

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Thursday, September 8, 2016
9:58 a.m.

COMMISSIONERS PRESENT:

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AGENDA	PAGE
Context for Medicare payment policy - Jennifer Podulka, Maggie Herman.....	3
An overview of the medical device industry - Eric Rollins.....	68
Public Comment.....	132
Uniform outcome measures under a unified post-acute care payment system - Carol Carter.....	133
Physician affiliation and practice size - Kate Bloniarz.....	174
Preventing avoidable hospitalizations of long-stay nursing facility residents - Stephanie Cameron.....	217
Public Comment.....	289

P R O C E E D I N G S

[9:58 a.m.]

1
2
3 DR. CROSSON: Okay. Let's see if we can sit down
4 and get the meeting started. I'd like to welcome our
5 guests to MedPAC's 2016-2017 series of meetings. We have
6 an interesting array of discussions both today and
7 tomorrow, and we're going to start off, as we customarily
8 do, with the presentation of the context for Medicare
9 payment policy. And we've got Maggie Herman and Jennifer
10 Podulka, and, Maggie, it looks like you are starting.

11 MS. HERMAN: Good morning.

12 Part of the Commission's mandate in law is to
13 consider the budgetary impacts of its recommendations and
14 to understand Medicare in the context of the broader health
15 care system.

16 One of the ways we meet these elements of the
17 mandate is to include in the March Report to the Congress
18 an introductory chapter that places the Commission's
19 recommendations for Medicare payment policy within the
20 context of the current and projected federal budget picture
21 and within the broader health care delivery landscape.

22 The chapter is intended to frame the Commission's

1 upcoming discussions regarding payment updates and policy
2 recommendations. While there are no policy
3 recommendations in the chapter, we are seeking your
4 comments today on its scope, substance, and tone.

5 In today's presentation, Jennifer and I will
6 discuss the main topics of the chapter, which include:
7 health care spending growth and the recent slowdown;
8 Medicare spending trends in detail; Medicare spending
9 projections; Medicare's effects on the federal budget;
10 characteristics of future Medicare beneficiaries and burden
11 of Medicare and health care spending on households; and
12 evidence of inefficient spending in the health care
13 delivery system and challenges faced by Medicare to
14 increase its efficiency.

15 Jennifer will start us off with the first topic.

16 MS. PODULKA: Thank you.

17 For decades, health care spending has risen as a
18 share of GDP, but then beginning in 2009 its growth rate
19 had slowed. As shown by this graph, that general trend is
20 true for health care spending both by the private sector
21 payers as well as by Medicare.

22 As a share of GDP, total health care spending --

1 shown here in the top blue line -- more than doubled from
2 1974 to 2009, increasing from about 8 percent to a little
3 over 17 percent of GDP.

4 Over that same time period, private health
5 insurance spending -- the middle yellow line -- more than
6 tripled and Medicare spending -- the bottom line -- more
7 than quadrupled.

8 Then from 2009 to 2013, health care spending as a
9 share of GDP remained relatively constant, as highlighted
10 by the shaded portion of the spending curves.

11 However, government actuaries estimate that
12 spending modestly accelerated beginning in 2014 driven in
13 part by health insurance expansions under the Patient
14 Protection Affordable Care Act and increases in
15 prescription drug spending mainly on new treatments for
16 hepatitis C.

17 The actuaries project that over the next decade
18 health care spending will continue to gradually increase.
19 Growth rates are projected fall between the lows of the
20 recent slowdown and the earlier highs.

21 Taking a closer look at Medicare during the 2009-
22 13 slowdown period, the year-to-year change in spending per

1 beneficiary slowed in traditional fee-for-service, Medicare
2 Advantage, and Part D. Now, these lines on the chart look
3 a little bit noisy jumping around, but keep in mind that
4 they're showing just the year-to-year changes. The lower
5 rates were generally due to both decreased use of health
6 care services and restrained payment rate increases.
7 Beginning in 2012, the Affordable Care Act reduced annual
8 payment rate updates for many types of fee-for-service
9 providers and in 2011 began lowering payments to MA plans
10 to bring payments more in line with fee-for-service
11 spending.

12 Beginning in 2014, growth is more mixed. Part D
13 shot up to 9 percent in both 2014 and 2015. Fee-for-
14 service growth increased as well but just in 2014 due to an
15 increase in per beneficiary spending on outpatient
16 services. However, overall growth in fee-for-service and
17 MA remained low in the most recent period.

18 Taking a closer look at fee-for-service, even
19 before the slowdown, per beneficiary spending was not
20 uniform across settings. Hospice, SNF, outpatient, and
21 labs, as you can see here, all had high growth in the first
22 set of bars. Then the slowdown from 2009 to 2013, shown by

1 the middle sets of bars, affected settings differently.
2 For example, SNF and labs dropped a lot from their earlier
3 growth rates, while outpatient remained pretty high.

4 There is also variation in growth patterns in the
5 period following the slowdown, shown in the last set of
6 bars. Again, outpatient remained high while this time labs
7 rebounded.

8 Note home health and DME sets of bars. These
9 switched over to negative. These are two settings where
10 Medicare has implemented specific policies to improve
11 efficiency, and the results demonstrate that it is possible
12 for the program to affect spending trends and yield
13 savings.

14 Comparing across the decades on the left side of
15 the graph, the upper light portion of the bars indicates
16 that per beneficiary spending growth has fallen from
17 average annual rates of 10 percent in the '80s down to 1
18 percent from 2010 to 2015.

19 Looking ahead to the next decade, as shown by the
20 right-hand side of the graph, the Medicare Trustees and CBO
21 both project that Medicare beneficiary spending growth will
22 fall between the recent lows and the past highs, with an

1 average annual growth rate of 4 percent.

2 In addition, the aging of the baby-boom
3 generation is causing an increase in enrollment growth, as
4 shown in the bottom darker portion of the bars. Enrollment
5 growth increased from about 1 to 2 percent historically to
6 3 percent over the last 5 years. This increase is
7 projected to continue throughout the next decade. Hence,
8 the Trustees and CBO project growth in total spending,
9 shown in the numbers above the bars, to average 7 percent
10 annually through 2025, which is faster than growth in GDP.

11 This means that the size of the Medicare program
12 will nearly double over the next 10 years. It will rise
13 from \$600 billion in total spending in 2015 to about \$1
14 trillion in 2022 and about \$1.2 trillion by 2025.

15 While spending is growing, Medicare's financing
16 is growing more strained. Workers pay for Medicare
17 spending in part through payroll taxes and taxes that are
18 deposited into the general fund of the treasury. As
19 Medicare enrollment rises, the number of workers per
20 beneficiary is projected to decline. This ratio has
21 already declined from nearly 4.5 percent around the
22 program's inception to 3 today. By 2030 -- the year by

1 which all baby boomers will have aged into the program --
2 the Trustees project there will only be about 2.3 workers
3 for every beneficiary. These demographics are creating a
4 financing challenge for the Medicare program.

5 As you may have heard, the Trustees project that
6 the Hospital Insurance Trust Fund will become insolvent by
7 2028 -- two years earlier than projected in last year's
8 report -- but that date doesn't tell the whole financial
9 story.

10 The HI Trust Fund covers less than half of
11 Medicare spending. It covers Part A services and is
12 financed by that dedicated payroll tax. It is projected to
13 become insolvent in just 12 years as payroll tax revenues
14 are not growing as fast as Part A spending.

15 The Supplementary Medical Insurance Trust Fund
16 accounts for 57 percent of total Medicare spending. It
17 covers services under Parts B and D. It is financed by
18 general tax revenues, which cover about three-quarters of
19 spending, and premiums paid by beneficiaries, which cover
20 the remaining quarter.

21 General tax revenue transfers and premiums are
22 reset each year to match expected Parts B and D spending.

1 Since by design SMI income grows at the same rate as Parts
2 B and D spending, its trust fund is never expected to go
3 insolvent. This doesn't mean that it doesn't also face
4 major financing challenges. It does, which the next slide
5 shows.

6 The line at the top of this graph depicts
7 Medicare spending as a share of GDP. The layers below the
8 line represent sources of Medicare funding.

9 Working up from the bottom, all the layers up to
10 the very skinny red layer in the middle represent dedicated
11 funds collected specifically to finance Medicare spending
12 such as payroll taxes and premiums paid by beneficiaries.

13 Up at the top, that purple area below the total
14 Medicare spending line represents the Part A deficit
15 created when payroll taxes fall short of Part A spending.
16 And in between, the blue layer represents the large and
17 growing share of Medicare spending funded through general
18 revenue. That share is already over 40 percent today. And
19 keep in mind here that general revenue includes both
20 general tax revenue as well as federal borrowing.

21 Of course, these same tax dollars and deficit
22 spending could be used to fund other federal programs, such

1 as education and infrastructure investment. And there's
2 great competition for these tax and borrowed dollars.

3 The white line at the top of this graph
4 represents total federal spending as a percentage of GDP.
5 And the layers below the top line on this slide depict
6 federal spending by program. That aqua line represents
7 total federal revenues.

8 Note that with few exceptions between 1966 and
9 2046, total federal spending exceeds total federal
10 revenues, creating annual deficits that continue to add to
11 the federal debt.

12 Again, working up from the bottom of the layers,
13 Medicare spending is projected to rise from 3.5 percent of
14 our economy today to a little over 6 percent in 25 years,
15 by 2040, indicated by that vertical line toward the end of
16 the graph.

17 In fact, by 2040, spending on Medicare, Medicaid,
18 the other major health programs, Social Security, and net
19 interest will reach about 20 percent of our economy and by
20 themselves exceed total federal revenues.

21 And a final note. The projection here is
22 optimistic in assuming that federal revenues will increase

1 above 19 percent, and it is a little hard to see on the
2 slide. It's an optical illusion. That aqua line is
3 actually inclining up in those later years. It's hard to
4 see. So it's projecting 19 percent in later years, which
5 is greater than the historical share of GDP of about 17
6 percent on the earlier end of the graph. If, on the other
7 hand, federal revenues continue closer to that historical
8 average, spending on the major programs and net interest
9 could exceed total federal revenues even sooner than
10 projected.

11 Shifting from projections of spending, we next
12 summarize the characteristics of future Medicare
13 beneficiaries. A study by the United Health Foundation
14 compares the health status of middle-aged adults -- those
15 who are 60 to 64 years old -- in 2014 to that same age
16 cohort earlier in 1999, who are now current Medicare
17 beneficiaries. The study found that, compared to their
18 predecessors, middle-aged adults about to age into Medicare
19 smoke 50 percent less but have a 55 percent higher
20 prevalence of diabetes, have a 25 percent higher prevalence
21 of obesity, and have a 9 percent lower prevalence of very
22 good or excellent health status.

1 Additional studies indicate that new and incoming
2 beneficiaries have higher rates of some diseases and
3 chronic conditions, such as hypertension and high
4 cholesterol, but are much more likely to have them managed
5 and under control.

6 Evidence also suggests that baby boomers, who
7 largely make up the new and incoming Medicare
8 beneficiaries, may be less financially secure than previous
9 generations in retirement and, therefore, less able to bear
10 the burden of increasing out-of-pocket costs.

11 Since the Great Recession began in 2007, real
12 median household income declined for all age groups under
13 age 65.

14 In 2014, the real median household income for
15 those 55- to 65-year-olds had fallen 4 percent over the
16 previous decade. In contrast, a decade earlier, the real
17 median household income for members of this age cohort had
18 increased by 13 percent.

19 Also, since the Great Recession began, family net
20 worth has declined. In 2013, the 55- to 64-year-olds' real
21 median family net worth had fallen 42 percent in the
22 previous six years. In contrast, over the six-year period

1 ending in 2004, the same age cohort's real median family
2 net worth had increased by 70 percent.

3 In addition, during the same time frame, out-of-
4 pocket costs for Medicare beneficiaries have grown faster
5 than Social Security benefits, which make up a significant
6 or even complete share of many beneficiaries' income.

7 And, finally, the burden of out-of-pocket costs
8 falls on those with private insurance, too. In the last
9 decade, per capita health care spending and premiums have
10 grown much more rapidly than median household incomes.

11 From 2004 to 2014, premiums for individuals and
12 family coverage, which are the top pink and orange lines on
13 the graph, grew 63 percent and 69 percent, respectively.
14 Per capita personal health care spending, which is the aqua
15 line in the middle, also grew more than 60 percent, while
16 the median household incomes shown in the yellow line at
17 the bottom grew just 21 percent. And note that growth is
18 because these are in current year unadjusted dollars. In
19 real dollar terms, median household income actually fell
20 over the decade.

21 In fact, a recent study found that from 2007 to
22 2014, middle-income households' health care spending

1 actually grew by 25 percent while their spending for other
2 essential categories, including food, housing, clothing,
3 and transportation, all fell.

4 Now I'll pass to Maggie so she can discuss some
5 options and challenges to addressing the spending growth.

6 MS. HERMAN: There is a mechanism in law to
7 address Medicare spending growth. PPACA established the
8 Independent Payment Advisory Board, or IPAB.

9 IPAB would consist of 15 presidentially appointed
10 and senatorially confirmed advisors. At this point in
11 time, no advisors have been appointed.

12 This board would have broad authority to propose
13 Medicare payment policies aimed at reducing Medicare
14 spending growth. However, the statute does specify certain
15 sectors that are temporarily exempt from being included in
16 an IPAB proposal.

17 The proposal also cannot ration care, raise
18 beneficiary premiums, increase cost sharing, or alter
19 eligibility.

20 Note that even if no board members are appointed,
21 the IPAB process still proceeds. The responsibility for
22 making Medicare savings recommendations is shifted to the

1 Secretary of HHS. MedPAC would play a role in reviewing
2 these recommendations.

3 The IPAB process is triggered in a year that the
4 Medicare actuaries determine that the projected Medicare
5 spending growth exceeds a specified target. The IPAB or
6 Secretary will then be required to prepare a proposal that
7 reduces Medicare spending growth to fall within the target.
8 To date, the target growth rates have not been exceeded.
9 However, the Medicare actuaries project that it may be
10 triggered next year.

11 The IPAB or Secretary's savings proposal
12 automatically becomes law unless Congress affirmatively
13 acts to amend or block the proposal within a stated period
14 of time and under circumstances specified in the act.
15 Changes to the package are limited to those that would
16 produce at least as much Medicare savings as the submitted
17 legislation.

18 So are there opportunities for savings? Yes,
19 there is strong evidence that a sizable share of current
20 health care spending in Medicare (and overall) is
21 inefficient providing an opportunity for policymakers to
22 reduce spending, extend the life of the program, and reduce

1 pressure on the federal budget. For example, research on
2 Medicare spending shows that areas with higher spending or
3 more intensive use of services do not have higher quality
4 of care or improved patient outcomes. Services that have
5 been widely recognized as low value and even harmful
6 continue to be performed regularly.

7 Also, the United States spends significantly more
8 on health care, both per capita and as a share of GDP, than
9 any other country in the world. There is ample evidence
10 that this difference is driven not by utilization, which is
11 similar to other countries, but by higher prices. As a
12 result, Americans pay more for prescription drugs, hospital
13 and physician services, and other medical goods and
14 services.

15 Despite higher prices and resulting additional
16 spending, studies consistently show that the U.S. ranks
17 poorly on indicators of efficiency and outcomes.

18 For example, In 2013, out of 44 OECD and related
19 countries, the United States ranks first on health care
20 spending, as you can see illustrated by the blue bars, but
21 we rank 28th on life expectancy at birth, shown by the
22 yellow line. And life expectancy in the U.S. at age 65

1 falls below the OECD average and has increased more slowly
2 since the introduction of the Medicare program than gains
3 in other countries.

4 The Medicare program as well as the health care
5 system more generally faces challenges in achieving
6 savings. Medicare has a fragmented payment system across
7 multiple health care settings, reducing incentives to
8 provide patient-centered, coordinated care. It has limited
9 tools to restrain fraud and overuse.

10 Medicare's benefit design consists of multiple
11 parts, each covering different services, and requiring
12 different levels of cost sharing.

13 Medicare can pay different prices for the same
14 service depending on where the service is delivered.

15 And, finally, in the process of setting prices
16 for thousands of services, some services are undervalued
17 and others are overvalued, producing incorrect incentives
18 for their use.

19 The Commission's approach to overcoming these
20 challenges has been to pursue accurate prices that promote
21 the efficient provision of services, to develop policies
22 that encourage high-quality care and the coordination of

1 care across settings, to support policies that improve the
2 information that beneficiaries and providers receive, to
3 advocate for medical education and training that focuses on
4 team-based approaches to care coordination, and, finally,
5 to engage beneficiaries in the decisionmaking about their
6 health care.

7 So, with that, I'll conclude. The presentation
8 only covered a portion of the information that was included
9 in the mailing materials. We welcome your questions and
10 comments on any of the issues discussed in the mailing
11 materials and look forward to your discussion.

12 DR. CROSSON: Thank you, Maggie and Jennifer, for
13 a very excellent review.

14 We're going to start our discussion now. For
15 those of you in the audience who haven't been here before,
16 generally speaking, we have a discussion period that has
17 two elements, where we invite the Commissioners to ask
18 questions of clarification from the presenters, and then
19 Round 2, we begin with a substantive discussion of the
20 issues on the table.

21 So I'm looking for hands for clarifying
22 questions. Bill Hall, David, Jon, Jack. Bill.

1 DR. HALL: Could we go to Slide 10, which is a
2 graph that we've seen a lot of over the last couple of
3 years, always ending in the collapse of the fiscal
4 structure of Medicare, just that the time is getting closer
5 all the time.

6 I just wanted as a clarification, what
7 assumptions go into this graph, which his very potent, and,
8 for example, does it take into factor, other factors that
9 might influence the revenues, for example, immigration into
10 this country that might result in more employed people,
11 more revenue projections, more payment into the federal
12 system; or is this just the straight assumption that there
13 will be no other social or economic changes that might
14 change all these time parameters?

15 MS. PODULKA: This is built off the Medicare
16 trustee's projections, the chart here, and they definitely
17 include estimates of what the beneficiary population is
18 going to look like, what the overall population is going to
19 look like, and so that includes births, deaths,
20 immigration.

21 Now, granted, the further you move out in a
22 projection, the more it becomes an element of methodology

1 and unexpected changes. So we could have a huge number of
2 people who opt to delay requirement, remain in the
3 workforce, and it could look different than expected here.

4 Definitely, the years closer probably are closer
5 to reality. The years out, for anyone making that
6 projection, it's -- I don't want to say guessing game, but
7 it's a little bit more amorphous.

8 DR. CROSSON: I'm going to take Jon out of order
9 here because his question is on the same topic.

10 DR. CHRISTIANSON: Yes, same slide.

11 I was wondering if you had run across some work
12 that Henry Aaron at the Brookings Institute has done on
13 this, and he basically points out that CBO is required to
14 project the Part A trust fund problem as though once the
15 trust fund is exhausted, any difference in terms of
16 spending and stuff will be covered by general revenues,
17 even though -- so that they are required to do that
18 projection, even though they also -- Congress is required
19 by law to keep the trust fund solvent. So he produces a
20 graph under that assumption that looks quite different than
21 the graph that you put there in terms of from 2030 on, it
22 looks a lot different. So, if you haven't seen that,

1 that's worth taking a look at.

2 MS. PODULKA: Thank you.

3 DR. CROSSON: David.

4 DR. NERENZ: Thank you. Slide 12, please.

5 The last bullet, I'm wondering if there's any
6 data on how these two counter-forces net out. The little
7 symbol here implies that there's essentially a wash, that
8 you have higher prevalence, but the better control. Is
9 that symbol meaningful? Are there actually data on how
10 this projects out in terms of likely Medicare costs going
11 forward?

12 MS. PODULKA: This is our incredibly shorthand
13 version of trying to show that the projections are mixed.
14 There are some clear pluses. Smoking 50 percent less is an
15 all-around good, and it's hard to imagine that's a bad
16 thing.

17 The issues there at the bottom where there's some
18 diseases and chronic conditions -- and I mentioned two
19 examples -- have higher rates, but medical care now has
20 better treatments, and patients tend to be more on them.

21 Again, this is looking forward and projecting, so
22 they estimate there's going to be maybe higher utilization

1 while beneficiaries are experiencing a higher quality of
2 life.

3 DR. NERENZ: My question is only on that last
4 point because, as you're just saying, there's an up force
5 and a down force. Are there actual data on how those two
6 forces balance?

7 MS. PODULKA: Well, there are studies that we
8 cite. It's how do you measure that balance. Again, is it
9 greater spending? Yes, there will probably be greater
10 spending, but compared to what? If they didn't have the
11 conditions at all, there's greater spending because you're
12 treating, but if they had the conditions and they were left
13 untreated until they became more severe, there would be
14 even greater spending. So it's hard to say if it's a wash.
15 It's definitely mixed.

16 DR. NERENZ: Well, there's an implied comparison,
17 I guess, just in the wording. We're saying higher rates.
18 I presume that means higher, relative to the recent past.

19 MS. PODULKA: To the previous cohort, yes.

20 DR. NERENZ: Okay. But then that sets the
21 context. Again, because the other graphics here are about
22 trend lines going forward, I'm just trying to figure out on

1 this last point, are these two things net, adding to net
2 higher expected spending, or is the better control
3 reducing, or is it a wash? Or maybe we don't know.

4 MS. PODULKA: Mark, did you want to jump in here?

5 DR. MILLER: I would say we don't know.

6 MS. PODULKA: Yes.

7 DR. MILLER: That's what I would say.

8 DR. CROSSON: On this point, Kathy?

9 MS. BUTO: Yeah. I think it's on the same point,
10 only a related issue. Is there any way -- maybe the answer
11 is what Mark just said: We don't really know, but is there
12 any way to figure out which conditions are really driving
13 or sort of the key conditions driving costs in Medicare?

14 I know some time ago now -- it's been quite a
15 while ago -- CBO did an analysis showing that diabetes was
16 one of the root-cause conditions to drive higher costs in
17 cardiovascular and hospitals and all sorts of related
18 services, and I guess it would be useful if we had some way
19 of trying to quantify that. I think work has been done by
20 the Commission before on the big drivers of cost in terms
21 of beneficiary conditions.

22 MS. PODULKA: Definitely. And thank you for

1 mentioning that. We did include some information in the
2 chapter on leading causes of morbidity and mortality. We
3 can link that to more studies on driving costs as well.

4 MS. BUTO: Right. Spending growth would be
5 helpful.

6 DR. CROSSON: Jack.

7 DR. HOADLEY: On Slide 5, I was struck by the
8 outpatient is the one that's been sort of in a growth mode
9 in all three time periods. Is it fair to assume that part
10 of that is the shift -- the hospital acquisition of
11 practices and therefore the shift of some services from the
12 physician and other health professional bars to the OPD
13 bars?

14 MS. PODULKA: I think that's a fair assumption to
15 make there.

16 DR. MILLER: I think you have some of the basic
17 shift from inpatient to outpatient --

18 DR. HOADLEY: Outpatient.

19 DR. MILLER: -- and then you have what you're
20 talking about, among other things.

21 DR. HOADLEY: And it would be interesting just to
22 -- I don't know if we have any other way to sort of tease

1 that out and whether it's a fundamental shift upwards
2 versus a shift across sectors.

3 DR. MILLER: We will look at it.

4 DR. HOADLEY: Yeah.

5 DR. MILLER: I don't want for you to have too
6 high expectations. I'm always interested in knocking those
7 down whenever I can. But there's also some things we can
8 put back in front of you and perhaps cite a bit in the
9 chapter, where the hospital crew did some estimates of how
10 much some of the -- it wasn't a complete picture. It was
11 looking at selective services and how much they were having
12 an impact on growth and outpatient. We can extract that
13 and bring that back in and see if there's anything else we
14 can bring to that.

15 DR. HOADLEY: Yeah. Just even citing some of
16 that other work --

17 DR. MILLER: Yeah.

18 DR. HOADLEY: -- to give a little more context --

19 DR. MILLER: It's a good point.

20 DR. HOADLEY: -- seems useful.

21 On Slide 15 on the IPAB, one of the questions I
22 had in the chapter, I think you clarified here on this

1 slide, but I just want to ask it to make sure I'm clear.
2 If there is no IPAB and the Secretary is the one that makes
3 the recommendations, all of the next steps follow so that
4 MedPAC would comment on the Secretary's proposal, IPAB, and
5 the Secretary's proposal would have the same sort of
6 treatment in Congress and automatically going into effect
7 if Congress didn't act. Is that correct?

8 MS. HERMAN: Yes, that's correct.

9 DR. HOADLEY: And you had a timeline in the
10 chapter. It looked to me like a sort of shorthand way to
11 summarize it. It's from the time of the trigger that the
12 actuary reports till the time that the default going into
13 law by Congress or if Congress wants to do something is
14 something upwards of a year. So it looked like you didn't
15 actually put a final day. I don't know if there's one in
16 the law as to when Congress has to act or it goes into
17 effect, but it looked like that was somewhere maybe in the
18 12-to-18-month range. Is that --

19 MS. HERMAN: Yes. It moves very quickly. So
20 that the trustees part, which would trigger the IPAB, in
21 the laws projected to come out in April. Typically, it's
22 come out closer to July or August --

1 DR. HOADLEY: Right.

2 MS. HERMAN: -- but then by August of the
3 following year, so the implementation year. If Congress
4 hasn't acted by then, then the IPAB proposal would
5 automatically go into law.

6 DR. HOADLEY: So from April of year one or if
7 delayed and then August of year two.

8 MS. HERMAN: Yes.

9 DR. HOADLEY: Okay. So you're talking about an
10 effective date. So I just think that's helpful. Maybe the
11 chapter could just pick a little more of that, sort of the
12 overall sweep of that time.

13 And then I had one question from the chapter on
14 pages -- it's sort of in the pages 7 to 11, where you're
15 showing one figure that Medicare is about 22 percent of
16 total spending in the system, and then when you break it
17 down by sector, it looked like Medicare was more than 20
18 percent in almost every sector. You don't need to answer
19 this now, but if it's mostly because the other categories
20 that you left out would balance out offers, is there some
21 difference in how the numerator and denominator are
22 calculated? Because it just seems odd to say 22 percent

1 overall, and then I think most of the sectors are sort of
2 22 and updates.

3 MS. PODULKA: That's a good point.

4 DR. HOADLEY: Yeah.

5 MS. PODULKA: We definitely don't want to create
6 confusion with your juxtaposition.

7 DR. HOADLEY: Right. Thank you.

8 DR. CROSSON: Did I see your hand, Brian? Yes.

9 DR. DeBUSK: Yes. I was going to build on Dave
10 and Kathy's comment. As you dig into some of these
11 condition-specific cost drivers, shouldn't those be
12 reflected in the MA-HCCs? I mean, shouldn't there be a
13 correlation there?

14 DR. CROSSON: What are those?

15 DR. DeBUSK: The HCC adjustments that are done in
16 an MA plan. I mean, in theory, shouldn't those reflect the
17 specific costs of some of the conditions that we were
18 trying to break out?

19 DR. MILLER: When you build a risk adjustment
20 system and adjust, yes.

21 DR. DeBUSK: Yes.

22 DR. MILLER: But this isn't always -- depending

1 on what we're looking at here at any given point in time,
2 it isn't necessarily risk-adjusted.

3 DR. DeBUSK: Well, I think the original question
4 was, for example, higher incidence of diabetes or obesity
5 and things like that. Can we break those costs out and try
6 to figure out if the costs of those are being offset by
7 treatment?

8 DR. MILLER: Here is how I would answer this,
9 Jennifer.

10 [Laughter.]

11 DR. MILLER: Pay attention because --

12 MS. PODULKA: I'm ready.

13 DR. MILLER: Right, got it.

14 What I think we can do is go back into the -- I
15 forget the proper title of the condition and organized data
16 set -- give you a sense of some historical sense of here is
17 a condition and here is how spending and incidence or
18 utilization -- or beneficiaries who have these particular
19 conditions. And so you can come away with some sense of
20 what seems to be driving overall spend.

21 I just want to say, again, I don't think we're
22 going to be able to litigate David's question of

1 offsetting. I think that probably gets into a little bit
2 more complication of offsetting over what time period. "I
3 manage somebody's condition, but they live longer," those
4 types of things. I'm not going to promise that because I
5 think that gets into some bigger-order, higher-order
6 questions that I don't know that I could promise you to
7 come back.

8 But I think I can come back and say, "Here is
9 your conditions. Here is what they look like. Here is
10 what the big players look like."

11 Are you okay with all that, Jennifer?

12 [No response.]

13 DR. DeBUSK: No follow-up.

14 DR. MILLER: Okay.

15 DR. CROSSON: Okay. I have Kathy and Rita, and
16 then we're going to move into -- and Warner, and then we're
17 going to move into the discussion. We have a half an hour
18 left. Kathy?

19 MS. BUTO: Okay. A quick question on Slide 5,
20 and I think there's a table in the mailing materials too.
21 And I know this is a selected number of services that
22 you've identified, but I'm wondering if we have a breakdown

1 for IRFs and other post-acute care settings, the ones that
2 we've looked at, because I think as we look at post-acute
3 care, it's helpful to know among them which are
4 experiencing higher growth rates.

5 MS. PODULKA: We can take a look at that.

6 MS. BUTO: Okay. And if you could also just note
7 total spending associated -- share of spending associated
8 with these. So I think per beneficiary, growth rates is
9 helpful, but if we have the Big Megillah or the big area of
10 spending, it is now outpatient hospital. And it's a huge
11 amount of money. It's good to know that as well on that
12 one.

13 And do you have a breakdown also for Part D and
14 Part B drugs or not? Part B, I know is already -- it's
15 sort of incorporated into physician and other health
16 services, but it just strikes me that since we're spending
17 so much time on drugs and growth and drug spending, it
18 would be helpful to have that broken out as well.

19 MS. PODULKA: I believe we can use the same
20 methodology for Part D as well, but I will check on that.
21 I don't want to --

22 MS. BUTO: Okay. I thought you had Part D at

1 least.

2 MS. PODULKA: Yeah.

3 MS. BUTO: And then, lastly, on IPAB again, which
4 I think was Slide 12, I thought huge categories -- and I
5 think the report touches on this -- are exempt from any
6 reductions like hospital services. I guess I try to make
7 more of that in the report. I think that could be
8 dependent. I understand there will be a modest -- I guess
9 exceeding of the growth chart, it's believed, in 2017, but
10 that, I think, poses some unique problems, potentially,
11 because if you put together what IPAB is doing with, say,
12 Slide 5, where the growth is occurring, they may not match
13 up. In other words, we may be taking reductions through a
14 mandatory process that hit areas that aren't growing as
15 fast or where there's an access problem. So I think
16 somewhere, we have to -- although it's in the law, there
17 has to be some acknowledgment that that could happen.

18 MS. HERMAN: Yes, definitely.

19 So, with the certain provider groups that are
20 exempt, they are temporarily exempt, so to expire most of
21 them at the end of 2019. So say IPAB is triggered, they
22 would be exempt from this round, but they wouldn't be

1 exempt in the future. And the reason that they're exempt
2 is because they're already receiving productivity
3 adjustments under PPACA, and not all of that adjustment,
4 but a certain portion of the reduction will expire in 2019.
5 And though IPAB is bound to these rules, the MedPAC report
6 may differ. The law -- it's not entirely clear how all
7 these elements will play out because IPAB hasn't been
8 triggered, so this law hasn't been implemented or subject
9 to rulemaking. So things are still a little bit murky.

10 DR. CROSSON: Rita.

11 DR. REDBERG: Thank you.

12 On Slide 3, when I was reading -- and it relates
13 a little bit to your second question -- it's the whole
14 question of absolute and percentages. Do you think you can
15 account for any of the recent slowdown and growth of health
16 spending? For example, if spending kept going up \$100 a
17 year, it would keep going up \$100 per year, but the
18 percentage would keep dropping because the pie has gotten
19 so big. And the pie is huge now. We're talking \$3
20 trillion in health care spending. I'm just wondering if we
21 looked at absolute numbers because it's certainly striking
22 we spend so much more per capita than OECD, and we only had

1 one year of that OECD. But I'm sure it's been true for the
2 last 20 years or 30 years that you've given us on this
3 graph. But I just wonder if there's any way to sort of
4 give the absolute spending as well as the percentage of GDP
5 over time.

6 MS. PODULKA: We do -- we struggle with this one
7 because we're sorry we made you look at all those many
8 figures and pages.

9 DR. MILLER: We're not sorry for that.

10 [Laughter.]

11 MS. PODULKA: You don't be sorry. I'll be sorry.

12 So Slide 7, that includes the projection, is in
13 total dollars. We're shifting back and forth, and that's
14 also kind of problematic. We have a tendency to like to
15 put it all together in one graph, and then Mark and Jim
16 kind of cringe on that one because nobody can read this
17 thing. So we're struggling with how to present it.

18 We do need some more references back and forth.
19 Now, this is a share of -- remember on the total pie or
20 this is a share of percentage -- is continuing to use share
21 of DDP in part of the figures helpful at all?

22 DR. REDBERG: Oh, yes. It is, particularly when

1 you start talking about those huge percentages that are
2 coming up and cutting into the general tax revenue and
3 displacing other things. We worry about the future when
4 we're crowding out education for Medicare spending,
5 especially when you don't see improvement in quality or
6 outcomes associated with it. It doesn't seem like a good
7 plan for continued health of the nation.

8 MS. PODULKA: We'll take a look and see if we can
9 -- and put things together in a slightly different way,
10 maybe reorganizing and including the words to explain,
11 like, you need to look at this and this figure at the same
12 time or in conjunction.

13 DR. MILLER: Yeah. It does feel like if we can
14 get some absolute numbers in places, that will address
15 this.

16 DR. CROSSON: Warner.

17 MR. THOMAS: On Slide 4, the three buckets of
18 expenditure, Part D, fee-for-service, MA, do you roughly
19 know the amounts of expenditures in each of those three
20 areas, roughly? I mean, I see the total. I might have
21 missed it in the reading, but --

22 DR. MILLER: So you are just looking for the

1 total of those three lines?

2 MR. THOMAS: Yeah. Like total for Part D, total
3 for fee-for-service, total for MA.

4 DR. MILLER: Yeah. So, without being tied to --

5 MR. THOMAS: I mean, not exactly, but just kind
6 of --

7 DR. MILLER: Yeah. Okay. As long as you don't -
8 - and everybody in the public doesn't listen to this.

9 [Laughter.]

10 MR. THOMAS: I don't think they're listening,
11 Mark.

12 DR. MILLER: I don't think they are either --

13 MR. THOMAS: Between you and I.

14 DR. MILLER: -- and that's kind of annoying me,
15 you know? I'll go and talk to them.

16 So I think you're probably talking about 400
17 billion for fee-for-service, 150 for MA, 100 for Part D.
18 Anybody want to say something better than that? Everybody
19 good?

20 [No response.]

21 DR. MILLER: Okay. That's my answer, Warner.

22 MR. THOMAS: Okay, great.

1 And then on the Part D, I mean, obviously, for
2 '14 and '15, it seems like it's somewhat out of alignment
3 with what's happening in other areas. So you mentioned Hep
4 C as one of the big drivers. Are there others that you
5 kind of view as kind of the big drivers of the 9 percent,
6 kind of annual increase, besides Hep C?

7 MS. PODULKA: Anyone from the Part D team?

8 DR. MILLER: I would say that Hep C had a lot --

9 MS. PODULKA: To do with it.

10 DR. MILLER: -- to do with that.

11 MS. PODULKA: Yes.

12 DR. SCHMIDT: Yes, for those particular years,
13 but you also have some prices of all branded drugs we've
14 seen in our price index going up quite a bit over those
15 past few years, but in 2014, 2015 were particular driven by
16 Hep C.

17 MR. THOMAS: That's it. Thanks.

18 DR. CROSSON: Okay. Thank you.

19 So now we're going to proceed to the discussion.
20 We'd like to hear -- we've heard some, but we'd like to
21 hear Commissioners' perspectives on this overview, and
22 we're going to start with Bruce.

1 MR. PYENSON: Thank you very much. My question
2 or request is really related to Slide 14, and you had --
3 Jennifer had identified that median household income,
4 although it appears to be growing in Slide 14, is really
5 declining when you take into account inflation and other
6 items, and my impression is that within the health care
7 sector, wages are increasing and employment is increasing.
8 And so the question is, if we disaggregate the workforce
9 between the health care workforce and the non-health care
10 workforce, we know the total is going down and has been
11 decreasing for a number of years. I think that would
12 highlight the potential impact that the growth in health
13 care is having on the non-health care wages.

14 Now this is a bit different from household income
15 because household is, you know, is household, but on the
16 individual basis. And the second part of that is how the
17 wage index plays in with that, the number of the fees that
18 Medicare pays are related to wage index, and to what extent
19 is the wage index driving the contributor to that spread.

20 DR. MILLER: [Off microphone.]

21 MR. PYENSON: No. The spread I'm hypothesizing
22 between what I believe is a wage increase in real wages for

1 the health care sector and a decline in the non-health care
2 worker wages.

3 DR. MILLER: Here's what I would say. I think we
4 can bring something to bear on your first question in
5 looking at wages by different professions, whether it's
6 fully integrated into -- and I think you've already
7 acknowledged this -- median household income, not so much,
8 but we could certainly bring some color to the discussion
9 and say now let's talk about what's happening in different
10 sectors. We may be able to blow that out a little bit and
11 give you a sense of that.

12 I want to think about your second question. For
13 me, anyway, Jennifer, I'm not 100 percent sure I know how
14 to answer that yet, so I want to think about that one a
15 little bit.

16 MR. PYENSON: I recognize the wage index is
17 supposed to be the wage index -- you know, urban area.
18 It's supposed to include health care and non-health care
19 workers. But there's a mix issue that's not reflected
20 perhaps in the wage index.

21 DR. MILLER: Yeah, I might want to get you
22 offline, like ruin your lunch or something, and get you to

1 talk us through that a little bit more, and where we might
2 be -- I think I have a sense of what you're asking.

3 DR. CROSSON: From -- so, Bruce, in terms of the
4 perspective behind your question, it seems to me -- and
5 correct me if I'm wrong -- that I think what you're saying
6 is that the data as presented, as great as it is, may, in
7 fact, understate, for large segments of our society, the
8 impact of the growth of health care expenditures, and
9 therefore, you know -- because I think, you know, a couple
10 three years ago or so, as people noted, the flattening out
11 of health care -- of the increase in health care
12 expenditures, and Medicare expenditures as well, some, but
13 not many people were saying, "Well, gee, it's really great.
14 We solved that problem." And I think we have data to
15 suggest now that that's not the case, that keeping the
16 pedal to the medal, if you will, in terms of Medicare
17 expenditures, which is part of our charge, is at least as
18 important now as it has been in the past, and maybe even
19 more important than this data suggests.

20 MR. PYENSON: You have my intent there. I would
21 also suggest that if the economy is shrinking in real
22 terms, or to the extent it is, or things like wages are

1 shrinking in real terms, then if the health care system is
2 relatively prosperous on even a flat level, so comparing
3 the two segments of the economy I think would be helpful
4 and useful.

5 DR. CROSSON: Thank you very much. Other
6 perspectives? Paul?

7 DR. GINSBURG: Yeah. I wanted to follow up on
8 something Bruce said, which made me think of this for the
9 first time, is that, you know, usually when we talk about
10 the problems of rapid growth in Medicare spending we're
11 talking about, you know, both premiums the beneficiaries
12 pay and its impact on the federal budget.

13 But it might be useful for us to also talk about,
14 for growth in total health spending, the degree to which
15 this is a drag and damages the rest of the economy, because
16 periodically, you know, you hear things about, well,
17 greater health spending means more jobs so it must be a
18 good thing for us all. That's only looking at a piece of
19 it, and I don't know if the Commission has ever included
20 that in its context chapter but it might be something to
21 look into.

22 DR. MILLER: And just a quick commercial.

1 Actually, Kate Baicker wrote a piece on that a couple of
2 years back and we can immediately scoop that up and cite it
3 in response to that, and look to see if there's anything
4 else on that.

5 DR. CROSSON: I may have missed hands. Bill
6 Gradison, did I see -- or --

7 MR. GRADISON: I'll wait until later.

8 DR. CROSSON: David? Amy?

9 DR. NERENZ: Maybe on a slightly different point
10 if that's okay, but it's Round 2.

11 This is going to reference and sort of toggling
12 Slides 16 and 17.

13 The question, I guess, is what really are the
14 outcomes that we should be paying attention to when we
15 judge Medicare spending or health care spending in general?
16 The example here given to us is life expectancy, and
17 certainly in the Dartmouth Atlas data, as you've pointed
18 out, that we see a lack of association between high and low
19 spending regionally in that measure, as well as some
20 others. And then we conclude, well, that must mean that
21 some of the spending is wasteful and inefficient.

22 I think, then, what's implied is if somehow we

1 could magically make all the spending truly efficient and
2 not wasteful then we actually may see a closer association
3 between spending and that outcome -- if it were good
4 spending, okay. So that's so far. That's 16.

5 Now if we flip to 17 -- now I don't know a lot
6 about all these other countries. I just have to assume
7 that at least in some of them health care spending is
8 reasonably rational or efficient, perhaps more than ours.
9 But I look at that chart. There is no association
10 whatsoever between spending and life expectancy, none.

11 So now that suggests to me life expectancy is not
12 a good outcome of health care spending and we should quit
13 talking about it as an outcome of health care spending.
14 Now maybe that's too radical a conclusion but at least
15 that's where I wanted to go with this, that what are the
16 outcomes? Now maybe the outcomes are more in the domain of
17 pain relief, functional independence, functional status.
18 Maybe that's what we spend our money for.

19 But this one suggests to me that across the whole
20 world, if we're spending our money on enhancing life
21 expectancy, we're all doing a pretty bad job of it.

22 DR. CROSSON: And I think I'd add individual

1 worker productivity to that as well as quality of life.

2 DR. NERENZ: That would be fine, but at least I'd
3 like to -- for us to carry the discussion into that,
4 because presumably -- now, in a Medicare population the
5 worker productivity issue may slip off a little bit. But
6 still, I mean, functional independence, individual
7 productivity -- I guess I'd like us, as we carry this
8 forward, to be thinking more clearly about what really are
9 the high priority outcome metrics of health care spending.

10 DR. CROSSON: Okay. So I've got that. Amy,
11 Jack, and then Rita. Bill -- I'm sorry. You --

12 [Off microphone.]

13 DR. CROSSON: Yeah. Okay. Let me -- I'm getting
14 confused now. Okay. Amy, Jack, Bill --

15 DR. REDBERG: Rita.

16 DR. CROSSON: -- Rita -- sorry -- Rita, Sue,
17 Greg, Jack ahead, Warner.

18 DR. MILLER: Alice, are you still in?

19 DR. COOMBS: Yeah, I'm in.

20 DR. CROSSON: I'm sorry, Alice. Missed that.
21 Now I'm totally confused. Warner -- it takes longer to
22 write than -- okay. Amy.

1 MS. BRICKER: Okay. Thank you. Slide 18
2 references fraud, and I didn't, in the chapter, see how --
3 if we have some information to quantify, really, the
4 attribute that fraud has on the overall spend. And is
5 there an area -- and I think about Slide 5 -- that is more
6 subject to fraudulent claims. And the impact, then, that
7 if fraud -- if I assume, and I don't know if this is true,
8 that fraud has actually increased over the life of the --
9 of Medicare, the drag that that's having also on the per
10 bene spend as we kind of peanut-butter that across the
11 Medicare populations.

12 So any insight that you can provide relative to
13 fraudulent billing, and what's true? What's real? What --
14 you know, what spending has actually occurred, because
15 there's been a patient on the other end of it versus
16 fraudulent claiming that -- claims that are then just
17 spread across the population?

18 DR. MILLER: We can see what we can bring to
19 bear.

20 DR. CROSSON: Okay. Here's what we're going to
21 do. We're going to do Bill Gradison, then Rita, and then
22 we'll march down this side.

1 MR. GRADISON: Okay. There are several
2 references in the paper to the implications of the increase
3 in health spending to the budget. I don't want to take a
4 lot of time about the details except to say that the
5 references, the way they're written, are somewhat
6 inconsistent with each other. There's one at the bottom of
7 page -- it begins at the bottom of page 25, and there's one
8 at the -- sort of towards the top of 66.

9 I am, very specifically -- and I think you can
10 probably straighten those out with words -- I am
11 particularly concerned, though, on the top of 66, by the
12 sentence that says "absent increased revenue." First of
13 all, this is maybe me, I don't include borrowing with
14 revenue but I think you do, because -- and I think that
15 that is a distinction that we should be careful to avoid,
16 to emphasize.

17 But, anyway, "absent increased revenue, other
18 public investments such as education and infrastructure,
19 will be crowded out." I don't think we know that. I'd say
20 "may," and I think it's a serious issue. So could national
21 defense. So could tax cuts. So could any other federal
22 expenditure. And, furthermore, in this reference -- and

1 with this I read it -- mentions education and
2 infrastructure, could be -- would be affected, but the
3 previous one, which goes into page 26, has a much more --
4 has a longer list of programs that could be affected,
5 including research and development.

6 So I think we ought to be really careful how we
7 refer to their budgetary implications. I'm not saying
8 there are none, but I think some of it is more "may" than
9 "will."

10 DR. CROSSON: Thank you, Bill. Rita.

11 DR. REDBERG: Thank you. Thanks for an excellent
12 chapter. I wanted to talk a little bit about, so on page
13 53 and 54, the mailing materials, looking at indicators,
14 because I think a lot of, in particular, these diseases and
15 chronic conditions, we should be careful what we're calling
16 diseases. Like I don't think high cholesterol is really a
17 disease. You know, it's not something anyone feels bad.
18 It's not clear to me that, you know, that's -- it -- it's a
19 laboratory value.

20 And part of what's going on is that we have the
21 medical profession, I mean, now has changed our definitions
22 for all of these. And so, you know, when I was in medical

1 school and doing my cardiology fellowship, even what we
2 considered high cholesterol was very different than what we
3 now -- you know, now, like, I have very health patients
4 that come in with cholesterol of 202 and the lab has
5 flagged that as high. It's not high.

6 But -- and so that's part of the problem. And
7 then, of course, that leads to a lot of -- and the same
8 thing with hypertension. We've changed our definitions. I
9 mean, you talk about it specifically with cancer, which is
10 a whole other area where we've now gotten much more
11 aggressive and diagnosed all these, you know, early
12 cancers, or they're not cancers, they're ductal carcinoma
13 in situ, but we -- people treat them as if they were
14 cancers once they get diagnosed. But that certainly
15 contributes a lot of spending and no benefit on outcome.

16 So when I look at those tables on why are we
17 spending so much and we're not a healthier nation,
18 certainly you have to look there.

19 And getting to the high cholesterol, of course,
20 you know, there's a big debate, and I fall on the category
21 of thinking we are really over-treating a lot of people
22 with statins because there is no benefit on mortality.

1 These are healthy people. They are not going to live
2 longer. There are a lot of side effects. There has been --
3 there was a study from Sugiyama, et al. that was published
4 in JAMA Internal Medicine now two years ago that showed, in
5 the last 10 years, statin users were more likely to gain
6 weight and become more sedentary over time than non-statin
7 users, and I think, you know, it can be an unintended
8 consequence when people think they're taking a pill and
9 they don't have to watch their diet and they don't have to
10 exercise. And it's relevant to the obesity and diabetes,
11 because, you know, when we talk about diabetes we're really
12 talking about obesity. You know, the higher rates of
13 diabetes are because of higher rates of obesity. And it's
14 very relative to Medicare because Medicare, I believe, is
15 now going to start paying for these diabetes prevention
16 programs.

17 And I was recently -- I'm on the California
18 Technology Assessment Forum and we had a whole day of
19 evidence review on the DPP programs, and, I mean, there's
20 no way I can say that they don't look like weight loss
21 programs, newly named Diabetes Prevention Programs, because
22 that's their outcome. They're weight loss. Weight loss is

1 good, but we don't -- there is no outcomes data that these
2 programs are going to improve outcomes. None of the
3 Diabetes Preventions Programs had improved clinical
4 outcomes as an endpoint. They're all weight loss
5 endpoints, where at most they'll measure HbA1c, which is
6 another one of those markers that hasn't been tied to
7 clinical outcomes.

8 So I just mention it because I think it's another
9 area where we can spend a lot of money and not see actual
10 Medicare beneficiary benefits, and a growing area, and one
11 that I suspect we're a lot better, as a country, addressing
12 with public health programs, and we're going to be able to
13 spend a lot of Medicare money and not getting improved
14 outcomes.

15 MS. PODULKA: Rita, could I ask if you have any
16 specific conditions or states or diseases that we should
17 focus on, because we were very concerned about this. There
18 is the bar shifting over time to defining conditions as
19 diseases, et cetera. And then there is a cost driver, but
20 is it the state of the person or is it the medical
21 profession saying this is now a disease, we're going to
22 treat it, and now we've driven up a whole line of business.

1 So are there specific conditions, issues,
2 diseases that would be better for us to focus on?

3 DR. REDBERG: I'd be happy to follow up with you.

4 MS. PODULKA: Great. Thank you.

5 DR. CROSSON: Okay. So I'm going to go down this
6 side now. We are tight on time. We've going a little
7 late. But I'd ask for succinctness. Alice.

8 DR. COOMBS: So a couple of things. The chart
9 with the cost variations. So I was wondering about the
10 lab, in the sense that it says physicians or private labs
11 increase that last period. And I was just curious as to
12 whether or not that could be divided, because I find it
13 interesting that if this is a growing industry, it might be
14 something that we should look into. You know, just that
15 piece of -- it says "physician offices with labs versus
16 outside private labs."

17 MS. PODULKA: And I'm sorry. I don't remember
18 the data well enough, but we'll go back and check and see
19 if we can split it.

20 DR. COOMBS: Okay. And then two more, 10
21 seconds.

22 The bit about workforce and matching workforce,

1 the last paragraph, I think, somewhere in the paper
2 regarding how we address Medicare spending going forward,
3 I've been interested, and am still interested in the
4 breakout between physicians versus other clinicians, only
5 in the sense that I think the fraction of abortion is
6 changing drastically, and what that looks like is going to
7 be very important in terms of independent nurse
8 practitioners and independent PAs working separately, and
9 just their ability to attribute what's it looks like for
10 both, because if you have a lower spending environment or a
11 higher spending environment you probably would want to
12 address that as well.

13 And then, lastly, cost variations. Massachusetts
14 has done an incredible job of doing cost reports, and the
15 last one, 2013, I'd like you to take a look at it and you
16 can incorporate that in. One of the things it talks about
17 is you have the big one, the partner center, the cost --
18 the payment there is 1.43 times the lower levels, and then
19 some are even 0.7. So how that affects Medicare
20 beneficiaries in terms of occupancy of those elite
21 institutions and access to -- Medicare beneficiaries'
22 access to very advanced interventions is, I think, affected

1 by the top paid institutions, hospitals specifically, being
2 saturated, whereas there's no flow for, you know, time-
3 sensitive therapies. Not just stroke, because now stroke
4 we can treat in the community with tPA, with lytics, but
5 just in terms of how that impacts Medicare access for, say,
6 critical illness in terms of being able to -- patients to
7 transfer from other institutions.

8 DR. CROSSON: Craig.

9 DR. SAMITT: So thank you. I think the chapter
10 did a really good job, sort of highlighting the problems in
11 front of us, specifically Medicare's challenges. But I
12 would imagine that the point of the chapter is to point us
13 to actionable interventions, and I feel that it's light in
14 that regard.

15 You know, some of the things that I would be
16 interested in, for example, on Slide 18, Medicare's
17 Challenges, I'm curious if we've ever done an assessment of
18 sort of the magnitude of each of these challenges and to
19 what degree each of these problems drives, to Amy's point
20 about, to what degree is fraud, waste, and abuse a major
21 component of the challenges that Medicare faces.

22 And, you know, I'm curious to know, given the

1 problems in front of us, which, you know, my anxiety raises
2 as -- you know, increases every time I hear this report
3 every year. It doesn't seem like it's getting any better.
4 How do we prioritize these challenges, and for MedPAC's
5 approach to addressing the challenges, how well do we tie
6 our focus to those prioritized challenges? And, frankly,
7 how successful have we been in driving and recommending
8 improvements that address the biggest challenges?

9 So I don't know whether there's any room to shift
10 some of the focus from problems to solutions, but I would
11 imagine that that's part of our charge and I would love to
12 see the chapter enhance that if we could.

13 DR. MILLER: I'll take this one, Jennifer,
14 because I don't know that the answer will be highly
15 satisfactory.

16 So here's the way I think about it, anyway. And
17 I think you made two comments, and I'm going to try and
18 deal with both of them.

