSSON: Right, exactly. Okay. All right.
17 Cori?

18 DR. MILLER: Do you want --

19 DR. CROSSON: I'm sorry. Miss somebody?

20 DR. MILLER: I couldn't tell whether I was
21 getting -- I mean, another way to say this -- and I'm
22 trying to pick up on your point of this dollar could move

1 through in a way and it could feel just like business as
2 usual, even though I'm in an APM. I mean, if you had
3 defined risk very not aggressively -- I couldn't come up
4 with the right word at that -- very nominal risk, and if
5 the APM was not successful at either containing costs or
6 improving quality or those types of things, but 75 percent
7 of your revenue came through it, quote-unquote, you would
8 be getting the 5 percent. And I think you're saying, wait
9 a second -- and it's been said over here, too, like wasn't
10 the point that there should be some connection between
11 performance and that extra money. And I feel like I'm
12 hearing that in a couple of different places around the
13 table, and I'm just saying it out loud to make sure, and
14 make sure that the rest of the world is hearing it.

15 I'm sorry, Jay.

16 MS. UCCELLO: So I wonder if -- I can't even
17 speak. You get 5 percent, you get 5 percent.

18 [Laughter.]

19 MS. UCCELLO: I'm wondering about if a concern
20 here of setting the criteria too aggressively and making
21 this APM very much modeled on an ACO where they would be
22 the only ones who would be able to meet the criteria, you

1 know, what that means in terms of geographic issues. You
2 know, we have had presentations in the past that show, you
3 know, ACOs -- comparing ACOs, MA, and fee-for-service in
4 different areas, and whether this would be disadvantaging
5 providers in particular areas. And I think we would still
6 -- even in low spending fee-for-service areas, I think
7 there's still room for better coordination and that kind of
8 thing, and we would want to encourage providers in those
9 areas to also be moving toward those kinds of models. So I
10 think, you know, we don't want to set these criteria so
11 rigorously that that wouldn't be -- wouldn't happen.

12 DR. COOMBS: So I think of all the thoughts that
13 I had today, I think Mary's on clarity is really important.
14 And the attempt of MACRA to find a pay-for for the SGR is
15 an important piece of this whole conundrum of whether or
16 not MA plans should be included or not.

17 For me, I think the most important thing, putting
18 my physician hat on, is transition, and as a part of the
19 Massachusetts Payment Reform Commission, what we found was
20 that if you were able to address the infrastructure changes
21 that were necessary for physicians to go into global
22 payment, then you made a big difference. And physicians'

1 greatest concern was, Do I have the infrastructure to
2 compete? And when you're in an APM, there are certain
3 things that are going to be required.

4 This whole notion of being able to flow free in
5 and out of an MA plan as an individual provider is not that
6 simple, and I think we're forgetting that, you know, the
7 physician doesn't -- the clinician doesn't wake up one day
8 and say, "I'm going to be part of the MA plan." It doesn't
9 happen like that. And in many areas, it's actually
10 restrictive, and it may be restricted because there's
11 certain requirements of the MA plan for providers to enter
12 in. So I think it is a fallacy for us to assume that
13 providers can just float in and out of MA plans.

14 Isn't it true that we want the fee-for-service to
15 be more coordinated care? Isn't it what we want, we want
16 to be able to allow the transition of providers to go into
17 a more robust integrated health care delivery system? So
18 why wouldn't we address the transition?

19 So I don't think that we can have this
20 conversation without talking about the transition of the
21 workforce. And that being said, I was very concerned -- I
22 mean, Herb said something about the vulnerability in

1 geographic regions, and it is really true. We have the
2 data from the Pioneer ACOs and how many dropped out. That
3 should be evidence about the risks taken, what providers
4 are willing to take risks. And so there was a lot that
5 stayed in the shared savings, but what about the Pioneer
6 ACOs as an example to us looking at what the workforce will
7 be willing to do in terms of signals?

8 So I think for us to deal with the transition, to
9 look at not just, you know, the workforce, but also the
10 beneficiary and access in those areas where workforces are
11 challenged for fee-for-service. And I think this whole
12 notion of bullets as to clarity of where we want to go in
13 terms of objectives and then how do you actually transition
14 to a different state is really important for providers.

15 DR. CROSSON: Alice, let me ask you one question
16 I thought of as you were talking. So you've been through
17 the alternative quality contract process in Massachusetts.
18 Would you suggest that there may be some lessons that we
19 could learn from that, that we should look at that as part
20 of these considerations?

21 DR. COOMBS: I think there's a whole packet
22 that's on the website on the Payment Reform Commission's

1 final report, but what we had to actually look at is this
2 whole notion of carrots and sticks and where do you go with
3 that. And to be honest with you, the benchmarks that have
4 been achieved with the transition to global payment have
5 been rather satisfying, and it had a lot to do with being
6 able to have multi-stake involvement and actually work with
7 the providers on this whole notion of infrastructure,
8 because they needed to have really robust eHR systems. And
9 then as a part of the MIPS, don't forget there's resource
10 utilization. I mean, you've got to be able to grab that
11 data from your panel. You've got to be able to say, okay,
12 am I shovel-ready for this? Can I fit into this kind of
13 setup or this model? And I think that was really helpful,
14 just the tool set of being able to provide providers with
15 what they need to say, "I can compete." And I think the
16 transition is really important.

17 I'm just thinking about, you know, just the
18 physician and the nurse practitioners, their part that they
19 play. And you know what? We could have a consequence
20 whereby we have titration, small changes with access in
21 regional areas where someone says, okay, I got a 0 percent
22 update, I'm in the MIPS class, I got the sequester

1 affecting me, I also have the low-value service penalties
2 redistribution, and I have a bunch of other things that I
3 have at work, I'm going to make a decision that really will
4 affect a group of small community in terms of access for a
5 small community beneficiaries.

6 DR. SAMITT: So I think most of the important
7 things that need to be said have been said, but I would add
8 just two comments.

9 My sense to Bill Hall's comment earlier is the
10 intent of this whole model if we go back is to encourage
11 and reward clinicians to deliver care in models that will
12 most likely deliver on the promise of the Triple Aim. I
13 think that was the intent here, that we believe that
14 Medicare Advantage and perhaps ACO models are more likely
15 to deliver on that promise, and so we want to encourage and
16 reward movement in that direction.

17 So based upon that concept, I would have two
18 concerns about the APM program. I think that the APM
19 funnel needs to be more selective, that if we're going to
20 award the 5 percent bonus to APM alternatives that don't
21 move us any further in the direction of the Triple Aim,
22 then I would say that those should not count as APMs. You

1 know, just to give them the reward to sort of get them out
2 of their fee-for-service comfort zone, I don't think that's
3 enough. I think it needs to hold the promise of better
4 care at a lower cost. So I think the funnel should be very
5 selective and that we should be careful about which types
6 of models or organizations meet that criteria.

7 But, also, I'm a little worried and want to know
8 more about MIPS, because this 9 percent -- you know, if I
9 can achieve the 9 percent in an environment where I also am
10 not furthering the principles of population health, then
11 why would I become part of an APM?

12 So I think that the whole notion is that there
13 need to be consequences and implications to stay in fee-
14 for-service for those who aren't delivering better care,
15 better outcomes. And so I think we also have to be very
16 careful of the criteria that quantify those that will get
17 bonuses and those that will lose revenue in the MIPS space.
18 That requires very careful consideration.

19 And then the third quick thing that I would add
20 that I mentioned quickly earlier is that I don't think it
21 should be just A and B. If it is all accountability, it
22 should be D as well for the reasons we described earlier,

1 that accountability is going to also be including the costs
2 of drugs.

3 DR. CROSSON: Last word, Kathy.

4 MS. BUTO: Okay. So really two quick points.
5 One is I guess a feeling that although this is the
6 replacement for SGR, it really does not address the issue
7 that we've all looked at, which is the disparity, if you
8 will, between primary care and specialty care. It does
9 nothing about that. In fact, might make it worse because
10 it takes the attention off of that issue to me and really
11 focuses more on the update factor.

12 And so the way I looked at this -- and it almost
13 seems more like an alternative update model than an
14 alternative payment model, and maybe I'm missing something,
15 but I think we had talked about having a per beneficiary
16 primary care amount for the add-on for managing primary
17 care, but ultimately, you know, does this model -- I guess
18 it's an open question -- allow for the possibility of
19 really developing an alternative payment system for primary
20 care that focuses on more of a per beneficiary kind of
21 focus, because to me that's more of an alternative payment
22 model, and continuing to pay fee-for-service only under

1 different rules for how you measure, you know, who has made
2 or hasn't made their payment targets is much more focused
3 on fundamentally trying to change the way we pay.

4 DR. CROSSON: Thank you. You know, our policy on
5 incenting more equity in payment for primary care is still
6 on the table, but your point here, which is to think
7 through whether or not there's anything in this, in the
8 regulations as they're written, that could help augment a
9 solution to that problem is a good one. Thank you.

10 Okay. This is an initial look, and sometimes
11 those initial looks are pretty messy. This one was in that
12 category, but extremely helpful, a lot of good ideas, and I
13 think for Mark and the staff now, their job is to take
14 these ideas, to use Bill Hall's term, distill them down to
15 some choices that we can start talking about, do this, do
16 that, do this or do that. And we'll be looking forward to
17 that discussion. Thanks very much.

18 [Pause.]

19 DR. CROSSON: Okay. Andy, you're going to talk
20 to us about the health risk assessment and its impact on
21 coding adjustments and make some recommendations, so go
22 ahead.

1 DR. JOHNSON: All right. Good afternoon. In
2 this session, I will present the results of analyses
3 examining the use of health risk assessments in Medicare
4 Advantage and will discuss options for addressing
5 differences in diagnostic coding intensity between Medicare
6 fee-for-service and MA.

7 Yes?

8 DR. MILLER: Andy, pull the microphone just a
9 little bit closer.

10 DR. JOHNSON: Sure.

11 In this presentation, we will first review
12 background information about health risk assessments and
13 the Medicare Advantage risk adjustment model. Next, I will
14 discuss our findings about diagnoses identified using
15 health risk assessments and their impact on payments to MA
16 plans. Finally, we will discuss how health risk
17 assessments affect differences in diagnostic coding between
18 Medicare fee-for-service and MA, and will consider options
19 for addressing the impact of overall diagnostic coding
20 differences.

21 Health risk assessments are a preventative care
22 tool used to identify health risks and evaluate patients

1 for the presence of disease or disability. Once a
2 patient's health has been assessed, patients may receive
3 counseling about relevant health risks and referrals for
4 follow-up care. This process can improve patient
5 engagement in health decision-making. The Patient
6 Protection and Affordable Care Act required that a health
7 risk assessment be administered as part of Medicare's
8 annual wellness visit, which is available to all Medicare
9 beneficiaries.

10 In MA, most health risk assessments are
11 administered during a visit to an enrollee's home. These
12 home visits typically last about an hour and may include
13 reviewing a patient's self-reported medical history,
14 measuring vital signs, conducting blood or urine tests,
15 reviewing medications, and assessing the risks present in
16 an enrollee's home.

17 In-home visits are frequently initiated by MA
18 organizations, either through a third-party vendor or their
19 own home visit program. In recent years, the number of
20 assessments administered in enrollees' homes has been
21 increasing.

22 In your mailing material, I described several

1 examples of the increase in the number of home visits and
2 the expansion of related entities. Here I will cite the
3 example of one home visit vendor that over the past 3 years
4 increased the average number of home visits provided per
5 day from over 1,300 to over 1,800. This vendor also cites
6 current capability at up to 2,500 home visits per day.

7 Next, we will review MA risk adjustment. CMS
8 pays health plans in MA a capitated rate for each enrollee.
9 This rate is adjusted so that MA organizations receive a
10 greater payment for enrollees who are expected to be more
11 costly. These adjustments are made through the CMS
12 hierarchical condition category, or HCC model. This model
13 includes enrollee demographic information and also includes
14 diagnosis codes, which are grouped into HCCs.

15 In order to support accuracy and integrity, HCCs
16 are selected for inclusion in the model, in part based on
17 their ability to predict medical expenditures, and on their
18 clinical meaningfulness and specificity, so that
19 inappropriate manipulation or discretionary coding is
20 minimized.

21 For payment purposes, each demographic component
22 and HCC is associated with an expected amount of Medicare

1 spending. The Medicare payment rate for an enrollee equals
2 the sum of the expected spending amounts for all relevant
3 components relevant for that enrollee.

4 For example, annual Medicare payment for an 84-
5 year-old male with congestive heart failure would have been
6 about \$7,800 in 2013. This total is comprised of about
7 \$4,700 for demographic characteristics and about \$3,100 for
8 congestive heart failure. If this enrollee was found also
9 to have polyneuropathy, Medicare payment would have
10 increased by about \$2,900, for a total of approximately
11 \$10,700.

12 For each of the 70 HCCs in the 2013 risk
13 adjustment model, this figure shows the increase in annual
14 Medicare payment to an MA organization for the first
15 identification of a given HCC during the data collection
16 year, which was 2012. For the example I just presented,
17 annual payment for congestive heart failure and
18 polyneuropathy are highlighted in yellow in the figure.
19 This figure also shows that annual payment for about two-
20 thirds of HCCs was between 1- and \$5,000, while payment for
21 other HCCs was several thousand dollars higher.

22 Next, I will present our analysis of health risk

1 assessments in MA using encounter data for 2012, the first
2 year encounter data were collected.

3 First, I identified encounters with a health risk
4 assessment based on three HCPCS codes, two for an annual
5 wellness visit and one specifically for the administration
6 of a health risk assessment. However, we became aware that
7 other HCPCS codes were used for health risk assessment
8 encounters. For example, certain MA contacts known to have
9 a home assessment program in 2012 did not have any
10 encounters with these HCPCS codes. Given that this
11 analysis would have underestimated the use of health risk
12 assessments in MA, we added to the analysis encounters that
13 took place in an enrollees' homes for evaluation and
14 management, or E&M services.

15 In each analysis, we focused on HCCs that were
16 identified only through a health risk assessment or only
17 through a home E&M visit. In other words, these HCCs were
18 not identified on any other physician or other health
19 professional, inpatient, or outpatient encounter that was
20 used for risk adjustment.

21 In the first round of analysis, shown in the
22 center column, we found that 1.4 million health risk

1 assessments were administered to 1.2 million MA enrollees
2 in 2012. From these assessments, we identified nearly
3 200,000 HCCs that were found only on health risk assessment
4 encounters. These assessment-only HCCs included all 70
5 HCCs in the risk adjustment model and were associated with
6 Medicare payments of \$602 million in payment year 2013.

7 In the second round of analysis, shown in the
8 right-hand column, we found that 2.3 million health risk
9 assessments and home E&M visits took place in 2012, and 1.7
10 million MA enrollees received one of these assessments or
11 home visits. In this analysis, nearly 750,000 unique HCCs
12 were identified only on a health risk assessment or home
13 E&M visit encounter. These assessment- or home visit-only
14 HCCs were associated with Medicare payments of \$2.3
15 billion in payment year 2013.

16 Furthermore, we found significant variation
17 across MA contracts in the number of HCCs identified only
18 through a health risk assessment or home E&M visit. For
19 each HMO and PPO contract, this figure shows the amount of
20 Medicare payment per enrollee generated by assessment- or
21 home visit-only HCCs.

22 As you can see on the right side of the figure,

1 the largest increases in Medicare payment from assessment-
2 or home visit-only HCCs was highly concentrated among a
3 small number of MA contracts in 2012.

4 Eleven contracts, with a combined enrollment of
5 about 385,000 enrollees, generated Medicare payments of
6 \$1,000 or more per enrollee from assessment- or home visit-
7 only HCCs.

8 Please note that this number of contracts and
9 enrollees is a correction from the figures in your mailing
10 material. Although it is hard to see in this figure, 86
11 percent of contracts generated some Medicare payment from
12 assessment- or home visit-only HCCs. This suggests that
13 many MA contracts have the potential to increase the amount
14 of Medicare payment generated from these sources.

15 Our review and analysis of health risk
16 assessments in MA generate some concerns about their use in
17 risk adjustment. As mentioned earlier, the accuracy of
18 Medicare payments in covering the cost of treating an MA
19 enrollee's conditions is supported by the HCCs' clinical
20 meaningfulness and their ability to predict medical
21 expenditures.

22 We noted that health risk assessments often rely

1 on patients' self-report of medical conditions.
2 Allegations from two whistleblower lawsuits also raised
3 concern about the accuracy of diagnoses identified during
4 some home assessments. These lawsuits cite a reliance on
5 patient recollection, medications, and tests using limited
6 equipment. Concerns are even greater for HCCs identified
7 only through assessments or home visits because these HCCs
8 lack a corroborating medical encounter from which the
9 presence of the HCC could be confirmed.

10 We learned about other aspects of MA home visits
11 from focus groups we conducted in three cities across the
12 country. Every year, we conduct focus groups with
13 Medicare beneficiaries and primary care physicians
14 addressing access to care, coverage choices, and the
15 organization of care.

16 This year, MA home assessment visits came up
17 during the first focus group, and we asked subsequent
18 groups about their experience. Although the sample of MA
19 enrollees was small, nearly all had received a phone call
20 offering an in-home visit. Roughly half of these enrollees
21 accepted the offer and most appreciated the hour-long
22 discussion with a nurse about their health. The other half

1 said they were annoyed by persistent phone calls offering
2 an in-home visit. Some enrollees who declined the home
3 visit offer said they were uncomfortable with the idea of a
4 nurse visiting their home.

5 Several enrollees said they were offered gift
6 cards for \$25 or more as an incentive to receive a home
7 visit. Primary care physicians said they generally
8 received reports from home visits for some of their
9 patients. They found the reports mostly unhelpful because
10 they were too lengthy or contained information that was
11 either already known or lacked context in their patient's
12 current care. Some primary care physicians said they spent
13 time ruling out diagnoses that were incorrectly identified
14 during a home visit and addressing their patient's
15 subsequent concern or confusion.

16 We are now going to discuss overall differences
17 in diagnostic coding intensity. Compared to Medicare fee-
18 for-service, the risk adjustment model creates is a greater
19 incentive to identify and report diagnoses in MA. As a
20 result, enrollees of equivalent health status have higher
21 risk scores and therefore generate higher Medicare payments
22 when enrolled in MA.

1 Health risk assessments are only one possible
2 source of diagnostic coding differences between the two
3 programs. As reported earlier this spring, we estimated
4 that 2013 MA risk scores were about 8 percent higher than
5 fee-for-service as a result of faster MA risk score growth.
6 These results are consistent with other research in finding
7 that this faster growth is due to differences in diagnostic
8 coding intensity.

9 For example, Kronick and Welch estimated that MA
10 risk scores in 2013 were 9 percent higher than fee-for-
11 service as a result of diagnostic coding differences.
12 Their paper also showed that the impact of coding
13 differences varied across MA contracts. Other recent
14 research showed similar variation by plan type.

15 To adjust for differences in coding intensity,
16 CMS reduces all MA payments by a single factor. Since
17 2014, a minimum adjustment size has been mandated. For
18 2016, MA will reduce all MA payments by the statutory
19 minimum, 5.41 percent.

20 Furthermore, in 2014, CMS began phasing in a
21 version of the risk adjustment model that removed certain
22 diagnosis codes for which different coding rates were found

1 between fee-for-service and MA.

2 Researchers have estimated that the removal of
3 these diagnosis codes would reduce differences in risk
4 score growth rates by about 30 percent. For 2016, MA
5 payment will be based fully on the model with some
6 diagnosis codes removed.

7 Finally, CMS has twice proposed excluding from MA
8 risk adjustment, diagnoses identified through a health risk
9 assessment or a home visit. CMS did not implement either
10 proposal. Instead, CMS required MA organizations to flag
11 diagnoses identified through a home assessment starting in
12 2014 and is tracking these diagnoses to see if follow-up
13 care is being provided.

14 For 2016, CMS issued guidance on best practices
15 for providing in-home health risk assessments.

16 Although CMS's policies help, they do not address
17 the full impact of coding intensity differences. MA risk
18 scores in 2016 will be higher than fee-for-service by the
19 amount estimated for 2013, which was approximately 8 or 9
20 percent, plus three additional years of accumulated impact.
21 We believe that the total impact on MA risk scores in 2016
22 will be larger than the combined effect of CMS's

1 adjustments.

2 We are now going to discuss two options CMS could
3 implement to address coding intensity differences. In
4 option one, health risk assessments will continue to be
5 provided to MA enrollees when they are valuable as a tool
6 for prevention or care planning, or when provided as part
7 of a Medicare's annual wellness visit. However, diagnoses
8 identified through any health risk assessment would not be
9 used for risk adjustment.

10 To the extent that new conditions requiring
11 follow-up care are identified through health risk
12 assessments, those diagnoses will be identified and
13 included in risk adjustment calculations when subsequent
14 treatment is provided. This option only affects diagnoses
15 identified through a health risk assessment that are not
16 identified on any other encounter used for risk adjustment.

17 In order to maintain parity between risk
18 adjustment data sources, this option would exclude health
19 risk assessment-based diagnoses from the risk adjustment
20 model for both Medicare fee-for-service and MA.

21 Finally, this option would adjust for diagnostic
22 coding differences in a way that is equitable across MA

1 contracts. In other words, MA contracts with many
2 assessment-only HCCs would have a larger effective
3 adjustment, while MA contracts with no assessment-only HCCs
4 would have no effective adjustment.

5 A second option for addressing differences in
6 coding intensity is to use two years of fee-for-service
7 diagnostic data to estimate the risk adjustment model and
8 two years of MA diagnostic data to calculate MA risk
9 scores. Currently, only one year of each is used in risk
10 adjustment.

11 HCCs generally identify chronic conditions. Thus,
12 changes in HCC identification from one year to the next are
13 more likely due to variation in coding than changes in
14 condition status.

15 In MedPAC's June 2012 report, we showed that some
16 proportion of both MA and fee-for-service beneficiaries who
17 had a chronic condition identified in 2007 did not have the
18 same condition identified in 2008. These year-to-year
19 differences varied significantly across HCCs.

20 Our preliminary analysis of using two years of
21 data for risk adjustment shows that this option would
22 reduce the impact of diagnostic coding differences between

1 fee-for-service and MA. Furthermore, this option would
2 naturally target HCCs with inconsistent coding across years
3 or with more difference between fee-for-service and MA
4 coding rates. Therefore, we believe that this option
5 adjusts for coding differences in a way that improves
6 equitability across MA plans.

7 Options 1 and 2 can be implemented
8 simultaneously, but there is no guarantee that, together,
9 these options would address the full impact of coding
10 differences between fee-for-service and MA. A single
11 adjustment factor may still be needed to address the
12 remaining difference in coding intensity. This remaining
13 difference, however, would be much smaller than the current
14 difference, and overall equity across MA contracts would be
15 improved.

16 Implementing options 1 and 2, along with a single
17 adjustment factor, has the potential to address the full
18 impact of coding a difference in a way that improves the
19 quality and consistency of diagnostic data used for risk
20 adjustment.

21 I am now happy to take your questions, and I look
22 forward to hearing your discussion. Thank you.

1 DR. CROSSON: Thank you very much, Andy.

2 We will start the discussion of clarifying
3 questions, and I am going to do one. And I hope I don't
4 violate my own standard here.

5 But with respect to Option number 1, a lot of the
6 build-up had to do with the issue of home visits as a site
7 for the health risk assessment. In the proposal, you have
8 made the choice to exclude diagnoses from health risk
9 assessments entirely, not just those done in the home
10 setting. And could you talk a little bit about that choice
11 and the reasons for that and the pros and cons or whatever?

12 DR. JOHNSON: Sure. I think there are probably
13 two factors that play heavily, and that is that if a home
14 assessment is provided in the home or provided in a clinic
15 and the same visit takes place in which there's an
16 assessment identifying diagnoses codes and then that's it,
17 no other services are provided, I think that those codes
18 have equal or lack -- they both lack value in the in the
19 risk adjustment model.

20 The second is that if excluding diagnosis codes
21 only from home health risk assessments was implemented, I
22 think that there would probably be some change in location,

1 whether it be to retail health clinics or new clinics being
2 set up in order to conduct the same types of visits, just
3 in a different location.

4 DR. CROSSON: Right. Okay.

5 Let's take clarifying questions. Cori.

6 MS. UCCELLO: So I've already asked you this, but
7 I want to ask you again. So on slide 10, it shows kind of
8 this distribution across contracts and shows that it seems
9 to be concentrated in a smaller share of contracts, that
10 the large numbers of the home-only HCCs. So for those who
11 are more on the left-hand side who don't have a lot of
12 home-only HCCs, do they still conduct a lot of home risk
13 assessments and have codes for those, but the codes show
14 somewhere else, so they wouldn't be the home-only, HRA-only
15 HCCs?

16 DR. JOHNSON: So, I think there are a couple
17 different points there. One is that the majority of all
18 contracts had some risk assessments for some of their
19 enrollees. The variation in the proportion of enrollees
20 who received them was different across the contracts, but
21 most were providing some health risk assessments. In some
22 of the contracts, there were many more HCCs identified in

1 total, and depending on the contract, some of them were
2 health risk assessment only HCCs and some of them had more
3 HCCs identified on this assessment, but also identified on
4 another encounter.

5 So, there were sort of three groups, I guess.
6 One that had provided health risk assessments but didn't
7 have many HCCs identified, others that had a lot of HCCs
8 identified and a lot of health risk assessment -- or,
9 excuse me, assessment only HCCs identified, and others that
10 were sort of in the middle and that they were identifying a
11 lot of HCCs, but not many of those were only identified on
12 an assessment.

13 DR. CROSSON: Clarifying questions. All right.
14 I need to do this -- sorry -- I have got to do it in order.
15 So, Bill, we will start with you.

16 DR. HALL: I was intrigued by your finding that
17 when you look at home visits in the MA programs, that over
18 half of the people refuse a home visit even when they're
19 being paid. That's very counterintuitive to the human
20 nature. Do you have anything more to add to that?

21 DR. JOHNSON: From the focus groups -- again,
22 that was a small sample. I think the attitudes toward the

1 home visits were pretty clear in that some people just
2 didn't like the idea of somebody coming into their home.
3 That was roughly half the group sort of had an opinion
4 along those lines. Others thought it was fine and thought
5 it was nice to spend an hour with somebody, which is longer
6 -- it was noted that that was longer than a typical
7 physician visit in the office.

8 I don't know that there are any specific numbers
9 about the number of people who are offered a visit who end
10 up getting a visit in total, but from all background
11 sources, it seems to be roughly equal.

12 DR. HALL: I may want to say something about that
13 in round two. I have some ideas.

14 DR. MILLER: I just want to make sure, from the
15 public's point of view, again, that number, the half
16 refused, very small focus group, couple of communities,
17 just in terms of the breadth of that data.

18 DR. HALL: I think it's a pretty accurate number.

19 DR. CROSSON: Jack.

20 DR. HOADLEY: So, sort of following up on Cori's
21 question, are there -- so, back on Slide 10, are there
22 other patterns of which organizations were more likely

1 either to do the HRAs in general or specifically to do the
2 HRA only or the home only HCCs, in terms of types of plans,
3 geography, or anything like that?

4 DR. JOHNSON: Not that we were able to pull out
5 so far. There was a lot of variation, both across HMO and
6 PPO, across plan size, and we didn't get into any
7 geographic analysis quite yet.

8 DR. HOADLEY: You know, you kind of wonder if
9 there's funny behavior going on, in which case sometimes
10 we've seen that kind of thing very concentrated in types of
11 organizations or geography or something.

12 DR. CROSSON: Andy, along the same lines, you
13 don't have any way of knowing whether that right-hand size
14 of the curve are entities that subcontract this out in the
15 way that you described?

16 DR. JOHNSON: Not that I know of.

17 DR. HOADLEY: And my other question, on Slide 16,
18 when you talked about the earlier analysis using two years
19 of diagnostic data and lack of overlap, what was the
20 magnitude of the -- sort of, overall, what share of
21 diagnoses don't -- and some clearly shouldn't repeat --
22 somebody has a very acute condition that then is solved.

