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:

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
PAT WANG, JD

B&B Reporters
4520 Church Road
Hampstead, Maryland 21074
410-374-3340

AGENDA PAGE

P R O C E E D I N G S

[9:58 a.m.]

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

MS. HERMAN: Good morning.

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

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

The chapter is intended to frame the Commission's

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

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

Jennifer will start us off with the first topic.

MS. PODULKA: Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

average annual growth rate of 4 percent.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DR. CHRISTIANSON: Yes, same slide.

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

that's worth taking a look at.

MS. PODULKA: Thank you.

DR. CROSSON: David.

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

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

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

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

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

while beneficiaries are experiencing a higher quality of life.

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

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

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

MS. PODULKA: To the previous cohort, yes.

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

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

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

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

MS. PODULKA: Yes.

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

DR. CROSSON: On this point, Kathy?

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

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

MS. PODULKA: Definitely. And thank you for

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

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

DR. CROSSON: Jack.

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

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

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

DR. HOADLEY: Outpatient.

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

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

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

DR. MILLER: We will look at it.

DR. HOADLEY: Yeah.

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

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

DR. MILLER: Yeah.

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

DR. MILLER: It's a good point.

DR. HOADLEY: -- seems useful.

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

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

MS. HERMAN: Yes, that's correct.

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

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

DR. HOADLEY: Right.

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

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

MS. HERMAN: Yes.

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

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

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

MS. PODULKA: That's a good point.

DR. HOADLEY: Yeah.

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

DR. HOADLEY: Right. Thank you.

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

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

DR. CROSSON: What are those?

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

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

DR. DeBUSK: Yes.

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

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

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

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

[Laughter.]

DR. MILLER: Pay attention because --

MS. PODULKA: I'm ready.

DR. MILLER: Right, got it.

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

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

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

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

Are you okay with all that, Jennifer?

[No response.]

DR. DeBUSK: No follow-up.

DR. MILLER: Okay.

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

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

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

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

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

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

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

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

least.

MS. PODULKA: Yeah.

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

MS. HERMAN: Yes, definitely.

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

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

DR. CROSSON: Rita.

DR. REDBERG: Thank you.

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

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

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

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

[Laughter.]

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

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

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

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

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

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

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

DR. CROSSON: Warner.

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

DR. MILLER: So you are just looking for the

total of those three lines?

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

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

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

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

[Laughter.]

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

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

MR. THOMAS: Between you and I.

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

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

[No response.]

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

MR. THOMAS: Okay, great.

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

MS. PODULKA: Anyone from the Part D team?

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

MS. PODULKA: To do with it.

DR. MILLER: -- to do with that.

MS. PODULKA: Yes.

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

MR. THOMAS: That's it. Thanks.

DR. CROSSON: Okay. Thank you.

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

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

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

DR. MILLER: [Off microphone.]

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

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

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

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

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

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

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

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

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

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

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

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

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

DR. MILLER: And just a quick commercial.

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

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

MR. GRADISON: I'll wait until later.

DR. CROSSON: David? Amy?

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

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

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

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

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

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

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

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

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

worker productivity to that as well as quality of life.

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

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

[Off microphone.]

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

DR. REDBERG: Rita.

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

DR. MILLER: Alice, are you still in?

DR. COOMBS: Yeah, I'm in.

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

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

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

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

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

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

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

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

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

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

DR. CROSSON: Thank you, Bill. Rita.

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

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

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

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

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

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

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

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

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

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

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

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

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

MS. PODULKA: Great. Thank you.

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

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

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

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

The bit about workforce and matching workforce,

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

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

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

DR. CROSSON: Craig.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DR. CROSSON: Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[Pause.]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Both the small and large device companies

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Implantable medical devices, or IMDs, such as

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

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

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

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

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

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

First, Medicare does not pay medical device

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

On your second question on the GPOs and the safe

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

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

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

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

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

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

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

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

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

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

MR. ROLLINS: Conceivably, yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DR. CROSSON: Okay, still on clarifying questions.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Those were some of my thoughts. Just some.

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

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

And then things kind of get worse with respect to

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

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

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

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

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

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

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

I've got a couple of other --

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

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

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

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

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

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

MR. PYENSON: Yes.

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

MR. PYENSON: Yes.

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

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

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

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

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

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

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

DR. CROSSON: Thank you. Jack.

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

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

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

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

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

So that's the perspective I'd offer.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

review.

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

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

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

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

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

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

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

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

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

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

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

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

Okay. Moving down this way. Yeah, Brian.

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

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

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

Number one, in information, I think UDI has

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

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

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

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

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

DR. CROSSON: Thank you. Very clear.

Kathy.

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

accountability.

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

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

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

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

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

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

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

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

DR. CROSSON: Thank you. Rita?

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

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

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

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

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

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

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

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

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

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

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

DR. CROSSON: Okay. Paul.

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

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

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

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

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

DR. GINSBURG: Actually, the way the mechanism

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

DR. CROSSON: I see. Okay.

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

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

DR. CROSSON: All right. Thanks very much.

Bill Hall?

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

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

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

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

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

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

meant by the price transparency?

Thank you.

DR. CROSSON: Brian.

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

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

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

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

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

[No response.]

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

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

AFTERNOON SESSION

[1:34 p.m.]

DR. CROSSON: Okay. I think we're ready to proceed with the afternoon session, welcoming back Carol Carter, who is going to bring us through the next chapter of her work on post-acute care, and we're going to be focusing in on the issue of quality measurement. Carol?

DR. CARTER: Good afternoon, everybody.

Post-acute care offers important recuperative and rehabilitation services to Medicare beneficiaries and refers to services furnished in four different settings: skilled nursing facilities, home health agencies, inpatient rehabilitation facilities, and long-term-care hospitals.

Of the beneficiaries who are hospitalized, about 40 percent go on to use post-acute care, and in 2014, Medicare spending on these services totaled $59 billion. Medicare currently uses different payment systems to pay for care in each setting, and that results in quite different payments for similar patients.

In June, the Commission reported on the design of a payment system to span the four settings. We noted that such a system was within reach and could implemented sooner

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

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

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

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

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

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

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

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

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

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

The PAC PPS work fits into a large body of work

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

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

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

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

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

The IMPACT Act also requires the Secretary to

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

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

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

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

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

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

measures.

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

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

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

I want to point out that the readmission measures

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

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

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

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

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

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

And with that, I look forward to your discussion.

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

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

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

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

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

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

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

DR. HALL: Thank you.

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

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

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

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

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

MS. WANG: Okay.

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

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

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

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

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

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

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

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

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

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

[Simultaneous discussion.]

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

MS. WANG: Right.

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

they would be included in the PAC provider.

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

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

DR. CARTER: -- condition.

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

[Laughter.]

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

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

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

Does that help at all?

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

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

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

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

[Simultaneous discussion.]

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

tiering based on your favorite measure of SES.

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

MR. LISK: [Off microphone.]

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

DR. CROSSON: David.

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

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

DR. CROSSON: Preventable.

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

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

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

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

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

we're talking about versus what's law.

DR. CROSSON: Bruce.

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

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

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

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

DR. CARTER: Okay.

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

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

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

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

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

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

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

[Off microphone.]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DR. CROSSON: Thank you, Alice. Bruce?

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

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

MR. PYENSON: Okay. Great. Thank you.

DR. CROSSON: David and Pat. David?

DR. NERENZ: Okay. Thanks. Just a question

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

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

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

DR. NERENZ: Okay, so --

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

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

DR. CARTER: Yeah.

DR. NERENZ: -- but it was actually there

already, at the end of the PAC stay.

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

DR. NERENZ: Okay.

DR. CARTER: Yeah.

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

DR. CARTER: Absolutely. Right.

DR. NERENZ: Yeah. Good. Okay.

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

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

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

DR. REDBERG: Oh.

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

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

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

DR. CROSSON: Rita.

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

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

But my comment was only on those policy options.

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

DR. CROSSON: Okay. Sue.

MS. THOMPSON: Carol, two different comments.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DR. CARTER: I'm good.

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

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

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

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

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

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

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

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

DR. CROSSON: Okay.

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

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

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

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

[Pause.]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Of the 70 percent of Medicare-billing physicians

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

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

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

Overall, 30 percent of Medicare physician

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

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

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

more complete over time.

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

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

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

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

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

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

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

DR. CROSSON: Okay, that's helpful.

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

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

DR. CROSSON: Okay. Thanks.

Clarifying questions? Rita, Jack, Warner. Rita?

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

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

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

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

MS. BLONIARZ: Oh.

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

MS. BLONIARZ: I can figure that out.

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

MS. BLONIARZ: Yeah.

DR. REDBERG: -- that would be interesting.

MS. BLONIARZ: Yep, I do.

DR. CROSSON: Jack.

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

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

DR. HOADLEY: Right.

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

DR. HOADLEY: Okay.

DR. CROSSON: Warner.

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

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

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

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

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

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

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

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

the landscape across different organizations like you guys just said?

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

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

DR. CROSSON: Pat.

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

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

DR. COOMBS: No.

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

[Laughter.]

DR. CROSSON: Just kidding. So --

[Laughter.]

DR. CROSSON: Everybody's jumping the gun.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[Laughter.]

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

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

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

Okay. Craig.

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

We've, I think, progressively formed hypotheses

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

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

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

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

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

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

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

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

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

DR. CROSSON: Yeah, go ahead.

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

DR. CHRISTIANSON: She just said it, yeah.

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

DR. CHRISTIANSON: I agree.

[Laughter.]

DR. MILLER: Okay.

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

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

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

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

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

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

do we make sure that the data is accurate, because just saying you should put your data in there, and if it doesn't like to payment providers we'll put stuff in there but it won't necessarily be accurate.

But I thought that this was an interesting thought, and one that I hadn't been thinking, and so I wanted to make sure that despite he didn't -- the fact that he didn't want to do it, that he should say it out loud.

DR. CHRISTIANSON: I think you raised a really good point in terms of the accuracy of the data set, and if we don't think there's a good chance that the data is going to be reasonable -- whatever that means -- reasonably accurate, then that's another caution about going down that street.

DR. CROSSON: Jack.

DR. HOADLEY: So on this question of the data sets, I don't feel like -- I'm sort of like Craig -- I don't feel like I've got the information. I think -- you know, what I am convinced is that, you know, yes, we should explore whether there are other -- continue to explore what other alternatives. But, you know, you seem reasonably convinced that -- or you seem to have reasonably convinced

me that this is, at least, pretty accurate in terms of at least a point in time kind of estimate, with the various caveats as noted, comparison over a longer period of time being one of them, the fact that you've got a quarter of the physicians still in this other category but maybe some ideas of how to work with those and to think about those.

But I go back to what both Warner and Pat said, is, I mean, I've been thinking about the question, when we've talked about MACRA, of, you know, the same questions Pat talked about, you know, what are the capabilities out there. You hear a lot of comment, you know, in the political environment about what's this going to do to small practices, and I came at that saying, but, you know, how big a sector -- are we already past that tipping point where there aren't many of these ones and twos physicians anymore. This starts to suggest that, you know, the trend may be in the other direction but there's still a lot of them out there.

So I think it helps us frame certainly the MACRA kind of conversation, but probably a number of other conversations to have that, a sense of how fast the trend is changing obviously helps that too. And I'm struck, even

in just this three-year trend, at least on the solo practice side, and eventually it would be useful to have that break out with the sort of 2-to-5 versus the larger group practices as -- you know, like you did on the service dollars.

But otherwise, you know, this is really helpful to say, you know, that solo practice really hasn't gone down very fast in a couple of years. Now, you know, would it have changed quite a bit over a decade? You know, maybe we'd see more. We've certain seen a bit of a tick-up in the hospital ownership.

So I think those are all just useful trends, but shares that really help us frame how much attention we need to give to accommodations for the small practice in a MACRA type of conversation, or other kinds of topics.

So I think that's where this is, to me, really useful. I mean, Craig also raised some of the other broader kinds of questions that this could be brought to, and I think that's spot-on as well.

DR. CROSSON: And, you know, it has been mentioned, but I think the -- and this is just subjective, but I think the issue of where the small practices are is

also strongly influenced by geography. So the aggregate numbers may indicate 20 percent, but in large population areas, you know, on the coasts, for example, or upper Midwest or other places, it may be very different from that.

DR. GINSBURG: As far as SK&A, you know, I think Jon's points are well taken. I think it is -- I've had a number of colleagues different places who have used it for research projects and were very enthusiastic, despite its limitations, at how much better it could get at some things that they were studying than anything else. So I think for just describing generally what's going on, I think it's quite useful. It's not the ultimate solution.

I was going to respond to Kate's question about, you know, next steps, and I was thinking about the fact that for Medicare in particular, I think the proportion of physicians that are in hospitals or hospital systems is by far the most directly important to the Medicare program, and that's -- so in a sense, as to whether we should go into IPAs, that's much more marginal. You know, they only relate to Medicare in the sense that Medicare Advantage plans contract with them. They're clearly a much looser

form of affiliation than a group in the sense that they're affiliated for HMO contracting. They're not allowed to affiliate for PPO contracting, except some that have gotten exceptions from the FTC. So in a sense, that's where I come down.

DR. CROSSON: Paul--

MR. GRADISON: Sorry. You mentioned me after Paul?

DR. CROSSON: Yeah, I just want to comment, though. Paul, I'm not sure I -- I'd ask you to elaborate a little bit, because I think from an analytical point of view, I understand what you're saying. But, for example, IPA physicians and their decisions about whether to hospitalize or whether to refer or what drugs to use, et cetera, et cetera, to my mind have an equal impact in the end on Medicare spending as physicians who happen to be working in a hospital setting. Or am I missing something you're saying?

DR. GINSBURG: No, I think you're right, and there certainly are likely to be spillovers from an IPA physician, you know, what they have gotten from the IPA through -- their contracted HMO patients will spill over

into the fee-for-service Medicare or private sector PPO patients. So in that sense, I didn't want to be dismissive of IPAs. I think in California IPAs are a very important part of the delivery system. I think they've had a very positive impact on the efficiency of quality of care in California.

When you get outside of California, except for eastern Massachusetts, I'm not really aware of that many areas that have real IPAs that really are having a significant impact.

MR. GRADISON: Looking at data over the years, as we might in the future, there's a variable that perhaps you've already mentioned or had in mind, but I want to mention it for sure, and that is, well, I thought initially of the age of the practitioner because to get a sense of how many of them may be retiring, and that would be interesting. Another way to think about it, if the records already show it, particularly the AMA records, when did they become a physician. That would be another way to measure it. It's sort of the same thing, but we might get a sense of how newly hatched physicians are organizing or not organizing as against those that have been out in

practice. But some of the data I've seen suggests the potential of a rather large retirement cohort over the next ten years or so. I don't know whether that is a right period to mention or not. But it might have important implications in terms of interpreting the data.

MS. BUTO: Thank you. What I was thinking was although the data set, this commercial data set may have limitations, sort of like Paul, I think that we might want to continue to work with it and recommend also that CMS proceed to seriously double down on its effort to come up with a better data set. I think in doing that it would be helpful if we could identify some of the analyses that we'd like to see be able to come out of the data set that CMS develops. For example, do we think the size of physician practices has what kind of impact on utilization? Coordination of care, does it matter if they're multi-specialty practices or single -- even the size of the group doesn't tell you whether -- you need to know multi-specialty or single specialty, that kind of thing.

So suggest the kinds of analyses that we think really need to be done, not just to satisfy MACRA but also to look at things like reforming payments to primary care

or beginning to look to more bundled payments. So what are the opportunities that might arise if we had a better sense of what different size practices are capable of doing?

MS. BRICKER: So curious. You know, I understand that we matched or you matched the SK&A to Medicare claims to identify those that are impacted by Medicare. But to what extent can we tease out the reliance that certain specialties would have on Medicare?

MS. BLONIARZ: So we know that from other sources, like I could tell you what share of a specific specialty's revenues come from Medicare. I mean, if that's something --

MS. BRICKER: I was just curious, because primary care -- we have pediatrics, you know, was listed and OB/GYNs, you know, how much of their practice is reliant. Then to correlate, because of policies that, you know, have been suggested or recommended, we believe, you know, practitioners are making different decisions about staying in solo practice or not. Is there a direct correlation?

MS. BLONIARZ: We can flesh that out.

MS. BRICKER: Thank you.

DR. MILLER: But it will come from a different

data source, right?

MS. BLONIARZ: Yes.

DR. MILLER: Because this data, once she links to Medicare, all she's got is their Medicare business, and she wouldn't know if they're 50 percent --

MS. BLONIARZ: Right.

DR. MILLER: So she'll come back to answer your question using a different data set and saying here is what it looks like.

MS. BLONIARZ: That's right.

DR. MILLER: As long as you guys followed.

MS. THOMPSON: You all made my points [off microphone].

DR. CHRISTIANSON: A real quick question. In your assessment of the SK&A data set, it was mainly having to do with comparing completeness in terms of number of physicians that reported. What incentives do the physicians have to report accurately for that data set that are sort of stronger than they would be under Medicare and reporting to Medicare? Are they paid for their reporting?

MS. BLONIARZ: You know that's a good question, and I don't know. I don't know whether -- I mean --

DR. CHRISTIANSON: So to Paul's point, it may have more information -- it does have more information than a lot of other data sets, so I can see why it would be attractive to researchers who can use it to address specific questions.

MS. BLONIARZ: Right, right.

DR. CHRISTIANSON: I'm wondering if it might not suffer from some of the same issues that the Medicare data suffer from. I don't know.

MS. BLONIARZ: And I think just I would say that, you know, to the extent Medicare is collecting this information through PECOS or, you know, through the TIN, those directly implicate Medicare payment, and so, you know, they are subject -- you know, misreporting a TIN is a false claim, and so we might expect that that would be quite robust. But if we wanted to move away from what Medicare -- you know, the things that determine payment and coverage, that might be where we'd get worse information.

DR. GINSBURG: Yeah, I have a sense that when it comes to whether a physician is employed by a hospital, I think work I've seen at ASPE, that's very difficult for you to get from Medicare data. I don't know that there's much

incentive for a physician in SK&A to, you know, report that incorrectly. So I think it's just, you know, if we -- by just being aware of the shortcomings of Medicare, we can see some areas where the SK&A probably does shed some useful light. And given -- you know, I don't think I answered Jay's question well about, you know, since Medicare is paying more for some of the physicians that are employed by the hospital, that is as direct, immediate implication as opposed to the more indirect one of how these things affect their patterns of practice.

DR. SAMITT: One other follow-up question. When we look at physician affiliations, have you looked at the commercial sector in terms of what's being done to collect similar information there? And would there be any relevance in terms of public-private partnership to sort of develop a more comprehensive data set there? Because there's a lot happening on the commercial side to try to understand provider affiliations and provider data accuracy there as well. So I don't know whether there's any opportunity to kind of bridge the divide there to develop a more complete database.

DR. CHRISTIANSON: Are you offering [off

microphone]?

DR. SAMITT: Well, I mean, I think there are organizations that are trying to facilitate, you know, payer to payer in the commercial side. I don't see why you wouldn't bridge commercial with government.

DR. CROSSON: Okay.

DR. MILLER: Did you follow that?

MS. BLONIARZ: So I know of some state databases. California has, I believe, one and I believe Massachusetts that have physician affiliation information largely collected by private insurers and using some of the same kind of databases that we're discussing here. But SK&A is all commercial physicians as well, I mean, to the extent, you know, it covers most of the physician workforce.

DR. MILLER: That was the point I wanted to make sure you were following.

DR. SAMITT: Yeah, and maybe I can sort of connect with you and compare notes about where a broader set of information could be coming from.

DR. CROSSON: Yeah, there are -- well, you know this. There are associations or consulting organizations and the like, mostly coming at it from the organized

physician side.

So to sum up --

DR. MILLER: This will be interesting. Let's get Jon to do it [off microphone].

[Laughter.]

DR. CROSSON: I think we started out with a couple of questions to try to answer. One, what do people feel about -- and I'll use the term "utility" -- accuracy of this particular data source? And we have a range of opinion, I think, even though it's been qualified on both ends. We have some folks who think it's the best tool around and so let's go with it, and we have others who have reservations, significant reservations.

And then the second connected question was sort of assuming that we're going to use the tool, what could we use it for? And what's the relative value of doing that? And we've got a range of opinion there as well from it would be absolutely vital to some of the work we're doing in physician payment in general and others I think who have had modest skepticism about, you know, the value of it.

So I'm going to -- I think the conclusion I'm coming to, and let's test it, is that we have a split

opinion here, which makes it hard to go quickly from the first question into the second one. In other words, if we don't have full confidence in the tool, it's kind of hard to say let's go gangbusters and apply it to our judgments about what to do in general with physician payment.

On the other hand, it is what exists at the moment, and I think it would be probably unwise to simply walk away and abandon it as opposed to tracking it, at least, number one, looking for change. I have heard several suggestions that we investigate with CMS -- tell me if this is possible -- investigate with CMS, you know, what should be or could be done within reason by them to help develop a more robust data source that could then be applied more directly to policy decisionmaking. This is not going to be a quick solution for sure, but it might in the end be worthwhile us investigating both informally and then discussing it, and, if reasonable, making a recommendation along those lines.

I think in parallel, as we discuss the issue of physician payment -- and we've talked about that, again, to go back to this morning, from the perspective of MACRA/MIPS, from the perspective of ACOs and what will work

and what doesn't wk, and also, you know, the basic utility of the physician payment formula that exists. I think we should mark as we go through that work situations in which, you know, we say, gee, we could make a much better decision here or much better judgment if only we had more complete information about the nature of the physician delivery system. And if we find that happening a lot, then, you know, we put more effort here. And if we find that it is interesting but not on the critical pathway to those decisions, that would suggest a different direction.