19 The first one is I really do see this chapter as
20 a stage-setting thing. We call it the context for that
21 reason. There are particular mandates in law that say, you
22 know, you shouldn't be just out there talking and making

1 recommendations; you should be aware of the financial
2 context that you're operating in. The law, you know,
3 definitely moves us in this direction.

4 Historically, what I've tried to do with this
5 chapter is not make it a solution chapter. A stage-setting
6 chapter, and our solutions come in the recommendations that
7 fall out in other chapters, and it triggers questions -- I
8 mean, it happened all over the table, but some of the
9 questions over here, I want you to focus on these data
10 because I think they point directions that we could go in.
11 And I have tried to avoid talking about solutions here as
12 much as solutions in our chapter when we pick an issue and
13 say this is what we think you should do.

14 Part of that is just biting off what you would
15 say at this level. It could become so macro and -- you
16 know, that it's hard for me, anyway, to think of like a
17 nice solid recommendation, which I think is what the
18 Commission can do well, you know, when it goes through an
19 issue and says this is what we think you should do.
20 Rightly or wrongly -- and you decide in the end -- that's
21 how I've tried to think about this chapter.

22 The other thing I would say is I do think -- and,

1 you know, again, to Amy's question and the question that I
2 think you're asking, we may be able to try and pull from
3 secondary sources the way people have tried to quantify
4 what might be, you know, attributes, underlying attributes
5 that drive some of what you see here. But I would lower
6 your expectations there at these kinds of levels, you know,
7 the impact of benefit design on what we've seen
8 historically. Even the fraud stuff, there's an annual
9 report that Medicare does, and there's raging arguments
10 about what the methodology that goes into it. And there's
11 a number that comes out. People disagree on it. The
12 number changes from year to year, in part because the
13 methodology. It will be somewhat unsatisfactory.

14 But for what it's worth, the way I think about
15 it, this is a stage-setting. Your solutions come
16 elsewhere. I think we've always struggled with what is our
17 priority. So, you know, you could rack these up and say
18 this is a big important thing, but you might not see a
19 lever to go after to do something about, and so some of our
20 stuff is driven by mandate, opportunity. We can do
21 something about this. And then some of it I think is
22 driven by your kinds of questions. Drugs seem to be headed

1 in a direction. We need to focus on that. But it's really
2 in the end an organic process of what you guys want to end
3 up pointing us to.

4 I'm sorry, that went on longer than I planned to.
5 I was mostly going to say I just don't know how to answer
6 your question.

7 DR. SAMITT: And my point was simply to have this
8 serve -- it obviously is a staging document, a staging
9 chapter, but that we drive to connect the dots to what our
10 agenda should be, will be, for the balance of the year,
11 where we think the greatest opportunities may lie, just
12 that it seemed very unsatisfactory toward the end where we
13 talked about our categories of interventions, but without
14 more detail there.

15 DR. MILLER: I'll tell you, a comment like that,
16 I think we can actually build that out at the end of the
17 chapter and point more to what we've done and what we'll be
18 looking at. That I don't think is a hard thing to do.

19 MS. BUTO: Can I just add on to Craig's point?
20 One thing I did think was missing here, in spite of the
21 fact that we do try to say some of the approach we use, is
22 our drive toward I guess I would call it capitulated payment

1 or at-risk payment in a way that enhances coordination of
2 care, accountability, and so on and so forth. That doesn't
3 really come through here. I mean, we talk about payment
4 accuracy and efficiency. We talk about care coordination.
5 But something that really to me underlies a lot of what we
6 do with payment reform, it would be good to strengthen that
7 part of it.

8 DR. CROSSON: Yeah, I agree with -- I would just
9 point out that, you know, in addition to using this
10 information in priority setting, like we did in July and
11 what you see here, we also, you know -- as you know, when
12 we had come up with policy solutions or recommendations, we
13 try to quantitate them. We're required to quantitate those
14 as well. So the question of, you know, a large overview of
15 the relative value -- and that's come up a few times this
16 morning -- I think is perhaps a little separate from that.

17 MS. WANG: This is, I think, a little bit in line
18 with what's been discussed, and I appreciate, you know,
19 Mark's comment about what this chapter is intended to do
20 and what it can't do. But I think that part of the
21 discussion, Rita's comments as well, is that it's sort of
22 also the expectation of what Medicare's going to solve. A

1 lot of the demographic information in here points to a
2 clear aging of the population, the number of Medicare
3 eligibles, the fact that Alzheimer's disease is on the list
4 of 2013 leading causes of death and it wasn't in 1980 is, I
5 think, indicative of the types of challenges that the
6 Medicare program is going to be asked to solve in the
7 future. And in that regard, it's -- I don't think that
8 MedPAC can solve this problem, but it might be useful to at
9 least acknowledge that there are other parts of the health
10 care system that have to somehow coordinate together. A
11 capitated payment for Medicare is really not going to solve
12 the problem of the dual who's in a nursing home. We're
13 going to talk a lot about post-acute care, but there's
14 something that leaves you kind of with an appetite for
15 finishing the conversation because there are many more
16 services and supports for the really elderly, aging,
17 disabled population that are not under the Medicare
18 umbrella. And I'm not saying that they necessarily should
19 be, but some acknowledgment that they're given -- the way
20 the demographics of the country are going, I'm not sure
21 Medicare can solve all these problems in isolation or if we
22 tried to, at least it should be clear this is what Medicare

1 is doing. There's a lot of other pieces of the health care
2 system that have to come in in coordination to make it work
3 for the beneficiary.

4 DR. MILLER: I think we can build in a comment
5 like that on demographics as an example. The other thing
6 is even things that are under Medicare's, you know, purview
7 are still influenced by factors that are outside of
8 Medicare and outside its control. I think this has come up
9 in some of our drug conversation. There are things
10 Medicare can do about its coverage and payment issues. But
11 there's lots of things happening in the environment that
12 are going to influence what goes on in Medicare. So we
13 could build a comment around a couple of examples like
14 that.

15 MS. THOMPSON: I will be quick. I too want to
16 say thank you for this chapter. I thought it was very
17 grounding and very much reminded me of the work we have to
18 do, which is pretty overwhelming, and you successfully
19 completely depressed me after I got done reading the
20 chapter. But what I did find -- and we've had a lot of
21 discussion about the detail of what's driven costs to date
22 is how you wove the fact that we're bringing on the baby

1 boomers, and while one piece of information, the 50 percent
2 reduction in smoking, is there something about this new
3 cohort of Medicare consumers that will be different and we
4 can engage? And are we in a time when we should think more
5 about engaging the consumer of Medicare in our thinking
6 around policy?

7 I think about the chronic conditions that --
8 whether they're conditions, diseases, or lab values, but
9 whatever. Is there a hope there that in our policy we can
10 think about maybe the baby boomers will engage with us? So
11 I offer that as just a theme that came through in what was
12 otherwise a completely overwhelming context chapter. But
13 thank you for that because it was very grounding.

14 DR. CROSSON: Thank you.

15 DR. HOADLEY: Also, thank you for the chapter,
16 and I think in addition to it depressing us, I think it has
17 also provoked us intellectually to think about a lot of
18 different things, and I think that's why we're struggling
19 for time here, is because there's so many different themes
20 here to talk about.

21 I just want to briefly allude to two, and one is
22 sort of from Slide 11, and I'm thinking about the revenue

1 line, and you talked about, you know, 17 percent to 19
2 percent. And there's sort of some -- almost an implicit
3 assumption that the revenue ought to be flat, and I think
4 that's something we should be careful about, because in a
5 lot of ways, what we're doing with that revenue has grown.
6 So I just look at this particular picture and see where you
7 talk about the Medicaid, CHIP, and exchange subsidy, I know
8 that's not our jurisdiction, but that's the government
9 taking on a new role that might have been taken -- either
10 not done or had been taken on by the employer sector on the
11 private side. And so it may be very appropriate for
12 revenue to end up rising over the next 30 years as a share
13 of GDP as some of the other things rise. And I just think,
14 you know, as we write about this, just make sure we're not
15 sort of building in an assumption that that somehow ought
16 to stay flat. You know, we don't have to judge where it
17 ought to be, but just I think make sure we're not making a
18 different kind of judgment.

19 And then on Slide 8, obviously one of the more
20 provocative points that's been in this discussion, but I do
21 want to call attention to some short briefs that Marilyn
22 Moon put out this past May that really provided both on

1 this point and sort of the workers per beneficiary and the
2 more general question of the financing challenge because of
3 the way this focuses on the HI Trust Fund and the payroll
4 tax and so forth, but that's only a part of the picture.
5 And then she also addresses some of the issues that you
6 didn't have on the slides but were in the chapter about the
7 lifetime value and what sort of people put in and then take
8 out, and comes up with a calculation that looks fairly
9 different than the one that has sort of been conventionally
10 seen. I think it's worthwhile to -- you know, we don't
11 have to endorse that that's a better way to look at it than
12 others, but I think to recognize that all of these things -
13 - and I think maybe just throughout, are there places where
14 other perspectives, other ways of defining questions can
15 give us a pretty different picture sometimes of -- some of
16 them are going to look worse, some of them are going to
17 look better, but, you know, we've got -- we get in the
18 habit of looking at certain ones either because they're
19 done by the trustees or CBO, but there are some other
20 perspectives out there.

21 MR. THOMAS: So I would just like to build on
22 Craig's comment about the context of the chapter. I think

1 -- and, Mark, I get your response that you're really trying
2 to put this in context of payment policy, but I actually
3 went back and looked at the chapter last year, and I think
4 one of the things I would encourage us to think about
5 having in here is a little more sense of urgency as to the
6 work that we need to do given the situation with the
7 program and the fact that, you know, the trust fund is
8 looking now to be depleted two years sooner, that, you
9 know, there's certain areas that have flat costs, there's
10 certain areas that have pretty significant escalation, and
11 making sure that, you know, we're targeting our efforts in
12 those areas.

13 So, you know, for example -- and this may not be
14 in the context of payment policy, but just, you know, the
15 reference that Jack was just making on, you know, numbers
16 of workers versus beneficiaries. I mean, it's striking to
17 see the difference over the past couple of decades. And,
18 you know, you could look at that and say it's going to be
19 very hard to have any sort of payment policy that's going
20 to help solve for that type of issue, but that that issue
21 as far as Medicare and as far as payments needs to be
22 addressed because there's not enough we can do on the

1 payment side to be able to mitigate the issues that are
2 happening in the workers per beneficiary. The math just
3 doesn't add up.

4 On the solutions piece, I would encourage us to
5 have more specificity in where we do want to target our
6 time and energy. So, for example, on the coordination, you
7 know, referencing that the payment models and the ACO
8 models need to be accelerated if -- I mean, if, in fact,
9 that's kind of where our thinking is, because, you know, we
10 think they can have a benefit to the payment system and
11 fragmentation is a major problem. So ACOs, if configured
12 properly and if incented properly, we believe can have a
13 big impact. I think those types of things should be --
14 should have more specificity, not that actually they make
15 the recommendation, but just, you know, kind of
16 directionally, where do we think we should be going with
17 our work?

18 You know, I think the issue around the drug costs
19 being at, you know, 9 percent for a couple years in a row,
20 if you look at fee-for-service and MA over the past five
21 years it has kind of bounced around, but it's relatively
22 flat for about a five-year period of time. It's up and

1 then it's negative, but it's relatively flat. Yet you've
2 got, you know, drug costs that's escalated, and you can't
3 pick a paper now without, you know, reading about it.

4 So I just think, you know, being more clear that
5 that is something it needs to be taken on in the Medicare
6 program. It's \$100 billion in Part D. But it's billions
7 of dollars in fee-for-service and MA even though it isn't
8 paid for directly by Medicare.

9 So, you know, I think these are issues that need
10 to be stated in a more definitive fashion, I believe, and I
11 think it also frames up the agenda and the work plan of
12 where MedPAC's going to go, and once again, in the other
13 chapters, having more specificity and more solutions. But
14 I would encourage us to have a little more specificity and
15 a lot more urgency given the state of where we are and the
16 trends that we're seeing going forward.

17 DR. CROSSON: Okay. I think Bruce on redirect,
18 we'll take yours, and then I think we're going to have to
19 move on. Go ahead.

20 MR. PYENSON: I just want to express the view
21 that I actually think having a general statement of context
22 setting is very valuable, and keeping that somewhat apart

1 from the particulars I think is a very useful construct,
2 because as this document gets read widely by many, many
3 different interests, having that baseline I think is very
4 valuable. I just wanted to express that because I'm
5 hearing differences of opinion on the Commission in that
6 regard.

7 DR. CROSSON: Okay. Thank you. A lot of good
8 input. Jennifer, Maggie, thank you for the work. And I
9 think we will conclude and move on to the next topic for
10 this morning, which is going to be an overview of the
11 medical device industry. This will be our first time, at
12 least in a comprehensive way, anyway, of taking a look at
13 this part of Medicare expenditures.

14 [Pause.]

15 DR. CROSSON: Okay. Eric, all set? You can
16 start off with the medical device industry.

17 MR. ROLLINS: Thank you, Jay, and good morning to
18 everyone.

19 Before I get started, I'd like to thank Amy
20 Phillips for her help in preparing today's presentation.

21 In recent years, the Commission has devoted
22 relatively little attention to medical devices in its

1 evaluation of Medicare payment policy. However, some
2 Commissioners have asked that we take a closer look at
3 medical devices, and so I'm here today to provide some
4 background information on the industry, which is an
5 important component of the larger health care system and
6 plays an essential role by developing new medical
7 technologies that can improve the ability to diagnose and
8 treat illness.

9 I'd like to start by outlining the issues I'll
10 cover in this morning's presentation. I'll begin by
11 describing at a high level the overall size and composition
12 of the medical device industry. I'll then discuss how new
13 medical devices are developed and outline the role that the
14 Food and Drug Administration plays in regulating medical
15 devices. After that, I'll describe some key features of
16 the medical device market, review how Medicare pays for
17 medical devices, and raise some possible topics for
18 discussion.

19 Turning now to Slide 3, the term "medical
20 devices" encompasses everything from common medical
21 supplies, such as latex gloves, to advanced imaging
22 equipment and implantable devices, such as pacemakers.

1 Given the wide range of items that can be considered
2 medical devices, there is no standard way of defining the
3 medical device industry, and estimates of its overall size,
4 number of firms, and employment vary.

5 Recent estimates of overall U.S. spending on
6 medical devices range from \$119 billion in 2011 to \$172
7 billion in 2013, or between 4 and 6 percent of overall
8 health care spending. The number of U.S. companies that
9 make medical devices is somewhere between 5,300 and 5,600.

10 Most device companies are small businesses that
11 are focused on developing new products, but there are also
12 a relatively small number of large, diversified companies
13 that account for most of the industry's overall sales and
14 employment. The industry has somewhere between 330,000 and
15 365,000 employees in all. The U.S. is the largest single
16 market for medical devices and accounts for about 40
17 percent of worldwide sales.

18 The financial performance of medical device
19 companies varies greatly depending on the size of the
20 company. The relatively small number of large, publicly
21 traded companies that account for most of the industry's
22 overall revenues have been highly profitable. Profit

1 margins for these companies, measured based on their
2 earnings before interest, taxes, depreciation, and
3 amortization, or EBITDA, are usually between 20 and 30
4 percent. These margins account for spending on research
5 and development. Spending on R&D is not measured
6 consistently and is, thus, hard to quantify accurately, but
7 studies by Wall Street financial analysts indicate that the
8 major device companies spend between 5 and 15 percent of
9 their revenue on R&D.

10 Revenue growth for these companies slowed
11 noticeably for a number of years after the recession, but
12 they were able to reduce their costs in response, and
13 overall profit margins remained stable.

14 In contrast, the smaller device companies that
15 are publicly traded are often much less profitable or lose
16 money. These companies are less diversified than the large
17 device companies, and their success or failure may depend
18 heavily on a particular device. These companies may lose
19 money for several years due to a combination of high
20 research and development costs and the time needed to
21 persuade physicians and hospitals to use their products.

22 Both the small and large device companies

1 contribute to the development of new medical devices.
2 Small companies typically focus on developing new products
3 in specific therapeutic areas, and they are often financed
4 by venture capital firms. Small companies that develop
5 promising new devices are frequently acquired by large
6 device companies, which can provide resources to further
7 develop a new technology.

8 Although small device companies are much more
9 numerous, the large device manufacturers conduct a majority
10 of the industry's overall research and development. The
11 total amount of funding that venture capital firms have
12 provided to startup medical device companies has declined
13 somewhat in recent years, which has generated concern that
14 the industry's ability to develop new medical devices could
15 suffer.

16 One particularly notable feature of the device
17 industry is its tendency to make frequent, incremental
18 changes to its products. As a result, the life cycles for
19 medical devices can be relatively short compared to
20 prescription drugs.

21 Moving now to slide 6, the Food and Drug
22 Administration is responsible for regulating the medical

1 device industry, and all new devices must satisfy FDA
2 requirements before entering the market. The level of FDA
3 scrutiny depends on the amount of risk that a device poses
4 to consumers.

5 All medical devices are assigned to one of three
6 categories. Class I devices, such as surgical gloves, pose
7 the lowest risk and do not require any FDA review before
8 entering the market.

9 Class II devices, such as power wheelchairs, pose
10 a moderate level of risk. Most devices in this category
11 must obtain what's known as a 510(k) clearance before they
12 can enter the market. The 510(k) process requires
13 manufacturers to demonstrate that their products are
14 substantially equivalent to an existing medical device and
15 usually takes between three and six months to complete.
16 The 510(k) process has been controversial because
17 manufacturers do not have to demonstrate that their
18 products are safe and effective.

19 Class III devices, such as heart valves, pose a
20 high level of risk and must obtain what's known as a
21 premarket approval, or PMA, before they can enter the
22 market. The PMA process requires manufacturers to submit

1 clinical data that demonstrates that their devices are safe
2 and effective and can take 18 to 24 months to complete.
3 The PMA process is the area of device regulation that most
4 closely resembles the FDA's regulation of prescription
5 drugs, but only about 1 percent of all medical devices are
6 required to use the PMA process before entering the market.

7 The FDA can never fully assess the safety and
8 effectiveness of medical devices prior to market entry, so
9 post-market surveillance is an important element in its
10 regulation of medical devices.

11 Device companies and health care providers, like
12 hospitals, are required to report to the FDA any adverse
13 events that involve the use of a medical device. The FDA
14 has also been developing something called the Sentinel
15 System, where the agency gains access to various forms of
16 electronic health data and can analyze that information to
17 more actively monitor potential safety issues. The FDA can
18 also recall medical devices that are found to pose a health
19 risk.

20 The FDA also now requires that all medical
21 devices have a unique device identifier, or UDI, which will
22 make it easier to identify and recall unsafe devices and to

1 conduct research that compares the effectiveness of
2 different device models. However, this requirement will
3 not be fully implemented for several years. There has been
4 some debate about including UDIs on claims data. The FDA
5 and other stakeholders have supported adding UDIs to claims
6 data, particularly for implanted devices, but CMS initially
7 expressed opposition due to the cost and complexity of
8 updating claims processing systems.

9 CMS now supports including some UDI information
10 for implanted devices on claims data but has warned that
11 the information may not be complete or accurate because it
12 does not affect payment. The final decision on the issue
13 will be made by a committee that oversees all changes to
14 the standard health claim layout and should come later this
15 year.

16 Starting with Slide 8 and continuing over the
17 next few slides, I'll touch on some of the key features of
18 the medical device market.

19 The first feature is the importance of coverage
20 determinations. Medicare and other health care payers are
21 not required to cover every medical device approved by the
22 FDA, so ensuring that new forms of medical technology are

1 eligible for reimbursement is an important consideration
2 for device companies, particularly for advanced products
3 such as implantable devices. Medicare's coverage decisions
4 have particular weight because they are often followed by
5 private health insurers.

6 Another important feature is the prominent role
7 played by group purchasing organizations, or GPOs. GPOs
8 are intermediaries that negotiate purchasing contracts with
9 device companies and other suppliers on behalf of providers
10 such as hospitals. GPOs do not purchase anything
11 themselves and play no role in distributing products from
12 manufacturers to purchasers. Virtually all hospitals use
13 GPOs to purchase at least some of their supplies, and GPO
14 purchases represent about 75 percent of total hospital
15 supply purchases. GPOs are primarily used to purchase
16 conventional products such as surgical gowns; more advanced
17 items such as implantable devices are often sold outside of
18 GPO contracts.

19 GPOs are primarily funded by contract
20 administrative fees that device companies and other
21 suppliers pay to the GPOs on the items sold through GPO
22 contracts. These fees typically equal a percentage of the

1 sales price, and total fees for the largest GPOs are
2 between 1 and 2 percent of their overall sales volume.
3 GPOs use some of the fees to cover their operating expenses
4 and typically distribute a significant portion of the fees
5 to the hospitals that are the GPOs' customers. The fees
6 would ordinarily be prohibited under the federal anti-
7 kickback statute as an inducement to obtain business, but
8 the Congress enacted a safe harbor exception in the 1980s
9 that allows GPOs to collect them.

10 There has been some debate over whether a
11 business model based on administrative fees is an
12 appropriate way to structure GPOs. Critics of the current
13 model argue that GPOs may not always have an incentive to
14 negotiate the lowest possible price. Since the fees are
15 based on overall sales volume, lower prices also result in
16 lower fees. Supporters of the current model note that
17 hospitals can switch GPOs if they wish and argue that
18 competition among GPOs for hospitals' business mitigates
19 any potential conflict of interest.

20 The medical device industry is also notable for
21 the significant ties that often exist between physicians
22 and device companies. These ties can take many forms. For

1 example, a device company may pay royalties to physicians
2 who helped to develop a particular device or pay consulting
3 fees to physicians who provide feedback on the performance
4 of the company's products.

5 A device company may also pay physicians for
6 giving speeches or presentations that promote the use of
7 the company's products or provide funding for research.

8 Drawing on recommendations that the Commission
9 made in 2009, device and drug manufacturers are now
10 required to submit information to CMS about their financial
11 relationships with physicians and teaching hospitals. We
12 analyzed this data and found that device companies made a
13 total of at least \$2.3 billion in payments in 2015. In
14 many cases, the relationships between physicians and device
15 companies can benefit the public by fostering the
16 development of new medical devices and educating physicians
17 about how devices can be used safely and effectively.
18 However, these relationships could also encourage
19 physicians to use a particular company's products and might
20 have the potential to improperly influence physicians'
21 treatment choices.

22 Implantable medical devices, or IMDs, such as

1 artificial joints and pacemakers, are one of the highest-
2 profile segments of the device industry. As a group, IMDs
3 receive a lot of attention because they are both
4 technologically advanced and expensive. The purchase price
5 of an IMD can equal 30 to 80 percent of an insurer's
6 payment to a hospital for a procedure, and IMDs can be
7 highly profitable for device manufacturers.

8 The relatively high prices for IMDs are due to a
9 number of factors. There are significant barriers to
10 entry, such as high research and development costs,
11 regulatory requirements, and patents, and as a result,
12 there are relatively few competing firms.

13 Manufacturers also differentiate their devices
14 from those made by competing firms, which makes it harder
15 for hospitals to switch suppliers. Device companies also
16 prohibit hospitals from disclosing their purchase prices
17 for IMDs, which makes it harder for hospitals to compare
18 prices. Finally, hospitals have traditionally chosen to
19 purchase devices based on the preferences of physicians,
20 who often use a particular company's devices and have
21 little incentive to consider differences in cost. These
22 factors ultimately affect Medicare spending because its

1 inpatient and outpatient payment rates include an allowance
2 for medical devices that approximates the average amount
3 paid by hospitals.

4 The ability of some hospitals to obtain lower
5 prices on IMDs has improved in recent years due to such
6 factors as hospital consolidation, the rise in the number
7 of physicians employed by hospitals, and the use of new
8 payment models such as episode-based payments. These
9 payment models may include gain-sharing arrangements that
10 allow physicians to receive a portion of any savings that
11 are generated by keeping the cost of an episode below the
12 payment amount and help to align hospital and physician
13 incentives in reducing the cost of expensive supplies like
14 IMDs. However, these changes have not affected all
15 hospitals, and the impact on the hospitals that are
16 affected likely varies as well.

17 I'd now like to talk a little bit about how
18 Medicare pays for medical devices. As you know, Medicare
19 uses a wide variety of methods to pay for health care
20 services, but its payment rules for medical devices usually
21 have two common elements.

22 First, Medicare does not pay medical device

1 companies directly for their products. Instead, the
2 program uses an indirect approach and reimburses health
3 care providers, such as hospitals, physicians, and
4 suppliers of durable medical equipment when they use
5 medical devices to deliver care.

6 Second, Medicare rarely makes payments for
7 individual medical devices. Most medical devices serve as
8 inputs in the delivery of health care services and are not
9 regarded as services in their own right. In these
10 situations, paying separately for each individual medical
11 device would be administratively burdensome and give
12 providers little incentive to use devices in a cost-
13 effective manner. As a result, Medicare usually makes a
14 single payment that covers all of the inputs that are used
15 to provide a particular service, including any medical
16 devices. The best-known example of this approach is
17 probably the inpatient prospective payment system, which
18 makes a single payment to hospitals for all services
19 provided during an inpatient stay.

20 CMS uses a number of different methods to account
21 for the cost of medical devices when setting Medicare
22 payment rates. For example, it uses cost report data for

1 inpatient and outpatient hospital services, survey data for
2 clinician services, and competitive bids for many kinds of
3 DME.

4 Since medical devices are often bundled into
5 payment rates, there is no easy way to use claims data to
6 determine exactly how much Medicare spends on medical
7 devices, but it is nonetheless substantial. For example,
8 we analyzed cost report data for 2014 and found that
9 hospitals spent a total of \$14 billion on implantable
10 devices and \$10 billion on medical supplies for Medicare-
11 covered services. Those figures include both inpatient and
12 outpatient services, and together they represented about 15
13 percent of total hospital costs.

14 Moving now to the last slide, I'd like to close
15 with some potential topics for discussion. First and
16 foremost, we'd like to know what level of interest you have
17 in conducting future work related to medical devices, and
18 if so, what issues you would like us to examine. Given the
19 size and complexity of the medical device industry, that's
20 obviously a very broad topic area, so I will mention four
21 possible issues that we could explore as a way of starting
22 the discussion.

1 First, the Commission could explore the
2 implications of adding UDIs to claims data. As I mentioned
3 earlier, this step would make it easier for the FDA to
4 monitor the safety of medical devices, and UDI information
5 could have other uses as well. Staff could provide updates
6 on the effort to add UDIs to claims data and outline some
7 of the ways that UDI information could be used in future
8 analyses.

9 Second, the Commission could reiterate a
10 recommendation that it made in 2008 that gain-sharing
11 arrangements between physicians and hospitals should be
12 allowed. Gain-sharing has been an element in a number of
13 CMS demonstrations, including some of CMMI's work on
14 bundled payments, and has the potential to give hospitals
15 and physicians a shared incentive to reduce spending on
16 high-cost supplies like implantable devices.

17 Third, the Commission could make recommendations
18 that would improve the usability of the data that CMS now
19 collects as part of the Open Payments initiative, where
20 drug and device manufacturers submit information about
21 their payments to physicians and teaching hospitals. For
22 example, the data that is currently available does not

1 indicate if a company is a GPO or a manufacturer, or if a
2 manufacturer produces drugs, devices, or both. The Open
3 Payments system also does not include information on
4 payments to non-physician practitioners, such as physician
5 assistants.

6 Finally, the Commission could explore the
7 implications of greater price transparency for IMDs. Some
8 researchers have argued that greater price transparency
9 would make it easier for hospitals to negotiate more
10 favorable prices, and proposed legislation along these
11 lines has been introduced in the Congress in the past.

12 That concludes my presentation. I will now be
13 happy to take your questions.

14 DR. CROSSON: Well, thank you very much, Eric.
15 It's always difficult to break new ground, and you've done
16 a very nice job for us here.

17 So we're going to have a discussion now. I'd
18 just like to make the point here that Eric made, which is
19 we'd like to hear from the Commissioners, which of the
20 possibilities included on the last side or others that you
21 may have, you would view as the most important for us to
22 work on in the future. And I would ask you as well to keep

1 in mind the thrust of the discussion we just finished, and
2 that has to do with impact, potential impact to solve, in
3 this case, the cost problem that Medicare and the country
4 faces. So, as you're thinking about your recommendations
5 for the Commission's future work, think about that issue
6 with respect to these choices, relative impact, and also
7 the choice involved in working on this issue versus other
8 things that we could be working on.

9 So we'll start off with clarifying questions.
10 Bill? Bill, David, Kathy.

11 DR. HALL: Very much new ground, and we
12 appreciate that very much. One of the places we might
13 start -- and maybe I missed it in the chapter -- what do we
14 know about regional variations?

15 MR. ROLLINS: We did not look directly at
16 regional variation. To the extent that you are talking
17 about particular segments, you could look at things like
18 variation in use of imaging services or something like that
19 that involves medical devices or durable medical equipment
20 where we can use claims data to sort of really get at the
21 question. For things like implantable devices, there's
22 limits on what we can sort of see in the data that's

1 currently available, so that would be more difficult.
2 There's nothing specifically in the mailing materials that
3 sort of gets at this issue.

4 DR. NERENZ: Thanks, Eric. On Slide 6, please,
5 for the Class III devices, is there anything more you can
6 tell us about the definition of what "safe" and "effective"
7 actually mean in practice? For example, are there
8 quantitative criteria for devices? Is it different in some
9 meaningful way from drugs? What do those words mean?

10 MR. ROLLINS: So I can provide a little bit more
11 information. I'm not in a position to sort of go deep on
12 the issue. I believe, if I remember correctly, the sort of
13 statutory requirement is reasonable assurance of safety and
14 effectiveness that the devices are supposed to demonstrate.
15 In practice, what that means sort of for each individual
16 device is unclear. To my knowledge, it's not like FDA has
17 a standard set of criteria that it requires each
18 manufacturer to meet. To some extent, it kind of depends
19 on the particular device.

20 DR. REDBERG: I don't know, maybe it's a
21 clarifying question you can look at and come back to, but
22 on pages 16 and 17 of the mailing materials, you stated

1 that insurers are providing now stronger evidence, and I'm
2 just wondering if we could go a little more into that,
3 because it's not what I've observed, and it's certainly not
4 the way things have been going that anyone's requiring or
5 that we're seeing more stronger evidence.

6 And my other clarifying question was on page 18,
7 do you know -- it was talking about the GPOs, the group
8 purchasing organizations, but Congress enacted a safe
9 harbor exception that allows GPOs to collect these fees.
10 Why was that done? And is there any discussion of it
11 currently?

12 MR. ROLLINS: So on your first question, we did
13 see a number of reports that suggested private insurers are
14 requiring stronger evidence before they'll agree to cover a
15 new technology, but they didn't really get into the
16 specifics of sort of what are they requiring now that they
17 didn't require in the past. So I think, you know, to
18 really sort of get at that question, you would probably
19 need to interview some of the large health insurers to get
20 a sense of sort of how that is playing out within each
21 company.

22 On your second question on the GPOs and the safe

1 harbor exception, when GPOs were sort of becoming more
2 prominent in the early '80s, there were concerns that this
3 sort of fee-based model was sort of going to be out of
4 compliance with the anti-kickback statute. And so what
5 Congress can do and has done at various points is enact
6 what's called a safe harbor exception and say these certain
7 activities that might normally be sort of questionable
8 under the anti-kickback statute, we're going to allow, you
9 know, because we have these sort of overriding concerns.
10 And as I understand it, the conclusion that the Congress
11 reached was that, on net, the GPOs, using this fee model,
12 would be able to help hospitals get lower prices on their
13 supplies and that that was sort of the overriding benefit
14 of allowing this sort of GPO fee-based model.

15 DR. REDBERG: Although I think you said later in
16 that paragraph that that hasn't proven to be true, so I
17 just wonder if it's been readdressed.

18 MR. ROLLINS: They have not looked at it again,
19 to the best of my knowledge.

20 MS. BUTO: Eric, I wonder if you could remind us
21 what the current authority is with respect to gain sharing
22 -- I know CMMI is able to experiment or demonstrate gain-

1 sharing arrangements -- and what the statute of that is,
2 number one; and, number two, what the result -- remind us
3 again, I've forgotten, what the ACE demonstrations -- have
4 those been rolled out, has that authority been rolled out
5 more nationally and integrated into the program? I think
6 they have but I can't remember now, so I wondered if you
7 could remind us of both those

8 MR. ROLLINS: Sure. So gain sharing has been
9 sort of an element in a lot of the CMMI's bundled payment
10 work, and it was also used in some CMS demonstrations in
11 the past, like the acute-care episode demonstration.

12 The providers that are participating in those
13 sort of demonstrations aren't required to use gain sharing,
14 but they're allowed to. And so it's an element in like the
15 model two of the bundled pair -- bundled payments
16 initiative. It's part of the comprehensive payment for
17 joint replacements, and I think it's also envisioned in the
18 cardiac bundle that they're considering now.

19 But right now it's used as sort of just within
20 those models. There's no sort of broader allowance for
21 these kinds of arrangements to take place, which was sort
22 of the rationale for sort of potentially reiterating our

1 recommendation from earlier that, you know, rather than
2 doing this on sort of a demonstration-by-demonstration or
3 model-by-model basis, you might want to consider making
4 sort of a broader change to allow these kinds of
5 arrangements, you know, potentially with appropriate
6 safeguards.

7 MS. BUTO: But just to be clear, if those
8 demonstrations prove to be cost-effective, the gain-sharing
9 elements would be allowed to roll out and be used
10 nationally for those conditions, for those models.

11 MR. ROLLINS: Conceivably, yes.

12 DR. HOADLEY: So on Slide 11, you have the dollar
13 estimate that you made and granting all the difficulties
14 that you have pointed out in making this. This is just for
15 hospital inpatient and outpatient settings, presumably some
16 devices that are used in physician offices or other kinds
17 of settings. Do you have any sense whether you've picked
18 up in this 24 billion between these two numbers half of
19 everything that Medicare is doing, 90 percent of it? Do
20 you have even just sort of a general scope?

21 MR. ROLLINS: Unfortunately, I don't. We just
22 sort of provided this to give a sense of there's a certain

1 -- you know, there's a fair amount of spending here, but
2 even within the hospital sector, you would also have
3 spending on imaging equipment and things like that. So
4 even within hospitals narrowly, it doesn't sort of cover
5 everything. And to answer your question, we don't have a
6 number for sort of how much is being spent on devices and
7 things like physicians' offices or ASCs or things like
8 that.

9 DR. HOADLEY: And the numbers that were at the
10 front of your slides about total U.S. spending on devices,
11 are they presumed to be sort of everything, all kinds of
12 settings? Do you know anything about the methodology they
13 used?

14 MR. ROLLINS: They're meant to be a comprehensive
15 measure of everything that's spent on medical devices. But
16 as I noted in the mailing materials, there's no standard
17 definition, and so the numbers vary.

18 DR. HOADLEY: I mean, I'm struck that your number
19 on Medicare, which is obviously incomplete, would be about
20 14 percent of the \$172 billion that you show. So, I mean,
21 that may be some hint to sort of what's -- you know,
22 because we talked about in the context 22 percent of

1 general spending across the system is attributable to
2 Medicare. You know, so maybe there's just no way to dig
3 deeper into some of those other pieces.

4 The other number I was observing was your number
5 on the payments to providers of \$2.3 billion would be about
6 10 percent of the total that you identified from the
7 hospital claims. So it's striking, the amount of money
8 represented in those payments to providers.

9 DR. COOMBS: So I had a question regarding the
10 different classes. You have a great chart in there. I
11 really like looking at that chart with the top ten or so
12 device companies. And then you give some really persuasive
13 data about 1 percent being responsible for the cost of, you
14 know, the majority. Is there a way to look at -- I guess
15 maybe there's a -- you could aggregate those numbers to
16 look at the Class III in terms of the cost. I mean, I'm
17 looking at how we could prioritize in terms of -- the most
18 costly would be Class III, obviously, but to the degree of
19 the magnitude of what that -- how that is true, because I
20 know that high-volume things like epidural catheters and
21 very sophisticated catheters that we use on a regular
22 basis, the utilization of that is very high and pervasive

1 throughout the country. It might not be a true assumption,
2 so I'm just wondering, looking at that, you know, you have
3 a very high -- put in an AICD, which is a very costly
4 procedure, versus, you know, placing epidural catheters in,
5 you know, the parturient.

6 MR. ROLLINS: So in terms of what the medical
7 device companies are sort of reporting in like their
8 financial disclosures and SEC disclosures and things like
9 that, they're not in my experience breaking down their
10 revenues by sort of, you know, here's what our revenues are
11 for our Class I products, our Class II products, or Class
12 III. So I think sort of trying to disaggregate kind of the
13 top numbers that I had in the mailing materials, I'm not
14 sure if that's sort of easily doable. Certainly a lot of
15 your sort high-profile Class III devices are a big piece of
16 that sort of overall revenue story, but trying to sort of
17 nail down precisely how much I think may not be doable
18 given the data that the companies report.

19 DR. COOMBS: So for the Class I and II, I know
20 that most of them are generally -- at our hospital it's a
21 blanket charge as part of a day surgery procedure or part
22 of a routine hospitalization. So that's not kind of like -

1 - it's not under a bundled care, like a total joint, like a
2 total knee replacement or total hip replacement. But could
3 you get at it going that way with the Class III perhaps,
4 looking at their procedural -- would you be able to get at
5 the majority of the cost?

6 MR. ROLLINS: Even -- there might be some rough
7 approximations you could do using cost report data, because
8 there is a separate breakout now for just implanted
9 devices. But even then, you know, you're taking data that
10 the hospitals are sort of reporting in aggregate and trying
11 to sort of apportion that into sort of what was the cost
12 for a specific kind of procedure. And so there would be
13 some inherent difficulty and uncertainty in doing that.

14 DR. CROSSON: Okay, still on clarifying
15 questions.

16 MS. WANG: Can you say a little bit more about
17 what the value or intent of incorporating the UDI into
18 claims would be? It sounds like it's complicated, and I
19 guess my question is, you know, is the lemon worth the
20 squeeze? What do you get out of that?

21 MR. ROLLINS: The argument for including UDIs
22 right now is that claims data is sort of the main form of

1 electronic health data that's out there, and prior to the
2 advent of UDIs, there was no standard sort of unique
3 identifier for whatever devices were used in a procedure.
4 And the thought is that now that we're requiring UDIs, that
5 they really should be added to this sort of bread-and-
6 butter data set that, you know, everybody uses. So, for
7 example, if you wanted to know, you know, we've identified
8 problems with Company A's particular model for a heart
9 valve, well, how many people have these things in them?
10 Right now there's no easy way to know that. And if you had
11 UDIs on your claims data, with, of course, some of the
12 caveats about our hospitals reporting it correctly and
13 things like that, if you're the FDA, you have a much richer
14 data source available that would let you sort of pinpoint
15 problem areas much more easily than they do now.

16 The other arguments you see also revolve around
17 things like comparative effectiveness. You know, does
18 Model A for a particular kind of implanted device work
19 better than Model B? The claims data can't really tell you
20 which kind of device was used in which procedure. And if
21 you added UDIs to claims data, you would have a better way
22 of knowing, you know, here's the population of patients

1 that got one model, here's the population of patients that
2 got a different model, and see how their outcomes compare.

3 DR. CROSSON: We've come to the end of the
4 clarifying questions. Thank you for those. So now we're
5 going to entertain from the Commissioners recommendations
6 or perspectives on future work in this area, and Rita is
7 going to begin the discussion.

8 DR. REDBERG: Thanks, Eric, for a really
9 excellent chapter, and I'm glad that we're going to start
10 talking about medical devices because I think it is
11 consistent with our themes of trying to improve care and
12 improve quality because medical devices play a big part in
13 care of beneficiaries, as you've shown.

14 I just wanted to make a few comments, you know,
15 because I have been interested in why we spend so much
16 money in health care for a long time, and when you start
17 looking at it, you have to start looking at technology, and
18 so I've been interested in the regulatory approval process.
19 And I have to say, you know, I was already a cardiologist
20 in practice using medical devices for many years, and when
21 I looked at the approvals, I was quite shocked to find that
22 a lot of even high-risk devices are on the market without

1 clinical trials, and that even that 1 percent of premarket
2 approval, the clinical data is often not high-quality data.
3 It's not randomized controlled trials. They're often not
4 blinded, which is a big issue for procedures because
5 there's a big placebo effect. There's often no control
6 group at all. There's historical data. And I see it
7 becoming, you know, with this emphasis on getting things to
8 market fast, more and more of low-quality or no data, and
9 that's why I was asking that previous question. I tried to
10 find those references, but I'll need help.

11 So I think it's important to look at devices
12 because it's very consistent with the theme of quality.
13 Just for examples -- you know, and you gave the history in
14 the chapter, but it's a very complicated history because
15 FDA only started regulating devices in 1976, and there are
16 a lot more devices on the market now. They're a lot more
17 complex, and there are a lot potentially beneficial but
18 also potentially dangerous. And I just want to point out
19 the obvious, but these are not like drugs, because after
20 you get a device on the market and it's implanted and you
21 find out it was dangerous and perhaps it wasn't studied or
22 something else came out, you can't just stop the device.

1 It's inside someone. And so we have a lot of -- now
2 hundreds and thousands of Americans that have implanted
3 devices that have been recalled, and that's a big problem
4 because we can't just take it out safely. And so they're
5 now living with a device that is a danger to their health,
6 you know, metal-on-metal hips, the ICD lead recalls, the
7 pelvic mesh. I could go on and on.

8 And so I think we really do need to be careful
9 about device approvals. For example, one Class III device,
10 the intra-aortic balloon pump is Class III, but it was a
11 premarket approval, the 510(k), which is not, you know,
12 that uncommon, never been shown to improve outcomes in
13 clinical trials, and yet we still use it. There have
14 subsequently been clinical trials that show no benefit, but
15 we're -- you know, it's still on the market. And once
16 devices get on the market, it's very hard to have them go
17 away. That's just often not the way things happen. And
18 then subsequent trials, things will get done comparing one
19 device that was never shown to be beneficial to another,
20 and that's not really the question. So it's a really big
21 area and a big problem. I'm getting to the UDI. I just
22 have a few more comments.

1 I think UDIs are important, but I'm not sure -- I
2 think they're important for safety and effectiveness. I'm
3 not sure they're related to payment because those issues
4 are -- you know, the FDA for reasons I don't really
5 understand I think just announced a three-year delay in
6 implementing UDI -- because of the expense, I believe, for
7 manufacturers. I think it's implement to track, but I
8 don't know that that should be our focus because, as I
9 said, I don't think it's really as related to payment.

10 You know, CMS has tried mandating registries,
11 which essentially could have that same data because
12 registries, for example, when ICDs were approved, you had
13 to have a registry. It's just that in those registries
14 currently you don't know what model someone has. And so,
15 for example, when there are ICD lead recalls, it's a big
16 problem because every hospital is scrambling to try to
17 notify its own patients and find out who actually got the
18 ICDs that were recalled.

19 But I think registries are probably more
20 effective and we should have -- I mean, we should be
21 finding out how patients are doing, because now we're
22 putting lots of devices in people, and we don't know what

1 happens to them. We don't know if they're better off and
2 we should be increasing our use or they are worse off and
3 we should be not using them. You know, even for the men --
4 the ICD registry, it was a good idea, but it hasn't really
5 played out. We aren't getting outcomes from it. And CMS,
6 for example, another registry that was mandated, the left
7 ventricular assist device, CMS doesn't even have access to
8 that data. You know, I chaired the Medicare coverage
9 meeting when we were reviewing the LVADs, and every
10 question that I asked, first of all, CMS, even though they
11 pay for the LVADs, their registry is maintained by, I think
12 it is, the University of Alabama, and they're the only ones
13 that have access to the data. So, you know, we couldn't --
14 every question either had to have been addressed already or
15 they had to say, well, we'll have to look at that and get
16 back to you.

17 So I think CMS, you know, we're paying for the
18 devices. Those registries should be publicly available and
19 transparent, not, you know, kept, because they're not
20 useful. And then there was -- you know, for that one in
21 particular, six months after that meeting, there was a
22 report from the Cleveland Clinic and others about a very

1 serious problem in the LVAD. They were clotting off and
2 causing deaths. It never came out in that LVAD data, which
3 then led to all these questions about who was filling out
4 the registries, was the data any good, you know, everyone -
5 - the person who's actually sitting there, because maybe
6 you're just as strong as your weakest link, it's not their
7 job -- you know, they see it as an inconvenience to take
8 the time to fill out this registry, and there's concern
9 that you're not really getting high-quality data there and
10 that people may be underreporting adverse events because
11 people don't like to report adverse events on their own
12 patients or institutions.

13 So I guess I think sort of our approaches when
14 we're looking at bundled payment are really good options
15 because the more we focus on outcomes, I think the more we
16 can encourage devices that have been shown to improve
17 outcomes, you know, to be used in our beneficiaries and not
18 to use the devices that are not.

19 I guess the last thing about coverage
20 determinations, you know, because you mentioned there's
21 very few national coverage determinations, but one of them,
22 for example, cardiac CT, you know, I was on the Medicare

1 Coverage Committee in 2006 when we reviewed cardiac CT, and
2 it was very clear there was no evidence that showed
3 improved outcomes in the Medicare beneficiaries. CMS, I
4 think largely for political reasons, elected not to issue a
5 national coverage decision at that time, and so with a non-
6 decision, it went to local carriers. The American College
7 of Radiology, the American College of Cardiology, along
8 with the CT manufacturers quickly lobbied all of the local
9 coverage determinations, cardiac CT got covered, you know,
10 within about six months of CMS not issuing a national
11 coverage decision. And, you know, CT scanners have
12 improved. CMS, you know, a year later tried to pull back
13 and say, wait, we need some data because the cardiac CTs
14 have gone wild now in Medicare beneficiaries in terms of
15 use, and it's not clear that this is beneficial. Again,
16 got pushback.

17 So I think, again, there has to be a lot more
18 evidence and better use of evidence, and as I said,
19 particularly for devices because you can't just take them
20 out -- with the CT scanners, you know, once you've bought a
21 CT scanner, you're probably going to use the CT scanner.
22 It's expensive medical equipment. And certainly when we

1 look at, you know, claims for CTs, it substantiates that,
2 but it's very hard or impossible to find data that shows
3 improved outcomes as these related to that.

4 So the other areas that you mention in the report
5 that I think is worth us looking at are the PODs and the
6 GPOs, because it seems like there's a lot of opportunity to
7 improve the way devices are paid.

8 Those were some of my thoughts. Just some.

9 DR. CROSSON: Okay. Thank you, Rita. I'm going
10 to start with John, and I'm seeing a bunch of hands so I
11 think we're going to start at this end this time and work
12 back up. John starts.

13 DR. CHRISTIANSON: Okay. So I -- one of the
14 things that we do have a lot of concerns about is how
15 Medicare pays for things, and I thought your section on
16 page 30 and 31 of the report was very interesting. It
17 seems like we have only information on a very approximately
18 level for hospitals, in terms of what hospitals paid, and
19 whether we need to know that to think about what the right
20 prices is for paying hospitals, when you're bundling
21 devices into hospital payment.

22 And then things kind of get worse with respect to

1 physicians in the way that you describe it. I think one of
2 the phrases that you used is the information has been
3 thoroughly updated since 2004, which I found shocking, and
4 then some of the original prices were determined based on
5 review of one or two invoices, which I found even more
6 shocking.

7 So I'm wondering if there isn't a recommendation
8 -- I'm asking you, Eric, whether you think this would be a
9 fruitful area for the Commission to pursue recommendations
10 to CMS. I think it's important, personally, that we try to
11 get these prices right, so that we get the total payment
12 for hospitals as fair as possible, and so that we get the
13 payment for devices by physicians as accurate as possible.

14 MR. ROLLINS: I'm actually going to defer a
15 little bit to my colleagues, and maybe Mark, who know the
16 physician end of things better than I do, to get a sense of
17 sort of what's doable there in terms of given sort of the
18 data that's there.

19 DR. MILLER: Yeah, and what I would -- I would
20 also have to kind of get my head back into it. And I would
21 just ask, if you, and the rest of the Commissioners, think
22 it is worth diving in, we'll dive back into that.

1 DR. CHRISTIANSON: My question is whether this --
2 yeah, I guess I'd like to know if the Commissioners think
3 that a recommendation in the generation to CMS about trying
4 to get better price data for medical devices would be worth
5 something we should talk about.

6 DR. CROSSON: Okay. So we're on prioritization.
7 In this area we're going to go up this way. The first hand
8 is Bruce.

9 MR. PYENSON: I like several of the items here,
10 the greater transparency, and just a question for
11 exploration on that is that within CJF, and within BPCI,
12 ACOs are allowed to share savings to the payer, usually the
13 hospital, by moving to less expensive devices, and those
14 gain share arrangements, I believe, must be transparent to
15 CMS, and whether there's an ability to use that data to
16 understand the change in a purchase price, in particular
17 for joints.

18 I've got a couple of other --

19 MR. ROLLINS: Yeah. We would need to sort of
20 look a little bit to see what kind of data is actually
21 available. At this point in time we're sort of bundling
22 efforts.

1 MR. PYENSON: Another comment is on the value of
2 real-world evidence versus the orthodoxy of randomized
3 controlled trials, and how that might be at play more
4 easily with the device world, and tracking UDI through
5 real-world data, such as claims data, and whether this is
6 an area that could be utilized at the forefront of that
7 sort of tracking.

8 And a third comment, I thought the report, by the
9 way, was excellent and you point out the faster innovation
10 cycle for devices compared to pharmaceuticals, where often
11 the next generation of pharmaceutical coincides the a
12 patent expiration, and it seems to be faster in the device
13 world. And a few of whether that innovation is actually
14 substantial or it's along the lines of new and improved a
15 little bit, or maybe a mix of both, to contrast the two
16 innovation cycles.

17 DR. MILLER: I know are getting close to time but
18 can I just ask you a couple of follow-up things, Bruce, if
19 you don't mind?

20 I could either -- I could sweep through your
21 comments and interpret them one way. Then you had some
22 clarifications that you were sort of asking as you went

1 along. But I thought you said -- and this is where you
2 say, "No, I didn't say that" or "I did" -- that you had
3 some interest in price transparency as a policy direction.

4 MR. PYENSON: Yes.

5 DR. MILLER: Good. Number two, when you were
6 talking about the real-world evidence -- and I want to nail
7 this down a little bit because I think we got comments in a
8 slightly different direction from Rita -- that would entail
9 a UDI to do that. And so was that you also indirectly
10 saying you're interested in pursuing the UDI, or was that -
11 -

12 MR. PYENSON: Yes.

13 DR. MILLER: Yeah, okay. That was it.

14 DR. CROSSON: Thank you. Coming up this way,
15 Warner?

16 MR. THOMAS: Just a couple of comments. One,
17 thanks for doing the work on this. I know I probably
18 instigated some of this.

19 First of all, I think the transparency piece
20 would be very important. If you look at the information in
21 here around the variation in price, obviously there's
22 significant variation in price. I think certainly that the

1 transparency would probably help the purchaser in this
2 situation -- you know, hospitals or clinics or whatnot --
3 to be able to do a better job purchasing, and from a
4 pricing perspective.

5 As far as the allocation of time, I realize this
6 is about \$15 billion, and although it does kind of spill
7 over into the commercial world as well, so, you know, it
8 probably doesn't warrant as much work as some of the other
9 bigger areas, such as drugs and whatnot. But I would
10 encourage us to -- I think there's some work that could be
11 done here around transparency, and potentially around gain-
12 sharing, that may allow us to put a lot more pricing
13 discipline and pressure into this area, especially given
14 the margins, and I know we do margin comparisons across all
15 the providers and I think comparing it to devices and drugs
16 and others would certainly be helpful.

17 So those would be the two areas that I would
18 encourage us to do some more work in, going forward.

19 DR. CROSSON: Thank you. Jack.

20 DR. HOADLEY: Yeah. So I guess I'm interested --
21 I mean, it came up in my clarifying question, is, you know,
22 how do we get a better fix on how many dollars are really

1 going into this, and I think it goes to some of what John
2 was talking about -- can we get a better sense? And I
3 don't know if that implies, you know, use of the UDIs or
4 some other -- I mean, I'm thinking of this more now for
5 just identifying spending amounts. You know, it's
6 obviously a separate issue on some of the safety concerns.

7 But I think it goes to the point Warner made in
8 the sense of, you know, how big total -- how big a total
9 are we talking about? This is probably more money than
10 some of the smaller hospital categories that we sometimes
11 look at. So, I mean, it does, in that sense, seem worth
12 some attention.