1 But, a lot of other things, maybe it just doesn't get
2 picked up because there's no acute sort of version of it.

3 DR. JOHNSON: Were you asking about the magnitude
4 of HCCs identified that were identified only in an
5 assessment versus those that were also identified
6 elsewhere?

7 DR. HOADLEY: I'm thinking really of the previous
8 analysis that said, just generally looking at diagnoses
9 that were in, you said, I think, 2006 or --

10 DR. JOHNSON: Oh --

11 DR. HOADLEY: -- versus seven, or seven versus
12 nine, or whatever the pair of years was.

13 DR. JOHNSON: Related to using two years of data?

14 DR. HOADLEY: Right.

15 DR. JOHNSON: There is some information about
16 specific HCCs in the June 2012 report about how many were
17 identified in 2007 and not identified in 2008. I don't
18 know -- we have some preliminary analysis using that data
19 that, I think, suggests that there is an effect happening
20 from using two years of data, but we're working on some
21 updated analysis, I think, that would provide a more
22 specific number using current data.

1 DR. HOADLEY: It would be interesting to know how
2 much that varied between fee-for-service and MA and other
3 kinds of ways, because it might help us think about option
4 two.

5 DR. JOHNSON: Right.

6 DR. CROSSON: Kate, on this point?

7 DR. BAICKER: Yeah. My clarifying question is
8 very similar to this. Would you -- could you give us a
9 little more information about the frequency with which we
10 expect things to show up, and that affects my understanding
11 -- I was a little confused at points about whether the
12 analysis was focusing on HCCs that showed up only in a home
13 visit HSA, HRA, or whether they first showed up there and
14 then appeared later, because sometimes it said "new HCCs"
15 and sometimes it said "only there," and that made me
16 wonder, like, okay, if somebody has asthma and somebody
17 finds it on the home visit, would it -- if the person
18 really has asthma, would I expect it to show up on
19 subsequent claims or only on subsequent claims that related
20 to care delivered for asthma? And, so, I'm trying to
21 understand what we would expect and, therefore, what is a
22 warning sign about something that's showing up first at the

1 home visit and then not again for a while.

2 DR. JOHNSON: So, all of the analysis of HCCs
3 that we did just looked at HCCs identified only on a home
4 visit or a health risk assessment. So, some of those --
5 well, other HCCs were identified on a home visit and then
6 subsequently identified elsewhere as care may have been
7 given, and those were dropped from the analysis. So, that
8 is a good area for future research, to look at how often
9 that is happening. But --

10 DR. BAICKER: And I'm interested in knowing what
11 should be happening, in the sense of -- so, in some ways,
12 that could be a conservative thing to do if, then, say
13 you're diagnosed with asthma and I'm making all this
14 medicine up as usual, which is why people don't come to me
15 with their health complaints.

16 [Laughter.]

17 DR. BAICKER: Suppose you're identified with
18 asthma. Should, then -- routinely, is somebody going to
19 mark asthma on every time you're there, and, in fact, it's
20 no more real because it's marked the next time. It's just
21 that once it was flagged in your record, the provider sees,
22 oh, and yes, so-and-so has asthma and just checks it off

1 every single time. So, in some ways, then, excluding those
2 would be too conservative. Or, is it should asthma be
3 showing up then on the subsequent ones if the person really
4 has asthma? Is there information in the fact that it's
5 showing up later, or is it only showing up later if care is
6 being delivered for asthma?

7 DR. JOHNSON: I think that depends on what the
8 coding practices are of the subsequent providers, and I'm
9 not sure I have a good assessment of what is the
10 expectation between --

11 DR. REDBERG: A lot of medical records, once the
12 diagnosis is in, it will repeat, whether you add it there
13 or not. It's already in there. I mean, there are a lot of
14 things that show up on my patients I haven't put in there.

15 DR. BAICKER: So, that's why I'm trying to
16 understand what it means to show up only in the HRA visit.
17 Is that more about the system, where it should be auto-
18 populating and it's not, or is it about -- surely, if
19 somebody goes to the hospital for an asthma attack, it'll
20 show up there. But if somebody's just getting routine
21 care, what does it mean to have asthma showing up
22 subsequently on those records versus not? Is that about

1 whether the person really has asthma? Is it about the
2 system that's prepopulating or not prepopulating? Is it
3 about intensity of coding practices? I'm just not sure how
4 to interpret the subsequent appearances.

5 DR. CROSSON: Well, and a corollary question.
6 So, is this not showing up -- you know, so it's recorded in
7 the HRA and then it doesn't show up -- is that showing up
8 within that one claims year or is it any subsequent year?

9 DR. JOHNSON: This analysis is just for the 2012
10 calendar year. So, they had one health risk assessment, or
11 a number of health risk assessments that identified an HCC,
12 and any other time during that year, there was no --

13 DR. CROSSON: So, not showing up means within
14 that calendar year.

15 DR. JOHNSON: Correct.

16 DR. CROSSON: Okay. All right. I'm sorry.
17 Others, on this point. Alice?

18 DR. COOMBS: So, when you did the focus groups --
19 because I'm just kind of hung up where Bill is, and you get
20 a free gift certificate, you know, and you turn down the
21 gift certificate, did they say anything about having to go
22 to the office for an office visit in close proximity to the

1 HRA?

2 DR. JOHNSON: Umm --

3 DR. COOMBS: Did any of --

4 DR. JOHNSON: Not in direct connection from the
5 focus groups. Most just said, you know, I got a call. I
6 accepted. They sent a nurse to my house and it was offered
7 a gift card as part of this.

8 DR. COOMBS: But, they didn't complain about,
9 after they got the gift card, someone says, well, I suggest
10 you go and see this provider?

11 DR. JOHNSON: Not in the focus groups, no.

12 DR. COOMBS: Okay.

13 DR. CROSSON: Okay. We were marching up this
14 aisle here.

15 DR. CHRISTIANSON: Slide 10. Does that tell me
16 the same thing as knowing by plan what percentage of home
17 visits result in an additional diagnosis? Is that kind of
18 the same thing there?

19 DR. JOHNSON: You could get that information from
20 this slide in that if that additional diagnosis did not
21 show up anywhere else in the encounter data, then there
22 would be some payment related with that that shows up on

1 this.

2 DR. CHRISTIANSON: Yeah. The reason I ask is
3 I'm, as you were in the paper, struck by the concentration
4 of this and the sort of apparently inequitable approach to
5 penalize everybody for what seems to be the aberrant
6 behavior of a few. And, I was wondering if there were
7 other ways that would display that, maybe -- alternative
8 ways to display that from Slide 10, maybe, if you could
9 think about that for the future.

10 DR. JOHNSON: Yeah. I'll work on that.

11 DR. CROSSON: Clarifying. Rita.

12 DR. REDBERG: So, related to the gift cards, on
13 page six of the mailing materials, you have in the footnote
14 the explanation that they were not allowed to offer cash or
15 monetary rebates. So, I'm not clear. Are these gift cards
16 turned in for cash, and then isn't that a monetary rebate?

17 DR. JOHNSON: Apparently, part of the requirement
18 is that they are gift cards that cannot be redeemable for
19 cash. I'm not in a position to speak more about that.

20 DR. REDBERG: I just wonder what they would be
21 redeemable for. I mean, I could see a gift, perhaps, of
22 like a fresh --

1 DR. COOMBS: Starbucks.

2 [Simultaneous conversation.]

3 DR. REDBERG: Whatever it is, that's money,
4 right. I mean, give a fresh fruit basket or exercise
5 classes or something that encourages good health, but to
6 me, it seems that we are in direct contradiction of the CMS
7 rules here.

8 DR. JOHNSON: The only example that came from the
9 focus groups was that one of the people who were offered a
10 gift card said that it was for Walmart.

11 DR. REDBERG: Oh boy.

12 DR. CROSSON: Herb.

13 MR. KUHN: Two quick questions. One is, we're
14 only day eight into the conversion to ICD-10, but is there
15 any speculation whether the I-10 coding structure will
16 narrow the gap between fee-for-service and MA? Will it
17 exacerbate the gap? Or is there any speculation yet what
18 it might mean?

19 DR. JOHNSON: There isn't any that I know of. I
20 think that's something we'll have to look more into before
21 I speak to that.

22 MR. KUHN: And, the second question I had is a

1 little bit about on page 15, but I'm -- on that option one
2 -- but I'm curious, and correct me if I'm wrong here, but I
3 thought I read somewhere where this year when CMS issued
4 their call letter, they had a requirement in there that a
5 clinical issue identified in an HRA must be confirmed by
6 subsequent clinical encounter, but after comments, they
7 dropped it out. Is that correct?

8 DR. JOHNSON: In the advance notice for 2014,
9 they identified health risk assessments that did not have a
10 subsequent encounter. In 2015, they said that they had
11 spoken to some entities in the industry and said that most
12 of the assessments are happening at home, so they proposed
13 a slightly different policy of dropping diagnoses from home
14 visits. And both times, they dropped the proposal after
15 comments.

16 MR. KUHN: Thank you.

17 DR. CROSSON: Mary.

18 DR. NAYLOR: Very briefly. So, I wanted to --
19 Slide 15. When a health risk assessment is done as part of
20 the annual wellness visit, so the annual wellness visit is
21 usually comprehensive, and I'm wondering, isn't the
22 physical part and the labs that follow and so on -- I'm

1 just wondering what is the rationale for excluding
2 something that surfaces on an annual wellness visit for
3 which health risk assessment is a part.

4 DR. JOHNSON: My understanding is that the annual
5 wellness visit portion includes only the assessment of
6 health risks and that if other services are provided at the
7 same time, they can be identified separately as services
8 provided. So, if we were looking at encounters, I think
9 that would show up as two different HCPCS codes, one for an
10 annual wellness visit and one for whatever services were
11 provided subsequently.

12 DR. CROSSON: And just on that point, and then
13 the diagnoses would track to those -- would track
14 separately, is that right?

15 DR. JOHNSON: Correct, yeah.

16 DR. CROSSON: Scott.

17 MR. ARMSTRONG: Just, if you could go back to
18 Slide 10, that graph. I know -- I think I'm getting it
19 more, particularly listening to the other questions, but
20 this just presumes to the right is bad and to the left is
21 good, right? So, I'm just wondering, do we know which
22 plans there are, and are there five and four-and-a-half

1 star plans on the right end of that graph?

2 DR. JOHNSON: I have not done a comparison with
3 star ratings in place, but that's a good suggestion.

4 MR. ARMSTRONG: Great. Thanks.

5 DR. CROSSON: Okay. On this point, or just let
6 me finish down there. Warner.

7 MR. THOMAS: Just kind of a follow-up to Scott's
8 question. I mean, have we looked at -- I think we're
9 making an assumption here that home visits obviously drives
10 up risk scores, but we don't talk about the impact on other
11 costs. Do we look at, or have we looked at medical trend
12 of plans or members that have these home assessments to see
13 if there's any differential, because my -- I think we've
14 seen that in many of these, you end up catching or
15 identifying issues that, frankly, if they kind of were not
16 caught would lead into more hospitalizations, those types
17 of things. So, I didn't know if there was any data or any
18 assessment that's been done in that area.

19 DR. MILLER: In that circumstance, Warner,
20 wouldn't you also expect to see some other action -- not
21 hospitalization, but some other action on the diagnosis? I
22 mean, the phenomenon here is it shows -- again, as best as

1 we can estimate it -- the phenomenon here is that somebody
2 identifies something, and, you know, asthma was one thing
3 that was thrown on the table, and then nothing else happens
4 for the rest of the year. And I think one question is, is
5 that possible? Is there a condition where there wouldn't
6 be a follow-up?

7 Now, the question, I think, we have to
8 contemplate here is whether anything happens or not, in one
9 example, \$2,800 is added to the payment. The second is, if
10 they're identifying a condition and nothing else happens,
11 is that -- it's the reverse of that question. Isn't that
12 odd? And, I think, there's some clinical judgment involved
13 in this that makes it complicated. So, I just wanted to
14 get that out.

15 MR. THOMAS: And I think that's an absolute fair
16 assumption. I just -- I didn't know if there was, over
17 time, an impact or any sort of analysis on the medical cost
18 or trend of the different populations of patients and if
19 there's a difference.

20 DR. MILLER: And I think one of the other
21 complexities here, Andrew, in answering that question is,
22 this is the encounter data for which we have one year,

1 right, and, so, we're a bit stymied in thinking about your,
2 yeah, well, what about the trajectory, kind of question.

3 MR. THOMAS: And I guess the other question I
4 have, do we know of any -- are there any of the ACOs or
5 folks that are in alternative payment mechanisms -- to
6 bring that back -- that are using this model in those
7 different payment mechanisms and could that be something
8 that could be looked at, as well.

9 DR. JOHNSON: That's certainly something to look
10 into. I'm not sure what our ability is to do that, but
11 that's a good suggestion.

12 DR. MILLER: But, Andrew, this does go on in fee-
13 for-service, right?

14 DR. JOHNSON: In the ACO context, I think, yes.

15 DR. CROSSON: Okay. Clarifying -- sorry. Still
16 on clarifying?

17 DR. REDBERG: Just a comment on that.

18 DR. CROSSON: Yeah.

19 DR. REDBERG: Just looking, again, in the mailing
20 materials on page 13, Table 1, at the list of the diagnoses
21 that were identified by HRA, it does kind of raise
22 questions, you know.

1 DR. CROSSON: It seemed a little --

2 DR. REDBERG: Polyneuropathy was the most common

3 --

4 DR. CROSSON: -- a little creepy.

5 DR. REDBERG: That's a little, like, non-
6 specific. You can't really diagnose polyneuropathy, I
7 don't think, on a home visit, and a lot of people will --
8 various non-specific things that one could say.

9 DR. CROSSON: I agree.

10 DR. REDBERG: Vascular disease. They're just
11 kind of waste bucket, sort of.

12 DR. CROSSON: It's not like broken left arm.

13 DR. REDBERG: Yes.

14 [Laughter.]

15 DR. REDBERG: And they are things I would expect,
16 if they were really there, they would have follow-up.

17 DR. CROSSON: Okay. You thought that was a good
18 addition here.

19 [Laughter.]

20 DR. MILLER: Sorry. I'll be --

21 [Laughter.]

22 DR. CROSSON: Listen, I spent a lot of years in

1 training, you know, to be able to say something like that.

2 [Laughter.]

3 DR. CROSSON: Okay. So, let's have a discussion.

4 We've got some options on the table. Let's have a

5 discussion about the options that we've been presented

6 with, and who would like to lead the discussion? I see

7 Cori and Craig -- Cori and Craig. Cori.

8 MS. UCCELLO: So I think this whole chapter is

9 great, but I just find it very troubling. I think it's

10 hard to argue that these kinds of assessments are done for

11 disease management and care management purposes when you

12 don't see these codes showing up elsewhere. So I support

13 both of these options, notwithstanding kind of Kate's

14 question about how much would we expect it to show up.

15 And another thing to think about there, too, is

16 if -- and I think this was mentioned in the chapter. If it

17 doesn't show up later, if there wasn't any care specific to

18 that needed, well, then, it's not contributing to higher

19 costs, so it shouldn't be adjusted for in the payments.

20 And I think this highlights how these uniform downward

21 adjustments for coding really aren't appropriate because

22 they over penalize some and underpenalize others. So I

1 like the way that this better aligns things. If you just -
2 - you know, you can still do the assessments. They can
3 still help you with your care management if you find that,
4 you know, of value. But the codes will show up elsewhere
5 if indeed these were real issues that needed care.

6 DR. SAMITT: So, you know, I've worked in
7 organizations similar to what Warner described that really
8 have relied heavily on alternative visit locations. You
9 know, I think that we tend to think within our existing
10 paradigm that all care needs to be delivered either in the
11 hospital or in the provider office, when I think the world
12 is evolving to a point where patients have mobility issues
13 and there's a lot of value that can be identified by
14 visiting the patients at home. And I think a lot is missed
15 if we don't focus on care delivered at home.

16 So I'm concerned that we would make a policy, a
17 blanket policy recommendation that would penalize everyone
18 when what we really want to focus on is where are the bad
19 actors here, where coding perhaps may be happening that is
20 inappropriate. The experience that I've had is these home
21 visits and home risk assessments do identify gaps that the
22 clinical team can then help fill. And the reality is that

1 the services that are provided to fill these gaps may not
2 result in another encounter, so it is a fall risk
3 assessment or med reconciliation or even phone-based
4 telephonic case management that assures that these patients
5 don't get into trouble.

6 And so I'm concerned that we're undervaluing sort
7 of the promise and the importance of home visits. So I'm
8 not so sure. I think if I were to really focus our
9 attention, it stems from a lot of -- the difference on
10 Slide 10, I think it is, that identifies the fact that
11 there are some real outliers here, and I'm most interested
12 in studying these outliers. Perhaps what we should do, as
13 opposed to essentially eliminating coding that's associated
14 with HRAs, is to really look at where we see differentials,
15 either between RAPS and encounter data on a global basis at
16 a contract level or other examples of outliers that we
17 really should be studying and auditing but not necessarily
18 making a universal policy that applies to all.

19 DR. NAYLOR: So I fully concur with Craig in
20 terms of the extraordinary value of the home visit for all
21 of the reasons that you described, and as you suggest,
22 Andy, as a major prevention tool, care planning tool,

1 opportunity to really understand fully risks that people
2 are experiencing.

3 That said, I think that this notion of using the
4 National Academy of Medicine report on diagnostic errors,
5 the notion that using it as the opportunity to come to real
6 accuracy and diagnosis and coding I think extends the -- I
7 mean, I think that the home visit creates the communication
8 avenue for risks to the team that can be then involved in
9 actually doing all of that follow-up work. And the fact
10 that it's not happening, there isn't that follow-up, is
11 really of concern.

12 So, anyway, I support Options 1 and 2
13 simultaneously. I think that gets us to a playing field
14 where people understand how we can use all contexts, but
15 use them for the ways in which we can communicate, assure
16 continuity, get to accuracy and diagnosis.

17 DR. MILLER: Can I just inject one thing as we go
18 around. I'm really sorry. Andrew, you raised this concern
19 about any policy that would create a barrier to going into
20 the home. Option 2 I'm not sure does that.

21 DR. JOHNSON: Option 2 does not. It just uses
22 two years of data.

1 DR. MILLER: Okay. You don't have to -- I want
2 you to think about --

3 DR. SAMITT: Of the two options, I'd be more
4 concerned about Option 1. Option 2 I think is very valid
5 because it gives a greater window, that if there is going
6 to be a follow-up encounter, which we ultimately do want to
7 see, to validate some of the risks identified in the home,
8 having a longer period of time makes sense. I'm more
9 concerned about Option 1 with a narrow window.

10 DR. NAYLOR: So Option 1 doesn't prevent the home
11 visit. It really sees it as part of the whole continuum of
12 care and encourages risk assessment. I think that that's
13 exactly what could and should be going on. Then the
14 communication of the risks that lead to the whole
15 diagnostic process is part of what we want to see. So I
16 don't think that -- I didn't interpret that at all as
17 discouraging home visits or health risk assessments in home
18 visits. I specifically was talking about the coding or
19 diagnostic process that seems to be going on in those
20 visits.

21 MR. KUHN: So I liked what Craig had to say
22 because, you know, to me, at least the difference now with

1 MA is their ability to detect disease early and hopefully
2 promote early care. And I think that's what we all should
3 be about as part of this process. And, also, how can we
4 improve the accuracy of predicting health care costs? So I
5 can see how these health risk assessments can help us go
6 there, but I've listened to the other sides of the concern
7 about the not follow-up care that's out there.

8 So I'm interested in the two proposals out there,
9 but I would like to see, if possible, a refinement per what
10 Craig suggested of looking maybe at the outliers as well.
11 It doesn't preclude us coming back and visiting these, but
12 I think it would be nice to at least look at that either
13 refinement or yet a third option to at least see what that
14 would look like and how meaningful that might be in terms
15 of addressing some of these issues, because, again, we
16 don't want to do anything that doesn't promote this early
17 care and this early detection, but also we want to make
18 sure that, per the earlier conversation, we don't create
19 program vulnerabilities here either.

20 DR. CROSSON: Okay. I see Warner nodding. Rita?

21 DR. REDBERG: So I do think home visits can be
22 very valuable as part of the clinical care team, but I also

1 support Options 1 and 2 because I think we should think
2 about -- I mean, when I think about what a home visit can
3 offer that I can't do in my office, it's to do things to
4 evaluate safety and health at home. So, you know, looking
5 at fall risks for older patients, looking at, you know,
6 what's in the fridge, what are you eating, what's the home
7 environment like, are there health risks identified at
8 home, you know, social situations that seem unhealthy, how
9 are your medications organized and if there's some way we
10 could improve on that. But none of those are going to
11 result in an HRA diagnosis, particularly one that wouldn't
12 be identified in follow-up care in the office. And so
13 that's my concern, is that that's not what it's being used
14 for. It's being used for up-coding and increasing payment,
15 but not really things that are helping our beneficiaries
16 and preventing future problems.

17 DR. HALL: Well, I support both options as well.
18 And just to highlight the important of these home visits,
19 the practice that I belong to consists of a lot of frailer
20 older adults. In fact, almost all of them are frailer
21 older adults, and about 80 percent of them are in MA plans.
22 We would not be able to run our practice if we did not do

1 home visits, sometimes for assessment, but sometimes for
2 more than assessment. We're very convinced that this keeps
3 people out of the hospital and keeps them healthier.

4

5 In fact, it's significantly enough important to
6 us that every one of our first-year residents who are
7 trained in our programs cannot finish successfully the year
8 unless they have participated in an interdisciplinary home
9 visit that is videotaped, and then they have to present a
10 conference to their peers on this, because there's so much
11 value in these home visits, particularly for the frailer or
12 elderly person.

13 Where this is evolving I'm not sure, but it has
14 linkages to a couple of our other ongoing themes. One
15 would be bundling. I don't see how you could do successful
16 bundling, whether it's a hip fracture or whatever, without
17 having some mechanism to assess people in the home.

18 Also, we've talked a lot about getting involved
19 in telemedicine. I think telemedicine is going to totally
20 revolutionize the home visit. It's going to be a very
21 different thing. It will have its own issues about billing
22 and all the rest.

1 To be sure, there are abuses. There have been
2 physician groups that have overly utilized these services
3 and also were very much involved financially in home health
4 care agencies and pharmacies. There have been some notable
5 examples of that.

6 But this is really something we didn't want to
7 throw the baby out with the bath water here. I think this
8 is a very important part of the care of older adults, so I
9 think we could make a contribution to this in terms of
10 MedPAC.

11 DR. CROSSON: But, Bill, just to be clear, you
12 support Option 1 and 2?

13 DR. HALL: Yes, I do Yes, 1 and 2.

14 DR. HOADLEY: So I also support the combination
15 of Options 1 and 2. I guess I'm trying to think about
16 Craig's comments, and I guess one question, Andrew, is on
17 the -- when you added that second sort of variant on the
18 coding that says here "HRAs plus home E&M visit," so
19 there's still an indication on that event, that encounter,
20 that there was an HRA included in that, so that a straight
21 home visit, home E&M would or would not be in that
22 category?

1 DR. JOHNSON: It would be in that category. So
2 there was not another indicator identifying that a health
3 risk assessment was taking place. There was some other
4 background information, and CMS has said that they believe
5 that many of the home visits taking place include a health
6 risk assessment. But our analysis including home E&M
7 visits is attempting to capture some of those that we
8 couldn't identify in the data but may have some additional
9 --

10 DR. HOADLEY: So if there's a home E&M that was
11 more about follow-up and treatment, that would get lumped
12 in in this case with the codes that you've used?

13 DR. JOHNSON: Yeah, in this analysis today, yes,
14 it would. If we could conduct this analysis using the 2014
15 data, we'd be able to -- or the flag that CMS has been
16 collecting that identifies when a home health risk
17 assessment has been used to identify a diagnosis, that
18 would be an improvement in the accuracy of identifying when
19 health risk assessments are used.

20 DR. HOADLEY: So from the point of view of Option
21 1, I mean, we wouldn't be -- you know, in the kind of
22 scenario where Craig talked about it, there's a home visit,

1 to go ahead and respond to the things that were raised in
2 the assessment, with the newer codes you're talking about,
3 that could be distinguished. So that would at least help.

4 And I guess I'm also wondering if we have -- what
5 understanding we have about the kinds of things that MA
6 plans can do for treatment that maybe aren't allowed under
7 fee-for-service. So, you know, other kinds of encounters
8 that wouldn't be payable separately under fee-for-service,
9 they can still presumably generate these kinds of encounter
10 codings. And so I'm just trying to think through and
11 whether we have information on making sure that Option 1
12 doesn't go too far in the kinds of things that Craig was
13 raising. I don't know if I'm being clear or not.

14 DR. MILLER: Well, I'm going to ask, because I --
15 I'm sorry. I know we've got to be conscious of time, but I
16 need to extract this to make sure that when we come back --
17 the thing that tripped me up on your two exchanges, Andrew,
18 when they get the new coding in place, the flags, it
19 indicates whether it occurred in the home.

20 DR. JOHNSON: In the home from an assessment.

21 DR. MILLER: And it almost sounded like you said
22 in response to his question that it also indicated whether

1 it was follow-up care or whether it was -- oh, I see. So
2 it would be an indication that it was an assessment in the
3 home.

4 DR. JOHNSON: Yes.

5 DR. MILLER: And then anything else that happened
6 in the home, we would under Option 1 count or not count?

7 DR. JOHNSON: Count, under Option 1.

8 DR. MILLER: Okay. Now, I think I see the
9 distinction that you guys are making, and I apologize. I
10 didn't follow it.

11 DR. NERENZ: I would be inclined to like Option
12 1, but I want to make sure I understand the full
13 implication of Craig's comment, because what I thought I
14 was hearing is that there would be subsequent encounters
15 that would effectively deal with the thing identified, but
16 they would not show up in the billing system under our
17 usual common definition. Is that basically a paraphrase of
18 what you said?

19 DR. SAMITT: Yes, I guess I'm more interested in
20 knowing the follow-up encounters that would be needed.
21 What counts there? And are there services that MA plans or
22 others or delivery systems could be providing that wouldn't

1 count that would be follow-up management of complex risk?

2 DR. JOHNSON: All of the other services included
3 in the risk adjustment model would count, so that's
4 physician and other health professional face-to-face
5 visits. For the encounter data, CMS has proposed using
6 some CPT and HCPCS codes as a filter for physician visits
7 when they are replicating what encounters to use as a
8 source for diagnoses in the risk adjustment model. So
9 there is some mechanism that they are looking closely at
10 that, but if a physician visit would be included in the
11 risk adjustment model now, it would continue to be a source
12 for diagnoses under Option 1.

13 DR. NERENZ: But I thought, Craig, your point was
14 what about things other than physician office visits.
15 There would be legitimate things that would be appropriate,
16 clinical responses to the thing identified at the home
17 visit that would not currently show up under a narrower
18 definition of an encounter, and that would be a flaw in
19 this approach. Again -- okay.

20 DR. MILLER: But, again, I thought that's what
21 Jack was dealing out. I thought I understood it. You
22 guys, you've taken advantage of me.

1 DR. HOADLEY: The point I would say is -- I mean,
2 we don't necessarily have to resolve this in this
3 conversation, but we can create, it seems like, or at least
4 build the knowledge base around Option 1 with the goal of
5 making sure that the scenarios that Craig is talking about
6 don't penalize that organization because they did follow
7 up. Whether they all exist today in the codes, maybe it's
8 a modification of the codes.