That's the best I can do with the range of opinions that I've heard. But I will take alternative views.

DR. MILLER: Actually, I agree, and I wanted Jon to say it because I actually think we ought to take a little time and at a minimum talk to CMS and just figure out how much of a lift it is and what's out there, and then come back if there seems to be enough there, which is something that I wanted teased out of this.

I think my own view is we probably continue to work with this data set unless somebody happens to know of something a lot better, which, you know, we often come to

you looking for that, too. We'd probably stick with that. And to Kathy's comments and your comments just now, we ought to be very clear which analysis that we think we would like ideally because that would drive what we want out of SK&A, but also potentially out of CMS if we go that route. So, yeah, I agree with what you said.

DR. CROSSON: Okay. Kate, thank you very much.

[Pause.]

DR. CROSSON: So our last discussion for today is again a little bit of a new area for us. We're going to be looking at nursing homes. As most of you know, a good part of that care is part of the Medicaid program as well as other sources of payment, but it is an issue for the Medicare program to the extent that individuals who are cared for in long-stay nursing facilities find their way, inappropriately, into the hospital and generate Medicare charges.

I'm not giving your presentation, am I? I do that a lot.

[Laughter.]

DR. CROSSON: So Stephanie is going to take us through this issue, and I'm going to shut up.

MS. CAMERON: Good afternoon. Before we begin, I'd like to thank Carol Carter for her contributions to this work.

Today's presentation focuses on preventing avoidable hospital admissions of long-stay nursing facility residents.

As you may recall, the Commission discussed a population-based measure of potentially preventable hospital admissions in 2012. Then, in the fall of 2014, the Commission expressed interest in the patterns of hospitalizations of Medicare beneficiaries residing in nursing facilities. Today's presentation will provide background -- oh, excuse me. Then, in the fall of 2014, the Commission expressed interest in the patterns of the hospitalizations of Medicare beneficiaries residing in nursing facilities. Today's presentation will provide background information regarding strategies that nursing facilities are using to prevent hospitalizations of their long-stay residents. Next month, I will present findings related to the development of risk-adjusted measures of hospital use for this population.

To provide a bit of context, a majority of long-

stay nursing facility residents are Medicare beneficiaries, creating a easily defined population to target for better care coordination and quality of care. This population is primarily comprised of residents who are dually eligible for both Medicare and Medicaid. While the facilities that we are discussing today are typically the same facilities who provide care under Medicare's skilled nursing benefit, this presentation is focused on the long-stay resident population, who are on average older and more frail than the SNF population.

Existing literature has shown that a substantial portion of hospital admissions of long-stay nursing facility residents may be avoidable through better prevention or management by the nursing facility.

Transferring these residents to a hospital for conditions that could have been prevented exposes beneficiaries to several health risks, including falls, delirium, infections, and medication interactions. These hospitalizations also unnecessarily increase Medicare program spending.

The implementation of Medicare's hospital readmission reduction program has increased awareness of

hospital use among nursing facilities.

Today, I will discuss the increasingly competitive nursing facility environment and initiatives and strategies currently being implemented to reduce hospital use for nursing home residents. Next, I will present several key findings from interviews we conducted with nursing facility staff and related organizations. Finally, I will discuss the findings from the initiatives to date and our next steps.

Nursing facilities rely on admitting beneficiaries from hospitals for their short-term rehabilitation patients. Because about half of long-stay residents in a nursing facility begin from a hospital discharge, it's critical for nursing facilities to maintain relationships with hospitals. This appears to be increasingly true in light of Medicare's hospital readmission reduction program.

Facilities with lower readmission rates are better able to market themselves to hospitals and potential residents as being higher-quality providers. Many nursing facilities have begun focusing on observing and reacting to changes in beneficiary conditions, improving communication,

and providing additional staff training in an attempt to reduce readmission rates.

In the context of fee-for-service Medicare, about 140 nursing facilities volunteered to participate in an initiative funded by the Center for Medicare and Medicaid Innovation and implemented in collaboration with the Medicare-Medicaid Coordination Office. Beginning in 2012, the initiative to reduce avoidable hospitalizations among nursing facility residents or, as I will abbreviate it, the RAH-NFR initiative, provided funding to seven coordinating groups in different states to implement clinical interventions that include staff training, technical support, and education to participating nursing facilities. This funding also provides advanced practice nurses and other clinicians to guide the initiative within the facilities and provide direct patient care in five out of the seven interventions.

Phase II of this initiative, beginning this fall and planned to continue through 2020, will test a three-part payment model in conjunction with the interventions used in Phase I. Through Medicare Part B billing, Phase II will provide a new payment to facilities for the treatment

of qualifying conditions, an increased practitioner payment for the treatment of conditions on site at the nursing facility, and a new practitioner payment for care coordination and care-giver engagement.

CMMI funding for Phase I and Phase II of this initiative is expected to total about $230 million dollars. We also expect new Medicare spending associated with the payment model implemented in Phase II. The level of investment in this initiative raises questions regarding the long-term sustainability of this model after the funding ends in 2020 and for facilities currently operating without grant support.

Unlike the fee-for-service environment, the managed care model provides flexibility in providing services to enrolled beneficiaries. For example, United Healthcare's Nursing Home Plan uses Optum's CarePlus model, formerly known as Evercare, to provide care coordination and supplemental clinical care with advanced practice nurses for enrollees. In addition to providing clinician support, Optum's CarePlus model provides payments to nursing facilities when a beneficiary is treated for an acute illness within the nursing facility.

The Program of All-Inclusive Care for the Elderly, or PACE, integrates both Medicare and Medicaid benefits. This program is intended to keep beneficiaries in the community, instead of a residing in a nursing facility. PACE aims to reduce hospital use for this population by providing daily monitoring and observation to detect any changes in a patient's condition and to trigger a less intensive intervention.

Lastly, some nursing facilities are adopting strategies to reduce hospital admissions without additional staff or funding. RTI International found that over 95 percent of survey respondents not involved in the RAH-NFR initiative introduced policies or procedures into their facilities aimed at reducing avoidable hospital use of long-stay beneficiaries.

To better understand the strategies nursing facilities employ to reduce hospital use of long-stay residents, MedPAC contracted with NORC at the University of Chicago to conduct 10 interviews with organizations involved with these initiatives. Interviewees included participants in the RAH-NFR initiative, Optum's CarePlus model, and nursing facilities that implemented strategies

to reduce hospitalizations independently.

Through these interviews, we synthesized several common strategies to reduce hospital use among long-stay nursing facility residents. Improving communication between residents, facility staff, off-site clinicians, and families was cited frequently as the primary strategy to reduce hospital use. Many facilities we interviewed adopted new communication processes and tools, including the use of standardized forms among facility staff and between facility nurses and on-call clinicians. Facilities reported implementing new quality improvement programs and tools to varying degrees. For example, some facilities we spoke with used previously existing communication forms and did not undergo wholesale changes across all of their communication procedures.

Facilities also commonly focused on increasing the level of clinical training of staff members, including IV insertion for licensed nursing staff and safety procedures as they pertain to fall prevention. Facilities also provided education on how to detect and report changes in beneficiary health status. Some facilities implemented symptom-specific tools to guide evaluations conducted by

the licensed clinicians in the facility in a standardized manner.

Many respondents also discussed an expanded medication review process. Some interviewees stressed the importance of conducting a medication therapy review immediately following a hospital discharge to ensure that any new medications are properly administered and any medications that have changed are accurately updated in the facility's records.

Interviewees consistently mentioned advance care planning to reduce avoidable or unwanted hospital use. Advance care planning defines a broad group of conversations regarding an individual's preferences for end-of-life care and formalized through written documentation.

Lastly, one interview discussed employing telemedicine as another strategy for reducing admissions through the extended availability of health professionals.

We found consensus across interviewees regarding the key features necessary to implement strategies to reduce hospital use, which I will take in turn. Interviewees underscored the importance of consistent use

of tools to assist with communication especially between facility staff and physicians. We also heard from multiple interviewees that involving all levels of staff resulted in greater staff empowerment and higher levels of job satisfaction, which may affect staff turnover that I will discuss momentarily.

Respondents also emphasized the importance of facility leadership in supporting the initiative and clearly explaining the goals of the initiative, the expectations of staff, and the rationale behind any of the new processes implemented.

Once the new processes are developed and communicated, many facilities we spoke with discussed the need for ongoing educational efforts, including role play. Some interviewees described conducting root-cause analysis or so-called deep dives on certain cases that were admitted to the hospital. These detailed case reviews helped leadership better understand whether the facility's processes were followed and whether the admission could have been prevented. Many facilities we spoke with began to track patterns of hospital admissions in terms of the time of day, day of week, wing of facility, and triggering

event that lead to an admission to help focus their efforts.

Interviewees cited the facility's ability to manage staff turnover which include both direct patient care staff and facility leadership. Some facilities began training employees on their strategies to reduce hospital admissions during new hire training. Several respondents discussed the high level of turnover in their facilities and explained that the clinical staff associated with the Optum CarePlus model or the RAH-NFR initiative had been a source of continuity and institutional memory for the facility.

Several interviewees described the importance of clear communication with the resident's families upon admission and throughout the stay. One facility we spoke with provides information regarding the treatment capabilities of the facility and the extent to which they are able manage acute changes in health condition upon admission, setting expectation of care.

In terms of outcomes to date, RTI recently analyzed data from the RAH-NFR initiative and found statistically significant reductions in all-cause and

potentially avoidable hospitalizations across about half the interventions. RTI found mixed results across all-cause and potentially avoidable ED visits, where some interventions were found to increase use between 2012 and 2014. RTI did find reductions in Medicare expenditures for all-cause hospitalizations in 2014; however, on net, the reduction in total Medicare spending was not statistically significant.

An evaluation of the Optum CarePlus model found lower hospital use for enrolled beneficiaries, including both inpatient admissions and emergency department visits. Similarly, an evaluation of the PACE program found lower potentially avoidable hospitalizations compared to similar beneficiaries residing in nursing facilities. Because PACE and the Optum CarePlus program are funded on a capitated basis, reductions in spending do not result in savings to the Medicare program.

In its June 2016 release of the Scorecard on local health system performance, the Commonwealth Fund found reductions in hospital admissions of long-stay nursing home residents between 2010 and 2012. In its recent evaluation, RTI found that there was a decrease in

hospital use across facilities not participating in the RAH-NFR initiative. Other studies have also found reductions in hospitalizations associated with specific interventions. Nonetheless, we are unable to gauge the efficacy of tools and strategies to reduce hospital use among nursing facility residents nationally.

As for next steps, we will continue to monitor Phase II of the RAH-NFR initiative and the remaining evaluations of Phase I.

We are in the process of developing risk-adjusted measures to inform the Commission's understanding of hospital use patterns of long-stay nursing facility residents. This will include a potentially avoidable hospitalization measure to help us understand patterns across inpatient admissions; an all-cause hospitalization measure to also do the same; an all-cause ED and observation visit measure to ensure facilities and hospitals are not transferring residents to the emergency department as a substitute for inpatient care; and a measure of frequent SNF use by long-stay residents to determine the extent to which long-stay residents are hospitalized and then receive skilled care upon hospital

discharge.

Once finalized, we anticipate presenting these measures with our quantitative analysis at the October meeting and ultimately incorporate the findings into a June report chapter.

We are interested in your feedback regarding reactions to the initiatives, any other strategies or activities related to reducing potentially avoidable hospital use from your experience, and the planned measures. Next month, when we present our measures and findings, we will consider and discuss any policy options you have.

And with that, I turn it back to Jay.

DR. CROSSON: Thank you, Stephanie. Groundbreaking work. Again, very nice.

Let's take clarifying questions. Bill? Bill Gradison, then Bill Hall.

MR. GRADISON: Phase II, is that going to be the same group of nursing facilities that were in Phase I?

MS. CAMERON: It will be. So, when Phase II is rolled out, the group that received the intervention in Phase I will continue with that same intervention. Layered

on top of that will be a payment model. Then there will be a second group of facilities that will only receive the payment model. So there will be kind of the continued group of about 140. There is one state that is not included in Phase II that was in Phase I, so we expect it to be closer to about, I think, 120 facilities receiving both kind of the intervention with the advanced practice nurse assistance and all of kind of the education that goes along with that with the payment model and then likely a similar number of facilities, receiving only the payment model. And those facilities will be new to the initiative.

MR. GRADISON: Did you have any sense from the data so far whether the participants -- because this was over four years -- used their improved performance that you cited, to help get more business, to help get referrals?

MS. CAMERON: So a couple of things. First, you know, I do want to caution that the analysis to date that RTI has done was only through 2014, and the roll-out was a tiered roll-out that happened over time. So the initiative itself did not have all of the facilities online, I want to say, until late 2013. So although we were comparing the analysis -- the evaluation compares two years of data --

that first -- there was kind of one year in there that probably did not have the full evaluation.

And -- I'm sorry. I forgot the second part.

MR. GRADISON: I think the real question is, did the facilities that were doing better, in terms of less readmissions, use this for marketing purposes? I mean, that's really the question. Did they get a benefit in having higher occupancy already by virtue of participating in it? And maybe you don't know. I'm just curious about it.

MS. CAMERON: Sure. So I don't know if there were increases in their daily census. I did not see data that, you know, definitively said, yes, we were able to use this for marketing purposes and it increased our -- whether or not it was their skilled nursing census or their entire census overall. That I don't know.

What we had heard from our interviews, and some of our interviews did include facilities that were participating in the CMMI demo, was that, you know, we now have data to show that our readmissions are at a certain level, and that hospitals are looking to us to provide them that information. And so a hospital could say, you know,

of all the facilities we refer our patients to, these are the ones that have the lower readmission rates.

So I think there has been a sense, kind of beyond this initiative and out more broadly, that the facilities are, in fact, able to use kind of these rates to help their marketing.

MR. GRADISON: Thank you.

DR. CROSSON: Bill Hall and David.

DR. HALL: I had a question about how do we define success in your interviews. You mentioned that there was a lot of positive feedback, that training was better when these systems were put into place, that to some extent, not always, hospital admissions were reduced. Is that right?

Was there any emphasis on anything about the measures of quality of care in these places, and also, patient and family satisfaction, which is something that's very hard to get at?

MS. CAMERON: Speaking specifically to the initiative, I don't believe there were patient and family satisfaction measures but I will need to double-check that. The quality measures that RTI examined had very mixed

results, and I would say, you know, there was really no consensus on the quality aspect.

What we did hear from the interviews, however -- again, it's very anecdotal and we targeted facilities who were implementing these strategies, so it was a very specific group of facilities we spoke with -- thought that some of the benefits included better staff retention, because using some of the communication tools reduced -- it empowered staff and helped staff feel like if they saw a change in a patient's condition and reported that to the nurse on the floor, that that was actually looked at and they were taken seriously, and that they felt like they were empowered to help the patient and the beneficiary. I think some of the facilities would have said that is a success. We maybe kept some staff members on longer than otherwise would have; that's a success.

Other facilities spoke with discussed, again, anecdotally, that they had positive feedback from residents and also the resident's families for facilities that had long conversations about, you know, even just their capabilities upon admission of, "We're going to start having this conversation. This is what we would do if you

got ill in the facility. Are you interested in being transferred to the hospital for, you know, a serious of other ailments," and starting those conversations really, I think, opened the door of communication between the facilities and the patients, and that helped patient satisfaction. So I think, to some, that would be known as a success.

I think, you know, whether or not, in the long run, these do reduce hospital admissions, I think is still to be determined.

DR. CROSSON: David, and I've got Pat, Jack, Rita, and Alice.

DR. NERENZ: Thanks, Stephanie. Just to clarify, we're talking about here admissions, not readmissions, right?

MS. CAMERON: That's correct.

DR. NERENZ: Okay. And I just -- they were starting to get both in the conversation.

Now, then, my next question is, how separate are these? For example, are the long-stay facilities paid largely by Medicaid essentially separate facilities from those that are post-acute, paid by Medicare, so that not

only are the events separate, the facilities are separate, or is it not --

MS. CAMERON: No. By and large, these are the same facilities.

DR. NERENZ: The same facilities.

MS. CAMERON: And, by and large, they may even be the same bed in the facility, could have a beneficiary, could have entered a facility as a short-stay rehabilitation patient in Room C-101 and stayed in that same room over time and became a long-stay resident, because they were unable to be discharged. So it could be the exact same bed, the same facility.

DR. NERENZ: Okay. So that leads to the third and final clarification question. Are there financial incentives now, then, for these facilities to hospitalize patients -- let's say, I'll follow your example. I've got somebody in a bed who's long-term staying Medicaid. Pneumonia develops. The patient gets admitted. (a) That problem is out of my hair. (b) The patient comes back. Now it's a post-acute state and it's paid by Medicare. Does that happen? Is that a part of the story?

MS. CAMERON: Yes, I think that is part of the

story and that is one of the reasons that we'll be looking at the number of skilled nursing days for the long-stay beneficiaries, to try to understand, you know, what is the variation. Are beneficiaries being sent to the hospital kind of outside of the benefit period, so that they can trigger a new SNF stay?

So, yes, I think that's part of the rationale behind starting this endeavor, was to try to understand and get our hands around that.

DR. CROSSON: Okay. I have Pat, Jack, Rita, Alice, and Kathy. Have I missed anybody? Bruce.

MS. WANG: Is there any -- were there any questions or, I guess, concerns about potential -- I think that all of the initiatives in the demonstration, they're great. The more of that in the nursing home sector, the better. But I am wondering, because there was a lot going on in the hospital world too, in terms of changes in deciding to admit people. You know, forget avoidable readmission, avoidable initial admission. I mean, I think a lot of hospitals during this period of time were changing some of their practices, using observation beds more.

I just -- was there any concern that there's some

confounding -- I mean, is the credit for reduced hospitalizations all correctly attributed to the demo? Was that teased out, or was that a factor?

MS. CAMERON: So in our RTI's evaluation, they had a comparator group of facilities within the same state that the intervention was being conducted, and those comparator facilities had similar characteristics of the ones that were participating in the demo. So there was about a 2-to-1 match across most of the states.

So any changes on the basis of the hospitals would have been on both sides of the analysis, and when the difference in difference was run, the data should have reflected, you know, kind of teased that interaction out.

In terms of anything specific that was going on at other facilities, it's difficult to tell, but because this was a state-level analysis, you know, any changes in Medicaid, for example, were also presumably captured on both sides, and therefore the differences were actually captured from the intervention.

DR. MILLER: But I think it's a really fair question, and these things are hard to do. It depends on how well you did that propensity matching, and even if

within the state the policy is relatively constant, in different parts of the state if you're dealing with different -- so I don't think it's a concern. I don't think it's something that is, you know, completely, you know, clean. It's hard to do these things and get them right. And it's no disparaging of RTI's effort.

MS. CAMERON: That's right.

DR. MILLER: These things are hard to get right.

DR. CROSSON: Jack.

DR. HOADLEY: So two questions. One, the -- what you call the coordinating groups in each of the seven states, what kind of organizations are those? Were they created just for this project? Were they existing organizations?

MS. CAMERON: No. Some of them were groups funded by universities. I believe the Greater New York Hospital Association had one. So they were various types of groups. The University of Alabama was one, UPMC was one. I'll happily provide you a list if you want --

DR. HOADLEY: Yeah.

MS. CAMERON: -- but they were various groups. Some were educationally focused and backed, than others.

DR. HOADLEY: Okay. That's helpful. And my other question is, did you consider the dual demo program as another sort of source of looking at these kinds of differences? Presumably that's part -- I mean, we had a presentation on that last year. But it seems like that might fit into this rubric as well.

MS. CAMERON: That I did not look at --

DR. HOADLEY: Okay.

MS. CAMERON: -- but we could see if we can kind of incorporate it into the chapter as it fits. We can think about that.

DR. HOADLEY: I mean, as I recall they weren't getting a lot of -- there weren't a lot of results to look at yet in terms of this level of kind of thing --

MS. CAMERON: Right.

DR. HOADLEY: -- and it may be, but that may still be the case but another year has gone by. It might be more for you to work from.

DR. CROSSON: Rita.

DR. REDBERG: Thanks. So I think, certainly, you know, the initiatives to promote communications sound good no matter what, you know, but I would have thought they

would be listening to the staff, and if someone says someone's not looking poorly, you know, any facility would be paying attention.

But I just wanted to highlight, because it seems like, looking at the RTI analysis over time, it's really important to have control groups, because without having the other states we don't know if those were temporal trends or attributed to the very catchily named RAH-HFR program.

[Laughter.]

DR. REDBERG: So I'm glad that you had some other data, because just looking at the RTI analysis seemed to only look at the states that actually had the programs.

MS. CAMERON: That is correct, and just to keep in mind that the programs were not rolled out statewide. So in, you know, we'll say New York as the example, they did have their kind of test groups which included the facilities with the intervention and then a matched group, which was about double the size of the test group, that didn't have the intervention.

DR. CROSSON: Alice.

DR. COOMBS: Thank you very much, Stephanie.

This was excellent.

In terms of the telemedicine, did they use like a company that was really remotely linked to each of the facilities, or -- some of the for-profits in our area have one central telemedicine where they're peering into multiple hospitals at one time, and I was just curious. And it was most a -- it sounds like it was mostly off-hours, weekends, nights.

MS. CAMERON: Yes, that's right. So one of the interventions in the demo employed telemedicine with the kind of, I'll say, a demo provided nurse practitioner. So it wasn't a separate group or a conglomerate that they hired. It was centered around this initiative, and it was those involved in this demo at this specific site. And so that nurse was -- the nurse practitioner was on call certain hours, and if something in the facility would have otherwise triggered the need for the on-call, or the nurse, or an on-call physician, instead that nurse practitioner was contacted, and then, as necessary, would trigger a telemedicine session.