13 In trying to think about it, I mean, the question
14 that I wrote down when I finished reading the reading
15 materials was, sort of, what are the biggest leverage
16 factors for controlling spending? You know, what is it
17 that the program could do, because the spending is so
18 embedded inside PPS and other kinds of places. Sort of
19 where are the leverage points. So it is the bundling kind
20 of approach? You know, is it the gain sharing? You know,
21 is it price transparency that allows the providers to make
22 smarter decisions?

1 So I guess maybe I'm thinking at sort of a, you
2 know, slightly more conceptual level, you know, sort of
3 what are the levers that might work and help provide,
4 either from the level of the Medicare program or, given the
5 way it's paid for, more likely from the level of the
6 providers who are, in fact, making the decisions, how do we
7 get some leverage on, you know, making less -- to Rita's
8 point -- making less use of devices that aren't really
9 helpful, or in devices that are clearly valuable, making
10 smart purchasing decisions when there's a lot of price
11 variation out there.

12 So that's the perspective I'd offer.

13 DR. REDBERG: I just wanted to make the point, I
14 think \$15 billion is probably -- has to be the lower end
15 because you have to -- you know, there's so much downstream
16 that happens after you've implanted a device and all the
17 readmissions, for example. I mean, any of the recall
18 devices, the cost of removing them is all, you know,
19 additional cost. But even, you know, like with the pelvic
20 mesh, the complications that occur, and then people come
21 back in for more procedures and more procedures. So \$15
22 billion is, I think, a lot tinier than what we're really

1 talking about. It's just hard to get at.

2 MS. THOMPSON: And that was the point I was just
3 going to make. The device doesn't happen in isolation of,
4 and many times these are in ICU, so you have an extended
5 length of stay and many specialists and then the
6 complications. But even without complications, the device
7 itself doesn't happen in isolation. That's just the device.

8 And having said that, I think -- I can't help but
9 think about the consequences to the patients, and just
10 because we can doesn't mean we should implant these
11 devices. And I'm curious if there's any way to get our
12 arms around how many of these devices are implanted in the
13 last year of life, or the last six months of life, and
14 understanding -- I mean, in addition to the evidence,
15 broadly, that there's little impact on improving outcomes,
16 what are we spending in the last six months, year of these
17 individuals' lives, and many times related to, and extended
18 by these devices?

19 So if that means the implication is we should be
20 adding the UDI to the claim data to help us pull that, I
21 say yes, because I think it's much, much, much bigger than
22 this number, just on these devices alone.

1 DR. CROSSON: Good points. Thank you. Pat.

2 MS. WANG: I think -- I just want to clarify -- I
3 think this is that everybody, in talking about the broad-
4 term medical devices, talking about implantables, that's
5 what I would focus on. I think, you know, for me, medical
6 supplies, DME, is sort of a separate issue. But from the
7 safety and value perspective, implantable seems to, from my
8 perspective, be the focus.

9 From the discussion, it is disturbing to me that
10 there doesn't seem to be a good baseline way to really even
11 assess the quality, the relative quality of the different
12 implantables that are being used. Registries don't work.
13 UDI is difficult to do.

14 And so without opining on whether it's UDI or a
15 better registry, I do think that one of our priorities
16 should be to at least try to encourage CMS to develop a
17 comprehensive way of gathering information that would
18 inform an assessment of relative quality outcomes and cost,
19 because Medicare has a responsibility to pay for things
20 that are of value, and if it doesn't know what it's paying
21 for, that kind of a disturbing situation to be in. So I
22 understand that there are issues with all of those

1 approaches and I'm not sure which is the best. I think we
2 need it.

3 And then, you know, effectiveness research, I
4 think, is critically important. I don't think that bundled
5 payments and anything else is really going to be effective
6 if clinicians don't have evidence-based information about
7 which devices really would be better if they're in a
8 bundled payment, and from what, you know, Rita's comments
9 and others, it sounds like there really isn't that
10 information out there. So I think priority one should be
11 to establish a good system of collecting that information
12 and that will open up possibilities for the rest.

13 DR. CROSSON: Thank you. Thank you. Craig.

14 DR. SAMITT: So I'll echo a few comments that
15 have been made, but, you know, from an overarching
16 perspective I very much believe that this is future work
17 that we should concentrate on. I think it's important.

18 The fifth category that I've heard mentioned,
19 which is not listed, which, you know, is a notion of high-
20 value versus low-value coverage determinations for these
21 technologies, and I think that needs to be an area of
22 discussion and focus. And in my world there are often

1 instances where medical device organizations will come and
2 say, well, Medicare covers, so it should be covered more
3 broadly throughout the industry, and I think that we should
4 push on that and reassess high-value versus low-value
5 medical device coverage determination, specifically focused
6 on safety and efficacy, as others have mentioned.

7 The one that I'm less comfortable with, that I'm
8 not sure is in MedPAC's domain, which I think we need to
9 understand the implications, is the UDI's link to claims
10 data, and what is it we're trying to solve there, and are
11 there other ways. We've looked into this a bit, and to the
12 question about whether the juice is worth the squeeze, if
13 it's meant to make this link for purposes of a registry,
14 it's probably -- the juice is probably not worth the
15 squeeze. If the value is more than that, then perhaps it's
16 worth exploring.

17 The other question is, is can we link UDIs to
18 other alternatives like clinical data as opposed to claims
19 data, and does that get us what we need.

20 So I think that's the one I'm least comfortable
21 with on the list, but I think the others, plus the low-
22 value, high-value determination, are all game for us to

1 review.

2 DR. CROSSON: Thank you. Very clear. Alice.

3 DR. COOMBS: So I agree with the increased price
4 transparency, and actually investigating as to whether or
5 not we can actually look at some of the bundling CMMI
6 projects that are going on right now. There must be some
7 answers about how things are proportioned within the
8 demonstration project. So I think that there might be some
9 answers there.

10 Table 3 on page 21 gives us a nice outline of the
11 implantable devices and the costs, but one of the things
12 that I'm thinking about and, you know, we all are
13 discussing, you know, implantable devices like it's in a
14 vacuum, but I just sent someone in for an intra-aortic
15 balloon pump the other day. It works. It bridges life.
16 So I don't want us to underestimate that these devices are
17 useless. They actually work and save lives. And I think
18 what we're trying to get at is there a way in which we can
19 say what is the access to the devices that's appropriate
20 and what's not, and the indications. That's a very
21 different question. And as to one of these bullets on
22 here, which one gets at that? Which one gets at, you know,

1 you know, the setting in which you use it. I mean, we're
2 talking about the indications. We're talking about the
3 quality. We're talking about the access.

4 So it's problematic for me to discuss spending in
5 a vacuum in the sense that, you know, we're talking about,
6 you know, the cost. There are some poster childs. One is
7 the lumbar spine implants. Minnesota did an incredible
8 research project where they looked at beneficiaries going
9 into three different sites and actually giving them, well,
10 a little kickback to see if they would choose equal quality
11 at varying prices, and they were able to see that that was
12 an important thing.

13 And it would be interesting to get data like that
14 to say, okay, look at the devices that are implanted at
15 these various high costs, medium costs, and low costs. And
16 I think the cost is -- we're looking at the total cost and
17 saying, is that the difference between the instruments that
18 are being used. I don't think so. It's not always
19 extrapolated that the devices are directly correlated with
20 the total costs. So that's a problem in and of itself.

21 My brother just had a total knee and he says, "I
22 want to get the walk-around knee," and I said, "The walk-

1 around knee? Well, how is that different than just the
2 regular knee?"

3 So there's all these things that people decide to
4 do with the devices, and they may or may not increase the
5 global comprehensive cost. So I don't know if the UDIs get
6 at tracking devices. I mean, we had endografts that we
7 used to use with people with AAAs, and they recalled them
8 because the device was defective. How they identified
9 that? I think it was through the UDIs. I'm not sure. But
10 some of way, you have to be able to identify when a device is
11 -- you know, the number of devices have certain
12 complication rates, and what's listed, and the frequency of
13 it.

14 So I'm thinking that there's got to be ways in
15 which you can actually look at the end point of outcome. I
16 don't know that we deal with that here.

17 DR. CROSSON: So I've heard this several times
18 now. So, I mean, I think, Eric, you did cover the UDI very
19 well in the paper, but I'm wondering if we might, in terms
20 of future work, next steps, expand on it a little bit more
21 in terms of the range of -- and this might take some
22 imagination as opposed to research -- the range of ways in

1 which, if there's an investment put to this it could be
2 used, both for post-marketing surveillance of quality and
3 relative performance of different devices as well as
4 potentially something in the cost area.

5 Okay. Moving down this way. Yeah, Brian.

6 DR. DeBUSK: First all, I'd like to compliment
7 you on an extremely well-written report. That was a great
8 summary of the medical device industry.

9 And I do think devices are important because I
10 think there's a lot of spillover into other areas and I
11 think we'll find that there are a number of situations
12 where the device actually drives the behavior, and I'm not
13 sure the system should work that way. So, again, I think
14 this is an area worth exploring.

15 I think, on Chart 12 of your presentation, I
16 think your bullet points there really set an excellent road
17 map for what we should do going forward. I would
18 reclassify, though, your bullets, because basically what I
19 see there is information, proper alignment, and
20 transparency, and I'd like to speak just a little bit on
21 all three of those areas.

22 Number one, in information, I think UDI has

1 tremendous potential because not only does it provide the
2 safety and efficacy information that FDA would need, but it
3 also lays the groundwork for having an infrastructure for
4 truly tracking devices, even as they flow through a
5 hospital. And when you visit some of these hospitals, they
6 have difficulty tracking these devices, even within their
7 own four walls, let alone within CMS.

8 So, again, I think creating almost a way to
9 follow the money and follow the device, I think UDI -- and,
10 again, Jay, to your comment about maybe imagination versus
11 information, I think there are a lot of ways that you can
12 imagine UDI improving the way devices move in their track
13 throughout the system.

14 The other thing I'd expand on is this notion of
15 proper alignment. I want to emphasize the word "proper"
16 because there are already plenty of alignment mechanisms
17 out there. Rita, you mentioned a POD. A POD is an
18 alignment mechanism. It's just an unhealthy one. So I
19 think in the absence of us finding meaningful ways to align
20 providers and device manufacturers, I think what we're
21 really doing is we're inviting some dysfunctional alignment
22 mechanisms in the absence of that. So I do think that's

1 where we need to step in and make sure that the -- I would
2 rather have a competent, livable gain-sharing agreement,
3 for example, than allowing all these other spontaneous
4 alignment mechanisms to crop up.

5 And then my final point would be transparency.
6 In a perfect world, clinicians would be using devices based
7 on the quality, the service, and the price of the -- and
8 the cost of the device. I think there are a lot of actors
9 out there that try to pull us away from that, and again,
10 you've outlined a number of those in your report. I think
11 that is a third guiding principle, looking at what are the
12 establishments, what are the vehicles to pull us off of
13 that simple theme. I think that would be the other area
14 that I would focus on, but again, I would compliment you on
15 an extremely well-written report.

16 DR. CROSSON: Thank you. Very clear.

17 Kathy.

18 MS. BUTO: So I want to go back to something that
19 -- first of all, I want to go back to Rita's comment, which
20 if I were to sum it up, I would say you're extremely
21 frustrated because coverage, transparency, and incentives
22 seem to all be going in the wrong direction, and there's no

1 accountability.

2 If our goal was let's figure out how to provide
3 the right -- or let's figure out how we might recommend the
4 proper incentives for the appropriate use of devices while
5 disincenting inappropriate use, what would those be? And I
6 think Craig mentioned his issue of high value/low value as
7 a coverage criterion that needs to be looked at. I would
8 say let's even go back and look at what private payers have
9 done because my sense is because of the low number of
10 coverage decisions CMS makes, there's not much of a basis
11 when Medicare begins to cover new medical devices for
12 deciding what's important and what's not important.

13 So I would actually delve more deeply -- and it's
14 not on this list -- into what other payers are doing, this
15 issue of high-value/low-value coverage decisions, et
16 cetera, and have a way of prioritizing, and I think that we
17 could play a role in actually recommending in that area.

18 And then the other thing is once covered, what's
19 the accountability, and how does the program track
20 outcomes, particularly since the generation of devices
21 seems to change so often? That's where UDI, I think, comes
22 in and could be very helpful, but I think it's going to be

1 very difficult to keep track of the different generations
2 and associate issues with them, but I still think it's the
3 right direction to go in.

4 I actually think, ultimately, we do need to look
5 at greater use of bundling and accountability across from
6 the implanting of the device all the way through some
7 period of time, some kind of bundled payment episode that
8 will more tightly align incentives beyond just the initial
9 cost of the device. So I'd like to see more attention paid
10 to that bundling set of possibilities and what the
11 Commission might offer up in that regard.

12 DR. CROSSON: Kathy, just to be clear there, what
13 you're saying is it sounds to me like something that's
14 quite longitudinal in terms of bundling. So looking at,
15 for example, as Rita brought up, the number of times that
16 the devices causes a complication at some point in the
17 future, the number of times it has to be removed, is that
18 sort of what you're thinking?

19 MS. BUTO: It's really a bigger accountability
20 than just for the device. It could be the surgeon. It
21 could be the post-acute episode of care. But there would
22 be some accountable entity, whether it's the ACO or

1 whatever it is -- position organization, for the devices,
2 the use of that device, and what the outcomes are related
3 to it in terms of complications, but also the rest of the
4 care that's provided during that episode. So it's not just
5 a bundling related to that performance but to the whole
6 performance and quality of the outcome for the patient.

7 DR. CROSSON: Thank you. Rita?

8 DR. REDBERG: I just wanted to comment on a few.
9 I agree, certainly, with Kathy's comments, and I like
10 Brian's, the way you look at information alignment and
11 transparency.

12 I just wanted to make an additional comment on
13 the registry because, again, when CMS mandated the ICD
14 registry and when it expanded coverage for ICDs, it was a
15 good start. As I said, it didn't have outcomes data, but
16 another thing that I think we need in order to link it back
17 to payment and outcomes is to put that in there because
18 there was nothing. It just said collect data, but in no
19 way were we ever going to say there's never been a device
20 that came off the market based on the post-approval data.

21 You mentioned it a little bit in the mailing
22 materials, but when the preapproval data doesn't seem

1 robust, let's say, which is frequent, CMS will mandate
2 post-approval studies. Bu the post-approval studies often
3 don't get done. They don't get reported, and there
4 certainly isn't action taken on the basis of the post-
5 approval study. So there needs to be sort of, okay, this
6 is a conditional approval for two years, and we're really -
7 - and, again, as I said, you can't take off the market what
8 people already got, but to go back -- for implantables, to
9 go back and look at it. So the registries are a good start
10 but certainly not sufficient.

11 Again, on ICDs, I think everyone knows the DOJ --
12 and getting back to fraud, which I think Amy mentioned, DOJ
13 recently settled with several hundred hospitals because
14 Medicare was paying for ICDs that were clearly outside of
15 the national coverage decision. So, even though the NCD
16 was clearly stated, doctors were ordering, and Medicare was
17 paying for ICDs that were not -- and they were not in the
18 national coverage decision because they were dangerous,
19 that did poorly. People that had a heart attack very
20 recently, we know are more likely to die if they got an ICD
21 in that early period.

22 And just the last thing, I think Sue's point was

1 excellent on the ends of life because another thing in the
2 coverage is that you're not supposed to put these, to shock
3 somebody's heart in end of life, and there is a lot of --
4 in someone that has less than a year of life expectancy.
5 But, again, there are a lot of people that get them with
6 less than a year. I mean, there are a lot of good reasons
7 for it because it makes certainly dying very uncomfortable.

8 I had a patient when I was on service a few years
9 ago, an 80-something-year-old woman, who was very clearly
10 "do not resuscitate," "do not intubate." She had come from
11 another hospital where the week before, Medicare had paid
12 for a \$60,000 biventricular ICD, which shocks you. I said,
13 "Do you understand that that device is going to shock you?
14 And you've told me very clearly you don't want to be
15 resuscitated," and she said, "No. They didn't tell me
16 that." And then her daughters -- I mean, that was another
17 whole story about the lack of informed consent, but we have
18 the device deactivated. I mean, that was \$60,000, and it
19 was something -- and I followed her for several years after
20 that, just optimizing her medications for failure. She did
21 fine, but that device was hanging, you know, because when
22 you're an old and thin woman, it's a big, bulky thing, and

1 it hung in her chest. I mean, all together, it was not a
2 good thing for her or for the program, and I think that
3 kind of thing happens a lot and not just for ICDs. That
4 was just the example I gave.

5 DR. COOMBS: Jay, I had a question about is there
6 a way that we could look at the examples, like the
7 endograft being recalled, and look at the process for which
8 those things happen, because I'm interested in whether or
9 not the UDI has played a role historically. It will be
10 interesting.

11 I know they've had generator, pacemaker problems
12 with recalls and how it's discovered.

13 DR. CROSSON: Okay. Paul.

14 DR. GINSBURG: Yes. I've been thinking a lot
15 about price transparency because this is an area I've
16 studied for a long time, and I want to bring up the point
17 of view that I haven't heard yet from my colleagues, but
18 it's the norm in our antitrust agencies that in
19 consolidated markets, price transparency has the potential
20 to lead to higher prices. And there has been some
21 research. There's more going on now.

22 So my initial though was, well, why do we want to

1 do price transparency, because it likely doesn't work, but
2 then given that there's been legislation that Eric
3 mentioned in favor of price transparency, the fact that
4 most of my colleagues thought it might be a good idea, I'm
5 thinking that even if MedPAC comes out that it's not a good
6 idea, it would probably be worthwhile having taken it up
7 and concluding that. So I think I'd like us to get
8 involved in it.

9 The other comment I wanted to make is that I,
10 too, believe that appropriate gain-sharing arrangements
11 should be much broader than some bundled payment
12 experiments because I think gain-sharing clearly does lead
13 to hospitals paying lower prices for devices. This
14 eventually gets back to Medicare has lower payment rates
15 under the prospective payments system, so I think we should
16 work on that.

17 DR. CROSSON: Paul, let me see if I understand
18 because I wasn't quite clear. Is what you're saying that
19 price transparency -- and in this case, with respect to
20 hospitals and certain consolidated markets -- leads to
21 other hospitals' shadow pricing? Is that --

22 DR. GINSBURG: Actually, the way the mechanism

1 appears to work is that -- let's say you and I are device
2 men. We make the only device of a certain type. We have
3 similar models, and now we know the prices are hidden,
4 which means that if I want to get more sales, I can offer a
5 price cut to, say, a hospital that's buying it. But if I
6 knew that you would hear about that price cut right away
7 and figure that you would match it, well, then I won't make
8 the price cut in the first place.

9 DR. CROSSON: I see. Okay.

10 DR. GINSBURG: And this actually happens with
11 airline regulations, that airlines have prevented from
12 advertising their prices because other airlines would match
13 them instantaneously, and then the airlines wouldn't make
14 the price cut.

15 I was actually struck when I first got into it,
16 the degree to which it's a longstanding position in the
17 Federal Trade Commission and the Department of Justice to
18 prevent price transparency in consolidated markets because
19 of the conviction that it will lead to higher prices
20 because of the structure of the industry.

21 DR. CROSSON: All right. Thanks very much.

22 Bill Hall?

1 DR. HALL: If we do concentrate on transparency -
2 - I was surprised what you just said, Paul, but we don't
3 have any idea of the real costs associated with device
4 implantation and use. Most hospitals that do a lot of this
5 work -- I'll just talk about my own institution -- within
6 cardiology and within orthopedics now, we have people who
7 do nothing else but do what are called redos, removing
8 pacemaker wires, removing various types of defibrillators,
9 removing joints. All of that is occasioned by the initial
10 use of the implant.

11 So if we look at transparency, the cost of the
12 original device is, of course, important, but the real cost
13 of the decisions are much, much greater than that.

14 DR. GINSBURG: If I could follow up. This often
15 comes up in hospital payments. There are lots of ways of
16 getting data on costs without, in a sense, compromising the
17 competitiveness of the market. So that just saying we
18 don't want to necessarily broadcast every price of a
19 device, that there are ways that we can study what it
20 actually costs without violating that.

21 DR. CROSSON: Okay. Thank you. I have Amy, and
22 then Brian will have the last word.

1 DR. BRICKER: I wanted to agree with Paul. We
2 see this a lot with respect to pharmaceuticals as well, and
3 my question around really what do we mean by price
4 transparency was one that was still lingering. I think
5 it's important that CMS, that we know what we're paying
6 for, albeit the quality or understand fully the expense
7 associated with the device. I think beneficiaries should
8 understand what it is that is being paid for on their
9 behalf and the benefit or the risk associated, but concur
10 with all that was said a moment ago that providing that
11 level of price transparency actually does increase pricing
12 and does not encourage manufacturers to actually be more
13 competitive with respect to price because many studies, as
14 Paul has mentioned, have demonstrated that it does in fact
15 increase cost. And we saw this with respect to hepatitis C
16 when Manufacturer No. 2 came to market because they didn't
17 know what was going on Manufacturer No. 1 and private
18 negotiations. The resulting was that it decreased in cost
19 of up to 50 percent. So I think we just have to be careful
20 how far we take that conversation.

21 And I fully agree with the bullet. What are the
22 implications of greater price transparency, and what do we

1 meant by the price transparency?

2 Thank you.

3 DR. CROSSON: Brian.

4 DR. DeBUSK: I wanted to take a moment, too, and
5 agree with what Paul mentioned about transparency. I think
6 I have a slightly different take on transparency, but to
7 add to his comment, in the medical device industry, it's
8 not unusual to even go the next step and have a most
9 favored pricing clause attached to a specific product. And
10 what that can do is really lock down a market or even lock
11 down the entire country because you know your competitor
12 won't go below that most favored pricing clause unless
13 they're prepared to completely reprice their product
14 nationally. So it's signaling, but it's signaling as a
15 national level.

16 Now, what I would consider transparency is really
17 more around the drivers, and it's back to why did a
18 specific clinician use that specific device. And I think
19 understanding is it through -- is it, again, cost quality
20 and service, or is it a distribution arrangement, or is it
21 a group purchasing arrangement? And I'm not saying that
22 all of those are unhealthy, but I think understanding what

1 ultimately got that device into that clinician's hand is a
2 very important process because there are mechanisms there
3 that can distort who should win versus who does win in
4 these opportunities.

5 DR. CROSSON: Okay. Thank you very much. Eric,
6 you have plenty of fodder there to fertilize your mind and
7 bring us some future work. Thank you to the Commissioners
8 for some very thoughtful contributions.

9 We are now ready for the public comment period.
10 If there are any individuals in the audience who wish to
11 make a public comment at this time, could you come up to
12 the microphone so we can see who you are.

13 [No response.]

14 DR. CROSSON: Not seeing any, I will assume there
15 are no needs for public comment, and we will stand
16 adjourned until 1:30.

17 [Whereupon, at 12:41 p.m., the meeting was
18 recessed, to reconvene at 1:30 p.m. this same day.]

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1 than the current timetable. We also noted that it would be
2 important to monitor provider responses to the new PPS.

3 Over the coming year, our work on a PAC PPS will
4 continue. Today, we will discuss performance measures to
5 monitor provider behavior, and later this fall we plan to
6 discuss a transition to a new payment system.

7 For the new Commissioners and anyone in the
8 audience who has not followed this work, just so we're all
9 at the same starting point, I'll begin with a review of the
10 Commissions' work on a prospective payment system to span
11 the four PAC settings. Then I'll review the requirements
12 in the IMPACT Act for common quality and resource use
13 measures for PAC providers.

14 As we've noted in our comment letters to CMS on
15 measure specifications, we're concerned that the measures
16 are not quite uniform. Yet we need consistently defined
17 measures so we can monitor and compare provider responses
18 to the payment system when it is implemented. Then I'll
19 outline the analyses we're planning to compare two
20 performance measures across settings.

21 The IMPACT Act of 2014 mandated three studies of
22 a unified payment system. In the first, the Commission was

1 required to identify features of a unified PPS and estimate
2 impacts. Later, the Secretary must submit a report using
3 uniform patient assessment data that will have been
4 collected across the settings. We expect that report
5 sometime in 2022, and a year later, MedPAC must report on a
6 prototype design.

7 The first MedPAC report was completed in June.
8 We found that the costs of stays could be accurately
9 predicted (and, therefore, payments could be accurately
10 established) for most of the more than 40 patient groups we
11 examined. The report identified key features of a PAC PPS,
12 including a uniform unit of service, a uniform case-mix
13 system, other payment adjusters that would be needed, and
14 outlier policies for unusually short or unusually high-cost
15 stays. We found that the design would result in more
16 uniform alignment of payments with costs across different
17 types of cases. In terms of directional impacts, payments
18 would increase for medically complex care (such as
19 ventilator care) and decrease for rehabilitation care that
20 is unrelated to a patient's characteristics, and payments
21 would shift from higher-cost providers and settings to
22 lower-cost providers and settings.

1 The report also discussed a number of
2 implementation issues. First, because the work was based
3 on data that are readily available, the Commission noted
4 that a PAC PPS could be implemented sooner than the
5 timeline outlined in the IMPACT Act. It also discussed
6 regulatory changes to consider implementing at the same
7 time. If certain requirements are waived--for example, the
8 25-day length of stay for LTCHs or the intensive therapy
9 requirement for IRFs -- these providers could treat a
10 broader mix of patients than they currently do,

11 The Commission also noted that a transition
12 period to phase in PAC PPS payments would give providers
13 time to adjust their costs and practices. Given that we
14 found payments were much higher than the cost of PAC stays,
15 a transition could also consider the level of payments.

16 The report also discussed possible companion
17 policies to dampen the fee-for-service incentives to
18 generate volume and stint on care, and it identified
19 measures to monitor provider behavior and detect unintended
20 responses. And I'll come back to this last point in a
21 minute.

22 The PAC PPS work fits into a large body of work

1 the Commission has done over many years examining the
2 shortcomings of PAC. Because there is overlap in the
3 patients treated across settings, the Commission first
4 recommended the collection of uniform patient assessment
5 data back in 1999 and again in 2013. To help evaluate the
6 value of PAC, we've developed risk-adjusted, outcome-based
7 quality measures and moved towards aligning these as part
8 of our annual update work. The redesign work on SNF and
9 home health PPSs addressed the common problem that both
10 systems have that encourage unnecessary therapy. We
11 explored bundled payment for PAC as a way to encourage
12 efficient and coordinated care over an episode of care.
13 And with Medicare paying different rates for similar
14 patients treated in different settings, we first looked at
15 site-neutral payments between SNFs and IRFs for select
16 conditions and then designed features of a PAC PPS this
17 year.

18 In addition to mandating studies of payment
19 systems to span the four settings, the IMPACT Act also
20 required providers to collect uniform patient assessment
21 information, and it standardizes performance measures
22 across the four settings and requires the public reporting

1 of them. Together, these will assist purchasers and
2 consumers in comparing patient outcomes and enable Medicare
3 to move toward value-based payments.

4 The broad categories of patient assessment
5 information required by the act are listed on this slide.
6 CMS tested and validated elements for each of these domains
7 when it developed the CARE tool that was used to collect
8 uniform patient assessment information in its Post-Acute
9 Care Payment Reform Demonstration, which was completed in
10 2011. This information is important to be able to compare
11 patients and to risk-adjust outcomes across settings.

12 Although CMS' demonstration required
13 participating hospitals to gather patient assessment
14 information about patients at discharge, the IMPACT Act did
15 not include this requirement. We think this information is
16 important in two ways. First, it would help evaluate the
17 decision to discharge patients to post-acute care, and,
18 second, it would help validate the assessment information
19 that is collected at admission by PAC providers. The
20 Commission could consider requiring hospitals to collect a
21 small set of patient assessment items at discharge.

22 The IMPACT Act also requires the Secretary to

1 develop quality and resource use measures listed here to
2 enable comparisons across settings. You'll recognize some
3 of these measures. Our PAC work has evaluated changes in
4 function, discharge to community, and readmission rates in
5 its own work.

6 Given the deadline for measurement development
7 and the public reporting laid out in the act, CMS has been
8 busy developing the performance measures. To date, it has
9 developed measures listed on the left-hand side of the
10 slide. The Commission has commented on some of these, and
11 your concerns are summarized on the right. Most relevant
12 to work we have planned and we'd like to discuss today, the
13 definitions are not always uniform, and the risk adjustment
14 is setting-specific. The concern here is that differences
15 in rates could reflect differences in the way the rates
16 were calculated rather than differences in outcomes.

17 As I mentioned before, a key issue in
18 implementing a uniform payment system is the potential for
19 unintended impacts on provider behavior. The Commission
20 has played a key role in focusing attention on the
21 development of outcome measures and shifting the attention
22 away from process measures. The Commission can continue to

1 provide guidance to the Secretary in her development of
2 performance measures. Given the work the Commission has
3 done looking at the overlap of similar patients treated in
4 different settings, we have urged the Secretary to develop
5 performance measures that are uniformly defined so that
6 comparisons across settings can be made.

7 In addition, the Commission discussed
8 accelerating the implementation of the PAC PPS ahead of the
9 timetable anticipated in the IMPACT Act. To be able to
10 monitor provider responses, we need to have developed
11 measures and established a baseline so we can gauge
12 provider responses.

13 As part of its follow-on work on the PAC PPS, we
14 plan to develop and analyze provider performance measures
15 in two dimensions. We'll start with hospital readmissions
16 and a measure of resource use, that is, Medicare spending
17 per beneficiary. The measures are built from claims data
18 and, therefore, exclude the experience of MA enrollees
19 since providers do not submit claims for these stays. We
20 will compare performance across and within settings that
21 will provide a baseline for measuring changes under a PAC
22 PPS. In the future, we plan to expand this work to other

1 measures.

2 Our analysis of readmissions will look at three
3 measures. First, we'll examine those that occur anytime
4 during the PAC stay. The Commission has long held that
5 providers need to be held accountable for readmissions that
6 occur any time during their watch. But because lengths of
7 stay vary so much by setting, we will also explore a second
8 measure that compares readmissions during the same point in
9 time, for example, those that occur within two weeks of
10 admission to the PAC provider.

11 We also plan to analyze readmissions that occur
12 in the 30 days after discharge from the PAC setting. This
13 measure gauges how well the provider managed the transition
14 to the next setting or home.

15 The measures will count readmissions that are
16 considered potentially avoidable, will exclude planned
17 readmissions, and will be risk-adjusted. And I want to
18 note that there was a typo in the paper in the footnote and
19 that the conditions that were listed are the ones to be
20 included in the measure rather than the ones that are
21 excluded.

22 I want to point out that the readmission measures

1 need to exclude LTCHs for two reasons. First, key patient
2 assessment information has not been collected historically
3 by LTCHs, and we think this information is important for
4 risk adjustment. Second, the LTCH "interrupted stay
5 policy" prevents the detection of patients who are
6 readmitted to the hospital for three or fewer days. This
7 policy requires LTCHs to pay for these short hospital
8 stays, if the patient returns to the LTCH, and acute
9 hospitals do not submit claims for them. The Commission
10 could consider policy options to change the claims
11 submission requirements. Then we could detect these
12 readmissions and have information about how often they
13 occur and why.

14 The other performance measure we will examine is
15 the Medicare spending per beneficiary. This resource use
16 measures total Part A and Part B spending for an episode of
17 care and focuses providers' attention on the spending
18 incurred during their direct care and also during the
19 period after discharge. To keep the MSPB spending low, a
20 PAC provider has an incentive to have effective care
21 coordination, make referrals for needed subsequent care,
22 and collaborate with providers who have low readmission

1 rates. When a beneficiary's episode of care includes
2 multiple PAC stays, the measures for the providers will
3 overlap, thus aligning their incentives.

4 This slide tries to illustrate the alignment of
5 the incentives when an episode of care includes multiple
6 PAC stays. I've used the example of a patient who starts
7 in the hospital and then is discharged to an IRF and then
8 goes on to use a SNF. The green blocks are the initial
9 stays with each provider, and the purple blocks are the 30
10 days after discharge. The hospital stay and the care
11 furnished during the 30 days after discharge are included
12 in the hospital's MSPB measure -- and that's the first row
13 -- and this will include the IRF stay. Likewise, the IRF
14 stay -- that's in the second row -- and the care provided
15 during the 30 days after that discharge are included in the
16 IRF's MSPB measure. The hospital and the IRF measures thus
17 overlap, and thereby these providers' incentives are
18 overlapping and aligned. In this example, the beneficiary
19 is then discharged to a SNF, so the SNF stay starts its own
20 "stay plus 30 days," and that is included in the SNF's MSPB
21 measure, and this overlaps with the IRF measure, and that,
22 therefore, aligns the IRF and the SNF incentives.

1 Over the next several months, we will develop
2 uniformly defined measures and risk adjustments and analyze
3 the variation in rates and spending across and within
4 settings. For example, in the MSPB measure, we plan to
5 compare the share of spending attributable to readmissions,
6 subsequent PAC care, and physician services. We plan to
7 present the results in the spring and include the
8 information in a chapter in the June report on selected
9 topics related to the PAC PPS.

10 We'd like to get your thoughts about the planned
11 analyses and which performance measures to develop next.
12 We'd also like to get your reactions to whether we should
13 pursue policy options for requiring hospitals to gather
14 functional assessment data at discharge and requiring
15 changes to the claims submission requirements to be able to
16 measure all readmissions from LTCHs.

17 And with that, I look forward to your discussion.

18 DR. CROSSON: Okay. Carol, thank you very much.
19 Very clear, as usual. We'll start with clarifying
20 questions.

21 DR. HALL: Carol, thank you for this. There are
22 many kinds of post-acute facilities, but if we just sort of

1 concentrate on the ones that have a physical housing as
2 opposed to home health care, so SNFs, for example, the vast
3 majority of those patients will be coming in from a
4 hospital stay. And --

5 DR. CARTER: It's a requirement, right.

6 DR. HALL: Yeah, and I guess my clarification is:
7 Is there any way to look at the types of relationships
8 between the hospitals and referring the patients to a given
9 SNF? I think it's very different if there is a network of
10 nursing homes that a hospital works with as opposed to an
11 individual hospital just finding maybe the only facility in
12 town or different facilities. There's a lot more mutual
13 investment if there's continuity between these two systems.
14 Is there any way to kind of quantify that?

15 DR. CARTER: I don't know that we could quantify
16 it. There is literature that has looked at PAC placement
17 decisions and what are the factors that influence those
18 decisions. Ownership of PAC providers is one. Proximity
19 is another. Proximity to the patient's or beneficiary's
20 family is another. Another, sort of who else is in the
21 marketplace. And so I can bring that back to you. I'm not
22 sure -- at least at this point, we weren't planning on

1 quantifying those relationships, but other folks have
2 looked at that, if that would be helpful.

3 DR. HALL: Thank you.

4 MR. GRADISON: If the hospitals were required to
5 gather functional assessment data at the time of discharge,
6 would that information or should that information be
7 available to the PAC on admission so they'd see the same
8 information?

9 DR. CARTER: It should. And there is a
10 performance measure required in the IMPACT Act that the
11 transfer of information and beneficiary preferences are
12 transferred across the settings. So I think that the
13 expectation is there that that would happen, yes.

14 MS. WANG: Maybe I should know this. Can you
15 just back up and say a little bit more about the
16 measurement of readmissions? Because now we've got lots of
17 overlapping, so, you know, a hospital has -- there's a
18 measurement of readmissions for certain specified
19 conditions within 30 days of discharge. In your chart on
20 page 16, for example, you have the example that the patient
21 goes to an IRF. Are the readmissions measured for that IRF
22 different from -- there's some overlap, I guess, to the

1 admissions at the hospital is measured on, but, you know,
2 the diagram illustrates 30 days post, but, you know, given
3 some of the thinking about point in time and anytime during
4 the PAC stay, I'm just trying to sort of understand the
5 number of readmissions that might be measured and counted
6 against whom, because let's say that there is a readmission
7 in the first 30 days of the IRF stay for an IRF readmission
8 measure that would not count as a hospital readmission
9 measure. I mean, that's possible, right? So you could
10 have lots of overlapping readmissions being kind of tracked
11 and measured and attributed back to different provider
12 types. Is that --

13 DR. CARTER: Yeah, so your question is spot on,
14 which is right now the current hospital measure only looks
15 at readmissions for specific types of cases. And the
16 measures that we're developing -- and, actually, in the IRF
17 and SNF chapter -- in our update work currently, we look at
18 potentially avoidable readmissions, and those are uniform
19 between those settings. And we're planning on expanding
20 that definition to home health. So that would be different
21 than the readmissions that are counted for the hospital.

22 MS. WANG: Okay.

1 DR. CARTER: But we're at least trying to align
2 what the PAC providers are being held accountable for, and
3 the 30 days after -- so one set of measures looks at what's
4 the PAC provider within their four walls, if you will, and
5 then we have a separate measure that's looking at sort of
6 how well did they handle the transitions, and that's a
7 readmission rate for the 30 days post. But, again, those
8 would be across all types of cases, not selected.

9 MS. WANG: For example, is joint replacement of
10 the, like, SNF or IRF readmission measures?

11 DR. CARTER: No. We're looking at potentially
12 avoidable things, the things that we think should have been
13 able to have been managed by the PAC provider sufficiently
14 well, that it wouldn't cause a hospital readmission. So
15 those are things like dehydration or managing CHF.

16 MS. WANG: But joint replacement is one of the
17 hospital readmission -- preventable readmission measures.
18 Is that right? No.

19 DR. CARTER: I think it is. Craig is waving his
20 head yes.

21 MS. WANG: Okay. So if a hospital does a joint
22 replacement and discharges to inpatient -- to acute rehab,

1 and there is a readmission for the joint replacement within
2 30 days of the initial stay in the acute rehab setting,
3 that would not count against the --

4 DR. CARTER: Well, if the -- so the joint patient
5 is one of the measures that's tracked in the hospital, but
6 if the patient was readmitted for dehydration, then it
7 would count in the hospital measure and it would also count
8 in the PAC provider rate because that was a potentially
9 avoidable condition.

10 MS. WANG: So it would expand the universe of
11 readmissions that the hospital would be responsible for?

12 DR. CARTER: Well, the hospital rates look at
13 conditions -- when the patient was at the hospital -- so
14 it's the joint replacement it's -- there's a cardiac one?

15 [Simultaneous discussion.]

16 DR. CARTER: And then it looks for any cause for
17 readmission for those types of cases.

18 MS. WANG: Right.

19 DR. CARTER: And so in that sense, if they're
20 potentially avoidable reasons for those select set of
21 hospital conditions, if those were potentially avoidable
22 then they would be included in the hospital measure and

1 they would be included in the PAC provider.

2 But my understanding is we're moving towards an
3 all-cause --

4 DR. MILLER: I want to get in one place --

5 DR. CARTER: -- condition.

6 DR. MILLER: -- one place where you guys might be
7 talking past each other, although you're both correct, okay
8 --

9 [Laughter.]

10 DR. MILLER: -- is some of your question is
11 predicated on, but wait a minute, how is the hospital being
12 measured now, and a lot of her conversation is, where
13 should we be in measurement, in more of a unified PAC
14 basis. In the hospital setting, by law, you are correct.
15 It's condition-specific and it looks -- you know, the
16 exchange that you just had. The Commission has taken a
17 position it shouldn't be condition-specific. It should be
18 all conditions but potentially preventable. And then what
19 Carol was talking about today is looking down the road to a
20 unified PPS, how do we begin to move that concept more
21 completely through the post-acute care.

22 So I felt like some of your question was, "But

1 wait a minute. I'm looking at this condition-specific
2 thing in the hospital right now," and you're correct, that
3 is what you're facing. A lot of what I think she's talking
4 about is a different world.

5 Does that help at all?

6 DR. CARTER: Well, and I think the hospital
7 measures -- what the Commission's been on record as saying,
8 we think that the hospital measure needs to evolve.

9 MS. WANG: Okay. I've got it. Can I just ask
10 you one more question? Given the past recommendations of
11 the Commission, is it assumed, in all of these
12 recommendations around measuring readmission, that
13 socioeconomic status is adjusted for?

14 DR. CARTER: So the Commission has urged that
15 that not be included in the adjustment, because that hides
16 differences in quality between providers.

17 MS. WANG: Okay. I guess I'm thinking about the
18 stratification --

19 [Simultaneous discussion.]

20 DR. CARTER: So, right. So it thinks that the
21 rates should be what they are, and then if you go to then
22 compare providers, you stratify providers by, you know,

1 tiering based on your favorite measure of SES.

2 DR. MILLER: Or to put it a little bit
3 differently, we don't -- we haven't taken a position that
4 you adjust the measures that you present to the provider or
5 to the public and say this is SES-adjusted. But we do
6 recognize that SES is an issue and some providers may have
7 a more difficult problem, if they have a greater
8 preponderance of certain populations, and we would put
9 people into peer, or -- what did you just say? Peer
10 groups? Is that the current term we're using? -- and it
11 might be that if there was a dollar shift, either through a
12 VBP or a penalty or anything like that, moderate or mediate
13 the effect so that, you know, based on what -- how you're
14 represented by the SES.

15 MR. LISK: [Off microphone.]

16 DR. MILLER: Kind of. We just do it differently
17 than a lot of researchers come out and talk about it, but
18 there's a lot of organizations who are kind of moving it in
19 that direction.

20 DR. CROSSON: David.

21 DR. NERENZ: I just want to quick clarification
22 to follow directly on Pat. An example. Let's say a

1 patient was discharged from hospital with AMI diagnosis, so
2 it's in-the-hospital denominator for readmission. Goes
3 through an IRF. Within two weeks goes back to the
4 hospital. I was not aware that there was any filter under
5 the concept of preventively avoidable -- what was it,
6 potentially avoidable?

7 DR. CROSSON: Preventable.

8 DR. NERENZ: It just counts against the hospital
9 no matter what, right?

10 DR. CARTER: It's all cause for those select
11 conditions.

12 DR. NERENZ: Okay, fine, because I thought we
13 were weaving in that there was a judgment on potentially
14 avoidable, and I -- okay, I just wanted to clarify that.

15 DR. CARTER: No. I think that's where --

16 DR. MILLER: Wait a second. That's current law
17 now, but the Commission has taken a position that that's
18 not how it should be administered in the hospital. It
19 should be all-condition but potentially preventable, and
20 then she's exporting that concept into the post-acute care
21 setting. Okay? I just want to be clear. And if you guys
22 -- I just want to make sure the public is following what

1 we're talking about versus what's law.

2 DR. CROSSON: Bruce.

3 MR. PYENSON: Thank you very much, Carol. Could
4 you comment on the pros and cons of potentially preventable
5 versus all readmissions, because there seems to be a high
6 correlation between the two. And is there a concern that
7 focusing in on potentially preventable will have a
8 distorting effect on incentives?

9 DR. CARTER: So this is my personal opinion. I
10 think that potentially avoidable is fairer. It's not
11 holding providers accountable for things they have no
12 control over. So if you're treating a patient in a SNF and
13 they have a stroke, that's not the fault of the SNF, and so
14 I think they should be held harmless, if you will, for
15 that. So that's my position.

16 Would it possibly influence coding to avoid
17 patients being in or out of the measure? Maybe. Is that
18 behind your question?

19 MR. PYENSON: That's helpful. Thank you.

20 DR. CARTER: Okay.

21 DR. REDBERG: I just -- it's not that simple. I
22 agree with -- I mean, it could be the fault of the SNF.

1 Maybe they didn't give the Coumadin when, you know --

2 DR. CARTER: Right. It's true, and so maybe
3 that's not a great example.

4 DR. REDBERG: No. I'm just -- I'm just -- it's
5 not black and white. I mean, I understand the intent. I
6 mean, maybe if you walked out and got hit by a car, that's
7 clearly on you. But --

8 DR. CARTER: Right. And so when we've worked
9 with our contractor on our list of potentially avoidable,
10 we've tried to develop a list that's more or less
11 bulletproof, that people around the table would reasonably
12 agree that they are generally, potentially avoidable. And
13 these are rates so we're not pointing to that patient and
14 saying that one should have been and that one not. These
15 are rates, so we're looking at an entire book of business
16 over a year.

17 DR. CROSSON: Well, I think it's useful to point
18 out here that, you know, there's a behavioral response
19 embedded in this with respect to the relationship between
20 the hospital and the hospital's choice of post-acute care
21 settings. And if a hospital is continually getting
22 readmissions that are the fault of the PAC provider, in the

1 market that would be suitable for this, the hospital,
2 presumably, then, even though they need to provide
3 information about all choices to the beneficiaries, the
4 hospital is free to influence patient choice in favor, in
5 this case, particularly, of higher quality institutions.

6 [Off microphone.]

7 DR. CROSSON: -- we're done with that. So we're
8 going to have a discussion now and we've got Slide 18 up
9 there. So Carol is looking for feedback with respect to
10 her analysis to date.

11 Carol, I heard you also mention the question of
12 whether or not there might be a suggestion for more quality
13 -- additional quality measures. So I'm going to ask you
14 just to expand on that for a second, because I think I've
15 probably asked you, do you think there need to be. And
16 then -- I'll just finish -- and then input on these two
17 policy options as well.

18 So, Carol, quality measures. More quality
19 measure? Do you think we need them?

20 DR. CARTER: I think, yeah. Yes. I think a
21 broader measure of quality. We're trying to capture one
22 dimension and it's good, but I think there are other

1 measures of quality that could be added, and some of them,
2 like discharge to community, are claims-based, they're
3 relatively easy to develop in terms of risk adjustment,
4 and, you know, the definition is definitely more
5 straightforward than a readmission measure. So that one, I
6 think, is probably something that would be pretty easy.

7 This isn't really a quality measure but if I were
8 thinking about how to monitor provider responses to a PAC
9 PPS, I would want a baseline of the mix of cases and the
10 volume of PAC, so that we know, down the road, how those
11 are changing. We expect them to change, but I think having
12 a baseline of what the volume is and the mix would be
13 helpful, to know what have been the responses to the PAC
14 PPS.

15 DR. CROSSON: Great. Thank you. Let me just
16 roughly see the hands of those who have comments.

17 So I think we don't need to march then. We'll
18 start with Alice, and I had Craig. No, Alice. Okay. So
19 Alice, Bruce, David.

20 DR. COOMBS: Thank you, Carol. So with acute
21 care hospitals we've established some rough numbers of what
22 readmission rates look like that are good, and what ones

1 cross the line for the benchmark. And so establishing that
2 for the SNF I think is going to be interesting, because we
3 need to have some kind of a reference point going forward.
4 And so that piece introduces the whole thing of risk
5 adjustment and what that looks like.

6 So a couple of things that's in the literature.
7 One is the LACE Index. There's a very robust score that
8 the Brigham and Women's Hospital, that they perform this,
9 to look at readmission rates at the acute level, and a
10 couple of things that kind of fell out were oncologic
11 diagnosis, whether or not the primary acute-care hospital
12 admission was for an emergency versus an elective type of
13 admission. And so there's a long list. I won't go through
14 the whole list.

15 But I think that's kind of interesting because we
16 want to kind of, I think, parallel some of the stuff that's
17 been done on the acute-care hospital readmission side,
18 realizing that we can't be exactly the same.

19 And then I think you mentioned this in the paper,
20 is starting from the day of the acute-care hospitalization
21 and having an interval that it won't lead to confusion when
22 you get a PAC to a PAC. So I think you mentioned that and

1 I agree with that. Say, for instance, if you have day 1
2 someone goes in for a congestive heart failure, and then,
3 say day 10 they get transferred out and then they wind up
4 going from maybe an IRF to a SNF, so that if you did just
5 one simple, straightforward interval, that might work.

6 DR. CARTER: Well, the other thing, I think, I
7 tried to point out in the paper is if some PAC use is
8 second-stay PAC use, and let's -- I think home health is
9 around 10 or 15 percent of home health use, it's actually
10 downstream use of, you know, the second stay. Well, I
11 would expect the readmission rates for that to be lower
12 because we've looked at when readmissions occur, and they
13 are the most likely to happen early in a stay and then they
14 decline.

15 So if you're looking at PAC use that's really a
16 second PAC use, I would expect the readmission rates to be
17 lower. So at least in our first round of measure
18 development, we're just going to look at first PAC use, and
19 exclude the stays that are really second PAC use, in sort
20 of a whole episode of care.

21 DR. COOMBS: So I liked some of the tool sets
22 that have been used for measuring readmission at the acute

1 -- it's going to be really important to get the risk
2 adjustments right for this, because it could lead to
3 selection in the community. And so I think that was one of
4 the things that really drew me to let's have the best tool
5 possible going forward, so that some communities are not
6 adversely affected.

7 So the other question is the historical controls,
8 the historical benchmarks and utilizing historical
9 benchmarks for, okay, this is reasonable. I think that's
10 what the Blue Cross Blue Shield alternative contract is.
11 They looked at historical spending and the Medicare
12 spending per beneficiary. They looked at historical
13 spending and then they start with that as a reference
14 point, and then they used a temporal kind of timeline to
15 say, okay, this is Year 1, Year 2, Year 3.

16 But we almost have to have a timeline for looking
17 at the spending going forward and I don't know how that
18 looks. But you talk about transition period for this
19 readmission piece, but also looking at the timeline for
20 going forward, setting the benchmarks for how you measure,
21 you know, both -- Medicare beneficiary spending.

22 DR. CARTER: I think that's why we're working on

1 these measures now, is to at least describe current
2 practice, so we have the -- I don't know if they're
3 benchmarks because some of them might be high. But at
4 least we know what current practice is and can use that to
5 compare what happens after the PPS is implemented.

6 DR. COOMBS: And so the other thing is to choose
7 what we do currently, which started off with MI failure and
8 pneumonia, COPD added, and joint, as a reference, because
9 that might be a good framework to work within. I mean, we
10 have -- I think, Carol, we came up with a really, really
11 long list. Our list is longer than their list, when you
12 did the original work.

13 DR. CARTER: It's, I forget, 12 or 13 conditions
14 of potentially avoidable. Right.

15 DR. CROSSON: Thank you, Alice. Bruce?

16 MR. PYENSON: I would request, Caroline, that
17 when you do the modeling for this that you evaluate total
18 readmissions as well as the potentially preventable.

19 DR. CARTER: We are going to do that, yeah.

20 MR. PYENSON: Okay. Great. Thank you.

21 DR. CROSSON: David and Pat. David?

22 DR. NERENZ: Okay. Thanks. Just a question

1 about the point about functional assessment data. The
2 specific wording here is to require that of hospitals, and
3 I understand that then serves as a point of input into the
4 PAC context.

5 If the policy goal here, the challenge is to
6 develop an outcome measure or set of measures for PAC, it
7 would seem like functional assessment is the essence of the
8 PAC outcome. That's what PACs do. But we're not talking
9 about requiring the PAC providers to have an assessment at
10 discharge. Now, is that impossible?

11 DR. CARTER: That's actually a current policy.

12 DR. NERENZ: Okay, so --

13 DR. CARTER: Yeah. So what we're doing -- what
14 we're saying is if we're getting an admission and discharge
15 assessment from post-acute care providers, it would be
16 really helpful to have, what did these patients look like
17 when they came from the hospital.

18

19 DR. NERENZ: Okay, fine. I just had missed that
20 in the discussion --

21 DR. CARTER: Yeah.

22 DR. NERENZ: -- but it was actually there

1 already, at the end of the PAC stay.

2 DR. CARTER: Yeah. Okay. I'll make that clear.

3 DR. NERENZ: Okay.

4 DR. CARTER: Yeah.

5 DR. NERENZ: Yeah, either the functional status
6 at the end of PAC stay or, ideally, the change would strike
7 me as an important outcome measure.

8 DR. CARTER: Absolutely. Right.

9 DR. NERENZ: Yeah. Good. Okay.

10 DR. CROSSON: Rita, do you want to make a comment
11 on this?

12 DR. REDBERG: On this slide? On the policy
13 options? Are we doing that one?

14 DR. CROSSON: That's next, and then you go.

15 DR. REDBERG: Oh.

16 MS. WANG: You know, this just back to the
17 earlier discussion. I would just request that when you do
18 your analyses admissions, total admissions, et cetera, that
19 you continue to evaluate whether the construct that MedPAC
20 had previously identified to identify or isolate or account
21 for differences in SES status be continued, to see whether
22 there is any different effect for these providers, et

1 cetera. I think it's really important to continue looking
2 at that issue. I realize at this point it's an analytical
3 exercise but at some point this may translate into payment,
4 and I just think it's important to kind of keep that in the
5 bucket of how do we risk adjust for post-acute care.

6 DR. CARTER: So the way I would think that we
7 could handle that, consistent with kind of current
8 Commission policy, is to develop our measures and then
9 stratify performance by some of these dimensions.

10 DR. CROSSON: Rita.

11 DR. REDBERG: Sorry. Earlier I thought we were
12 going down the line. That's why --

13 And actually, no, I was just -- to follow on
14 Pat's comment, in the context chapter there was that
15 reference to how mortality rates differ, depending on the
16 economic and social environment. I think it's an
17 interesting issue because clearly there are things outside
18 of medical care system's control that influence
19 readmissions and how best -- yeah, which is why it is
20 relevant that what gets -- what health care is crowding
21 out, the costs of health care.