9 DR. MILLER: Agreed. That's kind of what I'm
10 thinking, too, but I'm also trying to keep an eye on him,
11 like, you know, what information will be available to do
12 it. Because the other way to answer that question or this
13 concern here, we're just going to tell you what's going to
14 be ruled out, and anything else that's going on that
15 currently is ruled in and counts we're not going to take
16 on. And I'm just trying to make sure that the coding that
17 they change and is going to start showing up in 14, or
18 whatever you said there, allows us to construct the policy
19 that way. And if we need to have this conversation, we'll
20 take it offline. But I think I'm hearing the principle,
21 which is, you know, this circumstance won't count in your
22 risk order, but everything else that's out there we're not

1 -- you know, we're not going to interfere with that.
2 That's what I think the philosophical bent is here, and
3 then I'll work with Andrew to figure out whether we have
4 the information to implement that. Is that okay, or are
5 you having --

6 DR. JOHNSON: No. I'm on board with that.

7 DR. MILLER: Okay.

8 DR. COOMBS: So I support Option 1 and 2, and one
9 of the issues that I had -- and I think it's okay to say
10 that the last row could be however you wanted to have a
11 provider come in, whether it's a private physician visit,
12 provider visit, nurse practitioner comes into the house,
13 makes the diagnosis, or the patient gets referred to a
14 clinic. That last is that it's confirmed -- the encounter
15 is confirmed by some health -- some entity in the health
16 care system.

17 The piece of it that's really kind of hard with
18 the list on page 24 and 25 is you have these diagnoses that
19 are pretty dramatic, and they're only diagnosed with the
20 HRA-only frequency, and as I was trying to tease out from
21 the focus group, what about the follow-up care when
22 something is discovered in terms of actual benchmarks? I

1 look at schizophrenia, and 1,300 people who were just HRA,
2 and they say, "Okay, you're schizophrenic. Bye."

3 [Laughter.]

4 DR. COOMBS: No follow-up. I mean, okay, you're
5 going to stay at home. No meds.

6 I'm just trying to reconcile that part of it, and
7 so -- and it might have been a check-off list that a vendor
8 came in and said schizophrenic, thought disorder,
9 delusions. I mean, so that piece of it is still kind of --
10 I guess is ruminating within me.

11 The rest in terms of the last row, I don't have
12 any problem with that. And I think Kate said it. If you
13 have an asthma attack, someone came in and says you have
14 asthma, and they never, ever had another symptom for two
15 years for the second option, then you'd have to say that
16 didn't increase your risk. At some point you have to say -
17 - there has to be a line drawn about what would increase
18 your risk so that you get a pass on the severity of illness
19 or co-morbid condition.

20 MS. BUTO: I like Option 2 because I think it
21 will further reinforce the plan's attention to encounter
22 data. And I actually think that if you choose Option 2,

1 implicitly you also are choosing Option 1 and vice versa,
2 because if you choose Option 1, which is don't count, you
3 know, the visit as -- the HRA visit as a way of achieving
4 risk adjustment or contributing to risk adjustment, then
5 you have to have some way of doing risk adjustment. It
6 strikes me that you would then turn to the data. Whether
7 it's two years or one year or three years, I don't know.
8 But I like the idea of strengthening the resolve to submit
9 encounter data and then some ability for the agency to deal
10 with what could be great variation of the use of home
11 visits, as we saw, to contribute to risk adjustment by
12 really turning to the data.

13 So to me, it solves a real problem, and then on
14 1, I think a good MA plan is going to do home visits as
15 needed, for all the reasons that people have said.

16 DR. CROSSON: So you don't think Option 1 would -
17 - you're supporting Option 1 as well? You don't think that
18 would inhibit the --

19 MS. BUTO: I assume a good plan is going to do
20 Option 1. That's home visits for a variety of purposes,
21 not for risk adjustment, right? And the question then
22 becomes, well, then, how do you do risk adjustment? And I

1 think you have to either turn to Option 2 or something like
2 Option 2, which is you rely on data to inform that.

3 DR. MILLER: It's that sentence that just throws
4 me off, but I want to really nail the exchange the two of
5 you just had.

6 And Mary made this point very strongly, which is
7 you can still do home visits, and if they help you plan
8 care and follow up on care, there's nothing about Option 1
9 that prevents you from doing that.

10 But then you said you have to turn to a different
11 -- or to the data to do risk adjustment. I mean, in a
12 sense, what we're saying with Option 1 is you're doing all
13 these types of things with the patient. You're seeing them
14 in an office. You're seeing them in a hospital, and all
15 that feeds into your risk adjustment score. And then
16 there's this sliver of, but if this shows up here in the
17 home and nowhere else, it doesn't count.

18 And so we expect they're still engaged in all
19 this activity and using that information to get the risk
20 score for the beneficiary. It's just this one sliver where
21 it would say home risk assessment only, and that's the only
22 place that code shows up? Then it doesn't count.

1 MS. BUTO: And my point was just that Option 2 is
2 using the data. So I don't know why we're choosing between
3 these because I think they are kind of going to go hand in
4 hand.

5 DR. CROSSON: I'm sorry. It's not clear we have
6 to choose between them. Choose one or the other or both or
7 none.

8 MS. BUTO: Right.

9 DR. CROSSON: Jon.

10 DR. CHRISTIANSON: I like the Option 1 and 2. I
11 think they are cleverly put together.

12 I would say that there's still a potential to not
13 be equitable to MA plans that are doing risk adjustment --
14 or doing home visits appropriately, identify a code that's
15 legitimate, and I think about, if I'm saying this right,
16 we're saying before that, the patient shows up in an office
17 and has the code confirmed there, you're not going to get
18 paid at the higher rate.

19 DR. JOHNSON: No, you will get paid at the higher
20 rate.

21 DR. CHRISTIANSON: Okay. So you get paid at
22 whatever you submit based on the home visit, and then it

1 gets taken away from you later or not?

2 DR. JOHNSON: No, not based on the health risk
3 assessment. But if that beneficiary then goes to the
4 physician's office and the same diagnosis is identified in
5 that setting, it will be included in the --

6 DR. CHRISTIANSON: So it depends on, doesn't it,
7 how long it takes before the person goes to the physician's
8 office because you'll be paid? No?

9 DR. JOHNSON: No.

10 DR. CROSSON: Well, there probably is some issue
11 in the data. If the home visit and the HRA is in November,
12 right, but the patient doesn't get in to see the physician
13 for a confirming thing in January, those are in two
14 different claims years.

15 DR. JOHNSON: That's correct.

16 DR. CROSSON: So that would --

17 DR. JOHNSON: And that's the same timing issues
18 that would occur in the current setup, with or without
19 Option 1, and that the data collection year is strictly the
20 calendar year, and it's used -- data from that year is used
21 to predict spending for the next calendar year, so --

22 DR. CROSSON: Right. Okay. But that would be

1 made up -- that problem would be made up in the subsequent
2 year?

3 DR. JOHNSON: Correct.

4 DR. CROSSON: Well, yeah. I mean, you can't go
5 back and change the payment for the previous year.

6 Kate had something, and then Scott.

7 DR. BAICKER: So I'm supportive of these options.
8 I don't think that they will discourage home visits because
9 it's such a small piece of what should be going on in the
10 home visit. So I'm not worried about that.

11 I think it would be -- this is -- my
12 understanding of our goal is to try to identify a situation
13 where we really think there is just coding intensity going
14 on that's leading to higher payments. That is not really
15 warranted by the health care needs of the patient, and
16 you've flagged a really salient one of these things that
17 show up only in HRAs at home health visits.

18 So it's not that HRAs at home health visits are
19 bad; it's that we think it's a particular source of this
20 potential up-coding.

21 So to understand the degree to which that is a
22 good -- both sensitive and specific, it would be nice to

1 have a better understanding of those questions about when
2 things show up later, what does it mean? Should they show
3 up later? Shouldn't they show up later? Is there a way to
4 write something down that's slightly more specific where
5 something that shows up in a home health visit that really
6 should show up later and doesn't is more suspicious than
7 something that shows up in a home health visit and you have
8 no reason to think that it should necessarily show up
9 later?

10 So if we can tweak the -- maybe the broad bucket
11 is about as sensitive and specific as we're going to get
12 and it's fine, or maybe there's a way to slightly refine it
13 to flag more of the problematic cases.

14 What I want to be careful not to do is
15 inadvertently introduce -- undo our perspective or our risk
16 adjustment that's independent of the care used by saying,
17 "Ah, you get a higher payment if you enroll these patients
18 and send them to the hospital," or something like that. So
19 we want to be sure that the -- we don't want to go so far
20 as to incentivize utilization to justify the diagnosis that
21 otherwise we were going to disallow, and that I would think
22 would be a bigger risk in some kinds of diagnoses than

1 others. And that would play into trying to write down
2 perhaps a more focused list of diagnoses that are not
3 subject to that, not inducing utilization, and more likely
4 to show up in this kind of behavior.

5 DR. CROSSON: Scott.

6 MR. ARMSTRONG: Yeah. I just wanted to repeat a
7 point that Craig had made earlier, and I was worrying it
8 was getting a little bit lost in this, because it reflects
9 my discomfort with Option Number 1, and that is just that
10 we have teams of MDs, nurse practitioners, others going to
11 patients' homes and drawing conclusions, both through a
12 really engaging health risk assessment dialogue and all
13 this kind of stuff. And there could be a really
14 legitimate, effective course of care that doesn't trigger
15 subsequent HCCs, and we just need to make sure we're not
16 discouraging what could actually be exactly the kind of
17 future we want to encourage going forward.

18 And so I just wanted to restate Craig's point on
19 that one more time as we go forward looking at this policy.

20 DR. CROSSON: Warner and then Jack, and then I
21 think we -- and Cori. We have five minutes.

22 MR. THOMAS: I'll be really brief. I would

1 concur with Scott's point and Craig's point.

2 If you look at slide 10, you can see on this
3 slide, you've got a small percentage of folks that are out
4 to the right that I think are problematic. And I would
5 encourage us to maybe look at more of the excess or the
6 problematic areas versus having a blanket approach to this,
7 because I think it could have very negative consequences on
8 the type of preventative care we want to have.

9 DR. CROSSON: I'm sorry. I forgot already. Jack
10 and then Cori.

11 DR. HOADLEY: I just wanted to go back and try to
12 clarify. With these options, are we replacing the across-
13 the-board adjustments that are being used now or replacing
14 the higher across-the-board adjustment that we've called
15 for in the past? How do they interact with what's being
16 done now?

17 DR. JOHNSON: I think Option 1, 2, and an
18 additional single factor adjustment would replace the
19 current format, but the single factor adjustment that
20 exists now would still exist. But it would need to be
21 adjusted in size to account for the difference in -- of
22 impact and coding differences after implementing Options 1

1 and 2.

2 DR. HOADLEY: Okay. Because part of the
3 advantage of this, as you had laid it out, is that instead
4 of being the blunt tool that sort of penalizes all plans
5 for the assumption that somewhere in the system there is
6 this inappropriate coding. It tries to target it better to
7 where that coding exists, and so that would actually -- a
8 plan that would kind of do things by the board would
9 actually benefit off of this.

10 DR. CROSSON: Cori, the last word.

11 MS. UCCELLO: Yeah. Just building off of what
12 Kate said, that was the concern about not giving incentives
13 for plans to have an assessment, find a code, and then
14 justify it by encouraging follow-up. That's actually why I
15 had asked Andy about the left side of slide 10,
16 understanding a little more about those plans on the left.
17 Are they just finding more legitimate codes, or are they
18 finding ways to justify the codes that the other plans did
19 not? And so understanding that more would, I think, give
20 us a little more confidence that doing this would not
21 provide kind of perverse incentives.

22 DR. CROSSON: Okay. And then -- yeah, go ahead.

1 DR. SAMITT: Mine is just a follow-up request.
2 We have spent most of the time talking about HRAs as it
3 relates to risk adjustment, and I know -- I can't remember
4 whether it was last year or the year before we had a
5 discussion about the general accuracy of risk adjustment.
6 I am wondering if we could have another conversation about
7 it, because I do wonder what's the latest thinking about
8 the accuracy.

9 We didn't talk about excluded codes. We didn't
10 talk about the single factor adjustment and whether that's
11 fair and equitable within MA. So I don't know whether
12 there's room in our agenda to process this a little bit
13 further, but I wonder if we should.

14 DR. CROSSON: Okay. So I did a little informal
15 count here, and we didn't spend a lot of time on Option 2.
16 We had one mention of Option 2. We spent most of our time
17 really on Option Number 1 and whether we should do that or
18 not, and I've got something like 7 to 4 and-a-half in terms
19 of let's do it or we have significant reservations.

20 From my own perspectives, I think looking at the
21 case that's been made here, if you combine the distribution
22 curve on slide 10 with the nature of the diagnoses that are

1 listed, most of which are rather subject, to put it one
2 way, it sort of suggests that somewhere out there, there is
3 a set of behaviors going on which at least are suspicious
4 if not, frankly, abusive, and that what we need to do, if
5 we can do so, is to craft a solution for that.

6 So I think we can't -- my guess is with this
7 degree of split, I don't think we're ready to make a
8 decision on this. You've had some suggestions about
9 additional information that I think we could look at. I
10 think anything that we can get, for example, that could
11 help us hone in both in terms of information that you could
12 elaborate -- and I realize the difficulties of what you're
13 dealing with in terms of the data -- in terms of where this
14 behavior is going on, the characteristics of it, the
15 characteristics of the organizations, for example, and see
16 whether or not we can come back the next time with a more
17 targeted option, at least as one of the options we address.

18 We may have to come back with these options as
19 well, but that's kind of where I think we are.

20 Are you all right with that, Jon?

21 DR. CHRISTIANSON: Yeah.

22 DR. CROSSON: Okay, good.

1 Andy, thank you so much.

2 [Pause.]

3 DR. CROSSON: Thank you. We're right on schedule
4 and we're going to take a look at the MA benchmark process.
5 Scott has two proposals for us to look at which affect MA
6 benchmarks, one moving in one direction, the other moving
7 in the other direction, although presumably in different
8 geographic areas, different plans, et cetera.

9 So, Scott, do you want to take us through.

10 MR. HARRISON: Sure. Good afternoon. In the
11 last session, Andy discussed some inequities introduced by
12 plan actions. In this session, I will be talking about
13 inequities introduced by the MA payment system,
14 specifically the setting of the county benchmarks.

15 Now, usually when we talk about Medicare
16 Advantage benchmarks, the Commission has generally focused
17 on the overall equity of MA payments compared with payments
18 to the Medicare fee-for-service system, and we will revisit
19 that comparison in our December meeting. This session,
20 however, focuses on issues of equity across counties.

21 The use of county benchmarks and plan bids to
22 determine payments to MA plans began in 2006. The original

1 MA benchmarks were based on the county-level payment rates
2 used to pay MA plans before 2006. The Patient Protection
3 and Affordable Care Act of 2010 changed the way benchmarks
4 are set. We are currently transitioning to new benchmarks,
5 and staff expects that in 2017, when all MA benchmarks have
6 fully transitioned under the Act, benchmarks will average
7 just slightly above average fee-for-service spending. So,
8 we believe there will be rough equity between MA and fee-
9 for-service Medicare. However, equity issues surrounding
10 the distribution of benchmarks and payments across counties
11 will remain.

12 We will first go over the basic benchmark setting
13 process and then look at some policy issues surrounding
14 three special provisions of the system. First, benchmarks
15 are capped at county historical rates. Also, certain
16 counties are eligible to receive double quality bonuses,
17 again, based on historical factors. And, finally, we will
18 look at how CMS calculates county-level fee-for-service
19 spending.

20 Each county's benchmark, excluding quality
21 bonuses, is determined by organizing the counties into
22 quartiles based on their per capita risk adjusted fee-for-

1 service spending. Counties are ranked by average fee-for-
2 service spending. The lowest-spending quartile of counties
3 have base benchmarks set at 115 percent of local fee-for-
4 service spending. The next quartile of county benchmarks
5 is set at 107-and-a-half percent of fee-for-service
6 spending, followed by a quartile set at 100 percent of fee-
7 for-service spending, and the highest-spending quartile has
8 benchmarks set at 95 percent of local fee-for-service
9 spending.

10 Conceptually, low fee-for-service spending
11 counties have benchmarks higher than fee-for-service in
12 order to help attract plans, and high fee-for-service
13 spending counties have benchmarks lower than fee-for-
14 service to generate Medicare savings.

15 High-quality county benchmarks are calculated as
16 the base benchmarks plus a quality bonus of five percent of
17 the county's fee-for-service spending. These benchmarks
18 are the benchmarks that apply to four-star or higher plans.

19 And, as I mentioned, we are currently
20 transitioning to these benchmarks, and for 2016, 68 percent
21 of the MA enrollees live in counties that have fully
22 transitioned.

1 Now, let's talk about equity concerns. The first
2 equity concern is that the payment formulations include a
3 cap on each county's benchmark. The cap is set at the
4 higher of the county's expected fee-for-service spending
5 and the county's 2010 benchmark increased by a national
6 measure of growth. So, a county's cap is calculated and
7 then compared with the benchmarks I described on the last
8 slide.

9 The concern is that local fee-for-service growth
10 will naturally vary around the national growth rate, and
11 there is no reason to think that the distribution of
12 relative spending in 2010 should be perpetuated forever.

13 If the cap is below the base benchmark, the
14 benchmark is base capped, and because the cap is also
15 compared with the higher quality bonus benchmarks, the caps
16 can more frequently be bonus capped, resulting in the
17 denial or limitation of quality bonuses.

18 For 2016, benchmark caps will apply if a county's
19 2016 benchmark is projected to be more than approximately
20 six-and-a-half percent above its 2010 benchmark, and if the
21 benchmark is above the estimated 2016 fee-for-service
22 spending in the county. Counties are most likely to be

1 affected by the caps if their relative spending has grown
2 faster than the national average.

3 Nineteen percent of MA enrollment is affected by
4 the caps on the quality benchmarks. They are enrolled in
5 high-quality MA plans in bonus capped counties and the
6 plans they are in are losing some or all of the quality
7 bonuses.

8 Six percent of MA enrollment lives in base cap
9 counties where the benchmarks are capped below the base
10 rate. All of the MA enrollment in these counties is
11 affected by the caps.

12 Now, if you look at the zero percent in the
13 middle of the right-hand column, you will notice that no
14 base benchmarks are capped in the highest-spending
15 quartile, and that's because the base benchmarks for these
16 counties are already set below fee-for-service spending.

17 The bottom row shows the average benchmark
18 reduction caused by the cap. It estimates that at \$40 per
19 member per month, although some counties have reductions
20 over \$100. The lower-spending counties see larger
21 reductions than the higher-spending counties.

22 The benchmark caps create inequities across

1 counties. Some counties have lower benchmarks than similar
2 spending counties because of the outdated fee-for-service
3 spending patterns perpetuated by the caps. Mostly, the
4 caps cut the quality bonuses available in some counties,
5 and one option for addressing the inequity would be to
6 eliminate or limit the effect of the cap.

7 Another source of inequity is the double quality
8 bonus. PPACA allows certain counties to receive double
9 quality bonuses. There are three criteria to be one of
10 these counties. First, the county must have been paid
11 urban floor rates in 2004. Okay. Urban floor counties
12 must have been in metropolitan areas with a population of
13 about 250,000 -- of at least 250,000 people and had fee-
14 for-service spending below the floor level.

15 Second, at least 25 percent of Medicaid
16 beneficiaries in the county had to have been enrolled in a
17 private plan in 2009.

18 And, the county's projected fee-for-service
19 spending must be lower than the national average.

20 For 2016, the 236 double bonus counties are
21 dispersed around the country, but the process is
22 inequitable across counties because the double bonus is

1 tied to old geographic spending patterns rather than
2 additional quality performance.

3 Looking at the effects for 2016, 19 percent of MA
4 enrollees live in the 236 double bonus counties and were
5 enrolled in an MA plan with four or more stars in 2015.
6 Because all the counties in the 95 percent quartile have
7 fee-for-service spending above the national average, there
8 are no double bonus counties in the 95 percent quartile.
9 Also, there are fewer double bonus counties in the 100
10 percent quartile than in the two lower-spending quartiles.

11 Assuming the county benchmarks are not capped,
12 the double bonuses will add an additional five percent of
13 fee-for-service to the county high quality benchmarks. The
14 maximum double bonus in 2016 would add \$40 to the county
15 benchmark for high quality plans.

16 Again, the double bonus policy is not separately
17 linked to additional quality performance and perpetuates
18 old payment distribution policies. The policy is
19 inequitable because it pays some plans twice as much to
20 reach the same levels of quality performance.

21 So, we have one policy, the benchmark cap, that
22 inequitably lowers benchmarks and quality bonuses for some

1 counties, and another policy, the double quality bonus,
2 that inequitably raises quality bonuses in some counties.

3 One option to address the inequities would be to
4 eliminate both the benchmark caps and the double bonuses.
5 This option would simplify the MA payment system while
6 improving equity across counties.

7 This chart shows that the caps, weighted by MA
8 enrollment, currently lower benchmarks by a total of \$821
9 million in 2016. The bulk of the reductions are for
10 enrollees in the lower-spending counties. At the same
11 time, the double bonuses raise benchmarks by over \$1
12 billion, with the increases also occurring across the three
13 lowest fee-for-service quartiles.

14 We estimate the elimination of both the benchmark
15 caps and the double quality bonuses would result in a net
16 reduction of benchmarks of \$197 million for 2016, although
17 it would be possible to make adjustments to have the
18 changes be budget neutral.

19 Note that, for the most part, the cap reductions
20 in the double bonus, the increases are distributed
21 similarly across quartiles. Through eliminating these two
22 sources of inequity across counties, we could simplify the

1 MA payment system, keep aggregate payments roughly
2 constant, and keep the distribution of payments across
3 quartiles from changing a great deal.

4 Now, let's consider the measurement of fee-for-
5 service spending. The starting point for calculating a
6 county benchmark is the estimate of the county's Medicare
7 fee-for-service per capita spending. CMS has been
8 calculating county level fee-for-service spending by adding
9 up all the fee-for-service spending for the county
10 residents and dividing by the total number of fee-for-
11 service residents. When CMS does this, it includes all
12 Medicare beneficiaries who have either Part A or Part B or
13 both. The main problem with this approach is that MA
14 enrollees must be enrolled in both Part A and Part B, and
15 we have found that beneficiaries who are in both Part A and
16 Part B have higher spending for Part A than those
17 beneficiaries who were enrolled in Part A only, meaning
18 they were not also in Part B.

19 We found that in 2012, nine percent of
20 beneficiaries enrolled in Medicare fee-for-service and Part
21 A were not enrolled in Part B. The percentage of Part A
22 only beneficiaries ranged across counties from about one

1 percent to 22 percent.

2 Given that we found that beneficiaries with both
3 Parts A and B have higher Part A spending than those
4 beneficiaries without Part B, we are concerned that the
5 uneven distribution of Part A only beneficiaries could lead
6 to inequitable fee-for-service calculations across
7 counties. Simply put, in counties where a relatively large
8 share, say 20 percent, of fee-for-service beneficiaries are
9 Part A only, fee-for-service will likely be underestimated.
10 And in counties where a relatively small share, say three
11 percent, of fee-for-service beneficiaries are in Part A
12 only, fee-for-service will likely be overestimated.

13 I did a quick look and confirmed those
14 likelihoods, but more work would be needed as a
15 comprehensive solution would need to examine the relative
16 spending and relative risk of different groups of
17 beneficiaries, including those with both Part A and B,
18 those with Part A only, and those with Part B only. If you
19 would like, we could invest some more time on this issue
20 and report back.

21 In summary, we have identified three sources of
22 inequity across counties in the current benchmark setting

1 system. Benchmark caps reduce some county benchmarks based
2 on old fee-for-service spending patterns. The double
3 quality bonuses increase some county benchmarks based on
4 old spending patterns. And the measurement of fee-for-
5 service spending based on the spending of beneficiaries
6 with Part A or Part B can lower the benchmarks for counties
7 with relatively high shares of Part A only beneficiaries.

8 The caps and double bonuses could be eliminated
9 together to improve equity and simplify the system. We are
10 not ready with a fleshed-out option on the fee-for-service
11 spending measurement, but we can continue to examine the
12 potential of using only data from beneficiaries with both
13 Part A and Part B to measure fee-for-service spending.

14 Thank you. I look forward to your questions,
15 comments, and guidance on these issues.

16 DR. CROSSON: Thank you, Scott.

17 We are up for clarifying questions. Craig will
18 start off, and then we'll go that way.

19 DR. SAMITT: So, on Slide 3, but also referencing
20 some of the material sent in advance, I'm having trouble
21 with the math. So, we talk about benchmarks being set in
22 the four quartiles that have the weightings as described

1 here, but then the average benchmark is 101.5 percent of
2 fee-for-service spending. So, if you think about the
3 allocation in these four quartiles, this does not average
4 to 101.5 percent. So, I'm having trouble with the
5 discrepancies.

6 MR. HARRISON: The 101.5 would be enrollee
7 weighted. Each quartile has the same number of counties,
8 so --

9 DR. SAMITT: Right. So it's not enrollee-based.

10 MR. HARRISON: Right.

11 DR. SAMITT: I've got it. And then my second
12 clarifying question, do we have available information that
13 shows the trends of the per capita costs in each of the
14 quartiles over time? So, I'm just curious that the 115
15 percent for the lowest cost quartile has been in existence
16 for a while, but what's been happening to the PMPM cost in
17 that quartile over time? Would it be valuable -- or I
18 would find it valuable to look at that trend over the
19 years.

20 MR. HARRISON: I mean, I save the worksheets from
21 every year, so we can certainly go back a few years and
22 come up with something for you.

1 DR. SAMITT: It would be interesting to see
2 what's happening there. I mean, it's a different topic
3 that we should discuss about whether the 115 percent is
4 still right. But as the trend begins to rise in the lower-
5 cost counties, how applicable does this weighting -- is
6 this weighting still relevant to, essentially, what's been
7 happening with the baseline costs.

8 DR. CROSSON: Okay. It's a little on the margin
9 of a clarifying question versus position, but for the
10 moment, we'll accept it.

11 DR. SAMITT: Thank you.

12 [Laughter.]

13 DR. CROSSON: Clarifying questions. David.

14 DR. NERENZ: This is arithmetic, also. It really
15 is clarifying. If we can start with Slide 3, this is going
16 to be like Craig, go a little different direction. The
17 counties that have the 115 percent, these are the low-
18 spending counties.

19 MR. HARRISON: Correct.

20 DR. NERENZ: Okay. So, the benchmark is set in
21 those counties by multiplying per capita fee-for-service by
22 115 percent, okay. That's three.

1 MR. HARRISON: Correct.

2 DR. NERENZ: Okay, now let's flip to four. It
3 says, benchmarks are capped at the greater of the counties'
4 fee-for-service spending. So, let's just pause there,
5 okay. So, we've taken a low-spending county. We've gone
6 up 115, and then we cap -- we come right back down again,
7 it sounds like.

8 MR. HARRISON: The higher of, so --

9 DR. NERENZ: Yeah, but 115 is higher than 100 --

10 MR. HARRISON: It is, but -- no, it's the higher
11 of their old benchmark aged forward --

12 DR. NERENZ: Well, and -- okay. That's what I
13 want you to walk through.

14 MR. HARRISON: Yeah.

15 DR. NERENZ: Okay. So, it's the 2010 aged
16 forward. Do you have an example? I mean, I think --

17 MR. HARRISON: Yeah.

18 DR. NERENZ: I just wanted to clarify the
19 concept, but I just was trying to figure out how this cap
20 doesn't immediately just contradict the effect of the 115
21 percent, but I guess it does --

22 MR. HARRISON: Okay. So, you do find that there

1 are more capped counties in the 115. That's true. But,
2 what happened is -- so, in 2010, all the benchmarks were at
3 least 100 percent of fee-for-service, but some of them were
4 quite a bit higher, I mean, like up to 140 percent.

5 DR. NERENZ: All right. Didn't know that. Okay.
6 Okay.

7 MR. HARRISON: All right, and so that's what gets
8 aged forward, the old benchmark, not the old fee-for-
9 service spending.