This, I think, has been slow to pick up, so this was -- we -- only one of the interventions, as part of the

demo, implemented a telemedicine component, and I think it has been underutilized to date, based on what they had expected.

DR. CROSSON: Kathy.

MS. BUTO: Thanks, Stephanie. I have a question about the coordination between this Medicare payment demo and Medicaid, for the dually eligible.

So I'm looking at Phase II and thinking that the payment to the facility to provide treatment of qualifying conditions is really designed to enhance, in a sense, a Medicaid payment, if that person is not going to be admitted to the hospital and triggering a new Medicare stay, and post-acute care, and so on and so forth.

And then the two other payments look like they're enhanced payments to clinicians, and I don't -- and I'm assuming those are Medicare payments. But I guess I'm wondering, on those two, why enhanced payment would be necessary, why we aren't paying appropriately to -- paying clinicians appropriately to treat acute changes in condition, number one, and then, two, to conduct better care coordination for, you know, long-standing nursing home residents. It seems to me both of those things would be

necessary and shouldn't require additional payment.

I'd just be curious as to your sense. That's an adequacy issue to me, in terms of a physician fee schedule, and then the first one is, is that the only conjunction between Medicare and Medicaid, where it looks like Medicare is paying an additional enhancement to the Medicaid payment, to keep that person treated in the nursing facility.

MS. CAMERON: So the first payment is, in fact, you're right, in addition to the Medicaid presumably daily rate, or the Medicaid payment. However, one could view this as it is payment for treatment for an acute condition, so treatment that may go above and beyond what the Medicare payment is intended to cover.

The other two payments, one of the concerns had been that the payments to providers who see beneficiaries in a nursing facility are lower than the payments in a hospital-based setting. So the nursing facility, as a location modifier, reduces that payment. And what this does is, for that first visit, in one of these changing condition visits, the provider is now able to bill an amount that would have been equal to the amount in the

hospital. And I think the intent of that is, instead of having the patient go to the hospital to see a provider, this provides kind of the same incentive on the provider's, you know, financial incentive to see the beneficiary in the facility.

The next payment, again, it is another provider payment, and that has to do a lot with the coordination and the provision of discussing advanced care planning, coordinating care, and in working also with the family. So it is another payment, explicitly for that purpose.

I'll say, in the demo, the rules around, and the limits on when these different payments can be billed are fairly defined. You know, so for the facility payment, first it's only for six select conditions, those most commonly -- the most common preventably avoidable conditions seen in the facility. And the beneficiaries have to meet certain clinical guidelines and criteria before the facility can get paid for those. So it's a very kind of targeted payment.

The kind of enhanced provider payment, that can only be billed the first of the visit, and it can't be billed repeatedly for that beneficiary. And then the

payment for coordination, that can be billed in association with a major change in health status, or annually.

So again, you know, there are pretty tight rules as to when those can be billed.

MS. BUTO: Yeah. My only point is that as this progresses, and I'm sure they're going to look at this, as they evaluate the results of Phase II, if that seems to have a significant impact on reducing hospitalizations and improving care for these acute conditions, then at least the physician payments ought to somehow be, you know, kind of folded into general issues around adequacy of payment for primary care, whether it's at the RUC or in our own discussions about, you know, adequate payments for primary care in a variety of settings, because it seems to me, fundamentally, this should be going on now, and this is kind of a recognition that it's not, and they require -- they think they require additional payment.

As to the payment to the facility, I see that as kind of a way to, you know, reduce some of the incentive someone else was talking about, which is to have the nursing facility have an incentive to send that patient to the hospital.

Beyond that, though, I'm disappointed that there isn't more coordination between Medicare and Medicaid payments for these patients, and maybe there is something beneath the surface in this demo that we're just not able to touch on.

MS. CAMERON: I believe you're right. The coordination of Medicaid payments is not part of this demo. There are another series of financial alignments that are happening right now that do incorporate Medicare and Medicaid payment through more of a managed care realm, which I did not talk about in this paper.

DR. CROSSON: Okay. Thank you.

MR. PYENSON: Thank you very much, Stephanie. I think Kathy raised some of the questions I wanted to raise, as did Jack. But do you see a difference in how this program works in states with mandatory managed care like MLTC programs versus a fee-for-service state?

DR. MILLER: Precisely what we discussed in your office yesterday. So I see his question as, Could you tease out the difference in a state that had LTSS -- I think we're saying the same thing; you said LTC -- services under managed care? And I think when you and I talked, if

that's your question -- do I get a nod out of that? Okay. So this is the conversation you and I had in your office yesterday, and it goes back to the methodology that Pat implicated. Do you want to run that? Or do you want me to do it?

MS. CAMERON: Sure, I'll take a stab at it. So I think those -- this initiative hasn't been tested in many of those states. This population hasn't typically been the target for long-term-care -- or for managed care. This is kind of the frail institutional population. So we haven't seen a lot of evidence of that yet. And, again, this demo was run in seven states. So at this point, I haven't seen that integration.

DR. MILLER: The other thing you said yesterday -- and I'm sorry to interrupt you, but it does get back to something that you triggered -- is if they were propensity matched on their characteristics, the LTSS and managed care would have been on both sides because it was designed to tease out these specific things, and so it would have flattened out any effect that you would have seen from the managed --

MR. PYENSON: Well, maybe Pat will get at MLTCs

in New York.

MS. WANG: I would just -- what Bruce is referring to is MLTC is called LTSS in other states, and it's the capitated mandatory program for the Medicaid portion of a dual benefit, and it was cover folks' long stay in the nursing home.

The reason I don't think that that is such an important or meaningful variable -- and this is a problem with nonintegrated programs -- is that a plan that is only responsible for the Medicaid portion gets nothing when somebody is not admitted on the Medicare side. I think partial cap programs are starting to figure out that they should try to contract with nursing homes that are a little bit more advanced and have these capabilities, but, candidly, it doesn't really matter because they're only paying for the hotel services. They're not paying for any -- they don't get any benefit from Medicare. That's why FIDA -- you know, the FIDA D-SNP, the integrated products, PACE, are -- the savings is on the Medicare side, not on the Medicaid side. You know, Kathy, your comment about wanting to see more integration with Medicaid was interesting because what most state Medicaid programs would

say is, yeah, I want to share of the Medicare savings because I'm still paying for every single day. That's their issue when they've designed the duals demo. They want to reduce their spending in the anticipation that Medicare is saving money.

MS. BUTO: Just to add to that, I think Evercare is an example where that model worked very well for Evercare because they were able to get a very generous per capita payment for that population, but didn't have to share it back with Medicaid.

DR. MILLER: Well, and this is one of the issues that when the integrated duals demo came up and was discussed in the Commission, the states were quite clear what they wanted, which is we want to spend less, we want you to spend more, and, you know, if you get savings, fine, you can finance that spending out of savings, but we wanted it. And some of the real struggle in trying to come to the agreements were how do you actually, you know, have both sides taking risk.

The other thing I wanted to say about Kathy's point is these demonstrations are difficult in a way that, you know, you see what's happening here, is they're saying,

okay, we're going to pay you to do all of this stuff. And, of course, as a demonstration, once it comes out of demonstration, you have to ask the question of, like, where's that money coming from, and then I think it makes it harder to show savings because I think -- I don't want to screw this up. I mean, basically there were statistically insignificant results on the savings here, right?

MS. CAMERON: That's right.

DR. MILLER: Okay. You know, it gets harder and harder to show savings if you're pumping money in to do all of this, and then you even get an effect. You still have to get past what you spent in order to show some net savings. It's a real issue.

Sorry. I think I might have interrupted you.

MS. WANG: I just -- you know, I mean, I'm kind of bleeding over into the comments section. The one comment I would make is in the future, in all of these efforts that somebody mentioned before, the introduction of quality metrics is really very important because, you know, the reason that I feel that these are very important efforts is that they will kind of -- you know, there are

some nursing homes that are much more advanced than other nursing homes, and when it comes to the long-stay population, which produces a lot of Medicare admissions, long-stay without acute rehab capability, for example, are going to be less and less sophisticated. So these efforts to sort of raise the level of training, communication, et cetera, in those settings I think is really important, but I think it's very important to introduce very consistent, standardized metrics for quality, because just the fact that somebody's not admitted doesn't mean that they're getting cared for the way that you would want them to. It's just an incentive to avoid an admission and might not be a good thing. So I think quality and outcomes is very important to track.

DR. CROSSON: Okay. Just to check here, so we are still on Phase 1. We are still doing qualifying questions. And as happens often, we've started to leak into commentary and suggestions and the like. So I've got Bruce, Brian, and Warner for Phase 1 questions.

MR. PYENSON: I think this is a very useful topic in part to highlight the potential of integration of Medicare and Medicaid, and I think incorporating some of

the lessons -- there's I-SNPs, there's other programs out there in addition to the United program and the PACE program. I think there's a number of issues. But on the issues of what the states are saying, you know, it is the case that states do have a stake in reducing admissions. For example, they're on the hook for -- most states are on the hook for the cost sharing of dual eligibles. So that's an issue. From a system standpoint, this is a little more finesse of an argument. I think perhaps 20 percent of the nursing home residents are single eligibles, meaning single Medicaid eligibles. So programs that will reduce admissions for those folks are direct savings to the states, if they can be won there.

But from a financial accounting standpoint, the ACA tax on insurers is waived for long-term supportive services, and that has meant that states have had to allocate their premium into long-term care and non-long-term-care components. So the financial distinction there is something that states should be familiar with and can parse that out. The reason that's relevant is that that more directly makes the financial case of how much states are paying for long-term supports and services out of the

total capitation that they're paying of managed care. So there's a number of technical pieces there that I've heard raised as obstacles that are really technical issues that could be solved.

So I guess my main point is that I think this is a very useful exercise on its own for the innovation program and evaluating that, but also to highlight the potential for moving faster on dual integration programs.

DR. CROSSON: Okay.

DR. MILLER: Can I get just a couple of clarifications?

DR. CROSSON: Yeah.

DR. MILLER: So the first point on cost sharing I took as hospitals may have an incentive -- or, sorry, states may have an incentive to avoid the hospitalization because they may be on the hook for cost sharing. And the only thing I would say there is many states, as long as that cost sharing exceeds what their rates are, don't pay it. So, you know, it's there, but it's there in some states, and I think it's not in the majority of states.

Then the second thing that you said, would you just say it again? I didn't pick up on it.

MR. PYENSON: For managed care programs, if a state has a managed Medicaid program, for example, a component of the capitation is for long-term care. And that has to be identified separately for -- in order for the insurers to avoid the ACA tax. So when we're talking about -- we've been talking about long-term residents, but there's also a spectrum of people that come in and out of nursing homes that Medicaid pays for, for a variety of reasons. So there's another component of spending that's not just what you might think of as a long-term permanent residence. And understanding the potential spending of the states in that detail I think will help the states see that they have a stake in reducing the hospitalizations and other care.

DR. MILLER: Thank you.

DR. CROSSON: Okay.

MS. WANG: [off microphone].

DR. CROSSON: Is it on this point? Because Warner's next. Are you passing, Warner?

MR. THOMAS: No, I just had a quick question. Was there any comparison to any sort of data on this with MA versus traditional?

MS. CAMERON: No. So --

MR. THOMAS: And is there any data out there that would be comparable?

MS. CAMERON: I'm not aware of any. Pat, do you know of some?

MS. WANG: [off microphone]. That would be the I-SNP and the PACE results, which I think --

MS. CAMERON: But the I-SNP and the PACE results -- well, I guess they do compare -- the comparator, you're right.

MS. WANG: That's the MA experience with reducing the admission rate from nursing homes [off microphone].

MR. THOMAS: I guess in the data is there any differential between MA and traditional Medicare readmissions in this population that we can discern from the data?

MS. CAMERON: Not that I know of. The encounter data has a whole host of issues, so we wouldn't be able to tease that out of any readmissions at this point, I don't think, out of the encounter data for MA. So I have not seen any studies that looked strictly at a fee-for-service population in a nursing facility and a Medicare Advantage

population in a facility and then comparing those two populations as a whole.

DR. MILLER: And just to color that a little bit, you know, we have a longer march on this, but we may be able at some point to be able to talk about readmissions or hospitalizations out of, you know, nursing facilities maybe in comparing just straight rates between traditional fee-for-service and MA using encounter data and our existing claims data -- or encounter data and our existing fee-for-service claims data.

If your question was but can you tell me whether these initiatives have any differential effect in MA and fee-for-service, I would say, no, we will not be able to do that. It would just be like a straight rate type of comparison between an MA population and a fee-for-service population.

MR. THOMAS: Yeah, I'm just trying to get at is there -- you know, under that more managed model, is there a differential in these readmissions? That was my first question.

The second question is, getting back to a comment we had earlier -- I think Jay brought it up -- is the

effort and, you know, what's the outcome. Do we have any idea what sort of dollars are tied to these efforts and these readmissions? I mean, is it material, or how material is it?

MS. CAMERON: So dollars in terms of the CMMI initiative and what has gone in to date, or--

MR. THOMAS: No; dollars in terms of, you know, how many dollars are kind of driven by these readmissions.

MS. CAMERON: So the best study -- and this is something we're looking at as well. There was a study that was published in 2010 by RTI for CMS looking at cost drivers for the dual-eligible population. And what that study found was that there were about $1.9 billion in potentially avoidable hospitalizations for the nursing facility dual-eligible population.

And then to kind of just further put that in context, I believe they found -- you know, there were at that time just over a million dual-eligible beneficiaries residing in nursing facilities, and I believe there were about 500,000 total hospital admissions from that, and then a subset of those in the 200,000 to 300,000 range were deemed potentially avoidable by that study.

MS. WANG: My question is actually a little bit related to that. In the calculation of savings, is there consideration -- David raised this earlier -- of Medicare's avoidance of resetting a SNF stay that is paid for by Medicare when the person comes back from the hospital? Because that's a savings to Medicare as well.

MS. CAMERON: The results to date did look at spending across many categories of Medicare expenditure. They included skilled nursing spending, physician spending, hospital spending, I think lab spending, a whole series of different categories. And when they looked on total spending on net, that was not statistically significant across Medicare.

I don't know offhand if they specified it for the skilled nursing facility, but I have that on my desk and would be happy to look and let you know if there was anything there.

MS. BUTO: Stephanie, that was just for Phase I.

MS. CAMERON: That's right. And just to clarify, it's not the final, final evaluation. This was a mid kind of for year three, which, again, you know, not all facilities were up and running. So this is really looking

at between 2012 and 2014, but in reality, only about one year of the initiative being fully implemented.

MS. BUTO: It's just hard to believe, because all that was in Phase I were the -- maybe it was the infrastructure and setting up these entities, but mainly it was staff training, technical support, and so on, and you'd think that -- I'm like you. I'm thinking avoided hospitalizations, SNF days, physician services, all of that did not add up to a statistically significant saving over providing staff training? I mean, that's surprising.

MS. CAMERON: And keep in mind they also all had -- most of the facilities had, if not an advanced practice nurse full time in the facility, at least part time. And I think -- yeah.

DR. CROSSON: Okay. Well, I have to admit I feel a lot better?

DR. MILLER: Really?

DR. CROSSON: Yeah, because now that I remembered who was going to lead off the discussion, I realize that person forgot and he left. I'm just kidding. Bill will have a chance when he comes back. I think he gave up, actually.

[Laughter.]

DR. CROSSON: Okay. I have to admit we have had a lot of substantial discussion here during the qualifying questions piece of this. So there may be nothing left, but I'm going to see.

Let's look at page 13 here for the next steps that Stephanie has outlined here, monitoring the initiative. And she's going to come back next month with some recommendations about risk-adjusted measures of potentially avoidable hospital admissions. So to the extent that people still have ideas, try to focus them in on this page and make some recommendations to Stephanie with respect to -- and Bill is getting to his seat, and now he's going to lead off.

[Laughter.]

DR. HALL: Thank you for that introduction, as someone who had a bathroom emergency.

[Laughter.]

DR. CROSSON: Well, I dragged it out.

So we want to provide help to Stephanie, and, Bill, you're going to lead off.

DR. HALL: So I think this is a very meritorious

effort that you've started, but I think we've got a lot of mixed metaphors in here that I think maybe we could just say a word or two about.

I think we all recognize that we're really not talking so much about what we talked about this morning, about bundling post-acute care in SNF patients and readmissions within 30 days to the hospital. This is a very different, totally different topic. This is how do we cope with the problem of inadequate care in nursing homes, for the most part, in a population that has a substantial number of dual eligibles. Who is going to pay for it? How does this fit into the overall mission of MedPAC, I think, is where I want to go with this. So I think the answer is yes and no.

I live in a community that has a lot of experience with some of these things. We have a longstanding experience with hospital-sponsored PACE programs. We've been through Evercare and Optum now. I don't know whether -- can I use the term "RAH-NFR" for the long series of six things? I don't know whether we have any activity in that area.

A couple of things I wanted to put forward, I

don't think that we should bundle the PACE programs in this with the demonstration project. PACE was really set up not so much as a, quote, long-term care program, but a program to keep people out of all facilities in their communities, so a lot of emphasis on home services, et cetera.

On the other hand, there is no question that there is a very substantial population of Medicare-eligible individuals in nursing homes who have been receiving very poor care. To the extent that they're part of our payment system, we should pay attention to it. I think several people mentioned that this is largely a Medicaid problem if we want to be pill-splitters here.

But I think if we could take a careful look at whether the demonstration projects seem to have some real meat to the bones, whether after a demonstration period, they can continue to show impressive results, it reminds me a little bit of when we first went into the managed care. It was pretty easy to improve things because nobody had paid attention to a lot of problems in various areas of medical care, but if we could look at that with the emphasis also on the numbers of Medicare recipients that might be affected by any change that takes place here, I

think that would be good.

Now, on the other side of this coin is that once you start with, say, an Optum program, a couple things happen in most American communities that I know of. One is that it's totally distinct from the patterns of care that came in beforehand. The idea is to bring in an organized group of well-trained providers who did all the things that you talked about here, and generally, what happens is that whatever infrastructure was in the community before then, sponsored by hospitals or sponsored by the community, disappear overnight. So, basically, it's a program that comes in and does something, but I have real problems about does it have teeth, is it going to last, is it really going to be a benefit to our recipients, long term. So I think that's one point.

I think I mentioned the other. I think PACE is probably not where we should be going with this. PACE has its own issues, and I don't see much happenings there.

I can't help but be compelled, too, by the fact that the care of older patients in nursing homes leaves a great deal to be desired. That would be the best way that I could put this. There is no question about that. That's

largely a staffing problem. I don't know that it's going to be improved by having any group of medical experts come in and remind people to tell older people not to fall. So, if we concentrate our efforts on a relatively smaller group of patients, I think we'll probably get some more important information out of this.

DR. CROSSON: I'm sorry, Bill. Perhaps I missed it, but the smaller group of patients is?

DR. HALL: Not bringing PACE programs into this at all, any further investigation that we do.

DR. CROSSON: I'm sorry. I thought you said at the end, concentrate our efforts on a smaller group of patients, but I wasn't quite clear what that smaller group is.

DR. HALL: To what extent -- how much of a problem is this in terms of -- why do we want to bring in an effort to see if we can reduce the number of hospital admissions? That is a laudable thing to be doing, preventing avoidable hospitalizations. But is that a Medicare issue? Medicare Commission issue is what I'm thinking about. I'm not making myself very clear here, am I?

DR. CROSSON: So I think the notion here is that many or a large majority of these individuals are dual eligible.

DR. HALL: Yes.

DR. CROSSON: So even though they are being paid fundamentally by Medicaid or in some cases private payment as well to stay in the nursing home, two things happen in this case if they're not properly cared for and they are admitted to the hospital when they didn't need to be. Medicare then foots the hospital bill, but in addition, they then come back to the nursing home to the same bed but in a different classification as a SNF patient and then are paid for, for a period of time, by Medicare. So, to the extent that that's true and it raises Medicare program costs, it is our issue, I think.

DR. HALL: So, as opposed to a system that would encourage hospitals to do more in the way of bundling, to have longer-term responsibilities than they do now, that is another, totally alternative approach, which may or may not work.

DR. CROSSON: No, it certainly would be. Yeah. And I think we've discussed that type of approach on

several occasions.

DR. HALL: Right.

DR. CROSSON: I'm not arguing for any approach. I'm just simply trying to address two things. Number one, the question of whether there's a legitimate issue for us to be discussing, and number two, I was trying to understand the end of your discussion here.

DR. HALL: So I think I'm a little reluctant to put too much emphasis on demonstration programs that show equivocal results and to say that that's the direction in which we should go, particularly if it disrupts any hope that there be a more integrated system throughout hospitals and health care systems.

DR. CROSSON: Okay. I got that point.

DR. HALL: Okay.

DR. CROSSON: Thank you.

Okay. So now we're in Phase 2. I saw Brian, Jack. Okay, Brian.

DR. DeBUSK: First of all, I enjoyed your presentation.

One of the things as you go forward -- and, again, I'm sure we'll see you again on this subject -- it

would be nice to have an understanding. I'm familiar with that process of recycling patients for Medicaid into Medicare. What would be nice is to have an understanding of just how much money is at stake, just so we can get a feel for what we're up against, because just at first impression, I'm concerned that even though we have some carrots that we can hand out here, some awards and some ways to incentivize better treatment, better behavior, I am a little concerned that the underlying nursing home may still have such a financial benefit from flipping that patient that we just don't have enough money to throw at that problem from one angle.

DR. CROSSON: Good point right there.