22 But my comment was only on those policy options.

1 I would favor both requiring hospitals together functional
2 assessment data at discharge and also requiring changes to
3 claim submissions, to be able to measure the readmissions
4 from LTCHs. I think it's really important to collect the
5 LTCH data because that's a very expensive and a not-clear
6 benefit for some beneficiaries, and I think we should have
7 more data, and it's too bad that they haven't been
8 collecting until recently a lot of the functional
9 assessment data that we do need.

10 DR. CROSSON: Okay. Sue.

11 MS. THOMPSON: Carol, two different comments.

12 First of all, from our ACO experience, it strikes
13 me we're in year five since we first began with some of the
14 MSSP and Pioneer ACOs, then there was the three-day waiver
15 that was available. I'm curious, is there enough
16 information available to us now to understand what impact
17 did the three-day waiver have on overall spend related to
18 the overall, you know, beneficiary spend? And then is
19 there any impact on readmission by not having gone through
20 the at-least-three-day inpatient hospital stay? So I think
21 that would be an interesting set of information to get our
22 hands on as we set these measures.

1 Also, in terms of requiring hospitals to gather
2 functional assessment information, I'm just thinking about
3 the impact to hospitals. How much -- and I'm going into
4 the weeds here a little bit, but when a hospital has a
5 patient that's being evaluated for skilled care and whether
6 or not they qualify, how much more data are we expecting be
7 collected in addition to what's just -- you're basically
8 qualified for skilled care -- to fully complete a
9 functional assessment?

10 DR. CARTER: Well, I think what we have been
11 including in some of the risk adjustment for the PAC
12 providers is a measure of mobility and self-care. So those
13 different -- and cognition. So those three dimensions of
14 function would be important. Some of the other information
15 about a patient's impairment may be discernible from what's
16 on the claim already, but I know that each of the patient
17 assessments usually has specific questions about the
18 impairment, and it is -- when CMS is trying to align the
19 patient assessment items across the four different
20 assessment tools, there are questions about impairment.
21 And so I would need to look through those to see -- I was
22 thinking about mostly about function and cognition, but

1 there might be some questions about patient impairment that
2 might be helpful.

3 MS. THOMPSON: Because if there's some cognition
4 assessment that would need to be done only by a
5 neurologist, for example, I would hate -- the unintended
6 consequence here is we would slow down the transition of
7 the patient from inpatient.

8 DR. CARTER: Right. No, I wasn't thinking of a
9 neurology consult.

10 DR. GINSBURG: Just one more thought about the
11 potentially avoidable versus all-cause hospitalizations. I
12 noticed from the presentation we'll be getting to at the
13 end of the day that the ECCP interventions did reduce
14 hospitalizations, all-cause hospitalizations more, smaller
15 percentage but more than just the potentially avoidable
16 hospitalizations. So it's probably a more difficult sell
17 politically, but there might be this class of
18 hospitalizations that are not ironclad enough to include in
19 the potentially avoidable list, but still where there's
20 potential to reduce them. And it's just something that we
21 should probably toy with as to, you know, which one should
22 be in the measure, or maybe both.

1 DR. CROSSON: So just let me ask -- and maybe
2 this is Carol or Paul or both -- is it possible to get at
3 those exact diagnoses for admission that might fall into
4 that category? Or is that just speculation?

5 DR. CARTER: Well, I'm not sure how detailed the
6 data to us would be for looking at what were the conditions
7 that resulted in the broader mix of readmissions that
8 Paul's referring to. But we can ask -- I'll work with
9 Stephanie on finding out from the evaluator kind of what
10 they've looked at. But I think you raise a good question,
11 which is we've defined a narrow mix because we wanted to be
12 kind of broadly in agreement. But that doesn't mean there
13 aren't kind of conditions in the gray areas that could have
14 been potentially, you know, avoidable. But we haven't
15 counted them, and so there is potential to reduce those as
16 well.

17 DR. CROSSON: Okay. Good point there. Thank
18 you.

19 MS. BUTO: Carol, both readmissions and the
20 Medicare spending per beneficiary are things that could be
21 done relatively quickly, and I think you're anticipating
22 they could be adopted by CMS before they actually have to

1 go into a full implementation of a PAC PPS. What's the
2 timing that we could imagine if they were to agree that
3 these should be -- you know, these should be adopted for
4 including them?

5 DR. CARTER: Well, CMS has developed its own
6 definitions of these measures, and so they're working on
7 these. They've developed them. And our concern is that
8 because they're not exactly uniform, that for us, in
9 comparing rates across providers, we would rather for our
10 own work be comparing our measures that use a uniform
11 definition and risk-adjustment measure. But CMS is meeting
12 the deadlines laid out in the IMPACT Act of developing
13 these measures and moving forward.

14 MS. BUTO: So you're saying that we really will
15 move ahead and analyze based on these two measures rather
16 than seeing what Medicare's going to do with those.

17 DR. MILLER: Yeah, so I'll say two things. First
18 is I think her question -- and she's sitting right here, so
19 -- I think your question is: If we wanted to move these
20 measures forward, what is the timeline we could see that
21 happening? And, you know, it's a really good question.
22 It's not one I asked you anywhere along the way. Did you

1 want to speculate on that? Like when do we think we'll be
2 wired out on our development of the measures? We're pretty
3 close, right?

4 DR. CARTER: I'm planning on presenting them in
5 the spring.

6 DR. MILLER: Okay, so spring, and then, Kathy,
7 you know, figure there's the processing and then
8 regulatory, you know, et cetera. So let's just say for
9 sport -- I'm making this up; feel free to change it -- two
10 years. Does anybody have a heart attack with that? Mostly
11 you.

12 DR. CARTER: I'm good.

13 DR. MILLER: Okay. So maybe our measures could
14 be in play, you know, reasonably in play within -- yeah, in
15 two years. But the other thing, the implication of the
16 exchange between the two of you that I do want to hit --
17 again, I think you two got it, but I want to make sure
18 everybody else gets it. CMS is out developing things.
19 We're a little worried that they might get pushed off of
20 the true uniform, and that's the other reason we're staying
21 in this space. I'm pretty sure you got it, but I want to
22 make sure other people got it.

1 DR. NERENZ: Yeah, I hadn't intended to get into
2 the issue of SES adjustment, but I want to follow up on Pat
3 on this, and some of you know what I'm -- Carol, you
4 accurately described the position of the Commission I think
5 three years, three and a half years ago. I think it was
6 early 2013 that we recommended that stratified approach to
7 the hospital readmission measure. And I'd just observe
8 that that was a reasonable thing in the context of a
9 specific measure, a specific measurement context.

10 Now, since that time, I think people know, a
11 great deal of empirical work has been done on this issue.
12 There's been a lot of policy discussion. There are reports
13 coming out currently from the National Academy of Medicine.
14 There was a big policy change at National Quality Forum a
15 couple years ago. Academics like Ashish Jha have been
16 writing about this. So I guess I would observe that I
17 don't think -- I don't consider that to be set in stone for
18 us. I think we should continue to think about it, as you
19 said. And our thinking in this context may end up being
20 different than what it was in the hospital readmission
21 context three and a half years ago.

22 DR. CROSSON: Maybe I'm fuzzy here, but I thought

1 we had this discussion since I came back to MedPAC, which
2 would have been 2014, 2015.

3 DR. NERENZ: I don't recall any recommendations
4 that we voted one way or the other. I know it's come up in
5 a couple of contexts, but I think, you know, Carol, your
6 phrasing was, "It is the position of the Commission," and
7 I'm just thinking that's a pretty firm and strong statement
8 if we have not actually voted a set of recommendations.

9 DR. CROSSON: Correct me if I'm wrong. My
10 understanding was that we decided by consensus to not make
11 a recommendation to make that correction, and instead of
12 that, we decided, as was announced, as was mentioned
13 earlier, that the piercing or tiering was the most sensible
14 approach. I'm not saying we can't revisit it. I'm just
15 not -- I'm not certain it's as old as three and a half
16 years. Am I wrong?

17 DR. MILLER: There was a conversation, and if my
18 memory serves, it was around MA where we revisited it, and
19 we had the exchange that you just went through.

20 DR. CROSSON: Okay.

21 DR. DeBUSK: I wanted to mention, in the June
22 report on the unified PAC, there are a lot of things to get

1 excited about. It's a very positive message. It was an
2 exciting chapter to read. And then your subsequent report,
3 also very promising. But the one thing that really jumps
4 out at me about this isn't necessarily the specifics of a
5 unified PAC model, but it's also the role that standards
6 can play. I mean, I can get really excited about the idea
7 of the outputs of one venue being the inputs into another
8 venue. And this idea of trying to modularize different
9 stages of care so that you're actually comparing and using
10 standardized measures -- so, you know, we talk about things
11 like readmissions, we talk about things like SES
12 adjustments. I'd just like to point out that I'm not sure
13 that the specific methodology that we use is as important
14 as the fact that we just apply it uniformly, then we stick
15 to those measures.

16 So, again, the PAC PPS chapter was extremely
17 exciting to me for a number of reasons, but I think
18 standards were one of the top ones.

19 DR. CROSSON: Okay. Seeing no more comments,
20 suggestions, Carol, thank you so much once again, and we'll
21 be seeing you.

22 [Pause.]

1 DR. CROSSON: Okay. We're going to move on to
2 the second afternoon discussion. This is kind of an
3 initial level-setting presentation that Kate has prepared
4 for us. We're going to be taking a look at the nature of
5 physician practice in the United States, issues of group
6 formation consolidation, et cetera, as a basis for later
7 discussions.

8 MS. BLONJARZ: So, as Jay described, I'm talking
9 today about the physician practice landscape and changes
10 over time.

11 The reorganization of physician practices has
12 implications for the Medicare program as well as for the
13 health care delivery system as a whole. These changes can
14 affect the way care is provided, change practice patterns,
15 and affect spending due in part to different payment rates
16 across settings.

17 I'll report on two physician practice measures,
18 the share of physicians reporting that they are affiliated
19 with a hospital or health system and the size of physician
20 group practices.

21 For the first measure, there are a variety of
22 different kinds of financial relationships that occur

1 between physicians and hospitals or health systems. I am
2 using the term "affiliation" to describe that there is some
3 kind of financial integration between the two entities, but
4 not the degree. I will describe a data source that could
5 be of use in our analysis and report on what these data
6 show and compare it to other sources of similar
7 information. I will also present trend information and what
8 I found when matching it to Medicare claims.

9 The information currently available on hospital
10 and health system purchasing of physician practice and
11 physician practice size comes from a few places. I'll
12 describe three in more detail.

13 The American Hospital Association issues a survey
14 to all hospitals asking them to report the number of
15 physicians that they have financial arrangements with in
16 one of eight different categories of financial integration
17 between hospitals and physicians.

18 The American Medical Association conducts a
19 survey of a convenience sample of physicians, asking them
20 about their practice size, whether their group practice is
21 owned by physicians or other entities, and if a hospital or
22 health system fully or partially owns the practice.

1 And last, there is information on Medicare fee-
2 for-service claims that could help identify group
3 practices. Physicians and other clinicians can reassign
4 their Medicare billing rights to an organization such as a
5 group practice or a hospital. Some researchers have used
6 the tax ID number of the organization that billed for the
7 service and received payment for it as a proxy for a
8 physician group.

9 The data source I will described today is the
10 SK&A Office-based physician database. It is a commercial
11 file of nearly 600,000 physicians and their practice
12 information. It is constructed and updated through
13 periodic phone calls to practices, Internet research, and
14 administrative sources.

15 For our purposes, the benefits are that it is a
16 national file containing physician national provider
17 identifiers and has variables for each physician's group
18 practice, whether their practice is affiliated with a
19 hospital or health system, and the number of physicians in
20 the practice.

21 There are some limitations to the file. The
22 database appears to have fewer physicians in certain

1 hospital-based specialties -- radiologists, pathologists,
2 anesthesiologists, hospitalists, and emergency room
3 physicians. And the data file only indicates hospital or
4 health system affiliation but not the degree, whether it's
5 full ownership or something different. And it appears that
6 the completeness of the SK&A file has improved over time,
7 and this could affect our ability to assess trends over the
8 long term.

9 Finally, I'd note that there is not a single
10 reference point for the total number of currently-
11 practicing physicians in patient care. For example, the
12 AMA Masterfile of physicians has a higher number than that
13 extracted from state licensing records. So it's difficult
14 to pin down the exact number of physicians that might be
15 missing from the SK&A file.

16 As an initial step, I categorized each physician
17 in the SK&A database into the broadest organizational
18 structure that they report affiliation with. For example,
19 every physician with a health system flag is grouped into
20 the health system bucket. Of those remaining, every
21 physician with a hospital flag is grouped into the hospital
22 bucket, then multi-location group practices, single-

1 location group practices, then solo physicians, and then
2 the category of "Other." There is more detail about the
3 other category in your mailing materials, and I can address
4 it on questions.

5 What this means is that physicians that I
6 describe later as group practice are by definition not
7 affiliated with a hospital or health system. If they had
8 both group practice information and hospital affiliation
9 information, then we would classify them in the hospital
10 category.

11 So, as I said before, there are about 595,000
12 physicians in the SK&A database. This is about 50,000 less
13 than the number of physicians that billed Medicare that
14 year and about 100,000 less than an estimate of the non-
15 federal physician workforce from the AMA Masterfile.

16 Recall, too, that the SK&A database that we have
17 only contains physicians, and there are over 400,000 other
18 types of providers who are paid through Medicare's fee
19 schedule.

20 When we applied our physician affiliation method,
21 I found a higher share of physicians reporting hospital or
22 health system affiliation in the SK&A database than in some

1 other sources. The estimates of group size are more
2 comparable, although we have a slightly smaller share of
3 physicians in solo practice than in the AMA survey, and
4 that might be sensitive to how we categorized physicians
5 into the "Other" category.

6 Between 2012 and 2014, the share of physicians in
7 the SK&A database reporting hospital or health system
8 affiliation increased from 34 percent to 39 percent. I
9 mentioned earlier that improvements in data completeness
10 could make very long-term trends more difficult, but it
11 should be robust over the three years I've presented here.

12 The AMA survey of physicians also has comparable
13 growth over the same time period in their survey category
14 assessing hospital or health system ownership.

15 And recall here again that these categories are
16 hierarchical from the bottom up. So group practices are by
17 definition not associated with a hospital or health system.

18 There is variation in practice affiliation by
19 specialty. For example, cardiologists and emergency
20 medicine doctors are much more likely than other
21 specialties to report that they have hospital or health
22 system affiliation, and orthopedic surgeons are much more

1 likely to be in group practices without such affiliations.
2 Twenty percent of primary care doctors were classified as
3 solo practice.

4 This also tracks to some of the news reports
5 about the types of physician practices that have been
6 acquired by hospitals and health systems. For example,
7 hospital purchasing of cardiology practices over the past
8 decade has been significant, and more recently, there have
9 been reports of acquisitions of emergency medicine
10 practices by a variety of organizations, including
11 hospitals and health systems.

12 Turning to physician practice size, the share of
13 physicians working in practices with more than 50
14 physicians grew from 16 percent in 2009 to 22 percent in
15 2014.

16 I'd like to make a second point here from data
17 that's not shown on the slide. I looked at two measures of
18 group size. First is the number of physicians working in
19 the group across all locations of the practice, and second,
20 the number of physicians working in the physician's
21 specific practice location. The share of physicians
22 working in the largest practices increased when we looked

1 across all locations in the practice. That's this slide.

2 But the share of physicians working in the
3 largest practices was unchanged when we looked at the
4 physician's specific office location. That could be
5 consistent with a story that physician practices are being
6 acquired or consolidating into larger practices but are not
7 physically merging their practice locations when they do
8 so.

9 I matched the SK&A database to the Medicare fee-
10 for-service physician claims using the performing NPI on
11 the claim. I could match about 70 percent of the Medicare-
12 billing physicians in 2014, and this accounts for 84
13 percent of services and 84 percent of spending.

14 The 30 percent of physicians that didn't have a
15 record in the SK&A database were more likely to be
16 hospital-based specialties, like I mentioned earlier --
17 emergency room physicians, radiologists, anesthesiologists
18 and pathologists, and internal medicine doctors that we
19 believe are working as hospitalists. The non-matching
20 physicians also accounted for a smaller share of Medicare
21 spending and services.

22 Of the 70 percent of Medicare-billing physicians

1 that could be matched, their distribution by practice
2 affiliation was similar to the entire universe of SK&A
3 physicians, and we'd expect this, since most of the
4 physicians in the SK&A database billed for a Medicare
5 service.

6 Thirty-nine percent of the SK&A Medicare-billing
7 physicians reported hospital or health system affiliation,
8 24 percent reported a group practice not affiliated with a
9 hospital or health system, and 16 percent reported that
10 they were solo practitioners.

11 We also looked at the distribution of Medicare
12 fee schedule services and spending. I want to make two
13 caveats. First, we're missing 30 percent of the physicians
14 that account for 16 percent of the services and dollars,
15 and second, these figures reflect the general distribution
16 of Medicare physician services across specialties. Much of
17 Medicare services and spending is concentrated in certain
18 specialties, like cardiology, ophthalmology, and oncology,
19 and so the practice affiliation of those specialties that
20 account for a lot of Medicare services will dominate these
21 pictures.

22 Overall, 30 percent of Medicare physician

1 services was performed by physicians in group practices
2 without hospital or health system affiliation, 20 percent
3 were performed by solo practitioners, and 27 percent by
4 physicians with hospital or health system affiliation.

5 With respect to group size, there is still a
6 sizable share of Medicare services and spending that is
7 performed by physicians in small practices, five physicians
8 or less, and two-thirds of spending is for physicians in
9 group practices of 10 physicians or less. But, again,
10 recall that the practice size of certain specialties that
11 account for a large share of Medicare spending will
12 dominate these pictures.

13 So, to summarize, we had two main goals in this
14 preliminary work. First is to understand the SK&A database
15 and see whether it offers advantages over other sources of
16 similar data. It does contain unique physician information
17 that allows for matching to Medicare claims and has
18 information on all reported physician linkages. Analyses
19 of the file over time show an increase in the share of
20 physician reporting a hospital or health system
21 affiliation, but time trends before a few years ago are
22 difficult to make because the file appears to have gotten

1 more complete over time.

2 We were able to match 70 percent of the Medicare-
3 billing physicians to an SK&A record in 2014, and the
4 distribution of physicians billing Medicare is similar to
5 the overall physician population in the SK&A database.
6 Group practices not affiliated with hospital or health
7 systems account for 30 percent of Medicare fee schedule
8 services, and over 50 percent of fee schedule services and
9 spending is for physicians in practices of five or fewer.
10 And this is due in large part to the physician specialties
11 that account for a large share of Medicare spending.

12 So there are some clear next steps we see that we
13 could take, including adjusting Medicare service and
14 spending for specialty mix, adding in other types of
15 organizations, such as independent practice associations,
16 to reduce the physicians classified as having "Other"
17 practice affiliation. We are also using the SK&A database
18 in a project looking at private sector pricing, but I'd
19 welcome your reactions and any specific suggestions, and
20 I'm happy to take any questions.

21 DR. CROSSON: Okay, Kate. Thanks very much.

22 I think what we'll do is we'll start with

1 questions of clarification. I have a couple, so I'm going
2 to start that off, and then we'll have the discussion.

3 In the paper, I think health system is defined as
4 an entity that is comprised of more than one hospital.

5 MS. BLONIARZ: It doesn't have to be. It's a
6 number of health facilities. It could be one hospital and
7 a post-acute care provider. It could be a set of practices
8 owned by an insurer. We kind of defer to SK&A on how they
9 classify hospitals and then health systems.

10 DR. CROSSON: Okay, that's helpful.

11 And the second one is, Does the database
12 distinguish between single-specialty groups and
13 multispecialty groups or not?

14 MS. BLONIARZ: That's something we could
15 construct. So it's a physician-level data file. So we
16 could look at the physician specialties of people in a
17 group practice and say whether we think, okay, most of them
18 appear to be internal medicine, so that's single specialty.

19 DR. CROSSON: Okay. Thanks.

20 Clarifying questions? Rita, Jack, Warner. Rita?

21 DR. REDBERG: Well, you asked one of them on
22 multi and single.

1 But my other question, I was a little struck by
2 that the smaller single physicians or smaller accounted for
3 so much, and you said that it was due to cardiology,
4 ophthalmology, and oncology. I'm assuming because those
5 were the higher billing. Were they evenly distributed, or
6 was one of those more common in the higher billing?

7 MS. BLONIARZ: So future go-rounds, I can kind of
8 pull out what are the most -- the highest-billing Medicare
9 specialties, but generally, it's internal medicine,
10 cardiology, hematology, oncology, ophthalmology, radiology.
11 Yes. So those are going to have kind of a bigger impact
12 than --

13 DR. REDBERG: I don't think I was clear. I meant
14 in particular in the single-practitioner that was
15 accounting for --

16 MS. BLONIARZ: Oh.

17 DR. REDBERG: Were they more likely to be one of
18 those?

19 MS. BLONIARZ: I can figure that out.

20 DR. REDBERG: And if you have any data on
21 geographic variation --

22 MS. BLONIARZ: Yeah.

1 DR. REDBERG: -- that would be interesting.

2 MS. BLONIARZ: Yep, I do.

3 DR. CROSSON: Jack.

4 DR. HOADLEY: So you gave us the caveat on Slides
5 12 and 13 about their being dominated by these certain
6 specialties. I guess I'm trying to get a sense of how much
7 wiggle do we think is going on there if we looked within --
8 with some other definition or within some of the other
9 specialties. I mean, I'm just trying to think how much to
10 put on this notion that 50 percent of the services are in
11 these one to five groups, for example. If I looked at some
12 of the other specialties that weren't these particular ones
13 that are dominating, would it be half bad, double bad? I
14 mean, were you talking those kinds of differences? Do you
15 have a sense of that yet?

16 MS. BLONIARZ: Well, so what I tried to do in the
17 paper was describe kind of the Medicare-billing physicians,
18 right? So that does show a larger share of physicians in
19 bigger practices, but adjusted by kind of the service mix
20 and the Medicare population. The only point I was trying
21 to make here is there's still a lot of services and
22 spending in these very small practices.

1 DR. HOADLEY: Right.

2 MS. BLONIARZ: Just because of the types of
3 specialties that provide the preponderance of care.

4 DR. HOADLEY: Okay.

5 DR. CROSSON: Warner.

6 MR. THOMAS: I don't know if this would be a
7 question for Kate or for Mark or Jay, but I guess what I'm
8 trying to understand, with the chapter, is what are we
9 trying to accomplish with doing this work? I mean, is
10 there -- what's the outcome we want to try to get to?

11 MS. BLONIARZ: So I think, initially, we just
12 wanted to see if there were other sources of information
13 kind of beyond what's available, either through claims or
14 data that we couldn't actually match to other sources, and
15 to see what this information is showing.

16 I think, you know, we could kind of track
17 information over time, but I think more utility will come
18 like with -- as we apply it to other projects. So we have
19 a project going on, private sector pricing, and I think
20 there's other areas that we've thought about, you know,
21 using this kind of information for.

22 MR. THOMAS: So you see, going forward, you know,

1 looking at -- trying to look at quality measures based upon
2 the size or type of practice, looking at, you know, cost in
3 this model? I mean, is that kind of what you're thinking?

4 MS. BLONJARZ: I think that's right. I think,
5 yeah, we'll just have to see, you know, how much -- how
6 comfortable we are ascribing differences that we see to
7 actual differences in the practice size, or, you know, the
8 affiliation, but that's the idea.

9 DR. MILLER: And I'm just going to do my version
10 of it, which is not really different, but just -- the way I
11 think about it -- and Pat made some comments earlier today
12 about the significance of consolidating and changing in the
13 landscape. We get questions from you guys, either directly
14 or implicitly, along those lines all the time. We also get
15 them from Congressional committees and that type of thing.
16 And the data sources, as Kate has reviewed, are all
17 incomplete or somewhat, you know, okay or not okay in their
18 own ways.

19 Then I would see two exercises if you had the
20 perfect data set, and she said this. What are the trends
21 over time, and then if you could link to either claims data
22 or quality measures, that type of thing, could you look at

1 the landscape across different organizations like you guys
2 just said?

3 I think a third thing that's going on in this
4 particular session is whether this data set has -- you
5 know, which, Kate, I think, has carefully tried to lay out
6 pros and cons, gets us where we want to be, and I think
7 John is going to have some comments later on, on that. So
8 I think that's the third ball in play here, is, is this
9 good enough to do what we want to do on the first two
10 things.

11 MR. THOMAS: And -- go ahead, sorry. I was just
12 going to say I think the other question I would have is --
13 I mean, number one, I was actually kind of struck by how
14 many small practices there still are, and I would imagine
15 if you do the geographic distribution they're probably more
16 in rural areas, I would imagine, but it would be
17 interesting to know that, and then what does this trend
18 look like over time, because I think we -- I think there's
19 a feeling that there's been a lot of physician
20 consolidation but yet the numbers are, you know, still
21 indicating a pretty fragmented piece of the health care
22 system.

1 DR. CROSSON: Pat.

2 MS. WANG: So just taking these at face value, I
3 think that's an important comment for any efforts to design
4 new physician payment models, particularly those that do
5 require some level of infrastructure, whether it's a macro
6 or something like that, because if taken at face value, 20
7 percent of Medicare physicians are still practicing in
8 onesie-tvosie offices, that's important to know so that
9 somebody doesn't recommend what was just recommended every
10 body, you know, go into up- and down-side risk right away,
11 because onesie-tvosie offices probably are going to have a
12 little difficulty doing that. So I think it's relevant for
13 that kind of reason too.

14 DR. CROSSON: Okay. So I think -- thank you, Pat
15 -- I think we're moving into, you know, commentary. Alice,
16 a clarifying question?

17 DR. COOMBS: No.

18 DR. CROSSON: Oh, no, you -- but the sentence was
19 not out of my mouth, and it's like, only this far out.

20 [Laughter.]

21 DR. CROSSON: Just kidding. So --

22 [Laughter.]

1 DR. CROSSON: Everybody's jumping the gun.

2 Let's have a comment session, and I think I've
3 been hanging around with Mark too long because he pretty
4 much said the same thing I was going to say.

5 So in the session, comments on the quality of
6 this data, its breadth of utility based on the issues that
7 are in it -- and I don't mean issues of fact. I mean
8 issues of the adequacy of the database, because I think
9 some will comment on that.

10 But then, also, ideas about its applicability.
11 Assuming that people say, "Well, this is not perfect but
12 it's good enough," its applicability to the goals that we
13 have, you know, and the work plan that we have, and how it
14 might fit in, you know, over time, to help us parse what
15 we're trying to do and make judgments. So those are both
16 on the table at the same time.

17 So, I saw Alice and I saw -- okay. So Alice,
18 Craig, Jack, Bruce, and Paul. Alice.

19 DR. COOMBS: What we don't know is, on the pie
20 chart, whether or not some of these groups on the 50
21 percent are hospital affiliated. So we have an overlap, if
22 you will, of the one pie chart that tells you the size of

1 the groups and then we have one that tells you if they have
2 hospital affiliation or health care system affiliation. So
3 we don't -- what it doesn't tell us is that there's some of
4 the 2-to-5 groups that may be actually hospital affiliated.
5 So -- and I think you mentioned that in the paper about,
6 you know, some consolidation occurring where they both have
7 -- they have a bunch of groups that have different numbers
8 for tax ID.

9 MS. BLONJARZ: I just wanted -- yeah, I just
10 wanted to make a point about this. So we show, you know,
11 about somewhere in the range of 30 percent hospital or
12 health system -- 40 percent hospital or health system
13 affiliation.

14 Some of the other ways of measuring kind of group
15 size using Medicare billing information, shows much larger
16 group practices, and I think what might be going on there
17 is there could be a collection of practices that are all
18 owned by one large system, which is billing kind of using a
19 common tax ID number. But the clinicians in those groups
20 think of themselves as belonging to a much smaller entity.

21 So I think one thing I've kind of struggled with
22 is what level of financial integration are we able to

1 capture. Is it that groups that are part of systems -- you
2 know, how are we counting that? So one thing I could do is
3 kind of roll up to a total physician count for the entire
4 entity and see what that looks like?

5 DR. COOMBS: This speaks to another issue that
6 I've seen in our area and that is, where you might have a
7 nephrologist who has his foot -- he's spread between three
8 different entities, and so that it looks kind of odd, he's
9 not really committed to one solo entity, so that changes
10 the numbers a little bit.

11 But you mentioned -- I think you mentioned the
12 Federation of State Medical Boards. Somewhere along the
13 line you talked about state medical boards as a source.

14 MS. BLONJARZ: This is more in trying to get at
15 the question of what is the coverage of the SK&A database,
16 you know, the 600,000 physicians that it has, how much of
17 the universe do we think that is, of total practicing
18 physicians. And the only point I wanted to make there is
19 that there are differences in the number of practicing
20 physicians in patient care, if you look at the AMA
21 Masterfile, or if you look at Census survey information, or
22 if you look at state licensing records. So there's just --

1 there's no one single reference point for that number.

2 DR. COOMBS: And I just wanted to support you in
3 that, Kate, because we saw that in Massachusetts where we
4 have somewhere, you know, a little shy of, you know, a
5 single-digit percentage of people who are actually licensed
6 to practice medicine yet they don't practice medicine and
7 they keep their license up. So that is not necessarily a
8 reflection of clinical activity.

9 And then this whole notion of the RAPERs --
10 radiologists, anesthesiologists, pathologists, and the
11 emergency room physicians -- and what they add to the plan
12 of the big picture, in terms of vertical integration, and
13 what that's going to look like for the poor
14 anesthesiologists out there trying to slum in the
15 neighborhood.

16 [Laughter.]

17 DR. COOMBS: But what it does say is that missing
18 those 30 percent is really an important part of the
19 database, and any conclusions that you come up with,
20 without -- with the absence of those entities, I think you
21 have to consider that the impact of the MIPS and the -- you
22 know, the MIPS mostly, on those individuals.

1 And so we've talked about this notion of vertical
2 -- virtual vertical integration, and so there's been a lot
3 of talk and I think there's been some discussion in
4 Congress about how do you get to a reasonable affiliation
5 via when there's different geographic regions. I don't
6 know that the data that we have is robust enough for us to
7 draw major conclusions. It might be something doable with
8 studying some geographic region. I'm wondering if a pilot
9 in a geographic region would be better served, because you
10 could get at a more realistic picture of how the numbers
11 correlate with the actual outputs.

12 DR. CROSSON: First, an apology. Apparently my
13 brain emptied out over lunch and I forgot you were supposed
14 to lead this off and the last one. I'm sorry.

15 Okay. Craig.

16 DR. SAMITT: So I think this data is fascinating
17 and is a good first step, and, you know, I'm probably the
18 least qualified to determine whether this database is
19 accurate enough to do the analysis. I'm more interested in
20 the analysis that can come from this. I think that this is
21 crucial.

22 We've, I think, progressively formed hypotheses

1 about what different physician cohorts will achieve in
2 terms of performance, and I think these types of analyses
3 will help us either prove or dispel those hypotheses. So,
4 for example, I wonder whether a hypothesis is is that we're
5 going to get higher performance of a provider group if
6 they're hospital-employed or if they're in a multi-
7 specialty group, and that independent practice associations
8 could not achieve a comparable level of performance. Well,
9 I'd love to look at the data and see what that actually
10 shows.

11 I also would be interested in knowing, not just
12 from a quality perspective but from a cost perspective, is
13 there an optimal size of a practice that achieves highest
14 quality, lowest cost? Do we see differences when the
15 physicians are independent versus employed by hospital
16 systems or health systems?

17 So I think there is an enormous amount of very
18 helpful data that I think educates some of our ACO
19 observations, but also really helps us as we begin to think
20 about what do we want to encourage, from a payment reform
21 perspective, as it relates to physician consolidation
22 affiliation, and so on and so forth.

1 So I think we need to go much further with this,
2 choose the right database, because I think that there is a
3 treasure trove of information that we can get from this.

4 DR. CROSSON: Thank you. Bruce. Sorry, Jack.
5 Bruce.

6 MR. PYENSON: A question about the alternative of
7 getting CMS to fix the PECOS system. Is that in the cards?

8 MS. BLONIARZ: So CMS was given authority and
9 instruction to improve the validity of PECOS. They're
10 doing revalidation audits. Oh, so PECOS is the provider
11 enrollment system for Medicare. I think, ideally, it would
12 contain much of this information, but, you know, OIG
13 studies have found it to be fairly incomplete and difficult
14 to use, and even information that probably should be in
15 PECOS, like a physician that's reassigned its billing to a
16 group practice, sometimes those linkages aren't there.

17 So I think that's one thing that you could
18 definitely talk about is should this be information that
19 Medicare collects and, you know, is PECOS a mechanism for
20 doing that.

21 DR. MILLER: So I know there's a list, Jay.

22 DR. CROSSON: Yeah, go ahead.

1 DR. MILLER: But Jon. Is this the place --

2 DR. CHRISTIANSON: She just said it, yeah.

3 DR. MILLER: Well, I think you should say it.

4 DR. CHRISTIANSON: I agree.

5 [Laughter.]

6 DR. MILLER: Okay.

7 DR. CHRISTIANSON: I think there's a real value
8 in what you did in terms of just describing the
9 shortcomings of the different data sets and comparing them.
10 And so you get back to the question of, as a group, do we
11 think this is a data set we want to hang our hat on. I'm
12 really worried about it. I think it exists to provide
13 targeted reports and so forth, primarily to the
14 pharmaceutical industry. They could change the way they
15 have their definitions at any point in time. So if we're
16 going to sort of track changes over time, I worry about,
17 you know, hanging it all on this data set.

18 But, on the other hand, it gets back to Warner's
19 comment about, you know, how important is it that we do
20 this. If it's really important that we have a great data
21 set then I think we do need to go back to the CMS and
22 possibly make some recommendations and really say here's

1 the data you need to be collecting. If it isn't all that
2 important and if we just want sort of in general or small
3 practices declining, or are they increasing, just give me a
4 general picture, then we can probably get that from looking
5 at four data sets and sort of seeing whether we get a
6 similar story with the four data sets.

7 So I think it is something that we should think
8 about, whether we want to make a recommendation to CMS or
9 not. I am quite -- even though this is the best data set
10 that you could come up with, I'm quite concerned about sort
11 of saying this is what we're going to do going forward,
12 relying on this data set.

13 DR. MILLER: And that's what I wanted to get out
14 on the table for you to think about. You know, it may be
15 the data set we use, because it's the best one out there,
16 you know, unless one of you also comes across something or
17 sees something that we should be paying attention to.

18 But I hadn't been thinking, until Jon mentioned
19 this yesterday, and PECOS may be the place. If we made a
20 recommendation along these lines we'd want to be clear
21 about what we wanted in the data set, where we wanted CMS
22 to collect it, and also probably have to think through how

1 do we make sure that the data is accurate, because just
2 saying you should put your data in there, and if it doesn't
3 like to payment providers we'll put stuff in there but it
4 won't necessarily be accurate.

5 But I thought that this was an interesting
6 thought, and one that I hadn't been thinking, and so I
7 wanted to make sure that despite he didn't -- the fact that
8 he didn't want to do it, that he should say it out loud.

9 DR. CHRISTIANSON: I think you raised a really
10 good point in terms of the accuracy of the data set, and if
11 we don't think there's a good chance that the data is going
12 to be reasonable -- whatever that means -- reasonably
13 accurate, then that's another caution about going down that
14 street.

15 DR. CROSSON: Jack.

16 DR. HOADLEY: So on this question of the data
17 sets, I don't feel like -- I'm sort of like Craig -- I
18 don't feel like I've got the information. I think -- you
19 know, what I am convinced is that, you know, yes, we should
20 explore whether there are other -- continue to explore what
21 other alternatives. But, you know, you seem reasonably
22 convinced that -- or you seem to have reasonably convinced

1 me that this is, at least, pretty accurate in terms of at
2 least a point in time kind of estimate, with the various
3 caveats as noted, comparison over a longer period of time
4 being one of them, the fact that you've got a quarter of
5 the physicians still in this other category but maybe some
6 ideas of how to work with those and to think about those.

7 But I go back to what both Warner and Pat said,
8 is, I mean, I've been thinking about the question, when
9 we've talked about MACRA, of, you know, the same questions
10 Pat talked about, you know, what are the capabilities out
11 there. You hear a lot of comment, you know, in the
12 political environment about what's this going to do to
13 small practices, and I came at that saying, but, you know,
14 how big a sector -- are we already past that tipping point
15 where there aren't many of these ones and twos physicians
16 anymore. This starts to suggest that, you know, the trend
17 may be in the other direction but there's still a lot of
18 them out there.

19 So I think it helps us frame certainly the MACRA
20 kind of conversation, but probably a number of other
21 conversations to have that, a sense of how fast the trend
22 is changing obviously helps that too. And I'm struck, even

1 in just this three-year trend, at least on the solo
2 practice side, and eventually it would be useful to have
3 that break out with the sort of 2-to-5 versus the larger
4 group practices as -- you know, like you did on the service
5 dollars.

6 But otherwise, you know, this is really helpful
7 to say, you know, that solo practice really hasn't gone
8 down very fast in a couple of years. Now, you know, would
9 it have changed quite a bit over a decade? You know, maybe
10 we'd see more. We've certainly seen a bit of a tick-up in
11 the hospital ownership.

12 So I think those are all just useful trends, but
13 shares that really help us frame how much attention we need
14 to give to accommodations for the small practice in a MACRA
15 type of conversation, or other kinds of topics.

16 So I think that's where this is, to me, really
17 useful. I mean, Craig also raised some of the other
18 broader kinds of questions that this could be brought to,
19 and I think that's spot-on as well.

20 DR. CROSSON: And, you know, it has been
21 mentioned, but I think the -- and this is just subjective,
22 but I think the issue of where the small practices are is

1 also strongly influenced by geography. So the aggregate
2 numbers may indicate 20 percent, but in large population
3 areas, you know, on the coasts, for example, or upper
4 Midwest or other places, it may be very different from
5 that.

6 DR. GINSBURG: As far as SK&A, you know, I think
7 Jon's points are well taken. I think it is -- I've had a
8 number of colleagues different places who have used it for
9 research projects and were very enthusiastic, despite its
10 limitations, at how much better it could get at some things
11 that they were studying than anything else. So I think for
12 just describing generally what's going on, I think it's
13 quite useful. It's not the ultimate solution.

14 I was going to respond to Kate's question about,
15 you know, next steps, and I was thinking about the fact
16 that for Medicare in particular, I think the proportion of
17 physicians that are in hospitals or hospital systems is by
18 far the most directly important to the Medicare program,
19 and that's -- so in a sense, as to whether we should go
20 into IPAs, that's much more marginal. You know, they only
21 relate to Medicare in the sense that Medicare Advantage
22 plans contract with them. They're clearly a much looser

1 form of affiliation than a group in the sense that they're
2 affiliated for HMO contracting. They're not allowed to
3 affiliate for PPO contracting, except some that have gotten
4 exceptions from the FTC. So in a sense, that's where I
5 come down.

6 DR. CROSSON: Paul--

7 MR. GRADISON: Sorry. You mentioned me after
8 Paul?

9 DR. CROSSON: Yeah, I just want to comment,
10 though. Paul, I'm not sure I -- I'd ask you to elaborate a
11 little bit, because I think from an analytical point of
12 view, I understand what you're saying. But, for example,
13 IPA physicians and their decisions about whether to
14 hospitalize or whether to refer or what drugs to use, et
15 cetera, et cetera, to my mind have an equal impact in the
16 end on Medicare spending as physicians who happen to be
17 working in a hospital setting. Or am I missing something
18 you're saying?

19 DR. GINSBURG: No, I think you're right, and
20 there certainly are likely to be spillovers from an IPA
21 physician, you know, what they have gotten from the IPA
22 through -- their contracted HMO patients will spill over

1 into the fee-for-service Medicare or private sector PPO
2 patients. So in that sense, I didn't want to be dismissive
3 of IPAs. I think in California IPAs are a very important
4 part of the delivery system. I think they've had a very
5 positive impact on the efficiency of quality of care in
6 California.

7 When you get outside of California, except for
8 eastern Massachusetts, I'm not really aware of that many
9 areas that have real IPAs that really are having a
10 significant impact.

11 MR. GRADISON: Looking at data over the years, as
12 we might in the future, there's a variable that perhaps
13 you've already mentioned or had in mind, but I want to
14 mention it for sure, and that is, well, I thought initially
15 of the age of the practitioner because to get a sense of
16 how many of them may be retiring, and that would be
17 interesting. Another way to think about it, if the records
18 already show it, particularly the AMA records, when did
19 they become a physician. That would be another way to
20 measure it. It's sort of the same thing, but we might get
21 a sense of how newly hatched physicians are organizing or
22 not organizing as against those that have been out in

1 practice. But some of the data I've seen suggests the
2 potential of a rather large retirement cohort over the next
3 ten years or so. I don't know whether that is a right
4 period to mention or not. But it might have important
5 implications in terms of interpreting the data.

6 MS. BUTO: Thank you. What I was thinking was
7 although the data set, this commercial data set may have
8 limitations, sort of like Paul, I think that we might want
9 to continue to work with it and recommend also that CMS
10 proceed to seriously double down on its effort to come up
11 with a better data set. I think in doing that it would be
12 helpful if we could identify some of the analyses that we'd
13 like to see be able to come out of the data set that CMS
14 develops. For example, do we think the size of physician
15 practices has what kind of impact on utilization?
16 Coordination of care, does it matter if they're multi-
17 specialty practices or single -- even the size of the group
18 doesn't tell you whether -- you need to know multi-
19 specialty or single specialty, that kind of thing.

20 So suggest the kinds of analyses that we think
21 really need to be done, not just to satisfy MACRA but also
22 to look at things like reforming payments to primary care

1 or beginning to look to more bundled payments. So what are
2 the opportunities that might arise if we had a better sense
3 of what different size practices are capable of doing?

4 MS. BRICKER: So curious. You know, I understand
5 that we matched or you matched the SK&A to Medicare claims
6 to identify those that are impacted by Medicare. But to
7 what extent can we tease out the reliance that certain
8 specialties would have on Medicare?

9 MS. BLONJARZ: So we know that from other
10 sources, like I could tell you what share of a specific
11 specialty's revenues come from Medicare. I mean, if that's
12 something --

13 MS. BRICKER: I was just curious, because primary
14 care -- we have pediatrics, you know, was listed and
15 OB/GYNs, you know, how much of their practice is reliant.
16 Then to correlate, because of policies that, you know, have
17 been suggested or recommended, we believe, you know,
18 practitioners are making different decisions about staying
19 in solo practice or not. Is there a direct correlation?

20 MS. BLONJARZ: We can flesh that out.

21 MS. BRICKER: Thank you.

22 DR. MILLER: But it will come from a different

1 data source, right?

2 MS. BLONJARZ: Yes.

3 DR. MILLER: Because this data, once she links to
4 Medicare, all she's got is their Medicare business, and she
5 wouldn't know if they're 50 percent --

6 MS. BLONJARZ: Right.

7 DR. MILLER: So she'll come back to answer your
8 question using a different data set and saying here is what
9 it looks like.

10 MS. BLONJARZ: That's right.

11 DR. MILLER: As long as you guys followed.

12 MS. THOMPSON: You all made my points [off
13 microphone].

14 DR. CHRISTIANSON: A real quick question. In
15 your assessment of the SK&A data set, it was mainly having
16 to do with comparing completeness in terms of number of
17 physicians that reported. What incentives do the
18 physicians have to report accurately for that data set that
19 are sort of stronger than they would be under Medicare and
20 reporting to Medicare? Are they paid for their reporting?

21 MS. BLONJARZ: You know that's a good question,
22 and I don't know. I don't know whether -- I mean --

1 DR. CHRISTIANSON: So to Paul's point, it may
2 have more information -- it does have more information than
3 a lot of other data sets, so I can see why it would be
4 attractive to researchers who can use it to address
5 specific questions.

6 MS. BLONJARZ: Right, right.

7 DR. CHRISTIANSON: I'm wondering if it might not
8 suffer from some of the same issues that the Medicare data
9 suffer from. I don't know.

10 MS. BLONJARZ: And I think just I would say that,
11 you know, to the extent Medicare is collecting this
12 information through PECOS or, you know, through the TIN,
13 those directly implicate Medicare payment, and so, you
14 know, they are subject -- you know, misreporting a TIN is a
15 false claim, and so we might expect that that would be
16 quite robust. But if we wanted to move away from what
17 Medicare -- you know, the things that determine payment and
18 coverage, that might be where we'd get worse information.

19 DR. GINSBURG: Yeah, I have a sense that when it
20 comes to whether a physician is employed by a hospital, I
21 think work I've seen at ASPE, that's very difficult for you
22 to get from Medicare data. I don't know that there's much

1 incentive for a physician in SK&A to, you know, report that
2 incorrectly. So I think it's just, you know, if we -- by
3 just being aware of the shortcomings of Medicare, we can
4 see some areas where the SK&A probably does shed some
5 useful light. And given -- you know, I don't think I
6 answered Jay's question well about, you know, since
7 Medicare is paying more for some of the physicians that are
8 employed by the hospital, that is as direct, immediate
9 implication as opposed to the more indirect one of how
10 these things affect their patterns of practice.

11 DR. SAMITT: One other follow-up question. When
12 we look at physician affiliations, have you looked at the
13 commercial sector in terms of what's being done to collect
14 similar information there? And would there be any
15 relevance in terms of public-private partnership to sort of
16 develop a more comprehensive data set there? Because
17 there's a lot happening on the commercial side to try to
18 understand provider affiliations and provider data accuracy
19 there as well. So I don't know whether there's any
20 opportunity to kind of bridge the divide there to develop a
21 more complete database.

22 DR. CHRISTIANSON: Are you offering [off

1 microphone]?

2 DR. SAMITT: Well, I mean, I think there are
3 organizations that are trying to facilitate, you know,
4 payer to payer in the commercial side. I don't see why you
5 wouldn't bridge commercial with government.

6 DR. CROSSON: Okay.

7 DR. MILLER: Did you follow that?

8 MS. BLONJARZ: So I know of some state databases.
9 California has, I believe, one and I believe Massachusetts
10 that have physician affiliation information largely
11 collected by private insurers and using some of the same
12 kind of databases that we're discussing here. But SK&A is
13 all commercial physicians as well, I mean, to the extent,
14 you know, it covers most of the physician workforce.

15 DR. MILLER: That was the point I wanted to make
16 sure you were following.

17 DR. SAMITT: Yeah, and maybe I can sort of
18 connect with you and compare notes about where a broader
19 set of information could be coming from.

20 DR. CROSSON: Yeah, there are -- well, you know
21 this. There are associations or consulting organizations
22 and the like, mostly coming at it from the organized

1 physician side.

2 So to sum up --

3 DR. MILLER: This will be interesting. Let's get
4 Jon to do it [off microphone].

5 [Laughter.]

6 DR. CROSSON: I think we started out with a
7 couple of questions to try to answer. One, what do people
8 feel about -- and I'll use the term "utility" -- accuracy
9 of this particular data source? And we have a range of
10 opinion, I think, even though it's been qualified on both
11 ends. We have some folks who think it's the best tool
12 around and so let's go with it, and we have others who have
13 reservations, significant reservations.

14 And then the second connected question was sort
15 of assuming that we're going to use the tool, what could we
16 use it for? And what's the relative value of doing that?
17 And we've got a range of opinion there as well from it
18 would be absolutely vital to some of the work we're doing
19 in physician payment in general and others I think who have
20 had modest skepticism about, you know, the value of it.

21 So I'm going to -- I think the conclusion I'm
22 coming to, and let's test it, is that we have a split

1 opinion here, which makes it hard to go quickly from the
2 first question into the second one. In other words, if we
3 don't have full confidence in the tool, it's kind of hard
4 to say let's go gangbusters and apply it to our judgments
5 about what to do in general with physician payment.

6 On the other hand, it is what exists at the
7 moment, and I think it would be probably unwise to simply
8 walk away and abandon it as opposed to tracking it, at
9 least, number one, looking for change. I have heard
10 several suggestions that we investigate with CMS -- tell me
11 if this is possible -- investigate with CMS, you know, what
12 should be or could be done within reason by them to help
13 develop a more robust data source that could then be
14 applied more directly to policy decisionmaking. This is
15 not going to be a quick solution for sure, but it might in
16 the end be worthwhile us investigating both informally and
17 then discussing it, and, if reasonable, making a
18 recommendation along those lines.

19 I think in parallel, as we discuss the issue of
20 physician payment -- and we've talked about that, again, to
21 go back to this morning, from the perspective of
22 MACRA/MIPS, from the perspective of ACOs and what will work

1 and what doesn't wk, and also, you know, the basic utility
2 of the physician payment formula that exists. I think we
3 should mark as we go through that work situations in which,
4 you know, we say, gee, we could make a much better decision
5 here or much better judgment if only we had more complete
6 information about the nature of the physician delivery
7 system. And if we find that happening a lot, then, you
8 know, we put more effort here. And if we find that it is
9 interesting but not on the critical pathway to those
10 decisions, that would suggest a different direction.

11 That's the best I can do with the range of
12 opinions that I've heard. But I will take alternative
13 views.

14 DR. MILLER: Actually, I agree, and I wanted Jon
15 to say it because I actually think we ought to take a
16 little time and at a minimum talk to CMS and just figure
17 out how much of a lift it is and what's out there, and then
18 come back if there seems to be enough there, which is
19 something that I wanted teased out of this.

20 I think my own view is we probably continue to
21 work with this data set unless somebody happens to know of
22 something a lot better, which, you know, we often come to

1 you looking for that, too. We'd probably stick with that.
2 And to Kathy's comments and your comments just now, we
3 ought to be very clear which analysis that we think we
4 would like ideally because that would drive what we want
5 out of SK&A, but also potentially out of CMS if we go that
6 route. So, yeah, I agree with what you said.

7 DR. CROSSON: Okay. Kate, thank you very much.

8 [Pause.]

9 DR. CROSSON: So our last discussion for today is
10 again a little bit of a new area for us. We're going to be
11 looking at nursing homes. As most of you know, a good part
12 of that care is part of the Medicaid program as well as
13 other sources of payment, but it is an issue for the
14 Medicare program to the extent that individuals who are
15 cared for in long-stay nursing facilities find their way,
16 inappropriately, into the hospital and generate Medicare
17 charges.

18 I'm not giving your presentation, am I? I do
19 that a lot.

20 [Laughter.]

21 DR. CROSSON: So Stephanie is going to take us
22 through this issue, and I'm going to shut up.

1 MS. CAMERON: Good afternoon. Before we begin,
2 I'd like to thank Carol Carter for her contributions to
3 this work.

4 Today's presentation focuses on preventing
5 avoidable hospital admissions of long-stay nursing facility
6 residents.

7 As you may recall, the Commission discussed a
8 population-based measure of potentially preventable
9 hospital admissions in 2012. Then, in the fall of 2014,
10 the Commission expressed interest in the patterns of
11 hospitalizations of Medicare beneficiaries residing in
12 nursing facilities. Today's presentation will provide
13 background -- oh, excuse me. Then, in the fall of 2014,
14 the Commission expressed interest in the patterns of the
15 hospitalizations of Medicare beneficiaries residing in
16 nursing facilities. Today's presentation will provide
17 background information regarding strategies that nursing
18 facilities are using to prevent hospitalizations of their
19 long-stay residents. Next month, I will present findings
20 related to the development of risk-adjusted measures of
21 hospital use for this population.

22 To provide a bit of context, a majority of long-

1 stay nursing facility residents are Medicare beneficiaries,
2 creating a easily defined population to target for better
3 care coordination and quality of care. This population is
4 primarily comprised of residents who are dually eligible
5 for both Medicare and Medicaid. While the facilities that
6 we are discussing today are typically the same facilities
7 who provide care under Medicare's skilled nursing benefit,
8 this presentation is focused on the long-stay resident
9 population, who are on average older and more frail than
10 the SNF population.

11 Existing literature has shown that a substantial
12 portion of hospital admissions of long-stay nursing
13 facility residents may be avoidable through better
14 prevention or management by the nursing facility.

15 Transferring these residents to a hospital for
16 conditions that could have been prevented exposes
17 beneficiaries to several health risks, including falls,
18 delirium, infections, and medication interactions. These
19 hospitalizations also unnecessarily increase Medicare
20 program spending.

21 The implementation of Medicare's hospital
22 readmission reduction program has increased awareness of

1 hospital use among nursing facilities.