10 DR. NERENZ: And that's what can be greater --
11 thank you. Okay.

12 MR. HARRISON: Yeah.

13 DR. NERENZ: That's the missing piece. Thank
14 you.

15 DR. CROSSON: Jack.

16 DR. HOADLEY: Is there any sense that the
17 particular issues of either the double quality bonus or the
18 benchmark caps is getting worse or better over time, or
19 looking forward to the extent that you have a crystal ball
20 to do that, or is this something that seems like it should
21 be fairly stable from year to year?

22 MR. HARRISON: I guess the caps could get worse

1 each year, because, you know --

2 DR. HOADLEY: By the kind of logic you were just
3 talking about.

4 MR. HARRISON: Right. If a county is growing
5 faster, then they could bump up --

6 DR. HOADLEY: I was just trying to get a sense of
7 --

8 MR. HARRISON: Yeah.

9 DR. HOADLEY: -- of scaling the problem. I mean
10 --

11 MR. HARRISON: Yeah.

12 DR. HOADLEY: -- if this is something that was
13 going to go away on its own, we might have less interest.
14 If it's going to get worse, we might have more interest.

15 MR. HARRISON: In a sense, there's a limited
16 population of counties that you can be double bonus. It'll
17 only change from year to year based on whether or not they
18 are over 100 percent of local fee-for-service.

19 DR. HOADLEY: Okay.

20 MR. HARRISON: I'm sorry, whether their fee-for-
21 service is above the national average. But, all the other
22 factors are historical.

1 DR. HOADLEY: Okay. My other question, on the A
2 versus -- the Part A, Part B baseline measure, people who
3 are -- one of the reasons people are in A and not B is
4 because they're still working and their Medicare is the
5 secondary payer. Are they still included in this
6 calculation, because they would have, presumably, a lot
7 less Medicare spending.

8 MR. HARRISON: They are included. Medicare
9 secondary payer is a factor in the risk system, so --
10 although it's a little different. Plans get an adjustment
11 based on how many MSP people they have, but, yes, I believe
12 there are --

13 DR. HOADLEY: In terms of contributing to the
14 baseline. I just wonder if that's a -- what that would do,
15 if that's another piece that could be put into that way of
16 --

17 MR. HARRISON: Yeah, and there is a sense that
18 the A only population is growing as a share, also.

19 DR. HOADLEY: Right. Okay.

20 DR. CROSSON: Because of financial issues --

21 MR. HARRISON: People continuing to work, the
22 high-income premium.

1 DR. HOADLEY: Also, a lot of federal retirees,
2 presumably, who choose not to --

3 MR. HARRISON: I know some of them, yes.

4 [Laughter.]

5 DR. HOADLEY: They have double sources of
6 coverage.

7 DR. CROSSON: Clarifying questions. Scott.

8 MR. ARMSTRONG: Yeah. This is maybe a little bit
9 of a question about the history about how we got here, and
10 these are -- so, I'm particularly talking about the cap
11 that eliminates the quality payments, because these are two
12 really different payment policy ideas. One, to reconcile
13 Medicare Advantage with the regional fee for county-
14 specific fee-for-service payment rates, and so you have
15 these quartiles and we've been phasing them in over time
16 and we're about to get there.

17 A totally different goal was to incentivize high-
18 quality MA plans with this quality bonus. And, I just --
19 how did we get to the place where the quality bonus
20 actually is part of the calculation that gets capped? It
21 just seems like those were developed separately, or
22 separate payment policies, and it just -- and now it

1 creates an issue that we're looking for a solution to.

2 MR. HARRISON: That's the way the legislation was
3 written. I can't tell you what the intent was.

4 MR. ARMSTRONG: Okay. All right. Okay.

5 DR. CROSSON: Other clarifying questions. I'm
6 not seeing any. I'm looking at Jon -- no, Jon? Okay.

7 So, Scott, we've got -- Scott has put three
8 things on the table. One has to do with the capping in
9 counties that has the effect that in some counties of
10 essentially making part or all of the quality bonus
11 disappear. The second one has to do with the fact that,
12 for historical reasons, based on something called urban
13 floor counties, which was always an interesting term, I
14 thought, some counties receive double quality bonuses.

15 And those two things can and do, in certain parts
16 of the country, create inequities between one county and
17 the other. And so the question is -- there are two, or
18 two-and-a-half questions here. One is, do we want to
19 recommend changing those, and Scott has then linked them, I
20 think in part because it happens that, at least from the
21 perspective of the cost to Medicare, they kind of cancel
22 each other out. And, in fact, we would be -- I think would

1 be resulting in a net savings to Medicare, not a net cost.
2 But, they're roughly equivalent.

3 And then the third question is, or fourth,
4 really, because one is do we want to do A and B, do we want
5 to link them, and then the third one is, do we want more
6 work done on the question of how to solve the potential
7 inequity created by using -- if I've got this right -- only
8 A and B for Medicare Advantage, but in fee-for-service, it
9 would include people of only A or, in some cases, only B.
10 Is that right?

11 MR. HARRISON: That's the current situation --

12 DR. CROSSON: Right.

13 MR. HARRISON: -- and the idea would be to make
14 the populations similar --

15 DR. CROSSON: And what you're asking is --

16 MR. HARRISON: -- both A and B.

17 DR. CROSSON: -- is do we want to see you do more
18 work and come back with a recommendation to resolve that
19 issue, right?

20 So, those are the three questions on the table.
21 We'll start with Kathy.

22 MS. BUTO: Just -- do they all require a change

1 in legislation, Scott? In other words, the A population
2 being included, is that a choice by the agency, because --

3 MR. HARRISON: I think the agency has some
4 discretion on the A and B issue.

5 DR. CROSSON: So, one would be a recommendation -
6 - potentially, the first two or combined would be a
7 recommendation to this Congress. This could be a
8 recommendation to the Secretary, right?

9 DR. MILLER: And the only thing I would say is we
10 kind of conceived of the two together because it was almost
11 an equity issue of quality. So, you know, there's Scott's
12 point of how is it that this ended up taking the bonus
13 away, or part of it or whatever the case may be, and in the
14 second case, I might be on the other side of the county
15 line doing exactly what, you know, the same population,
16 everything is exactly the same, you get paid twice, I get
17 paid once. And, so, it's sort of --

18 DR. CROSSON: Right. So, it's not just a
19 financial coincidence.

20 DR. MILLER: In fact, the financial thing was a
21 little bit of a surprise, and we made Scott go back and
22 check the numbers a couple of times.

1 [Laughter.]

2 DR. CROSSON: Thank you. That makes more sense.

3 MR. ARMSTRONG: You just made a point I wanted to

4 --

5 DR. CROSSON: On this point?

6 MR. ARMSTRONG: You said the first couple of
7 issues would require legislation and the last might not,
8 and I just wanted to make sure. That's not necessarily my
9 understanding, and are we really sure about that?

10 DR. CROSSON: Well, I mean --

11 MR. ARMSTRONG: I'm not sure that's really that
12 important for us, but --

13 DR. CROSSON: Kathy asked the question. That's
14 the answer we got, so --

15 MR. ARMSTRONG: Okay.

16 DR. MILLER: [Off microphone.] I mean, I
17 wouldn't -- I'd be happy to go and --

18 [Laughter.]

19 DR. MILLER: I'd be happy to go back and check
20 it. That was my instinct, too, and when he gave his
21 answer, but we'll go back and check this, and particularly
22 if you're not comfortable, we'll definitely look at it.

1 MR. ARMSTRONG: Okay.

2 DR. CROSSON: Craig.

3 DR. SAMITT: So, I think that these -- the
4 recommendations make sense to me, the first two, in terms
5 of removing cap and the double bonus counties. And I do
6 think it's worth exploring alternative methodologies to
7 develop an apples-to-apples comparison for benchmarking
8 purposes regarding A and B.

9 My only caveat is what I'm not clear regarding
10 the removal of the caps is why are we seeking to do that?
11 Are we seeking to do that to appropriately award plans for
12 achieving the quality bonus? Well, the other way to do
13 that would be preserve the cap but allow the quality bonus
14 to not count toward that cap. So, is there still a need to
15 suppress something, quality aside, that would warrant
16 preservation of the cap plus quality payment on top? So, I
17 don't quite understand the distinction there. We certainly
18 should remove the cap if folks are not getting recognized
19 for quality. But if there's also some additional concern
20 beyond that, maybe the alternative would be preserve the
21 cap and pay quality separate.

22 DR. CROSSON: That would be an additional choice,

1 an additional option.

2 MR. ARMSTRONG: I'm not sure I know the
3 difference. Could you --

4 DR. CROSSON: He's saying -- I think what you're
5 saying is, leave the caps in place, but not apply the cap
6 to counties who -- or to plans in counties that receive the
7 quality bonus.

8 MR. ARMSTRONG: So, the quality bonus, you don't
9 calculate toward hitting the cap?

10 DR. CROSSON: Hitting the cap.

11 MR. ARMSTRONG: So, how is that different than
12 what's proposed?

13 DR. MILLER: It would -- Scott, I think what it
14 would mean is there may be still -- it's not a lot, but
15 there are still some counties that their base rate would be
16 restrained a bit by this cap, and so instead of their base
17 benchmark being here, it would be here, but then they get
18 their full --

19 MS. BUTO: [Off microphone.] Quality bonus.

20 DR. MILLER: Right, quality bonus, and much
21 smaller financial impact, would be my guess there.

22 MR. HARRISON: Most of the impact of the cap is

1 the quality.

2 DR. MILLER: Oh, no, actually, it wouldn't be a
3 small --

4 MR. HARRISON: Yeah. Most of the cap --

5 DR. MILLER: You're right --

6 MR. HARRISON: Most of the impact of the cap is
7 the quality.

8 DR. MILLER: That's right. So, it's still
9 roughly the same cost associated.

10 MR. HARRISON: Roughly.

11 DR. CROSSON: But, as you said before, that's the
12 observation now. That might not be the observation three
13 years, four years, or five years from now, right?

14 MR. HARRISON: Could be. Could be.

15 DR. CROSSON: David.

16 DR. NERENZ: Just in support of that idea, I
17 thought that's what your comment almost automatically
18 implied, that they just ought to be run as separate things.
19 Keep the cap on if there's a reason for the cap, but then
20 let the payment float up above through the quality measure.
21 Two separate things, not one thing.

22 DR. CROSSON: That was -- on this point, Kathy?

1 MS. BUTO: This point, yes. Can you just explain
2 again how we get a lot of savings from eliminating the
3 double quality bonus, but yet -- I think we're all talking
4 as if the quality bonus is going to increase costs. Am I
5 not following this?

6 MR. HARRISON: So, there's two separate things
7 going on. One is there's this double quality bonus, and it
8 adds --

9 MS. BUTO: It has three factors or three
10 criteria.

11 MR. HARRISON: To get in there.

12 MS. BUTO: Yeah.

13 MR. HARRISON: And, basically, the counties that
14 qualify for the double bonus are going to be pretty large
15 counties. They're from urban areas. And, so, you have a
16 lot of -- actually, the people turned out to be about the
17 same. About 19 percent of people are in double capped --
18 sorry, in bonus capped counties, and about 19 percent --
19 not the same, but some overlap -- are in double bonus
20 counties.

21 DR. MILLER: [Off microphone.] Was that your
22 question, though? Was it about the populations, or I

1 thought your question was --

2 MS. BUTO: Well, I thought that the spirit of
3 what Craig was saying was, hey, why don't we keep the
4 constraint on trying to, in a sense, reduce the variation
5 in the cap, the benchmark caps, which is what those
6 benchmark caps are, is to reduce the variation around the
7 country and try to move the low fee-for-service areas up in
8 their caps, or allow greater growth, if you will. But,
9 let's let the quality bonus float free, right? And, so, I
10 was just trying to figure out, looking at the table, why
11 the double quality bonus eliminate -- yeah, eliminating the
12 double quality bonus gets you the big savings.

13 DR. MILLER: [Off microphone.] Because you're --

14 MS. BUTO: It's really the urban area issue, it
15 sounds like, in part, anyway.

16 DR. MILLER: [Off microphone.] Well, I mean,
17 there is this basic point, which is whatever you would
18 qualify -- so, let's say a plan that has -- so, let's say
19 you had a plan that qualified because it had the correct
20 number of stars, four-and-a-half, five stars, and it
21 qualified for a five percent bonus. In County A, it would
22 get five percent. In County B, it would get ten. And this

1 would say, no, in both of those counties, they get five,
2 and so that second county, it would bring it down to five.
3 That's your savings.

4 Was that what you were asking?

5 MS. BUTO: Yeah, I'm just going to keep thinking
6 about this --

7 DR. MILLER: Okay.

8 MS. BUTO: -- and make sure I follow the
9 difference between the double quality bonus and, I think,
10 the spirit of what Craig was talking about, which is let's
11 free the quality bonus from these caps.

12 DR. MILLER: [Off microphone.] And then that's a
13 different idea, which is in a different set of counties,
14 the benchmark comes up against this cap, and this is what
15 Scott and Craig, I think, are discussing, such that if I
16 had qualified for the five percent, because I did all the
17 right things, it would say, oh, no, there's no headroom. I
18 can't give that to you. And, so, here, if we eliminate
19 that, then the five percent goes in place and that's a
20 cost.

21 MS. BUTO: Okay. All right. They offset each
22 other.

1 DR. MILLER: [Off microphone.] Correct. That's
2 the word.

3 DR. CROSSON: David.

4 DR. NERENZ: Scott, I wonder if you could state,
5 or restate if I missed it, the rationale or policy goal for
6 the double quality bonus --

7 [Laughter.]

8 DR. NERENZ: -- because I really think through
9 the three criteria --

10 DR. MILLER: [Off microphone.] It was a non-
11 policy reason.

12 MR. HARRISON: You didn't miss anything.

13 DR. NERENZ: Good.

14 [Laughter.]

15 MR. HARRISON: There were not discernible policy
16 reasons for naming the counties that were named, or doing
17 it the way they did it.

18 DR. NERENZ: Well, that's a clear answer. Thank
19 you.

20 [Laughter.]

21 DR. CROSSON: Other points? Jack, are you
22 looking at me?

1 DR. HOADLEY: [Off microphone.] I'm trying to
2 decide.

3 [Laughter.]

4 DR. HOADLEY: I mean, the problem -- I think the
5 thing we're struggling with is this is really down in the
6 weeds compared to even some of the down in the weeds things
7 we often do. I think it's just hard to grasp some of the
8 pieces. It does sound like these are reasonable
9 directions, with or without the modification that's been
10 suggested, and there is a logic to sort of rethinking about
11 the baseline, the A/B baseline, as well, although I do
12 think maybe thinking about whether secondary payer belongs
13 in there somehow or they should just be thrown out would be
14 another way to -- I don't know what they would do to the
15 numbers. Maybe it wouldn't matter, but -- so, I mean, I
16 generally think this is a reasonable way to go.

17 DR. CROSSON: Going this way. Scott, and then
18 Herb.

19 MR. ARMSTRONG: Yeah. I just very briefly would
20 echo Craig's comments and say that, consistent with a
21 question that I asked earlier, I think these are two
22 different payment policies, and I'm really talking about

1 the problem we have with capping and, therefore,
2 eliminating the quality bonuses in some markets.

3 You should have the four different quartiles and
4 the caps and all that kind of stuff that's for good reason
5 and so forth, but we really hurt what's an important policy
6 objective of ours, and that is to pay for results, pay for
7 quality, pay for performance, when, in fact, four-and-a-
8 half and five-star plans are actually not able to get any
9 incremental payment because they happen to be in a county
10 that's bumped up against that cap. I just believe they
11 should be separated the way we've been talking about it.
12 Thanks.

13 DR. CROSSON: herb.

14 MR. KUHN: So, just one question about the
15 quality bonus, and I think you're all onto something here
16 about freeing -- I think it's, in Scott's term, freeing the
17 bonus from the other, as well as Craig. But, I'm just
18 trying to recall on the quality bonus, I want to think
19 three or four years ago, at least in a comment letter,
20 MedPAC was concerned about some of the functionality of the
21 quality bonus or how it was put together, administered. Do
22 I remember that correctly? And I just want to make sure

1 that if we're saying we want to keep this thing free, is it
2 something we're saying that still needs further structure
3 or change?

4 DR. MILLER: Carlos, do you want to --

5 DR. CROSSON: Funny thing. You're going to be
6 here tomorrow, aren't you?

7 [Laughter.]

8 MR. ZARABOZO: So, this comment will substitute
9 for my presentation tomorrow, is that correct?

10 [Laughter.]

11 DR. MILLER: It will not. We'll wait and see
12 what it is.

13 MR. ZARABOZO: Yeah. The issue that was of
14 concern to us was the weight given to measures other than
15 outcome measures, that a lot of the measures were
16 administrative measures, and so now that the method of
17 determining the stars is different, there's more weight
18 given -- you know, they have different weights, more weight
19 to outcome measures, less weight to process measures, and
20 medium weight to patient experience measures. So, our
21 concern, then, was too many administrative measures went
22 into the star system.

1 DR. CROSSON: Okay. I'm not seeing any more
2 hands, and even a lot of people are avoiding my eyes.

3 [Laughter.]

4 DR. CROSSON: But, I seem to remember that from
5 being in school.

6 [Laughter.]

7 DR. CROSSON: So, it has been a long day, but, I
8 think, a very good one, very productive one, wonderful
9 presentations and great discussion.

10 So, we will be coming back to this issue. Scott,
11 I think you have some suggestions. Maybe we have a third
12 option to put on the table. And, I think what we're
13 hearing, or we didn't have a lot of discussion, was about
14 it, was encouragement to go ahead with the A/B issue with
15 respect to the benchmark creation.

16 Okay. Thank you so much, Scott.

17 Now, we have arrived at the end of our session
18 and time for the public comment. So, if there are
19 individuals in the audience who would like to make a public
20 comment, I'd ask you to come up to the microphone so we can
21 see who you are, or see that you're there.

22 [No response.]

1 DR. CROSSON: That was a bit of a head shake.

2 [Laughter.]

3 DR. CROSSON: So, seeing none, then we are
4 adjourned to 9:00 tomorrow morning. Thanks very much.

5 [Whereupon, at 4:26 p.m., the proceedings were
6 adjourned, to reconvene at 9:00 a.m. on Friday, October 9,
7 2015.]

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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 9, 2015
9:00 a.m.

COMMISSIONERS PRESENT:

FRANCIS J. CROSSON, MD, Chair
JON B. CHRISTIANSON, PhD, Vice Chair
KATHERINE BAICKER, PhD
KATHY BUTO, MPA
ALICE COOMBS, MD
WILLIS D. GRADISON, JR., MBA, DCS
WILLIAM J. HALL, MD, MACP
JACK HOADLEY, PhD
HERB B. KUHN
MARY NAYLOR, PhD, FAAN, RN
DAVID NERENZ, PhD
RITA REDBERG, MD, MSc
CRAIG SAMITT, MD, MBA
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DR. CROSSON: Okay. Good morning. We're going to open up our Friday session.

As you may remember, Scott Armstrong had to leave last night. He was involved in an important work endeavor that he could not change. And Craig has let us know that he's going to be a little late, so he'll be here in 15 or 20 minutes. So we'll go ahead.

We have two presentations and discussions this morning. The first one is going to be part of our continuing work on assuring access to health care services for Medicare beneficiaries who reside in rural areas. Despite the fact that we have add-on payments to sole community hospitals, Medicare-dependent hospitals, and cost-based payment to critical access hospitals -- all vitally important programs, by the way -- some facilities serving rural beneficiaries still struggle financially, in part due to declining admissions. And in those cases, admissions are the basis for their payments.

So this morning we are going to explore some additional options to provide Medicare services to

1 beneficiaries residing in those rural communities, and
2 we're going to hear from Jeff Stensland and Zach Gaumer,
3 and it's over to you.

4 DR. STENSLAND: Thanks, Jay.

5 So we'll talk about new models to preserve access
6 to care in rural areas, as Jay said, and specifically,
7 we'll talk about two ways to move beyond the inpatient-
8 centric models we currently have, including models where
9 you focus on providing the payments toward outpatient
10 emergency services. And before we start, I want to thank
11 Anna Harty for her work on this project

12 Over the past couple years, there has been a
13 concern over certain rural hospital closures. As we
14 discussed in our March report to Congress last year,
15 inpatient admissions have been declining for several years.
16 As admissions decline, closures increase. For the past
17 couple of years, the share of rural and urban hospitals
18 that have closed has been similar. In rural areas, 30
19 hospitals have closed. And if we expand the definition of
20 rural to include the rural portions of counties that are in
21 MSAs, the number increases to 41 rural closures since
22 January 2013.

1 Now, some closures are expected due to declining
2 patient volumes and may be appropriate if alternative
3 hospitals are located nearby. However, in some cases,
4 hospitals have closed without nearby alternatives for
5 emergency care. And it's precisely these situations that
6 motivate today's discussion.

7 Since the start of the Prospective Payment System
8 in 1983, there has been a series of programs designed to
9 preserve access to care in rural areas. However, the
10 current programs have historically focused on inpatient
11 services, and the largest program uses cost-based payments.
12 Despite these programs, we have seen this slight uptick in
13 closures in the last couple years, including some hospitals
14 that are 20 miles away or more from the nearest alternative
15 source of emergency care.

16 So this raises the two key questions for today:
17 First, what are the limitations of the current payment
18 models? And, second, what can Medicare do to help preserve
19 emergency access in these difficult situations?

20 The first limitation of the existing payment
21 models is that they are inpatient centric. The sole
22 community hospital program and the Medicare-dependent

1 hospital program both provide add-on payments to the
2 inpatient rates. The low-volume adjustment is another
3 inpatient special add-on that goes to 650 hospitals, some
4 of which also get the SCH and MDH add-ons. So the money
5 hospitals receive under these special programs is dependent
6 on maintaining their inpatient services. The most common
7 program, the critical access hospital program, provides
8 added inpatient and outpatient payments. But to qualify
9 for the CAH program, hospitals still must maintain
10 inpatient capacity.

11 Now, the inpatient focus of these programs
12 reflects the inpatient dominance of hospital inpatient
13 services in the 1980s, and that's when these programs or
14 their predecessors were started. However, this inpatient
15 focus is problematic as we see fewer and fewer patients
16 using rural hospitals for inpatient services.

17 Over the ten-year period from 2003 to 2013, rural
18 hospitals saw a 12 percent decline in discharges on
19 average. Critical access hospitals saw a 27 percent
20 decline over the same ten-year period. Part of this
21 reflects declining populations in rural areas. Some of it
22 also reflects more specialized services being shifted to

1 larger hospitals with higher volumes, more practice, and
2 more capabilities.

3 The trend of declining admissions has been
4 strongest in recent years with a 4 percent drop in CAH
5 discharges from 2012 to 2013 alone. By 2013, the volumes
6 at critical access hospitals had reached fairly low levels
7 for the lowest 10 percent. There were 130 CAHs that had an
8 average of two or fewer discharges per week in 2013. This
9 raises the question of whether the staff have enough
10 practice to provide high-quality care. There are also
11 economies-of-scale concerns. The fundamental question is:
12 Should all of these hospitals continue to be inpatient
13 facilities?

14 The second limitation of current models is that
15 they often use cost-based reimbursement. Most rural
16 hospitals today are critical access hospitals, and so they
17 receive cost-based payments for their inpatient,
18 outpatient, and post-acute-care services and swing beds.
19 And these cost-based payment cause three problems.

20 First, cost-based payments favor higher-cost
21 hospitals which tend to be hospitals in better financial
22 condition. For example, some of the poorest hospitals that

1 we visited on some of our site visits had decided to remain
2 PPS hospitals and take the PPS rate rather than the cost-
3 based rate because their cost structure was so low, their
4 costs were below PPS rates. In contrast, as we illustrate
5 in your mailing materials, some of the higher-cost
6 hospitals that we have seen are in wealthier communities,
7 and the general idea here is when a hospital has more
8 money, it tends to spend more money; when it doesn't have
9 money, it doesn't spend the money.

10 Second, cost-based payments could favor services
11 that have high Medicare or privately insured shares. For
12 example, CAHs have expanded their post-acute-care swing bed
13 services to some extent because they tend to have high
14 Medicare shares. CAHs have also expanded MRI services
15 which have high shares of private and Medicare patients.
16 In contrast, the Medicare share in the emergency room at
17 CAHs is relatively low, only about 30 percent. What that
18 means is that a CAH will get a bigger increase in its
19 Medicare payments when it increases its post-acute costs or
20 imaging department costs than it will when it spends money
21 on its emergency room.

22 Finally, cost-based payments reduce the incentive

1 for cost control. And as you can see from your mailing
2 materials, CAH costs -- in particular, capital costs --
3 have risen faster than at PPS hospitals over the past
4 decade.

5 Now, in the early years of the CAH program, rural
6 hospital closures almost ceased. However, over that time,
7 CAH admissions have continued to decline, and in recent
8 years we have seen 13 CAH closures in 2013 and 2014. This
9 tells us that while cost-based reimbursement has increased
10 payments to many providers, it does not always result in
11 the hospital doors staying open. As we show in your
12 mailing materials, we examined the seven CAHs that closed
13 in 2014. What we find is that they did receive payments
14 above PPS rates. The payments for post-acute-care swing
15 beds alone were \$550,000 higher than PPS rates at the
16 median closed CAH.

17 However, the extra dollars provided to these
18 hospitals were consumed by the costs of maintaining these
19 inpatient services. And this raises the question: Is
20 there a way to continue paying the hospitals similar levels
21 of supplemental payments, but to redirect those existing
22 subsidies toward emergency services and away from inpatient

1 services? In other words, could we offer rural hospitals
2 the option of being a financially viable outpatient-only
3 facility that provides emergency services?

4 At last month's meeting, several of you brought
5 up the idea of allowing rural facilities to become
6 freestanding emergency rooms. Warner suggested that it may
7 make sense to allow CAHs with a census of ten or fewer to
8 convert to freestanding emergency departments when their
9 inpatient operations were minimal and no other hospital was
10 nearby to provide emergency department services.

11 However, as Bill Gradison noted, Georgia had
12 three rural closures and had discussed converting those
13 hospitals to freestanding EDs. However, given the volume
14 of cases and the case mix in those communities,
15 freestanding EDs did not appear viable, and the facilities
16 remain closed. The viability of freestanding EDs appears
17 to depend on having either having a strong payer mix -- as
18 Zach talked about last month in some urban areas -- or
19 receiving some type of public assistance to compensate for
20 the poor payer mix and low volumes.

21 So the question arises: What is needed to make
22 these outpatient-only facilities financially viable? As

1 Dave said last month, there could be a fixed payment to
2 help cover standby costs and then a per unit payment to
3 cover marginal costs. And we'll explore that idea of a
4 fixed grant to help cover fixed costs.

5 While special payments may be needed to keep the
6 hospitals open, we made it clear in our 2012 report on
7 rural health care that the special payments should be
8 targeted to hospitals that are most needed for access.

9 We specifically said that Medicare should target
10 isolated providers. And the idea here is that if you have
11 two hospitals that are five miles from each other and
12 they're both struggling with low volumes, they both are
13 struggling to have enough practitioners to cover the
14 emergency department, in those situations it does not make
15 sense to split the emergency volume between two facilities
16 and make providers have double on-call burdens. To avoid
17 supporting duplicative services, the special payments we'll
18 talk about today would only be available to isolated
19 emergency departments.

20 What this means in practice is that freestanding
21 emergency departments would need to be some distance away
22 from full-service hospitals to get extra financial support.

1 For example, the extra payments could be limited to EDs
2 that were 20 or 25 miles from other hospitals. The
3 specific distance criteria could be discussed by you and it
4 could be different for the two models we'll discuss in a
5 moment.