Stephanie, you touched on this a little bit earlier. Do you want to talk about that again?

MS. CAMERON: So, in terms of the $1.9 billion estimate?

DR. CROSSON: Yeah. I mean, I think the point is if we were to spend X amount of money, what's the Y amount of money that we could expect to save, think taking into consideration the kind of behavioral -- I know you can't answer this. So I'm just --

[Laughter.]

DR. CROSSON: Taking into consideration the kind of behavior or anti-behavioral response Brian was talking about, is there any way to think about that?

MS. CAMERON: Well, I think one of the points that makes this very difficult is the fact that nursing homes do need hospital referrals because those hospital referrals become their bread and butter, and if nursing facilities lower their hospitalization rate or their rehospitalization rate, which we have seen -- and what we've heard is it's really from the Medicare readmission reduction program that facilities have felt compelled to be able to say, "We have a very low rate of readmissions. Think about this as you're referring your patients."

I don't know how we could tease that piece -- and that is a revenue, a potentially new revenue or a sustained revenue -- into this process. So while I think there are incentives, as we've discussed, on the basis of any beneficiary that is -- the long-stay beneficiary that is sent to the hospital for something that's avoidable, that nursing facility doesn't need to provide care to that beneficiary for, presumably, some level of costly services.

Upon readmission, if the beneficiary qualifies, that facility could get a higher skilled nursing payment rate for a period of time, and then it goes back to the Medicaid rate.

So that is a meaningful number, but I think there's other numbers in there where if you are able to -- if you as a facility are able to kind of reduce that, a brand-new admission from a referral that's new is very valuable as well, and maybe that does increase your census, and that does increase your revenues. And I'm not sure if we'll be able to tease all that out, but I think it's something we can start thinking about just in terms of where all those incentives are and maybe clearly kind of go through that.

DR. DeBUSK: I think there are two issues there, though. I mean, one is someone coming out of, say, an acute care hospital engaging in a steerage program trying to get them into the right skilled nursing facility to minimize readmissions. And I think with my familiarity with BPCI, there's no question that's happening on a national scale. Hospitals are learning to steer their patients to nursing homes with low readmission rates and

actually to nursing homes that will keep them for less than 21 days too, but again, that's more of a BPCI function.

But the other issue is let's say I have a custodial care patient. Clearly, in Medicaid, we've done -- I don't know that the incentive works. I could see them setting up an elaborate system to prevent a readmission, but then on the other side, for a patient who's been there 100 days, 200 days, will be there for the rest of their lives, I don't know that there is an incentive there. I mean, I understand we have projects to pay them incentives, but I don't know what we're up against.

The number you used earlier, the $1.9 billion, clearly some of that would have been the hospitalization, and then a portion of that would be those days, post-hospital SNF days. And I'm assuming they're going to max those out at 100.

MS. CAMERON: So I actually think the $1.9 billion estimate was the cost of hospitalization only and did not include the SNF.

DR. DeBUSK: Oh, okay.

MS. CAMERON: I'm fairly confident in that, that study, that the 1.9 was hospital.

DR. DeBUSK: Just to get a feel of what we're up against, it would be nice to see what the financial benefit of this recycling.

DR. CROSSON: One could imagine that there are differences across markets. There are some markets where there's a whole ton of nursing homes, and there are other markets where, for whatever reason, the hospitals don't have a lot of choice. Is that information that's knowable or not?

MS. CAMERON: I think we have done studies that have looked at that. I'm not sure when the most recent one was, but I'll work with my colleagues on that.

DR. MILLER: But, Stephanie, when you -- the data -- I don't want this on the record.

[Laughter.]

DR. MILLER: I want to do the Jon thing and refuse to speak.

The dataset that you're working up and the measures, okay, so we're working towards a measure of hospitalization rates out of a facility, and it will be measurable at the facility level?

MS. CAMERON: Yes. We're doing a facility-level

analysis.

DR. MILLER: Okay. And then I think all of her comments apply, which is, okay, you might be -- and this is what you're coming back with next month, right? I'm not --

MS. CAMERON: That's right.

DR. MILLER: Correct.

MS. CAMERON: God willing.

[Laughter.]

DR. MILLER: Okay. So we might not be able to get all of the hospitalization and who would have bounced and all of that, but it seems to me that -- and I'm not saying that you'll have this next month, so don't freak out. Okay. But we may at least have a platform of how much activity is going within what time frames, and then perhaps making some kind of rough estimates, maybe we could get you a number off of that. Does that seem insane? And I'm not committing you to next month.

MS. CAMERON: I don't think that seems insane, no.

DR. MILLER: Okay. Thank you. Yeah. This is all I get, though. I got to tell you.

DR. CROSSON: You have secured your job.

[Laughter.]

DR. CROSSON: Okay. So, on this point, Kathy, while I've got you on the list?

MS. BUTO: It's the same. I think it's the same point.

DR. CROSSON: Same?

MS. BUTO: On this issue of the payment to the facility, is there any flexibility in the design such that CMS could instead structure it or allow facilities to choose to share in the savings from an avoided hospitalization? Of course, then you get into gaming as to what's avoidable hospitalization, but I'm just wondering if there's -- I have a feeling this is going to be a nominal payment, and it's back to your point of what's going to really give the facility an incentive to get engaged here.

DR. DeBUSK: That's where I was ultimately going.

MS. CAMERON: So, at this point, my understanding is that the contracts for Phase II are pretty much wrapped up. I mean, it went out for proposal at the end of last year, and they have been working very hard since that point to get things up and running. They expect Phase II to commence in the fall. We're in September at this point,

and from my understanding, the deadline seems like it will be met this fall. So I think in terms of that, for this initiative, this phase, that is probably too late.

MS. BUTO: Okay. If you could, when we come back next month, give us a sense of what level that payment to the facility is, if we have any idea, or can negotiate.

MS. CAMERON: I can tell you what that level is right now.

MS. BUTO: Okay, great.

MS. CAMERON: So, for the on-site, the facility payment is going to be $218 per day for the treatment of those conditions. The number of days that the facility can receive a payment has a maximum threshold based on the condition, and that can be anywhere between five and seven days for those six conditions.

In terms of the provider payment for that first visit during a change in health condition, that went to -- I think originally the CPT that they would normally bill would be about $138 for a physician and then obviously reduced for nurse practitioners and others, and that payment is going to, I believe, just over $200.

The third payment for care-giver engagement,

which previously facilities would not have billed for, is $80.

DR. CROSSON: Just for the record, that interchange about the penalty, we're talking about Medicare imposing a penalty on the nursing home for the SNF portion after the hospitalization?

DR. MILLER: I mean, the question is we would have to talk this out. The question is whether you're paying them dollars to do something or whether somehow dollars are extracted, if they have high hospitalization rates, but there is a problem because it's crossing Medicaid and Medicare lines.

DR. CROSSON: Right. So that is why I was saying I could imagine that if you could determine that a hospitalization should -- rehospitalization, whatever, should not have occurred --

DR. MILLER: You go after the SNF patient.

DR. CROSSON: -- the patient goes back as a SNF patient. You then either don't pay for that or you reduce that payment. That would be --

DR. MILLER: That would be the pot of money.

DR. CROSSON: Okay. Jack and then Paul.

DR. HOADLEY: So I have several different comments that I think relate to each other and to what we've been talking about, though with this hour, I'm not completely sure.

One is that the SNF payment that is triggered by this admission to the hospital, I mean, it's going to still depend, I think, on the situation of the patient. So certain things they might go in for, there's not really a certification of a need for SNF. So it's not like it's automatically generated; is that right? And it's certainly not automatically generated for 100 days, although that question of who makes that judgment is always open.

MS. CAMERON: That's right. I mean, the patient has to meet the three days and then have a skilled need --

DR. HOADLEY: Have a skilled need.

MS. CAMERON: -- upon discharge from the hospital, and we have heard that skilled need to be looked at to various degrees.

DR. HOADLEY: Got it.

MS. CAMERON: I don't think there's a lot of consistency on how the skilled need is defined across MACs, for example.

DR. HOADLEY: And presumably based on what you've said up here, one of the things you would be looking at from the data is how much SNF use occurs in these situations of these avoidable hospitalizations; is that right?

MS. CAMERON: Yes.

DR. HOADLEY: Okay. The second point, I think we've said this all right by the end of this conversation, but it does seem to me like there's a very different environment for the readmission question, so people that have been in the hospital, heading in -- go off to the nursing home and then go back to the hospital. That triggers, A, they're probably still under SNF care, and that's the kind of thing where the hospital has the incentives that we talked about, versus the admissions that are occurring for somebody who's in the longer-term custodial care. And I think we just need to be careful that we don't combine those two together, although the nursing home's relationship with the hospital may sort of think about all those things at some level, but that's just a -- as I listen to this, get a little bit tangled at times.

And then, a little more substantively, it seems to me like, to go address this not quite yet fully established what the problem is or how big the problem is, but this question that all these efforts are going after, which is trying to reduce these admissions to the hospital, it's really -- it seems like, to me, it's a two-level challenge.

One is if we're operating in the un-integrated Medicare and Medicaid environment, we have all these issues that come up about Medicaid dollars are doing one set of things and Medicare dollars are doing another set of things, and that's why the logic, at least, of the dual demo, the financial alignment demos, says that you try to put both streams of money together and do that, whether that's going to work or whether that has other issues aside. But in all these other efforts it seems like you keep tripping over this idea that Medicare saves money, Medicaid benefits, vice versa, whatever. And so it seems like that's the first part of the challenge in trying to make any of these things work.

And then the second part of the challenge, to me -- and this is drawing as much from your interview kind of

comments as from the demo, in particular -- is how much investment is required for the nursing home, nursing facility, whether it comes from their own resources or from some other source of money, to carry out the kinds of things we're talking about -- the trainings, the better EHRs, and all the other things that you talked about in this.

And it seems to me, then, some of the questions are what are the differential abilities of different nursing facilities to do this. You've got a lot of -- I know when I did some interviews in Virginia on the dual demo there, they talk about so many of the nursing facilities are these really small, mom-and-pop kinds of operations. They don't have a lot of patients. They don't have a lot of beds. And, you know, they're going to be a lot more limited in being able to amp up the training or do some of these other kinds of things than much larger facilities, or maybe facilities that are connected with larger organizations.

And it seems like to think about how this is going to play out, that's at least one of the various dimensions we should think about is, in whatever means of

doing this, either looking for them to do it out of their own resources, or putting money in, how does that play out differently in a 20-bed facility that's independent versus a 200-bed facility that's part of a larger organization that can provide these things at a corporate level, or something like that?

And so, I mean, just thinking about the investment, where it comes from, where state Medicare or whoever is going to pump in some extra money to do this, it seems like it's got to take into account some of those difference out there in the market.

DR. CROSSON: Paul.

DR. GINSBURG: Yes. A number of things I wanted to say have been said, but I'm really struck by what Brian and Jack said about the two fairly distinct types of patients we're talking about -- you know, those discharged from a hospital where, I think appropriately, the incentive should be on the hospital to make sure that they don't come back, because the hospitals do have a lot of leverage over the nursing type.

The other type being the custodial patients, who may not have had an experience in the hospital until what

we're talking about. I think we're talking about the choice for them between an approach which we've been focusing on, which, in a sense, provides a lot of services to support the nursing home, to reduce hospitalizations, where sometimes it's hard to say, as Bill was saying, you know, that the savings seem fairly marginal. It's really hard to imagine this becoming our main strategy, a national program.

I wonder if we have to start thinking policy-wise about engaging the nursing home with financial incentives. You know, perhaps a combination of penalizing them for potentially avoidable hospital admissions from their custodial patient, but probably with the same -- so we'd have to pay them more, in irregular rates, you know, to give them some of the resources to do better here, because they're not going to get the savings. Which also gets into Medicare and Medicaid issues, that maybe Medicare needs to provide a payment, as well as the penalty, for the potentially avoidable admissions.

But just some thoughts about how we can move forward, moving this into policy. I think the agenda for next steps is about developing better risk-adjusted

measures of potentially avoidable hospital use is relevant for whatever approach we take.

DR. MILLER: And one way to connect that thought -- and, you know, Bruce, you may have thoughts along these lines too -- you know, maybe what you do with this is, at least you take it as far as, well, we should have a measure and have a sense of what's going on out there. And so that at least for a given nursing facility, even if money isn't attached one way or the other, it's like this nursing facility seems to have a lot of this; this one doesn't seem to have a lot of this, which may be helpful to other providers in just, you know, thinking about.

And you could have conversations about attaching incentives to that, or you could move out of that and say there's a measure, it is what it is, and start having conversations that I think Paul might be talking about, and Bruce, I think you had some thoughts like this. Do you say, for this population, where you constantly keep running up against the Medicare and Medicaid funding streams, do you really have to go back in and aggressively thinking about how you bolus streams together and think about more managed care route or whatever the case may be, because

it's going to be very hard to have the dollar conversation when we, you know, make policy on the Medicare side but we don't make it on the Medicaid side.

So that's kind of what I got out of your, Paul, comments, so I just --

MR. THOMAS: Just to be brief, I think -- I agree with Paul's point. I think that the real situation here, though, is, I mean, that hospitals have a lot of capability to identify nursing homes that want to work with them, and we've seen it to the extent we limit the nursing homes that we work with, and we work in a collaborative fashion. We've seen much better outcomes on readmissions and just better cost models.

So if you can think about ways that, you know, if there's ways that you can incent hospitals or nursing homes to be more collaborative from that perspective, and, you know, once again, if you use 20 versus 100, you're going to have a better coordination and better outcomes for the patients.

DR. CROSSON: Okay. I've got Pat and Jack.

MS. WANG: I just want to -- I think that this is an important initiative to track and that this work is very

important. I do think that it's a very important area for Medicare. The population is old today and it's going to get older as the future comes upon us. I think, personally, that the ultimate, and the ideal, even today, sort of -- there's a bundle of services that's appropriate. Just because somebody is called custodial today doesn't mean that they should be, candidly, that the best providers -- you know, I am a partial CAP plan. I am a FIDA SNP. I participated in the duals demo. The best post-acute care providers that I want to deal offer the whole array of services, everything we talked about before with PAC, as well as nursing home, because -- and one of the reasons I think that this initiative is important is that most nursing homes that have custodial patients today, this is not what they were built to do. This is not how they staffed themselves. This is kind of a new thing for them, but it's critically important to equip them with the tools to be able to fluidly move people to appropriate levels of care. I mean, it's important for the welfare of Medicare beneficiaries and I think the Medicaid funding question is -- it's the elephant in the room, you know.

Because, ideally, you know, if somebody is in the

hospital and they need to go to acute rehab, I might want to discharge them home with appropriate home care and then continue with personal care that's funded by Medicaid. That might be the best course for a dual-eligible person, and it might be the best from a spending perspective, all in. And, you know, it is a real struggle now because Medicaid is, you know, 50 different programs, there's different benefits in every states, and it's totally bifurcated. But at least for the Medicare piece, I think it's important to keep working on this initiative, personally, and put it in the context of post-acute care, generally, that is more fluid than just, you know, here's the custodial nursing home piece right here. It's really connected to all the other things that we've been talking about.

DR. CROSSON: Jack.

DR. HOADLEY: Probably just want to remind ourselves that the Medicaid dollars we're talking about, of course, are partly federal dollars, although they're not Medicare dollars and so they're not MedPAC's responsibility. But obviously another policy option for this is to federalize the Medicaid program for the dual-

eligibles, and then that, of course, creates a lot of things you'd have to do, but at least it gets rid of that but of the financial responsibility. That's obviously a much bigger issue.

DR. CROSSON: Can we do that next month?

[Laughter.]

DR. MILLER: Stephanie, would you take care of that for us?

Actually, if we ask her to do that, she will not be back next month. She's already right on the edge.

I mean, you know, if we had that conversation -- we talked a little bit in the June report, if I'm remembering correctly -- I'm looking at Eric -- about MSP and -- was that the right? -- and, you know, people -- the Medicare support programs, you know, to wrap around. Even the estimate there of saying, okay, why don't we take that over, is gigantic. The notion that -- you know, these are good conceptual ideas but the huge thing that you would be faced with is -- and where did you think you were getting the money? And, of course, one part of that money would be to go back to the states and say, well, there's a level of effort here and, you know, they're going to decidedly have

different views on that.

So we can talk about it but you will bump up against that pretty quickly, and that's often what makes these short conversations.

MS. BUTO: But, Mark, you know, Pat's earlier point about if Medicare were willing to share some savings on areas where there was a mutual interest, with Medicaid and Medicare has always been reluctant to go there, but I think that's an area that Medicare payment could actually benefit both Medicare and Medicaid. So, you don't have to go all the way to federalizing long-term care to look at options that really will work to both benefits.

DR. NERENZ: [Off microphone.]

DR. CROSSON: I'm sorry. I thought I had you.

DR. NERENZ: You did, but I changed my mind.

[Laughter.]

MR. PYENSON: Just -- Kathy, just a consideration on this sharing is that once you have capitated programs, you know, I think the sharing issue gets diminished. Right? The states take their bit out in advance by lowering capitation to a health plan, and, you know, then it's no longer their problem. So I think that's part of

the advantage of getting a dual integration, and when you have further alignment with the dual-eligibles, Medicare and Medicaid being managed by the same organization that manages the single eligibles, then it's more of a consistent program, because fundamentally the needs are often the same.

So I view that as a positive approach.

DR. CROSSON: Okay. Stephanie, thank you for this, and you've gotten plenty of feedback, so we're looking forward to seeing you next month. Thank you very much.

Now we're going to move on to the public comment session. I see one individual at the microphone. If there are any other individuals who would like to speak, it's probably useful to us if you would stand up and get in line so we can get a sense of it.

So the ground rules here, and I mentioned a couple of things, just for information for the audience, this is an opportunity for public comment on issues which we have discussed during the day. It's not the only way to provide input to the Commission and to the staff. Mark and his staff are open to receive comments through the website,

as well as, in some cases, individual meetings. So there are ways to provide information prior to the Commission's discussion, but this is an opportunity to do it subsequent to the discussion.

We would ask you to identify yourself and your institution, and limit your remarks to two minutes. So I'm going to -- when I stop talking I'm going to turn the light off and then when it goes back on I'd ask you to wrap up.

MR. LIND: Thank you. Keith Lind, AARP. I'd just like to go back to the post-acute payment discussion. I think you mentioned that hospitals will be allowed to influence patient choice of PAC provider to reduce readmissions. I think we understand about steering and that's come up again here in the context of trying to identify nursing homes that hospitals can work with.

So it would be really helpful -- this has come up more and more as we look at bundled payments and PAC demonstrations -- if you could explore, what the parameters, the permissible parameters for steering? I mean, are financial incentives allowed? If so, how big? How much pressure can you put on patients? I think the concern is, in the fee-for-service environment you want to

preserve some semblance of freedom of choice, and it would be great if -- we haven't heard much discussion of that.

AARP makes these comments periodically when we comment on these things, but it would be helpful if MedPAC would explore this in one of these chapters.

Just one other comment that was in that post-acute payment section. The reference was about reducing readmissions but I would just encourage you to explore looking at -- also looking at a measure of excess acute care days, which actually, I think, she mentioned that she was going to try to use in this context also, because that would capture hospital contacts with the emergency room and observation visits, return visits, as well as inpatient admissions, and it would be helpful to know if one measure was as good as, or better, than the other.

Thank you.

DR. CROSSON: Thank you very much for your comments. Seeing no one else at the microphone, we are adjourned until 8:30 tomorrow morning.

[Whereupon, at 5:03 p.m., the meeting was recessed, to reconvene at 8:30 a.m. on Friday, September 9, 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
PAT WANG, JD

B&B Reporters
4520 Church Road
Hampstead, Maryland 21074
410-374-3340

AGENDA PAGE

P R O C E E D I N G S

[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."

MACRA indicates that an initial report for this study is due July 1, 2017, and a final report is due July 1, 2021.

The analysis we present today has two broad parts. I will discuss the relationship between clinician services and Part A and Part B services, and Shinobu will discuss the relationship between clinician services and Part D drugs.

A key concept throughout our discussion is the correlation between clinician services and Part A, B, and D services. A positive correlation suggests that clinician services and the other services are complements, which means that as clinician services increase, the other services also increase. A negative correlation suggests that clinician services and the other services are substitutes, which means that as clinician services increase, the other services decrease.

MACRA requires that we look at both program spending and beneficiaries' service use, and we emphasize they are different measures. Program spending is monetary outlays by the Medicare program, and we made no adjustments to our spending data.

It's important to know that spending will differ between regions or years because of differences in Medicare prices and beneficiaries' health status.

To measure service use, we start with spending data, and then we arrive at the service use by removing from our spending data the geographic differences in Medicare prices, beneficiaries' demographics, and their health status.

Service use reflects volume of services provided and service intensity, which means that basic things like a simple X-ray has lower service use than a more complicated thing like a CT scan.

In our analysis, we focused on beneficiaries in fee-for-service Medicare and excluded beneficiaries in Medicare Advantage because MACRA directs us to evaluate Parts A, B, and D of Medicare but not Part C.

We made evaluations over time at the national level and within single years at the level of what we call "MedPAC units." The MedPAC units are our attempt at defining health care markets and are largely based on metropolitan statistical areas. And there are 484 MedPAC units.

We started our analysis by evaluating how Medicare program spending on clinician services as a share of all Part A and Part B services has changed over time. This is a national-level analysis, and the results are based on data from the Medicare Trustees' reports.

We found that program spending on clinician services was 19.1 percent of all Part A and Part B spending in both 1993 and 2013. However, this percentage fluctuated over that period. Sometimes it was above the 19.1; other times it was below.