2 Today, I will discuss the increasingly
3 competitive nursing facility environment and initiatives
4 and strategies currently being implemented to reduce
5 hospital use for nursing home residents. Next, I will
6 present several key findings from interviews we conducted
7 with nursing facility staff and related organizations.
8 Finally, I will discuss the findings from the initiatives
9 to date and our next steps.

10 Nursing facilities rely on admitting
11 beneficiaries from hospitals for their short-term
12 rehabilitation patients. Because about half of long-stay
13 residents in a nursing facility begin from a hospital
14 discharge, it's critical for nursing facilities to maintain
15 relationships with hospitals. This appears to be
16 increasingly true in light of Medicare's hospital
17 readmission reduction program.

18 Facilities with lower readmission rates are
19 better able to market themselves to hospitals and potential
20 residents as being higher-quality providers. Many nursing
21 facilities have begun focusing on observing and reacting to
22 changes in beneficiary conditions, improving communication,

1 and providing additional staff training in an attempt to
2 reduce readmission rates.

3 In the context of fee-for-service Medicare, about
4 140 nursing facilities volunteered to participate in an
5 initiative funded by the Center for Medicare and Medicaid
6 Innovation and implemented in collaboration with the
7 Medicare-Medicaid Coordination Office. Beginning in 2012,
8 the initiative to reduce avoidable hospitalizations among
9 nursing facility residents or, as I will abbreviate it, the
10 RAH-NFR initiative, provided funding to seven coordinating
11 groups in different states to implement clinical
12 interventions that include staff training, technical
13 support, and education to participating nursing facilities.
14 This funding also provides advanced practice nurses and
15 other clinicians to guide the initiative within the
16 facilities and provide direct patient care in five out of
17 the seven interventions.

18 Phase II of this initiative, beginning this fall
19 and planned to continue through 2020, will test a three-
20 part payment model in conjunction with the interventions
21 used in Phase I. Through Medicare Part B billing, Phase II
22 will provide a new payment to facilities for the treatment

1 of qualifying conditions, an increased practitioner payment
2 for the treatment of conditions on site at the nursing
3 facility, and a new practitioner payment for care
4 coordination and care-giver engagement.

5 CMMI funding for Phase I and Phase II of this
6 initiative is expected to total about \$230 million dollars.
7 We also expect new Medicare spending associated with the
8 payment model implemented in Phase II. The level of
9 investment in this initiative raises questions regarding
10 the long-term sustainability of this model after the
11 funding ends in 2020 and for facilities currently operating
12 without grant support.

13 Unlike the fee-for-service environment, the
14 managed care model provides flexibility in providing
15 services to enrolled beneficiaries. For example, United
16 Healthcare's Nursing Home Plan uses Optum's CarePlus model,
17 formerly known as Evercare, to provide care coordination
18 and supplemental clinical care with advanced practice
19 nurses for enrollees. In addition to providing clinician
20 support, Optum's CarePlus model provides payments to
21 nursing facilities when a beneficiary is treated for an
22 acute illness within the nursing facility.

1 The Program of All-Inclusive Care for the
2 Elderly, or PACE, integrates both Medicare and Medicaid
3 benefits. This program is intended to keep beneficiaries
4 in the community, instead of a residing in a nursing
5 facility. PACE aims to reduce hospital use for this
6 population by providing daily monitoring and observation to
7 detect any changes in a patient's condition and to trigger
8 a less intensive intervention.

9 Lastly, some nursing facilities are adopting
10 strategies to reduce hospital admissions without additional
11 staff or funding. RTI International found that over 95
12 percent of survey respondents not involved in the RAH-NFR
13 initiative introduced policies or procedures into their
14 facilities aimed at reducing avoidable hospital use of
15 long-stay beneficiaries.

16 To better understand the strategies nursing
17 facilities employ to reduce hospital use of long-stay
18 residents, MedPAC contracted with NORC at the University of
19 Chicago to conduct 10 interviews with organizations
20 involved with these initiatives. Interviewees included
21 participants in the RAH-NFR initiative, Optum's CarePlus
22 model, and nursing facilities that implemented strategies

1 to reduce hospitalizations independently.

2 Through these interviews, we synthesized several
3 common strategies to reduce hospital use among long-stay
4 nursing facility residents. Improving communication
5 between residents, facility staff, off-site clinicians, and
6 families was cited frequently as the primary strategy to
7 reduce hospital use. Many facilities we interviewed
8 adopted new communication processes and tools, including
9 the use of standardized forms among facility staff and
10 between facility nurses and on-call clinicians. Facilities
11 reported implementing new quality improvement programs and
12 tools to varying degrees. For example, some facilities we
13 spoke with used previously existing communication forms and
14 did not undergo wholesale changes across all of their
15 communication procedures.

16 Facilities also commonly focused on increasing
17 the level of clinical training of staff members, including
18 IV insertion for licensed nursing staff and safety
19 procedures as they pertain to fall prevention. Facilities
20 also provided education on how to detect and report changes
21 in beneficiary health status. Some facilities implemented
22 symptom-specific tools to guide evaluations conducted by

1 the licensed clinicians in the facility in a standardized
2 manner.

3 Many respondents also discussed an expanded
4 medication review process. Some interviewees stressed the
5 importance of conducting a medication therapy review
6 immediately following a hospital discharge to ensure that
7 any new medications are properly administered and any
8 medications that have changed are accurately updated in the
9 facility's records.

10 Interviewees consistently mentioned advance care
11 planning to reduce avoidable or unwanted hospital use.
12 Advance care planning defines a broad group of
13 conversations regarding an individual's preferences for
14 end-of-life care and formalized through written
15 documentation.

16 Lastly, one interview discussed employing
17 telemedicine as another strategy for reducing admissions
18 through the extended availability of health professionals.

19 We found consensus across interviewees regarding
20 the key features necessary to implement strategies to
21 reduce hospital use, which I will take in turn.

22 Interviewees underscored the importance of consistent use

1 of tools to assist with communication especially between
2 facility staff and physicians. We also heard from multiple
3 interviewees that involving all levels of staff resulted in
4 greater staff empowerment and higher levels of job
5 satisfaction, which may affect staff turnover that I will
6 discuss momentarily.

7 Respondents also emphasized the importance of
8 facility leadership in supporting the initiative and
9 clearly explaining the goals of the initiative, the
10 expectations of staff, and the rationale behind any of the
11 new processes implemented.

12 Once the new processes are developed and
13 communicated, many facilities we spoke with discussed the
14 need for ongoing educational efforts, including role play.
15 Some interviewees described conducting root-cause analysis
16 or so-called deep dives on certain cases that were admitted
17 to the hospital. These detailed case reviews helped
18 leadership better understand whether the facility's
19 processes were followed and whether the admission could
20 have been prevented. Many facilities we spoke with began
21 to track patterns of hospital admissions in terms of the
22 time of day, day of week, wing of facility, and triggering

1 event that lead to an admission to help focus their
2 efforts.

3 Interviewees cited the facility's ability to
4 manage staff turnover which include both direct patient
5 care staff and facility leadership. Some facilities began
6 training employees on their strategies to reduce hospital
7 admissions during new hire training. Several respondents
8 discussed the high level of turnover in their facilities
9 and explained that the clinical staff associated with the
10 Optum CarePlus model or the RAH-NFR initiative had been a
11 source of continuity and institutional memory for the
12 facility.

13 Several interviewees described the importance of
14 clear communication with the resident's families upon
15 admission and throughout the stay. One facility we spoke
16 with provides information regarding the treatment
17 capabilities of the facility and the extent to which they
18 are able manage acute changes in health condition upon
19 admission, setting expectation of care.

20 In terms of outcomes to date, RTI recently
21 analyzed data from the RAH-NFR initiative and found
22 statistically significant reductions in all-cause and

1 potentially avoidable hospitalizations across about half
2 the interventions. RTI found mixed results across all-
3 cause and potentially avoidable ED visits, where some
4 interventions were found to increase use between 2012 and
5 2014. RTI did find reductions in Medicare expenditures for
6 all-cause hospitalizations in 2014; however, on net, the
7 reduction in total Medicare spending was not statistically
8 significant.

9 An evaluation of the Optum CarePlus model found
10 lower hospital use for enrolled beneficiaries, including
11 both inpatient admissions and emergency department visits.
12 Similarly, an evaluation of the PACE program found lower
13 potentially avoidable hospitalizations compared to similar
14 beneficiaries residing in nursing facilities. Because PACE
15 and the Optum CarePlus program are funded on a capitated
16 basis, reductions in spending do not result in savings to
17 the Medicare program.

18 In its June 2016 release of the Scorecard on
19 local health system performance, the Commonwealth Fund
20 found reductions in hospital admissions of long-stay
21 nursing home residents between 2010 and 2012. In its
22 recent evaluation, RTI found that there was a decrease in

1 hospital use across facilities not participating in the
2 RAH-NFR initiative. Other studies have also found
3 reductions in hospitalizations associated with specific
4 interventions. Nonetheless, we are unable to gauge the
5 efficacy of tools and strategies to reduce hospital use
6 among nursing facility residents nationally.

7 As for next steps, we will continue to monitor
8 Phase II of the RAH-NFR initiative and the remaining
9 evaluations of Phase I.

10 We are in the process of developing risk-adjusted
11 measures to inform the Commission's understanding of
12 hospital use patterns of long-stay nursing facility
13 residents. This will include a potentially avoidable
14 hospitalization measure to help us understand patterns
15 across inpatient admissions; an all-cause hospitalization
16 measure to also do the same; an all-cause ED and
17 observation visit measure to ensure facilities and
18 hospitals are not transferring residents to the emergency
19 department as a substitute for inpatient care; and a
20 measure of frequent SNF use by long-stay residents to
21 determine the extent to which long-stay residents are
22 hospitalized and then receive skilled care upon hospital

1 discharge.

2 Once finalized, we anticipate presenting these
3 measures with our quantitative analysis at the October
4 meeting and ultimately incorporate the findings into a June
5 report chapter.

6 We are interested in your feedback regarding
7 reactions to the initiatives, any other strategies or
8 activities related to reducing potentially avoidable
9 hospital use from your experience, and the planned
10 measures. Next month, when we present our measures and
11 findings, we will consider and discuss any policy options
12 you have.

13 And with that, I turn it back to Jay.

14 DR. CROSSON: Thank you, Stephanie.
15 Groundbreaking work. Again, very nice.

16 Let's take clarifying questions. Bill? Bill
17 Gradison, then Bill Hall.

18 MR. GRADISON: Phase II, is that going to be the
19 same group of nursing facilities that were in Phase I?

20 MS. CAMERON: It will be. So, when Phase II is
21 rolled out, the group that received the intervention in
22 Phase I will continue with that same intervention. Layered

1 on top of that will be a payment model. Then there will be
2 a second group of facilities that will only receive the
3 payment model. So there will be kind of the continued
4 group of about 140. There is one state that is not
5 included in Phase II that was in Phase I, so we expect it
6 to be closer to about, I think, 120 facilities receiving
7 both kind of the intervention with the advanced practice
8 nurse assistance and all of kind of the education that goes
9 along with that with the payment model and then likely a
10 similar number of facilities, receiving only the payment
11 model. And those facilities will be new to the initiative.

12 MR. GRADISON: Did you have any sense from the
13 data so far whether the participants -- because this was
14 over four years -- used their improved performance that you
15 cited, to help get more business, to help get referrals?

16 MS. CAMERON: So a couple of things. First, you
17 know, I do want to caution that the analysis to date that
18 RTI has done was only through 2014, and the roll-out was a
19 tiered roll-out that happened over time. So the initiative
20 itself did not have all of the facilities online, I want to
21 say, until late 2013. So although we were comparing the
22 analysis -- the evaluation compares two years of data --

1 that first -- there was kind of one year in there that
2 probably did not have the full evaluation.

3 And -- I'm sorry. I forgot the second part.

4 MR. GRADISON: I think the real question is, did
5 the facilities that were doing better, in terms of less
6 readmissions, use this for marketing purposes? I mean,
7 that's really the question. Did they get a benefit in
8 having higher occupancy already by virtue of participating
9 in it? And maybe you don't know. I'm just curious about
10 it.

11 MS. CAMERON: Sure. So I don't know if there
12 were increases in their daily census. I did not see data
13 that, you know, definitively said, yes, we were able to use
14 this for marketing purposes and it increased our -- whether
15 or not it was their skilled nursing census or their entire
16 census overall. That I don't know.

17 What we had heard from our interviews, and some
18 of our interviews did include facilities that were
19 participating in the CMMI demo, was that, you know, we now
20 have data to show that our readmissions are at a certain
21 level, and that hospitals are looking to us to provide them
22 that information. And so a hospital could say, you know,

1 of all the facilities we refer our patients to, these are
2 the ones that have the lower readmission rates.

3 So I think there has been a sense, kind of beyond
4 this initiative and out more broadly, that the facilities
5 are, in fact, able to use kind of these rates to help their
6 marketing.

7 MR. GRADISON: Thank you.

8 DR. CROSSON: Bill Hall and David.

9 DR. HALL: I had a question about how do we
10 define success in your interviews. You mentioned that
11 there was a lot of positive feedback, that training was
12 better when these systems were put into place, that to some
13 extent, not always, hospital admissions were reduced. Is
14 that right?

15 Was there any emphasis on anything about the
16 measures of quality of care in these places, and also,
17 patient and family satisfaction, which is something that's
18 very hard to get at?

19 MS. CAMERON: Speaking specifically to the
20 initiative, I don't believe there were patient and family
21 satisfaction measures but I will need to double-check that.
22 The quality measures that RTI examined had very mixed

1 results, and I would say, you know, there was really no
2 consensus on the quality aspect.

3 What we did hear from the interviews, however --
4 again, it's very anecdotal and we targeted facilities who
5 were implementing these strategies, so it was a very
6 specific group of facilities we spoke with -- thought that
7 some of the benefits included better staff retention,
8 because using some of the communication tools reduced -- it
9 empowered staff and helped staff feel like if they saw a
10 change in a patient's condition and reported that to the
11 nurse on the floor, that that was actually looked at and
12 they were taken seriously, and that they felt like they
13 were empowered to help the patient and the beneficiary. I
14 think some of the facilities would have said that is a
15 success. We maybe kept some staff members on longer than
16 otherwise would have; that's a success.

17 Other facilities spoke with discussed, again,
18 anecdotally, that they had positive feedback from residents
19 and also the resident's families for facilities that had
20 long conversations about, you know, even just their
21 capabilities upon admission of, "We're going to start
22 having this conversation. This is what we would do if you

1 got ill in the facility. Are you interested in being
2 transferred to the hospital for, you know, a serious of
3 other ailments," and starting those conversations really, I
4 think, opened the door of communication between the
5 facilities and the patients, and that helped patient
6 satisfaction. So I think, to some, that would be known as
7 a success.

8 I think, you know, whether or not, in the long
9 run, these do reduce hospital admissions, I think is still
10 to be determined.

11 DR. CROSSON: David, and I've got Pat, Jack,
12 Rita, and Alice.

13 DR. NERENZ: Thanks, Stephanie. Just to clarify,
14 we're talking about here admissions, not readmissions,
15 right?

16 MS. CAMERON: That's correct.

17 DR. NERENZ: Okay. And I just -- they were
18 starting to get both in the conversation.

19 Now, then, my next question is, how separate are
20 these? For example, are the long-stay facilities paid
21 largely by Medicaid essentially separate facilities from
22 those that are post-acute, paid by Medicare, so that not

1 only are the events separate, the facilities are separate,
2 or is it not --

3 MS. CAMERON: No. By and large, these are the
4 same facilities.

5 DR. NERENZ: The same facilities.

6 MS. CAMERON: And, by and large, they may even be
7 the same bed in the facility, could have a beneficiary,
8 could have entered a facility as a short-stay
9 rehabilitation patient in Room C-101 and stayed in that
10 same room over time and became a long-stay resident,
11 because they were unable to be discharged. So it could be
12 the exact same bed, the same facility.

13 DR. NERENZ: Okay. So that leads to the third
14 and final clarification question. Are there financial
15 incentives now, then, for these facilities to hospitalize
16 patients -- let's say, I'll follow your example. I've got
17 somebody in a bed who's long-term staying Medicaid.
18 Pneumonia develops. The patient gets admitted. (a) That
19 problem is out of my hair. (b) The patient comes back.
20 Now it's a post-acute state and it's paid by Medicare.
21 Does that happen? Is that a part of the story?

22 MS. CAMERON: Yes, I think that is part of the

1 story and that is one of the reasons that we'll be looking
2 at the number of skilled nursing days for the long-stay
3 beneficiaries, to try to understand, you know, what is the
4 variation. Are beneficiaries being sent to the hospital
5 kind of outside of the benefit period, so that they can
6 trigger a new SNF stay?

7 So, yes, I think that's part of the rationale
8 behind starting this endeavor, was to try to understand and
9 get our hands around that.

10 DR. CROSSON: Okay. I have Pat, Jack, Rita,
11 Alice, and Kathy. Have I missed anybody? Bruce.

12 MS. WANG: Is there any -- were there any
13 questions or, I guess, concerns about potential -- I think
14 that all of the initiatives in the demonstration, they're
15 great. The more of that in the nursing home sector, the
16 better. But I am wondering, because there was a lot going
17 on in the hospital world too, in terms of changes in
18 deciding to admit people. You know, forget avoidable
19 readmission, avoidable initial admission. I mean, I think
20 a lot of hospitals during this period of time were changing
21 some of their practices, using observation beds more.

22 I just -- was there any concern that there's some

1 confounding -- I mean, is the credit for reduced
2 hospitalizations all correctly attributed to the demo? Was
3 that teased out, or was that a factor?

4 MS. CAMERON: So in our RTI's evaluation, they
5 had a comparator group of facilities within the same state
6 that the intervention was being conducted, and those
7 comparator facilities had similar characteristics of the
8 ones that were participating in the demo. So there was
9 about a 2-to-1 match across most of the states.

10 So any changes on the basis of the hospitals
11 would have been on both sides of the analysis, and when the
12 difference in difference was run, the data should have
13 reflected, you know, kind of teased that interaction out.

14 In terms of anything specific that was going on
15 at other facilities, it's difficult to tell, but because
16 this was a state-level analysis, you know, any changes in
17 Medicaid, for example, were also presumably captured on
18 both sides, and therefore the differences were actually
19 captured from the intervention.

20 DR. MILLER: But I think it's a really fair
21 question, and these things are hard to do. It depends on
22 how well you did that propensity matching, and even if

1 within the state the policy is relatively constant, in
2 different parts of the state if you're dealing with
3 different -- so I don't think it's a concern. I don't
4 think it's something that is, you know, completely, you
5 know, clean. It's hard to do these things and get them
6 right. And it's no disparaging of RTI's effort.

7 MS. CAMERON: That's right.

8 DR. MILLER: These things are hard to get right.

9 DR. CROSSON: Jack.

10 DR. HOADLEY: So two questions. One, the -- what
11 you call the coordinating groups in each of the seven
12 states, what kind of organizations are those? Were they
13 created just for this project? Were they existing
14 organizations?

15 MS. CAMERON: No. Some of them were groups
16 funded by universities. I believe the Greater New York
17 Hospital Association had one. So they were various types
18 of groups. The University of Alabama was one, UPMC was
19 one. I'll happily provide you a list if you want --

20 DR. HOADLEY: Yeah.

21 MS. CAMERON: -- but they were various groups.
22 Some were educationally focused and backed, than others.

1 DR. HOADLEY: Okay. That's helpful. And my
2 other question is, did you consider the dual demo program
3 as another sort of source of looking at these kinds of
4 differences? Presumably that's part -- I mean, we had a
5 presentation on that last year. But it seems like that
6 might fit into this rubric as well.

7 MS. CAMERON: That I did not look at --

8 DR. HOADLEY: Okay.

9 MS. CAMERON: -- but we could see if we can kind
10 of incorporate it into the chapter as it fits. We can
11 think about that.

12 DR. HOADLEY: I mean, as I recall they weren't
13 getting a lot of -- there weren't a lot of results to look
14 at yet in terms of this level of kind of thing --

15 MS. CAMERON: Right.

16 DR. HOADLEY: -- and it may be, but that may
17 still be the case but another year has gone by. It might
18 be more for you to work from.

19 DR. CROSSON: Rita.

20 DR. REDBERG: Thanks. So I think, certainly, you
21 know, the initiatives to promote communications sound good
22 no matter what, you know, but I would have thought they

1 would be listening to the staff, and if someone says
2 someone's not looking poorly, you know, any facility would
3 be paying attention.

4 But I just wanted to highlight, because it seems
5 like, looking at the RTI analysis over time, it's really
6 important to have control groups, because without having
7 the other states we don't know if those were temporal
8 trends or attributed to the very catchily named RAH-HFR
9 program.

10 [Laughter.]

11 DR. REDBERG: So I'm glad that you had some other
12 data, because just looking at the RTI analysis seemed to
13 only look at the states that actually had the programs.

14 MS. CAMERON: That is correct, and just to keep
15 in mind that the programs were not rolled out statewide.
16 So in, you know, we'll say New York as the example, they
17 did have their kind of test groups which included the
18 facilities with the intervention and then a matched group,
19 which was about double the size of the test group, that
20 didn't have the intervention.

21 DR. CROSSON: Alice.

22 DR. COOMBS: Thank you very much, Stephanie.

1 This was excellent.

2 In terms of the telemedicine, did they use like a
3 company that was really remotely linked to each of the
4 facilities, or -- some of the for-profits in our area have
5 one central telemedicine where they're peering into
6 multiple hospitals at one time, and I was just curious.
7 And it was most a -- it sounds like it was mostly off-
8 hours, weekends, nights.

9 MS. CAMERON: Yes, that's right. So one of the
10 interventions in the demo employed telemedicine with the
11 kind of, I'll say, a demo provided nurse practitioner. So
12 it wasn't a separate group or a conglomerate that they
13 hired. It was centered around this initiative, and it was
14 those involved in this demo at this specific site. And so
15 that nurse was -- the nurse practitioner was on call
16 certain hours, and if something in the facility would have
17 otherwise triggered the need for the on-call, or the nurse,
18 or an on-call physician, instead that nurse practitioner
19 was contacted, and then, as necessary, would trigger a
20 telemedicine session.

21 This, I think, has been slow to pick up, so this
22 was -- we -- only one of the interventions, as part of the

1 demo, implemented a telemedicine component, and I think it
2 has been underutilized to date, based on what they had
3 expected.

4 DR. CROSSON: Kathy.

5 MS. BUTO: Thanks, Stephanie. I have a question
6 about the coordination between this Medicare payment demo
7 and Medicaid, for the dually eligible.

8 So I'm looking at Phase II and thinking that the
9 payment to the facility to provide treatment of qualifying
10 conditions is really designed to enhance, in a sense, a
11 Medicaid payment, if that person is not going to be
12 admitted to the hospital and triggering a new Medicare
13 stay, and post-acute care, and so on and so forth.

14 And then the two other payments look like they're
15 enhanced payments to clinicians, and I don't -- and I'm
16 assuming those are Medicare payments. But I guess I'm
17 wondering, on those two, why enhanced payment would be
18 necessary, why we aren't paying appropriately to -- paying
19 clinicians appropriately to treat acute changes in
20 condition, number one, and then, two, to conduct better
21 care coordination for, you know, long-standing nursing home
22 residents. It seems to me both of those things would be

1 necessary and shouldn't require additional payment.

2 I'd just be curious as to your sense. That's an
3 adequacy issue to me, in terms of a physician fee schedule,
4 and then the first one is, is that the only conjunction
5 between Medicare and Medicaid, where it looks like Medicare
6 is paying an additional enhancement to the Medicaid
7 payment, to keep that person treated in the nursing
8 facility.

9 MS. CAMERON: So the first payment is, in fact,
10 you're right, in addition to the Medicaid presumably daily
11 rate, or the Medicaid payment. However, one could view
12 this as it is payment for treatment for an acute condition,
13 so treatment that may go above and beyond what the Medicare
14 payment is intended to cover.

15 The other two payments, one of the concerns had
16 been that the payments to providers who see beneficiaries
17 in a nursing facility are lower than the payments in a
18 hospital-based setting. So the nursing facility, as a
19 location modifier, reduces that payment. And what this
20 does is, for that first visit, in one of these changing
21 condition visits, the provider is now able to bill an
22 amount that would have been equal to the amount in the

1 hospital. And I think the intent of that is, instead of
2 having the patient go to the hospital to see a provider,
3 this provides kind of the same incentive on the provider's,
4 you know, financial incentive to see the beneficiary in the
5 facility.

6 The next payment, again, it is another provider
7 payment, and that has to do a lot with the coordination and
8 the provision of discussing advanced care planning,
9 coordinating care, and in working also with the family. So
10 it is another payment, explicitly for that purpose.

11 I'll say, in the demo, the rules around, and the
12 limits on when these different payments can be billed are
13 fairly defined. You know, so for the facility payment,
14 first it's only for six select conditions, those most
15 commonly -- the most common preventably avoidable
16 conditions seen in the facility. And the beneficiaries
17 have to meet certain clinical guidelines and criteria
18 before the facility can get paid for those. So it's a very
19 kind of targeted payment.

20 The kind of enhanced provider payment, that can
21 only be billed the first of the visit, and it can't be
22 billed repeatedly for that beneficiary. And then the

1 payment for coordination, that can be billed in association
2 with a major change in health status, or annually.

3 So again, you know, there are pretty tight rules
4 as to when those can be billed.

5 MS. BUTO: Yeah. My only point is that as this
6 progresses, and I'm sure they're going to look at this, as
7 they evaluate the results of Phase II, if that seems to
8 have a significant impact on reducing hospitalizations and
9 improving care for these acute conditions, then at least
10 the physician payments ought to somehow be, you know, kind
11 of folded into general issues around adequacy of payment
12 for primary care, whether it's at the RUC or in our own
13 discussions about, you know, adequate payments for primary
14 care in a variety of settings, because it seems to me,
15 fundamentally, this should be going on now, and this is
16 kind of a recognition that it's not, and they require --
17 they think they require additional payment.

18 As to the payment to the facility, I see that as
19 kind of a way to, you know, reduce some of the incentive
20 someone else was talking about, which is to have the
21 nursing facility have an incentive to send that patient to
22 the hospital.

1 Beyond that, though, I'm disappointed that there
2 isn't more coordination between Medicare and Medicaid
3 payments for these patients, and maybe there is something
4 beneath the surface in this demo that we're just not able
5 to touch on.

6 MS. CAMERON: I believe you're right. The
7 coordination of Medicaid payments is not part of this demo.
8 There are another series of financial alignments that are
9 happening right now that do incorporate Medicare and
10 Medicaid payment through more of a managed care realm,
11 which I did not talk about in this paper.

12 DR. CROSSON: Okay. Thank you.

13 MR. PYENSON: Thank you very much, Stephanie. I
14 think Kathy raised some of the questions I wanted to raise,
15 as did Jack. But do you see a difference in how this
16 program works in states with mandatory managed care like
17 MLTC programs versus a fee-for-service state?

18 DR. MILLER: Precisely what we discussed in your
19 office yesterday. So I see his question as, Could you
20 tease out the difference in a state that had LTSS -- I
21 think we're saying the same thing; you said LTC -- services
22 under managed care? And I think when you and I talked, if

1 that's your question -- do I get a nod out of that? Okay.
2 So this is the conversation you and I had in your office
3 yesterday, and it goes back to the methodology that Pat
4 implicated. Do you want to run that? Or do you want me to
5 do it?

6 MS. CAMERON: Sure, I'll take a stab at it. So I
7 think those -- this initiative hasn't been tested in many
8 of those states. This population hasn't typically been the
9 target for long-term-care -- or for managed care. This is
10 kind of the frail institutional population. So we haven't
11 seen a lot of evidence of that yet. And, again, this demo
12 was run in seven states. So at this point, I haven't seen
13 that integration.

14 DR. MILLER: The other thing you said yesterday -
15 - and I'm sorry to interrupt you, but it does get back to
16 something that you triggered -- is if they were propensity
17 matched on their characteristics, the LTSS and managed care
18 would have been on both sides because it was designed to
19 tease out these specific things, and so it would have
20 flattened out any effect that you would have seen from the
21 managed --

22 MR. PYENSON: Well, maybe Pat will get at MLTCs

1 in New York.

2 MS. WANG: I would just -- what Bruce is
3 referring to is MLTC is called LTSS in other states, and
4 it's the capitated mandatory program for the Medicaid
5 portion of a dual benefit, and it was cover folks' long
6 stay in the nursing home.

7 The reason I don't think that that is such an
8 important or meaningful variable -- and this is a problem
9 with nonintegrated programs -- is that a plan that is only
10 responsible for the Medicaid portion gets nothing when
11 somebody is not admitted on the Medicare side. I think
12 partial cap programs are starting to figure out that they
13 should try to contract with nursing homes that are a little
14 bit more advanced and have these capabilities, but,
15 candidly, it doesn't really matter because they're only
16 paying for the hotel services. They're not paying for any
17 -- they don't get any benefit from Medicare. That's why
18 FIDA -- you know, the FIDA D-SNP, the integrated products,
19 PACE, are -- the savings is on the Medicare side, not on
20 the Medicaid side. You know, Kathy, your comment about
21 wanting to see more integration with Medicaid was
22 interesting because what most state Medicaid programs would

1 say is, yeah, I want to share of the Medicare savings
2 because I'm still paying for every single day. That's
3 their issue when they've designed the duals demo. They
4 want to reduce their spending in the anticipation that
5 Medicare is saving money.

6 MS. BUTO: Just to add to that, I think Evercare
7 is an example where that model worked very well for
8 Evercare because they were able to get a very generous per
9 capita payment for that population, but didn't have to
10 share it back with Medicaid.

11 DR. MILLER: Well, and this is one of the issues
12 that when the integrated duals demo came up and was
13 discussed in the Commission, the states were quite clear
14 what they wanted, which is we want to spend less, we want
15 you to spend more, and, you know, if you get savings, fine,
16 you can finance that spending out of savings, but we wanted
17 it. And some of the real struggle in trying to come to the
18 agreements were how do you actually, you know, have both
19 sides taking risk.

20 The other thing I wanted to say about Kathy's
21 point is these demonstrations are difficult in a way that,
22 you know, you see what's happening here, is they're saying,

1 okay, we're going to pay you to do all of this stuff. And,
2 of course, as a demonstration, once it comes out of
3 demonstration, you have to ask the question of, like,
4 where's that money coming from, and then I think it makes
5 it harder to show savings because I think -- I don't want
6 to screw this up. I mean, basically there were
7 statistically insignificant results on the savings here,
8 right?

9 MS. CAMERON: That's right.

10 DR. MILLER: Okay. You know, it gets harder and
11 harder to show savings if you're pumping money in to do all
12 of this, and then you even get an effect. You still have
13 to get past what you spent in order to show some net
14 savings. It's a real issue.

15 Sorry. I think I might have interrupted you.

16 MS. WANG: I just -- you know, I mean, I'm kind
17 of bleeding over into the comments section. The one
18 comment I would make is in the future, in all of these
19 efforts that somebody mentioned before, the introduction of
20 quality metrics is really very important because, you know,
21 the reason that I feel that these are very important
22 efforts is that they will kind of -- you know, there are

1 some nursing homes that are much more advanced than other
2 nursing homes, and when it comes to the long-stay
3 population, which produces a lot of Medicare admissions,
4 long-stay without acute rehab capability, for example, are
5 going to be less and less sophisticated. So these efforts
6 to sort of raise the level of training, communication, et
7 cetera, in those settings I think is really important, but
8 I think it's very important to introduce very consistent,
9 standardized metrics for quality, because just the fact
10 that somebody's not admitted doesn't mean that they're
11 getting cared for the way that you would want them to.
12 It's just an incentive to avoid an admission and might not
13 be a good thing. So I think quality and outcomes is very
14 important to track.

15 DR. CROSSON: Okay. Just to check here, so we
16 are still on Phase 1. We are still doing qualifying
17 questions. And as happens often, we've started to leak
18 into commentary and suggestions and the like. So I've got
19 Bruce, Brian, and Warner for Phase 1 questions.

20 MR. PYENSON: I think this is a very useful topic
21 in part to highlight the potential of integration of
22 Medicare and Medicaid, and I think incorporating some of

1 the lessons -- there's I-SNPs, there's other programs out
2 there in addition to the United program and the PACE
3 program. I think there's a number of issues. But on the
4 issues of what the states are saying, you know, it is the
5 case that states do have a stake in reducing admissions.
6 For example, they're on the hook for -- most states are on
7 the hook for the cost sharing of dual eligibles. So that's
8 an issue. From a system standpoint, this is a little more
9 finesse of an argument. I think perhaps 20 percent of the
10 nursing home residents are single eligibles, meaning single
11 Medicaid eligibles. So programs that will reduce
12 admissions for those folks are direct savings to the
13 states, if they can be won there.

14 But from a financial accounting standpoint, the
15 ACA tax on insurers is waived for long-term supportive
16 services, and that has meant that states have had to
17 allocate their premium into long-term care and non-long-
18 term-care components. So the financial distinction there
19 is something that states should be familiar with and can
20 parse that out. The reason that's relevant is that that
21 more directly makes the financial case of how much states
22 are paying for long-term supports and services out of the

1 total capitation that they're paying of managed care. So
2 there's a number of technical pieces there that I've heard
3 raised as obstacles that are really technical issues that
4 could be solved.

5 So I guess my main point is that I think this is
6 a very useful exercise on its own for the innovation
7 program and evaluating that, but also to highlight the
8 potential for moving faster on dual integration programs.

9 DR. CROSSON: Okay.

10 DR. MILLER: Can I get just a couple of
11 clarifications?

12 DR. CROSSON: Yeah.

13 DR. MILLER: So the first point on cost sharing I
14 took as hospitals may have an incentive -- or, sorry,
15 states may have an incentive to avoid the hospitalization
16 because they may be on the hook for cost sharing. And the
17 only thing I would say there is many states, as long as
18 that cost sharing exceeds what their rates are, don't pay
19 it. So, you know, it's there, but it's there in some
20 states, and I think it's not in the majority of states.

21 Then the second thing that you said, would you
22 just say it again? I didn't pick up on it.

1 MR. PYENSON: For managed care programs, if a
2 state has a managed Medicaid program, for example, a
3 component of the capitation is for long-term care. And
4 that has to be identified separately for -- in order for
5 the insurers to avoid the ACA tax. So when we're talking
6 about -- we've been talking about long-term residents, but
7 there's also a spectrum of people that come in and out of
8 nursing homes that Medicaid pays for, for a variety of
9 reasons. So there's another component of spending that's
10 not just what you might think of as a long-term permanent
11 residence. And understanding the potential spending of the
12 states in that detail I think will help the states see that
13 they have a stake in reducing the hospitalizations and
14 other care.

15 DR. MILLER: Thank you.

16 DR. CROSSON: Okay.

17 MS. WANG: [off microphone].

18 DR. CROSSON: Is it on this point? Because
19 Warner's next. Are you passing, Warner?

20 MR. THOMAS: No, I just had a quick question.
21 Was there any comparison to any sort of data on this with
22 MA versus traditional?

1 MS. CAMERON: No. So --

2 MR. THOMAS: And is there any data out there that
3 would be comparable?

4 MS. CAMERON: I'm not aware of any. Pat, do you
5 know of some?

6 MS. WANG: [off microphone]. That would be the
7 I-SNP and the PACE results, which I think --

8 MS. CAMERON: But the I-SNP and the PACE results
9 -- well, I guess they do compare -- the comparator, you're
10 right.

11 MS. WANG: That's the MA experience with reducing
12 the admission rate from nursing homes [off microphone].

13 MR. THOMAS: I guess in the data is there any
14 differential between MA and traditional Medicare
15 readmissions in this population that we can discern from
16 the data?

17 MS. CAMERON: Not that I know of. The encounter
18 data has a whole host of issues, so we wouldn't be able to
19 tease that out of any readmissions at this point, I don't
20 think, out of the encounter data for MA. So I have not
21 seen any studies that looked strictly at a fee-for-service
22 population in a nursing facility and a Medicare Advantage

1 population in a facility and then comparing those two
2 populations as a whole.

3 DR. MILLER: And just to color that a little bit,
4 you know, we have a longer march on this, but we may be
5 able at some point to be able to talk about readmissions or
6 hospitalizations out of, you know, nursing facilities maybe
7 in comparing just straight rates between traditional fee-
8 for-service and MA using encounter data and our existing
9 claims data -- or encounter data and our existing fee-for-
10 service claims data.

11 If your question was but can you tell me whether
12 these initiatives have any differential effect in MA and
13 fee-for-service, I would say, no, we will not be able to do
14 that. It would just be like a straight rate type of
15 comparison between an MA population and a fee-for-service
16 population.

17 MR. THOMAS: Yeah, I'm just trying to get at is
18 there -- you know, under that more managed model, is there
19 a differential in these readmissions? That was my first
20 question.

21 The second question is, getting back to a comment
22 we had earlier -- I think Jay brought it up -- is the

1 effort and, you know, what's the outcome. Do we have any
2 idea what sort of dollars are tied to these efforts and
3 these readmissions? I mean, is it material, or how
4 material is it?

5 MS. CAMERON: So dollars in terms of the CMMI
6 initiative and what has gone in to date, or--

7 MR. THOMAS: No; dollars in terms of, you know,
8 how many dollars are kind of driven by these readmissions.

9 MS. CAMERON: So the best study -- and this is
10 something we're looking at as well. There was a study that
11 was published in 2010 by RTI for CMS looking at cost
12 drivers for the dual-eligible population. And what that
13 study found was that there were about \$1.9 billion in
14 potentially avoidable hospitalizations for the nursing
15 facility dual-eligible population.

16 And then to kind of just further put that in
17 context, I believe they found -- you know, there were at
18 that time just over a million dual-eligible beneficiaries
19 residing in nursing facilities, and I believe there were
20 about 500,000 total hospital admissions from that, and then
21 a subset of those in the 200,000 to 300,000 range were
22 deemed potentially avoidable by that study.

1 MS. WANG: My question is actually a little bit
2 related to that. In the calculation of savings, is there
3 consideration -- David raised this earlier -- of Medicare's
4 avoidance of resetting a SNF stay that is paid for by
5 Medicare when the person comes back from the hospital?
6 Because that's a savings to Medicare as well.

7 MS. CAMERON: The results to date did look at
8 spending across many categories of Medicare expenditure.
9 They included skilled nursing spending, physician spending,
10 hospital spending, I think lab spending, a whole series of
11 different categories. And when they looked on total
12 spending on net, that was not statistically significant
13 across Medicare.

14 I don't know offhand if they specified it for the
15 skilled nursing facility, but I have that on my desk and
16 would be happy to look and let you know if there was
17 anything there.

18 MS. BUTO: Stephanie, that was just for Phase I.

19 MS. CAMERON: That's right. And just to clarify,
20 it's not the final, final evaluation. This was a mid kind
21 of for year three, which, again, you know, not all
22 facilities were up and running. So this is really looking

1 at between 2012 and 2014, but in reality, only about one
2 year of the initiative being fully implemented.

3 MS. BUTO: It's just hard to believe, because all
4 that was in Phase I were the -- maybe it was the
5 infrastructure and setting up these entities, but mainly it
6 was staff training, technical support, and so on, and you'd
7 think that -- I'm like you. I'm thinking avoided
8 hospitalizations, SNF days, physician services, all of that
9 did not add up to a statistically significant saving over
10 providing staff training? I mean, that's surprising.

11 MS. CAMERON: And keep in mind they also all had
12 -- most of the facilities had, if not an advanced practice
13 nurse full time in the facility, at least part time. And I
14 think -- yeah.

15 DR. CROSSON: Okay. Well, I have to admit I feel
16 a lot better?

17 DR. MILLER: Really?

18 DR. CROSSON: Yeah, because now that I remembered
19 who was going to lead off the discussion, I realize that
20 person forgot and he left. I'm just kidding. Bill will
21 have a chance when he comes back. I think he gave up,
22 actually.

1 [Laughter.]

2 DR. CROSSON: Okay. I have to admit we have had
3 a lot of substantial discussion here during the qualifying
4 questions piece of this. So there may be nothing left, but
5 I'm going to see.

6 Let's look at page 13 here for the next steps
7 that Stephanie has outlined here, monitoring the
8 initiative. And she's going to come back next month with
9 some recommendations about risk-adjusted measures of
10 potentially avoidable hospital admissions. So to the
11 extent that people still have ideas, try to focus them in
12 on this page and make some recommendations to Stephanie
13 with respect to -- and Bill is getting to his seat, and now
14 he's going to lead off.

15 [Laughter.]

16 DR. HALL: Thank you for that introduction, as
17 someone who had a bathroom emergency.

18 [Laughter.]

19 DR. CROSSON: Well, I dragged it out.

20 So we want to provide help to Stephanie, and,
21 Bill, you're going to lead off.

22 DR. HALL: So I think this is a very meritorious

1 effort that you've started, but I think we've got a lot of
2 mixed metaphors in here that I think maybe we could just
3 say a word or two about.

4 I think we all recognize that we're really not
5 talking so much about what we talked about this morning,
6 about bundling post-acute care in SNF patients and
7 readmissions within 30 days to the hospital. This is a
8 very different, totally different topic. This is how do we
9 cope with the problem of inadequate care in nursing homes,
10 for the most part, in a population that has a substantial
11 number of dual eligibles. Who is going to pay for it? How
12 does this fit into the overall mission of MedPAC, I think,
13 is where I want to go with this. So I think the answer is
14 yes and no.

15 I live in a community that has a lot of
16 experience with some of these things. We have a
17 longstanding experience with hospital-sponsored PACE
18 programs. We've been through Evercare and Optum now. I
19 don't know whether -- can I use the term "RAH-NFR" for the
20 long series of six things? I don't know whether we have
21 any activity in that area.

22 A couple of things I wanted to put forward, I

1 don't think that we should bundle the PACE programs in this
2 with the demonstration project. PACE was really set up not
3 so much as a, quote, long-term care program, but a program
4 to keep people out of all facilities in their communities,
5 so a lot of emphasis on home services, et cetera.

6 On the other hand, there is no question that
7 there is a very substantial population of Medicare-eligible
8 individuals in nursing homes who have been receiving very
9 poor care. To the extent that they're part of our payment
10 system, we should pay attention to it. I think several
11 people mentioned that this is largely a Medicaid problem if
12 we want to be pill-splitters here.

13 But I think if we could take a careful look at
14 whether the demonstration projects seem to have some real
15 meat to the bones, whether after a demonstration period,
16 they can continue to show impressive results, it reminds me
17 a little bit of when we first went into the managed care.
18 It was pretty easy to improve things because nobody had
19 paid attention to a lot of problems in various areas of
20 medical care, but if we could look at that with the
21 emphasis also on the numbers of Medicare recipients that
22 might be affected by any change that takes place here, I

1 think that would be good.

2 Now, on the other side of this coin is that once
3 you start with, say, an Optum program, a couple things
4 happen in most American communities that I know of. One is
5 that it's totally distinct from the patterns of care that
6 came in beforehand. The idea is to bring in an organized
7 group of well-trained providers who did all the things that
8 you talked about here, and generally, what happens is that
9 whatever infrastructure was in the community before then,
10 sponsored by hospitals or sponsored by the community,
11 disappear overnight. So, basically, it's a program that
12 comes in and does something, but I have real problems about
13 does it have teeth, is it going to last, is it really going
14 to be a benefit to our recipients, long term. So I think
15 that's one point.

16 I think I mentioned the other. I think PACE is
17 probably not where we should be going with this. PACE has
18 its own issues, and I don't see much happenings there.

19 I can't help but be compelled, too, by the fact
20 that the care of older patients in nursing homes leaves a
21 great deal to be desired. That would be the best way that
22 I could put this. There is no question about that. That's

1 largely a staffing problem. I don't know that it's going
2 to be improved by having any group of medical experts come
3 in and remind people to tell older people not to fall. So,
4 if we concentrate our efforts on a relatively smaller group
5 of patients, I think we'll probably get some more important
6 information out of this.

7 DR. CROSSON: I'm sorry, Bill. Perhaps I missed
8 it, but the smaller group of patients is?

9 DR. HALL: Not bringing PACE programs into this
10 at all, any further investigation that we do.

11 DR. CROSSON: I'm sorry. I thought you said at
12 the end, concentrate our efforts on a smaller group of
13 patients, but I wasn't quite clear what that smaller group
14 is.

15 DR. HALL: To what extent -- how much of a
16 problem is this in terms of -- why do we want to bring in
17 an effort to see if we can reduce the number of hospital
18 admissions? That is a laudable thing to be doing,
19 preventing avoidable hospitalizations. But is that a
20 Medicare issue? Medicare Commission issue is what I'm
21 thinking about. I'm not making myself very clear here, am
22 I?

1 DR. CROSSON: So I think the notion here is that
2 many or a large majority of these individuals are dual
3 eligible.

4 DR. HALL: Yes.

5 DR. CROSSON: So even though they are being paid
6 fundamentally by Medicaid or in some cases private payment
7 as well to stay in the nursing home, two things happen in
8 this case if they're not properly cared for and they are
9 admitted to the hospital when they didn't need to be.
10 Medicare then foots the hospital bill, but in addition,
11 they then come back to the nursing home to the same bed but
12 in a different classification as a SNF patient and then are
13 paid for, for a period of time, by Medicare. So, to the
14 extent that that's true and it raises Medicare program
15 costs, it is our issue, I think.

16 DR. HALL: So, as opposed to a system that would
17 encourage hospitals to do more in the way of bundling, to
18 have longer-term responsibilities than they do now, that is
19 another, totally alternative approach, which may or may not
20 work.

21 DR. CROSSON: No, it certainly would be. Yeah.
22 And I think we've discussed that type of approach on

1 several occasions.

2 DR. HALL: Right.

3 DR. CROSSON: I'm not arguing for any approach.
4 I'm just simply trying to address two things. Number one,
5 the question of whether there's a legitimate issue for us
6 to be discussing, and number two, I was trying to
7 understand the end of your discussion here.

8 DR. HALL: So I think I'm a little reluctant to
9 put too much emphasis on demonstration programs that show
10 equivocal results and to say that that's the direction in
11 which we should go, particularly if it disrupts any hope
12 that there be a more integrated system throughout hospitals
13 and health care systems.

14 DR. CROSSON: Okay. I got that point.

15 DR. HALL: Okay.

16 DR. CROSSON: Thank you.

17 Okay. So now we're in Phase 2. I saw Brian,
18 Jack. Okay, Brian.

19 DR. DeBUSK: First of all, I enjoyed your
20 presentation.

21 One of the things as you go forward -- and,
22 again, I'm sure we'll see you again on this subject -- it

1 would be nice to have an understanding. I'm familiar with
2 that process of recycling patients for Medicaid into
3 Medicare. What would be nice is to have an understanding
4 of just how much money is at stake, just so we can get a
5 feel for what we're up against, because just at first
6 impression, I'm concerned that even though we have some
7 carrots that we can hand out here, some awards and some
8 ways to incentivize better treatment, better behavior, I am
9 a little concerned that the underlying nursing home may
10 still have such a financial benefit from flipping that
11 patient that we just don't have enough money to throw at
12 that problem from one angle.

13 DR. CROSSON: Good point right there.

14 Stephanie, you touched on this a little bit
15 earlier. Do you want to talk about that again?

16 MS. CAMERON: So, in terms of the \$1.9 billion
17 estimate?

18 DR. CROSSON: Yeah. I mean, I think the point is
19 if we were to spend X amount of money, what's the Y amount
20 of money that we could expect to save, think taking into
21 consideration the kind of behavioral -- I know you can't
22 answer this. So I'm just --

1 [Laughter.]

2 DR. CROSSON: Taking into consideration the kind
3 of behavior or anti-behavioral response Brian was talking
4 about, is there any way to think about that?

5 MS. CAMERON: Well, I think one of the points
6 that makes this very difficult is the fact that nursing
7 homes do need hospital referrals because those hospital
8 referrals become their bread and butter, and if nursing
9 facilities lower their hospitalization rate or their
10 rehospitalization rate, which we have seen -- and what
11 we've heard is it's really from the Medicare readmission
12 reduction program that facilities have felt compelled to be
13 able to say, "We have a very low rate of readmissions.
14 Think about this as you're referring your patients."

15 I don't know how we could tease that piece -- and
16 that is a revenue, a potentially new revenue or a sustained
17 revenue -- into this process. So while I think there are
18 incentives, as we've discussed, on the basis of any
19 beneficiary that is -- the long-stay beneficiary that is
20 sent to the hospital for something that's avoidable, that
21 nursing facility doesn't need to provide care to that
22 beneficiary for, presumably, some level of costly services.

1 Upon readmission, if the beneficiary qualifies, that
2 facility could get a higher skilled nursing payment rate
3 for a period of time, and then it goes back to the Medicaid
4 rate.

5 So that is a meaningful number, but I think
6 there's other numbers in there where if you are able to --
7 if you as a facility are able to kind of reduce that, a
8 brand-new admission from a referral that's new is very
9 valuable as well, and maybe that does increase your census,
10 and that does increase your revenues. And I'm not sure if
11 we'll be able to tease all that out, but I think it's
12 something we can start thinking about just in terms of
13 where all those incentives are and maybe clearly kind of go
14 through that.

15 DR. DeBUSK: I think there are two issues there,
16 though. I mean, one is someone coming out of, say, an
17 acute care hospital engaging in a steerage program trying
18 to get them into the right skilled nursing facility to
19 minimize readmissions. And I think with my familiarity
20 with BPCI, there's no question that's happening on a
21 national scale. Hospitals are learning to steer their
22 patients to nursing homes with low readmission rates and

1 actually to nursing homes that will keep them for less than
2 21 days too, but again, that's more of a BPCI function.

3 But the other issue is let's say I have a
4 custodial care patient. Clearly, in Medicaid, we've done -
5 - I don't know that the incentive works. I could see them
6 setting up an elaborate system to prevent a readmission,
7 but then on the other side, for a patient who's been there
8 100 days, 200 days, will be there for the rest of their
9 lives, I don't know that there is an incentive there. I
10 mean, I understand we have projects to pay them incentives,
11 but I don't know what we're up against.

12 The number you used earlier, the \$1.9 billion,
13 clearly some of that would have been the hospitalization,
14 and then a portion of that would be those days, post-
15 hospital SNF days. And I'm assuming they're going to max
16 those out at 100.

17 MS. CAMERON: So I actually think the \$1.9
18 billion estimate was the cost of hospitalization only and
19 did not include the SNF.

20 DR. DeBUSK: Oh, okay.

21 MS. CAMERON: I'm fairly confident in that, that
22 study, that the 1.9 was hospital.

1 DR. DeBUSK: Just to get a feel of what we're up
2 against, it would be nice to see what the financial benefit
3 of this recycling.

4 DR. CROSSON: One could imagine that there are
5 differences across markets. There are some markets where
6 there's a whole ton of nursing homes, and there are other
7 markets where, for whatever reason, the hospitals don't
8 have a lot of choice. Is that information that's knowable
9 or not?

10 MS. CAMERON: I think we have done studies that
11 have looked at that. I'm not sure when the most recent one
12 was, but I'll work with my colleagues on that.

13 DR. MILLER: But, Stephanie, when you -- the data
14 -- I don't want this on the record.

15 [Laughter.]

16 DR. MILLER: I want to do the Jon thing and
17 refuse to speak.

18 The dataset that you're working up and the
19 measures, okay, so we're working towards a measure of
20 hospitalization rates out of a facility, and it will be
21 measurable at the facility level?

22 MS. CAMERON: Yes. We're doing a facility-level

1 analysis.

2 DR. MILLER: Okay. And then I think all of her
3 comments apply, which is, okay, you might be -- and this is
4 what you're coming back with next month, right? I'm not --

5 MS. CAMERON: That's right.

6 DR. MILLER: Correct.

7 MS. CAMERON: God willing.

8 [Laughter.]

9 DR. MILLER: Okay. So we might not be able to
10 get all of the hospitalization and who would have bounced
11 and all of that, but it seems to me that -- and I'm not
12 saying that you'll have this next month, so don't freak
13 out. Okay. But we may at least have a platform of how
14 much activity is going within what time frames, and then
15 perhaps making some kind of rough estimates, maybe we could
16 get you a number off of that. Does that seem insane? And
17 I'm not committing you to next month.

18 MS. CAMERON: I don't think that seems insane,
19 no.

20 DR. MILLER: Okay. Thank you. Yeah. This is
21 all I get, though. I got to tell you.

22 DR. CROSSON: You have secured your job.

1 [Laughter.]