6 So the first outpatient-only model we will
7 discuss is a freestanding emergency department model. In
8 this case the facility would maintain an emergency
9 department that is open 24/7. Medicare would pay the
10 facility outpatient PPS rates just like it was a hospital-
11 based ED. This would level the payment rates between the
12 freestanding EDs and any full-service hospitals. However,
13 as we discussed, that may not be enough given the low
14 volumes and the payer mix in many rural communities.
15 Therefore, there would be a fixed grant to help with
16 standby capacity costs.

17 In order to receive the fixed standby payment,
18 the hospital would have to give up acute inpatient services
19 and give up cost-based reimbursement of its post-acute-care
20 services. The hospital could still continue to lease
21 hospital beds to a SNF that would then receive SNF rates,
22 and this conversion of hospital beds in rural areas to SNFs

1 is not uncommon. So the bottom line is that skilled
2 nursing care could continue in the community, but cost-
3 based payments would not.

4 Finally, this new option, this Model 1, would be
5 seen as a choice for hospitals and not a requirement. So
6 many hospitals will decide to continue to be a CAH or a PPS
7 hospital. But this would provide a clear option and a
8 clear path for those that are struggling to survive due to
9 declining inpatient volumes.

10 The second option is for smaller communities that
11 cannot support a 24/7 emergency department. In these
12 communities, there may not be enough patients, or even more
13 likely, there may not be enough clinicians -- physicians,
14 PAs, and NPs -- to really staff an ER 24/7.

15 In this case there could be primary care clinic
16 which is also affiliated with an ambulance service. The
17 clinic could be open 8 or 12 hours a day; the ambulance
18 would be available 24/7. Currently this model is being
19 evaluated by the Kansas Hospital Association.

20 The clinic would get two types of payment. One
21 is a PPS rate per unit of service. The second is a fixed
22 grant to help cover the standby costs of the ambulance

1 service. For example, it may cover the cost of hiring a
2 paramedic to coordinate the volunteer ambulance EMTs.

3 It could also help cover the uncompensated care
4 costs at the clinic and the uncompensated care of the
5 ambulance service. This combination of a fixed grant and a
6 payment per unit of service is similar to the FQHC model.
7 And some people think of this as the FQHC+ model.

8 So this is the first of several discussions on
9 rural access issues. If you decide that this topic we have
10 talked about today is worth pursuing, there are several
11 other issues we need to discuss in the future. For
12 example, what size would the grants need to be or what size
13 should they be? And as we discuss in your mailing
14 materials, we'll also have to address beneficiary cost
15 sharing and minimum levels of emergency department staffing
16 at these 24/7 EDs.

17 Finally, there could be a requirement for some
18 type of a matching grant from the local community. The
19 program we're talking about could be better targeted if it
20 was limited to EDs where the local community believes the
21 facility provides enough value so that they are willing to
22 contribute local tax dollars. In the end, both Medicare

1 and the local community could provide support for these
2 facilities' emergency standby capacity.

3 So this brings us to some discussion issues, and
4 you all could talk about whether we should allow hospitals
5 to move away from the inpatient models in some rural areas.
6 We could talk about the PPS plus grant approach and whether
7 that is reasonable for the outpatient-only model with the
8 24/7 ED we talked about and/or for the clinic with
9 ambulance model we talked about that doesn't have a 24/7
10 ED. And, of course, we'll be available for any other
11 questions or comments on the presentation or your mailing
12 materials. I look forward to your discussion.

13 DR. CROSSON: Thank you, Jeff and Zach.

14 We'll start off with questions, clarifications.

15 MR. GRADISON: Most of the -- I guess all the
16 current plans in effect are based upon mileage between
17 hospitals, and I understand that. I doubt if that will
18 change. But I am concerned about whether there is some way
19 that might be explored also to take into account driving
20 times, and I particularly would, if you have not already
21 done so, encourage you to take a look at the questions that
22 are being raised about the VA's policies in this regard. I

1 know and maybe all of us know of situations in which people
2 may literally be only a couple of miles from a hospital
3 with a mountain in between and where the mileage does not
4 mean very much. The VA experience is different in the
5 sense that they're basically, I think, trying to get people
6 to stay in network, and some people feel that they're
7 making it much harder than necessary to go out of network.
8 That's not our situation. So I think that might be
9 illuminating, and I would encourage you to take a look at
10 it.

11 I appreciate your response on the Georgia
12 experience. To me, what that -- well, I'll come back to
13 that in Round 2.

14 With regard to closing that have occurred so far,
15 have you done a breakdown or could you do a breakdown of
16 those into whether they are Medicaid expansion states under
17 the ACA or non-expansion states under the ACA? Some people
18 feel that that is -- some people are actually pointing --
19 some people in authority are actually pointing to that as
20 an explanation for some of the things that are happening,
21 like in Kansas.

22 MR. GAUMER: We've heard talk of that as well,

1 and that's something that we will be looking at when we
2 evaluate closures, and we will bring that up in front of
3 you, I guess it's in December this time around.

4 DR. HALL: And, finally, with regard to getting
5 matching grants from local governments, my understanding is
6 that in some states, maybe many states, local governments'
7 authority is limited with regard to which kinds of
8 institutions they can support with their grants. As a
9 general proposition -- and I'm not saying I've got this
10 entirely correctly, but as a general proposition, it's not
11 surprising they probably can't make grants to for-profit
12 hospitals. But I think some of them are also limited in
13 their ability to make grants to nonprofit nongovernmental
14 hospitals, community hospitals that aren't owned by the
15 government agency. In other words, many of them, I think,
16 can only make grants if it's a public hospital. And any
17 light you could shed on this I think would be useful, since
18 the suggestion, and a good one, of course, of some
19 arrangement with matching grants has some appeal.

20 Thank you.

21 DR. MILLER: Can I ask one thing? Were we
22 thinking state grants or community grants?

1 DR. STENSLAND: We were thinking community
2 grants, so this is the idea that you have -- a lot of
3 hospitals already have hospital district funding, so they
4 might get \$300,000 or \$400,000 from their local hospital
5 district, and they have their own taxing authority to do
6 that. And the idea of -- they would just take that
7 \$400,000 which is going to the XYZ Hospital, and they could
8 still go -- and they could even still call it the XYZ
9 Hospital probably. It just wouldn't have inpatient
10 capacity anymore.

11 DR. MILLER: Yeah, and, Bill, your point may
12 still stand. We'd have to -- it's what level to look at
13 it.

14 MR. GRADISON: Of course. Thank you [off
15 microphone].

16 DR. HALL: So the premise that you've presented
17 to us is the dilemma these hospitals face, that if they
18 close the hospital, they're not going to be able to support
19 the ambulatory services. Is that right? Have I got that
20 right?

21 DR. STENSLAND: If they close the hospital, there
22 won't be any more emergency services in the community.

1 DR. HALL: So does the data support that
2 supposition in terms of -- I mean, we have a lot of
3 experience nationally. In fact, are these communities
4 where these hospitals closed, are they destitute of
5 emergency services? Is there any evidence that this has
6 really affected health care overall?

7 DR. STENSLAND: So I think there's a real wide
8 diversity of these closures, and I think two key points are
9 not all critical access hospitals are the same and not all
10 closures are the same. I can think of -- you know, in the
11 extreme, you'll talk about a closure where something is 60
12 miles away from the nearest hospital, and they don't think
13 they can financially support their emergency department.
14 And the other extreme, you might have a critical access
15 hospital closing, but it was in visual range of another
16 hospital, so there's no real decline in the emergency
17 access.

18 DR. HALL: Okay.

19 DR. STENSLAND: There's also some situations in
20 some of these closures where they have closed the hospital,
21 but they said, "We're going to keep the emergency
22 department open." And there is a real question that I

1 think is for further research for us to say how often is
2 that viable.

3 DR. HALL: Exactly.

4 DR. STENSLAND: And in some cases, it has -- they
5 open it, and later they closed it. And there are some
6 cases it stays open, but some of those freestanding ERs in
7 rural areas that are viable, it looks generally like they
8 have a pretty good payer mix in the -- you know, there's
9 one that's close to the Walmart headquarters and people
10 have private insurance and this is going to work. In some
11 of the other poorer communities without such a good payer
12 mix, it will be very different. So it's a wide spectrum,
13 and we could probably -- in the next round, we could talk
14 maybe a little bit more about the diversity of these
15 closures.

16 DR. HALL: Thank you.

17 DR. CROSSON: Jack.

18 DR. HOADLEY: So, somewhat related to Bill's
19 question about Medicaid expansion, have you taken any kind
20 of look at the impact of changes in DSH dollars and what
21 role that might be playing? I mean, all the details of how
22 the dollars relate to some of these particular hospital

1 categories.

2 DR. STENSLAND: We could look at that. I think
3 it's probably not a big issue in most of the closures --

4 DR. HOADLEY: Okay.

5 DR. STENSLAND: -- because the DSH dollars are
6 only going to the PPS hospitals, not the CAH hospitals --

7 DR. HOADLEY: Okay.

8 DR. STENSLAND: -- and a lot of the PPS hospitals
9 are close to other hospitals. In some cases, it may have
10 an effect, and we can look at that. But, the CAHs don't
11 get DSH --

12 DR. HOADLEY: CAHs don't get DSH, okay.

13 DR. STENSLAND: -- and so there, it wouldn't be -
14 -

15 DR. HOADLEY: And then my other question is, any
16 -- to what extent have you looked at the pattern of other
17 providers in some of these affected communities, you know,
18 thinking about the isolated sort of definition relative to
19 other hospitals, but what about the existence of an FQHC or
20 a rural health center in one of these communities or the
21 existence of home health or other PAC providers and whether
22 that's either a factor in terms of their viability or

1 something that we might take into account in terms of
2 thinking about that vector of isolation.

3 DR. STENSLAND: We can look into that more.

4 DR. HOADLEY: Okay. Thank you.

5 DR. CROSSON: David.

6 DR. NERENZ: Slide 10, please. If you could just
7 clarify a little bit the third bullet point about no acute.
8 It seemed like the main premise here is that the hospital
9 was going to close, and then the options were how do you
10 preserve ED capacity. So, the no inpatient bed is
11 essentially a pre-set decision. But, your phrasing when
12 you mentioned the slide was sort of the other way, that if
13 a hospital accepted a grant for freestanding, they would
14 have to close the inpatient beds. Now, some of that's just
15 semantic. That's what freestanding means. But, can you
16 talk a little -- is there some other logic point there
17 about why the beds would have to close if they -- or is
18 that -- is it just a phrasing issue?

19 DR. STENSLAND: I think the idea is to really
20 target this just to facilities that are going to be
21 inpatient or outpatient only and not allow this just to be
22 an extra add-on to some hospital saying, well, I just want

1 to continue doing everything the way I just have in the
2 past. I just want this extra grant. So, we're saying they
3 wouldn't qualify. That's all it --

4 DR. NERENZ: So, in our later discussion, we
5 could discuss that -- okay.

6 DR. CROSSON: Sue, Kathy, Cori, and Alice.

7 MS. THOMPSON: Thank you. This was an excellent
8 overview.

9 I have a question related to those hospitals that
10 have closed. We frame it in terms of lack of inpatient
11 costs, but how many of them have closed because they simply
12 don't have a physician anymore? I mean, obviously, the
13 physician drives the utilization of inpatient, but I think
14 there's a fundamental issue here about recruiting
15 physicians and access to primary care in communities as you
16 have described. So, do we have any information that speaks
17 to the availability of the physician in this setting that
18 might be something to do with why we're having these
19 difficulties?

20 DR. STENSLAND: No, we can look into that, and
21 when I've looked at the closures so far, I'm not aware of
22 any that didn't have any physicians in the community.

1 Certainly, recruitment is a real difficult problem for all
2 of these communities, and one of the ideas here is that
3 actually having a closure might actually help some
4 recruitment in some situations, because there is this
5 situation where the people coming out of residency aren't
6 that interested in being on call all the time, and if
7 you're in one of these communities and there's only two
8 doctors in town, you're kind of on call almost all of the
9 time.

10 And if you have two of these things next to each
11 other -- these communities, in general, the supply of
12 people who want to be on call that much in practice like
13 that is below the demand for that. So, there's an excess
14 need for these people, and if we have two hospitals next to
15 each other and one of them closes, all of a sudden, the on
16 call duty of those doctors could be cut in half and it
17 might actually make it easier to recruit physicians into
18 that community.

19 DR. CROSSON: Kathy.

20 DR. BAICKER: This is sort of related to Sue's
21 question. I was trying to understand the difference
22 between option one and option two, and option one looks

1 like it would require a greater staffing by physicians.
2 Option two looks like it could be staffed by nurse
3 practitioners or other primary care providers with an
4 ambulance service. Am I reading that correctly? One is
5 more of an emergency department service with the idea of
6 stabilizing the patient. The other one could be more of a
7 primary care clinic with that capability to transfer
8 patients to an emergency department. So, I'm just trying
9 to understand the differences between these two models.

10 DR. STENSLAND: So, in the first one, the 24/7 ED
11 department, the way most people talk about that is you have
12 a physician, a nurse practitioner, or a PA at least on
13 call. So -- and you could all talk about, at some point,
14 what the minimum level of staffing should be for these
15 things. But for a Critical Access Hospital, you don't have
16 to have a -- the existing Critical Access Hospitals don't
17 have to have a physician in the hospital. They don't have
18 to have a PA or a NP in the hospital. They could just have
19 a nurse practitioner in the hospital and the PA that's on
20 call 20 minutes away who drives in after somebody shows up
21 at the Ed. So, that's kind of the level that they're
22 talking about, the Critical Access Hospital now, and it

1 could be a discussion point of whether that's the right
2 level or it should be a different level in a 24/7
3 freestanding ED.

4 For the other service, I think the idea there is
5 -- it kind of gets back to what Sue is saying. These
6 communities just might not have enough practitioners that
7 really want to be on call 24/7. If you try to divide up
8 that 24 hours a day and who's on call, it would just be too
9 much burnout for maybe the two practitioners you have in
10 the community, a physician and a nurse practitioner. And,
11 so, the idea there would be they actually wouldn't be on
12 call at night. Maybe you would try to use some of the
13 standby grant capacity to increase the training of your
14 volunteer service from basic life support to advanced life
15 support or maybe higher, a paramedic to coordinate. We
16 have seen that happen in different communities that have
17 lost their hospitals. But in the end, you have a period of
18 the day where there would not be a physician, NP, or PA on
19 call, and it would be those EMS people that would treat
20 them and transport them somewhere else to get their care.

21 DR. MILLER: And, I almost spoke up when she was
22 asking -- when Sue was asking her question to make this

1 point, but just to kind of hit this one more time, in the
2 second model, does it have to have a physician on staff?

3 DR. STENSLAND: I think that could be a
4 discussion point, and it wouldn't necessarily have to, and
5 you actually can run a CAH, in theory, without a physician
6 in the local community.

7 DR. MILLER: And that was what I -- I thought
8 your answer was very complete, but I do kind of want to
9 draw off her point, which is staffing requirements between
10 these two things could be different and the relief could
11 not just be the 24 hours. It could also be the ability to
12 get the level that a lot of these communities have a hard
13 time with.

14 DR. CROSSON: On this point, Jon?

15 DR. CHRISTIANSON: No.

16 DR. CROSSON: Okay. So, Cori, Alice, Jon --

17 MS. UCCELLO: My question was already answered.

18 DR. CROSSON: Oh, okay. All right. So, Alice.

19 DR. COOMBS: I just wanted to add to that point,
20 it would probably depend on state-based regulations. So,
21 that's the other confounding variable.

22 My question is related to EMTALA regulations

1 within the model two. If you had two facilities that were
2 close enough, one decided to convert to a freestanding ED
3 and the other is still in the critical access realm with
4 inpatients, one of the questions would be if you didn't
5 have the distance between the two, an evaluation of how
6 often patient -- the word that's used is dumping -- would
7 occur because the inpatient -- a capacity on the second
8 hospital is close enough to say, we will tier or triage
9 patients from our facility to another facility. That would
10 be one concern with model two, to kind of work through that
11 process, looking at the -- just the medical protocols for
12 patient transfers within a given region. And if you -- I
13 don't know if you -- if you kind of increase the distance
14 between two facilities, it probably would be probably a
15 little bit more protective in that frequency of that
16 occurring with both facilities that are both located within
17 rural areas.

18 The question I had was, of those 1,300 -- you
19 guys do a great job just describing just the demographics
20 and the distribution, but of the 1,300 rural hospitals, you
21 describe 34 percent as being in areas where there's a
22 radius of 25 miles or greater between the distance. Is

1 there anything you can say about the proximities and
2 whether or not there's an infiltration of for-profit
3 freestanding facilities within the areas? You might know
4 something about the 1,300. I don't know if you know about
5 the smaller group in terms of for-profit penetration.

6 DR. STENSLAND: There are almost no for-profit
7 freestanding EDs in the rural areas, and I think it's a
8 payer mix issue.

9 DR. COOMBS: Okay.

10 DR. MILLER: But, were you asking that or asking
11 how many of the CAHs are for-profit? The 1,300 is the
12 Critical Access Hospitals. There's additional rural
13 hospitals --

14 DR. COOMBS: So, actually, of the 1,300, which
15 are for profit.

16 DR. MILLER: Yeah. If we don't know that
17 offhand, that's certainly knowable.

18 DR. STENSLAND: There is a few for-profit CAHs,
19 but it's a handful, and there's also a few for-profit PPS
20 hospitals in these rural areas.

21 DR. COOMBS: Okay. And if, as in model two,
22 clinic with ambulance, then we're saying that they're not

1 necessarily -- this is a full-fledged clinic, so that if
2 I'm a primary care doctor in a community, I could escalate
3 to this and get some of the opportunities that this would
4 provide, right? Say, I'm not necessarily affiliated and I
5 want to kind of develop my freestanding practice that I
6 have into a model two. Is that a possibility, or am I
7 exempted from that?

8 DR. STENSLAND: That would be an issue of
9 discussion. I think there is the question of whether -- if
10 it's a for-profit entity, like, let's say, the individual's
11 own personal business --

12 DR. COOMBS: Right.

13 DR. STENSLAND: -- that would be a discussion
14 point of do you actually want to give them a grant, and if
15 there was a matching grant requirement, would the county
16 actually give a grant to a physician to run their own
17 practice. So, that's a discussion point.

18 DR. COOMBS: Okay.

19 DR. MILLER: And at least the starting point
20 here, Jeff, is the way we had come up to this point was,
21 it's a -- and this goes to an earlier point -- it's a
22 hospital saying, I'm going to let my inpatient go in order

1 to move to this. That was at least the opening
2 proposition.

3 DR. COOMBS: So, I was --

4 DR. MILLER: No, I see what you're saying.

5 DR. COOMBS: -- the other direction. Okay.

6 DR. CROSSON: Jon.

7 DR. CHRISTIANSON: I have, I think, two questions
8 of clarification. There was one part of your written
9 materials, a paragraph that almost seemed counterintuitive,
10 so I want to make sure I understand the logic. So, I think
11 in that paragraph the argument was actually having a higher
12 percentage of patients that were Medicare would be
13 detrimental to the financial viability of the Critical
14 Access Hospitals, which seemed counterintuitive, because
15 usually you'd think, well, the more patients you'd have who
16 you knew you were going to get your costs plus on, the
17 better you'd like it. But, the argument seemed to be that
18 means that there are fewer private pay patients to
19 subsidize uncompensated care. Is that -- do I have that
20 thinking right in that paragraph, or -- and does that imply
21 that the cost-plus based reimbursement for Critical Access
22 Hospitals doesn't include any dollars there that

1 acknowledge the fact that you're getting uncompensated
2 care?

3 DR. STENSLAND: I think I'll probably have to go
4 back and see what the wording is on that. But, I think the
5 main two levels to think about are the uncompensated level
6 and the private pay level.

7 DR. CHRISTIANSON: Mm-hmm.

8 DR. STENSLAND: And what I was trying to get
9 there is the Medicare is basically paying its cost. So
10 then you're in trouble if you have more uncompensated care
11 than you do private pay patients and private pay profits,
12 because the private pay profits have to cover the
13 uncompensated care because Medicare isn't covering any of
14 that because it's just paying its costs.

15 DR. CHRISTIANSON: Mm-hmm.

16 DR. STENSLAND: And that's the point I was trying
17 to get at.

18 DR. CHRISTIANSON: So, I took it too far by
19 saying that the more Medicare patients you have, the harder
20 it would be, then, for you to cover your uncompensated
21 care, because you have fewer private pay patients.

22 DR. STENSLAND: Yeah. If I worded it that way, I

1 probably shouldn't, because in theory, if you had 100
2 percent Medicare, you'd be okay, because all your costs
3 would be covered.

4 DR. CHRISTIANSON: Yeah. So, the second question
5 was, has there been any research, or have you guys looked
6 at the question of if you convert to this freestanding
7 emergency department and do away with the inpatient care
8 beds, that the emergency department becomes less
9 attractive? In other words, if people have a choice of
10 traveling ten more minutes to go to an emergency department
11 associated with a hospital, they would now do that, and,
12 therefore, that -- I mean, you kind of alluded to that,
13 because you said some places have tried this and it worked
14 for a couple of years and then not so good. So, is this a
15 transition to no emergency care, because people will just
16 see it as a less attractive -- gee, if I'm going to -- if I
17 have an emergency, I want to go someplace where, if I need
18 to be admitted to a hospital, I can be admitted to the
19 hospital.

20 DR. STENSLAND: I'm not aware of any research on
21 that, but that is a key question of what will the volume be
22 at these facilities. And what you're saying is the volume

1 might not be the same as it used to be.

2 DR. CHRISTIANSON: Right.

3 DR. STENSLAND: And then the question is, even if
4 it goes down, will it be high enough to maintain. There
5 are a couple freestanding EDs that have lasted a while in
6 rural areas, and we can look at it from that standpoint.

7 DR. CHRISTIANSON: I think that would be good.

8 DR. CROSSON: Other clarifying questions? Warner
9 and Mary.

10 MR. THOMAS: Just a quick question. Has there
11 been any -- have you seen any information about trying to
12 repurpose any of the inpatient capacity in these facilities
13 with any other types of services? For example, I know one
14 area that we see a significant shortage of are just mental
15 health beds. So, I know we've looked at some opportunities
16 in some of these facilities to repurpose the beds in mental
17 health. So, I don't know if you've seen that anywhere else
18 or what you think about that idea.

19 MR. GAUMER: The only thing I'll add here is that
20 we have seen a couple of closures turn -- inpatient
21 closures turn into SNFs, but just a couple.

22 DR. CROSSON: Mary.

1 DR. NAYLOR: So, we've been talking about this in
2 the context of conversions, and wondering if this
3 opportunity presents -- is it only designed for
4 conversions, or does it present the opportunity for new
5 models -- emergency departments, clinic with ambulance --
6 to develop that have not been formerly inpatient units.

7 DR. STENSLAND: That just gets an issue -- maybe
8 it's an issue for discussion, of how targeted should this
9 be, and just from a political standpoint, how could you
10 kind of keep a lid on how big the program gets if you did
11 that. If you're just saying, for closed hospitals, we're
12 going to help your community out, it kind of puts a
13 boundary around how big the program would get and how much
14 it would cost. If you just -- if you opened it up, that
15 would be a political science question.

16 DR. MILLER: And are we in round one or round
17 two?

18 DR. CROSSON: This would be round one, clarifying
19 questions.

20 DR. MILLER: Okay, because if it were round two,
21 what I would have said is --

22 [Laughter.]

1 DR. MILLER: -- we should focus very much on
2 this, because this has come up a couple of times. You
3 know, you could be building a whole new program and double
4 what is out there, and I think at least we came into this
5 with the discussion of trying to help the community that's
6 struggling with its volume.

7 I apologize for saying something about round two.
8 [Laughter.]

9 DR. CROSSON: Speaking of round two, I think
10 we're ready for round two.

11 DR. MILLER: Oh, so I was leading off.

12 DR. CROSSON: Well, wait. What is this? Is that
13 -- I'm sorry. More clarifying questions? Yes.

14 DR. REDBERG: I think it's clarifying.
15 [Laughter.]

16 DR. CROSSON: Okay. Well, you ask it and I'll
17 clarify.

18 [Laughter.]

19 DR. REDBERG: Okay. I was just -- you know, I'm
20 always interested in outcomes and impact on outcomes, and I
21 think it's a little hard to measure in areas where there
22 are closures and things. But I'm wondering if we have any

1 information on sort of case mix and the kind of problems
2 that are seen at CAH hospitals and rural hospitals and
3 hospitals that closed, and does it look different? How
4 does it impact? And, you can get back to me on that.

5 DR. STENSLAND: First, in terms of the impact of
6 closures, Karen Joynt did a study recently and she looked
7 at hospitals that closed and she didn't see any long-term
8 impacts, or statistically significant long-term impacts on
9 the patients' health. Now, the number of isolated rural
10 hospital closures in her sample was really small, so maybe
11 that's why there was nothing there.

12 In terms of what the CAHs do, it's really a wide
13 open spectrum of what kind of services they offer. You
14 know, some services are -- just have a very limited
15 inpatient capacity with a general practitioner there as the
16 only physician in the area, maybe even a single one. Other
17 places will have an orthopedic surgeon, a general surgeon.
18 Some places offer dialysis stations, 24/7 ED, emergency
19 trained physicians. So, there's just this big wide
20 spectrum of what a CAH is.

21 One of the things that we did talk about in the
22 paper and in our rural report is this concern about volume

1 and outcomes, and you know at least as well as I do the
2 volume outcomes literature. So, if some of these did
3 close, there would be a shift in the volume from that
4 facility to another facility, possibly an urban facility or
5 possibly another small rural facility. So, there could be
6 some potential, though I don't think anybody has ever
7 quantified it, of potential quality improvements at even
8 the neighboring hospital. So, it's not just about this
9 individual community. It's this neighboring hospital,
10 which now it has more volume, now its nurses have more
11 practice, and that actually could be a good thing for the
12 people in the neighboring community.

13 DR. REDBERG: Thank you. That's helpful.

14 DR. CROSSON: Pretty good, Rita.

15 DR. REDBERG: Was that clarifying?

16 DR. CROSSON: Pretty good, yeah. Pretty good.

17 DR. REDBERG: Thank you.

18 [Laughter.]

19 DR. CROSSON: Clarifying questions? No?

20 [No response.]

21 DR. CROSSON: Okay. So, now we're going to enter
22 round two. Throw up Slide 13, please. And, who would like

1 to lead off? I have Jon. We're getting a lot here. So,
2 all right. So, we're going to start with Jon, and then
3 we're going to move this way.

4 DR. CHRISTIANSON: So, back to my clarifying
5 question, which I am now going to turn into something else
6 -- so if -- the way you described it, it seems like the
7 problem is if you have Medicare patients, you're okay
8 because they cover your cost. If you have private-pay
9 patients, you're probably covering your cost. So the
10 problem with some of these hospitals that are closing is
11 they had too much uncompensated care. So why are we
12 talking about some new approach to uncompensated care for
13 some of these hospitals instead of a whole new program
14 around emergency care and so forth?

15 DR. CROSSON: So the notion would be to have an
16 additional add-on payment that varied related to the amount
17 of uncompensated care.

18 DR. CHRISTIANSON: I don't know -- I don't know
19 what -- it seems like if the problem is being driven by
20 uncompensated care that can't be covered, then maybe
21 there's another approach.

22 DR. CROSSON: So is that something that could be

1 modeled, Jeff, Zach?

2 DR. STENSLAND: There's lots of things you could
3 do. You could just make some of the CHs eligible for the
4 uncompensated care pool. You could see how much, how big
5 this uncompensated care payment would be.

6 I think one of the issues here is that also the
7 hospital has this inpatient volume, which is really low,
8 and it's a really high cost per unit. So part of the thing
9 is if they maintain the inpatient capacity, then the amount
10 of money you're going to have to give them to cover each
11 uncompensated care day in that inpatient unit is going to
12 be a lot higher, so that is an issue.

13 And there could be -- there's lots of ways to go
14 with Jon's comment. You could say keep it the same and
15 give them uncompensated care. You could say make them
16 outpatient only and give them an uncompensated care
17 payment.