In more recent years, this percentage has been pretty stable. For example, it was 19.3 percent in 2008 and 19.1 percent in 2013.

A caveat is that we believe that service use is a better measure than the spending data that we discuss on this slide because the spending data is affected by prices and health status, which can distort our perception of providers' practice patterns and how service use differs between years and between regions.

Because we view service use as the better measure, the rest of our analysis of Parts A and B focused on service use rather than program spending.

We began our analysis of service use with a national-level time series analysis that evaluated how use of clinician services as a percent of all Part A and Part B services changed from 2008 through 2013.

Our 2008 data file did not have clinician services as a distinct category. Instead, it had carrier services, which includes all clinician services plus a few others. We did find, though, that spending on clinician services is about 90 percent of the spending on carrier services (if you include Part B drugs in the clinician services), so we used carrier services as a proxy for the clinician services.

We found that carrier services as a share of all Part A and Part B services increased from 24.4 percent in 2008 to 26.3 percent in 2013.

In addition to evaluating service use at the national level, we evaluated use of Part A and B services at the level of our geographic units.

For the geographic units, we measured the correlation between the percent change from 2008 to 2013 in use of clinician services and the percent change in use of all Part A and Part B services, net of the clinician

services.

We did a regression that had the change in clinician services as the explanatory variable and the change in the other Part A and Part B services as the dependent variable. And the regression results indicate a positive correlation, but it has a small coefficient on percent change in clinician services and a low R-squared, which indicates that positive relationship is a weak one.

On this diagram, we show the relationship between the percent change in use of the clinician services and the percent change in use of other Part A and Part B services for our 484 geographic units.

If there was a close, strong relationship between the two measures, you'd see these data points clustered tightly around a straight line. But, instead, we see a very loose relationship, without any clustering around any specific line.

Our final evaluation of Part A and Part B services was a cross-sectional analysis of the correlation between the per capita use of clinician services in 2013 and the per capita use of other Part A and Part B services across our 484 geographic units.

A regression that has per capita use of other Part A and Part B services as the dependent variable and per capita use of clinician services as the explanatory variable reveals nearly zero correlation. That is, it is neither positive nor negative. The R-squared from the regression is nearly zero, and the coefficient on the per capita clinician services is not significantly different from 0 at the 10 percent level.

On this diagram we show the relationship between per capita use of clinician services and the per capita use of other Part A and Part B services for our 484 geographic units. And as you can see, there's not really much of a discernable relationship.

So a summary of our analysis of the relationship between clinician services and all Part A and Part B services includes that program spending on clinician services as a share of all Part A and Part B services has been stable, which suggests that spending on clinician services has been increasing at about the same rate as all other Part A and Part B services. Also, the correlation between use of clinician services and use of all Part A and Part B services is positive but weak or perhaps maybe zero.

Now I turn things over to Shinobu, who will discuss the relationship between clinician services and Part D drugs.

MS. SUZUKI: Before we talk about the findings, I wanted to quickly go over the data and methods used for the analysis of clinician services and Part D drugs. The analytical framework generally follows what Dan used for Parts A and B services.

One of the main differences is that, for this part, we focus on beneficiaries enrolled in standalone prescription drug plans, which is a subset of fee-for-service beneficiaries, as you'll see on the next slide.

We are not able to look at all fee-for-service beneficiaries because some of them receive their drug coverage from sources other than Part D, such as their former employers. We have no drug spending data for those beneficiaries.

Drug use is gross spending adjusted for variation in prices across regions, demographic characteristics such as age, gender, and health status.

We use the same correlation analysis and geographic units used for the analysis of Parts A and B

services to look at both the level of service use and the change in service use between 2008 and 2013.

There's been some change in the patterns of Part D enrollment among the fee-for-service beneficiaries between 2008 and 2013. You can see this in the table at the top.

Our study sample for 2008 includes 18.6 million beneficiaries, accounting for half of fee-for-service beneficiaries, and nearly 70 percent of Part D enrollees.

For 2013, the study sample includes about 24 million beneficiaries, accounting for over 60 percent of fee-for-service beneficiaries, an increase from 50 percent in 2008. But as a share of Part D enrollees, they account for a smaller share than in 2008, reflecting the shift in Part D enrollment towards drug plans operated by Medicare Advantage plans.

This change in enrollment patterns has resulted in somewhat different demographic characteristics in 2013 compared with 2008.

For example, compared with 2008, a smaller share of beneficiaries were disabled beneficiaries under age 65 and receive the low-income subsidy.

Here's a summary of our findings.

Clinician services and Part D drugs grew at similar rates between 2008 and 2013, regardless of whether the measure was unadjusted per capita spending or per capita service use.

A cross-sectional analysis across the geographic units showed a weak to modest positive correlation between the levels of clinician service use and drug use in both 2008 and 2013, suggesting they may be weak complements.

That positive correlation was somewhat stronger in 2013. It's not clear whether this is due to a change in the relationship between those two sectors or a result of the change in study population that's not fully captured by the demographic and health status adjustments we included in our model.

But looking at the change in service use between 2008 and 2013, we found a weak negative correlation between clinician service use and drug use, suggesting they may be weak substitutes.

So we found weak positive and weak negative, but in all cases our findings show generally weak relationship with small correlation coefficients and low R-squared

values. These findings seem to suggest that there is very little relationship between clinician service use and drug use across geographic units.

In summary, our findings of weak to no correlation suggest clinician service use and other Medicare service use are neither clear complements nor substitutes.

A major caveat is that, as you saw with the scatterplots, our findings are aggregate results and may not represent any individual circumstances or specific geographic areas.

As Dan said at the beginning of this presentation, this is a mandated report with an initial report due in 2017. We plan to incorporate your comments from today's discussion and include this material in our June 2017 report. If any of the comments we receive today require us to make substantive changes, we could come back to you in the spring.

With that, we are now open for questions.

DR. CROSSON: Thank you, Shinobu and Dan. That was a very clear exposition of a somewhat complicated idea, and I think you've done a wonderful job with that. So

we're now open for clarifying questions.

MR. GRADISON: I don't recall hearing a reference to the term "MedPAC units" before. Did you develop it just for this study?

DR. ZABINSKI: No. They've been -- how to say it? The staff --

MR. GRADISON: I see some smiles. Is there something wrong with my question?

[Laughter.]

DR. ZABINSKI: We've had them around for a few years. This is, I think, the first time we used that term.

DR. MILLER: It is the first time.

DR. ZABINSKI: I wasn't sure what to call them so...

MR. GRADISON: The reason, I just was frankly curious as to whether this was a breakdown that you would expect to use for other purposes in the future that you think is a superior geographic breakdown. That's really why I'm asking the question.

DR. ZABINSKI: Well, I think in the future, yeah -- I mean, we've used it in the past, so I don't see why we wouldn't use it in the future.

MR. GRADISON: Oh.

DR. ZABINSKI: You know, in January 2011 I think it was, we had a report on geographic variation on service use where we used not exactly the same thing, pretty close to the same thing. And I know in the Medicare Advantage work that Scott and Carlos --

MR. GRADISON: Use the same.

DR. ZABINSKI: They may include these as well.

DR. MILLER: It's really the label [off microphone].

MR. GRADISON: Fair enough. Thank you,

DR. MILLER: We use this all over the place [off microphone].

DR. COOMBS: So was the 2008 starting point something that was dictated in the legislation? Or why not start in 2009 when there were more similar groups between 2009 and 2013?

DR. ZABINSKI: That's a good question. It was not mandated. I chose 2008 because it's a five-year period, for no other reason beyond that. And, you know, 2009 could work just as well.

DR. COOMBS: Only for, you know, just similar

comparisons, and you won't have to deal with the other factor of the carrier with physician services incorporated in.

DR. ZABINSKI: I'm not sure if 2009 -- I hadn't looked at the 2009 data. I'm not sure if they have the carrier services disaggregated to physician services that are not...

DR. COOMBS: I thought I read that in your paper [off microphone].

MS. SUZUKI: One of the things we were trying to do is we were supposed to look at the change over time, and 2013 was the latest data available at the time of the analysis, and we wanted to have as many years as possible without going too far back that there's no Part D program.

DR. COOMBS: So my question would be if the 2009 differs that much, especially with the -- it does?

DR. MILLER: I'm pretty sure you're not going to find anything different if you do it, but if you want us to chop off a year and take a look at it, we can do that.

DR. SAMITT: Shinobu may have answered my question, but the distinction between the initial report and the final report, was that simply to create a baseline

and then to do a follow-up study four years later? Is that sort of the intention in terms of the gap between initial and final?

DR. MILLER: It would appear, and I'm not saying that to be sarcastic. It would appear that they think that there's something about MACRA that they want to see in a few years to see it's affected this relationship. That's the way we interpret it unless somebody up there has some other idea.

MS. BUTO: I wondered whether we'd see the same weak correlation if we broke it down primary care versus procedural and surgery services; in other words, I mean, I just -- it feels like surgery and procedural would have a stronger relationship, correlation to the production of A and B services, but I don't really know. It might be exactly the same result. I wondered if you looked at that.

MS. SUZUKI: We have not separated the sample into primary care versus specialty care, and...

MS. BUTO: Is that hard to do?

DR. MILLER: You know, the primary care involves some gymnastics just because it has got a separate definition, and I wouldn't immediately commit to time

series and whether there's any complexity in replicating it at any point in time. It may be perfectly fine, but just since I haven't thought about it for more than three seconds, I wouldn't say. It's probably easier to break it down into, you know, procedural and that type of stuff, the stuff that follows the fee schedule more directly. Again, to what end, you know, what purpose for all of that? And, again, if you just strictly are following the mandate, the mandate isn't pushing that all --

MS. BUTO: It's for all services.

DR. MILLER: Yeah, which I haven't read recently, but --

MS. BUTO: Okay.

DR. ZABINSKI: Just a point to add. You know, the data that we used for the analysis of the spending, that was just simply pulling things off the trustees' tables and the trustees' reports, and that was really easy. And then the service use, we pulled spending data from a data file for claims information is used to aggregate program expenditures into service categories -- carrier, inpatient, outpatient, SNF, et cetera. To go into specific specialties, primary care, surgical, et cetera, that would

require us to ourselves go into claims and identify all the, you know, primary care claims, all the surgical claims, and then run that data.

MS. BUTO: Yeah, I wouldn't --

DR. ZABINSKI: Not a huge task, but additional work.

MS. BUTO: Yeah, I wouldn't do that given that that's not part of the required scope of work. But I'm just curious. Again, to what end, I think is the real question.

DR. MILLER: If you're interested in the relationships of these things at least in terms of geographic variation, we have written reports looking at geographic variation and then subdividing that into classes of service, post-acute care, inpatient, outpatient, that type of thing, and looked at that. And, if that's where your mind is headed, there's actually a couple of older reports we could bring back or just give to you for nighttime reading, that type of thing. You know, I don't know what you do.

[Laughter.]

DR. MILLER: And it might get your mind thinking

along those lines. Actually, in some ways, if your mind goes along those ways, those lines, or anyone else's, I have more of an interest -- and this is going to surprise Dan, but I like assigning work in this context because then it can't fight back as much -- of whether we replicate, Dan, geographic work lately, update it, because we had a little bit of this conversation in the hallway.

MR. ZABINSKI: Right. And there's some interesting things in that.

DR. MILLER: Yeah. If that's your thinking, I actually would prefer to dive in and go that direction than do it here where the --

MS. BUTO: You're saying geographic work related to the differences?

DR. MILLER: So looking across geographically and what you generally see is you know there's this old and longstanding point where you see vast geographic variation and utilization of services across the country. In addition to that, we've gone in and kind of broken it down into post-acute care to see how all of that works. And one of the main findings of that work back in the day, which Dan was part of and a couple other people were part of, is

a lot of that variation gets driven by the post-acute care sector. If your mind is wandering along those paths, I'd almost go back down that road and sort of replicate that and bring that back in front.

MS. BUTO: Well, I think that's a worthwhile thing to do, but I don't think it's related to this, per se.

DR. MILLER: I agree. And I am trying to drive you off of this because I think --

[Laughter.]

DR. MILLER: Well, I'm being --

MS. BUTO: But succeeded.

DR. MILLER: Yeah. Because I also think the other thing that's gone on here -- and I will stop after this -- I think probably when you look at least geographically, there are other factors that drive behaviors across the entire spectrum of spending as opposed to this notion of dose this set of services affect that set of services, and I think if you're thinking along those lines, there's a whole different way to look and ask that question.

DR. CROSSON: Warner.

MR. THOMAS: So just to make sure I understand, this is the mandated report, and I guess our takeaway is there's really not a lot to discern from the analysis done, but it's something that we have to do when we're reviewing it. It doesn't seem like there's -- is there other information that we need to try to glean from this, or is that -- I'm just trying to get the takeaway from the staff and leadership.

DR. MILLER: My takeaway is this is a fairly structured mandate. We've answered the mandate. If this triggers other questions in your mind that enough people think it's worth pursuing, I'd probably build something around that as opposed to build it around this. This, I would tend to -- you know, we met the mandate.

And it may be -- and I think Alice or somebody just said it. It may be that if they're looking for something to happen, if anything happened to 2021, again, I'm not sure how much time I'd spend churning on this.

DR. CROSSON: Remembering that because of the mandate, we will be coming back again with a subsequent analysis, and in that time, we might learn as part of the basis for the new analysis that there are other factors

that need to be looked at. And that can be done retrospectively as well.

Other clarifying questions?

[No response.]

DR. CROSSON: Not seeing any, we'll come to Craig. Craig, that was the whole thing. They were trying to give me a hint. Thanks so much.

DR. SAMITT: Trying to signal that, and since I won't be here in 2021 to comment, I thought I would comment in 2016.

I can't say that I'm surprised by the results, obviously. The mandate, the study is well done. I think we've sort of responded to the request of the mandate. I think the frank reality is I think the pools are too large to really discern any correlation, and so there is a weak correlation. It's certainly not surprising.

But to Kathy's point, I think if we were interested in this, there are other types of analyses that I think would be more intriguing. I am more interested in trends within these pools as opposed to between these pools, and that we're likely to see tradeoffs within Part B, within Part A, within clinician services between primary

care and specialty.

And I also think if we wanted to do that type of analysis, we also should look at encounter data as it relates to differential trends in Medicare Advantage to see if there's differential shifts in the Medicare Advantage world than in the fee-for-service world.

But in terms of this report, it seems very well done, and we answered the question. It just doesn't give us a lot of information.

DR. CROSSON: Thank you. Other comments?

Yes, Alice.

DR. COOMBS: Thank you, Dan. As you know, one of the things in reading the report is that the weakly positive and the weakly, weakly, weakly, weakly -- I just think that at some point, we probably should have a take-home message to the rank-and-file people who read this report that there is no correlation when you give point-zero-zero-something in an R factor. So I think that we should have a synopsis that says at this juncture, we can't see a narrative that actually speaks to the fact that the numbers bear out, that you cannot form any conclusions at this time. So I think that should be our narrative because

I would hate for someone to say, "Oh, it was weakly positive," and to glean something as a complement versus a substitute based on what we see.

I was just thinking -- and, Mark, you helped to frame it -- that it was a legislative mandate, but I was thinking that maybe in someone's mind, it might have been a thought process that someone thought that with intense clinical services that at some point in the future, it would cause a reduction in the cost of A and B or D, and since that it was an early intervention or access was improved so much so that the other services were decreased because of the type of access that was achieved. Maybe that was the thought that went into it. I'm not sure.

DR. MILLER: Yeah. It is possible.

DR. CROSSON: Yeah.

DR. MILLER: You were going to say --

DR. CROSSON: No, I was just going to say I agree. I mean, one could infer -- we are only doing inferences here, but one could infer, I think reasonably, that if we see over the next four years, in this case, greater use of alternative payment mechanisms, particularly those that create incentives for the management of A and B

costs, maybe D -- that's not on the table right now -- that that could change the situation, and we could see the kind of relationship or tradeoff between physician services and what we would call downstream costs.

I agree with you. What we see right now is little to none. So I think it's perfectly reasonable to come back in four years, maybe four. Who knows if four years is the right amount of time? But that's what the law says, so come back in four years and take another look, and see if there's anything changed.

DR. MILLER: And I also want to make sure I just put the marker down. I agree with you, Alice, and I think your first comment was you want a very plain-language statement at the front end of this report and the executive summary, and we'll definitely craft that, because I think your point is well taken. Most people consuming that are not going to have all the methods, background. That's well taken.

DR. REDBERG: I would just say we don't usually put pictures, but I think a picture is worth a thousand words because it's -- clearly, there is no correlation, and I think you fulfilled the mandate very clearly. And we can

move on.

DR. CROSSON: I saw Jack, then Jon, then Bill.

DR. HOADLEY: I mean, I think building on Alice's comments, another part, maybe what to emphasize -- and I think it was somewhere in the mailing materials -- is correlation isn't causation. And I'm thinking about the sort of clinician services versus Part D services, and I can think of forces going in both directions, which could, of course, lead to a zero correlation among other things, if you have enough things going both ways. So you can think about better adherence to Part D drives, reducing illness. That means people aren't taking other services. You could say the fact that people are on medications, they're going to the doctor more often to manage those services and get their refills and so forth. You can think of a bunch of things going in either direction that could either lead to what we see, or if the results were different, it would say it's not necessarily that the causation is in one particular direction or the other.

The only other thing I would mention, sort of following on Kathy's note, if we do decide to look back at geographic variation, certainly geographic variation and

drug user would be an interesting part of that. I can't remember if we've done any of that to date, but there are certainly some -- you see evidence in the data, certainly see evidence in premiums that there's a lot of geographic variation.

DR. MILLER: Yeah. My recollection of the geographic -- well, the last geographic report, it was kind of like you organized it here. We went through A/B, and then we had a D section, right? So yes.

DR. HOADLEY: Yeah.

DR. CROSSON: Jon.

DR. CHRISTIANSON: Yeah. Just following up on what Jack said, you had a very highly statistically significant coefficient in the negative relationship between drug use and services, very low R-square. So, if you were going to devote any more effort in this report, that would seem to be someplace you might pay some attention, try to understand what's going on, particularly given the general public policy discussion and the fact that it's a negative coefficient. Understanding what Jack said with the various different things that could be going on, it is consistent with an explanation that drugs reduce

-- if you were to imply causation, which we understand you shouldn't do, but it's consistent with the causation explanation that drugs reduce use of clinical services. So that's an area where you've actually got a significant findings. If you want to spend more time trying to understand it, that's probably where I would look, not so much on the other analyses.

DR. MILLER: What we could do in short order -- and I can't remember where your term and when this report was done, but there was a point where Shinobu and Rachel and some other outside folks did some work looking at the relationship between D and its effect on A/B, but at much more. And I think somebody over here said it: "Let's look at this condition and see what the relationship is." And we found that -- and I'm really dredging memory here, Shinobu -- that it was very different from condition to condition, and the duration of the effect faded 6 to 12 months out.

So what I could so immediately for this report is kind of bring that back in and say, "If you really want to understand this, you really kind of got to get down in the weeds, and the one time we did it, this is what we found."

If that's good with you, we'll import that into the report.

DR. CROSSON: Bill Hall.

DR. HALL: In academic circles, there's sometimes horror when you find that you have negative results, particularly when you've been doing something that you don't really understand why you're doing it, and our tendency is to be somewhat apologetic or softened. I suppose that's the reason we use statistical techniques is to get over that sort of inherent bias.

Just in general, when we write our reports and we get negative results, we sometimes sort of soften the blow by saying slightly, a slight tendency, or possibly -- if we're going to use statistics, let's call it what it is. There's no correlation.

I think in everybody in circles where we use statistics, we know that, but then we get out to the public. I think we have to be not quite so equivocal. We did the report. It was done properly. There does not seem to be any sort of positive correlation here, period. And that may help us get through all of that.

DR. CROSSON: Okay. Thank you very much. Good discussion. Excellent, clear report, meeting the

requirements of the mandate, and we'll be interested in seeing what happens four years from now. Thank you so much.

[Pause.]

MR. WINTER: Are you ready, Jay?

DR. CROSSON: Okay. We're going to return to the topic of physician payment, physician and other professionals, and Ariel Winter and Kevin Hayes are going to begin for us a discussion which I think will take us through the majority of this term, and we're going to focus this morning on the issue of misvalued clinician services. Go ahead. Who's going to begin?

MR. WINTER: I am. Thank you. Good morning.

Today, we will be talking about how Medicare pays for clinician services and concerns with how those services are priced. And before we begin, I want to thank Amy Phillips for her help with this presentation.

So we'll start with the context for this session and background on the fee schedule for clinician services. We will talk about prior Commission recommendations to correct misvalued services in the fee schedule. Then we'll describe what's happened since the Commission made

those recommendations and any remaining issues. And we'll conclude by outlining potential steps for further work in this area.

In 2015, the Medicare Access and CHIP Reauthorization Act, or MACRA, repealed the sustainable growth rate. It established two new paths for clinicians to receive payment updates: a path for clinicians who participate in advanced alternative payment models, APMs; and a path for all other clinicians, whose updates will be determined by a revised performance assessment system.

Because MACRA made significant changes with broad implications for clinicians, it has received a lot of attention. But it's still important to ensure the accuracy of the fee schedule, for two reasons:

First, it is still the basic mechanism by which Medicare pays for clinician services, including under APM models.

Second, it has the potential to affect the delivery system. For example, payment differences can lead to an oversupply of certain specialties and an undersupply of others, such as primary care.

In 2014, Medicare spent over $69 billion for

physician and other health professional services through the fee schedule.