2 DR. CROSSON: Okay. So, on this point, Kathy,
3 while I've got you on the list?

4 MS. BUTO: It's the same. I think it's the same
5 point.

6 DR. CROSSON: Same?

7 MS. BUTO: On this issue of the payment to the
8 facility, is there any flexibility in the design such that
9 CMS could instead structure it or allow facilities to
10 choose to share in the savings from an avoided
11 hospitalization? Of course, then you get into gaming as to
12 what's avoidable hospitalization, but I'm just wondering if
13 there's -- I have a feeling this is going to be a nominal
14 payment, and it's back to your point of what's going to
15 really give the facility an incentive to get engaged here.

16 DR. DeBUSK: That's where I was ultimately going.

17 MS. CAMERON: So, at this point, my understanding
18 is that the contracts for Phase II are pretty much wrapped
19 up. I mean, it went out for proposal at the end of last
20 year, and they have been working very hard since that point
21 to get things up and running. They expect Phase II to
22 commence in the fall. We're in September at this point,

1 and from my understanding, the deadline seems like it will
2 be met this fall. So I think in terms of that, for this
3 initiative, this phase, that is probably too late.

4 MS. BUTO: Okay. If you could, when we come back
5 next month, give us a sense of what level that payment to
6 the facility is, if we have any idea, or can negotiate.

7 MS. CAMERON: I can tell you what that level is
8 right now.

9 MS. BUTO: Okay, great.

10 MS. CAMERON: So, for the on-site, the facility
11 payment is going to be \$218 per day for the treatment of
12 those conditions. The number of days that the facility can
13 receive a payment has a maximum threshold based on the
14 condition, and that can be anywhere between five and seven
15 days for those six conditions.

16 In terms of the provider payment for that first
17 visit during a change in health condition, that went to --
18 I think originally the CPT that they would normally bill
19 would be about \$138 for a physician and then obviously
20 reduced for nurse practitioners and others, and that
21 payment is going to, I believe, just over \$200.

22 The third payment for care-giver engagement,

1 which previously facilities would not have billed for, is
2 \$80.

3 DR. CROSSON: Just for the record, that
4 interchange about the penalty, we're talking about Medicare
5 imposing a penalty on the nursing home for the SNF portion
6 after the hospitalization?

7 DR. MILLER: I mean, the question is we would
8 have to talk this out. The question is whether you're
9 paying them dollars to do something or whether somehow
10 dollars are extracted, if they have high hospitalization
11 rates, but there is a problem because it's crossing
12 Medicaid and Medicare lines.

13 DR. CROSSON: Right. So that is why I was saying
14 I could imagine that if you could determine that a
15 hospitalization should -- rehospitalization, whatever,
16 should not have occurred --

17 DR. MILLER: You go after the SNF patient.

18 DR. CROSSON: -- the patient goes back as a SNF
19 patient. You then either don't pay for that or you reduce
20 that payment. That would be --

21 DR. MILLER: That would be the pot of money.

22 DR. CROSSON: Okay. Jack and then Paul.

1 DR. HOADLEY: So I have several different
2 comments that I think relate to each other and to what
3 we've been talking about, though with this hour, I'm not
4 completely sure.

5 One is that the SNF payment that is triggered by
6 this admission to the hospital, I mean, it's going to still
7 depend, I think, on the situation of the patient. So
8 certain things they might go in for, there's not really a
9 certification of a need for SNF. So it's not like it's
10 automatically generated; is that right? And it's certainly
11 not automatically generated for 100 days, although that
12 question of who makes that judgment is always open.

13 MS. CAMERON: That's right. I mean, the patient
14 has to meet the three days and then have a skilled need --

15 DR. HOADLEY: Have a skilled need.

16 MS. CAMERON: -- upon discharge from the
17 hospital, and we have heard that skilled need to be looked
18 at to various degrees.

19 DR. HOADLEY: Got it.

20 MS. CAMERON: I don't think there's a lot of
21 consistency on how the skilled need is defined across MACs,
22 for example.

1 DR. HOADLEY: And presumably based on what you've
2 said up here, one of the things you would be looking at
3 from the data is how much SNF use occurs in these
4 situations of these avoidable hospitalizations; is that
5 right?

6 MS. CAMERON: Yes.

7 DR. HOADLEY: Okay. The second point, I think
8 we've said this all right by the end of this conversation,
9 but it does seem to me like there's a very different
10 environment for the readmission question, so people that
11 have been in the hospital, heading in -- go off to the
12 nursing home and then go back to the hospital. That
13 triggers, A, they're probably still under SNF care, and
14 that's the kind of thing where the hospital has the
15 incentives that we talked about, versus the admissions that
16 are occurring for somebody who's in the longer-term
17 custodial care. And I think we just need to be careful
18 that we don't combine those two together, although the
19 nursing home's relationship with the hospital may sort of
20 think about all those things at some level, but that's just
21 a -- as I listen to this, get a little bit tangled at
22 times.

1 And then, a little more substantively, it seems
2 to me like, to go address this not quite yet fully
3 established what the problem is or how big the problem is,
4 but this question that all these efforts are going after,
5 which is trying to reduce these admissions to the hospital,
6 it's really -- it seems like, to me, it's a two-level
7 challenge.

8 One is if we're operating in the un-integrated
9 Medicare and Medicaid environment, we have all these issues
10 that come up about Medicaid dollars are doing one set of
11 things and Medicare dollars are doing another set of
12 things, and that's why the logic, at least, of the dual
13 demo, the financial alignment demos, says that you try to
14 put both streams of money together and do that, whether
15 that's going to work or whether that has other issues
16 aside. But in all these other efforts it seems like you
17 keep tripping over this idea that Medicare saves money,
18 Medicaid benefits, vice versa, whatever. And so it seems
19 like that's the first part of the challenge in trying to
20 make any of these things work.

21 And then the second part of the challenge, to me
22 -- and this is drawing as much from your interview kind of

1 comments as from the demo, in particular -- is how much
2 investment is required for the nursing home, nursing
3 facility, whether it comes from their own resources or from
4 some other source of money, to carry out the kinds of
5 things we're talking about -- the trainings, the better
6 EHRs, and all the other things that you talked about in
7 this.

8 And it seems to me, then, some of the questions
9 are what are the differential abilities of different
10 nursing facilities to do this. You've got a lot of -- I
11 know when I did some interviews in Virginia on the dual
12 demo there, they talk about so many of the nursing
13 facilities are these really small, mom-and-pop kinds of
14 operations. They don't have a lot of patients. They don't
15 have a lot of beds. And, you know, they're going to be a
16 lot more limited in being able to amp up the training or do
17 some of these other kinds of things than much larger
18 facilities, or maybe facilities that are connected with
19 larger organizations.

20 And it seems like to think about how this is
21 going to play out, that's at least one of the various
22 dimensions we should think about is, in whatever means of

1 doing this, either looking for them to do it out of their
2 own resources, or putting money in, how does that play out
3 differently in a 20-bed facility that's independent versus
4 a 200-bed facility that's part of a larger organization
5 that can provide these things at a corporate level, or
6 something like that?

7 And so, I mean, just thinking about the
8 investment, where it comes from, where state Medicare or
9 whoever is going to pump in some extra money to do this, it
10 seems like it's got to take into account some of those
11 difference out there in the market.

12 DR. CROSSON: Paul.

13 DR. GINSBURG: Yes. A number of things I wanted
14 to say have been said, but I'm really struck by what Brian
15 and Jack said about the two fairly distinct types of
16 patients we're talking about -- you know, those discharged
17 from a hospital where, I think appropriately, the incentive
18 should be on the hospital to make sure that they don't come
19 back, because the hospitals do have a lot of leverage over
20 the nursing type.

21 The other type being the custodial patients, who
22 may not have had an experience in the hospital until what

1 we're talking about. I think we're talking about the
2 choice for them between an approach which we've been
3 focusing on, which, in a sense, provides a lot of services
4 to support the nursing home, to reduce hospitalizations,
5 where sometimes it's hard to say, as Bill was saying, you
6 know, that the savings seem fairly marginal. It's really
7 hard to imagine this becoming our main strategy, a national
8 program.

9 I wonder if we have to start thinking policy-wise
10 about engaging the nursing home with financial incentives.
11 You know, perhaps a combination of penalizing them for
12 potentially avoidable hospital admissions from their
13 custodial patient, but probably with the same -- so we'd
14 have to pay them more, in irregular rates, you know, to
15 give them some of the resources to do better here, because
16 they're not going to get the savings. Which also gets into
17 Medicare and Medicaid issues, that maybe Medicare needs to
18 provide a payment, as well as the penalty, for the
19 potentially avoidable admissions.

20 But just some thoughts about how we can move
21 forward, moving this into policy. I think the agenda for
22 next steps is about developing better risk-adjusted

1 measures of potentially avoidable hospital use is relevant
2 for whatever approach we take.

3 DR. MILLER: And one way to connect that thought
4 -- and, you know, Bruce, you may have thoughts along these
5 lines too -- you know, maybe what you do with this is, at
6 least you take it as far as, well, we should have a measure
7 and have a sense of what's going on out there. And so that
8 at least for a given nursing facility, even if money isn't
9 attached one way or the other, it's like this nursing
10 facility seems to have a lot of this; this one doesn't seem
11 to have a lot of this, which may be helpful to other
12 providers in just, you know, thinking about.

13 And you could have conversations about attaching
14 incentives to that, or you could move out of that and say
15 there's a measure, it is what it is, and start having
16 conversations that I think Paul might be talking about, and
17 Bruce, I think you had some thoughts like this. Do you
18 say, for this population, where you constantly keep running
19 up against the Medicare and Medicaid funding streams, do
20 you really have to go back in and aggressively thinking
21 about how you bolus streams together and think about more
22 managed care route or whatever the case may be, because

1 it's going to be very hard to have the dollar conversation
2 when we, you know, make policy on the Medicare side but we
3 don't make it on the Medicaid side.

4 So that's kind of what I got out of your, Paul,
5 comments, so I just --

6 MR. THOMAS: Just to be brief, I think -- I agree
7 with Paul's point. I think that the real situation here,
8 though, is, I mean, that hospitals have a lot of capability
9 to identify nursing homes that want to work with them, and
10 we've seen it to the extent we limit the nursing homes that
11 we work with, and we work in a collaborative fashion.
12 We've seen much better outcomes on readmissions and just
13 better cost models.

14 So if you can think about ways that, you know, if
15 there's ways that you can incent hospitals or nursing homes
16 to be more collaborative from that perspective, and, you
17 know, once again, if you use 20 versus 100, you're going to
18 have a better coordination and better outcomes for the
19 patients.

20 DR. CROSSON: Okay. I've got Pat and Jack.

21 MS. WANG: I just want to -- I think that this is
22 an important initiative to track and that this work is very

1 important. I do think that it's a very important area for
2 Medicare. The population is old today and it's going to
3 get older as the future comes upon us. I think,
4 personally, that the ultimate, and the ideal, even today,
5 sort of -- there's a bundle of services that's appropriate.
6 Just because somebody is called custodial today doesn't
7 mean that they should be, candidly, that the best providers
8 -- you know, I am a partial CAP plan. I am a FIDA SNP. I
9 participated in the duals demo. The best post-acute care
10 providers that I want to deal offer the whole array of
11 services, everything we talked about before with PAC, as
12 well as nursing home, because -- and one of the reasons I
13 think that this initiative is important is that most
14 nursing homes that have custodial patients today, this is
15 not what they were built to do. This is not how they
16 staffed themselves. This is kind of a new thing for them,
17 but it's critically important to equip them with the tools
18 to be able to fluidly move people to appropriate levels of
19 care. I mean, it's important for the welfare of Medicare
20 beneficiaries and I think the Medicaid funding question is
21 -- it's the elephant in the room, you know.

22 Because, ideally, you know, if somebody is in the

1 hospital and they need to go to acute rehab, I might want
2 to discharge them home with appropriate home care and then
3 continue with personal care that's funded by Medicaid.
4 That might be the best course for a dual-eligible person,
5 and it might be the best from a spending perspective, all
6 in. And, you know, it is a real struggle now because
7 Medicaid is, you know, 50 different programs, there's
8 different benefits in every states, and it's totally
9 bifurcated. But at least for the Medicare piece, I think
10 it's important to keep working on this initiative,
11 personally, and put it in the context of post-acute care,
12 generally, that is more fluid than just, you know, here's
13 the custodial nursing home piece right here. It's really
14 connected to all the other things that we've been talking
15 about.

16 DR. CROSSON: Jack.

17 DR. HOADLEY: Probably just want to remind
18 ourselves that the Medicaid dollars we're talking about, of
19 course, are partly federal dollars, although they're not
20 Medicare dollars and so they're not MedPAC's
21 responsibility. But obviously another policy option for
22 this is to federalize the Medicaid program for the dual-

1 eligibles, and then that, of course, creates a lot of
2 things you'd have to do, but at least it gets rid of that
3 but of the financial responsibility. That's obviously a
4 much bigger issue.

5 DR. CROSSON: Can we do that next month?

6 [Laughter.]

7 DR. MILLER: Stephanie, would you take care of
8 that for us?

9 Actually, if we ask her to do that, she will not
10 be back next month. She's already right on the edge.

11 I mean, you know, if we had that conversation --
12 we talked a little bit in the June report, if I'm
13 remembering correctly -- I'm looking at Eric -- about MSP
14 and -- was that the right? -- and, you know, people -- the
15 Medicare support programs, you know, to wrap around. Even
16 the estimate there of saying, okay, why don't we take that
17 over, is gigantic. The notion that -- you know, these are
18 good conceptual ideas but the huge thing that you would be
19 faced with is -- and where did you think you were getting
20 the money? And, of course, one part of that money would be
21 to go back to the states and say, well, there's a level of
22 effort here and, you know, they're going to decidedly have

1 different views on that.

2 So we can talk about it but you will bump up
3 against that pretty quickly, and that's often what makes
4 these short conversations.

5 MS. BUTO: But, Mark, you know, Pat's earlier
6 point about if Medicare were willing to share some savings
7 on areas where there was a mutual interest, with Medicaid
8 and Medicare has always been reluctant to go there, but I
9 think that's an area that Medicare payment could actually
10 benefit both Medicare and Medicaid. So, you don't have to
11 go all the way to federalizing long-term care to look at
12 options that really will work to both benefits.

13 DR. NERENZ: [Off microphone.]

14 DR. CROSSON: I'm sorry. I thought I had you.

15 DR. NERENZ: You did, but I changed my mind.

16 [Laughter.]

17 MR. PYENSON: Just -- Kathy, just a consideration
18 on this sharing is that once you have capitated programs,
19 you know, I think the sharing issue gets diminished.
20 Right? The states take their bit out in advance by
21 lowering capitation to a health plan, and, you know, then
22 it's no longer their problem. So I think that's part of

1 the advantage of getting a dual integration, and when you
2 have further alignment with the dual-eligibles, Medicare
3 and Medicaid being managed by the same organization that
4 manages the single eligibles, then it's more of a
5 consistent program, because fundamentally the needs are
6 often the same.

7 So I view that as a positive approach.

8 DR. CROSSON: Okay. Stephanie, thank you for
9 this, and you've gotten plenty of feedback, so we're
10 looking forward to seeing you next month. Thank you very
11 much.

12 Now we're going to move on to the public comment
13 session. I see one individual at the microphone. If there
14 are any other individuals who would like to speak, it's
15 probably useful to us if you would stand up and get in line
16 so we can get a sense of it.

17 So the ground rules here, and I mentioned a
18 couple of things, just for information for the audience,
19 this is an opportunity for public comment on issues which
20 we have discussed during the day. It's not the only way to
21 provide input to the Commission and to the staff. Mark and
22 his staff are open to receive comments through the website,

1 as well as, in some cases, individual meetings. So there
2 are ways to provide information prior to the Commission's
3 discussion, but this is an opportunity to do it subsequent
4 to the discussion.

5 We would ask you to identify yourself and your
6 institution, and limit your remarks to two minutes. So I'm
7 going to -- when I stop talking I'm going to turn the light
8 off and then when it goes back on I'd ask you to wrap up.

9 MR. LIND: Thank you. Keith Lind, AARP. I'd
10 just like to go back to the post-acute payment discussion.
11 I think you mentioned that hospitals will be allowed to
12 influence patient choice of PAC provider to reduce
13 readmissions. I think we understand about steering and
14 that's come up again here in the context of trying to
15 identify nursing homes that hospitals can work with.

16 So it would be really helpful -- this has come up
17 more and more as we look at bundled payments and PAC
18 demonstrations -- if you could explore, what the
19 parameters, the permissible parameters for steering? I
20 mean, are financial incentives allowed? If so, how big?
21 How much pressure can you put on patients? I think the
22 concern is, in the fee-for-service environment you want to

1 preserve some semblance of freedom of choice, and it would
2 be great if -- we haven't heard much discussion of that.

3 AARP makes these comments periodically when we
4 comment on these things, but it would be helpful if MedPAC
5 would explore this in one of these chapters.

6 Just one other comment that was in that post-
7 acute payment section. The reference was about reducing
8 readmissions but I would just encourage you to explore
9 looking at -- also looking at a measure of excess acute
10 care days, which actually, I think, she mentioned that she
11 was going to try to use in this context also, because that
12 would capture hospital contacts with the emergency room and
13 observation visits, return visits, as well as inpatient
14 admissions, and it would be helpful to know if one measure
15 was as good as, or better, than the other.

16 Thank you.

17 DR. CROSSON: Thank you very much for your
18 comments. Seeing no one else at the microphone, we are
19 adjourned until 8:30 tomorrow morning.

20 [Whereupon, at 5:03 p.m., the meeting was
21 recessed, to reconvene at 8:30 a.m. on Friday, September 9,
22 2016.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, September 9, 2016
8:30 a.m.

COMMISSIONERS PRESENT:

FRANCIS J. CROSSON, MD, Chair
JON B. CHRISTIANSON, PhD, Vice Chair
AMY BRICKER, RPh
KATHY BUTO, MPA
ALICE COOMBS, MD
BRIAN DeBUSK, PhD
PAUL GINSBURG, PhD
WILLIS D. GRADISON, JR., MBA, DCS
WILLIAM J. HALL, MD, MACP
JACK HOADLEY, PhD
DAVID NERENZ, PhD
BRUCE PYENSON, FSA, MAAA
RITA REDBERG, MD, MSc
CRAIG SAMITT, MD, MBA
WARNER THOMAS, MBA
SUSAN THOMPSON, MS, RN
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AGENDA	PAGE
Mandated report: Relationship between physician and other health professional services and other Medicare services	
- Dan Zabinski, Shinobu Suzuki.....	3
Misvalued clinician services: Current status and next steps	
- Ariel Winter, Kevin Hayes.....	31
Public Comment.....	145

P R O C E E D I N G S1
2
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4
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[8:30 a.m.]

DR. CROSSON: Okay. Good morning again. This morning we have two presentations, and the first one is an analysis that has been done for us based on a mandated report that was part of MACRA. And I think, Dan, you are going to begin? Okay. Dan and Shinobu are going to be presenting the report.

DR. ZABINSKI: All right. Good morning. As Jay just said, Shinobu and I are going to discuss a mandated report of the relationship between physician and other health professional services and other MedPAC services.

The Medicare Access and CHIP Reauthorization Act, or MACRA, requires MedPAC to submit a report to the Congress that evaluates the relationship between physician and other health professional services and the services provided under Parts A, B, and D of Medicare. And we are directed to evaluate the relationship of both program spending and use of all services.

Note that for the rest of this presentation, we will refer to services that are provided by physicians and other health professionals as "clinician services."

1 MACRA indicates that an initial report for this
2 study is due July 1, 2017, and a final report is due July
3 1, 2021.

4 The analysis we present today has two broad
5 parts. I will discuss the relationship between clinician
6 services and Part A and Part B services, and Shinobu will
7 discuss the relationship between clinician services and
8 Part D drugs.

9 A key concept throughout our discussion is the
10 correlation between clinician services and Part A, B, and D
11 services. A positive correlation suggests that clinician
12 services and the other services are complements, which
13 means that as clinician services increase, the other
14 services also increase. A negative correlation suggests
15 that clinician services and the other services are
16 substitutes, which means that as clinician services
17 increase, the other services decrease.

18 MACRA requires that we look at both program
19 spending and beneficiaries' service use, and we emphasize
20 they are different measures. Program spending is monetary
21 outlays by the Medicare program, and we made no adjustments
22 to our spending data.

1 It's important to know that spending will differ
2 between regions or years because of differences in Medicare
3 prices and beneficiaries' health status.

4 To measure service use, we start with spending
5 data, and then we arrive at the service use by removing
6 from our spending data the geographic differences in
7 Medicare prices, beneficiaries' demographics, and their
8 health status.

9 Service use reflects volume of services provided
10 and service intensity, which means that basic things like a
11 simple X-ray has lower service use than a more complicated
12 thing like a CT scan.

13 In our analysis, we focused on beneficiaries in
14 fee-for-service Medicare and excluded beneficiaries in
15 Medicare Advantage because MACRA directs us to evaluate
16 Parts A, B, and D of Medicare but not Part C.

17 We made evaluations over time at the national
18 level and within single years at the level of what we call
19 "MedPAC units." The MedPAC units are our attempt at
20 defining health care markets and are largely based on
21 metropolitan statistical areas. And there are 484 MedPAC
22 units.

1 We started our analysis by evaluating how
2 Medicare program spending on clinician services as a share
3 of all Part A and Part B services has changed over time.
4 This is a national-level analysis, and the results are
5 based on data from the Medicare Trustees' reports.

6 We found that program spending on clinician
7 services was 19.1 percent of all Part A and Part B spending
8 in both 1993 and 2013. However, this percentage fluctuated
9 over that period. Sometimes it was above the 19.1; other
10 times it was below.

11 In more recent years, this percentage has been
12 pretty stable. For example, it was 19.3 percent in 2008
13 and 19.1 percent in 2013.

14 A caveat is that we believe that service use is a
15 better measure than the spending data that we discuss on
16 this slide because the spending data is affected by prices
17 and health status, which can distort our perception of
18 providers' practice patterns and how service use differs
19 between years and between regions.

20 Because we view service use as the better
21 measure, the rest of our analysis of Parts A and B focused
22 on service use rather than program spending.

1 We began our analysis of service use with a
2 national-level time series analysis that evaluated how use
3 of clinician services as a percent of all Part A and Part B
4 services changed from 2008 through 2013.

5 Our 2008 data file did not have clinician
6 services as a distinct category. Instead, it had carrier
7 services, which includes all clinician services plus a few
8 others. We did find, though, that spending on clinician
9 services is about 90 percent of the spending on carrier
10 services (if you include Part B drugs in the clinician
11 services), so we used carrier services as a proxy for the
12 clinician services.

13 We found that carrier services as a share of all
14 Part A and Part B services increased from 24.4 percent in
15 2008 to 26.3 percent in 2013.

16 In addition to evaluating service use at the
17 national level, we evaluated use of Part A and B services
18 at the level of our geographic units.

19 For the geographic units, we measured the
20 correlation between the percent change from 2008 to 2013 in
21 use of clinician services and the percent change in use of
22 all Part A and Part B services, net of the clinician

1 services.

2 We did a regression that had the change in
3 clinician services as the explanatory variable and the
4 change in the other Part A and Part B services as the
5 dependent variable. And the regression results indicate a
6 positive correlation, but it has a small coefficient on
7 percent change in clinician services and a low R-squared,
8 which indicates that positive relationship is a weak one.

9 On this diagram, we show the relationship between
10 the percent change in use of the clinician services and the
11 percent change in use of other Part A and Part B services
12 for our 484 geographic units.

13 If there was a close, strong relationship between
14 the two measures, you'd see these data points clustered
15 tightly around a straight line. But, instead, we see a
16 very loose relationship, without any clustering around any
17 specific line.

18 Our final evaluation of Part A and Part B
19 services was a cross-sectional analysis of the correlation
20 between the per capita use of clinician services in 2013
21 and the per capita use of other Part A and Part B services
22 across our 484 geographic units.

1 A regression that has per capita use of other
2 Part A and Part B services as the dependent variable and
3 per capita use of clinician services as the explanatory
4 variable reveals nearly zero correlation. That is, it is
5 neither positive nor negative. The R-squared from the
6 regression is nearly zero, and the coefficient on the per
7 capita clinician services is not significantly different
8 from 0 at the 10 percent level.

9 On this diagram we show the relationship between
10 per capita use of clinician services and the per capita use
11 of other Part A and Part B services for our 484 geographic
12 units. And as you can see, there's not really much of a
13 discernable relationship.

14 So a summary of our analysis of the relationship
15 between clinician services and all Part A and Part B
16 services includes that program spending on clinician
17 services as a share of all Part A and Part B services has
18 been stable, which suggests that spending on clinician
19 services has been increasing at about the same rate as all
20 other Part A and Part B services. Also, the correlation
21 between use of clinician services and use of all Part A and
22 Part B services is positive but weak or perhaps maybe zero.

1 Now I turn things over to Shinobu, who will
2 discuss the relationship between clinician services and
3 Part D drugs.

4 MS. SUZUKI: Before we talk about the findings, I
5 wanted to quickly go over the data and methods used for the
6 analysis of clinician services and Part D drugs. The
7 analytical framework generally follows what Dan used for
8 Parts A and B services.

9 One of the main differences is that, for this
10 part, we focus on beneficiaries enrolled in standalone
11 prescription drug plans, which is a subset of fee-for-
12 service beneficiaries, as you'll see on the next slide.

13 We are not able to look at all fee-for-service
14 beneficiaries because some of them receive their drug
15 coverage from sources other than Part D, such as their
16 former employers. We have no drug spending data for those
17 beneficiaries.

18 Drug use is gross spending adjusted for variation
19 in prices across regions, demographic characteristics such
20 as age, gender, and health status.

21 We use the same correlation analysis and
22 geographic units used for the analysis of Parts A and B

1 services to look at both the level of service use and the
2 change in service use between 2008 and 2013.

3 There's been some change in the patterns of Part
4 D enrollment among the fee-for-service beneficiaries
5 between 2008 and 2013. You can see this in the table at
6 the top.

7 Our study sample for 2008 includes 18.6 million
8 beneficiaries, accounting for half of fee-for-service
9 beneficiaries, and nearly 70 percent of Part D enrollees.

10 For 2013, the study sample includes about 24
11 million beneficiaries, accounting for over 60 percent of
12 fee-for-service beneficiaries, an increase from 50 percent
13 in 2008. But as a share of Part D enrollees, they account
14 for a smaller share than in 2008, reflecting the shift in
15 Part D enrollment towards drug plans operated by Medicare
16 Advantage plans.

17 This change in enrollment patterns has resulted
18 in somewhat different demographic characteristics in 2013
19 compared with 2008.

20 For example, compared with 2008, a smaller share
21 of beneficiaries were disabled beneficiaries under age 65
22 and receive the low-income subsidy.

1 Here's a summary of our findings.

2 Clinician services and Part D drugs grew at
3 similar rates between 2008 and 2013, regardless of whether
4 the measure was unadjusted per capita spending or per
5 capita service use.

6 A cross-sectional analysis across the geographic
7 units showed a weak to modest positive correlation between
8 the levels of clinician service use and drug use in both
9 2008 and 2013, suggesting they may be weak complements.

10 That positive correlation was somewhat stronger
11 in 2013. It's not clear whether this is due to a change in
12 the relationship between those two sectors or a result of
13 the change in study population that's not fully captured by
14 the demographic and health status adjustments we included
15 in our model.

16 But looking at the change in service use between
17 2008 and 2013, we found a weak negative correlation between
18 clinician service use and drug use, suggesting they may be
19 weak substitutes.

20 So we found weak positive and weak negative, but
21 in all cases our findings show generally weak relationship
22 with small correlation coefficients and low R-squared

1 values. These findings seem to suggest that there is very
2 little relationship between clinician service use and drug
3 use across geographic units.

4 In summary, our findings of weak to no
5 correlation suggest clinician service use and other
6 Medicare service use are neither clear complements nor
7 substitutes.

8 A major caveat is that, as you saw with the
9 scatterplots, our findings are aggregate results and may
10 not represent any individual circumstances or specific
11 geographic areas.

12 As Dan said at the beginning of this
13 presentation, this is a mandated report with an initial
14 report due in 2017. We plan to incorporate your comments
15 from today's discussion and include this material in our
16 June 2017 report. If any of the comments we receive today
17 require us to make substantive changes, we could come back
18 to you in the spring.

19 With that, we are now open for questions.

20 DR. CROSSON: Thank you, Shinobu and Dan. That
21 was a very clear exposition of a somewhat complicated idea,
22 and I think you've done a wonderful job with that. So

1 we're now open for clarifying questions.

2 MR. GRADISON: I don't recall hearing a reference
3 to the term "MedPAC units" before. Did you develop it just
4 for this study?

5 DR. ZABINSKI: No. They've been -- how to say
6 it? The staff --

7 MR. GRADISON: I see some smiles. Is there
8 something wrong with my question?

9 [Laughter.]

10 DR. ZABINSKI: We've had them around for a few
11 years. This is, I think, the first time we used that term.

12 DR. MILLER: It is the first time.

13 DR. ZABINSKI: I wasn't sure what to call them
14 so...

15 MR. GRADISON: The reason, I just was frankly
16 curious as to whether this was a breakdown that you would
17 expect to use for other purposes in the future that you
18 think is a superior geographic breakdown. That's really
19 why I'm asking the question.

20 DR. ZABINSKI: Well, I think in the future, yeah
21 -- I mean, we've used it in the past, so I don't see why we
22 wouldn't use it in the future.

1 MR. GRADISON: Oh.

2 DR. ZABINSKI: You know, in January 2011 I think
3 it was, we had a report on geographic variation on service
4 use where we used not exactly the same thing, pretty close
5 to the same thing. And I know in the Medicare Advantage
6 work that Scott and Carlos --

7 MR. GRADISON: Use the same.

8 DR. ZABINSKI: They may include these as well.

9 DR. MILLER: It's really the label [off
10 microphone].

11 MR. GRADISON: Fair enough. Thank you,

12 DR. MILLER: We use this all over the place [off
13 microphone].

14 DR. COOMBS: So was the 2008 starting point
15 something that was dictated in the legislation? Or why not
16 start in 2009 when there were more similar groups between
17 2009 and 2013?

18 DR. ZABINSKI: That's a good question. It was
19 not mandated. I chose 2008 because it's a five-year
20 period, for no other reason beyond that. And, you know,
21 2009 could work just as well.

22 DR. COOMBS: Only for, you know, just similar

1 comparisons, and you won't have to deal with the other
2 factor of the carrier with physician services incorporated
3 in.

4 DR. ZABINSKI: I'm not sure if 2009 -- I hadn't
5 looked at the 2009 data. I'm not sure if they have the
6 carrier services disaggregated to physician services that
7 are not...

8 DR. COOMBS: I thought I read that in your paper
9 [off microphone].

10 MS. SUZUKI: One of the things we were trying to
11 do is we were supposed to look at the change over time, and
12 2013 was the latest data available at the time of the
13 analysis, and we wanted to have as many years as possible
14 without going too far back that there's no Part D program.

15 DR. COOMBS: So my question would be if the 2009
16 differs that much, especially with the -- it does?

17 DR. MILLER: I'm pretty sure you're not going to
18 find anything different if you do it, but if you want us to
19 chop off a year and take a look at it, we can do that.

20 DR. SAMITT: Shinobu may have answered my
21 question, but the distinction between the initial report
22 and the final report, was that simply to create a baseline

1 and then to do a follow-up study four years later? Is that
2 sort of the intention in terms of the gap between initial
3 and final?

4 DR. MILLER: It would appear, and I'm not saying
5 that to be sarcastic. It would appear that they think that
6 there's something about MACRA that they want to see in a
7 few years to see it's affected this relationship. That's
8 the way we interpret it unless somebody up there has some
9 other idea.

10 MS. BUTO: I wondered whether we'd see the same
11 weak correlation if we broke it down primary care versus
12 procedural and surgery services; in other words, I mean, I
13 just -- it feels like surgery and procedural would have a
14 stronger relationship, correlation to the production of A
15 and B services, but I don't really know. It might be
16 exactly the same result. I wondered if you looked at that.

17 MS. SUZUKI: We have not separated the sample
18 into primary care versus specialty care, and...

19 MS. BUTO: Is that hard to do?

20 DR. MILLER: You know, the primary care involves
21 some gymnastics just because it has got a separate
22 definition, and I wouldn't immediately commit to time

1 series and whether there's any complexity in replicating it
2 at any point in time. It may be perfectly fine, but just
3 since I haven't thought about it for more than three
4 seconds, I wouldn't say. It's probably easier to break it
5 down into, you know, procedural and that type of stuff, the
6 stuff that follows the fee schedule more directly. Again,
7 to what end, you know, what purpose for all of that? And,
8 again, if you just strictly are following the mandate, the
9 mandate isn't pushing that all --

10 MS. BUTO: It's for all services.

11 DR. MILLER: Yeah, which I haven't read recently,
12 but --

13 MS. BUTO: Okay.

14 DR. ZABINSKI: Just a point to add. You know,
15 the data that we used for the analysis of the spending,
16 that was just simply pulling things off the trustees'
17 tables and the trustees' reports, and that was really easy.
18 And then the service use, we pulled spending data from a
19 data file for claims information is used to aggregate
20 program expenditures into service categories -- carrier,
21 inpatient, outpatient, SNF, et cetera. To go into specific
22 specialties, primary care, surgical, et cetera, that would

1 require us to ourselves go into claims and identify all
2 the, you know, primary care claims, all the surgical
3 claims, and then run that data.

4 MS. BUTO: Yeah, I wouldn't --

5 DR. ZABINSKI: Not a huge task, but additional
6 work.

7 MS. BUTO: Yeah, I wouldn't do that given that
8 that's not part of the required scope of work. But I'm
9 just curious. Again, to what end, I think is the real
10 question.

11 DR. MILLER: If you're interested in the
12 relationships of these things at least in terms of
13 geographic variation, we have written reports looking at
14 geographic variation and then subdividing that into classes
15 of service, post-acute care, inpatient, outpatient, that
16 type of thing, and looked at that. And, if that's where
17 your mind is headed, there's actually a couple of older
18 reports we could bring back or just give to you for
19 nighttime reading, that type of thing. You know, I don't
20 know what you do.

21 [Laughter.]

22 DR. MILLER: And it might get your mind thinking

1 along those lines. Actually, in some ways, if your mind
2 goes along those ways, those lines, or anyone else's, I
3 have more of an interest -- and this is going to surprise
4 Dan, but I like assigning work in this context because then
5 it can't fight back as much -- of whether we replicate,
6 Dan, geographic work lately, update it, because we had a
7 little bit of this conversation in the hallway.

8 MR. ZABINSKI: Right. And there's some
9 interesting things in that.

10 DR. MILLER: Yeah. If that's your thinking, I
11 actually would prefer to dive in and go that direction than
12 do it here where the --

13 MS. BUTO: You're saying geographic work related
14 to the differences?

15 DR. MILLER: So looking across geographically and
16 what you generally see is you know there's this old and
17 longstanding point where you see vast geographic variation
18 and utilization of services across the country. In
19 addition to that, we've gone in and kind of broken it down
20 into post-acute care to see how all of that works. And one
21 of the main findings of that work back in the day, which
22 Dan was part of and a couple other people were part of, is

1 a lot of that variation gets driven by the post-acute care
2 sector. If your mind is wandering along those paths, I'd
3 almost go back down that road and sort of replicate that
4 and bring that back in front.

5 MS. BUTO: Well, I think that's a worthwhile
6 thing to do, but I don't think it's related to this, per
7 se.

8 DR. MILLER: I agree. And I am trying to drive
9 you off of this because I think --

10 [Laughter.]

11 DR. MILLER: Well, I'm being --

12 MS. BUTO: But succeeded.

13 DR. MILLER: Yeah. Because I also think the
14 other thing that's gone on here -- and I will stop after
15 this -- I think probably when you look at least
16 geographically, there are other factors that drive
17 behaviors across the entire spectrum of spending as opposed
18 to this notion of dose this set of services affect that set
19 of services, and I think if you're thinking along those
20 lines, there's a whole different way to look and ask that
21 question.

22 DR. CROSSON: Warner.

1 MR. THOMAS: So just to make sure I understand,
2 this is the mandated report, and I guess our takeaway is
3 there's really not a lot to discern from the analysis done,
4 but it's something that we have to do when we're reviewing
5 it. It doesn't seem like there's -- is there other
6 information that we need to try to glean from this, or is
7 that -- I'm just trying to get the takeaway from the staff
8 and leadership.

9 DR. MILLER: My takeaway is this is a fairly
10 structured mandate. We've answered the mandate. If this
11 triggers other questions in your mind that enough people
12 think it's worth pursuing, I'd probably build something
13 around that as opposed to build it around this. This, I
14 would tend to -- you know, we met the mandate.

15 And it may be -- and I think Alice or somebody
16 just said it. It may be that if they're looking for
17 something to happen, if anything happened to 2021, again,
18 I'm not sure how much time I'd spend churning on this.

19 DR. CROSSON: Remembering that because of the
20 mandate, we will be coming back again with a subsequent
21 analysis, and in that time, we might learn as part of the
22 basis for the new analysis that there are other factors

1 that need to be looked at. And that can be done
2 retrospectively as well.

3 Other clarifying questions?

4 [No response.]

5 DR. CROSSON: Not seeing any, we'll come to
6 Craig. Craig, that was the whole thing. They were trying
7 to give me a hint. Thanks so much.

8 DR. SAMITT: Trying to signal that, and since I
9 won't be here in 2021 to comment, I thought I would comment
10 in 2016.

11 I can't say that I'm surprised by the results,
12 obviously. The mandate, the study is well done. I think
13 we've sort of responded to the request of the mandate. I
14 think the frank reality is I think the pools are too large
15 to really discern any correlation, and so there is a weak
16 correlation. It's certainly not surprising.

17 But to Kathy's point, I think if we were
18 interested in this, there are other types of analyses that
19 I think would be more intriguing. I am more interested in
20 trends within these pools as opposed to between these
21 pools, and that we're likely to see tradeoffs within Part
22 B, within Part A, within clinician services between primary

1 care and specialty.

2 And I also think if we wanted to do that type of
3 analysis, we also should look at encounter data as it
4 relates to differential trends in Medicare Advantage to see
5 if there's differential shifts in the Medicare Advantage
6 world than in the fee-for-service world.

7 But in terms of this report, it seems very well
8 done, and we answered the question. It just doesn't give
9 us a lot of information.

10 DR. CROSSON: Thank you. Other comments?

11 Yes, Alice.

12 DR. COOMBS: Thank you, Dan. As you know, one of
13 the things in reading the report is that the weakly
14 positive and the weakly, weakly, weakly, weakly -- I just
15 think that at some point, we probably should have a take-
16 home message to the rank-and-file people who read this
17 report that there is no correlation when you give point-
18 zero-zero-something in an R factor. So I think that we
19 should have a synopsis that says at this juncture, we can't
20 see a narrative that actually speaks to the fact that the
21 numbers bear out, that you cannot form any conclusions at
22 this time. So I think that should be our narrative because

1 I would hate for someone to say, "Oh, it was weakly
2 positive," and to glean something as a complement versus a
3 substitute based on what we see.

4 I was just thinking -- and, Mark, you helped to
5 frame it -- that it was a legislative mandate, but I was
6 thinking that maybe in someone's mind, it might have been a
7 thought process that someone thought that with intense
8 clinical services that at some point in the future, it
9 would cause a reduction in the cost of A and B or D, and
10 since that it was an early intervention or access was
11 improved so much so that the other services were decreased
12 because of the type of access that was achieved. Maybe
13 that was the thought that went into it. I'm not sure.

14 DR. MILLER: Yeah. It is possible.

15 DR. CROSSON: Yeah.

16 DR. MILLER: You were going to say --

17 DR. CROSSON: No, I was just going to say I
18 agree. I mean, one could infer -- we are only doing
19 inferences here, but one could infer, I think reasonably,
20 that if we see over the next four years, in this case,
21 greater use of alternative payment mechanisms, particularly
22 those that create incentives for the management of A and B

1 costs, maybe D -- that's not on the table right now -- that
2 that could change the situation, and we could see the kind
3 of relationship or tradeoff between physician services and
4 what we would call downstream costs.

5 I agree with you. What we see right now is
6 little to none. So I think it's perfectly reasonable to
7 come back in four years, maybe four. Who knows if four
8 years is the right amount of time? But that's what the law
9 says, so come back in four years and take another look, and
10 see if there's anything changed.

11 DR. MILLER: And I also want to make sure I just
12 put the marker down. I agree with you, Alice, and I think
13 your first comment was you want a very plain-language
14 statement at the front end of this report and the executive
15 summary, and we'll definitely craft that, because I think
16 your point is well taken. Most people consuming that are
17 not going to have all the methods, background. That's well
18 taken.

19 DR. REDBERG: I would just say we don't usually
20 put pictures, but I think a picture is worth a thousand
21 words because it's -- clearly, there is no correlation, and
22 I think you fulfilled the mandate very clearly. And we can

1 move on.

2 DR. CROSSON: I saw Jack, then Jon, then Bill.

3 DR. HOADLEY: I mean, I think building on Alice's
4 comments, another part, maybe what to emphasize -- and I
5 think it was somewhere in the mailing materials -- is
6 correlation isn't causation. And I'm thinking about the
7 sort of clinician services versus Part D services, and I
8 can think of forces going in both directions, which could,
9 of course, lead to a zero correlation among other things,
10 if you have enough things going both ways. So you can
11 think about better adherence to Part D drives, reducing
12 illness. That means people aren't taking other services.
13 You could say the fact that people are on medications,
14 they're going to the doctor more often to manage those
15 services and get their refills and so forth. You can think
16 of a bunch of things going in either direction that could
17 either lead to what we see, or if the results were
18 different, it would say it's not necessarily that the
19 causation is in one particular direction or the other.

20 The only other thing I would mention, sort of
21 following on Kathy's note, if we do decide to look back at
22 geographic variation, certainly geographic variation and

1 drug user would be an interesting part of that. I can't
2 remember if we've done any of that to date, but there are
3 certainly some -- you see evidence in the data, certainly
4 see evidence in premiums that there's a lot of geographic
5 variation.

6 DR. MILLER: Yeah. My recollection of the
7 geographic -- well, the last geographic report, it was kind
8 of like you organized it here. We went through A/B, and
9 then we had a D section, right? So yes.

10 DR. HOADLEY: Yeah.

11 DR. CROSSON: Jon.

12 DR. CHRISTIANSON: Yeah. Just following up on
13 what Jack said, you had a very highly statistically
14 significant coefficient in the negative relationship
15 between drug use and services, very low R-square. So, if
16 you were going to devote any more effort in this report,
17 that would seem to be someplace you might pay some
18 attention, try to understand what's going on, particularly
19 given the general public policy discussion and the fact
20 that it's a negative coefficient. Understanding what Jack
21 said with the various different things that could be going
22 on, it is consistent with an explanation that drugs reduce

1 -- if you were to imply causation, which we understand you
2 shouldn't do, but it's consistent with the causation
3 explanation that drugs reduce use of clinical services. So
4 that's an area where you've actually got a significant
5 findings. If you want to spend more time trying to
6 understand it, that's probably where I would look, not so
7 much on the other analyses.

8 DR. MILLER: What we could do in short order --
9 and I can't remember where your term and when this report
10 was done, but there was a point where Shinobu and Rachel
11 and some other outside folks did some work looking at the
12 relationship between D and its effect on A/B, but at much
13 more. And I think somebody over here said it: "Let's look
14 at this condition and see what the relationship is." And
15 we found that -- and I'm really dredging memory here,
16 Shinobu -- that it was very different from condition to
17 condition, and the duration of the effect faded 6 to 12
18 months out.

19 So what I could so immediately for this report is
20 kind of bring that back in and say, "If you really want to
21 understand this, you really kind of got to get down in the
22 weeds, and the one time we did it, this is what we found."

1 If that's good with you, we'll import that into the report.

2 DR. CROSSON: Bill Hall.

3 DR. HALL: In academic circles, there's sometimes
4 horror when you find that you have negative results,
5 particularly when you've been doing something that you
6 don't really understand why you're doing it, and our
7 tendency is to be somewhat apologetic or softened. I
8 suppose that's the reason we use statistical techniques is
9 to get over that sort of inherent bias.

10 Just in general, when we write our reports and we
11 get negative results, we sometimes sort of soften the blow
12 by saying slightly, a slight tendency, or possibly -- if
13 we're going to use statistics, let's call it what it is.
14 There's no correlation.

15 I think in everybody in circles where we use
16 statistics, we know that, but then we get out to the
17 public. I think we have to be not quite so equivocal. We
18 did the report. It was done properly. There does not seem
19 to be any sort of positive correlation here, period. And
20 that may help us get through all of that.

21 DR. CROSSON: Okay. Thank you very much. Good
22 discussion. Excellent, clear report, meeting the

1 requirements of the mandate, and we'll be interested in
2 seeing what happens four years from now. Thank you so
3 much.

4 [Pause.]

5 MR. WINTER: Are you ready, Jay?

6 DR. CROSSON: Okay. We're going to return to the
7 topic of physician payment, physician and other
8 professionals, and Ariel Winter and Kevin Hayes are going
9 to begin for us a discussion which I think will take us
10 through the majority of this term, and we're going to focus
11 this morning on the issue of misvalued clinician services.
12 Go ahead. Who's going to begin?

13 MR. WINTER: I am. Thank you. Good morning.

14 Today, we will be talking about how Medicare pays
15 for clinician services and concerns with how those services
16 are priced. And before we begin, I want to thank Amy
17 Phillips for her help with this presentation.

18 So we'll start with the context for this session
19 and background on the fee schedule for clinician services.
20 We will talk about prior Commission recommendations to
21 correct misvalued services in the fee schedule. Then
22 we'll describe what's happened since the Commission made

1 those recommendations and any remaining issues. And we'll
2 conclude by outlining potential steps for further work in
3 this area.

4 In 2015, the Medicare Access and CHIP
5 Reauthorization Act, or MACRA, repealed the sustainable
6 growth rate. It established two new paths for clinicians
7 to receive payment updates: a path for clinicians who
8 participate in advanced alternative payment models, APMs;
9 and a path for all other clinicians, whose updates will be
10 determined by a revised performance assessment system.

11 Because MACRA made significant changes with broad
12 implications for clinicians, it has received a lot of
13 attention. But it's still important to ensure the accuracy
14 of the fee schedule, for two reasons:

15 First, it is still the basic mechanism by which
16 Medicare pays for clinician services, including under APM
17 models.

18 Second, it has the potential to affect the
19 delivery system. For example, payment differences can lead
20 to an oversupply of certain specialties and an undersupply
21 of others, such as primary care.

22 In 2014, Medicare spent over \$69 billion for

1 physician and other health professional services through
2 the fee schedule.

3 Medicare's fee schedule lists payment rates for
4 7,000 CPT codes. The payment rates are based on the
5 relative value units, RVUs, for clinician work, practice
6 costs -- which includes office rent and equipment -- and
7 professional liability insurance.

8 Clinician work account for 51 percent of fee
9 schedule spending, practice expenses account for 45
10 percent, and professional liability insurance accounts for
11 the remaining 4 percent. And I want to make a couple of
12 notes about the terminology we'll be using at this point.

13 In this presentation, when we talk about the
14 "value" of a service, what we mean is the time, effort, and
15 resources involved in providing the service.

16 In other contexts, the word "value" can refer to
17 the value of a service to a patient or purchaser or its
18 clinical value. But that's not what we mean here.

19 Another terms that we use is "misvalued," which
20 is a term from the Medicare statute, the section of the
21 statute that requires the Secretary to identify and adjust
22 misvalued codes. And in this presentation we also use the

1 term "mispriced," and "mispriced" and "misvalued" are
2 synonymous.

3 So we have raised several concerns with the fee
4 schedule, which Kevin will be discussing in more detail.

5 First, many services in the fee schedule --
6 particularly procedures and tests -- are mispriced. And as
7 a consequence, primary care is undervalued relative to
8 services delivered by specialists. The process for pricing
9 clinician services does not focus sufficiently on
10 overvalued services, and the data that are available to
11 value services are inadequate.

12 Second, paying separately for 7,000 CPT codes
13 creates opportunities for physicians to upcode by billing
14 for a more complex rather than a less complex service. It
15 is also more difficult for CMS to maintain accurate payment
16 rates for 7,000 unique services.

17 And, third, the orientation of the fee schedule
18 towards discrete services leads to fragmented care.

19 This slide shows the wide income disparities
20 between primary care and certain specialties. Average
21 annual compensation for primary care, which is the second
22 bar from the left, was about \$250,000 in 2014. By

1 contrast, compensation for radiology and nonsurgical
2 procedural specialties, which are the last two bars on the
3 right, was more than twice as high at over \$500,000.

4 Now I'll turn things over to Kevin, who will
5 discuss issues related to mispriced services.

6 DR. HAYES: Our first issue concerns primary
7 care. The Commission's position is that, in the fee
8 schedule, primary care is undervalued.

9 Primary care is labor intensive, which limits the
10 potential for efficiency gains and volume growth. By
11 contrast, for other services, efficiency gains are more
12 likely with advances in technique, technology, and other
13 factors.

14 For those services with efficiency gains, RVUs
15 should go down, and under the statute's budget neutrality
16 provision, RVUs should go up for other services, including
17 primary care. Such a redistribution of RVUs does not
18 occur, however, if the process for valuing services does
19 not adequately account for efficiency gains.

20 One further potential source of misvaluation:
21 Some specialties can increase their volume of services more
22 readily than can primary care clinicians.

1 In response to these concerns, the Commission
2 made several recommendations: one, a payment adjustment
3 for primary care services billable under the fee schedule;
4 two, repeal of the sustainable growth rate and in its place
5 specified updates that favor primary care; three, a per
6 beneficiary payment for primary care which would replace
7 the then-expiring primary care incentive payment program
8 that I'll describe in a moment. The years in which the
9 Commission made these recommendations are shown in
10 parentheses.

11 Since the Commission made its recommendations,
12 there have been several developments. The Patient
13 Protection and Affordable Care Act had provision for a
14 primary care incentive payment program. The program
15 included a 10 percent bonus payment for selected services
16 billable under the fee schedule -- these were mostly office
17 visits -- when the services were furnished by clinicians
18 eligible for the bonus. The program started in 2011, but
19 it was not replaced when it expired at the end of 2015.

20 Separately, under its administrative authority,
21 CMS has established in the fee schedule new billing codes
22 for primary care. Two of the codes are for transitional

1 care management of patients recently discharged from a
2 hospital or certain other facilities. A third code, a
3 chronic care management code, is for the non-face-to-face
4 management of patients with two or more chronic conditions.

5 Outside of the fee schedule, the CMS Innovation
6 Center is testing a number of models aimed toward improving
7 primary care. But from the standpoint of Commission
8 recommendations, there is a remaining issue here. There
9 has been no action yet to establish a per beneficiary
10 payment for primary care.

11 The second issue the Commission has considered is
12 one of process. Is the process for maintaining the fee
13 schedule's RVUs sufficiently focused on services that have
14 become overvalued? As we noted in connection with the
15 undervaluation of primary care, services can become
16 overvalued if there are improvements in efficiency that
17 arise from, say, technological advances. Services can also
18 become overvalued if there are changes in clinical
19 practice.

20 The Commission's concern has been that the
21 process for review of the fee schedule's RVUs relied
22 heavily on advice from an entity known as the American

1 Medical Association Specialty Society Relative Value Scale
2 Update Commitment, or RUC. The specialty societies
3 represented on the RUC have a financial stake in the
4 outcomes of the review process.

5 Adding to this concern, the sheer size of the fee
6 schedule, as Ariel mentioned -- that is, the large number
7 of billing codes -- makes it difficult to maintain.

8 To improve the valuation process, the Commission
9 recommended:

10 First, that the Secretary establish a standing
11 panel of experts to review recommendations from the RUC and
12 otherwise assist CMS in identifying overvalued services.

13 Second, in consultation with this expert panel,
14 the Secretary should review services that meet certain
15 criteria, indicating that they may be overvalued. The
16 criteria included such things as services with substantial
17 changes in volume, services where the site of service is
18 changed, and so on.

19 Third, the Congress should direct the Secretary
20 to expand the multiple procedure payment reduction policy.

21 Fourth, the Congress should establish an annual
22 numeric goal, or target, for identifying overvalued

1 services, a target that the Secretary would meet annually.

2 Since the Commission made its initial
3 recommendations on misvalued services, a number of services
4 have been reviewed.

5 Counts of these services depend on the source and
6 the starting point for the reviews. Between them, CMS and
7 the RUC report a range, from about 1,700 to 1,800 services
8 as of 2016. The results are a mix: some increases in
9 relative values, some decreases, and some codes that stayed
10 the same.

11 In addition, CMS has contracts in place for
12 technical assistance on statistical models to validate the
13 fee schedule's relative values. The RUC, for its part, has
14 advised CMS on the relative values for services reviewed
15 and has made procedural and other changes.