18 DR. MILLER: And I think we're saying the same
19 thing.

20 I mean, at the most extreme, when you have a
21 couple of hospitals that are -- and let's just make the
22 example extreme, five miles apart. They are both competing

1 to maintain -- and in your context, a question, Jon, would
2 be if we keep the inpatient and the swing-bed payment, they
3 are going to continue to engage in a lot of maintaining
4 that mission in order to pull that subsidy in, and I think
5 there's some real questions -- and the quality question got
6 into this -- about what exactly the role of a hospital --
7 and the most extreme situation, it's five miles apart from
8 another one -- in these particular lines of business. So
9 it would at least continue to try and think about how to
10 give them incentives to get a more consolidated inpatient
11 situation where hospitals are competing really close to
12 each other, and we're just fueling that competition through
13 the subsidies.

14 DR. CHRISTIANSON: Well, I think, certainly, the
15 quality question is something that is out there, but I
16 don't know that I could tie it that closely to this, I
17 guess.

18 I mean, if there's a quality issue right now, we
19 should be dealing with suggestions relative to the quality
20 issue.

21 DR. MILLER: And I guess the only thing I would
22 ask is, in the situation where you're saying an

1 uncompensated care addition, which it is definitely
2 something we would -- we can think about, would you keep
3 the inpatient mission, say, in a hospital that has really
4 low volume? Were you thinking that, or was it just a
5 different way to kind of --

6 DR. CHRISTIANSON: I was just -- I wasn't
7 thinking that far ahead. I was just thinking if the
8 problem is X, there seems to be a straightforward way of
9 dealing with the problem. If the problem was X, Y, Z, and
10 a bunch of other things, then I think the argument for what
11 we're doing here becomes quite a bit more complex.

12 DR. STENSLAND: Yeah. And at least for me, I'm
13 thinking there's thinking the uncompensated care problem is
14 an issue, and implicitly, what we, I think, were talking
15 about here is you're sort of recognizing that the Medicare
16 dollar in this instance, while it would be reorganized into
17 a flat payment and all of that, is playing this role of
18 subsidizing for uncompensated care. But I also think
19 there's this other problem of sending money out to two
20 hospitals that are in close proximity to one another.

21 DR. CROSSON: So, theoretically, I think there is
22 two really fundamental, pretty different ways of doing it.

1 The one that -- the one that we've talked about here is
2 essentially a redistribution model, saying you're already
3 getting all these extra special -- extra subsidies on the
4 inpatient side. Let's take the existing extra subsidies
5 and shift it to the outpatient side, and then we get rid of
6 the inpatient costs. And that's really where the savings
7 for the whole system comes by.

8 Another way of thinking of it is saying, "Oh,
9 we're worried about the uncompensated care cost, so we'll
10 just come up with new money and put it on the uncompensated
11 care," and that would be a separate model.

12 DR. CROSSON: So, theoretically, one could be
13 cost-neutral or even cost savings; the other would be an
14 added cost to the program. Is that --

15 DR. MILLER: Depending on how he's thinking about
16 it. That's the point I was trying to get at.

17 DR. CHRISTIANSON: Well, I guess I was just
18 wondering if we could do some thinking about it.

19 DR. MILLER: We can.

20 DR. CROSSON: Sue.

21 MS. THOMPSON: Lots of thinking to do.

22 In the State of Iowa, there's 118 hospitals, 88

1 of which are critical access. I am very familiar with a
2 number of those hospitals and recognize not only the great
3 economic boost they give to many, many of these communities
4 -- and that's substantial -- but the passion that these
5 communities hold, the pride they hold for these hospitals,
6 but also the challenges that goes with particularly
7 recruiting physicians to many of these communities.

8 I'm curious to know -- and I'm going to make some
9 more comment, but one of the questions I'm very interested
10 to know is how did we come to have a county where there are
11 99 counties in Iowa, and in one of the counties, we have 4
12 critical access hospitals? And there's less than 40,000
13 people in that county. So what was the intent, and how --
14 I mean, that goes well beyond, I think, meeting access
15 issues.

16 So I think there's some underlying questions here
17 that we need to understand, and is there an opportunity in
18 that to better understand not only reducing the
19 competition? And obviously, there's challenges around
20 competency of the staff who are caring for minimal numbers,
21 but where is the opportunity, I think, in much of what
22 Warner was suggesting about converting some of this

1 capacity to services that would better serve the Medicare
2 population?

3 With that, the other learning that in our
4 observation in Iowa is that we have had counter-incentive
5 when we've worked towards value-based contracts. I mean,
6 these organizations have been working to increase volume
7 and increase utilization in order to survive, and in many
8 cases, that's not been consistent with what we've wanted to
9 do in terms of not only improving quality, but reducing
10 PMPM on these contracts.

11 So if there's anything we can do to invite and
12 incent these communities to become a part of what it is
13 we're doing to transform health care for Medicare -- and I
14 think there are opportunities there, but it has to do with
15 what's in those allowable costs, because in that cost
16 report, we assume Medicare costs are covered, to the extent
17 that are defined by allowable costs. And today, that does
18 not include all emergency service costs.

19 So there's a lot of devil in the detail here, but
20 there's so much opportunity. I'm just really excited, the
21 fact that we're having this conversation, so those would be
22 my comments.

1 DR. CROSSON: Herb.

2 MR. KUHN: So I too want to add my thanks for
3 this conversation and put my comments in kind of two
4 levels. Let me make some general comments and then make a
5 few observations about the options that you put forward.

6 First, I like this idea that it's an alternative
7 for low-volume rural hospitals. It makes a lot of sense.

8 Also, what I like is the information you shared
9 about what's going on in Kansas, and I know those kind of
10 conversations are going on in other states that are out
11 there. So I think we're kind of moving along with some of
12 the conversations that small communities, but some of these
13 states are trying to grapple with. And so, in that regard,
14 I'm really excited about when we get to the public comment
15 period because I would want to hear what the rural
16 advocates that are in the audience have to say about hits,
17 but also, if not today, hopefully they're engaging the
18 MedPAC staff to help us refine this thinking as we continue
19 to move forward.

20 But just a couple of other thoughts. One is you
21 have to really put your -- try to put yourself in the minds
22 of these small rural hospitals and particularly the

1 governance of those small rural hospitals. Many of those
2 boards for those small hospitals are elected in those
3 communities. Some have had good governance education; some
4 have had less. And so they're grappling with these very
5 complex issues trying to make these decisions, and if they
6 see something that comes down the road that they don't
7 think is in the best interest of their community, they
8 won't take it or they would overturn a decision, perhaps,
9 of another board after the next election that's out there.

10 So the one thing as we think about this, what it
11 augers for me is that we have to have maximum flexibility,
12 if they get this conversion opportunity, to design a system
13 that works best for that community because, again, you've
14 seen one CAH, you've seen one CAH.

15 Also, I would just raise a cautionary note about
16 these distance requirements. I think Sue raised a good
17 point about four in one county. But you may have a
18 critical access hospital that's 20 miles away from one
19 hospital, but then the next hospital is 50 miles away as
20 well. So the distance stuff, it's difficult. You have to
21 grapple with it, but just kind of bear that in mind.

22 So let me talk a little bit about the options.

1 So, obviously, it's to redirect a subsidy, to get us away
2 from an inpatient-centric model to kind of an ambulatory-
3 centric model. I like that. I think it makes a lot of
4 sense.

5 But I do worry a little bit about the notion of
6 the changes that we're talking about for post-acute care
7 services, particularly swing beds. I see the notion of
8 moving them to a PPS system. I'm not sure if I'm there
9 yet. I still think the transitional care nature of what
10 these entities can be is pretty important, whether it's
11 observation status or whether it's swing-bed status of
12 keeping those folks in the communities for those services,
13 and whether a PPS versus cost-based would work for them as
14 they go forward, something just to think a little bit more
15 about that.

16 I also worry about how these smaller facilities
17 are going to service their debt in the future. Many of
18 them are old Hill-Burton facilities, but some have rebuilt
19 into new types of facilities, and they have accumulated
20 some debt, and would this work for them to be able to
21 manage that that's out there?

22 Other issues to think about is telemedicine and

1 the opportunity. We've talked a little bit about physician
2 recruitment. Could this be a real incentive that these
3 folks that do the conversion maybe get some special
4 opportunities through telemedicine, maybe for ED physician
5 coverage? Or for supervision coverage opportunities they
6 could facilitate that through telemedicine. That way,
7 they're not struggling with the recruitment issues, but
8 they still have the coverage issues out there. It might be
9 a sweetener to add to this to help them think that through.

10 There's other kind of regulatory things that I
11 think we'll have to look at. Well, just going back to the
12 telemedicine thing is Medicare has always had a bias that
13 they want face-to-face encounters for billing purposes, for
14 program integrity, all those kind of issues that are out
15 there. It's time to face the facts that the technology is
16 there. We're going to have to move in this direction, and
17 maybe there is a way for opportunity.

18 On other regulatory things that are out there,
19 will these facilities continue to keep their Part A status?
20 And I think that has a lot to do in terms of the rural
21 health clinic opportunity if they don't have a Part A
22 status. So if they lose their inpatient capacity, what has

1 happened there? It's something to think about.

2 Also, their ability to go outside the hospital to
3 deliver services -- and it's an example I remember years
4 ago. I don't know whether it's ever been fixed or not, but
5 the hospital lab wanted to go to a skilled nursing facility
6 or to do lab samples, draw blood with phlebotomists from a
7 patient, and Medicare would not allow them to go off site.
8 Everything had to be done in the hospital. So you had to
9 transport that elderly person from the nursing home to the
10 hospital just to do a blood draw and then back. And so
11 there's some regulatory things that I think could make it
12 more seamless for the communities to help them think that
13 stuff through.

14 I do think there ought to be requirements here
15 that they have to have a formal partnership with a larger
16 facility for both clinical and operational assistance.

17 I do think there needs to be community skin in
18 the game. The taxing authorities you talked about is
19 something that's out there. The communities have to be
20 invested in these facilities. I think that's an important
21 part of that.

22 And then, finally, this will probably be a tough

1 one for some folks, but I think we have to at least have a
2 conversation about it, is that if they make a decision to
3 do this conversion, but they come a few years down the road
4 and said, "This was a mistake. It's not giving us the
5 services we need in the community. Can we convert back?" I
6 think there at least ought to be a one-time opportunity
7 that you get to convert back if it's not meeting the
8 community needs because you don't want to lock them into
9 something that's just not going to serve them as they go
10 forward, so just some random thoughts here.

11 DR. MILLER: Can I get you to say one more
12 sentence on what you meant by the Part A status?

13 MR. KUHN: Yeah. So my understanding, Mark, is
14 that with the Part A status -- and I'd have to go back and
15 look at more detail -- it triggers at least rural health
16 clinic ability for payment system through RACs, and so
17 there might be other things that are triggered through Part
18 A status. I just want to make sure that we understand what
19 those are and we don't limit them from other services that
20 they could be providing to the ambulatory side.

21 DR. STENSLAND: So I think what you're talking
22 about is if you have a hospital and you have a hospital-

1 based rural health clinic, you can get cost-based
2 reimbursement for those rural health clinic visits without
3 a limit. So you could have, like, a \$200 per visit at your
4 rural health clinic if you're a hospital. If it was a
5 freestanding rural health clinic, you wouldn't get that.
6 You would be limited at the limited rate that they give to
7 rural health.

8 DR. NAYLOR: So, Herb, I don't know that you said
9 it all, but --

10 MR. KUHN: Sorry.

11 [Laughter.]

12 DR. NAYLOR: I know. No, wonderful.

13 I just wanted to reinforce that I also think this
14 should be a focus on conversion, even though I raised the
15 question about whether or not it opens the door in thinking
16 about alternative systems, care delivery models.

17 As we think of the models, I also believe that we
18 need to think how models are emerging, so federally
19 qualified health centers, patient-centered medical homes
20 are moving to 24/7. So we need to think about how existing
21 services in these communities are changing in response to
22 new expectations and whether or not that factors in as

1 we're looking at assessment or of availability of services.
2 So then it might mean that a federally qualified health
3 center now gets extended ambulance capacity to be able to
4 meet the needs. Telehealth, I think is also a central
5 opportunity as we think about alternatives here.

6 We had a wonderful study on ambulances a long
7 time ago. I don't know to what extent all of that, those
8 recommendations come into play here, but it seems like we
9 spent a year looking at them. And I'm really excited that
10 we're getting a chance to reintegrate that knowledge back
11 into our work.

12 And then, finally, on workforce, I would really
13 want to make sure that we know fully the evidence about who
14 is providing care in these environments, and nurse
15 practitioners and PAs have played a central role in the
16 delivery of services in these communities, for which there
17 is a robust body of evidence around quality. So I hope
18 that as we think about the workforce and teams that we need
19 to be thinking about that we build on that.

20 And lastly, to Rita's point, quality is
21 everything. So as we think about these alternative
22 opportunities, however they are constructed, can we make

1 sure that we link some performance expectations to these
2 sites?

3 MR. GRADISON: I too congratulate Herb on his
4 home run.

5 [Laughter.]

6 MR. GRADISON: My understanding of this situation
7 is that there is not a single problem, that there are
8 multiple ways in which these problems can develop, and that
9 there is unlikely to be a single solution that would fit
10 all these circumstances as well.

11 Now, having said that, I ask myself is it
12 possible for Medicare -- does Medicare have the flexibility
13 to deal with the variation? And I think that's something
14 that really -- you could call it a broad philosophical
15 issue, but I think it's really kind of fundamental to how
16 we deal with this.

17 And it suggests to me a couple of things. One of
18 them is it's pretty early in the game to figure out what
19 the needs may be because the -- yes, there have been
20 closings, and even one closing can be very damaging and
21 affect our beneficiaries. I got that.

22

1 But considering the potential and the number of
2 uncertainties out there, I think it's relatively early to
3 try to identify the issues and the potential solutions in
4 any kind of a final way.

5 I also want to suggest a great deal of caution
6 with regard to this matter of uncompensated care. To the
7 extent that the uncompensated care may, in some instances,
8 be the result of underpayments, payments less than cost by
9 Medicaid, which does happen, I would simply remind my
10 colleagues -- not necessary for me to remind everybody, but
11 we faced this same issue with regard to SNFs, which came in
12 and said, "The states are underpaying us in Medicaid;
13 therefore, Medicare has got to pay us a lot more than real
14 costs in order to permit us to keep our doors open," and we
15 have said no. So I think we need to know a little bit more
16 about where this uncompensated -- what occasions this
17 uncompensated care, which is why I earlier asked about the
18 expansion versus the non-expansion states.

19 From a point of view of next steps, I think it
20 might be beneficial, staff to staff, if you had
21 conversations with our counterparts on the Medicaid side
22 and see how this issue looks to them, if it's even on their

1 radar. At least that would be very helpful to me in trying
2 to think that through, and maybe you've already done that.

3 DR. STENSLAND: You mean states or MACPAC?

4 MR. GRADISON: MACPAC. Yeah, MACPAC.

5 DR. CROSSON: Kate.

6 DR. BAICKER: So I want to build on comments by
7 Rita in Round 1 and feel that I don't -- I haven't been
8 thinking of this primarily as an issue of uncompensated
9 care, and I very much agree that we don't want to be in the
10 business of filling buckets that other leave under-filled.
11 Rather, I think of this as a critical mass issue, and that
12 in places with thin populations, cost structures are
13 different, and you need -- we want to ensure that everybody
14 has access to emergency services in a timely way, everybody
15 has access to primary care, and that this is about making
16 sure the payment structure is consistent with places that
17 may have low variable cost and high fixed cost because of
18 their geography. And we have a -- I think we think it's
19 particularly important to have access to emergency care in
20 a closer radius.

21 Building on Rita's point, which was one of the
22 main takeaways I took from this, I don't think we want

1 people getting lots of inpatient care at facilities that
2 don't do very much of it. That's not time-sensitive care.
3 We want people going to other hospitals to have higher
4 quality outcomes, not that these hospitals and providers
5 aren't doing the very best that they can in providing vital
6 services, but we know that you need critical mass of
7 different procedures to get them done effectively.

8 So the models that you've laid out seem like
9 great steps in the direction of preserving access to things
10 that we think are time sensitive for everyone, while not
11 paying to prop up inefficient and not time-sensitive access
12 to services in places where there just isn't critical mass.
13 So I'm very supportive of moving towards alternative models
14 that have that lends of which services do we want to ensure
15 are provided everywhere and devoting the money that's
16 necessary to cover those services for our enrollees, which
17 is going to look different in a low-volume area, and
18 creating incentives to move people for the other kinds of
19 services to places where they can get higher quality and
20 more cost-effective care.

21 DR. CROSSON: Thank you.

22 Warner?

1 MR. THOMAS: I would just concur with a couple of
2 my colleagues that, one, I think creating incentives for
3 folks to transition out of inpatient care that is just not
4 material or has a very low census I think is a benefit to
5 beneficiaries at the end of the day, and I think going to
6 the point made is a benefit to other hospitals that, you
7 know, folks would be transferred to. I think it creates a
8 better experience.

9 Two comments. I do thinking about an opportunity
10 for these facilities to transition some of their inpatient
11 capacity to something else that is worthwhile, whether it
12 be skilled nursing, as you mentioned, whether it be mental
13 health, is something to contemplate or think about and
14 maybe explore whether that would be a potential.

15 And then I would concur with Herb's point about
16 the opportunity to have a one-time option to go back,
17 because I think one of the things you're going to run into
18 is boards are really going to avoid doing this because
19 they're going to wonder what's going to happen. And I
20 think if they have an option to have a lookback on this,
21 they're more likely to go down that road and try it. I
22 think once they try it, they'll see it's actually a better

1 solution. But many will avoid trying it because they're
2 just worried about the consequences of that.

3 So I would really encourage that type of option
4 because I think that's going to incent more organizations
5 to try this as an option.

6 DR. CROSSON: Thanks, Warner.

7 DR. HALL: I think this has been a terrific
8 discussion, a topic we have talked about before, but this
9 is really getting into the weeds.

10 I wonder if there isn't also a possibility of
11 considering a Model 3, and a Model 3 would be that instead
12 of propping up some of these communities and wondering how
13 we're going to get expensive emergency services in there,
14 what if we incentivized the closest hospital, full-service
15 hospital, to get involved in this and extend their own
16 network in a way that makes sense? It's not going to work
17 in every community, but I've visited a lot of communities
18 over the years where there have been tragedies, hospitals
19 have closed in a community, a lot of hand wringing about
20 this. And sometimes the quality of medical care and the
21 access to services has improved logarithmically once the
22 system was there.

1 I spend a bit of my year in rural northern
2 Michigan. I'm 45 miles away from a full-service hospital,
3 north, south, east, west. So it's a minimum of a 45-minute
4 drive. Hospitals have closed in three of the little
5 communities around there, but the major hospital has taken
6 this up -- and I don't know how they did that, what the
7 state regulations were, but they basically take
8 responsibility for the delivery of care to this entire
9 area. And it has made a vast difference so that I can get
10 probably better medical care there than in my home state
11 when I live practically a block away from a major academic
12 medical center.

13 After all, we do want to have systems of care
14 develop, and we always say, well, rural, they're too small,
15 the margins are such that they can't be part of a health
16 care system, but I would challenge that and say that we
17 should look at some of these models that have been very,
18 very successful, and I think every state will have some of
19 them, and see whether -- take the subsidies away from the
20 rural communities and put them in a place, but have some
21 teeth in it in terms of what they have to do to these
22 areas.

1

2 When we have these very major hospitals and
3 Medicare is a substantial buyer of services, why is it that
4 one of the requirements can't be to take care of your area?
5 We talk about this all the time, but we don't do it very
6 often. Maybe this is not a problem but an opportunity to
7 consider these kinds of models.

8 DR. CROSSON: So, Bill, can I just ask you, when
9 you say for that one hospital to expand its network to take
10 care of the surrounding communities that perhaps have lost
11 their hospitals, what would that look like? Would that
12 look like these models we're describing of emergency
13 services, or what?

14 DR. HALL: Well, I think it would take care of
15 the staffing issues, because the responsibility for
16 staffing would be at the mother ship more or less, so that
17 every emergency service, outpatient clinic, whatever it is,
18 these are employees of the system, not of East Podunk or
19 whatever the community is.

20 DR. CROSSON: Right. I'm just trying to
21 understand whether you're suggesting that the core entity
22 would function to keep the other hospitals functioning or -

1 -

2 DR. HALL: No.

3 DR. CROSSON: No. Okay.

4 DR. HALL: Not at all. Not at all.

5 DR. CROSSON: But they very well then could
6 include in their network the kinds of facilities we're
7 talking about here.

8 DR. HALL: Right, and maybe it's just a question
9 of transferring the subsidies that are already in the
10 system through Medicare and encourage people to think out
11 of the box in terms of these networks. I can give you
12 several examples of communities that have done this.

13 DR. MILLER: I'm going to ask the same question
14 just one more time, because at first I thought -- I think I
15 heard it this way, and now I think I'm hearing it
16 differently. So the model you might be talking about --
17 and I'm not trying to get you to say anything you haven't
18 said. You might be talking about there's currently a
19 subsidy going to this hospital, and it's five miles away,
20 and it's a very low volume; and there's another -- and
21 let's just say for sport -- larger and, you know, maybe
22 system, that type of thing. This subsidy goes away. The

1 money moves over here, and they're --

2 DR. HALL: Right.

3 DR. MILLER: Okay. I follow that.

4 DR. HOADLEY: So I concur with what a lot of
5 others have said, that this, I think, is a very intriguing
6 model. I like a lot of what I hear, and I think the
7 discussion you guys provided for us was great.

8 You know, I've been hearing -- I can remember
9 examples going back into the 1980s of hearing people talk
10 about, you know, how are we going to address this in one
11 particular state, you know, and really a lot of some of
12 these same ideas, taking a small hospital that can't
13 sustain itself and figuring out what function it should
14 serve. And I think, you know, what you're talking about
15 here provides a mechanism to allow that to happen.

16 I share with Bill Gradison -- I mean, the issue
17 of whether Medicaid -- you know, the failure to expand
18 Medicaid is one of the explainers on the uncompensated care
19 side I think is something we don't want to sort of fill in
20 a gap for a state that hasn't expanded Medicaid. So, I
21 think, you know, thinking about that side of it.

22 Beyond that, I think, you know, so on the core --

1 the two words that came to my mind were "sustainability"
2 and "flexibility," and we heard a lot of discussion about
3 different elements of that flexibility sort of within this
4 notion of transitioning away from critical access
5 hospitals, what are the rules. I think this notion of how
6 the community partnership -- and, like Bill, I've heard
7 examples of places where, you know, some counties have this
8 taxing authority, but it has to be granted by the state,
9 and so other counties would have to go to the state
10 legislature to get it. So we obviously need to be
11 sensitive and flexible to those kinds of arrangements.

12 And sustainability I think is -- you know, maybe
13 part of it is this idea that Herb put up, that if you have
14 this one chance to go back, that's one of the kinds of
15 ability to sort of address sustainability, is, okay, you
16 know, if I'm worried, and you've heard this in a lot of the
17 other things going on. I'm not sure I want to do this
18 because what if I get on this path and it doesn't work?
19 Maybe that's one of the kinds of ways you try to address
20 the sustainability.

21 I think, you know, notions of grant funding and
22 community grants and things are always things that can be

1 on the chopping block the next time around, and I think we
2 also should think about whether creating this sort of grant
3 notion inside what we're doing makes it more vulnerable to
4 staying funded over time as opposed to the funding streams
5 that, you know, are just core parts of the funding system
6 that we have in Medicare. The fact that the politics of
7 rural areas tends to help sustain things may make some of
8 those less of an issue than they might otherwise be. But I
9 do think, you know, sort of thinking about how -- what's
10 our ability to sustain a community of this size to do this,
11 and make sure that they can continue to do it over a period
12 of years once they've sort of taken this big step is just
13 something that -- one of the lenses we should use.

14 DR. NERENZ: Just a general point, because others
15 have made all sorts of more insightful comments than I have
16 about real care.

17 The intriguing thing to me in this discussion is
18 this idea of grants for standby capacity, and I say that
19 because it's just a special case of this larger question of
20 how does Medicare pay for something that's not a service,
21 or whether Medicare should pay for something that's not a
22 service. And this thing gets woven actually into other

1 topics and other discussions we've had around this table,
2 standby capacity, emergency preparedness capacity, that
3 kind of thing. And the way it's typically done is that
4 there is some sort of an add-on to a service payment, but I
5 think about Mike Chernew when he was here as playing out
6 that that kind of sort of side door/back door approach to
7 payment sometimes leads to perverse incentives that then
8 leads to other problems.

9 So in this case, actually, there's a reasonably
10 straightforward thing to consider with some reasonable
11 boundaries around it that may be sort of an instructive
12 test case of how this might work on a larger scale, and how
13 and whether should Medicare pay for something that is not
14 inherently a billable service.

15 DR. CROSSON: Thanks, David.

16 DR. NERENZ: It's a non-service. By definition,
17 it's somebody or something sitting there.

18 DR. CHRISTIANSON: It's called option value [off
19 microphone].

20 [Laughter.]

21 DR. COOMBS: This has been a really exciting
22 time, I think, because it's getting at all aspects of rural

1 medicine, and I thank you, Susan, for some of the points
2 that you brought up, being from Iowa and understanding the
3 landscape.

4 The scenario that I was speaking of earlier is
5 exactly what you said, for rural hospitals within --
6 critical access hospitals within a short distance from each
7 other. I just think that if we do a payment or grant for
8 standby capacity, it should be tied to something. And so I
9 had experience in Ghana where I went to a hospital and
10 talked to the workforce there, and they said, "We just want
11 you to help us to help the people who get in accidents on
12 the roadside, to get them stabilized to get them to the
13 Korle Bu Hospital." And it was really an interesting
14 thing. When I think about EDs, freestanding, whether it's
15 a small critical access hospital, is what kind of tool sets
16 can Medicare actually enhance for the beneficiary who gets
17 stuck by the roadside with some kind of travesty, whether
18 it's an MVA, whether they come in with a cold stroke or MI.
19 And the critical thing is time. I mean, you know, several
20 people have pointed out time-sensitive therapy. I think
21 the distance makes a difference in terms of who we try to
22 really support.

1 And so I think the distance is going to be a
2 factor. I think telemedicine is going to be a factor. If
3 you get a grant or some kind of special monies, I think
4 this should be tied to some kind of contingency that says
5 telemedicine is a piece of that process. And I'm thinking
6 about, you know, we have the elderly beneficiaries, they're
7 going to have strokes, they're going to have heart attacks.
8 What are we doing to incentivize something that is in the
9 health care delivery system to take care of the true
10 emergencies?

11 So if there's money for standby capacity, then
12 there should be standby capacity strategies that are woven
13 into a requirement. And I think as I sit here and think
14 about it, I think those are the important things to me as a
15 provider if I was in a freestanding ED.

16 And then the other piece of this is how we deal
17 with the other clinics or whatever kind of other facilities
18 that are there to try to meet the needs of the community.
19 I think we ought to approach this in the population health
20 perspective. I like what Bill had said, but I don't like
21 it where it forces an entity to have to be under the
22 umbrella of a larger entity totally, because they may be

1 more dictatorial and not understand the nuances within the
2 grassroots of that community.

3 So I like what Bill said in terms of utilizing
4 the resources from the integrated delivery system, but I
5 don't know that there has to be a formal contractual
6 agreement there.

7 DR. CROSSON: Thanks, Alice.

8 MS. BUTO: I wondered whether we really --
9 whether we believe that or we're ready to say that all the
10 hospitals that meet our mileage criteria, the CAHs really
11 should be converted. In other words, I guess what troubles
12 me a little bit is putting in place new programs that
13 surely will be taken up and creating whole new categories
14 of providers.