Medicare's fee schedule lists payment rates for 7,000 CPT codes. The payment rates are based on the relative value units, RVUs, for clinician work, practice costs -- which includes office rent and equipment -- and professional liability insurance.

Clinician work account for 51 percent of fee schedule spending, practice expenses account for 45 percent, and professional liability insurance accounts for the remaining 4 percent. And I want to make a couple of notes about the terminology we'll be using at this point.

In this presentation, when we talk about the "value" of a service, what we mean is the time, effort, and resources involved in providing the service.

In other contexts, the word "value" can refer to the value of a service to a patient or purchaser or its clinical value. But that's not what we mean here.

Another terms that we use is "misvalued," which is a term from the Medicare statute, the section of the statute that requires the Secretary to identify and adjust misvalued codes. And in this presentation we also use the

term "mispriced," and "mispriced" and "misvalued" are synonymous.

So we have raised several concerns with the fee schedule, which Kevin will be discussing in more detail.

First, many services in the fee schedule -- particularly procedures and tests -- are mispriced. And as a consequence, primary care is undervalued relative to services delivered by specialists. The process for pricing clinician services does not focus sufficiently on overvalued services, and the data that are available to value services are inadequate.

Second, paying separately for 7,000 CPT codes creates opportunities for physicians to upcode by billing for a more complex rather than a less complex service. It is also more difficult for CMS to maintain accurate payment rates for 7,000 unique services.

And, third, the orientation of the fee schedule towards discrete services leads to fragmented care.

This slide shows the wide income disparities between primary care and certain specialties. Average annual compensation for primary care, which is the second bar from the left, was about $250,000 in 2014. By

contrast, compensation for radiology and nonsurgical procedural specialties, which are the last two bars on the right, was more than twice as high at over $500,000.

Now I'll turn things over to Kevin, who will discuss issues related to mispriced services.

DR. HAYES: Our first issue concerns primary care. The Commission's position is that, in the fee schedule, primary care is undervalued.

Primary care is labor intensive, which limits the potential for efficiency gains and volume growth. By contrast, for other services, efficiency gains are more likely with advances in technique, technology, and other factors.

For those services with efficiency gains, RVUs should go down, and under the statute's budget neutrality provision, RVUs should go up for other services, including primary care. Such a redistribution of RVUs does not occur, however, if the process for valuing services does not adequately account for efficiency gains.

One further potential source of misvaluation: Some specialties can increase their volume of services more readily than can primary care clinicians.

In response to these concerns, the Commission made several recommendations: one, a payment adjustment for primary care services billable under the fee schedule; two, repeal of the sustainable growth rate and in its place specified updates that favor primary care; three, a per beneficiary payment for primary care which would replace the then-expiring primary care incentive payment program that I'll describe in a moment. The years in which the Commission made these recommendations are shown in parentheses.

Since the Commission made its recommendations, there have been several developments. The Patient Protection and Affordable Care Act had provision for a primary care incentive payment program. The program included a 10 percent bonus payment for selected services billable under the fee schedule -- these were mostly office visits -- when the services were furnished by clinicians eligible for the bonus. The program started in 2011, but it was not replaced when it expired at the end of 2015.

Separately, under its administrative authority, CMS has established in the fee schedule new billing codes for primary care. Two of the codes are for transitional

care management of patients recently discharged from a hospital or certain other facilities. A third code, a chronic care management code, is for the non-face-to-face management of patients with two or more chronic conditions.

Outside of the fee schedule, the CMS Innovation Center is testing a number of models aimed toward improving primary care. But from the standpoint of Commission recommendations, there is a remaining issue here. There has been no action yet to establish a per beneficiary payment for primary care.

The second issue the Commission has considered is one of process. Is the process for maintaining the fee schedule's RVUs sufficiently focused on services that have become overvalued? As we noted in connection with the undervaluation of primary care, services can become overvalued if there are improvements in efficiency that arise from, say, technological advances. Services can also become overvalued if there are changes in clinical practice.

The Commission's concern has been that the process for review of the fee schedule's RVUs relied heavily on advice from an entity known as the American

Medical Association Specialty Society Relative Value Scale Update Commitment, or RUC. The specialty societies represented on the RUC have a financial stake in the outcomes of the review process.

Adding to this concern, the sheer size of the fee schedule, as Ariel mentioned -- that is, the large number of billing codes -- makes it difficult to maintain.

To improve the valuation process, the Commission recommended:

First, that the Secretary establish a standing panel of experts to review recommendations from the RUC and otherwise assist CMS in identifying overvalued services.

Second, in consultation with this expert panel, the Secretary should review services that meet certain criteria, indicating that they may be overvalued. The criteria included such things as services with substantial changes in volume, services where the site of service is changed, and so on.

Third, the Congress should direct the Secretary to expand the multiple procedure payment reduction policy.

Fourth, the Congress should establish an annual numeric goal, or target, for identifying overvalued

services, a target that the Secretary would meet annually.

Since the Commission made its initial recommendations on misvalued services, a number of services have been reviewed.

Counts of these services depend on the source and the starting point for the reviews. Between them, CMS and the RUC report a range, from about 1,700 to 1,800 services as of 2016. The results are a mix: some increases in relative values, some decreases, and some codes that stayed the same.

In addition, CMS has contracts in place for technical assistance on statistical models to validate the fee schedule's relative values. The RUC, for its part, has advised CMS on the relative values for services reviewed and has made procedural and other changes.

Specific to the Commission's recommendation on the multiple procedure payment reduction, CMS has implemented a reduction in the professional component of imaging services when more than one service is provided by the same practitioner during the same session. And the Congress established a target for adjusting the relative values of overvalued services.

With respect to the valuation process, there are several remaining issues:

One, the Secretary has not established a standing panel of experts to help identify overvalued services.

Two, the multiple procedure payment reduction could be expanded to all imaging services and to additional types of diagnostic tests.

Three, stakeholders have expressed concerns about the RUC's composition. The Commission considered this issue in its March 2006 report but has not revisited the topic recently.

And, four, the misvalued services target expires at the end of 2018.

The third topic we wanted to review with you today concerns the data available to maintain the fee schedule. The Patient Protection and Affordable Care Act requires that the Secretary validate the fee schedule's RVUs. The issue for the Commission has been that the Secretary lacks current, objective data necessary to fulfill this requirement.

For example, the RVUs for the work of clinicians are largely of function of assumptions that have been made

for each service in the fee schedule, assumptions about how long it takes for a clinician to furnish the service. Those time assumptions in turn are derived from specialty society surveys.

Another example: The data available for the practice expense RVUs have been a problem. Specifically, the prices for equipment and supplies are often out-of-date.

The Commission has also expressed concerns about the methods by which the data for the fee schedule are collected. If collected service by service, data collection can be costly, burdensome, and biased.

Overall, there's no ongoing data collection activity to maintain the fee schedule. Instead, there's a reliance on ad hoc surveys that end up having low response rates.

In making a recommendation on data collection and validation of RVUs, the Commission's intent was that the data should be collected more accurately and simply than has been the case so far and that ad hoc surveys should be avoided.

The recommendation has three parts:

One, the Secretary should regularly collect data -- including service volume and work time -- to establish more accurate work and practice expense RVUs.

Two, the data should be collected from a cohort of selected practices rather than a sample of all practices.

Three, if necessary, practices should be paid to participate in data collection.

As to what's happened in collecting data on misvalued services, the CMS contracts mentioned earlier both have elements of data collection. A contract with the Urban Institute will include development of time estimates for selected services and associated data collection activities.

A contract with the RAND Corporation will include work on claims-based reporting of post-operative care furnished as part of global surgical services. These contracts notwithstanding, the remaining issue here is that there is no data collection activity under way of the type the Commission recommended.

The Commission, for its part, has worked with a contractor -- the University of Minnesota -- to develop an

alternative method CMS could use to validate the fee schedule's RVUs.

The Commission's method has, as its starting point, the clinician as the unit of analysis. Data would be collected on: one, each clinician's service mix -- that is, the number of services billed to all payers by billing code; and, two, each clinician's total time worked. These data would permit a comparison of actual hours worked and hours worked as estimated in the fee schedule.

The contractor's feasibility study showed how such data could be used to identify types of services that may be overvalued. For example, in one of the cardiology practices participating in the study, time assumed in the fee schedule for services provided exceeded actual hours worked by an average of 60 percent.

The physicians with the greatest difference between hours assumed in the fee schedule and hours worked tended to furnish more imaging services than their colleagues.

Such a finding, if replicated with more data like this, would suggest that the imaging services furnished are candidates for further review.

That's all we have on the Commission's recommendations and where things stand with each of them. Ariel will now go over some ideas for possible next steps.

MR. WINTER: Okay. So, first, we could revisit our prior recommendations that have not yet been implemented. These could include: establishing an expert panel to help CMS identify overvalued services and to review recommendations from the RUC; expanding the multiple procedure payment reduction; and/or collecting data from a cohort of selected practices to validate payment rates and set more accurate rates.

Alternatively, we could explore new directions. In the area of primary care, we could think about going beyond our recommendation to establish a monthly per beneficiary payment for primary care providers.

At our meeting last November, we discussed a payment model for primary care that would blend fee-for-service and capitation. We identified several issues with this partial capitation approach, such as the size of the capitated amount, whether risk adjustment would be necessary, how to attribute beneficiaries to a practitioner, and whether there should be practice

requirements. We could return to this topic if you are interested in doing so.

We could also work on the idea of combining CPT codes into families of codes. For example, we could examine options for grouping codes into categories, and we could also explore options for how to price families of codes.

So for your discussion, please let us know if you have any questions or would like us to clarify anything we have said. And we'd like to get your thoughts on potential next steps in this area.

Thank you.

DR. CROSSON: Thank you, Kevin and Ariel.

We're going to ask for clarifying questions. I will point out that what's obvious, I guess, to everybody is that we really have multiple issues on the table here at one time. They all relate to physician payment, of course, and also that this is this year's first entrée into this larger topic. Specifically, you know, the presentation has described the problem of the primary care services being undervalued relative to procedural services. We've talked about that before. We've made recommendations. Our

current recommendation has not been picked up.

There is still the ongoing concern that there is not a robust process to revalue misvalued services, and so we have a number of suggestions -- had suggestions in the past. The question is: Do we want to reiterate our previous ideas or are there other ideas? And then related to that is the question of if there's going to be a process for revaluation, is it going to be an interrupted one periodically because these changes in technology or technique or efficiency are not static, they change over time and, therefore, the ideal is to have some process which is, in fact, ongoing and not simply periodic.

So this is not all we're going to be doing in this term through next April on physician and other professional services payment, but it's a core piece. It's one that we've worked on before. So we're going to be looking from the Commission for emphasis, where people see the priorities here, as well as other ideas that we've not thought of before, and try to help inform, you know, not just Ariel and Kevin but Mark and the rest of his staff. So I'd like to start off because I have a couple of clarifying questions myself.

When the RUC/CMS both have gone about the process of revaluing codes in the last number of years, what technique has been employed? Because we have talked about the fact that there's a paucity of data, certainly with respect to the time element, perhaps other parts of the fee schedule. How robust -- is there anything we can learn from the process that has been employed to date.

DR. HAYES: The process to date, I think we could identify two elements of it. One would be how the services reviewed were identified, and secondly, then how the services were reviewed, what process under which they were reviewed.

As to the first point, how to identify services, the procedure involved was largely consistent with what the Commission had recommended. I gave a real brief summary of it in one of the slides, but it had to do with identifying services where there had been rapid growth and volume, where there's some evidence that there had been shifts in site of care, suggesting maybe that the amount of work involved in furnishing the service had changed because now the service was provided, say, in an outpatient setting where previously it had been an inpatient, that kind of

thing.

Another commonly used criterion was services that are often furnished together. The thought was that, well, if we see that services were valued independently, but it turned out that the services were often furnished in combination with each other, then we could expect to see some sort of efficiencies derived because of that. And so there was an examination of claims data to identify services that were, as it turned out, commonly furnished together.

So it was that kind of thing was used to sort of identify services that might be misvalued. That then triggered -- once a service was sort of kind of -- hit one of those screening criteria and got on a radar screen for purposes of review, then that triggered the review process that pretty much was already in place for review of services, and so it was a process of CMS in some cases asking the RUC to review a service, or the RUC itself applying the criteria and deciding that a service needed to be reviewed. And then we had the process of specialty societies surveying physicians and asking them about the work and time involved and a review by the RUC and so

forth.

DR. CROSSON: Thank you. That sort of was what I was trying to get at. There was no fact-based, data-based scientific analysis that occurred during that reevaluation. It was simply a reiteration of the process that's been used in the past.

DR. HAYES: Right.

DR. CROSSON: And I'm sorry. I have one other question. The payments that were created for transitional care management and chronic care management, as you noted, have not been taken up, to a large degree, and I think the hope had been that that would go -- that those together would go partway to solving the issue of the disparity of payment between primary care and specialty care. Could you just briefly review for us the status of that and why it has not achieved the goal that Congress intended.

MR. WINTER: Right. So I can speak more to the CCM codes than the TCM codes because that's where we've done some analysis.

We have looked at -- or Zach actually had looked at preliminary claims data from 2015, so about 90 percent of claims from 2015, and found, as we expected, that take-

up has been low. Only about 270,000 unique beneficiaries received a CCM service in that year. There were a total of 840,000 CCM services, and generally, typically a beneficiary would get a CCM service for about three months, and then on a monthly basis, you sort of saw it pretty low take-up at the beginning of the year and then reaching about 90,000 claims per month by August 2015 through the end of the year.

And take-up could be -- we've heard various things about why take-up might be low. One thing we've heard is that there are a lot of practice requirements that a clinician has to meet in order to bill for the service; for example, 24/7 access to care management services, having access to the care plan in electronic format, documenting 20 minutes of staff time per month. So that's been one concern of a possible reason for why there's been low take-up.

We've heard concerns that the payment rate is too low. It's hard for us to evaluate that. The current rate for this code in 2016 is $41, and in response to these concerns, CMS has proposed for next year to loosen some of the requirements for this code in the area, for example, of

beneficiary consent and electronic sharing of the care plan.

They're also proposed two new CCM codes. Right now, there's only one. That covers 20 minutes of staff time per month. The two new codes would cover -- would be a higher rate for high-complexity patients, high-complexity decision-making. It would also be a code for an additional 30 minutes per month, and we have in our response -- in our comment letter in response to these proposals, we've said we generally support improving payment for coordinated care, but we do have concerns about program integrity. And we've referenced the fact that in some cases, CMS has made duplicate CCM payments to the same beneficiary in the same month. In other words, multiple providers are billing for the same beneficiary and the same month, which is against the rules, but we're seeing this in the claims data. So we do have these concerns.

Another concern that we've raised is that any provider can build for a CCM code. It's not limited to primary care practitioners, and that's a statutory requirement. And we understand that CMS is bound by that. Our recommendation has been to have a dedicated payment for

primary care practitioners, and I don't have data at this point on what extent it's being billed by PCP versus other specialties, but that's something we can look at further if you're interested.

DR. CROSSON: Thank you. More than a complete answer. I appreciate it.

Okay. Clarifying questions? David, Bill. Okay. David, Bill, Kathy, and Jack.

DR. NERENZ: Thanks. This was great.

I was actually, before you started, prepared to ask you a clarifying question of the definition of value, but you did such a nice job in stating it, I don't have to.

But now a fine-point question about that, on Slide 4, the clinician work component, the 2011 report that we were given to read actually has a very nice expression of this. It's a combination of time and intensity, with time being the dominant factor.

The question about intensity, is that concept applied sort of within families of services so that the RVUs, say, for different types of surgery are given relative judgments for intensity, or is intensity applied to cross-types? So it says like a surgery is more

intensive than E&M or vice versa. How does intensity work?

DR. HAYES: The intensity is handled -- I guess we could say in two ways. It has two parts of it. One is physicians are asked about the stress they experience when furnishing a test, the risk to the patient of a bad outcome, how much skill is required, that kind of thing.

And then the second part of it is that physicians are asked to compare the given service to a similar service, and the similar service, whether it's with -- I mean, the family is kind of not quite the right way I would characterize it, but there is a benchmark kind of service that's used for comparison purposes. It has some similarities to the service under discussion.

DR. NERENZ: So at least in principle, the concept of intensity applies the same metric basically across the entire range of physician services. Is that a fair statement?

DR. MILLER: I heard the opposite. I thought I heard the opposite. It's not the same reference service in each instance.

DR. NERENZ: Okay, fine. That's the point I wanted to clarify. All right. That's fine.

I'm not sure it's fine, but it's fine to go forward in discussion.

DR. MILLER: You understand the words.

DR. NERENZ: Yes, I understand the words.

DR. MILLER: That's all you're agreeing to.

DR. CROSSON: It's the difference between right and correct.

Bill Gradison.

MR. GRADISON: You have mentioned in your presentation that 17- or 1800 services had been reviewed through about now. On balance, what was the net effect of that on payment to primary care? Did it tend to shift any money or take money away from primary care?

DR. HAYES: If we look at these numbers, at, say, the 1700 services, there was a redistribution of dollars within the fee schedule --

MR. GRADISON: Yes.

DR. HAYES: -- toward services other than these. The services that were reviewed did not include primary care. So it's fair to say, I think, in response to your question that there was a shift of -- I can't -- I wish I could give you a number, but the net effect was positive.

MR. WINTER: And we know for at least 2016, for the current year, they did redistribute about 0.3 percent of the fee schedule dollars based on the target they were required to meet for 2016. And they proposed for 2017 to be distributed about 1 percent of fee schedule spending to other services, and that would be towards not only primary care, but everything else in the fee schedule that was not being reduced under the review for 2017.

MR. GRADISON: Even small, it was for primary care, included primary care.

MR. WINTER: Primary care would be one of the services receiving --

MR. GRADISON: Receiving it.

MR. WINTER: -- receiving redistributed dollars.

MR. GRADISON: I'm interested in whether there's any way to approach this issue from market payments rather than in this indirect way, and in particular, is the payment level, if we knew what it was, for these very same services under MA at all relevant if we could get the data? That's 30 percent of the payments on average, I would suppose.

DR. GINSBURG: Actually, I could offer something,

Bill.

MR. GRADISON: Thank you.

DR. GINSBURG: Fairly quickly, after the Medicare Free Schedule was enacted, it was striking, the degree to which private insurers adopted it and, in a sense, using the same relative value scale and then developing their own conversion factor based on the markets. And so I have done some interviewing of insurers about why they haven't tried to innovate in this area, and they did not claim to have innovated. They just talked about the problems of not having Medicare's credibility or clout to be able to do this.

So my guess would be in Medicare Advantage, you would see the same structure of fees. In fact, actually the conversion factor in Medicare Advantage, based on some research I'm doing now, is very close to -- I think it's slightly below the conversion factor in fee-for-service.

So this is an area where I don't think we could look to the private sector for innovation.

MR. GRADISON: Because they have been looking to Medicare.

DR. GINSBURG: That's right.

MR. WINTER: There are also cases where Medicare rates diverge -- fee-for-service rates diverge from commercial rates perhaps due to market power, where there are large practice groups that can demand higher rates than they can under Medicare of commercial payers.

DR. MILLER: I just wanted -- and I think most everybody understands this, but just in case the complete audience -- so, when you were using the term "does it reallocate money to primary care," in the fee schedule, there's no primary care per se. Most people's minds tend to go in E&M. Remember E&M. Lots of specialists do E&M too. So it's in the wash, and I think you got that answer. But I want to make sure people understand there's no target primary care.

DR. CROSSON: Kathy.

MS. BUTO: So just to comment on the last question from Bill, a long time ago when the fee schedule first started, Pennsylvania physicians either sued the agency -- I can't remember now exactly how it came amount, but it turned out the market rates for physician services ended up driving payment in Pennsylvania. And I don't remember. There was a clause in the original statute that

went to some kind of differential like that. So, at least in that one case, they had an impact on what Medicare paid in Pennsylvania. I think it meant Medicare ended up paying more than it otherwise would have. I don't know if that's still in effect.

My question really is about Slide 7 and I think 2 in the mailing materials, where we talk about some specialties can increase the volume of services more readily than primary care clinicians. So I'm wondering. Do we actually know the volume increases by primary care surgery and nonsurgical procedures, so what the volume increases have been? And, in particular, do you have in mind certain specialties? Are these the proceduralists, like dermatology? What did you have in mind here? I think it's helpful to know exactly which specialties you think are actually able to do that kind of volume increase.

DR. HAYES: Right. Right. I can give you kind of an orders-of-magnitude question on the growth rates, not precise numbers, but if we look at broad categories of services, let's say, much like the ones that we look at for purposes of the physician update chapter that you'll see in December, we have broad categories that would include

evaluation in management services, major surgical procedures, imaging, tests, and procedures other than major procedures -- colonoscopies and that kind of thing.

And so there when we look at -- and we've been doing this for some time, and so this would go back to, say, the year 2000 or so. We would see cumulative growth rates for some services much higher than for others, and so, for example, at the top of the scale would be tests, EKGs and nerve conduction studies and all that --

MS. BUTO: Imaging, that kind of thing. Right.

DR. HAYES: -- and imaging and the other procedures, the less invasive, less intensive procedures. And then at the bottom of the scale, we have much lower growth rates for major surgical procedures and for evaluation and management.

The differences are big. I mean, we've got cumulative growth rates for the first three categories of services that are two times-plus what they are for the major procedures in E&M.

MS. BUTO: Yeah. Okay. I think that would be --

DR. HAYES: It gives you an idea.

MS. BUTO: That would be really helpful as a

table or an example --

DR. HAYES: Sure, sure, sure.

MS. BUTO: -- in either the appendix or some part of the document.