16 Specific to the Commission's recommendation on
17 the multiple procedure payment reduction, CMS has
18 implemented a reduction in the professional component of
19 imaging services when more than one service is provided by
20 the same practitioner during the same session. And the
21 Congress established a target for adjusting the relative
22 values of overvalued services.

1 With respect to the valuation process, there are
2 several remaining issues:

3 One, the Secretary has not established a standing
4 panel of experts to help identify overvalued services.

5 Two, the multiple procedure payment reduction
6 could be expanded to all imaging services and to additional
7 types of diagnostic tests.

8 Three, stakeholders have expressed concerns about
9 the RUC's composition. The Commission considered this
10 issue in its March 2006 report but has not revisited the
11 topic recently.

12 And, four, the misvalued services target expires
13 at the end of 2018.

14 The third topic we wanted to review with you
15 today concerns the data available to maintain the fee
16 schedule. The Patient Protection and Affordable Care Act
17 requires that the Secretary validate the fee schedule's
18 RVUs. The issue for the Commission has been that the
19 Secretary lacks current, objective data necessary to
20 fulfill this requirement.

21 For example, the RVUs for the work of clinicians
22 are largely of function of assumptions that have been made

1 for each service in the fee schedule, assumptions about how
2 long it takes for a clinician to furnish the service.
3 Those time assumptions in turn are derived from specialty
4 society surveys.

5 Another example: The data available for the
6 practice expense RVUs have been a problem. Specifically,
7 the prices for equipment and supplies are often out-of-
8 date.

9 The Commission has also expressed concerns about
10 the methods by which the data for the fee schedule are
11 collected. If collected service by service, data
12 collection can be costly, burdensome, and biased.

13 Overall, there's no ongoing data collection
14 activity to maintain the fee schedule. Instead, there's a
15 reliance on ad hoc surveys that end up having low response
16 rates.

17 In making a recommendation on data collection and
18 validation of RVUs, the Commission's intent was that the
19 data should be collected more accurately and simply than
20 has been the case so far and that ad hoc surveys should be
21 avoided.

22 The recommendation has three parts:

1 One, the Secretary should regularly collect data
2 -- including service volume and work time -- to establish
3 more accurate work and practice expense RVUs.

4 Two, the data should be collected from a cohort
5 of selected practices rather than a sample of all
6 practices.

7 Three, if necessary, practices should be paid to
8 participate in data collection.

9 As to what's happened in collecting data on
10 misvalued services, the CMS contracts mentioned earlier
11 both have elements of data collection. A contract with the
12 Urban Institute will include development of time estimates
13 for selected services and associated data collection
14 activities.

15 A contract with the RAND Corporation will include
16 work on claims-based reporting of post-operative care
17 furnished as part of global surgical services. These
18 contracts notwithstanding, the remaining issue here is that
19 there is no data collection activity under way of the type
20 the Commission recommended.

21 The Commission, for its part, has worked with a
22 contractor -- the University of Minnesota -- to develop an

1 alternative method CMS could use to validate the fee
2 schedule's RVUs.

3 The Commission's method has, as its starting
4 point, the clinician as the unit of analysis. Data would
5 be collected on: one, each clinician's service mix -- that
6 is, the number of services billed to all payers by billing
7 code; and, two, each clinician's total time worked. These
8 data would permit a comparison of actual hours worked and
9 hours worked as estimated in the fee schedule.

10 The contractor's feasibility study showed how
11 such data could be used to identify types of services that
12 may be overvalued. For example, in one of the cardiology
13 practices participating in the study, time assumed in the
14 fee schedule for services provided exceeded actual hours
15 worked by an average of 60 percent.

16 The physicians with the greatest difference
17 between hours assumed in the fee schedule and hours worked
18 tended to furnish more imaging services than their
19 colleagues.

20 Such a finding, if replicated with more data like
21 this, would suggest that the imaging services furnished are
22 candidates for further review.

1 That's all we have on the Commission's
2 recommendations and where things stand with each of them.
3 Ariel will now go over some ideas for possible next steps.

4 MR. WINTER: Okay. So, first, we could revisit
5 our prior recommendations that have not yet been
6 implemented. These could include: establishing an expert
7 panel to help CMS identify overvalued services and to
8 review recommendations from the RUC; expanding the multiple
9 procedure payment reduction; and/or collecting data from a
10 cohort of selected practices to validate payment rates and
11 set more accurate rates.

12 Alternatively, we could explore new directions.
13 In the area of primary care, we could think about going
14 beyond our recommendation to establish a monthly per
15 beneficiary payment for primary care providers.

16 At our meeting last November, we discussed a
17 payment model for primary care that would blend fee-for-
18 service and capitation. We identified several issues with
19 this partial capitation approach, such as the size of the
20 capitated amount, whether risk adjustment would be
21 necessary, how to attribute beneficiaries to a
22 practitioner, and whether there should be practice

1 requirements. We could return to this topic if you are
2 interested in doing so.

3 We could also work on the idea of combining CPT
4 codes into families of codes. For example, we could
5 examine options for grouping codes into categories, and we
6 could also explore options for how to price families of
7 codes.

8 So for your discussion, please let us know if you
9 have any questions or would like us to clarify anything we
10 have said. And we'd like to get your thoughts on potential
11 next steps in this area.

12 Thank you.

13 DR. CROSSON: Thank you, Kevin and Ariel.

14 We're going to ask for clarifying questions. I
15 will point out that what's obvious, I guess, to everybody
16 is that we really have multiple issues on the table here at
17 one time. They all relate to physician payment, of course,
18 and also that this is this year's first entrée into this
19 larger topic. Specifically, you know, the presentation has
20 described the problem of the primary care services being
21 undervalued relative to procedural services. We've talked
22 about that before. We've made recommendations. Our

1 current recommendation has not been picked up.

2 There is still the ongoing concern that there is
3 not a robust process to revalue misvalued services, and so
4 we have a number of suggestions -- had suggestions in the
5 past. The question is: Do we want to reiterate our
6 previous ideas or are there other ideas? And then related
7 to that is the question of if there's going to be a process
8 for revaluation, is it going to be an interrupted one
9 periodically because these changes in technology or
10 technique or efficiency are not static, they change over
11 time and, therefore, the ideal is to have some process
12 which is, in fact, ongoing and not simply periodic.

13 So this is not all we're going to be doing in
14 this term through next April on physician and other
15 professional services payment, but it's a core piece. It's
16 one that we've worked on before. So we're going to be
17 looking from the Commission for emphasis, where people see
18 the priorities here, as well as other ideas that we've not
19 thought of before, and try to help inform, you know, not
20 just Ariel and Kevin but Mark and the rest of his staff.
21 So I'd like to start off because I have a couple of
22 clarifying questions myself.

1 When the RUC/CMS both have gone about the process
2 of revaluing codes in the last number of years, what
3 technique has been employed? Because we have talked about
4 the fact that there's a paucity of data, certainly with
5 respect to the time element, perhaps other parts of the fee
6 schedule. How robust -- is there anything we can learn
7 from the process that has been employed to date.

8 DR. HAYES: The process to date, I think we could
9 identify two elements of it. One would be how the services
10 reviewed were identified, and secondly, then how the
11 services were reviewed, what process under which they were
12 reviewed.

13 As to the first point, how to identify services,
14 the procedure involved was largely consistent with what the
15 Commission had recommended. I gave a real brief summary of
16 it in one of the slides, but it had to do with identifying
17 services where there had been rapid growth and volume,
18 where there's some evidence that there had been shifts in
19 site of care, suggesting maybe that the amount of work
20 involved in furnishing the service had changed because now
21 the service was provided, say, in an outpatient setting
22 where previously it had been an inpatient, that kind of

1 thing.

2 Another commonly used criterion was services that
3 are often furnished together. The thought was that, well,
4 if we see that services were valued independently, but it
5 turned out that the services were often furnished in
6 combination with each other, then we could expect to see
7 some sort of efficiencies derived because of that. And so
8 there was an examination of claims data to identify
9 services that were, as it turned out, commonly furnished
10 together.

11 So it was that kind of thing was used to sort of
12 identify services that might be misvalued. That then
13 triggered -- once a service was sort of kind of -- hit one
14 of those screening criteria and got on a radar screen for
15 purposes of review, then that triggered the review process
16 that pretty much was already in place for review of
17 services, and so it was a process of CMS in some cases
18 asking the RUC to review a service, or the RUC itself
19 applying the criteria and deciding that a service needed to
20 be reviewed. And then we had the process of specialty
21 societies surveying physicians and asking them about the
22 work and time involved and a review by the RUC and so

1 forth.

2 DR. CROSSON: Thank you. That sort of was what I
3 was trying to get at. There was no fact-based, data-based
4 scientific analysis that occurred during that reevaluation.
5 It was simply a reiteration of the process that's been used
6 in the past.

7 DR. HAYES: Right.

8 DR. CROSSON: And I'm sorry. I have one other
9 question. The payments that were created for transitional
10 care management and chronic care management, as you noted,
11 have not been taken up, to a large degree, and I think the
12 hope had been that that would go -- that those together
13 would go partway to solving the issue of the disparity of
14 payment between primary care and specialty care. Could you
15 just briefly review for us the status of that and why it
16 has not achieved the goal that Congress intended.

17 MR. WINTER: Right. So I can speak more to the
18 CCM codes than the TCM codes because that's where we've
19 done some analysis.

20 We have looked at -- or Zach actually had looked
21 at preliminary claims data from 2015, so about 90 percent
22 of claims from 2015, and found, as we expected, that take-

1 up has been low. Only about 270,000 unique beneficiaries
2 received a CCM service in that year. There were a total of
3 840,000 CCM services, and generally, typically a
4 beneficiary would get a CCM service for about three months,
5 and then on a monthly basis, you sort of saw it pretty low
6 take-up at the beginning of the year and then reaching
7 about 90,000 claims per month by August 2015 through the
8 end of the year.

9 And take-up could be -- we've heard various
10 things about why take-up might be low. One thing we've
11 heard is that there are a lot of practice requirements that
12 a clinician has to meet in order to bill for the service;
13 for example, 24/7 access to care management services,
14 having access to the care plan in electronic format,
15 documenting 20 minutes of staff time per month. So that's
16 been one concern of a possible reason for why there's been
17 low take-up.

18 We've heard concerns that the payment rate is too
19 low. It's hard for us to evaluate that. The current rate
20 for this code in 2016 is \$41, and in response to these
21 concerns, CMS has proposed for next year to loosen some of
22 the requirements for this code in the area, for example, of

1 beneficiary consent and electronic sharing of the care
2 plan.

3 They're also proposed two new CCM codes. Right
4 now, there's only one. That covers 20 minutes of staff
5 time per month. The two new codes would cover -- would be
6 a higher rate for high-complexity patients, high-complexity
7 decision-making. It would also be a code for an additional
8 30 minutes per month, and we have in our response -- in our
9 comment letter in response to these proposals, we've said
10 we generally support improving payment for coordinated
11 care, but we do have concerns about program integrity. And
12 we've referenced the fact that in some cases, CMS has made
13 duplicate CCM payments to the same beneficiary in the same
14 month. In other words, multiple providers are billing for
15 the same beneficiary and the same month, which is against
16 the rules, but we're seeing this in the claims data. So we
17 do have these concerns.

18 Another concern that we've raised is that any
19 provider can build for a CCM code. It's not limited to
20 primary care practitioners, and that's a statutory
21 requirement. And we understand that CMS is bound by that.
22 Our recommendation has been to have a dedicated payment for

1 primary care practitioners, and I don't have data at this
2 point on what extent it's being billed by PCP versus other
3 specialties, but that's something we can look at further if
4 you're interested.

5 DR. CROSSON: Thank you. More than a complete
6 answer. I appreciate it.

7 Okay. Clarifying questions? David, Bill. Okay.
8 David, Bill, Kathy, and Jack.

9 DR. NERENZ: Thanks. This was great.

10 I was actually, before you started, prepared to
11 ask you a clarifying question of the definition of value,
12 but you did such a nice job in stating it, I don't have to.

13 But now a fine-point question about that, on
14 Slide 4, the clinician work component, the 2011 report that
15 we were given to read actually has a very nice expression
16 of this. It's a combination of time and intensity, with
17 time being the dominant factor.

18 The question about intensity, is that concept
19 applied sort of within families of services so that the
20 RVUs, say, for different types of surgery are given
21 relative judgments for intensity, or is intensity applied
22 to cross-types? So it says like a surgery is more

1 intensive than E&M or vice versa. How does intensity work?

2 DR. HAYES: The intensity is handled -- I guess
3 we could say in two ways. It has two parts of it. One is
4 physicians are asked about the stress they experience when
5 furnishing a test, the risk to the patient of a bad
6 outcome, how much skill is required, that kind of thing.

7 And then the second part of it is that physicians
8 are asked to compare the given service to a similar
9 service, and the similar service, whether it's with -- I
10 mean, the family is kind of not quite the right way I would
11 characterize it, but there is a benchmark kind of service
12 that's used for comparison purposes. It has some
13 similarities to the service under discussion.

14 DR. NERENZ: So at least in principle, the
15 concept of intensity applies the same metric basically
16 across the entire range of physician services. Is that a
17 fair statement?

18 DR. MILLER: I heard the opposite. I thought I
19 heard the opposite. It's not the same reference service in
20 each instance.

21 DR. NERENZ: Okay, fine. That's the point I
22 wanted to clarify. All right. That's fine.

1 I'm not sure it's fine, but it's fine to go
2 forward in discussion.

3 DR. MILLER: You understand the words.

4 DR. NERENZ: Yes, I understand the words.

5 DR. MILLER: That's all you're agreeing to.

6 DR. CROSSON: It's the difference between right
7 and correct.

8 Bill Gradison.

9 MR. GRADISON: You have mentioned in your
10 presentation that 17- or 1800 services had been reviewed
11 through about now. On balance, what was the net effect of
12 that on payment to primary care? Did it tend to shift any
13 money or take money away from primary care?

14 DR. HAYES: If we look at these numbers, at, say,
15 the 1700 services, there was a redistribution of dollars
16 within the fee schedule --

17 MR. GRADISON: Yes.

18 DR. HAYES: -- toward services other than these.
19 The services that were reviewed did not include primary
20 care. So it's fair to say, I think, in response to your
21 question that there was a shift of -- I can't -- I wish I
22 could give you a number, but the net effect was positive.

1 MR. WINTER: And we know for at least 2016, for
2 the current year, they did redistribute about 0.3 percent
3 of the fee schedule dollars based on the target they were
4 required to meet for 2016. And they proposed for 2017 to
5 be distributed about 1 percent of fee schedule spending to
6 other services, and that would be towards not only primary
7 care, but everything else in the fee schedule that was not
8 being reduced under the review for 2017.

9 MR. GRADISON: Even small, it was for primary
10 care, included primary care.

11 MR. WINTER: Primary care would be one of the
12 services receiving --

13 MR. GRADISON: Receiving it.

14 MR. WINTER: -- receiving redistributed dollars.

15 MR. GRADISON: I'm interested in whether there's
16 any way to approach this issue from market payments rather
17 than in this indirect way, and in particular, is the
18 payment level, if we knew what it was, for these very same
19 services under MA at all relevant if we could get the data?
20 That's 30 percent of the payments on average, I would
21 suppose.

22 DR. GINSBURG: Actually, I could offer something,

1 Bill.

2 MR. GRADISON: Thank you.

3 DR. GINSBURG: Fairly quickly, after the Medicare
4 Free Schedule was enacted, it was striking, the degree to
5 which private insurers adopted it and, in a sense, using
6 the same relative value scale and then developing their own
7 conversion factor based on the markets. And so I have done
8 some interviewing of insurers about why they haven't tried
9 to innovate in this area, and they did not claim to have
10 innovated. They just talked about the problems of not
11 having Medicare's credibility or clout to be able to do
12 this.

13 So my guess would be in Medicare Advantage, you
14 would see the same structure of fees. In fact, actually
15 the conversion factor in Medicare Advantage, based on some
16 research I'm doing now, is very close to -- I think it's
17 slightly below the conversion factor in fee-for-service.

18 So this is an area where I don't think we could
19 look to the private sector for innovation.

20 MR. GRADISON: Because they have been looking to
21 Medicare.

22 DR. GINSBURG: That's right.

1 MR. WINTER: There are also cases where Medicare
2 rates diverge -- fee-for-service rates diverge from
3 commercial rates perhaps due to market power, where there
4 are large practice groups that can demand higher rates than
5 they can under Medicare of commercial payers.

6 DR. MILLER: I just wanted -- and I think most
7 everybody understands this, but just in case the complete
8 audience -- so, when you were using the term "does it
9 reallocate money to primary care," in the fee schedule,
10 there's no primary care per se. Most people's minds tend
11 to go in E&M. Remember E&M. Lots of specialists do E&M
12 too. So it's in the wash, and I think you got that answer.
13 But I want to make sure people understand there's no target
14 primary care.

15 DR. CROSSON: Kathy.

16 MS. BUTO: So just to comment on the last
17 question from Bill, a long time ago when the fee schedule
18 first started, Pennsylvania physicians either sued the
19 agency -- I can't remember now exactly how it came amount,
20 but it turned out the market rates for physician services
21 ended up driving payment in Pennsylvania. And I don't
22 remember. There was a clause in the original statute that

1 went to some kind of differential like that. So, at least
2 in that one case, they had an impact on what Medicare paid
3 in Pennsylvania. I think it meant Medicare ended up paying
4 more than it otherwise would have. I don't know if that's
5 still in effect.

6 My question really is about Slide 7 and I think 2
7 in the mailing materials, where we talk about some
8 specialties can increase the volume of services more
9 readily than primary care clinicians. So I'm wondering.
10 Do we actually know the volume increases by primary care
11 surgery and nonsurgical procedures, so what the volume
12 increases have been? And, in particular, do you have in
13 mind certain specialties? Are these the proceduralists,
14 like dermatology? What did you have in mind here? I think
15 it's helpful to know exactly which specialties you think
16 are actually able to do that kind of volume increase.

17 DR. HAYES: Right. Right. I can give you kind
18 of an orders-of-magnitude question on the growth rates, not
19 precise numbers, but if we look at broad categories of
20 services, let's say, much like the ones that we look at for
21 purposes of the physician update chapter that you'll see in
22 December, we have broad categories that would include

1 evaluation in management services, major surgical
2 procedures, imaging, tests, and procedures other than major
3 procedures -- colonoscopies and that kind of thing.

4 And so there when we look at -- and we've been
5 doing this for some time, and so this would go back to,
6 say, the year 2000 or so. We would see cumulative growth
7 rates for some services much higher than for others, and
8 so, for example, at the top of the scale would be tests,
9 EKGs and nerve conduction studies and all that --

10 MS. BUTO: Imaging, that kind of thing. Right.

11 DR. HAYES: -- and imaging and the other
12 procedures, the less invasive, less intensive procedures.
13 And then at the bottom of the scale, we have much lower
14 growth rates for major surgical procedures and for
15 evaluation and management.

16 The differences are big. I mean, we've got
17 cumulative growth rates for the first three categories of
18 services that are two times-plus what they are for the
19 major procedures in E&M.

20 MS. BUTO: Yeah. Okay. I think that would be --

21 DR. HAYES: It gives you an idea.

22 MS. BUTO: That would be really helpful as a

1 table or an example --

2 DR. HAYES: Sure, sure, sure.

3 MS. BUTO: -- in either the appendix or some part
4 of the document.

5 And just kind of a somewhat related question is I
6 also think it's helpful for the context for us to see kind
7 of the absolute dollar share of the 70 billion for each of
8 these categories, E&M, surgery, and procedural non-surgery,
9 and then the growth rates related to those, because as we
10 talk about primary care is undervalued and it's not -- you
11 know, we're concerned about participation and so on and so
12 forth. That provides us a context of what's happening.

13 DR. HAYES: And let me reiterate what Mark said
14 about the differential, the difference between primary care
15 as a subset of evaluation and management services. There
16 is a difference there too to keep in mind.

17 MS. BUTO: Right. And, Kevin, I don't know if we
18 can do it, but I think my recollection is it's about half
19 of E&M are provided by non-primary care physicians. So, I
20 mean, I think it's helpful to break that out too.

21 DR. CROSSON: Jack.

22 DR. HOADLEY: So I have two questions. One was

1 mostly asked by Jay about a the new billing codes, but I
2 did wonder -- and it sounds like maybe you haven't done
3 this analysis -- on the transitional care management that's
4 been around a couple more years, is there any sense of a
5 learning curve that people, clinicians learn that it's
6 there first and sort of when it's appropriate to use it,
7 and there might be some increase in its use? My hunch is
8 that's not the case, but it seems like that's at least an
9 interesting question.

10 MR. WINTER: Yeah. We can look into that and do
11 some work on that.

12 DR. HOADLEY: Okay. And then on Slide 13, you
13 talked about the target expiring. Is that something that's
14 designated by CMS? Is that in statute?

15 DR. HAYES: It's in statute.

16 DR. HOADLEY: It's in statute.

17 DR. HAYES: The Protecting Access to Medicare Act
18 of 2014 had the original provision, and then it was
19 subsequently amended, but it was for a three-year span.

20 DR. HOADLEY: It's not something that CMS could
21 simply expand --

22 DR. HAYES: No, no.

1 DR. HOADLEY: -- but, presumably, they could do
2 something like it.

3 DR. CROSSON: Rita.

4 DR. REDBERG: So in thinking about the misvalued
5 services and certainly trying to increase primary care,
6 there is still a huge disparity between primary care and
7 procedures. I'm wondering if we could have -- thinking
8 about a reference pricing. You mentioned colonoscopy.
9 Well, when we do colorectal cancer screening, you could
10 either do fecal occult blood testing, which has been shown
11 in randomized clinical trials to reduce colorectal cancer
12 mortality, or you could offer a colonoscopy. The doctor
13 will get a lot more money for the colonoscopy, which has
14 not been shown in randomized control trials to reduce
15 mortality. And we know that most patients are never even
16 offered that choice, and they get colonoscopy. They don't
17 even know that you could have had -- there's a huge -- they
18 have a disparity, and it's not going to be addressed by --
19 colonoscopy is more intense than handing someone fecal
20 occult blood testing, but if you're looking at sort of
21 outcomes of what you're trying to accomplish, the
22 colorectal cancer screening, I think you would be choosing

1 fecal occult blood testing.

2 And now Medicare is paying for anesthesia, so
3 we're really the only country in the world that's offering
4 anesthesia, propofol, and increasing use with
5 anesthesiology. So it's become very expensive.

6 Or my specialty, when I see a patient in my
7 office with stable coronary disease, I can offer them
8 medical management, or I can do a cardiac cath and a stent.
9 I get paid a lot more by Medicare to do the stent, and
10 guess what? Most people never get offered that choice.
11 They get sent for a cath. Studies have been done 15 years
12 ago and 5 years ago, and they showed the same thing. Most
13 patients that are sent for a cath, they didn't know they
14 had a choice. They thought it was an emergency. They
15 think that having a stent is going to prevent a heart
16 attack and the medicine as well, which isn't true.

17 And so I think we have to address the sort of
18 fact that when two methods are equally effective for
19 treatment, when you have this big payment disparity, we are
20 unintentionally kind of driving a lot more procedure-
21 oriented care that's not necessarily -- that is not in our
22 beneficiary's interest. And just revaluing the codes is

1 not going to address that. You have to have, like I said,
2 reference pricing or kind of a diagnosis-based approach to
3 payment, like the DRGs, because it's a big issue. I think
4 we are spending a lot and not doing a lot in terms of value
5 or outcomes for our beneficiaries.

6 DR. CROSSON: Thank you, Rita. Clarifying --
7 okay.

8 DR. COOMBS: Is this Round 2?

9 DR. CROSSON: No. Round 1, still Round 1.

10 DR. REDBERG: That was a question.

11 DR. MILLER: But it was a clarifying one.

12 DR. CROSSON: It was a clarifying question, so
13 it's okay.

14 Let me just see again. I saw Pat, Warner, Bruce.
15 Okay, Pat.

16 MS. WANG: Can you reiterate what the benefits or
17 purpose of grouping CPT codes into families would be, and
18 can you say more about whether this is something that
19 MedPAC has sort of -- is anybody working on this? Has
20 anybody tested the feasibility of this? Could you just
21 talk about it a little bit more?

22 MR. WINTER: Yeah. So this is actually a new

1 issue that we're just raising with you for the first time,
2 although it might have come up in prior discussions.

3 So the concern here is that when you have 7,000
4 unique codes and in many cases they're similar, the
5 gradations of codes, there is an incentive to bill for the
6 higher-priced code. An example would be there are a series
7 of codes for excision of skin lesions that are based on the
8 size of the lesion. There is one payment for a lesion
9 that's less than 0.5 centimeters. Then there is one for
10 0.6 to 1.0 centimeters, 1.0 to 1.2. You can imagine that
11 there's an incentive to take out a little bit more so you
12 get a higher payment rate. So that's one concern.

13 Another concern is that you can bill separately
14 for multiple components of a single service. An example
15 would be a pathology test where there's multiple codes
16 involved, and you bill separately for each one. You get a
17 separate payment for each. You can imagine there's an
18 incentive to bill for more codes.

19 And then a third issue is that when you have
20 7,000 unique, distinct services and each one has three
21 components and each component has lots of moving parts,
22 it's very difficult for CMS to keep up with that and

1 maintain an accurate fee schedule.

2 So the idea we're throwing out there for your
3 reaction is, do you think it would make sense for us to
4 explore this idea of grouping these 7,000 codes into a more
5 manageable number of families, whether it's 100, 500, or
6 800, and pay on that basis, and aggregate clinically
7 similar codes into one group, so that there's one payment
8 rate for the services in that group, perhaps to package
9 ancillary services, which can currently be billed
10 separately in many cases?

11 A similar model to think about could be the
12 hospital outpatient system, which uses ambulatory payment
13 classification groups. And we're not saying that the
14 payment rate should be the same, but just think of that as
15 like a similar kind of typology that groups lots of codes
16 into a smaller number of payment categories.

17 And you asked if there's been work on this in the
18 past, and the thing that comes to mind is 3M did work
19 creating ambulatory payment groups, which became the
20 prototype for APCs, which are now used in the hospital
21 outpatient payment system. And they still, I think,
22 maintain APGs, so that's something we could think about.

1 We could think about looking at, if you're interested.

2 DR. GINSBURG: Ariel, if you went this way, you
3 still would have to get the family's relative value
4 correct.

5 MR. WINTER: Absolutely.

6 DR. GINSBURG: So there's still going to be a
7 need for a significant updating process.

8 MR. WINTER: Yes.

9 DR. CROSSON: I'll just summarize a little bit
10 what Ariel said. This is a concept yet to be worked out
11 for us, first of all. But, in theory, it contains a little
12 bit of reference pricing. It could contain a little bit of
13 bundling. And -- just one second, Paul. And it could also
14 provide for a much more efficient revaluation process than
15 the one that exists now, because as you may remember from
16 the text, it's taken I am not sure how many years to go
17 through a relatively small percentage of the codes when the
18 process is to do one service, one code at a time.

19 So, you know, Pat, you're right to identify this
20 as a new idea. It's a new idea. It's a raw idea. But
21 it's one that has potential value along those, you know,
22 three parameters at least.

1 I'm sorry. Paul, you want to comment?

2 DR. GINSBURG: Sorry for interrupting before.
3 Reference pricing is something else. Really, reference
4 pricing is a network strategy, which means that you're
5 going to tell your enrollees that if you go to certain
6 providers, you're going to have to pay more in the way of
7 cost sharing than if you go to others. I don't see that
8 happening in Medicare. I don't see there's a need for it
9 in Medicare because Medicare gets pretty low prices in the
10 aggregates for physician services. So I just wanted to
11 clarify that I don't think that reference pricing is going
12 to be part of this equation.

13 DR. CROSSON: Right. So I apologize if I used
14 the term improperly. I think we have sometimes used the
15 term a little more loosely than that definition to kind of
16 describe a situation in which there's, you know, a price
17 set for a range of services that could be delivered, and
18 that's set at some percentage or point along that range,
19 and then it provides for flexibility on the part of the
20 decisionmaker and potentially some financial risk one way
21 or the other. If "reference pricing" is not the correct
22 term, then I apologize.

1 MS. BUTO: I think it is the correct term, and,
2 Paul, I think the way I interpreted it, it was more like
3 Rita's example of fecal occult blood testing versus
4 colonoscopy grouped in the same code and then paid on some
5 sort of weighted average at a lower rate than colonoscopy
6 and a higher rate than fecal occult blood testing.

7 DR. REDBERG: Right.

8 MS. BUTO: And we won't go into our views on it,
9 but I think that is reference pricing, because you're
10 setting some kind of single rate.

11 DR. GINSBURG: Yeah, maybe it's a reference
12 service.

13 DR. CROSSON: And I have to say that would be an
14 extreme example, right? Because there you're taking, you
15 know, a significant procedure with all the attendant costs
16 to that and comparing it to, you know -- so but the --

17 DR. REDBERG: That is what I meant, that you
18 would be oriented towards -- the idea is colorectal cancer
19 screening, we're going to pay this much for colorectal
20 cancer screening, then you choose what you want to do.

21 DR. CROSSON: Correct. But, you know, without
22 going to an example that extreme, there could be, you know,

1 other situations. You don't think it's extreme, all right?

2 [Laughter.]

3 DR. GINSBURG: I actually think we might want to
4 come up with a number -- a different name for that, because
5 I think there's going to be a lot of confusion, because,
6 you know, Rita's journal has published a number of studies
7 about reference pricing in commercial insurance, and it's a
8 different animal.

9 DR. CROSSON: Okay. Well, we'll work on that,
10 and I'm thoroughly and appropriately chastened. Yes, Pat,
11 continue.

12 MS. WANG: Thank you for the reminder about APGs
13 and APCs. Conceptually, what is different about
14 approaching the 7,000 codes in the fee-for-service fee
15 schedule from the effort that went into creating the
16 hospital outpatient? Is it an apple and an orange? Or is
17 it to varieties of apples? How different is this concept?

18 MR. WINTER: So I think it depends on how you'd
19 want to pursue it, but it might help if I explain a little
20 bit more about how the APCs are created in the hospital
21 outpatient payment system. So they start with the CPT
22 codes, the 7,000 or so CPT codes, and actually more than

1 that because they include Part B, drugs, lab tests now, and
2 other things. And they grouped them into categories based
3 on clinical similarity and also cost similarity using
4 hospital outpatient cost data. And that's how they create
5 the 700 or so APCs. And you could think about a similar
6 method for creating groups of codes for the clinician fee
7 schedule, although we don't have the cost data, so that
8 would be -- at least the same kind of cost data we have for
9 the hospital outpatient department. So that would be a
10 challenge. But we could use that approach perhaps for
11 analyses, sensitivity testing, in terms of -- because it
12 does have clinical similarity within those categories, and
13 that might be something -- might be a typology to look at.

14 MS. WANG: Thank you [off microphone].

15 MR. THOMAS: On Slide 6, the income comparison,
16 have we looked at this over multiple years to see if
17 there's -- I mean, is the disparity similar? Is it
18 changing over multiple years?

19 DR. HAYES: We have been doing this kind of work
20 for some years now, and there has been -- you know, if we
21 were to contrast, say, primary care with the specialty
22 groups at the top end of the scale -- Ariel mentioned it.

1 You know, the difference is two times or more. We've seen
2 that kind of disparity all along. There's been maybe a
3 little bit of shrinkage, you know, a little bit of
4 narrowing of the disparity, but not a lot. But it's been,
5 you know, two times or more, is what we've been saying in
6 terms of characterizing the slide for a while now.

7 MR. THOMAS: And we say I think in the first
8 point, Issue 1, primary care is undervalued, so are you
9 looking at that from what is paid for the service, or are
10 you looking at that based on Slide 6, the total
11 compensation, or both?

12 DR. HAYES: It's a little bit of both, I suppose,
13 but I mean, the points that are made here on Slide 7 are
14 more at the level of the services as a rationale, as a
15 justification, as a point of view with respect to
16 undervaluation. And then you could think of that
17 undervaluation problem as contributing to the disparities
18 in compensation that we see on Slide 6. That's a way to
19 think about it.

20 DR. MILLER: And I would just build it out a
21 little bit further. In characterizing the positions that
22 the Commission has taken, you know, Kevin is sweeping

1 through many years of conversation, and I think
2 Commissioners have come to the table and sort of seen this
3 kind of thing, you know, just compensation, and why is one
4 service valued so much more.

5 I think also some Commissioners have said this is
6 driving people out of primary care when they look down the
7 road, remembering what Paul said that these relative values
8 also travel into the commercial insurance world. And so if
9 we -- and then a third thought, which is related -- I'm not
10 sure it's an entirely separate thought, but if you think
11 about -- and, again, this is Commissioners talking at
12 different points in time -- a reformed delivery system, you
13 know, you want more of the left, less of the right. I
14 think I got that right. And so I think that collection of
15 comments has kind of driven the Commission to say it's
16 under valued.

17 So I think you gave a very direct answer on the
18 compensation, but I think other things have -- and I know
19 you know this -- have arrived in the conversation.

20 MR. WINTER: And another issue the Commission has
21 raised is whether the fee schedule itself is a good
22 mechanism for paying for primary care services, which are

1 often non-face-to-face, not oriented around specific
2 encounters, and involve a lot of coordination between
3 visits. And so that's what drove the Commission to make
4 its recommendation for a per-beneficiary payment for
5 primary care services.

6 MR. THOMAS: So has there been thought given to -
7 - you know, once again this is -- I mean, I don't disagree
8 with any of the points but has there been thought given to
9 what would fair value be? and what is fair compensation,
10 as we think about this graph? So is it being at the
11 average of all? Is it being above the average of all?

12 Because we are kind of making the statement that
13 we have under value. And the question is so what would be
14 the right value? Has there been any thought about that?

15 DR. CROSSON: I think I am going to jump in here
16 because, as you properly observe, it's very difficult to
17 make any sort of judgment about how much a particular
18 physician specialty should be earning, either relative to
19 another specialty or absolutely.

20 I think one way I like to think about it is to
21 what extent is the misvaluation of the fee schedule
22 contributing to long-term problems for Medicare

1 beneficiaries? Because although we spend a lot of time
2 working on mechanics, and right now we're working on the
3 mechanics of the fee schedule, ultimately we also owe a
4 duty to the beneficiaries to look down the path towards the
5 future and ask, for example, is the physician and other
6 professional manpower pipeline appropriate to the needs of
7 people in the future?

8 In fact, if we see -- as Mark suggested -- that
9 there is something about the fee schedule which makes it
10 likely that that distribution of manpower in the future is
11 going to be inappropriate, then that's reason to consider
12 changing the fee schedule without necessarily trying to
13 make a judgment about how much one number should be versus
14 another.

15 At least that's one way of thinking about it.

16 MR. THOMAS: Yeah and I totally get that we
17 probably don't want to go down the road of what is the
18 compensation level for a primary care physician, what do we
19 want that to be. But I guess the point I'm trying to get
20 at is do we think it's a 5 percent issue or do we think
21 it's a 30 percent issue? Because that is a -- you would
22 take a very different approach to try to solve those two

1 different issues. So I think that's more of what I'm
2 trying to understand. And then you can think about how do
3 you solve for that?

4 So I'm just trying to understand has there been
5 any thought given to how material an issue it is? So I
6 would just lay that out as something we ought to think
7 about, understanding that we don't want to target
8 compensation.

9 And I guess if we think that primary care is
10 undervalued, so then we're kind of getting back to
11 overvalued. And just clarify for me a little bit more how
12 we're determining overvalued again. What is the judgment
13 or comparison that we're using, as we think about that?

14 DR. HAYES: The way that comparison, that
15 assessment, has been made to this point has been largely --
16 it has been entirely based on a code-by-code assessment of
17 the RVUs in the fee schedule for services. And what the
18 Commission has been saying, going back to the letter it
19 sent to the Congress in 2011 about the SGR, was that well
20 no, there needs to be a kind of a pullback and a look more
21 broadly at the valuation of services at the level of the
22 clinician of the practitioner and doing things -- I touched

1 on it briefly in here -- about comparing actual hours
2 worked -- hours worked is estimated in the fee schedule.
3 And then going about it in that way can then point toward
4 where you would want to look at services individually. But
5 the starting point is that kind of broader perspective.

6 And then -- you know, with 7,000 codes you've got
7 to figure out where your problems are. And so that's a
8 perspective on the matter that allows a focus on which
9 codes need to be reviewed.

10 Does that answer the question?

11 MR. THOMAS: Yeah, I get it. Because I'm just
12 going back to -- and I'm not trying to get into phase 2,
13 but I'm just trying to understand the -- to me, there's a
14 differential between the capability and work that goes into
15 a procedure versus what I kind of view as Rita's point is
16 really around the utilization and volume of the procedure.

17 So what you're really talking about is more
18 volume of the procedures versus the actual skill level that
19 goes into -- and the value we put on doing a procedure.

20 DR. REDBERG: I was thinking more of if there are
21 two equally effective ways to accomplish something.

22 MR. THOMAS: I understand.

1 DR. REDBERG: Do we want to look at it that way,
2 as opposed to....

3 MR. THOMAS: Anyway, that's helpful. Thank you.

4 DR. CROSSON: I've got Bruce and then Craig.

5 DR. SAMITT: Are we still on round 1? [Off
6 microphone.]

7 DR. CROSSON: We are still on round 1.

8 DR. SAMITT: I'll wait for round 2. [Off
9 microphone.]

10 DR. CROSSON: Jon, did you want to get in on
11 this?

12 DR. CHRISTIANSON: Bruce wants to get on this.
13 Go ahead, and I'll follow him. Same discussion.

14 DR. CROSSON: Go ahead, Jon.

15 DR. CHRISTIANSON: So I think the use of
16 undervalued and overvalued, in the present context, is --
17 and Rita, I'm sure, back me up on this. So when we talk
18 about value, we pick some measure of value. Maybe it's
19 healthy years of life or something like that. So when we
20 talk about overvalued versus undervalued, for some people
21 that language implies that you are saying that for an equal
22 amount of expenditure on primary care, you're going to get

1 more healthy years of life than you will spending the
2 dollars on specialty care.

3 I don't think you've done that analysis, or maybe
4 you're just drawing in general on the literature. But for
5 many people it will imply that. It will imply that you're
6 saying that the additional healthy years of life for a
7 dollar spent on specialty care is less than a dollar spent
8 on primary care and therefore we ought to reallocate
9 dollars in the Medicare program.

10 So I think we need to be clear. Your response to
11 value tends to be -- what I've heard -- doesn't tend to go
12 in that direction. You've got a different idea of
13 overvalue or undervalue than what I've just said. Maybe
14 I'm wrong. Maybe I haven't heard you articulate that.

15 But if you do think about it that way, then
16 there's a lot of work that would need to be done and
17 literature that would need to be drawn on to sort of
18 readjust the relative weights based on that kind of
19 analysis.

20 So I think there's a good part of the world that
21 when you say overvalued and undervalued, they will go right
22 to that.

1 MR. WINTER: Yeah, as I tried to clarify, when we
2 use the term value in this presentation, what we're talking
3 about is the relative levels of clinician work, that is the
4 time and intensity of effort and the practice costs and the
5 PLI, or medical malpractice insurance. So it's really the
6 work and resources involved in providing the service,
7 rather than the impact on outcomes or quality.

8 DR. CHRISTIANSON: So when you talk about
9 overvalued or undervalued services, you're not really
10 talking about value to the patient per dollar spent?

11 MR. WINTER: Correct.

12 DR. CHRISTIANSON: And that's the distinction I
13 think you ought to be careful you make when you do this
14 discussion.

15 DR. MILLER: Yeah. I think you're right about
16 this and you're not the first person who brought it up.

17 DR. CHRISTIANSON: I thought I was [Off
18 microphone.]

19 [Laughter.]

20 DR. MILLER: You're the first person who brought
21 it up, absolutely, Jon. Some other people brought it up
22 very close at the same time, but....

1 DR. CHRISTIANSON: [Off microphone.] Not as
2 clearly, either.

3 DR. MILLER: They were a little behind you. I'm
4 sorry, I was out of line a moment ago.

5 I think what we're really about here is
6 mispriced. I think we're awkwardly caught in a world where
7 the law and the relative value scale and there's 20 and 30
8 years of vocabulary that runs through certain parts of the
9 community.

10 But I think your point is well taken. I think it
11 could be easily misunderstood. And I think what we're
12 really talking about in the end is pricing here. We will
13 start cleaning things up.

14 DR. CROSSON: Bruce.

15 MR. PYENSON: Actually picking up on that point,
16 what we're talking about is the RBRVS system, the resource-
17 based relative value scale. And on Slide 4, you identified
18 the three components of that.

19 Most of the discussion, I think, correct me if
20 I'm wrong, and most of the planning is on the first
21 component of that, the work and not the practice and not
22 the malpractice.

1 MR. WINTER: We envision -- this is really your
2 call, but the way we've laid it out, it could encompass
3 both because practice expense is almost half of fee
4 schedule spending.

5 The work that we've done in the past, on
6 addressing the process for value services and the data
7 available for setting RVUs, that has encompassed both work
8 and practice expense.

9 But it is your judgment, as to what you want to
10 focus on.

11 MR. PYENSON: Thank you.

12 The suggestion, which I think is terrific, to
13 measure hours of physicians, that's focused on the work
14 component, I believe?

15 DR. HAYES: Although, there is a portion of
16 practice expense that is similarly valued, in terms of the
17 amount of time that say a technician or nurse or what have
18 you devotes to a service. So some of what we've been
19 talking about in connection with clinician work would
20 translate over to that portion of practice expense that's
21 driven by the time that those other workers put into a
22 service.

1 MR. PYENSON: Thank you. Very helpful. A
2 related question. As you know, there's GPCIs, the
3 geographic indices. They get multiplied by the three
4 components. Is there a potential distortion that occurs in
5 the weights, either driving the primary versus specialty or
6 some of the other end products we're looking at, based on
7 how those geographic indices are applied?

8 DR. HAYES: Yes. That's a possibility. The
9 Commission had a mandated study to do on the GPCIs a few
10 years ago, and we can make sure that you get access to that
11 work. But there again, there was another set of concerns
12 that the Commission raised about that too, but we, for
13 purposes of the discussion today, were focusing on the
14 relative value units in the calculation as opposed to the
15 GPCIs.

16 MS. BUTO: Bruce, can you be more specific about
17 the distortion that you're talking about?

18 MR. PYENSON: I don't know, but it seems as
19 though, if high-cost areas have more specialists, more
20 procedures, low-cost areas have fewer, depending on how the
21 geographic indices are used and weighted, that could
22 complicate some of the income figures we're seeing and

1 there could be other --

2 DR. GINSBURG: Bruce, I don't think that happens,
3 because the GPCIs are really looking at basic data like
4 rents and wages for staff that physicians hire, and I don't
5 think it's really related to these relative value issues.

6 DR. CHRISTIANSON: I agree with Paul. Another
7 place to look, there was an absolutely brilliant study done
8 by an IOM committee about five years ago on the GPCIs and
9 you might want to refer to that.

10 DR. MILLER: [Off microphone.]

11 [Laughter.]

12 DR. CHRISTIANSON: Coincidentally.

13 DR. CROSSON: Just happened to chair it. Brian,
14 do you have a comment on this?

15 DR. DeBUSK: Not after what Jon said.

16 [Laughter.]

17 DR. DeBUSK: No, my one comment was you may, as a
18 profession, to Bruce's point, may have an issue because you
19 are more likely to find a primary care physician in a rural
20 area, which presumably, to Paul's comment, would have lower
21 rents and lower geographic adjustments.

22 DR. MILLER: And that's absolutely understood. I

1 absolutely am -- well, I'm pretty sure, pending Kevin and
2 Ariel's response here, you can think of these problems
3 separately. You know, they're multiplicative in the
4 equation. If you want to focus on relative -- I'm sorry --
5 mispriced services -- sorry, John -- you know, you can go
6 through that exercise and then, you know, new paragraph, I
7 want to also look at the geographic variation and whether
8 that's properly scaled, and we've done some of that work in
9 the past. I think you can have that conservation, but I
10 think you can probably think of them as separate exercises.

11 You guys are going to blow me out of the water.

12 MS. WINTER: Kevin is shaking his head. No.

13 DR. DeBUSK: That does build on Warner's comment
14 earlier, though, in that when you try to look at primary
15 care as a profession, in absolute terms, you will have to
16 take into consideration more than we're just rurally
17 located.

18 DR. MILLER: Right, but when we do the
19 compensation stuff, that's adjusted, right?

20 DR. HAYES: Yes.

21 DR. MILLER: Right. So those -- and your point
22 still stands. I'm not taking your point down. But when

1 you look at the, you know, relative compensation or
2 mispricing, that is making those statements free of
3 geographic influences. When you put it all back together
4 and start paying people, then I think that geographic
5 component could come back into your conversation. That's
6 really all I'm trying to say.

7 DR. GINSBURG: One more thing. The GPCIs will
8 end up compressing the geographic variation in prices, so
9 that this was a positive for rural physicians and a
10 negative for, you know, physicians in some of the most
11 expensive urban areas.

12 MR. PYENSON: Thank you. A couple of other
13 questions. I wonder if you could compare your concept of
14 efficiency gains to the productivity gains that are built
15 into the DRG system, where there's a downward price built
16 into DRGs, based on a productivity gain.

17 DR. HAYES: If there's a formula that could be
18 used to make these adjustments -- that's what you're
19 asking?

20 MR. PYENSON: That was my next question.

21 DR. HAYES: Oh. Oh. We'll consider that and get
22 back to you next time we go over this, if it's all right

1 with you.

2 DR. MILLER: Your question sounded like you
3 thought there was some factor present here on efficiency
4 gain. Is that what you meant?

5 MR. PYENSON: Well, from a concept standpoint,
6 there's a concept that certain classes of services ought to
7 or do have an efficiency gain, and that's, of course, over
8 time, and others don't. And it seems like that concept is
9 already established for hospitals and other facilities in
10 DRGs.

11 DR. MILLER: This gets pretty high concept pretty
12 quickly, but I think there's a few points that are being
13 made here and then you'll have to use your judgment of how
14 related they are.

15 So I think the point that Kevin and Ariel are
16 making is that certain services lend themselves to learning
17 and becoming more efficient over time. I can -- I don't
18 want to do anybody an injustice but I can read a radiology
19 test more quickly and learn how to -- you know, and what
20 took me 20 minutes two years ago takes me, you know, 10
21 minutes, 12 minutes. You know, the technology changes.
22 People become more skilled at it, that type of thing.

1 Other services not so much, that a cognitive
2 service may be more difficult. You have to sit with a
3 patient, to gain that efficiency and really go through
4 history and that type of thing, and so it might be harder
5 to get an efficiency gain.

6 In contrast, the productivity factor that was put
7 in on the hospital side, and, you know, there's no clear
8 legislative history often written down for these things.
9 But my sense there, at the time that that was being talked
10 about -- and I think this is widely misunderstood -- is it
11 wasn't about the productivity gains in the industry itself
12 as much as if the economy is gaining productivity,
13 shouldn't the health care sector be held to those types of
14 gains, that the people who are paying the taxes are working
15 in improving their productivity, so shouldn't that be
16 enforced on, you know, the health care sector, as opposed
17 to going in and saying this productivity is occurring in
18 the hospital sector in this set of services, that type of
19 thing. That's my sense.

20 MR. PYENSON: One is, well, that was the second
21 part of my question, you know, if this is as a sound basis,
22 can't it be done prospectively as opposed to requiring a

1 periodic evaluation.

2 MS. WINTER: Are you suggesting applying it
3 prospectively to a certain category of services, or the
4 entire -- all services in the fee schedule?

5 MR. PYENSON: Well, services in the --

6 MS. WINTER: So it seems similar to an idea that
7 we've batted around in the past, which is for services that
8 are growing very rapidly, where you'd assume because of
9 rapid growth there are probably going to be efficiency
10 gains, productivity gains, there could be an automatic
11 formula payment reduction for those rapidly growing
12 services. So that seems like a somewhat similar concept to
13 what you're talking about.

14 The question, though, is like what should that
15 reduction be and what is that -- what data would that be
16 based on.

17 MS. BUTO: I'm sorry. Did you say prospective
18 adjustment, because you wouldn't want to discourage
19 efficiency gains, would you? You'd want to capture them
20 after they've occurred.

21 MS. WINTER: Yeah. I should have said
22 retrospective.

1 MS. BUTO: Okay.

2 MS. WINTER: Yeah. That's what we were thinking
3 of, and I think Bruce is suggesting --

4 MR. PYENSON: Oh, prospective.

5 MS. WINTER: -- before, in advance. Right. So
6 the question then is, what category of services do you
7 identify in advance as being subject to efficiency, liable
8 to have efficiency gains. Right.

9 DR. MILLER: And I am thinking -- and he's
10 sitting right here, so -- I'm taking your concept, Bruce,
11 as follows. I come out, I create a new code or, you know,
12 some service. It happens to be -- you know, I'm making a
13 bunch of assumptions here -- it happens to be a service
14 that most people, or everybody agrees, or the medical
15 profession, the RUC group, whoever, says this is a service
16 in which the learning function, people are going to become
17 much -- you know, it's going to be 30 minutes now but it's
18 going to be 15 minutes later. Now I don't know how you
19 reach all those judgments.
20 And I took Bruce's point as if you expect that to happen,
21 don't wait for re-evaluations, you know, when somebody
22 takes it upon themselves 10 years down the road to do it.

1 Start to take it out in advance. I think there would be
2 the \$64,000 questions that precede that -- On what basis,
3 are you doing it service, are you doing it in the macro, et
4 cetera. But I took him as saying prospective.

5 MR. PYENSON: You interpreted me correctly.

6 DR. CROSSON: Bruce, do you have another
7 question?

8 MR. PYENSON: I do. On the grouping and detail,
9 I assume that your thinking there is to preserve the
10 details of the CPT code infrastructure -- okay -- and just
11 grouping on the payment basis.

12 MS. WINTER: That's how we've been thinking about
13 it and that how it's done in the outpatient PPS, and that
14 would certainly make it easier for clinicians because they
15 would continue billing the same way. What would change
16 would be the payment, but the billing process would
17 continue on as it has in the past.

18 MR. PYENSON: We'd also make the value of real-
19 world information, real-world data, preserve that.

20 MS. WINTER: Yes. Correct.

21 MR. PYENSON: One other question, and this
22 relates to Bill's comment on data from the private sector.

1 In thinking about compensation from the -- for example, for
2 primary care from the private sector, there's often not
3 just fee for service but there's often a large component of
4 gain-sharing, and that shows up in -- as perhaps most
5 easily in income.

6 So has work been done on -- rather than on the
7 fee schedule per se, the income components relative to
8 private pay and the relativity among specialties, for
9 example? And one of the thoughts there, when that's done
10 in the private sector it's often a redistribution from --
11 not necessarily from other physicians or specialties but
12 from the hospital or facility sector, so the bonus is based
13 on reducing, if you will, the Part A piece, you know.

14 And so an underlying assumption here in budget
15 neutrality, I think, is that the Part B piece, and maybe
16 just the carrier piece, stays the same.

17 MS. WINTER: So are you asking whether there are
18 sources of data on commercial insurance compensation by
19 specialty, or by type of specialty, that this aggregates
20 gain-sharing payments from sort of the basic -- from other
21 payments?

22 DR. MILLER: Can I do this? Yes. There is an

1 implicit assumption that when you're talking about the
2 repricing of services, and as a starting point, that you're
3 moving things around within Part B, or within the fee
4 schedule.

5 To your point about the relationship with A and
6 that type of thing, in some ways my reaction to that is,
7 that's kind of concepts like the ACOs. The physicians
8 organize, they change their utilization patterns, they
9 bring it in under some fixed benchmark, they get a bonus.
10 But in this discussion, narrowly as we're discussing
11 pricing and mispricing, it's about moving money around
12 within the fee schedule.

13 MS. WINTER: And the chart that we showed you on
14 Slide 6, that's all income, from all sources, for
15 physicians.

16 DR. CROSSON: So I guess, you know, on this
17 point, my assumption would have been, if you look at the,
18 you know, performance of the majority of ACOs and what's
19 going on with other alternative payment models, that at
20 this point in time, although what Bruce talked about is
21 exactly what's going on, the amount of money relative to
22 the differences in income that we see is very small, so

1 far. In the future it could be --

2 MR. PYENSON: From a Medicare standpoint?

3 DR. CROSSON: From a Medicare standpoint.

4 MR. PYENSON: Right, because ACOs typically --
5 you know, the reports that are out there are not like
6 insurance company financials, right. What you're talking
7 about is the gain-sharing.