15 I'll give another example. The FQHC option,
16 which is FQHC plus ambulance, you know, why wouldn't FQHCs
17 that exist now want that option? So I think there is a
18 potential woodwork effect for the second option. I don't
19 know what that would be. And I'm worried about the first
20 option keeping or providing more funding to entities that
21 maybe should, I think as Bill Hall mentioned, affiliate
22 with a larger hospital or do something -- affiliate with

1 each other. I'm really not sure.

2 Bill Gradison asked the question of whether
3 there's some ability to provide CMS flexibility to work
4 with different situations, and I think the demo authority
5 that CMS already has, CMMI has, could be that flexibility.

6 So another thing that I thought was because we
7 don't know the array of entities or problems that they're
8 facing, you sort of want them to come to -- or have CMS go
9 out and say if you want to convert, come talk to us about
10 how you want to do that. How would it best fit your
11 circumstance? And then if that model works, it could be
12 taken nationwide and made available to other entities. I'm
13 just nervous about creating new categories of providers.

14 And then the issue of the grant troubles me a
15 little bit because I struggled to think of any other
16 circumstance where CMS provides a grant without it being
17 tied to some kind of per member per month or per patient
18 issue. So, yes, we provide Medicare Advantage payments in
19 advance, and we do that on a PM/PM. Usually it's tied to
20 some kind of service or beneficiary involvement. And this
21 one feels like it could go to an entity that never sees a
22 Medicare beneficiary. That would be the extreme case. So

1 I'm wondering whether -- I liked Alice's idea of actually
2 attaching -- if you're going to do a grant and assuming CMS
3 could get the authority to do that, and PHS wouldn't want
4 to take that over, which is the way I would see it, then
5 the idea of associating that with a series of requirements,
6 if you want this money, it's about converting -- it's a
7 little bit like the eHR thing. If you want additional
8 money to adopt information technology, we'll give you some
9 additional money. So maybe it could be that way.

10 And then I think several people have asked the
11 question -- I think Herb raised the question of could these
12 entities come back into the program. I don't see that
13 there's a reason why they couldn't as long as they met the
14 criteria for that type of provider, critical access
15 hospital, unless that -- is that program closed now?

16 MR. KUHN: The necessary provider program closed
17 in '06, and you can tell us how many people came through
18 the necessary provider program. Probably more than half
19 came through that --

20 MS. BUTO: Yeah, I don't think there would need
21 to be a special provision. I think there are avenues now,
22 and maybe you'd want to put that in there. But, again, my

1 basic nervousness is about creating new provider types
2 without knowing what the unintended consequences are.

3 DR. CROSSON: Kathy, could you just clarify one
4 thing? So when you said an option would be to have the
5 hospitals who have these difficulties come to CMS and say,
6 "We would like to convert, could you help us?" convert to
7 what?

8 MS. BUTO: Well, they'd have to -- as in a demo
9 program, they'd have to -- either CMS would have to go out
10 with a solicitation saying, look, we think there's an issue
11 for rural hospitals, we think the current system really
12 forces you to provide inpatient services or tries to get
13 you to provide inpatient services to be viable, we are
14 looking at alternatives, we'd like to look at, you know,
15 alternatives that would affiliate -- create a greater
16 affiliation with, say, a neighboring inpatient facility or
17 one that's 25 miles away, or whatever.

18 Again, this is a little bit of Bill Hall's idea
19 of CMS could go out with something, and then entities could
20 come in and say, look, this is our proposal to do it, this
21 is the kind of flexibility we need, we want to try this out
22 in our area, we think this is going to work.

1 I basically like the idea of letting different
2 circumstances and entities in those circumstances develop
3 their proposals for solving the problem within some general
4 framework and overseen by CMS and then evaluate it. So
5 that's the notion of a demonstration program.

6 I can't remember who said something about -- I
7 think it was Mark's clarification about, you know, in a
8 Bill Hall situation, would the inpatient hospital be the
9 one that gets the money essentially? Would you shift that?
10 It wouldn't have to be that way. I mean, you could set up
11 a circumstance where the entity gets to keep the money, but
12 in an affiliation agreement that stipulates what it is the
13 relationship is and so on.

14 So I mean, you could structure it a number of
15 different ways.

16 DR. MILLER: Yeah, I mean, the way I took the
17 comment -- and you intellectually may have come to it
18 entirely on your own, but it sort of pings from Bill to
19 Bill to Kathy. Bill was saying it may be too early to
20 really form a solution because -- and other people have
21 said this. You've seen one CAH, you've seen one CAH. And
22 Bill proposed this other option. And what I hear Kathy

1 saying is turning the thought on its head, instead of
2 Medicare saying I'm going to create this new category, set
3 up something through, let's say, CMMI or the demonstration
4 authority, put out a solicitation, have individual
5 hospitals come forward and say this is our solution for our
6 community. Maybe that solicitation includes some models,
7 like here's some stuff to think about, but come in and talk
8 to us, and let the motivation come from the field instead
9 of the opposite direction. That's sort of what I feel like
10 I hear you're saying.

11 MS. BUTO: That's kind of what I would prefer,
12 recognizing that there may be a need to save certain
13 institutions that are critical. But I'm trying to figure
14 out, okay, this option is going to require legislation.
15 That doesn't happen overnight. Are there some transitional
16 things that could be done through demo authority to keep
17 some of these entities more viable in a more reasonable
18 way? I don't know. You know, it could be just as hard to
19 do a demo.

20 DR. CROSSON: Thank you, Kathy.

21 DR. CHRISTIANSON: I think what I have to say is
22 consistent with the discussion here, and as we move

1 forward, if we could think about framing this a little
2 differently. The first slide sort of frames it as there's
3 closures out there, is there something we should be doing?
4 The discussion really is a much broader discussion than
5 that, I think. And so if we could think about just how to
6 approach this topic in the next round where we don't start
7 out with there have been some CAH closures and,
8 therefore...

9 And then the other thing I want to just put on
10 the table is I'm not totally conversant with this
11 literature, but my understanding is -- and I think Jeff is
12 into this better than me -- that it's not the case for a
13 wider range of quality measures that community access
14 hospitals are somehow lower quality. I don't get this
15 impression that if we can just get people to larger
16 hospitals in cities somehow they're going to get better
17 care. I don't think the literature necessarily supports
18 that across all the DRGs, and I just want to make sure that
19 we don't have this sort of general feeling that care is
20 always better in bigger hospitals.

21 DR. CROSSON: Okay. Other comments?

22 [No response.]

1 DR. CROSSON: You know, it seems to me that this
2 has been a good discussion. We have had, I think, two
3 options presented, and I think the kind of net takeaway
4 from this discussion is that we would like to see perhaps a
5 larger range of options, you know, brought forward, taking
6 into consideration both some of the implementation details
7 that might follow from the options you've presented as well
8 as, I think, Bill, Bill, and Kathy's idea that perhaps
9 there's a way that this could be done through a more
10 flexible approach.

11 I think it might be useful to have some more
12 details about the relative ease or difficulty of moving
13 different approaches forward so that we get a sense of what
14 we could do more quickly than perhaps some other approaches
15 and revisit this with a little bit of a broader look at the
16 questions. It seems to be I'm getting some bobblehead
17 consensus going on around that conclusion, so with that,
18 Jeff and Zach, thank you for your presentation, and we'll
19 see you again.

20 [Pause.]

21 DR. CROSSON: Okay. And speaking of second acts

22 --

1 MR. ZARABOZO: So you're the top banana and I'm
2 the --

3 [Laughter.]

4 DR. CROSSON: Carlos has come back to visit us.
5 As you may remember in September, we talked about the issue
6 of what to or how to deal with the issue that the Medicare
7 Advantage star program ratings can be influenced negatively
8 by the existence of low-income populations and/or high
9 numbers of under-65, disabled Medicare beneficiaries and
10 what we could do about that, and we had, I think, two
11 points of view on the Commission. One was, well, we
12 understand there's a problem, but we would prefer to not
13 change the measurement process in one way or the other
14 because the measures are what they are, and so perhaps the
15 most direct thing to do would be to deal with the financial
16 implications of the perturbation of the rating system and
17 others, I think, who would prefer seeing CMS change the
18 structure of the measurement process to make up for high
19 populations of low-income beneficiaries or disabled
20 beneficiaries.

21 So we were not able to reach a consensus, and
22 what we are going to do today is we're going to look at the

1 issue again. And we're going to hear from Carlos about
2 some potential solutions for that divergence of opinion,
3 and at the end of the discussion, I'd like to see us either
4 decide we want to go one way or the other or one of the
5 additional options, which would perhaps bridge the
6 differences, or come to the conclusion that we just simply
7 have a difference of opinion, with the realization that
8 there are other bodies working on the same problem.

9 MR. ZARABOZO: Thank you for that introduction.

10 This is, as Jay said, a follow-up to the
11 September presentation with a little bit of additional
12 information provided.

13 TO summarize the issue we're considering, the
14 Medicare Advantage program provides bonuses to plans that
15 perform well in the 5-star rating system. Plans with
16 overall ratings of 4 stars or higher are eligible for the
17 bonuses.

18 A concern has been raised by plans that primarily
19 serve low-income populations, such as special needs plans
20 for Medicare-Medicaid dually eligible beneficiaries. Such
21 plans do not achieve the same level of star rating as other
22 plans, making them ineligible for bonuses. These plans

1 attribute their relatively poorer performance to their
2 enrollees' more complex care needs and their socioeconomic
3 status.

4 In research that we have done and that RAND has
5 done for CMS, we do see an association between low star
6 ratings and a plan's share of low-income enrollees, as well
7 as a plan's share of enrollees under the age of 65 who are
8 entitled to Medicare on the basis of disability.

9 In September, we discussed some of the issues in
10 detail. Today we will review some of the CMS findings that
11 were released a couple days before the September meeting,
12 and we will talk about what the findings mean in terms of
13 their impact on star ratings. We will also talk about the
14 questions and issues you raised at the last meeting,
15 including some alternative approaches to address which you
16 discussed or which are possible.

17 There are two points to highlight from the CMS
18 findings released in September. One is that CMS found the
19 low-income effect and the disability effects apply to a
20 limited number of measures, and their effect at the measure
21 level is relatively small.

22 The other important point to highlight is that

1 after taking low-income status or disability status into
2 account, the addition of socioeconomic status as an
3 explanatory factor does not improve the ability to predict
4 or measure results; that is, low-income status and
5 disability status are sufficient to account for factors
6 such as the level of education and the poverty level of the
7 area where a beneficiary resides.

8 CMS stated that the effect is a small effect. So
9 what does that mean?

10 This table summarizes the RAND/CMS findings on
11 the low-income and disability effects. The researchers
12 examined only those measures with no case mix adjustment.
13 Of the 44 star measures, 16 were not case-mix-adjusted for
14 a low-income effect, and 15 did not have a case mix
15 adjustment related to disability status.

16 The researchers looked at within-contract
17 differences between each category of beneficiaries; that
18 is, for a given contract, how much higher or lower were the
19 results for low-income beneficiaries as compared to non-
20 low-income beneficiaries in the same contract.

21 What this table shows is what CMS reported as the
22 magnitude of the median difference for 90 percent of the

1 contracts; that is, excluding contracts with results at the
2 very high end and at the very low end. In the column
3 labeled "large effect," there are, at most, two measures
4 that we were referring to as having a large effect, where
5 the median population difference was about 8 percent.

6 In the next column, mid-range effect, there were
7 7 measures for low income and 11 measures for disability
8 status where the median difference was in the 2 to 7
9 percent range.

10 The last column shows the measures where the
11 difference was less than 2 percent, or where the median
12 performance level was better for low income or disabled
13 beneficiaries.

14 Another reason these results suggest a small
15 effect in the overall star ratings, as currently
16 constituted, is that the differences usually apply to a
17 relatively small segment of beneficiaries within a larger
18 contract, given that the stars are assigned at the MA
19 contract level.

20 For example, in 2012, among MA plans with a star
21 rating, the average share of enrollment of beneficiaries
22 under the age of 65 was 17 percent. As pointed out in the

1 slide, we could find for a given measure that there is an 8
2 percent difference between the result for enrollees under
3 65 compared to enrollees who are aged, but that 8 percent
4 difference translates to a 1.6 percent difference in the
5 measure results at the contract level if only 20 percent of
6 a plan's enrollees to whom the measure applies are under
7 65.

8 So the biggest effect of what is a small effect
9 to begin with is to be seen among specialized plans, and it
10 involves a very small share of overall enrollment.

11 So I'm going to give you some information that is
12 not contained in the slides. As noted in your mailing
13 material from last month, in 2012 there were 37 HMO
14 contracts with star ratings where the contract was 100
15 percent D-SNP contract, and they represented 3 percent of
16 all HMO enrollment in Medicare Advantage at that time.

17 For the disabled, of 25 HMO contracts, where 50
18 percent or more of the enrollment was comprised of
19 beneficiaries under the age of 65, 16 out of those 25 were
20 100 percent D-SNP contracts, and only 2 of the 25 were not
21 majority D-SNP contracts. Two percent of all HMO
22 enrollment was in the 25 contracts where half or more of

1 the enrollees were under age 65. So it's a small share of
2 enrollment in those kinds of plans.

3 So combining these two overlapping categories, in
4 2012 there would have been 46 contracts that were either
5 exclusively D-SNP or majority disabled, and they
6 represented about 3.5 percent of total enrollment.

7 If one were to adopt the peer grouping method of
8 evaluating these plans, that is to say, assigning star
9 ratings just within this subgroup for bonus purposes, and
10 if the peer grouping resulted in a distribution of bonus
11 plans that was the same as the program-wide distribution of
12 bonus plans in 2012 across all of MA, then 17 of the 46
13 plans would be bonus-eligible.

14 Using the current distribution where about 40
15 percent of plans are in bonus status, about 18 of the 46
16 contracts would be bonus-eligible. However, 7 of the
17 contracts already were four stars or above, so the net
18 change is about 10 or 11 contracts if you used this peer
19 grouping methodology to apply to these plans that would
20 move to bonus status.

21 Turning now to the issues discussed at the
22 September meeting, one question that Kate raised was

1 whether or not specialized plans show better performance
2 for the populations they serve when compared to non-
3 specialized plans.

4 Much of the discussion at the September meeting
5 also revolved around the question that can be summarized as
6 "Is it the stars or the dollars?" meaning that if any
7 changes are to be made, we need to consider their purpose
8 and end results. Is the purpose to make changes to the
9 star ratings so that more plans serving particular
10 populations receive star ratings at bonus levels and can
11 have those star levels reported, or is the purpose and
12 desired end result to provide additional funds, outside of
13 the star system, to particular plans?

14 Another way of looking at the issue is to ask, as
15 Cori did, whether the purpose is to level the playing field
16 for MA contracts in their star ratings, or is the purpose
17 to level the playing field for groups of beneficiaries
18 whose quality of care currently is below the levels of
19 other beneficiary groups.

20 So I will get around to answering Kate's
21 questions, but before doing so--

22 [Laughter.]

1 MR. ZARABOZO: Later tonight.

2 [Laughter.]

3 MR. ZARABOZO: I should mention that when we talk
4 about specialized plans, what we are talking about is
5 mainly the special needs plans for dually eligible
6 beneficiaries, or D-SNPs. Although the two populations of
7 concern are low-income beneficiaries and beneficiaries with
8 disability status, in terms of plans with significant
9 enrollment, there are only specialized MA plans for one
10 subset of the low-income population, the dually eligible
11 beneficiaries enrolled in D-SNPs. However, because a large
12 share of the under-65 population are dually eligible, D-
13 SNPs, other than those limited to aged beneficiaries, have
14 larger shares of under-65 enrollees than non-D-SNP plans.

15 While we do not have plans specializing in the
16 disabled, except for some chronic care special needs plans,
17 we would expect plans with large shares of under-65
18 enrollees to be able to address the care needs of their
19 enrolled population.

20 So in order to answer Kate's question, we used
21 the 7 star measures that we analyzed for last month's
22 presentation where we found statistically significant

1 differences for dually eligible beneficiaries and for
2 beneficiaries under the age of 65.

3 Controlling for other factors affecting measure
4 results, such as the presence of a diagnosis of dementia,
5 we compared results for the populations in different types
6 of plans. The first set of plans shown in the slide are D-
7 SNPs, where we compared their performance for their primary
8 population, beneficiaries with full Medicare-Medicaid dual
9 eligibility status, with the performance of non-D-SNP plans
10 with full dual eligibles enrolled. What we found is that
11 for the aged population, D-SNPs perform better than non-D-
12 SNPs. This is also true for the under-65 population,
13 though not to the same extent as for the aged population.

14 The second comparison set can be thought of as an
15 evaluation of whether plans that you might expect to
16 specialize in care for the under-65 population, which is
17 plans who have a large share of under-65 enrollees, do
18 better for these enrollees than plans with lower shares.
19 We used percent of enrollment under age 65 as an
20 explanatory variable for this analysis. What we found is
21 that for both D-SNPs and non-D-SNPs, having a higher share
22 of under-65 enrollment was not associated with better

1 performance on measures for the under-65 population.

2 So our findings that specialization may give D-
3 SNPs an edge over non-D-SNPs in serving their populations,
4 particularly among the aged, along with the finding that
5 plans with higher shares of enrollees under 65 do not show
6 better performance for the under-65, suggests that we
7 should pay more attention to the needs of the disabled.
8 Because our research and that of CMS found that there are
9 disparities in care for beneficiaries with disability
10 status, we want to pay particular attention to this
11 population and attempt to reduce disparities in care for
12 this population.

13 One way to focus attention on the needs of the
14 disabled is to use the star rating system as a vehicle for
15 improving care for the disabled. We know that MA
16 organizations pay attention to the star ratings because
17 they are tied to bonuses and they are publicly reported.
18 Currently, the measures in the star system pertain mostly
19 to the aged. If there were more measures that applied
20 mainly to the disabled and if such measures were more
21 heavily weighted, that would be a clear signal for focusing
22 on the needs of the disabled.

1 The lack of measures addressing care for the
2 disabled is not a new issue. In 2010, the Commission
3 recommended that more measures should be developed that
4 apply to people with disabilities.

5 There are ways to change the star rating system
6 that do not involve major changes to the manner in which
7 stars are determined. This slide lists two approaches that
8 CMS has used, or proposed, which change the relative
9 ranking of some plans in the star rating system.

10 CMS decides on the weights of each measure in the
11 star rating system. Currently, for example, outcome
12 measures have a weight of 3, while process measures have a
13 weight of 1. In the context of the topic we are
14 discussing, as mentioned in your material, CMS had proposed
15 reducing the weights for some measures where there were
16 population-based differences for low-income individuals,
17 but the proposal was withdrawn.

18 CMS has increased the weight of the two
19 improvement measures it calculates. They previously had
20 the same weight given to outcome measure of 3, but now the
21 two measures are each weighted 5. One possible
22 modification to the weighting approach which helps to

1 address the issue of disparities is to give more weight to
2 improvement only for measures in which we find disparities.

3 At the September meeting, you discussed whether
4 the way to improve care for certain populations is to
5 provide more direct financial assistance to plans with
6 large shares of particular populations. Such an approach
7 would be similar to the Commission's recommendation on
8 providing funds to designated providers through the QIO
9 program to improve their performance. That recommendation
10 called for funding on a budget-neutral basis.

11 On the question of care for the disabled,
12 something that might help is giving plans greater
13 flexibility to design benefit packages based on specific
14 diseases, which is something the Commission recommended
15 when we examined the issue of the various types of special
16 needs plans.

17 And for some additional information that is not
18 on this slide, on the question of funds available to MA
19 plans for low-income individuals, I should mention that as
20 mentioned in the mailing material, for example, the risk
21 adjustment system provides a bump up in payment for dually
22 eligible beneficiaries, about 20 percent for the aged and

1 about 10 percent for the under-65 dual eligibles. Also,
2 all dually eligible beneficiaries received a low-income
3 subsidy for the Part D premium. In addition, because some
4 categories of the dually eligible are full duals, they
5 received Medicaid benefits that the plan might otherwise
6 have to finance, and the Medicaid program is responsible
7 for the Medicare cost-sharing liability. So these other
8 sources of income free up rebate dollars for certain plans.

9 One final point is that when CMS released its
10 findings on this issue that we are talking about today in
11 late September -- in September, rather, the agency noted
12 that -- the direct quote here -- "Parallel analyses are
13 being conducted to determine if modifications are needed
14 for the payment risk adjustment models." They mentioned
15 this in the context of this issue because some of the
16 payment modifications could result in higher payments for
17 certain categories of beneficiaries.

18 Here we review why, for the time being, an
19 interim to this issue seems to be most feasible. We have
20 mentioned that the effects found to date would appear to
21 have a relatively small impact. The stars for 2016 have
22 been determined already and will be posted shortly at the

1 medicare.gov website, and if there are going to be any
2 changes to the star system, there may be a question of
3 whether it is legally permissible under the current
4 statutory authority to have separate stars for bonus
5 determinations and public reporting, if that is the route
6 that CMS would choose to pursue.

7 CMS and the Department of Health and Human
8 Services are continuing to look at this issue, as required
9 by the IMPACT Act in the case of the Department. Later
10 this year, possibly in November, CMS will issue a request
11 for comments that is a preview of the February call letter,
12 and in that preview document, CMS is likely to discuss what
13 its next steps will be on this particular issue.

14 As modifications to the star system are being
15 considered, policymakers need to keep in mind the degree of
16 infrastructure change needed, especially if we are talking
17 about a small effect and there are alternatives that are
18 simpler or more streamlined.

19 So I look forward to comments you may have on the
20 interim solutions and any other issues you would like to
21 discuss, and would remind everyone that we will continue to
22 monitor the ongoing work of CMS and the Department on this

1 issue. Thank you.

2 DR. CROSSON: Okay. Thank you, Carlos.

3 We'll start as usual with clarifying questions.

4 DR. BAICKER: This was very helpful, and thank
5 you for answering my question, and we can get back to that
6 in Round 2. But just a quick question about the assessment
7 of the small versus large impacts. I want to be sure I --
8 I think I understood from the mailing materials that the
9 measures that were excluded were case mix adjusted, which
10 is different from risk adjusted. That's about the survey
11 issues. I just want to be sure that the measures that were
12 excluded weren't the very ones in which we would expect
13 there to be a bigger effect. But I took that to be more
14 about the survey methodology than about risk adjustment.

15 MR. ZARABOZO: They excluded the case mix
16 adjusted measures, which is the CAHPS measures and the
17 measure, for example, of was there improvement of physical
18 or mental health coming from the health outcomes survey,
19 which are pretty heavily weighted.

20 DR. BAICKER: And the reason to exclude those is?

21 MR. ZARABOZO: That they already incorporate
22 these factors, such as low income, for example, in the

1 CAHPS.

2 DR. REDBERG: Thanks for the helpful
3 presentation. You had mentioned when you showed us Slide
4 12 that CMS withdrew their proposal to down-weight certain
5 measures. Were there particular reasons or problems? I'm
6 interested in --

7 MR. ZARABOZO: Yeah, that was mentioned in the
8 mailing material, that for some plans it did not help them
9 very much; other plans said, well, you know, you're not
10 paying attention to measures that are important to measure
11 and, therefore, you shouldn't be down-weighting them. And
12 once you start removing measures, what are you left with in
13 terms of the measures that you're looking at?

14 DR. MILLER: The other thing I would add to that
15 is I think there's a fairly -- these two statements are not
16 inconsistent with one another. You can say that there's a
17 statistical relationship, but the effect may not be large.
18 And I think there's a perception out there that this is
19 going to move large blocks of money around and a lot more
20 activity. And I think the realization is starting to dawn
21 that it might not be as big as people were thinking. And
22 so I think some of the reaction that CMS got to this was

1 where is the large action that we thought we were going to
2 see here.

3 MS. UCCELLO: So this is on the tailored benefit
4 package issue. Did CMS just recently announce a
5 demonstration or something that would allow MA plans, like
6 a VBID type approach?

7 MR. ZARABOZO: Yes, CMS announced a VBID
8 demonstration.

9 MS. UCCELLO: I was confused -- I didn't read it
10 in detail, but I was a little confused by it. It made it
11 sound like it was -- that you would still have plans that
12 were particular for certain people, almost like a C-SNP.
13 Or did I read it wrong? Could you just have one plan that
14 covers all these people, and you could vary the benefits
15 based on their condition?

16 MR. ZARABOZO: My impression was you could vary
17 the benefits. For example, targeting disease, so let's say
18 diabetics, you will provide transportation only for
19 diabetics because you want to see them. So it's similar to
20 our recommendation that we said, you know, rather than
21 having C-SNPs, we would like, within larger plans, the
22 ability to say, yes, we have a different benefit package

1 based on a person's disease, which is currently not
2 possible.

3 MS. UCCELLO: Okay. Thank you.

4 DR. MILLER: And that was the other reason or
5 even the main reason we put it on the list, is we were
6 trying to say -- you know, there's a couple different ways
7 that you can go at this, one of which is giving the plans
8 greater flexibility to tailor their benefit to the disabled
9 population, for example, that they have, even if it's
10 small, it may give them some greater ability to move the
11 quality and scores, et cetera, on them. And we just wanted
12 to make sure to remind you that we have a standing
13 recommendation in that area, and you could think of a
14 statement that says you need to do some things we said
15 before, and, you know, you could mix and match how you
16 responded.

17 MS. UCCELLO: I just have one more. So the risk
18 adjustment model includes factors for disability and low-
19 income?

20 MR. ZARABOZO: Yeah, originally entitled based on
21 disability as a factor, for example, and then the
22 demographic factors are age factors, and then low income.

1 As I mentioned, dual status gives you an increased payment.

2 MS. UCCELLO: And is there any sense that those
3 bump-ups aren't big enough?

4 MR. ZARABOZO: Well, on the dual status issue,
5 for example, Dan Zabinski did some work that said, you
6 know, currently the dual status bump-up is any category of
7 dual, which is both the partial duals and the full duals.
8 So if you make a distinction between the two when there's a
9 valid reason for doing so, you may have more payments going
10 on behalf of full duals, for example.

11 DR. HOADLEY: I think you started to hit on this
12 with Cori's question, but on the point about tailoring the
13 benefit package, can you remind me what were some of the
14 things that we had in mind in that recommendation of a
15 couple of years ago?

16 MR. ZARABOZO: It was, for example, reducing cost
17 sharing or eliminating cost sharing for physician visits
18 for people with certain diseases. I mentioned
19 transportation limited to -- so, for example, some of the
20 C-SNPs that we talked to said we do this for the purpose of
21 transportation, that's why we have a C-SNP for diabetes
22 because those people need to be seen more often. We cannot

1 to our entire population provide this level of
2 transportation. It's not economically feasible. So, you
3 know, the benefits and the cost sharing is what we were
4 looking for changes in.

5 DR. HOADLEY: Thank you.

6 DR. CROSSON: Okay. No more clarifying
7 questions, so I suggest we enter into a discussion here,
8 and I tried to see if I could catalogue the different
9 potential directions we could go in, and I may not have
10 gotten that completely correct. But one is that we could
11 decide that this problem, although it's real, is small
12 enough that we should just leave it alone and not propose
13 solutions that add complexity based on trying to solve a
14 problem that is real but relatively small.

15 We could simply reiterate previous positions of
16 the Commission, including that one way to address this
17 would be to allow for plan flexibility to tailor benefits
18 and, therefore, potentially improve the quality of care for
19 these populations and move their star ratings up.

20 We could suggest one or more set of changes to
21 the measurement process or the process of converting
22 measures into star ratings.

1 We could, on the other hand, suggest that the
2 star rating methodology and the conversion of the measures
3 to star ratings stay the same, but in recognition of the
4 financial impact of this on a small number of plans
5 suggests an add-on payment for plans that have some
6 percentage of disabled patients or low-income patients or
7 both.

8 Or we could simply suspend our discussion and
9 wait for the CMS proposed rule and then make comments on
10 that based upon our wisdom and thinking at the time.