And just kind of a somewhat related question is I also think it's helpful for the context for us to see kind of the absolute dollar share of the 70 billion for each of these categories, E&M, surgery, and procedural non-surgery, and then the growth rates related to those, because as we talk about primary care is undervalued and it's not -- you know, we're concerned about participation and so on and so forth. That provides us a context of what's happening.

DR. HAYES: And let me reiterate what Mark said about the differential, the difference between primary care as a subset of evaluation and management services. There is a difference there too to keep in mind.

MS. BUTO: Right. And, Kevin, I don't know if we can do it, but I think my recollection is it's about half of E&M are provided by non-primary care physicians. So, I mean, I think it's helpful to break that out too.

DR. CROSSON: Jack.

DR. HOADLEY: So I have two questions. One was

mostly asked by Jay about a the new billing codes, but I did wonder -- and it sounds like maybe you haven't done this analysis -- on the transitional care management that's been around a couple more years, is there any sense of a learning curve that people, clinicians learn that it's there first and sort of when it's appropriate to use it, and there might be some increase in its use? My hunch is that's not the case, but it seems like that's at least an interesting question.

MR. WINTER: Yeah. We can look into that and do some work on that.

DR. HOADLEY: Okay. And then on Slide 13, you talked about the target expiring. Is that something that's designated by CMS? Is that in statute?

DR. HAYES: It's in statute.

DR. HOADLEY: It's in statute.

DR. HAYES: The Protecting Access to Medicare Act of 2014 had the original provision, and then it was subsequently amended, but it was for a three-year span.

DR. HOADLEY: It's not something that CMS could simply expand --

DR. HAYES: No, no.

DR. HOADLEY: -- but, presumably, they could do something like it.

DR. CROSSON: Rita.

DR. REDBERG: So in thinking about the misvalued services and certainly trying to increase primary care, there is still a huge disparity between primary care and procedures. I'm wondering if we could have -- thinking about a reference pricing. You mentioned colonoscopy. Well, when we do colorectal cancer screening, you could either do fecal occult blood testing, which has been shown in randomized clinical trials to reduce colorectal cancer mortality, or you could offer a colonoscopy. The doctor will get a lot more money for the colonoscopy, which has not been shown in randomized control trials to reduce mortality. And we know that most patients are never even offered that choice, and they get colonoscopy. They don't even know that you could have had -- there's a huge -- they have a disparity, and it's not going to be addressed by -- colonoscopy is more intense than handing someone fecal occult blood testing, but if you're looking at sort of outcomes of what you're trying to accomplish, the colorectal cancer screening, I think you would be choosing

fecal occult blood testing.

And now Medicare is paying for anesthesia, so we're really the only country in the world that's offering anesthesia, propofol, and increasing use with anesthesiology. So it's become very expensive.

Or my specialty, when I see a patient in my office with stable coronary disease, I can offer them medical management, or I can do a cardiac cath and a stent. I get paid a lot more by Medicare to do the stent, and guess what? Most people never get offered that choice. They get sent for a cath. Studies have been done 15 years ago and 5 years ago, and they showed the same thing. Most patients that are sent for a cath, they didn't know they had a choice. They thought it was an emergency. They think that having a stent is going to prevent a heart attack and the medicine as well, which isn't true.

And so I think we have to address the sort of fact that when two methods are equally effective for treatment, when you have this big payment disparity, we are unintentionally kind of driving a lot more procedure-oriented care that's not necessarily -- that is not in our beneficiary's interest. And just revaluing the codes is

not going to address that. You have to have, like I said, reference pricing or kind of a diagnosis-based approach to payment, like the DRGs, because it's a big issue. I think we are spending a lot and not doing a lot in terms of value or outcomes for our beneficiaries.

DR. CROSSON: Thank you, Rita. Clarifying -- okay.

DR. COOMBS: Is this Round 2?

DR. CROSSON: No. Round 1, still Round 1.

DR. REDBERG: That was a question.

DR. MILLER: But it was a clarifying one.

DR. CROSSON: It was a clarifying question, so it's okay.

Let me just see again. I saw Pat, Warner, Bruce. Okay, Pat.

MS. WANG: Can you reiterate what the benefits or purpose of grouping CPT codes into families would be, and can you say more about whether this is something that MedPAC has sort of -- is anybody working on this? Has anybody tested the feasibility of this? Could you just talk about it a little bit more?

MR. WINTER: Yeah. So this is actually a new

issue that we're just raising with you for the first time, although it might have come up in prior discussions.

So the concern here is that when you have 7,000 unique codes and in many cases they're similar, the gradations of codes, there is an incentive to bill for the higher-priced code. An example would be there are a series of codes for excision of skin lesions that are based on the size of the lesion. There is one payment for a lesion that's less than 0.5 centimeters. Then there is one for 0.6 to 1.0 centimeters, 1.0 to 1.2. You can imagine that there's an incentive to take out a little bit more so you get a higher payment rate. So that's one concern.

Another concern is that you can bill separately for multiple components of a single service. An example would be a pathology test where there's multiple codes involved, and you bill separately for each one. You get a separate payment for each. You can imagine there's an incentive to bill for more codes.

And then a third issue is that when you have 7,000 unique, distinct services and each one has three components and each component has lots of moving parts, it's very difficult for CMS to keep up with that and

maintain an accurate fee schedule.

So the idea we're throwing out there for your reaction is, do you think it would make sense for us to explore this idea of grouping these 7,000 codes into a more manageable number of families, whether it's 100, 500, or 800, and pay on that basis, and aggregate clinically similar codes into one group, so that there's one payment rate for the services in that group, perhaps to package ancillary services, which can currently be billed separately in many cases?

A similar model to think about could be the hospital outpatient system, which uses ambulatory payment classification groups. And we're not saying that the payment rate should be the same, but just think of that as like a similar kind of typology that groups lots of codes into a smaller number of payment categories.

And you asked if there's been work on this in the past, and the thing that comes to mind is 3M did work creating ambulatory payment groups, which became the prototype for APCs, which are now used in the hospital outpatient payment system. And they still, I think, maintain APGs, so that's something we could think about.

We could think about looking at, if you're interested.

DR. GINSBURG: Ariel, if you went this way, you still would have to get the family's relative value correct.

MR. WINTER: Absolutely.

DR. GINSBURG: So there's still going to be a need for a significant updating process.

MR. WINTER: Yes.

DR. CROSSON: I'll just summarize a little bit what Ariel said. This is a concept yet to be worked out for us, first of all. But, in theory, it contains a little bit of reference pricing. It could contain a little bit of bundling. And -- just one second, Paul. And it could also provide for a much more efficient revaluation process than the one that exists now, because as you may remember from the text, it's taken I am not sure how many years to go through a relatively small percentage of the codes when the process is to do one service, one code at a time.

So, you know, Pat, you're right to identify this as a new idea. It's a new idea. It's a raw idea. But it's one that has potential value along those, you know, three parameters at least.

I'm sorry. Paul, you want to comment?

DR. GINSBURG: Sorry for interrupting before. Reference pricing is something else. Really, reference pricing is a network strategy, which means that you're going to tell your enrollees that if you go to certain providers, you're going to have to pay more in the way of cost sharing than if you go to others. I don't see that happening in Medicare. I don't see there's a need for it in Medicare because Medicare gets pretty low prices in the aggregates for physician services. So I just wanted to clarify that I don't think that reference pricing is going to be part of this equation.

DR. CROSSON: Right. So I apologize if I used the term improperly. I think we have sometimes used the term a little more loosely than that definition to kind of describe a situation in which there's, you know, a price set for a range of services that could be delivered, and that's set at some percentage or point along that range, and then it provides for flexibility on the part of the decisionmaker and potentially some financial risk one way or the other. If "reference pricing" is not the correct term, then I apologize.

MS. BUTO: I think it is the correct term, and, Paul, I think the way I interpreted it, it was more like Rita's example of fecal occult blood testing versus colonoscopy grouped in the same code and then paid on some sort of weighted average at a lower rate than colonoscopy and a higher rate than fecal occult blood testing.

DR. REDBERG: Right.

MS. BUTO: And we won't go into our views on it, but I think that is reference pricing, because you're setting some kind of single rate.

DR. GINSBURG: Yeah, maybe it's a reference service.

DR. CROSSON: And I have to say that would be an extreme example, right? Because there you're taking, you know, a significant procedure with all the attendant costs to that and comparing it to, you know -- so but the --

DR. REDBERG: That is what I meant, that you would be oriented towards -- the idea is colorectal cancer screening, we're going to pay this much for colorectal cancer screening, then you choose what you want to do.

DR. CROSSON: Correct. But, you know, without going to an example that extreme, there could be, you know,

other situations. You don't think it's extreme, all right?

[Laughter.]

DR. GINSBURG: I actually think we might want to come up with a number -- a different name for that, because I think there's going to be a lot of confusion, because, you know, Rita's journal has published a number of studies about reference pricing in commercial insurance, and it's a different animal.

DR. CROSSON: Okay. Well, we'll work on that, and I'm thoroughly and appropriately chastened. Yes, Pat, continue.

MS. WANG: Thank you for the reminder about APGs and APCs. Conceptually, what is different about approaching the 7,000 codes in the fee-for-service fee schedule from the effort that went into creating the hospital outpatient? Is it an apple and an orange? Or is it to varieties of apples? How different is this concept?

MR. WINTER: So I think it depends on how you'd want to pursue it, but it might help if I explain a little bit more about how the APCs are created in the hospital outpatient payment system. So they start with the CPT codes, the 7,000 or so CPT codes, and actually more than

that because they include Part B, drugs, lab tests now, and other things. And they grouped them into categories based on clinical similarity and also cost similarity using hospital outpatient cost data. And that's how they create the 700 or so APCs. And you could think about a similar method for creating groups of codes for the clinician fee schedule, although we don't have the cost data, so that would be -- at least the same kind of cost data we have for the hospital outpatient department. So that would be a challenge. But we could use that approach perhaps for analyses, sensitivity testing, in terms of -- because it does have clinical similarity within those categories, and that might be something -- might be a typology to look at.

MS. WANG: Thank you [off microphone].

MR. THOMAS: On Slide 6, the income comparison, have we looked at this over multiple years to see if there's -- I mean, is the disparity similar? Is it changing over multiple years?

DR. HAYES: We have been doing this kind of work for some years now, and there has been -- you know, if we were to contrast, say, primary care with the specialty groups at the top end of the scale -- Ariel mentioned it.

You know, the difference is two times or more. We've seen that kind of disparity all along. There's been maybe a little bit of shrinkage, you know, a little bit of narrowing of the disparity, but not a lot. But it's been, you know, two times or more, is what we've been saying in terms of characterizing the slide for a while now.

MR. THOMAS: And we say I think in the first point, Issue 1, primary care is undervalued, so are you looking at that from what is paid for the service, or are you looking at that based on Slide 6, the total compensation, or both?

DR. HAYES: It's a little bit of both, I suppose, but I mean, the points that are made here on Slide 7 are more at the level of the services as a rationale, as a justification, as a point of view with respect to undervaluation. And then you could think of that undervaluation problem as contributing to the disparities in compensation that we see on Slide 6. That's a way to think about it.

DR. MILLER: And I would just build it out a little bit further. In characterizing the positions that the Commission has taken, you know, Kevin is sweeping

through many years of conversation, and I think Commissioners have come to the table and sort of seen this kind of thing, you know, just compensation, and why is one service valued so much more.

I think also some Commissioners have said this is driving people out of primary care when they look down the road, remembering what Paul said that these relative values also travel into the commercial insurance world. And so if we -- and then a third thought, which is related -- I'm not sure it's an entirely separate thought, but if you think about -- and, again, this is Commissioners talking at different points in time -- a reformed delivery system, you know, you want more of the left, less of the right. I think I got that right. And so I think that collection of comments has kind of driven the Commission to say it's under valued.

So I think you gave a very direct answer on the compensation, but I think other things have -- and I know you know this -- have arrived in the conversation.

MR. WINTER: And another issue the Commission has raised is whether the fee schedule itself is a good mechanism for paying for primary care services, which are

often non-face-to-face, not oriented around specific encounters, and involve a lot of coordination between visits. And so that's what drove the Commission to make its recommendation for a per-beneficiary payment for primary care services.

MR. THOMAS: So has there been thought given to -- you know, once again this is -- I mean, I don't disagree with any of the points but has there been thought given to what would fair value be? and what is fair compensation, as we think about this graph? So is it being at the average of all? Is it being above the average of all?

Because we are kind of making the statement that we have under value. And the question is so what would be the right value? Has there been any thought about that?

DR. CROSSON: I think I am going to jump in here because, as you properly observe, it's very difficult to make any sort of judgment about how much a particular physician specialty should be earning, either relative to another specialty or absolutely.

I think one way I like to think about it is to what extent is the misvaluation of the fee schedule contributing to long-term problems for Medicare

beneficiaries? Because although we spend a lot of time working on mechanics, and right now we're working on the mechanics of the fee schedule, ultimately we also owe a duty to the beneficiaries to look down the path towards the future and ask, for example, is the physician and other professional manpower pipeline appropriate to the needs of people in the future?

In fact, if we see -- as Mark suggested -- that there is something about the fee schedule which makes it likely that that distribution of manpower in the future is going to be inappropriate, then that's reason to consider changing the fee schedule without necessarily trying to make a judgment about how much one number should be versus another.

At least that's one way of thinking about it.

MR. THOMAS: Yeah and I totally get that we probably don't want to go down the road of what is the compensation level for a primary care physician, what do we want that to be. But I guess the point I'm trying to get at is do we think it's a 5 percent issue or do we think it's a 30 percent issue? Because that is a -- you would take a very different approach to try to solve those two

different issues. So I think that's more of what I'm trying to understand. And then you can think about how do you solve for that?

So I'm just trying to understand has there been any thought given to how material an issue it is? So I would just lay that out as something we ought to think about, understanding that we don't want to target compensation.

And I guess if we think that primary care is undervalued, so then we're kind of getting back to overvalued. And just clarify for me a little bit more how we're determining overvalued again. What is the judgment or comparison that we're using, as we think about that?

DR. HAYES: The way that comparison, that assessment, has been made to this point has been largely -- it has been entirely based on a code-by-code assessment of the RVUs in the fee schedule for services. And what the Commission has been saying, going back to the letter it sent to the Congress in 2011 about the SGR, was that well no, there needs to be a kind of a pullback and a look more broadly at the valuation of services at the level of the clinician of the practitioner and doing things -- I touched

on it briefly in here -- about comparing actual hours worked -- hours worked is estimated in the fee schedule. And then going about it in that way can then point toward where you would want to look at services individually. But the starting point is that kind of broader perspective.

And then -- you know, with 7,000 codes you've got to figure out where your problems are. And so that's a perspective on the matter that allows a focus on which codes need to be reviewed.

Does that answer the question?

MR. THOMAS: Yeah, I get it. Because I'm just going back to -- and I'm not trying to get into phase 2, but I'm just trying to understand the -- to me, there's a differential between the capability and work that goes into a procedure versus what I kind of view as Rita's point is really around the utilization and volume of the procedure.

So what you're really talking about is more volume of the procedures versus the actual skill level that goes into -- and the value we put on doing a procedure.

DR. REDBERG: I was thinking more of if there are two equally effective ways to accomplish something.

MR. THOMAS: I understand.

DR. REDBERG: Do we want to look at it that way, as opposed to....

MR. THOMAS: Anyway, that's helpful. Thank you.

DR. CROSSON: I've got Bruce and then Craig.

DR. SAMITT: Are we still on round 1? [Off microphone.]

DR. CROSSON: We are still on round 1.

DR. SAMITT: I'll wait for round 2. [Off microphone.]

DR. CROSSON: Jon, did you want to get in on this?

DR. CHRISTIANSON: Bruce wants to get on this. Go ahead, and I'll follow him. Same discussion.

DR. CROSSON: Go ahead, Jon.

DR. CHRISTIANSON: So I think the use of undervalued and overvalued, in the present context, is -- and Rita, I'm sure, back me up on this. So when we talk about value, we pick some measure of value. Maybe it's healthy years of life or something like that. So when we talk about overvalued versus undervalued, for some people that language implies that you are saying that for an equal amount of expenditure on primary care, you're going to get

more healthy years of life than you will spending the dollars on specialty care.

I don't think you've done that analysis, or maybe you're just drawing in general on the literature. But for many people it will imply that. It will imply that you're saying that the additional healthy years of life for a dollar spent on specialty care is less than a dollar spent on primary care and therefore we ought to reallocate dollars in the Medicare program.

So I think we need to be clear. Your response to value tends to be -- what I've heard -- doesn't tend to go in that direction. You've got a different idea of overvalue or undervalue than what I've just said. Maybe I'm wrong. Maybe I haven't heard you articulate that.

But if you do think about it that way, then there's a lot of work that would need to be done and literature that would need to be drawn on to sort of readjust the relative weights based on that kind of analysis.

So I think there's a good part of the world that when you say overvalued and undervalued, they will go right to that.

MR. WINTER: Yeah, as I tried to clarify, when we use the term value in this presentation, what we're talking about is the relative levels of clinician work, that is the time and intensity of effort and the practice costs and the PLI, or medical malpractice insurance. So it's really the work and resources involved in providing the service, rather than the impact on outcomes or quality.

DR. CHRISTIANSON: So when you talk about overvalued or undervalued services, you're not really talking about value to the patient per dollar spent?

MR. WINTER: Correct.

DR. CHRISTIANSON: And that's the distinction I think you ought to be careful you make when you do this discussion.

DR. MILLER: Yeah. I think you're right about this and you're not the first person who brought it up.

DR. CHRISTIANSON: I thought I was [Off microphone.]

[Laughter.]

DR. MILLER: You're the first person who brought it up, absolutely, Jon. Some other people brought it up very close at the same time, but....

DR. CHRISTIANSON: [Off microphone.] Not as clearly, either.

DR. MILLER: They were a little behind you. I'm sorry, I was out of line a moment ago.

I think what we're really about here is mispriced. I think we're awkwardly caught in a world where the law and the relative value scale and there's 20 and 30 years of vocabulary that runs through certain parts of the community.

But I think your point is well taken. I think it could be easily misunderstood. And I think what we're really talking about in the end is pricing here. We will start cleaning things up.

DR. CROSSON: Bruce.

MR. PYENSON: Actually picking up on that point, what we're talking about is the RBRVS system, the resource-based relative value scale. And on Slide 4, you identified the three components of that.

Most of the discussion, I think, correct me if I'm wrong, and most of the planning is on the first component of that, the work and not the practice and not the malpractice.

MR. WINTER: We envision -- this is really your call, but the way we've laid it out, it could encompass both because practice expense is almost half of fee schedule spending.

The work that we've done in the past, on addressing the process for value services and the data available for setting RVUs, that has encompassed both work and practice expense.

But it is your judgment, as to what you want to focus on.

MR. PYENSON: Thank you.

The suggestion, which I think is terrific, to measure hours of physicians, that's focused on the work component, I believe?

DR. HAYES: Although, there is a portion of practice expense that is similarly valued, in terms of the amount of time that say a technician or nurse or what have you devotes to a service. So some of what we've been talking about in connection with clinician work would translate over to that portion of practice expense that's driven by the time that those other workers put into a service.

MR. PYENSON: Thank you. Very helpful. A related question. As you know, there's GPCIs, the geographic indices. They get multiplied by the three components. Is there a potential distortion that occurs in the weights, either driving the primary versus specialty or some of the other end products we're looking at, based on how those geographic indices are applied?

DR. HAYES: Yes. That's a possibility. The Commission had a mandated study to do on the GPCIs a few years ago, and we can make sure that you get access to that work. But there again, there was another set of concerns that the Commission raised about that too, but we, for purposes of the discussion today, were focusing on the relative value units in the calculation as opposed to the GPCIs.

MS. BUTO: Bruce, can you be more specific about the distortion that you're talking about?

MR. PYENSON: I don't know, but it seems as though, if high-cost areas have more specialists, more procedures, low-cost areas have fewer, depending on how the geographic indices are used and weighted, that could complicate some of the income figures we're seeing and

there could be other --

DR. GINSBURG: Bruce, I don't think that happens, because the GPCIs are really looking at basic data like rents and wages for staff that physicians hire, and I don't think it's really related to these relative value issues.

DR. CHRISTIANSON: I agree with Paul. Another place to look, there was an absolutely brilliant study done by an IOM committee about five years ago on the GPCIs and you might want to refer to that.

DR. MILLER: [Off microphone.]

[Laughter.]

DR. CHRISTIANSON: Coincidentally.

DR. CROSSON: Just happened to chair it. Brian, do you have a comment on this?

DR. DeBUSK: Not after what Jon said.

[Laughter.]

DR. DeBUSK: No, my one comment was you may, as a profession, to Bruce's point, may have an issue because you are more likely to find a primary care physician in a rural area, which presumably, to Paul's comment, would have lower rents and lower geographic adjustments.

DR. MILLER: And that's absolutely understood. I

absolutely am -- well, I'm pretty sure, pending Kevin and Ariel's response here, you can think of these problems separately. You know, they're multiplicative in the equation. If you want to focus on relative -- I'm sorry -- mispriced services -- sorry, John -- you know, you can go through that exercise and then, you know, new paragraph, I want to also look at the geographic variation and whether that's properly scaled, and we've done some of that work in the past. I think you can have that conservation, but I think you can probably think of them as separate exercises.

You guys are going to blow me out of the water.

MS. WINTER: Kevin is shaking his head. No.

DR. DeBUSK: That does build on Warner's comment earlier, though, in that when you try to look at primary care as a profession, in absolute terms, you will have to take into consideration more than we're just rurally located.

DR. MILLER: Right, but when we do the compensation stuff, that's adjusted, right?