8 DR. CROSSON: Exactly. Now are you saying that
9 in commercial ACOs you're seeing -- you think you're seeing
10 large increments of income changing, based on downstream
11 utilization?

12 MR. PYENSON: Well, you could. You could
13 actually -- we wouldn't know if that's going on within
14 ACOs, within even Medicare ACOs, because part of the gain-
15 sharing can be from within the hospital's expense side.
16 That was paid by DRGs. So the DRG wouldn't change.

17 DR. CROSSON: No, I agree with that all entirely.
18 All I was basically saying is that, empirically, at the
19 moment, I suspect, without -- as you're right, without the
20 data, even in the commercial world, that we're so early on
21 in the development of alternative payment mechanisms, gain-
22 sharing is one, that the amount of movement from other --

1 from the physician's ability to manage other services is
2 still small, and might not likely to be materially
3 affecting the differences that we see in income. That's
4 just -- and I'm just saying, that's what I think, although
5 in principle I agree with you.

6 We're still on clarifying questions. Clarifying
7 questions. Rita. I meant Alice.

8 [Laughter.]

9 DR. COOMBS: Guess what? Craig and I decided to
10 start Round 2 if you're okay with that.

11 [Laughter.]

12 DR. COOMBS: First of all, I'd like to say we
13 look --

14 DR. CROSSON: Paul's starting.

15 DR. COOMBS: Oh, he is?

16 DR. CROSSON: Paul is starting Round 2. So we're
17 still on clarifying questions. Sorry.

18 DR. COOMBS: We'll make one up.

19 [Laughter.]

20 DR. CROSSON: Okay. We've finished with
21 clarifying questions, so now we're going to substantive
22 comments on the material that's been presented, and, you

1 know, it asks for emphasis, and we've got a number of
2 pieces here, moving pieces. I haven't heard anything so
3 far saying, oh, my gosh, don't look at that; that's
4 meaningless. But I would like to see some prioritization,
5 some emphasis, or addition of new ideas.

6 Paul is going to start and then we'll move up
7 this way and around that way.

8 MR. PYENSON: Yeah, thanks. The presentation was
9 very, very good. Excellent.

10 The topic that has come out in the clarifying
11 question discussion is very important, because it's
12 affecting payment throughout the delivery system. This is
13 not just a Medicare issue.

14 In addition to commercial plans, Medicaid plans
15 all use the Medicare relative value scale, again with their
16 own conversion factors. And Rita really presented some of
17 the importance of it as far as the potential to distort
18 practice patterns, to get overuse of some of the services
19 that are very lucrative for physicians.

20 You know, the predecessor commission of MedPAC,
21 the Physician Payment Review Commission, was very heavily
22 involved in the enactment of the Medicare fee schedule. In

1 fact, others besides my involvements. Bill Gradison was
2 the ranking member of the Ways and Means Health
3 Subcommittee when the legislation was enacted, and Kathy
4 Buto was a very high-level official at HCFA, who worked on
5 implementing the fee schedule.

6 Some analysis that HCFA did a few years after the
7 implementation showed a very substantial change in the
8 structure of payment, as far as a very large boost to
9 primary care, and, you know, in a budget-neutral fashion
10 that came out of procedural services. I wish I had the
11 numbers with me, but I recollect it was something on the
12 order of a 40 percent increase in payment for evaluation
13 and management services.

14 What's been very painful for me, in recent years,
15 is on a number of occasions I've talked to some young
16 people in this field, and their impression of the Medicare
17 fee schedule was, "Yeah, yeah, they went to a fee schedule
18 and didn't change anything." The problem is still the
19 same. We're underpaying for primary care, but the reality
20 is that the fee schedule made a very large difference. And
21 then, I believe through a very flawed updating process,
22 that a lot of the change was lost over a long period of

1 time, and it's even possible that the structure of payments
2 is not that different now than it was before the fee
3 schedule, and what prompted Congress to ask for -- create a
4 commission and ask for proposals for reform.

5 Now MedPAC has addressed this issue on many
6 times, but I believe we should again, and I have two
7 thoughts -- I had a conversation. You know, Warner asked
8 about, that we're talking about a 5 percent or a 30 percent
9 distortion, and I think we're a lot closer to the 30
10 percent distortion, so I think this is really important and
11 worth doing.

12 I think the first thing that the Commission
13 should be doing is taking a look at the various processes
14 which have come from CMS and come from Congress, as far as
15 instructions to CMS, to try to get this schedule repriced,
16 and to make an assessment as to, is this up to the
17 magnitude of the problem. And my sense is that it's
18 clearly not.

19 You know, a .3 percent redistribution is very
20 trivial compared to the nature of the problem, and 1
21 percent would be better. But I still think that's very
22 small, and, of course, the legislation is only doing this

1 for three years. So I think that we need to make a
2 judgment about is what's current efforts, are they really
3 up to the task.

4 And the other thought I have to just add to what
5 the presentation said is that I find the idea of working
6 with large multispecialty practices, drawing data from
7 them, perhaps through creating a panel of practices in
8 different parts of the country, and perhaps paying them, as
9 Ariel said, is a way to go. When I read the previous
10 MedPAC description of this, I had the sense that if we had
11 gotten more concrete over how this would work, it might
12 actually improve the chances of this being adopted. So I
13 think it might be worth investing in more work, more
14 discussions with people, financial people, add some of the
15 large practices as to the type of data they might have and
16 how to do this.

17 So those are my thoughts about how we should get
18 into this issue.

19 DR. CROSSON: Paul, I agree with you. I'd just
20 add one thing. In terms of the notion, which is one of the
21 thoughts here is to try to get a different set of
22 benchmarks from, let's say, the large multispecialty group

1 practices, I think the choice of practice may also and
2 should be influenced by the nature of the payment that
3 those practices receive and also potentially the way the
4 physicians themselves are paid and whether it's a
5 productivity incentive or it's a different set of
6 incentives.

7 Okay. We are going to come up this way, but I'm
8 going to make one exception. Alice has an unavoidable
9 commitment, and she does need to leave, which was why she
10 was jumping up and down a little bit.

11 [Laughter.]

12 DR. CROSSON: So, Alice, we'll have you go
13 forward, and then we'll return to that end.

14 DR. COOMBS: Thank you so much.

15 I like that you gave history, Paul, because that
16 helps with just the overall approach.

17 One of the things that I thought about in reading
18 this chapter and venturing into this subject is that I had
19 a chance to actually go to the RUC and sit in the RUC, and
20 I would encourage more of you to do it because then you
21 would understand the process a little bit more.

22 I think Julie Somers, who was part of MedPAC as

1 well was there at the same time as I was.

2 DR. MILLER: And Kevin is gone. Well, Kevin told
3 us he's gone.

4 [Laughter.]

5 MR. WINTER: I saw him there.

6 DR. MILLER: You saw him there.

7 DR. CROSSON: Now, the fact that they keep coming
8 back with Cubs hats has got nothing --

9 DR. COOMBS: A couple of things I was impressed
10 with, because I had heard about the RUC -- and one of the
11 things is the process by which they decide. And it really
12 is multidisciplinary.

13 For instance, if you have a nephrostomy tube
14 placement, they would have the urologist there, the
15 radiologist there, and they would all talk about the time
16 input. And I was really impressed by the fact that if you
17 have a nephrostomy tube and the radiology suite, it
18 requires postoperative nursing. They had considered all of
19 those things, and the family of codes would agree that one
20 was not more advantaged or disadvantaged. It worked well,
21 and I saw from that standpoint.

22 Getting to some of the issues around the

1 components of the RVUs in terms of the work, the time, and
2 intensity, I don't think that we're able to deal with both
3 of those adequately. The intensity piece of it, which is a
4 skill set, is one part that I think you have to be reliant
5 on the specialty societies for that.

6 The other piece of it is, when we get into the
7 topic -- and this is a tough topic -- I would totally
8 separate the issue of work, income disparity for primary
9 care and specialists. And the reason why I would separate
10 that is, first of all, if you have a surgeon who is taking
11 call every third night, he may generate a revenue that is
12 significantly larger than a primary care because his hourly
13 time spent in the hospital is far greater.

14 So, when you look at salaries -- and we have to
15 stay at the level of the unit payment in terms of
16 reimbursement. So salary overall, when we discuss salary,
17 you have to be very intent on saying that the salaries are
18 reflective of multiple components in terms of the
19 individual physician productivity, and that's really
20 concerning.

21 For specialists, I'll give you an example because
22 I want it to stick -- is that I did a case many years ago

1 with a thoracic case where a tumor was on the chest wall,
2 and it took a long time to basically do this case. The
3 first hour for me and the nurse anesthetist, I put an
4 epidural in, an A line in, and we're watching this patient
5 because has comorbid conditions. First hour for Medicare
6 payment is \$324. It's \$81 every hour after that for as
7 long as the surgeon technically gets that tumor off the
8 wall.

9 We look at the disparities between specialists
10 and primary care. It really is so complex, with patient
11 issues that are surrounded around how fast can you do a
12 case, and the cases may not all be the same, first of all.
13 And the intensity or the skill sets required for different
14 cases are -- and I think physicians agree with that. I
15 mean, most physicians will get in a room, and there's some
16 wide range. But there are others that are not their gray
17 zones, and so I like the idea of possibly doing evaluation
18 at a group level and considering the large codes that are
19 very similar and looking at the time element. The
20 intensity, I think you have to depend on the specialists to
21 look at that management.

22 I would shy away from group -- I'm not going to

1 say reference pricing, but group pricing based on evidence-
2 based guidelines. I think evidence-based guidelines are
3 important, but combining the two might be very difficult to
4 do in this genre as we are here as MedPAC Commissioners. I
5 think it's a great idea, but combining the two introduces a
6 whole bunch of other complexities.

7 So I just wanted to say those few things. Thank
8 you.

9 DR. CROSSON: Thank you, Alice.

10 I just want to emphasize one point here, and that
11 has to do with the work component that you talked about
12 because I actually had forgotten this or didn't know it.
13 Can you remind us to what proportion of the work component
14 is made up of time versus intensity?

15 DR. HAYES: It depends upon the category of
16 service, but it's somewhere in the 75 to 90 percent range
17 in terms of that's how important time is compared to
18 intensity.

19 DR. CROSSON: What I've gathered from that is you
20 could do a lot of work, subjective work, as you suggest, on
21 the intensity piece, move it around or something, and not
22 get very much from it.

1 DR. COOMBS: Right.

2 DR. CROSSON: Whereas, to the extent that we want
3 to take a look at the payment formula itself, working on
4 the time part seems to be much more likely to yield
5 differences, which could be adjusted, and, of course, it's
6 not totally, but more objective than the intensity piece.
7 I agree it's subjective or largely subjective.

8 Okay. So now we'll start down at that end, and
9 it looks like Bill Gradison.

10 MR. GRADISON: Okay. I am reminded of the
11 writings of St. Thomas Aquinas trying to seek to define a
12 just price. We read about this every day in the newspapers
13 with regard to drugs, and somehow I think we're doing the
14 same thing here. And the reason I start it that way is
15 this is such a subjective area, and we're trying to
16 interject into it a degree of objective review. And I'm
17 skeptical that that's going to work.

18 Let me be more exact. We were told that after
19 the review of 17- or 1800 out of 7,000 procedures, hardly
20 anything moved very much, certainly not enough to deal with
21 primary care issue at all. I see no reason to assume that
22 going through the other 5,000 -- I don't say we shouldn't

1 do it or somebody shouldn't do it, but the notion that
2 that's going to materially resolve the problem is just
3 unrealistic, bordering on naïve.

4 I do have to say that the current process
5 disturbs me, and I've often thought of it as one of
6 regulatory capture in the sense that the people sitting
7 around those tables who are working hard -- and I respect
8 their professional skill and their contribution to this
9 decision-making process, but that's the only case I can
10 think of in America where people decide their own salaries,
11 indirectly to be sure, but for the group of people that's
12 their specialty. I'd love to have a job like that someday.

13 So what I come down here with basically is -- a
14 brief digression. Some of you know I taught briefly at
15 Harvard Business School, and we told our students that
16 there were no answers to business cases, that the best you
17 could come up with was currently useful generalizations.
18 And my currently useful generalization is that the process
19 that we're talking about simply won't work if our objective
20 is to have less divergence and payment for primary care
21 versus procedures. I'm basically saying what Alice did, I
22 think, in other words. That we've got to think of this as

1 a separate issue and work backwards from the choices people
2 are making when they go out of medical school today. I've
3 been told that in some areas, salaries are actually going -
4 - I have no data for this, but I've been told in some
5 areas, there's significant increases in the payment for
6 primary care because they're harder to find, so maybe the
7 market is beginning to work, and that's something I'd like
8 to really know more about as we get our current data.

9 But if you buy the notion that this -- it isn't
10 that the process shouldn't be pursued, but I just wouldn't
11 look for it to be a solution. We need something else.

12 Now, what might that be in a world where
13 everything has to be revenue neutral is, of course, the
14 challenge. We look at it, and we say we ought to pay 10
15 percent more or whatever -- 10 percent is pretty small too
16 -- and that we don't come up with a way to pay for that
17 other than to go back and cut the other folks, which is
18 really very hard to do. It's a give-back. It's a
19 "clawback," in labor relations terms and not very popular.
20 So I hope that suggestion is useful. At least it reflects
21 my current thinking about not relying on the current RUC
22 process to solve the problem.

1 DR. NERENZ: Just a couple points, and this would
2 follow, I think, most directly on what Jay said about
3 focusing on the time component, just because it's dominant
4 part of at least how value is currently defined, which I
5 agree with Jon is not the way you stated it, but it's
6 important to know that.

7 One of the most compelling things I think I've
8 heard in one of our earlier meetings on this was the idea
9 that an examination of some billing patterns, we find total
10 billings that just exceed possible reality. It looks like
11 people are working more than 24 hours a day. That strikes
12 me as being a solid ground to enter or to stand on as an
13 example of following up on time. But if a certain
14 procedure or a certain code is set up in a way that in
15 actual practice of billing, it creates the appearance of
16 somebody working more than 24 hours a day, something is
17 wrong. And that would seem then to be kind of a high-
18 priority target.

19 So I guess I would suggest that given how hard it
20 is to try to do some sort of philosophical assessment of
21 value and how hard it is to second-guess somebody on
22 intensity, that time is an objective thing, and there does

1 seem to be some evidence of situations where the time value
2 seems just to be blatantly incorrect.

3 MS. BUTO: First of all, I want to take some
4 responsibility for setting up the RUC process with the AMA,
5 which I was very much involved in, and our thinking at the
6 time, which looking back seems naïve -- but I actually
7 probably would have made the same decision today if I were
8 in the same shoes -- was that the government has a very
9 hard time valuing physician services. And even if the
10 government had overseen a committee to do it, it was
11 fraught with political and procedural difficulties, and we
12 had had much experience with having decisions overturned by
13 the Congress. And Bill can probably relate to this.

14 So, at the time, we thought government had the
15 oversight and the ability to overturn a RUC decision or a
16 recommendation and make its own decision, and that was
17 important. And, secondly, as long as we control the
18 conversion factor, that was important. So that was the
19 basis, for those of you who wondered how it got started.

20 Having said that, I really agree with Paul that
21 we're at a point now where an external committee actually
22 would make sense, and I think it would be more acceptable

1 to do some of the work that we're talking about doing here.

2 I do think it's important, as the Commission
3 proceeds with this work, that we be clear what problem
4 we're solving. A lot of problems have been laid out here,
5 including the decline in payments for primary care relative
6 to procedures and surgery, but it also strikes me that we
7 haven't emphasized enough. And I thin, it's implicit that
8 this underpayment, we believe, actually undermines the
9 ability of primary care physicians to do the kind of
10 comprehensive and sort of collaborative and coordinating
11 work that needs to be done to manage chronic conditions and
12 difficult complex patients. So I really would like to see
13 more of that, not just they're underpaid, but they're
14 probably not paid enough to do everything that we're
15 expecting them to do, even in a fee-for-service
16 environment.

17 Then I think another purpose, clearly, is that we
18 think they're overvalued procedures that lead to
19 overutilization, as I think Rita was pointing out earlier,
20 and that we need to find ways to capture on an ongoing
21 basis, productivity improvements. So, again, my point
22 there is really let's be clear what problem we're solving.

1 And then I just wanted to turn to slides -- I
2 think it's 18 and 19 -- and say that I support all of the -
3 - I think we can do both, revisit the prior
4 recommendations, and I would do all of those or recommend
5 that we proceed on all of those.

6 On the new directions, I really think to get to
7 the issue of is it a 30 percent problem -- and Bill
8 Gradison's point about even if you re-did all the values,
9 would it make much of a difference, I think that the
10 partial capitation approach is one that we ought to really
11 spend some time developing. This is going to be tough
12 because separating primary care physicians who get paid for
13 E&M from proceduralists who are getting paid for E&M, I
14 think it's going to require us to think about is there some
15 bundling of consultation services and so on that could go
16 into the procedural codes, or how would we actually do
17 that? So I think it's actually more complicated than we
18 probably have even thought about but worth pursuing because
19 I really think that if we're going to make a big difference
20 in the kind of service -- and I think, again, here we need
21 to define what is it we'd like to see primary care be able
22 to do -- that we ought to find a way to value that and pay

1 for it separately.

2 I think as many of you know, I'm not a fan of
3 reference pricing, and I worry about combining CPT codes
4 into families of codes. I think this particular issue
5 would benefit from examples. So the issue of paying
6 dermatology for different-sized lesions or warts or
7 whatever, I mean, I think a lot of people would understand
8 why that doesn't need to be separately paid for. But the
9 idea of, say, paying for angioplasty and bypass surgery at
10 a similar or same rate, I think would strike people as
11 fairly extreme.

12 So I think one needs to think about what we're
13 talking about and identify criteria that might be applied
14 if you were to pursue this because I think it's a worrisome
15 area, and I would not -- we have a tendency to compare
16 physician services in Part B to hospital DRGs or outpatient
17 PPS, and they're very different. Hospital services
18 payments are for operating costs and a lot of fixed costs.
19 Physician services are for a discrete service to a patient,
20 and I think we want to be careful about assuming that if
21 you group them together, you're going to get the efficient
22 outcome or the best value for the patient. I don't think

1 we know that. I think it will drive practice, but is it
2 going to drive practice the way we think that people
3 objectively would say is the right thing to do?

4 So I think if the problem we're trying to solve
5 is really paying primary care more appropriately and then
6 going after those overvalued procedures, I think that's
7 doable. This one feels like we potentially could open up a
8 can of worms, but again, I think it would benefit from
9 examples.

10 DR. CROSSON: Kathy, just on that last point, you
11 know, I agree with you, and that's why I was tussling with
12 Rita about what was extreme or what was not extreme. I
13 think anything that we do in this grouping area first of
14 all has to pass a clinical reasonableness test, and that
15 clinical reasonableness test may be a different kind of
16 admittedly subjective analysis than we have applied to
17 other thinking about other so-called -- sorry, Paul --
18 reference pricing approaches, like with pharmaceuticals and
19 things of that kind.

20 Yes, Rita.

21 DR. REDBERG: I just wanted to respond to that,
22 because, I mean, obviously, doing surgery takes more time

1 and intensity than medical management. But my point -- and
2 that's a problem, I think, with fee-for-service system, is
3 because if you're going to encourage things that are paid
4 more, you know, intentionally are not -- when there may not
5 be any benefit. In fact, you might be worse off because
6 they're riskier and more --

7 But to really accomplish, you know, a value
8 system where we're doing the best for beneficiaries and
9 using our money most wisely without encouraging a lot of
10 unnecessary or dangerous procedures, we need to talk about
11 a capitated payment system, you know, a per beneficiary per
12 month or a bundled payment system, which I think CMS is not
13 experimenting with, in limited ways. And I don't think
14 that's extreme at all. I mean, if we're looking at being
15 responsible stewards of the Medicare program we want to
16 spend the money in the way that's best for beneficiaries
17 and best for the solvency of the program.

18 You know, we have large populations to cover and
19 so we could estimate, you know, how many people would you
20 better, you know, with bypass surgery, how many people will
21 do better with medical management, how many people -- you
22 know, and that currently very different from what we're

1 actually doing, because many people are getting unnecessary
2 procedures and doing worse.

3 So I don't think that's -- I think that makes a
4 lot of sense, at least to me, and not extreme, I mean, not
5 if you're just going to compare payments and that, but, you
6 know, sort of focusing on -- instead of encouraging this
7 very high volume but not very high value system that we
8 currently have in our current system, I think we have to
9 think about alternative payment systems that don't
10 encourage that but focus on what we're trying to achieve,
11 which is better value, care, meaning giving our
12 beneficiaries what they need and don't what they don't need
13 and are suffering from.

14 DR. CROSSON: And as you might imagine, I
15 heartily agree with everything you said. My only point was
16 that this particular tool, whatever we call it, choose to
17 call it, of, you know, lumping things together into one
18 payment system, fits better with some clinical problems of
19 utilization that we have to solve, than others, you know,
20 and -- well, that's enough. Okay.

21 Coming up. Yes, Amy.

22 MS. BRICKER: So I'm reminded of yesterday and

1 the framework that was laid for us about, you know, the
2 future of the Medicare program and, you know, going back to
3 what others have already shared, what is the objective of
4 this discussion and this venture. Is it, in fact, the
5 question that Warner raised around is it 5 percent or 30
6 percent. Is it that primary care is undervalued? I think
7 when you look at the comparison, or we think, anecdotally,
8 yes, maybe it's not. Maybe it's that everything else is
9 over-valued. I think you have to follow the dollar.

10 And going back to what Rita and others have said
11 around alternative payment approach, I just don't know if a
12 complete overhaul of the system is going to be something
13 that will gain traction if we've attempted, over the course
14 of seemingly a decade, to make recommendations
15 incrementally that have been not adopted. I don't know if
16 a complete overhaul, at this point, would gain much
17 traction.

18 And so I am in support of looking at the 7000
19 codes. I don't know how in the world anyone could
20 actually, even with a RUC or no RUC, you know, make some
21 headway when you're looking at the vast number of codes and
22 seemingly the disparity between them.

1 So I'm in support, at least of that step, maybe
2 short-term, long-term, looking at something as an
3 alternative payment from a bundled perspective or capitated
4 approach.

5 You know, I also found it interesting that upon
6 survey, no one answered the phone, and I think -- or
7 attempting to survey, no one would engage -- and I think
8 that's human nature. If you're getting paid a lot, and
9 there isn't any pain, why, in fact, would you answer the
10 phone? When you're not able to keep your lights on and
11 you're not getting paid enough, you would probably take
12 that call and provide some feedback to the RUC or others
13 that are attempting to gain some information about your
14 satisfaction relative to payment. So I just found that to
15 be interesting.

16 Lastly, ensuring that, you know, other comments
17 have been made about, you know, taking from the other
18 group, non-primary care will be difficult, I think if we,
19 in fact, believe that primary care is undervalued, we've
20 got to figure out a way to approach in a budget-neutral
21 fashion, not just continuing to raise cost for other and
22 primary care.

1 Thank you.

2 DR. CROSSON: Thank you, Amy. Jon.

3 DR. CHRISTIANSON: Yeah. I think the comments
4 people have made about why are we doing this are really
5 important. I don't think correcting mispriced services is
6 going to have a huge effect on changing the income
7 distribution among different physician specialties, but I
8 think we need to do it, or try to do it.

9 When we think about stuff that we say we support
10 strongly, like ACOs, these are built on a fee-for-service
11 system, and if we have mispriced services, we're paying the
12 wrong amount, and we're paying the wrong amount for bundled
13 payments too, and we need to do the best we can to pay the
14 right amount for those things. I think that's going to be
15 very important for the credibility going forward. So I
16 think for that reason alone it's worth tackling this.

17 DR. CROSSON: Craig.

18 DR. SAMITT: So I want to go back to something
19 that you said earlier, Jay, and I'll try to paraphrase,
20 which is whether this mispricing of services is driving the
21 behaviors inconsistent with what's best for beneficiaries,
22 or that's driving behaviors that are inconsistent with a

1 more coordinated clinical model, and I really do believe
2 that they are. And so I think there is a misdistribution,
3 a maldistribution, as a result of this mispricing that
4 needs to be addressed and I think the question that we're
5 all struggling with is how to address it.

6 And as I look at the list of things on Slides 18
7 and 19, you know, I just begin to wonder which ones are
8 fixable and which ones will most influence an improvement
9 in the problem. And I have to say, I'm admittedly skeptical
10 about whether revisiting our prior recommendations will
11 have an effect. You know, I think others have mentioned
12 that before. I don't think there's a harm in us revisiting
13 the recommendations, but for all the reasons that we
14 described about, you know, how do we differentially
15 determine value of services, I think it's just going to be
16 a very difficult debate.

17 I also don't see how combining CPT codes solve
18 the redistribution problem, and it may do it in certain
19 small instances but I don't think it does it at a
20 substantive enough scale. So I'll sort of focus on my area
21 of strength, which is the issue of population health, and I
22 think when you look at -- you know, and Paul alluded to

1 this earlier -- I do think that we can take a page out of
2 the private system here, because I think where you do see
3 some substantive changes in income redistribution is in
4 those environments where organizations will take a cap, and
5 then forcefully redistribute that cap to reward the
6 behaviors that are most consistent with better care at a
7 lower cost.

8 And so I think the greater merits would be in
9 studying what else we can do in terms of this partial
10 capitation approach outside of the Medicare Advantage
11 space, because I think that's -- I'll say I agree with
12 others that have said, "I think we're more at the 30
13 percent maldistribution level, not at the 5 percent." And
14 it's, frankly, probably why we're stumbling a little bit in
15 the ACO world, that ACO gain-share is in the 5 percent
16 range. If we really want to see a change in the
17 transformation of population health, we probably have to go
18 far further than 5 percent. And so I do think that's the
19 one that I would ask that we concentrate our energies on.

20 DR. CROSSON: Thank you. Pat.

21 MS. WANG: So I am in agreement with the other
22 Commissioners that this is very important for MedPAC to

1 tackle, notwithstanding that past recommendations have gone
2 unheeded.

3 A couple of observations or comments would be,
4 number one, I do not think that -- I think it's confusing
5 to put up the slides on relative income by specialty. You
6 know, it's informative but I think it gives the wrong
7 impression, that that is how we are defining what's
8 undervalued and overvalued. There's a lot of -- you know,
9 I think the income slide is fine to show, but I don't think
10 that that should drive a determination of something as
11 underpriced versus overpriced.

12 I think it's important to continue the work,
13 whether it's through an expert panel or otherwise, to
14 perhaps focus on some more specific issues that we see.
15 So, for example, I think there's a general feeling that in
16 today's world, and if you talk to primary care doctors,
17 they are overwhelmed, because everybody is saying, "The
18 whole responsibility for fixing the system is in your
19 hands," which is, I think, completely unfair and
20 unrealistic. But what they are now developing their
21 practices to do with different kinds of practitioners and
22 educators and clinical health workers and so forth and so

1 on is kind of new. And so maybe there should be focus on
2 what are the specific elements of today's primary care
3 practice that are underpriced, and maybe there are new
4 element to introduce into the definition of work and
5 intensity that are not now captured, you know, something
6 qualitatively different.

7 To the extent that we feel that there is some
8 overpricing in the specialty world, I would try, maybe, if
9 we could, to sort of understand a little bit more what that
10 is about. If it's volume driven, if the specific RVUs for
11 a specific thing that a specialist does are, you know,
12 according to the process that's followed, kind of science,
13 is the issue that it's volume, and if it's volume, maybe
14 there's a very specific element of adjustment, you know,
15 picking up on Bruce's point earlier, about efficiency
16 gains, that should be, you know, introduced or focused, and
17 maybe that's an area of examination.

18 In terms of the new approaches, you know, the
19 bundling approach, I think, to the extent that there are
20 some obvious ones -- the example that Ariel gave about the
21 dermatology excisions -- you know, it sounds like it's
22 around the edges. I think it's worth looking at. I don't

1 think it gets us out of the work or the need to still
2 continue to value the individual RVUs underneath, though,
3 because the code still exists and they would roll up into
4 some sort of bundle.

5 Partial cap I understand the appeal of, and I
6 think that it is worth examining. Personally -- personally
7 -- as an HMO in the Medicare Advantage space, I think that
8 there's a lot of complexity to trying to introduce
9 something like a capitation model in fee for service.
10 What's the attribution? You know, I could say, you know,
11 Dr. Buto is my doctor but I'm still going to see Dr.
12 Crosson, and, you know, Dr. Samitt, because I rally like
13 them, and I'm just going wherever I want. There's no
14 control in the fee-for-service system around that.

15 I also, you know, just personally, we are an HMO.
16 We do compensate our primary care doctors in many ways,
17 although we do refer to the Medicare fee schedule as a
18 starting place. But whether it's, you know, surplus
19 sharing or quality bonuses or what have you. But we expect
20 a lot in return. I mean, there's a tremendous amount of
21 accountability, I think, that goes with a capitation
22 payment. How do you make sure that there is no stinting?

1 I mean, in a fee-for-service system, those are the kinds of
2 concerns that I have. I also think that it starts to bump
3 into the things that ACOs are trying to develop, so I would
4 just be careful about introducing more confusion and kind
5 of noise into the reform efforts. I think it's worth
6 looking at, but I just want to suggest my skepticism there.

7 But as far as the work of sort of looking at the
8 values of these, and the prices of these individual
9 services, perhaps we could focus, as Kathy suggested, on
10 what are the specific questions, and maybe really try to
11 hone in on those.

12 DR. CROSSON: Pat, I want to draw you out a
13 little bit on one thing I thought I heard you say.

14 So it's always been interesting for me -- and I
15 guess this goes back to some of our former Commissioners --
16 that the payment schedule, the payment formula is called
17 resource-based, relative value scale. The valuation is a
18 different kind of valuation than the value that I've heard
19 many Commissioners talking about today, that is the value
20 to the beneficiary, the value to society.

21 I thought I heard a little bit in what you were
22 saying, and I may have over-misestimated what you said, to

1 quote a term --

2 MS. WANG: That's okay.

3 DR. CROSSON: Anyway -- something about the
4 notion of potentially introducing into the payment formula,
5 into the fee schedule, some sort of element of the relative
6 value of what's actually being produced by that particular
7 service. Did I hear that or not?

8 MS. WANG: I think that it was -- I mean, that's
9 one way to interpret it. But again, the word "value" is, I
10 think, dangerous. Is that a moral value to society that
11 we're kind of making judgment calls on, or is it really
12 just an observation about pricing accuracy?

13 What I was suggesting is, to the extent that it
14 has not happened, maybe there should be a more robust
15 effort to really talk to primary care societies and primary
16 care physicians about what their work day today looks like,
17 and what they anticipate their work day looks like six
18 months and a year from now, because maybe there are
19 elements in the definition of work that should be
20 introduced into the idea of what is work, what is
21 intensity. You know, work is -- maybe it's more than time.
22 Maybe it's physician extenders. Maybe it's, you know, a

1 different augmentation or a multiple of I'm spending an
2 hour interviewing a new patient but it's a multiple event
3 because I now have to spend time, you know, educating the
4 clinical educator who's going to work with the family, or
5 setting up for them to go to a diabetes group management
6 session, those kinds of things.

7 DR. CROSSON: Thank you. Sue?

8 MS. THOMPSON: A couple of points have been made
9 by previous Commissioners as well, but just to underscore,
10 like Amy, I cannot help but tie back to the opening chapter
11 we started with yesterday, and the urgency that we face,
12 and having come through and continuing to be within an ACO
13 experience, especially in rural America the challenges
14 around primary care.

15 And not to belabor this, but there was, you know,
16 inference in the report, in 2015, about how nurse
17 practitioners and PAs are starting to play a growing role
18 in primary care, and I'm curious how big a role is this and
19 what's the pace at which that's occurring, and then, what
20 consequences are there to this piece that has happened as a
21 result of a lot of medical students not choosing primary
22 care.

1 The other piece in the ACO environment -- and Jon
2 referenced this, as well -- as long as we're battling the
3 fee-for-service incentive for our specialists, it's
4 difficult in the ACO world. So again, I think another
5 rationale for staying after this.

6 One of the comments that Kathy made about an
7 experience with a physicians, or we have compensated
8 physicians based upon a discrete experience or an episode,
9 I think that's true in the specialist, or in the procedural
10 world, but my relationship with Marcus Welby, as you
11 commented yesterday, or that the depleting number of Marcus
12 Welbys is a long-term relationship. And I'm curious, if
13 we're thinking about the cognitive primary care,
14 relationship-oriented practitioner in a way that doesn't
15 work, when we try to put it into value units, depending on
16 how you define value. But when you said that I thought,
17 that's not how I think about my relationship with my
18 primary care physician. So I just comment about that.

19 And last, and this is really, just, it caught my
20 eye, on page 92, when you talk or look at, we haven't had
21 numbers drawn since 2013, about physicians that are opting
22 out of Medicare. But as of 2013, while it said that

1 there's not a lot, half of those who had opted out were
2 psychiatrists and oral surgeons, and I'm looking forward to
3 the discussion we're going to have around mental health
4 with our geriatrics. Since 2013, how many more
5 psychiatrists are dropping out -- and they play a huge role
6 in working with primary care around some major medication
7 issues that we have with our Medicare beneficiaries.

8 So those are my points. Important, important
9 work, so thank you.

10 DR. CROSSON: Thank you, Sue. Jack.

11 DR. HOADLEY: So, again, I want to thank Kevin
12 and Ariel for framing this. I mean, it's obviously gotten
13 us really thinking hard about this.

14 I go back to what Paul started the discussion
15 with. I mean, we've tried a bunch of ways and made a bunch
16 of recommendations over the years to try to fix some of the
17 issues that we've identified, and I do think there's a lot
18 of value in sort of doubling down on that effort, seeing if
19 there are ways.

20 I mean, Paul, you've made one comments about
21 maybe reframing some of these with more specificity or
22 other ways to try to get more attention.

1 Sometimes because we have already made the
2 recommendation and we just sort of point to it, I don't
3 know if that gets the same attention as kind of figuring
4 out a way to reframe it and put it back in with a new vote
5 and new kinds of things. I mean, that's at a sort of
6 trivial, sort of marketing level almost, but if we can
7 figure out some ways to put some different meat on the
8 frameworks that we've already established, that might be
9 useful.

10 And I think a couple people made the point that
11 because the fee schedule still is the underpinning in ACOs
12 and to a great extent within MA, this is not like a fading-
13 out thing as fee-for-service gets to be a smaller and
14 smaller share. It continues to be the framework.

15 A lot of people made points about grouping codes
16 into families and so forth, and I guess the question we
17 asked on a couple of things yesterday, is it worth the
18 squeeze? I worry that we go through a pretty major
19 restructuring and yet the incentives to update the system,
20 the way people play within it don't necessarily change. We
21 might just do a lot of effort, even if you could imagine
22 the politics working to go for a major restructuring, and

1 then not really have changed the underlying incentives or
2 the underlying things.

3 And I think about, on the one hand, some examples
4 you've used where we could address some of the incentives
5 for using the higher-value codes, but I also think about
6 you can imagine families of codes where you really are
7 saying you're not paying enough to do this higher-end
8 service when it's needed, and it's the whole stenting kind
9 of thing.

10 In this whole discussion, whether we call it
11 reference pricing or common codes and so forth, we've had
12 the conversation on the Part B side of where is it that
13 it's under a design of trying to put incentives on the
14 consumer, on the beneficiary in our case, to make choices
15 around one model of reference pricing or in the Part B drug
16 discussion we talked about putting things under a common
17 code, so that the purchasers, the providers are faced with
18 an incentive of which choice to make.

19 In all of these questions about overused or
20 inappropriately used procedures, maybe it's not really the
21 fee schedule where we need to think about the structure,
22 but some other kinds of mechanisms to address that.

1 On the paying for primary care, your new
2 directions and personal capitation, I mean, I think one
3 thing -- I mean, it's frustrating to me, I thought, when we
4 made the recommendation on the per beneficiary, per capita
5 payment that that might be something. Given that the old
6 bonus was going away, it might be something that would
7 actually hit the sweet spot politically. Obviously, it
8 didn't, and I don't know if there's any way, again, to
9 reintroduce that as an idea to give it -- again, almost
10 from a marketing approach, to get people to stop and pay
11 some attention to it.

12 And I do think we should probably continue to
13 think about the kind of partial capitation things. I am
14 really struck by these notions of primary care practices in
15 the way Sue and Pat and so forth talked about it. It's the
16 long-term relationship. It's the investment, so many of
17 the things that aren't in the encounter, as several people
18 have said, the bringing in of other personnel into a
19 medical home-style practice. It seems like when we talk
20 about the partial capitation, it was still at a pretty
21 small level that wouldn't have really addressed those kinds
22 of things. And I don't know, short of shifts into Medicare

1 Advantage, whether there's other models to try to think of
2 a payment within the traditional Medicare side of the
3 program that could come up with a better way to compensate
4 a primary care practice to really encourage all those
5 outside the encounter kinds of activities or the extension
6 of the encounter beyond the initial provider that's making
7 the visit into something that we could do.

8 I don't have like a magic idea for how to do
9 that, but I think that's probably a worthwhile area to
10 think some more about.

11 DR. CROSSON: Thank you.

12 Warner.

13 MR. THOMAS: Just a couple of comments. It
14 sounds like there's been pretty good support that we think
15 the primary care reimbursement issue is material, not 5,
16 maybe more in the 30, and I would just encourage us to take
17 that on, seeing that it's so central to all the things we
18 want to do around our ACO development, around chronic
19 disease management.

20 Whether that's budget neutral or not or whether
21 it's budget neutral within physician fees or budget neutral
22 within Medicare, maybe it should be budget neutral just

1 within all Medicare spending. I would encourage us to take
2 that on and to drive that forward.

3 The other thing, I would agree with Bill. I
4 don't know if going through and looking at the other 5,000
5 codes is really going to yield a lot of benefit, given the
6 amount of time that that's going to take. But perhaps one
7 of the things that could be looked at, going to David's
8 point, is the ones that really are -- they seem -- maybe
9 "egregious" isn't the right word, but certainly very
10 significantly overvalued. And compare and contrast that to
11 areas where we know we have significant demand and not
12 enough supply, and the things I think about, like neurology
13 where it's another cognitive or mental health, as Sue
14 mentioned. I think we ought to be thinking about what are
15 those specialties that we just do not have the right supply
16 of folks versus a demand of services, and I think that may
17 evolve over time. But, certainly, today, we know some of
18 those more cognitive disciplines, that's certainly a big
19 issue.

20 I also would just make the comment that I think
21 instead of spending lots and lots of times on the fee-for-
22 service model, that we fix what we need to fix here, but

1 spend our time on the ACO and the global budget or global
2 payment model, which I think ultimately is where we need to
3 get. I understand this is the underpinning. We need to
4 fix some of these things, but to me, they are not
5 ultimately where we should be spending our time around
6 physician reimbursement, in my opinion. It doesn't mean
7 these things shouldn't be fixed, but I think that we need
8 to spend our time and put the right incentives on the total
9 cost of care and getting our physicians focused on that.

10 DR. CROSSON: Thank you. Thank you, Warner.

11 Bruce.

12 MR. PYENSON: Well, I want to thank Kevin and
13 Ariel. It's really great to have your expertise and in-
14 depth understanding and background here. It just really
15 comes out, and I want to thank you for that.

16 We heard from some of the veterans of the
17 development of the fee schedule -- Paul and Bill and Kathy.
18 I think I want to thank you because the structure that you
19 set up is still the foundation of what we're talking about
20 for the future. So that was good work. I know not
21 everything went the way you had hoped, but, boy, it's still
22 around. And we're still using it and looking at it for the

1 future, and I think the lesson there is that it doesn't
2 have to be perfect. And --

3 MR. GRADISON: Something happened on the way to
4 the forum.

5 [Laughter.]

6 MR. PYENSON: And I think if we look at it in the
7 future, my issue of the productivity gains, looking around,
8 we're all baby boomers here, and we're all carrying one of
9 these or having it literally in front of us here. Of
10 course, none of us are multitasking. We're in a generation
11 in an era where we're going to have self-driving cars in
12 five years or less. We're going to have self-driving
13 diabetics. My cardiologist is probably going to be in the
14 cloud and have a voice like Siri, and that's the future
15 transformation that's happening now. Having some
16 flexibility that recognizes the kinds of changes that are
17 going to go on, I think the structure we have can deal with
18 that. But I think that's going to be important.

19 Just a comment on -- I think the approach with
20 looking at the aggregate time is really very efficient, and
21 I think it's a very good way to go forward. So that takes
22 away a lot of the concerns about looking at thousands of

1 codes and so forth, and that's good enough to get it right
2 to do that.

3 So I support the potential next steps. Thank
4 you.

5 DR. CROSSON: Thank you, Bruce.

6 Other comments? Bill.

7 DR. HALL: I'm the last --

8 DR. CROSSON: Oh, I'm sorry.

9 DR. HALL: I think this has been one of our,
10 really, greatest discussions we've had since I've been on
11 the Commission, and I would echo Bruce's comments about the
12 legacy that's been talked about here and the ideas that
13 have been expressed.

14 I'm not going to obviously repeat what everybody
15 has said, but a couple of things that stood out for me in
16 listening to all of this is a couple of principles that
17 came out. One is that there is a history here, and if we
18 ignore the mistakes of others, we're found to repeat them.
19 So that maybe says that we need to think in a slightly
20 different way, maybe even out of the box. Certainly, I
21 think that Bill and Paul have given us some good things to
22 think about.

1 Craig brought in the issues of population health
2 as one of the key factors in solving this problem. I
3 certainly agree with that.

4 Kathy, I think your comment that you've repeated
5 several times, anything worth saying is sometimes worth
6 repeating several times, that what problem are we trying to
7 solve? Why the hell are we here? I guess I would answer
8 that, that we are at a very unique time in the history of
9 Medicare; that is, that there will never be as many
10 Medicare recipients in the entire history of the world as
11 there is going to be in the next 20 years. That is going
12 to culminate right about the time that we're supposedly
13 running out of funds to continue Medicare.

14 The way I would try to think of reframing this
15 problem is that we're here to service Medicare recipients
16 now and in the future. We're not necessarily here to
17 adjust payment structure disparities of physician payment,
18 all of the other kind of political issues that sometimes
19 muddy up the water here, not that they're not important,
20 but when we say what are we going to do about Medicare
21 recipients who don't seem to be getting the care that they
22 need or at least we think that that's probably what's going

1 on here.

2 So ways that we might want to think a little bit
3 out of the box here is to say maybe we don't have to repeat
4 the mistakes of others either. For example, there are some
5 established countries that have taken a very different view
6 of this whole thing; the National Health Service in
7 England, for example. Australia is in there, France to
8 some extent. In England, the rate of house calls for older
9 people, for example, is something like 500 percent higher
10 in England than it is in the United States, where it's
11 almost nonexistent.

12 So one of the things we might want to say is the
13 issue and the problem, Kathy, that we're trying to solve
14 here is how do we provide the best care to Medicare
15 patients, and by that, I mean the value equation, the value
16 proposition really works out.

17 And I would say that maybe this isn't a primary
18 care problem or how much money primary care doctors are
19 making. Maybe it's not a doctor issue. It's a health care
20 issue that can be solved in a whole variety of ways by a
21 mix of providers.

22 So I think we should take it really out of the

1 box here and say that it looks like this is not a problem
2 that's going to be solved in the fee-for-service system.
3 It's probably a problem that's going to look at large
4 organized motivated health systems who can redistribute
5 resources necessary to get at the problem.

6 This is not a doctor problem only. There are so
7 many other professionals in the business now who might be
8 able to actually do some of this a lot better than
9 physicians, quite frankly.

10 So I think we should both narrow our focus and
11 not worry so much about the disparities of the physician
12 payment but also broaden it and say that this is a really
13 incredible opportunity to develop a new system. Yes, it's
14 probably going to have a capitated mode to it. It's
15 probably not going to be fee-for-service. So this is our
16 chance, I think.

17 DR. CROSSON: Great. Thank you very much, Bill.

18 Okay. I see no other comments, so let me just
19 sum up a little bit here.

20 Just picking up on Bill's commentary, personally
21 I -- and Warner made the same point and I think Craig as
22 well -- I couldn't agree more with the fact that we really

1 need to replace the payment system with some sort of
2 population-based payment system. We need organized
3 delivery systems to be able to do that, whether they are
4 accountable care organizations or whatever. The progress
5 has been slow. If I had thought 10 years ago, 12 years
6 ago, when I first came on the Commission, that 12 years
7 later, we'd still be saying, "Boy, we really need this set
8 of changes," I think I would have been somewhat
9 disappointed. Nevertheless, it is proceeding. It's just
10 proceeding slowly.

11 And, in the meantime, I think -- and I heard
12 general support for this -- we shouldn't avoid trying to
13 fix what is mispriced within the fee-for-service system in
14 the meantime because I'm not sure how long the more
15 substantial changes is going to take.

16 I'd make one point here. I think in terms of the
17 balance between reiterating our prior recommendations and
18 coming up with new ideas, honestly I think I've heard
19 support for doing both. Not all of our recommendations
20 have gone unheeded. The 10 percent primary care increase
21 came pretty much from Commission recommendation prior to
22 the Affordable Care Act. The problem is that it had a

1 sunset clause in it, and because of the dynamics we are
2 seeing right now in the Congress, it has not been picked up
3 again.

4

5 In general, philosophically, we often deal with
6 this question of what is the political likelihood of some
7 recommendation that we come up with. What's the political
8 likelihood that it will be picked up, whether talking about
9 the Congress or the administration?

10 I certainly can remember myself trying to deal
11 with this early on, and I think Glenn used to say -- and I
12 have come to agree with him -- our job is to try to get the
13 policy right, and if we have to say it -- if we can get it
14 right and somebody does something about it the first time,
15 so much more credit to us. If we have to say the same
16 thing over again two times or three or four or five, which
17 is not an unknown phenomenon in the political process, then
18 that's what we need to do. So I do think there's value in
19 us reiterating and updating recommendations that we have
20 made before to the extent that elements have changed, but I
21 do think that there's also an opportunity and a need for
22 some new thinking. And we heard a lot of that today, and I

1 think that's been very useful.

2 I heard general support for going in most of
3 these directions. I think with respect to the grouping of
4 codes, the family of codes, I think if and when we come
5 back with that idea -- and I do think there's some -- as I
6 said earlier, I think this idea, which we kind of put out
7 here, is still very raw. I think if and when we come back
8 with this as part of a set of potential solutions, we will
9 come back with I with a pretty robust justification for why
10 it would be useful and in what way, and, in addition, I
11 think, as Kathy had suggested, with a good deal more
12 specificity, examples and things of that nature. And so
13 there's going to be a time, I think, for more thinking
14 about that particular piece.

15 But I appreciate the input. I think it's been
16 very helpful. I think we've advanced our thinking, and as
17 I said before, I think we are going to be revisiting this
18 issue of the physician payment process or whatever you want
19 to call it, the fee schedule plus MACRA and everything
20 else, a number of times at least through April, if not
21 beyond that.

22 I think, Mark, you want to make -- you looked

1 like you were -- no.

2 DR. MILLER: The only thing I was glad you said
3 at the end there that our recommendations haven't gone
4 unheeded because if you hadn't said it, I was going to give
5 you guys a little bit of a pep talk, and given my
6 personality, you don't really want to do that because I'm
7 not really that bubbly.

8 But I do actually want you to understand that
9 they have. So the primary care adjustment went in. They
10 sunset it. Okay. They also, Kevin, took the idea of the
11 revaluation and turned that into the formulaic thing that
12 got built into a law. Again, they took an idea, put their
13 own spin on it, and did it. And there's other examples out
14 there.

15 And he said it, and this is the last thing I'll
16 say. They tend to pick up our ideas when they legislate in
17 big steps. The ideas have to be out there, well-
18 articulated -- or re-articulated, Jack, as you were saying,
19 and ready to go. At ten o'clock at night, it's like,
20 "Okay. Now we're turning to this." They know where
21 they're reaching.

22 So I don't think you should look at this as they

1 aren't listening. I think in some ways, you have had a
2 measurable impact here. So I was glad that you got that
3 into your comment.

4 DR. CROSSON: Okay. So now it's time for the
5 public comment period. So if there are any members of the
6 audience who would like to make a public comment, I'd ask
7 you now to come up to the microphone so we can see who you
8 are or at least how many people there are. We've got one,
9 two, three people moving. It looks like a couple of
10 individuals. I'll wait for the commotion to quiet down for
11 a second.

12 MS. KEYSOR: Can you hear me?

13 DR. CROSSON: Just one sec. Sharon, are you
14 still in line or not?

15 MS. McILRATH: I'm still in line.

16 DR. CROSSON: Okay.

17 [Laughter.]

18 DR. CROSSON: Okay. So this is the public
19 comment period. Thank you, those of you who are going to
20 talk to us. This is a useful opportunity. I will make one
21 point which is it's not the only opportunity. This is an
22 opportunity to comment after the discussion. There are

1 opportunities to make comments to MedPAC and the staff
2 prior to the discussion, through Mark and his staff, the
3 website, as well as individual communications with Mark and
4 his staff. However, the Commission values this opportunity
5 as well.

6 We would ask you to identify yourself and your
7 association or affiliation, if you have one. We generally
8 ask you to hold your comments to about two minutes. We're
9 going to turn this light off in a second. When I turn it
10 back on, that's two minutes and we would ask you to wrap up
11 your comments.

12 Go ahead.

13 MS. KEYSOR: Katie Keysor from the American
14 College of Radiology. One of the prior recommendations
15 mentioned in the presentation was expanding the multiple
16 payment procedure payment reduction policy. I would remind
17 the Commission that the PAMA legislation mandated that CMS
18 publish the data used to justify the 25 percent multiple
19 procedure payment reduction for the professional component
20 of advanced diagnostic imaging services. CMS never
21 complied with this mandate.

22 Then, in December, the Consolidated

1 Appropriations Bill, just passed this last year, mandated
2 include a provision to roll back the professional
3 component, NPPR, from 25 percent to 5 percent, which is
4 backed by data. So any future NPPR recommendations should
5 be backed by supporting data.

6 Thank you.

7 DR. CROSSON: Thank you very much. Sharon.

8 MS. McILRATH: Sharon McIlrath, AMA. So I wanted
9 to first just address the process of the RUC and to repeat
10 Dr. Coombs' invitation that, really, you should come and
11 see it before you decide that it's not a robust process,
12 and that it's not based on fact. The claim -- it's all
13 based on claims data. There is a report that's on our
14 website. I will try to get a link to people so that you
15 can see that. It gives the most recent numbers on the
16 adjustments that they have had. It's up to about 2,100
17 that they either have done or are looking at; 1,260 of
18 those, I believe, resulted in either reductions or
19 deletions of codes, and when they are deleting a code,
20 often it is because they have bundled stuff back together.
21 So on the multiple procedure reductions, what they have
22 done is to go in, and when people are doing something at

1 the same time they've actually done a new code that
2 includes it all, and they also have adjusted the practice
3 expense and the work values to match that.

4 Altogether, so far, they have redistributed \$4
5 billion, and the redistribution, yes, it goes across the
6 fee schedule, but it also is used, in any given year when
7 you have other things, new services that are being paid
8 for, it's used to pay for those. So the new comprehensive
9 care and transitional care codes, those would have been
10 paid for with the reductions that came from the misvalued
11 codes. So, in many cases, it is actually sort of going
12 directly to those other services that, for the most part,
13 are done by primary care.

14 I think that the policy of the RUC has tried to
15 be, particularly in more recent years, to do what some of
16 you have talked about, about identifying services that
17 aren't currently being paid for -- new services as opposed
18 to saying that, you know, what's there is misvalued. So
19 that's where most of these codes, the new ones that CMS has
20 adopted, are -- were originally suggested by the RUC. In
21 some cases, the values that the RUC attached to those codes
22 were higher than what CMS had actually adopted.

1 Also, in some cases, there's some additional
2 things, such as anticoagulation management, that don't, you
3 know, sort of ever get into that list but that also benefit
4 the primary care.

5 DR. CROSSON: Thank you. Sharon, could you sum
6 up? Thanks.

7 MS. McILRATH: Well, the -- I just would urge you
8 also to look at what it is that they have -- many of the
9 kinds of criticisms that were made here of the system are
10 exactly the criteria that the RUC has used to do their
11 misvalued codes, so the business about new services and
12 that needing to come down. They have a new service review,
13 so I just would urge you to -- I'll get this link to you --
14 to look at what they actually are doing and to please, if
15 anybody would like to come and see one, we'd be happy for
16 you to do that.

17 DR. CROSSON: Thank you very much.

18 Seeing no one else at the microphone, we are
19 adjourned until next month's meeting.

20 [Whereupon, at 11:40 a.m., the meeting was
21 adjourned.]

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