11 I think those are the five options. I may be
12 wrong. So not seeing anything else, I thought we might
13 discuss and see whether there's a central tendency here on
14 the Commission to move in one direction or the other of
15 those -- and I'm very sorry -- five possibilities.

16 Who would like to lead off this one?

17 DR. SAMITT: So as I think about what we're
18 trying to accomplish here, I would imagine there are two
19 things. One is to assure that the plans have necessary
20 resources to manage this critical and disabled needy
21 population, and the second is to continue to instigate
22 toward further improvement in quality outcomes. And so of

1 the five options that you've identified, I don't think
2 there are many that achieve both.

3 I don't know the degree to which your Option 2,
4 allowing the plans flexibility around benefits, achieves
5 these various outcomes. So I'd love to learn more about
6 whether that allows the redeployment of resources to
7 improve quality that those plans don't currently have.

8 But the only other one that I also think does
9 both, gives necessary resources and instigates quality
10 improvement, would be to find a simple but elegant way to
11 change the measurement process or to allow like plans to
12 compare with each other from a stars achievement
13 perspective as opposed to being blended in the broader
14 stars pool. But, you know, I would not advocate for just
15 adding on to the plans with a larger percentage of disabled
16 patients because that doesn't necessarily instigate and
17 redirect those resources toward quality improvement. So
18 that would be my vote.

19 DR. CROSSON: Thank you. And I'm sorry, but
20 Craig actually brought up a sixth possibility.

21 [Laughter.]

22 DR. CROSSON: No, legitimate, because we had

1 thought about this as well, and that would be some process
2 of tiering. So taking plans that had a large percentage of
3 disabled or low-income individuals, beneficiaries, and put
4 them into a separate tier so that they would have their own
5 tier or star ratings separate from the others, and then the
6 regular rules -- but the measurement process would be the
7 same, but they'd be comparing like to like. That's a sixth
8 potential possibility.

9 DR. BAICKER: Just following up on Craig's point,
10 he mentioned simple but elegant, and I would note that that
11 does not appear to be our specialty.

12 [Laughter.]

13 DR. BAICKER: And given the magnitude -- I was
14 very interested to learn about how small a difference this
15 made in most cases to include some of the candidates we
16 thought were the most likely candidates, and that combined
17 with the absence of the simple, elegant improvement to the
18 less than simple and elegant system that we have right now
19 might argue for leaving well enough alone until we get the
20 next round of analysis, which I thought was really helpful
21 to my thinking about this.

22 DR. CROSSON: I'm sorry, Kate. Analysis from

1 MedPAC staff or --

2 DR. BAICKER: Wait for the CMS report.

3 DR. CROSSON: Yes, I see. Thank you. Okay.

4 Who else? David, you were the one who said --
5 yeah, go ahead.

6 DR. NERENZ: Yeah, just a couple of points, and I
7 think I may end up after this in our set of choices perhaps
8 where Kate was.

9 A few of the interim things that are discussed
10 here I think are okay, but obviously not perfect, and I
11 think in the long term, rather than down-weight some
12 measures, for example, it would actually be better to keep
13 them but adjust them. And I've made statements in this
14 room in the past why I think that's a good idea. We could
15 get into that again if you want to. So I don't know that
16 it makes sense to do something quick that's imperfect if we
17 could do something -- if it's not a crisis right now.

18 One of the things about that down-weighting that
19 I just want to point out is it does effectively distinguish
20 between process and outcome measures. The ones that are
21 down-weighted are outcome measures. And I think that
22 distinction really matters in this discussion. It is

1 crucial in this discussion. The measures in which these
2 social and other effects have their effect and generates
3 all the debate are largely in the outcome domain. They're
4 really not so much in the process domain.

5 And so one approach to a problem is to say, well,
6 let's just down-weight the measures in which we have the
7 problem and maybe it'll just go away if we sweep it under
8 the rug. But I think in other contexts, we've favored
9 outcome measures. We say outcome measures are important.
10 We want to move in that direction. And then I think
11 consistent with that is to say, yeah, let's move in that
12 direction, let's weight them heavily, but let's get it
13 right.

14 Now, just very briefly, part of the reason it's
15 in my head about getting it right is that the crucial thing
16 about outcome measures, at least as I would phrase it --
17 and an article in this week's JAMA said it the same way --
18 outcomes are determined by quality of care and other
19 things. They are multiply determined, and if you want the
20 measure to reflect quality of care, you have to deal
21 somehow with the other things. And that's a big debatable
22 philosophy point, but at least as I think about it, there's

1 quality of care and -- and you have to somehow deal with
2 the "and." Down-weighting just kind of pushes it away.

3 So a couple of points then about like additional
4 dollars for quality improvement or measures for
5 improvement. It sort of spins off the point I just said.
6 In some of the cases, plans will not be able to improve
7 because they can't affect the "and" where it's extremely
8 hard or expensive to affect the "and." So I don't want us
9 to get into this territory and say, well, let's just find
10 other ways to have plans improve and then it will all
11 eventually work out. I think one of the points about
12 adjustment is that some of the factors that are in play
13 here are just not subject, are not amenable to quality
14 improvement. Again, I understand it's debatable, but I
15 think we have to pay attention to that.

16 And then the last thing, just about what are big
17 or small effects, I just want to perhaps remind a point.
18 Because we're a Payment Advisory Commission, we naturally
19 pay closest attention to the dollars, and we look at which
20 dollars move where and which policy approaches move dollars
21 this way and that way. But the star system is not just
22 about dollars. It's about public reporting. It's about

1 identifying plans as good plans or bad plans, highest,
2 lowest, and presumably that public reporting exists for a
3 purpose, for people to use the information to choose.

4 So I don't want us to just pay attention to where
5 the dollars shift, of crossing one particular threshold. I
6 really want us to think about where the star ratings
7 themselves shift, because part of what goes on here is
8 public identification of plans as good or bad. Again,
9 we're doing it for doctors, we're doing it for hospitals.
10 But, you know, here the focus is on plans.

11 So short term, I think I may end up saying let's
12 -- if the better solution is one that takes a little more
13 time and is hingeing on some CMS action, maybe it would be
14 best to do that. Get it right rather than do something
15 half-baked quickly.

16 DR. CROSSON: Thank you. But the central
17 tendency, I think, of what you're saying is something in
18 the range of actually altering the measurement process or
19 perhaps -- and/or creating tiers. Would those be --

20 DR. NERENZ: I favor the former over the latter,
21 but latter does something -- again, the tier thing is
22 usually -- it's like what we did a couple years ago with

1 readmission. It does do perhaps a good thing with payment.
2 It doesn't speak to the problems of public reporting
3 because you still get flagged as -- now, in Craig's
4 example, you might tweak it that way. But, no, I actually
5 would be okay with changing the underlying measurements,
6 the specs of the measure to include adjustment when
7 justified, when there's a big "and" and a relatively small
8 quality contributor.

9 DR. CROSSON: So let me be clear what I was
10 saying in terms of tiering, because maybe that's not clear.
11 The notion would be, arguably, to take the plans that
12 qualified by having some percentage of low-income and/or
13 disability. They would then be put into the star rating
14 system, but compared among themselves. So they wouldn't
15 necessarily have the same low star ratings unless they
16 were, in fact, low in comparison to like plans.

17 DR. NERENZ: And we've essentially done that with
18 readmissions. I think it's not a bad thing to do here. So
19 I'd be generally okay with that. I think you start having
20 trouble when there starts being five, six, seven factors
21 upon which something matters, and then you've got this big
22 grid with 50 cells in it and the plan is in one cell and it

1 gets tough.

2 DR. CROSSON: Okay. So let's now start the
3 general discussion. We'll start with Kathy.

4 MS. BUTO: I was misunderstanding of the tiering.
5 I thought -- and I don't know if this is one of your six
6 options -- that you were talking about sort of a different
7 set of measures, particularly for plans that deal with
8 people with disabilities as opposed to -- because if you
9 look at the measures, the ones where there's great
10 disparity tend to be screening measures. Most of them are
11 process. Most are screening. It seems to me with an
12 under-65 disabled population we're talking about different
13 things that we care about and that the population cares
14 about when they're looking at which plan to choose, how
15 well does this plan actually manage different areas of
16 disability, whether it's mental disease or physical
17 disability or, you know, access to care in other ways.

18 So I don't know if that's an option, but I don't
19 think the low-income population is in the same bucket as
20 disability. I would actually leave the low-income
21 population in the general population and think about
22 whether CMS ought to dedicate some resources to providing

1 better resources, educational resources to those plans that
2 have a concentration of low-income to better reach those
3 populations in terms of screening. And when I was at HCFA,
4 one of the things we tried to do with HIV/AIDS testing is
5 we actually worked with different organizations like the
6 Council of Black Churches because you have to get out
7 information in a different way if you're trying to reach
8 certain populations that may not pay any attention to
9 Federal or even managed care plan outreach. So it just
10 seems to me the issues are different for the low-income
11 versus the plans that focus on disability.

12 I guess having said all that, I'm inclined to
13 wait because I don't see a clear solution. It doesn't seem
14 to me that just using the same measures with the disability
15 population in either downrating them or putting them in a
16 tier with low income really gets at either of those issues
17 very well, at least at the moment.

18 DR. CROSSON: Thank you, Kathy.

19 So just to be -- I was going to say "to be
20 clear." This is actually making it more obscure.

21 [Laughter.]

22 DR. CROSSON: A lot of the six solutions could

1 apply to both low-income and disability or to one or the
2 other. If you -- because, yes, I think Carlos has
3 demonstrated that the impact of high numbers of under-65
4 beneficiaries has more impact than the low-income. So
5 that's good. So let's go down this way.

6 MS. UCCELLO: So, last month, I think it was Dave
7 and I who sounded like we were probably on the opposite
8 sides of the continuum, and I think if -- but, I think we
9 actually agree more than we disagree. And if I can just
10 kind of engage him here to make sure I understand this, you
11 know, making sure we get the measure right, are you saying
12 that getting measures in there that truly can gauge the
13 quality for a disabled population and have that as part of
14 the whole quality ratings, is that where you're trying to
15 get at with that last part of your comment?

16 DR. NERENZ: Let me just emphasize again, I focus
17 very heavily on outcome measures, so some of what I'm going
18 to say has nothing to do with most process measures. If
19 you're going to use an outcome measure as a measure of
20 performance or a measure of quality of care, you have to
21 start with this idea that it's determined by quality and.
22 And I think to get the measurement right, if you're

1 considering quality of performance, you have to somehow
2 deal with the "and." It's just a basic fundamental -- why
3 do you ever adjust anything for anything.

4 But, that is driven by the idea that -- you have
5 to accept the idea that there's this "and" component. If
6 you look at the measure and say, that's just pure
7 unadulterated quality of care because we declare it so,
8 then you don't adjust. But, I don't view it that way.

9 MS. UCCELLO: And I think I just -- I try to push
10 that box out as much as we can on taking some of that "and"
11 and bringing it in, to the extent that's possible. But, in
12 general, in -- so, I like -- I personally want to keep the
13 bar as high as we can when we're assessing these plans,
14 along with giving plans the tools and the resources that
15 they need to help achieve what we hope they can achieve.
16 So, reiterating our comments and recommendations in the
17 past regarding fee bid type approaches for this population,
18 I think would be appropriate.

19 And, in terms of -- instead of thinking about
20 this payment add-on, if we recast that as kind of
21 reiterating our recommendation on the partial versus full
22 dual in the risk adjustment, I think that's where that kind

1 of add-on comes in and comes in appropriately. So, that
2 would be where I would want to go.

3 DR. MILLER: The other thing I'll say, and I
4 didn't realize we had sat you two right next to each other
5 --

6 [Laughter.]

7 DR. MILLER: -- but in retrospect --

8 DR. NERENZ: She said we really don't disagree
9 that much. We worked this out last month.

10 DR. MILLER: I think it was brilliant, actually,
11 doing it that way, whoever.

12 [Laughter.]

13 DR. MILLER: The other thing that I felt like I
14 heard in terms of your comments, both last time and to some
15 extent this time, is what public reporting is for, and
16 David, you seem to focus on the fact it's, like, well, it's
17 to say which plans are good and bad, and I think there's
18 some truth to that.

19 But, I think the reason public reporting was
20 created was to move quality for the population, and
21 sometimes I feel that's what you're saying. And while you
22 seem to be, but the "and" should be out if it's really an

1 "and," and I think Cori is trying to say, but, shouldn't --
2 Cori is saying maybe the "and" -- you know, reach to put
3 the "and" in, and that's, sometimes when I hear you two
4 talk, the difference that I hear.

5 And, now, Jim, could you move them to different
6 seats?

7 [Laughter.]

8 DR. BAICKER: But, also, just to --

9 [Laughter.]

10 DR. MILLER: Don't do it.

11 [Laughter.]

12 DR. BAICKER: Just to clarify my understanding of
13 the choice base, when we say include or exclude, it may
14 actually be the opposite of what people are picturing in
15 the model. When I hear you say you need to take the "and"
16 into account, to me, that means, no, put it in the
17 regression model because we want to hold fixed these other
18 things. And whereas you say including these factors, you
19 actually mean not including them in the regression because
20 you don't think that quality should vary based on those
21 things, so you don't want to control for them. And, then,
22 the --

1 DR. NERENZ: And there's exactly the distinction,
2 and this runs through this entire big debate every time we
3 have it. Is quality one contributor to outcome, among
4 other things, or is the outcome quality itself? And, I can
5 -- it's harder for me to articulate that second view. Is
6 that just -- is it a dimension of quality itself, and all
7 the contributors, whether it's community factors, crime in
8 the neighborhood, what not, that's just all wrapped into
9 quality. Dealing with it is quality. Maybe that's a way
10 to do the distinction. Is it or isn't it?

11 DR. BAICKER: But, what I took from what you said
12 is a really helpful distinction to draw is the goal is for
13 the stars to capture quality of care delivered by that
14 entity. For process measures, maybe we think you don't
15 need to control for those things, like giving the patient
16 the right -- giving the patient antibiotics before the
17 surgery should have nothing to do with those other factors.
18 It's a process measure. Cori's -- I'm going to call it
19 Cori's regression -- makes all sorts of sense, because you
20 don't -- those things shouldn't affect that, whereas for
21 the outcome measures, as you were distinguishing, we can't
22 use those as a clean measure of quality because all of

1 these other things contribute to it.

2 So, conceptually, it makes more sense to say, if
3 you want to isolate the quality delivered in that entity,
4 you need to control for those other factors because they
5 are directly affecting -- they are confounding your
6 estimates of quality --

7 DR. NERENZ: Independently affecting.

8 DR. BAICKER: -- and you do want to control for
9 them. So, with the same principle, you might get different
10 regressions, depending on whether the outcome variable is
11 more or less confounded by those factors.

12 DR. NERENZ: [Off microphone.] Yes.

13 DR. CROSSON: As you say.

14 [Laughter.]

15 DR. MILLER: Jim, if you could also get Kate into
16 a different --

17 [Laughter.]

18 DR. BAICKER: Could I be seated further away? Is
19 that possible?

20 [Laughter.]

21 DR. MILLER: That's what I'm asking.

22 [Laughter.]

1 DR. CROSSON: Moving on -- I'm sorry.

2 DR. HOADLEY: I'm not sure what I should say at
3 this point. You know, I'm finding this hard -- struggling
4 with trying to think about these things, and maybe that
5 comes back to that answer that we shouldn't try to take any
6 particular direction until we've heard more or until this
7 issue matures in some way. I think I'm going to leave it
8 at that.

9 DR. CROSSON: Okay.

10 DR. HALL: I sort of get into this conundrum and
11 then say, what's in it for the Medicare recipient? So, if
12 I'm the average Medicare recipient and I am in a community
13 that has seven or eight MA plans and I'm choosing, they
14 say, well, just look at the ratings. Well, it sounds like
15 four-and-a-half is better than four. I'm not sure that
16 actually means anything. It's like all ratings, that we
17 rate colleges, we rate medical schools, we rate toothpaste,
18 and the idea is you simplify it down to a point where it's
19 an almost meaningless measurement.

20 On the other hand, given all the discrepancies in
21 the things, if one plan has a rating of five and the other
22 one has a rating of one, I'm probably going to take that

1 pretty seriously.

2 So, I think we expect more from ratings that have
3 a five-star system -- that it's going to answer all of our
4 problems, and I think you're just pointing this out, that
5 it's impossible to do it. And maybe that's almost the
6 point that needs to be conveyed. And if we are really
7 worried that it's reflecting major quality issues, then we
8 need to revise it in a big, major way. But, I think we
9 need to know a lot more about this until we say it.

10 And, the other thing is, do we know much about
11 how consistent these populations are? When consumers have
12 choice of five or six MA programs, doesn't this change from
13 year to year, depending on sort of the luck of the draw,
14 more or less? You may have less low-income. You may have
15 less disabled. It's not a constant, is it, over time, or
16 is it?

17 MR. ZARABOZO: Well, the low-income, of course,
18 can change plans on a month-to-month basis.

19 DR. HALL: Right.

20 MR. ZARABOZO: But, there isn't really -- you
21 know, we did a little analysis of the movement. There's
22 not that much movement across plans, if that's your

1 question.

2 DR. HALL: Okay. So, I think we may be trying to
3 solve problems a little prematurely here.

4 DR. CROSSON: We'll come back up this way.
5 Warner.

6 MR. THOMAS: So, I tend to lean more towards
7 Craig's comment, that I think reporting similar plans and
8 comparing them is important. There is a difference here.
9 It may not be material, but there is a difference. And, to
10 me, that does impact the ratings. It impacts the quality
11 measures, and I think we need to take that into
12 consideration.

13 DR. CROSSON: Thanks. Herb. Oh, I'm sorry,
14 Bill.

15 MR. GRADISON: I support number five,
16 particularly because the timing of the cycle of the
17 announcements of the stars. I think that letting a few
18 months go by isn't going to substantially affect the
19 influence we might have simply because of the timing
20 situation.

21 Tiering, I'd like to give a lot more thought to
22 that, because I don't know what other tiers might be

1 suggested in the future. I haven't examined the data, but
2 what if we were to find, hypothetically, that in MA plans,
3 people over age, say, from 85 and over have substantially
4 different outcomes within the plans than people 65 to 75,
5 which could -- I don't know what the facts would show, but
6 if we were to find that, and if we start down this tiering,
7 I think we'd be hard-pressed to say, well, maybe we should
8 have a separate category for that, as well. So, I
9 appreciate that's purely a hypothetical, but, bottom line,
10 number five would be my choice at this time.

11 DR. CROSSON: Herb. Herb, and then Rita.

12 MR. KUHN: So, I appreciate this conversation,
13 because I think we're all trying to seek equity, equity for
14 the plans and equity for the beneficiaries and this issue
15 of outcomes, as David, I think, so artfully said, and the
16 "and" and how you deal with that.

17 But, I guess I have a question for Mark.
18 Obviously, there will be -- as Carlos said, there's some
19 information maybe come out next month, and then,
20 ultimately, a call letter in November. Do you have all
21 that you need with past positions the Commission has taken
22 in order to respond effectively to these asks for

1 information or these issues that CMS will be putting out?

2 DR. MILLER: I mean, the other thing, just before
3 I try and answer your question, is there's also a mandated
4 study that CMS is supposed to do which also comes in behind
5 those.

6 There is certainly -- as you can see, there's a
7 lot of material from positions the Commission has taken
8 where we could say some constructive things for you to
9 think about, CMS, are these, or bear in mind, Congress,
10 there are some legislative recommendations we have made
11 that we think could potentially help the situation, i.e.,
12 let all managed care plans tailor their benefits toward
13 certain populations. So, there are certainly constructive
14 things we can say without having to litigate this specific
15 issue, which the Commission doesn't seem to be completely -
16 - or having to litigate the issues in this room that the
17 Commission doesn't have consensus on. There are still
18 constructive things that we could say. And we could also
19 say it in a way of, these are just ideas that you, CMS,
20 could consider that are consistent with past positions.

21 So, there is, I think, reasonable responses that
22 could be put on the table without having to resolve the

1 thing -- the few things -- well, you know, without having
2 to mix up David and Cori, and then however Kate fits into
3 that --

4 [Laughter.]

5 DR. CROSSON: Rita.

6 DR. REDBERG: So, I think it's been a great
7 discussion, and I would favor, I think, leaving option
8 five, that is, until we have the CMS input announcement.

9 And, tiering is interesting, but I have some
10 concerns with it, because -- I mean, as David alluded to,
11 we sort of want good outcomes for everyone, and when you
12 start saying we're going to make adjustments and
13 suggesting, then we're suggesting less than the same
14 outcomes for some populations.

15 And I appreciate the reference to the JAMA
16 article, which, you know, was a comment on a JAMA Internal
17 Medicine article which I happen to know very well, which
18 pointed out that patient characteristics that are out of
19 our control, like housing and income and race, really
20 played a big part in sort of readmissions and probably
21 other quality ratings, and clearly that isn't something
22 that Medicare can -- itself can address and adjust for very

1 much.

2 But, it does also, I think, beg the important
3 question of what are the outcomes measures, because what we
4 have here listed as outcomes measures are not outcomes
5 measures, I would say. You know, these are -- I think they
6 called them intermediate outcomes, but they're really -- I
7 mean, outcomes are things that patients can feel. I mean,
8 these are -- controlling blood pressure, medication
9 adherence, we hope that they could reflect outcomes, but,
10 unfortunately, they don't actually reflect outcomes, most
11 of them.

12 For example, again, a paper published last year
13 in JAMA Internal Medicine from the Yale Group analyzing
14 Medicare data showed we have more admissions now for
15 hypoglycemia than we do for hyperglycemia, and some of
16 that, I think, can be attributed to the well-intentioned
17 outcomes measure of controlling HbA1c, and we've now gotten
18 so aggressive on controlling HbA1c that we're putting more
19 people into the hospital because they're too low on their
20 blood sugar, and I have a lot of concern.

21 I actually was talking to a colleague just a few
22 days ago at work who takes care of a lot of diabetes

1 patients who told me that another unintended consequence of
2 our outcomes measures is that a lot of doctors are now
3 screening healthy patients for diabetes because it's so
4 much easier to control HbA1c in people who are borderline,
5 not really diabetic, than they are -- and, so -- and the
6 same with the blood pressure measure. You know, a lot of
7 our Medicare beneficiaries suffer from falls because
8 they're on too many hypertensives.

9 So, I think before we start tying a lot to our
10 outcomes measures, we need to really have another look at
11 what we're calling outcomes, which I'm saying are not
12 outcomes measures, and look at harm and really kind of make
13 outcomes measures something meaningful that we can really
14 get behind.

15 The last thing I wanted to point out is that,
16 right now, we don't have any quality measures or process
17 tied to overuse, and there's a lot of overuse that leads to
18 harm in the Medicare population. For example, the diabetes
19 measures are supposed to apply to patients 18 to 75, but I
20 think a lot of our population is over 75 and more likely to
21 suffer. And then outside of these, the cancer screening
22 measures, a lot of them stop at age 75, because after --

1 you know, the mammography and colorectal cancer screening,
2 because the harm exceeds the benefit past that age group.
3 I think we should have quality measures that look at
4 overuse or inappropriate use in our beneficiaries over 75,
5 because that's where harm starts exceeding benefits.

6 DR. CROSSON: Thank you, Rita.

7 Jon.

8 DR. CHRISTIANSON: I think I agree with Kate, but
9 it's a long time ago, so --

10 [Laughter.]

11 DR. CHRISTIANSON: So, it's on a general
12 principle.

13 [Laughter.]

14 DR. CHRISTIANSON: No, I think the idea is the
15 dollars aren't that big. CMS has been charged to do work
16 in this area over the next few months and we have some
17 positions that we've taken in the past that are relevant,
18 so I would say that we shouldn't do anything other than
19 reaffirm those positions right now.

20 DR. CROSSON: Kathy.

21 MS. BUTO: Just to, I guess, keep my position
22 that I think we should wait for CMS, but I'm wondering,

1 Mark, whether we could encourage CMS to find out a little
2 bit more from the disability community as to whether the
3 star ratings are helpful. So, if they don't find them
4 helpful, or if they find them -- if they're distressed in
5 some way, it would be good to get that input as they think
6 about the next step in the process.

7 DR. CROSSON: Okay. Thank you, Kathy, and thank
8 you all.

9 This has actually been a very good discussion,
10 both this discussion and in September, because I think what
11 we've done here, not just for ourselves but for others who
12 are looking at this, including potentially our colleagues
13 at CMS, is to elaborate the complexity of this issue and
14 all the competing values that go into proposing a solution.
15 And I think that's very valuable work. Sometimes, we can
16 reach a consensus and come up to a conclusion, and that's
17 helpful for people who are our customers. But, sometimes
18 simply elaborating the complexity for people who, in this
19 case at CMS, are trying to wrestle with the same issues is
20 a very valuable service, also, although I would have to say
21 if I were at CMS and working on this and sitting in the
22 audience right now, I think I'd be considering a different

1 career. Just a joke.

2 [Laughter.]

3 DR. CROSSON: So, we will -- I think the
4 consensus here is fairly clear, and that is we will not
5 disengage from this issue, but we'll suspend our
6 deliberations pending at least the most -- the soonest
7 iteration of findings from CMS, and then I think we'll be
8 in a position to react and perhaps help refine that, and we
9 think that may occur sometime in the next few months, is
10 that --

11 DR. MILLER: [Off microphone.] -- a couple of
12 versions, but one is early and it's the next few months,
13 and then a couple other --

14 DR. CROSSON: Right. Right. So, any other
15 comments on this?

16 [No response.]

17 DR. CROSSON: Okay. Thank you again for the
18 discussion.

19 We're now at the point in time where we have an
20 opportunity for public comment. If there are any members
21 of the audience who would like to comment to the
22 Commission, please find your way to the microphone so we

1 can see who you are.

2 Okay, so we have one individual. Let me just
3 remind you, as well as the rest of the audience, that this
4 is an opportunity, but it's not the only opportunity for
5 input to the Commission, to the staff and their work. They
6 are available to the public and there is also a website
7 that is an opportunity to provide comments before MedPAC
8 deliberations.

9 So, I'd ask you to identify yourself and your
10 organization, and you have about two minutes to make a
11 comment. When this red light goes back on, that two
12 minutes is up. Thanks very much.

13 MR. ZAMAN: Good morning, and thank you to the
14 Commission for its insightful discussion today. My name is
15 Shahid Zaman and I'm commenting on behalf of America's
16 Essential Hospitals.

17 America's Essential Hospitals is a membership
18 association of over 250 hospitals and health systems
19 dedicated to high-quality care for all, including the most
20 vulnerable.

21 Our comments focus on the Commission's discussion
22 today around quality measurement in MA plans and the

1 discussion yesterday afternoon around the requirements of
2 the MACRA legislation.

3 Appropriate risk adjustment of measures, whether
4 in mix or in MA star ratings, is imperative to ensuring
5 providers and plans are not unduly penalized for serving
6 low-income patients. We are particularly encouraged that
7 CMS in its request for information on MACRA is seeking
8 comment on requiring quality measure data to be stratified
9 by demographic characteristics such as race, ethnicity, and
10 gender.

11 Other factors outside of hospitals' and
12 providers' direct control, such as homelessness, income
13 level, education, and primary language, can influence
14 health care outcomes and skew results in certain quality
15 measures, just such as those for readmissions. Without
16 proper risk adjustment, an essential hospital, other
17 provider, or MA plan serving a disproportionate share of
18 lower-income patients with confounding socio-demographic
19 challenges might be unduly penalized for reasons outside
20 its control.

21 We would ask that, going forward, the Commission
22 make recommendations that take into account the unique

1 challenges certain providers face due to their complex and
2 diverse patient populations.

3 We look forward to following the Commission's
4 work on these issues. Thank you for the opportunity to
5 provide comment.

6 DR. CROSSON: Thank you for your comments.

7 Seeing no other individuals at the microphone, we
8 are adjourned until next month. Thank you all again.

9 [Whereupon, at 11:33 a.m., the meeting was
10 adjourned.]

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