DR. HAYES: Yes.

DR. MILLER: Right. So those -- and your point still stands. I'm not taking your point down. But when

you look at the, you know, relative compensation or mispricing, that is making those statements free of geographic influences. When you put it all back together and start paying people, then I think that geographic component could come back into your conversation. That's really all I'm trying to say.

DR. GINSBURG: One more thing. The GPCIs will end up compressing the geographic variation in prices, so that this was a positive for rural physicians and a negative for, you know, physicians in some of the most expensive urban areas.

MR. PYENSON: Thank you. A couple of other questions. I wonder if you could compare your concept of efficiency gains to the productivity gains that are built into the DRG system, where there's a downward price built into DRGs, based on a productivity gain.

DR. HAYES: If there's a formula that could be used to make these adjustments -- that's what you're asking?

MR. PYENSON: That was my next question.

DR. HAYES: Oh. Oh. We'll consider that and get back to you next time we go over this, if it's all right

with you.

DR. MILLER: Your question sounded like you thought there was some factor present here on efficiency gain. Is that what you meant?

MR. PYENSON: Well, from a concept standpoint, there's a concept that certain classes of services ought to or do have an efficiency gain, and that's, of course, over time, and others don't. And it seems like that concept is already established for hospitals and other facilities in DRGs.

DR. MILLER: This gets pretty high concept pretty quickly, but I think there's a few points that are being made here and then you'll have to use your judgment of how related they are.

So I think the point that Kevin and Ariel are making is that certain services lend themselves to learning and becoming more efficient over time. I can -- I don't want to do anybody an injustice but I can read a radiology test more quickly and learn how to -- you know, and what took me 20 minutes two years ago takes me, you know, 10 minutes, 12 minutes. You know, the technology changes. People become more skilled at it, that type of thing.

Other services not so much, that a cognitive service may be more difficult. You have to sit with a patient, to gain that efficiency and really go through history and that type of thing, and so it might be harder to get an efficiency gain.

In contrast, the productivity factor that was put in on the hospital side, and, you know, there's no clear legislative history often written down for these things. But my sense there, at the time that that was being talked about -- and I think this is widely misunderstood -- is it wasn't about the productivity gains in the industry itself as much as if the economy is gaining productivity, shouldn't the health care sector be held to those types of gains, that the people who are paying the taxes are working in improving their productivity, so shouldn't that be enforced on, you know, the health care sector, as opposed to going in and saying this productivity is occurring in the hospital sector in this set of services, that type of thing. That's my sense.

MR. PYENSON: One is, well, that was the second part of my question, you know, if this is as a sound basis, can't it be done prospectively as opposed to requiring a

periodic evaluation.

MS. WINTER: Are you suggesting applying it prospectively to a certain category of services, or the entire -- all services in the fee schedule?

MR. PYENSON: Well, services in the --

MS. WINTER: So it seems similar to an idea that we've batted around in the past, which is for services that are growing very rapidly, where you'd assume because of rapid growth there are probably going to be efficiency gains, productivity gains, there could be an automatic formula payment reduction for those rapidly growing services. So that seems like a somewhat similar concept to what you're talking about.

The question, though, is like what should that reduction be and what is that -- what data would that be based on.

MS. BUTO: I'm sorry. Did you say prospective adjustment, because you wouldn't want to discourage efficiency gains, would you? You'd want to capture them after they've occurred.

MS. WINTER: Yeah. I should have said retrospective.

MS. BUTO: Okay.

MS. WINTER: Yeah. That's what we were thinking of, and I think Bruce is suggesting --

MR. PYENSON: Oh, prospective.

MS. WINTER: -- before, in advance. Right. So the question then is, what category of services do you identify in advance as being subject to efficiency, liable to have efficiency gains. Right.

DR. MILLER: And I am thinking -- and he's sitting right here, so -- I'm taking your concept, Bruce, as follows. I come out, I create a new code or, you know, some service. It happens to be -- you know, I'm making a bunch of assumptions here -- it happens to be a service that most people, or everybody agrees, or the medical profession, the RUC group, whoever, says this is a service in which the learning function, people are going to become much -- you know, it's going to be 30 minutes now but it's going to be 15 minutes later. Now I don't know how you reach all those judgments.

And I took Bruce's point as if you expect that to happen, don't wait for re-evaluations, you know, when somebody takes it upon themselves 10 years down the road to do it.

Start to take it out in advance. I think there would be the $64,000 questions that precede that -- On what basis, are you doing it service, are you doing it in the macro, et cetera. But I took him as saying prospective.

MR. PYENSON: You interpreted me correctly.

DR. CROSSON: Bruce, do you have another question?

MR. PYENSON: I do. On the grouping and detail, I assume that your thinking there is to preserve the details of the CPT code infrastructure -- okay -- and just grouping on the payment basis.

MS. WINTER: That's how we've been thinking about it and that how it's done in the outpatient PPS, and that would certainly make it easier for clinicians because they would continue billing the same way. What would change would be the payment, but the billing process would continue on as it has in the past.

MR. PYENSON: We'd also make the value of real-world information, real-world data, preserve that.

MS. WINTER: Yes. Correct.

MR. PYENSON: One other question, and this relates to Bill's comment on data from the private sector.

In thinking about compensation from the -- for example, for primary care from the private sector, there's often not just fee for service but there's often a large component of gain-sharing, and that shows up in -- as perhaps most easily in income.

So has work been done on -- rather than on the fee schedule per se, the income components relative to private pay and the relativity among specialties, for example? And one of the thoughts there, when that's done in the private sector it's often a redistribution from -- not necessarily from other physicians or specialties but from the hospital or facility sector, so the bonus is based on reducing, if you will, the Part A piece, you know.

And so an underlying assumption here in budget neutrality, I think, is that the Part B piece, and maybe just the carrier piece, stays the same.

MS. WINTER: So are you asking whether there are sources of data on commercial insurance compensation by specialty, or by type of specialty, that this aggregates gain-sharing payments from sort of the basic -- from other payments?

DR. MILLER: Can I do this? Yes. There is an

implicit assumption that when you're talking about the repricing of services, and as a starting point, that you're moving things around within Part B, or within the fee schedule.

To your point about the relationship with A and that type of thing, in some ways my reaction to that is, that's kind of concepts like the ACOs. The physicians organize, they change their utilization patterns, they bring it in under some fixed benchmark, they get a bonus. But in this discussion, narrowly as we're discussing pricing and mispricing, it's about moving money around within the fee schedule.

MS. WINTER: And the chart that we showed you on Slide 6, that's all income, from all sources, for physicians.

DR. CROSSON: So I guess, you know, on this point, my assumption would have been, if you look at the, you know, performance of the majority of ACOs and what's going on with other alternative payment models, that at this point in time, although what Bruce talked about is exactly what's going on, the amount of money relative to the differences in income that we see is very small, so

far. In the future it could be --

MR. PYENSON: From a Medicare standpoint?

DR. CROSSON: From a Medicare standpoint.

MR. PYENSON: Right, because ACOs typically -- you know, the reports that are out there are not like insurance company financials, right. What you're talking about is the gain-sharing.

DR. CROSSON: Exactly. Now are you saying that in commercial ACOs you're seeing -- you think you're seeing large increments of income changing, based on downstream utilization?

MR. PYENSON: Well, you could. You could actually -- we wouldn't know if that's going on within ACOs, within even Medicare ACOs, because part of the gain-sharing can be from within the hospital's expense side. That was paid by DRGs. So the DRG wouldn't change.

DR. CROSSON: No, I agree with that all entirely. All I was basically saying is that, empirically, at the moment, I suspect, without -- as you're right, without the data, even in the commercial world, that we're so early on in the development of alternative payment mechanisms, gain-sharing is one, that the amount of movement from other --

from the physician's ability to manage other services is still small, and might not likely to be materially affecting the differences that we see in income. That's just -- and I'm just saying, that's what I think, although in principle I agree with you.

We're still on clarifying questions. Clarifying questions. Rita. I meant Alice.

[Laughter.]

DR. COOMBS: Guess what? Craig and I decided to start Round 2 if you're okay with that.

[Laughter.]

DR. COOMBS: First of all, I'd like to say we look --

DR. CROSSON: Paul's starting.

DR. COOMBS: Oh, he is?

DR. CROSSON: Paul is starting Round 2. So we're still on clarifying questions. Sorry.

DR. COOMBS: We'll make one up.

[Laughter.]

DR. CROSSON: Okay. We've finished with clarifying questions, so now we're going to substantive comments on the material that's been presented, and, you

know, it asks for emphasis, and we've got a number of pieces here, moving pieces. I haven't heard anything so far saying, oh, my gosh, don't look at that; that's meaningless. But I would like to see some prioritization, some emphasis, or addition of new ideas.

Paul is going to start and then we'll move up this way and around that way.

MR. PYENSON: Yeah, thanks. The presentation was very, very good. Excellent.

The topic that has come out in the clarifying question discussion is very important, because it's affecting payment throughout the delivery system. This is not just a Medicare issue.

In addition to commercial plans, Medicaid plans all use the Medicare relative value scale, again with their own conversion factors. And Rita really presented some of the importance of it as far as the potential to distort practice patterns, to get overuse of some of the services that are very lucrative for physicians.

You know, the predecessor commission of MedPAC, the Physician Payment Review Commission, was very heavily involved in the enactment of the Medicare fee schedule. In

fact, others besides my involvements. Bill Gradison was the ranking member of the Ways and Means Health Subcommittee when the legislation was enacted, and Kathy Buto was a very high-level official at HCFA, who worked on implementing the fee schedule.

Some analysis that HCFA did a few years after the implementation showed a very substantial change in the structure of payment, as far as a very large boost to primary care, and, you know, in a budget-neutral fashion that came out of procedural services. I wish I had the numbers with me, but I recollect it was something on the order of a 40 percent increase in payment for evaluation and management services.

What's been very painful for me, in recent years, is on a number of occasions I've talked to some young people in this field, and their impression of the Medicare fee schedule was, "Yeah, yeah, they went to a fee schedule and didn't change anything." The problem is still the same. We're underpaying for primary care, but the reality is that the fee schedule made a very large difference. And then, I believe through a very flawed updating process, that a lot of the change was lost over a long period of

time, and it's even possible that the structure of payments is not that different now than it was before the fee schedule, and what prompted Congress to ask for -- create a commission and ask for proposals for reform.

Now MedPAC has addressed this issue on many times, but I believe we should again, and I have two thoughts -- I had a conversation. You know, Warner asked about, that we're talking about a 5 percent or a 30 percent distortion, and I think we're a lot closer to the 30 percent distortion, so I think this is really important and worth doing.

I think the first thing that the Commission should be doing is taking a look at the various processes which have come from CMS and come from Congress, as far as instructions to CMS, to try to get this schedule repriced, and to make an assessment as to, is this up to the magnitude of the problem. And my sense is that it's clearly not.

You know, a .3 percent redistribution is very trivial compared to the nature of the problem, and 1 percent would be better. But I still think that's very small, and, of course, the legislation is only doing this

for three years. So I think that we need to make a judgment about is what's current efforts, are they really up to the task.

And the other thought I have to just add to what the presentation said is that I find the idea of working with large multispecialty practices, drawing data from them, perhaps through creating a panel of practices in different parts of the country, and perhaps paying them, as Ariel said, is a way to go. When I read the previous MedPAC description of this, I had the sense that if we had gotten more concrete over how this would work, it might actually improve the chances of this being adopted. So I think it might be worth investing in more work, more discussions with people, financial people, add some of the large practices as to the type of data they might have and how to do this.

So those are my thoughts about how we should get into this issue.

DR. CROSSON: Paul, I agree with you. I'd just add one thing. In terms of the notion, which is one of the thoughts here is to try to get a different set of benchmarks from, let's say, the large multispecialty group

practices, I think the choice of practice may also and should be influenced by the nature of the payment that those practices receive and also potentially the way the physicians themselves are paid and whether it's a productivity incentive or it's a different set of incentives.

Okay. We are going to come up this way, but I'm going to make one exception. Alice has an unavoidable commitment, and she does need to leave, which was why she was jumping up and down a little bit.

[Laughter.]

DR. CROSSON: So, Alice, we'll have you go forward, and then we'll return to that end.

DR. COOMBS: Thank you so much.

I like that you gave history, Paul, because that helps with just the overall approach.

One of the things that I thought about in reading this chapter and venturing into this subject is that I had a chance to actually go to the RUC and sit in the RUC, and I would encourage more of you to do it because then you would understand the process a little bit more.

I think Julie Somers, who was part of MedPAC as

well was there at the same time as I was.

DR. MILLER: And Kevin is gone. Well, Kevin told us he's gone.

[Laughter.]

MR. WINTER: I saw him there.

DR. MILLER: You saw him there.

DR. CROSSON: Now, the fact that they keep coming back with Cubs hats has got nothing --

DR. COOMBS: A couple of things I was impressed with, because I had heard about the RUC -- and one of the things is the process by which they decide. And it really is multidisciplinary.

For instance, if you have a nephrostomy tube placement, they would have the urologist there, the radiologist there, and they would all talk about the time input. And I was really impressed by the fact that if you have a nephrostomy tube and the radiology suite, it requires postoperative nursing. They had considered all of those things, and the family of codes would agree that one was not more advantaged or disadvantaged. It worked well, and I saw from that standpoint.

Getting to some of the issues around the

components of the RVUs in terms of the work, the time, and intensity, I don't think that we're able to deal with both of those adequately. The intensity piece of it, which is a skill set, is one part that I think you have to be reliant on the specialty societies for that.

The other piece of it is, when we get into the topic -- and this is a tough topic -- I would totally separate the issue of work, income disparity for primary care and specialists. And the reason why I would separate that is, first of all, if you have a surgeon who is taking call every third night, he may generate a revenue that is significantly larger than a primary care because his hourly time spent in the hospital is far greater.

So, when you look at salaries -- and we have to stay at the level of the unit payment in terms of reimbursement. So salary overall, when we discuss salary, you have to be very intent on saying that the salaries are reflective of multiple components in terms of the individual physician productivity, and that's really concerning.

For specialists, I'll give you an example because I want it to stick -- is that I did a case many years ago

with a thoracic case where a tumor was on the chest wall, and it took a long time to basically do this case. The first hour for me and the nurse anesthetist, I put an epidural in, an A line in, and we're watching this patient because has comorbid conditions. First hour for Medicare payment is $324. It's $81 every hour after that for as long as the surgeon technically gets that tumor off the wall.

We look at the disparities between specialists and primary care. It really is so complex, with patient issues that are surrounded around how fast can you do a case, and the cases may not all be the same, first of all. And the intensity or the skill sets required for different cases are -- and I think physicians agree with that. I mean, most physicians will get in a room, and there's some wide range. But there are others that are not their gray zones, and so I like the idea of possibly doing evaluation at a group level and considering the large codes that are very similar and looking at the time element. The intensity, I think you have to depend on the specialists to look at that management.

I would shy away from group -- I'm not going to

say reference pricing, but group pricing based on evidence-based guidelines. I think evidence-based guidelines are important, but combining the two might be very difficult to do in this genre as we are here as MedPAC Commissioners. I think it's a great idea, but combining the two introduces a whole bunch of other complexities.

So I just wanted to say those few things. Thank you.

DR. CROSSON: Thank you, Alice.

I just want to emphasize one point here, and that has to do with the work component that you talked about because I actually had forgotten this or didn't know it. Can you remind us to what proportion of the work component is made up of time versus intensity?

DR. HAYES: It depends upon the category of service, but it's somewhere in the 75 to 90 percent range in terms of that's how important time is compared to intensity.

DR. CROSSON: What I've gathered from that is you could do a lot of work, subjective work, as you suggest, on the intensity piece, move it around or something, and not get very much from it.

DR. COOMBS: Right.

DR. CROSSON: Whereas, to the extent that we want to take a look at the payment formula itself, working on the time part seems to be much more likely to yield differences, which could be adjusted, and, of course, it's not totally, but more objective than the intensity piece. I agree it's subjective or largely subjective.

Okay. So now we'll start down at that end, and it looks like Bill Gradison.

MR. GRADISON: Okay. I am reminded of the writings of St. Thomas Aquinas trying to seek to define a just price. We read about this every day in the newspapers with regard to drugs, and somehow I think we're doing the same thing here. And the reason I start it that way is this is such a subjective area, and we're trying to interject into it a degree of objective review. And I'm skeptical that that's going to work.

Let me be more exact. We were told that after the review of 17- or 1800 out of 7,000 procedures, hardly anything moved very much, certainly not enough to deal with primary care issue at all. I see no reason to assume that going through the other 5,000 -- I don't say we shouldn't

do it or somebody shouldn't do it, but the notion that that's going to materially resolve the problem is just unrealistic, bordering on naïve.

I do have to say that the current process disturbs me, and I've often thought of it as one of regulatory capture in the sense that the people sitting around those tables who are working hard -- and I respect their professional skill and their contribution to this decision-making process, but that's the only case I can think of in America where people decide their own salaries, indirectly to be sure, but for the group of people that's their specialty. I'd love to have a job like that someday.

So what I come down here with basically is -- a brief digression. Some of you know I taught briefly at Harvard Business School, and we told our students that there were no answers to business cases, that the best you could come up with was currently useful generalizations. And my currently useful generalization is that the process that we're talking about simply won't work if our objective is to have less divergence and payment for primary care versus procedures. I'm basically saying what Alice did, I think, in other words. That we've got to think of this as

a separate issue and work backwards from the choices people are making when they go out of medical school today. I've been told that in some areas, salaries are actually going -- I have no data for this, but I've been told in some areas, there's significant increases in the payment for primary care because they're harder to find, so maybe the market is beginning to work, and that's something I'd like to really know more about as we get our current data.

But if you buy the notion that this -- it isn't that the process shouldn't be pursued, but I just wouldn't look for it to be a solution. We need something else.

Now, what might that be in a world where everything has to be revenue neutral is, of course, the challenge. We look at it, and we say we ought to pay 10 percent more or whatever -- 10 percent is pretty small too -- and that we don't come up with a way to pay for that other than to go back and cut the other folks, which is really very hard to do. It's a give-back. It's a "clawback," in labor relations terms and not very popular. So I hope that suggestion is useful. At least it reflects my current thinking about not relying on the current RUC process to solve the problem.

DR. NERENZ: Just a couple points, and this would follow, I think, most directly on what Jay said about focusing on the time component, just because it's dominant part of at least how value is currently defined, which I agree with Jon is not the way you stated it, but it's important to know that.

One of the most compelling things I think I've heard in one of our earlier meetings on this was the idea that an examination of some billing patterns, we find total billings that just exceed possible reality. It looks like people are working more than 24 hours a day. That strikes me as being a solid ground to enter or to stand on as an example of following up on time. But if a certain procedure or a certain code is set up in a way that in actual practice of billing, it creates the appearance of somebody working more than 24 hours a day, something is wrong. And that would seem then to be kind of a high-priority target.

So I guess I would suggest that given how hard it is to try to do some sort of philosophical assessment of value and how hard it is to second-guess somebody on intensity, that time is an objective thing, and there does

seem to be some evidence of situations where the time value seems just to be blatantly incorrect.

MS. BUTO: First of all, I want to take some responsibility for setting up the RUC process with the AMA, which I was very much involved in, and our thinking at the time, which looking back seems naïve -- but I actually probably would have made the same decision today if I were in the same shoes -- was that the government has a very hard time valuing physician services. And even if the government had overseen a committee to do it, it was fraught with political and procedural difficulties, and we had had much experience with having decisions overturned by the Congress. And Bill can probably relate to this.

So, at the time, we thought government had the oversight and the ability to overturn a RUC decision or a recommendation and make its own decision, and that was important. And, secondly, as long as we control the conversion factor, that was important. So that was the basis, for those of you who wondered how it got started.

Having said that, I really agree with Paul that we're at a point now where an external committee actually would make sense, and I think it would be more acceptable

to do some of the work that we're talking about doing here.

I do think it's important, as the Commission proceeds with this work, that we be clear what problem we're solving. A lot of problems have been laid out here, including the decline in payments for primary care relative to procedures and surgery, but it also strikes me that we haven't emphasized enough. And I thin, it's implicit that this underpayment, we believe, actually undermines the ability of primary care physicians to do the kind of comprehensive and sort of collaborative and coordinating work that needs to be done to manage chronic conditions and difficult complex patients. So I really would like to see more of that, not just they're underpaid, but they're probably not paid enough to do everything that we're expecting them to do, even in a fee-for-service environment.

Then I think another purpose, clearly, is that we think they're overvalued procedures that lead to overutilization, as I think Rita was pointing out earlier, and that we need to find ways to capture on an ongoing basis, productivity improvements. So, again, my point there is really let's be clear what problem we're solving.

And then I just wanted to turn to slides -- I think it's 18 and 19 -- and say that I support all of the -- I think we can do both, revisit the prior recommendations, and I would do all of those or recommend that we proceed on all of those.

On the new directions, I really think to get to the issue of is it a 30 percent problem -- and Bill Gradison's point about even if you re-did all the values, would it make much of a difference, I think that the partial capitation approach is one that we ought to really spend some time developing. This is going to be tough because separating primary care physicians who get paid for E&M from proceduralists who are getting paid for E&M, I think it's going to require us to think about is there some bundling of consultation services and so on that could go into the procedural codes, or how would we actually do that? So I think it's actually more complicated than we probably have even thought about but worth pursuing because I really think that if we're going to make a big difference in the kind of service -- and I think, again, here we need to define what is it we'd like to see primary care be able to do -- that we ought to find a way to value that and pay

for it separately.

I think as many of you know, I'm not a fan of reference pricing, and I worry about combining CPT codes into families of codes. I think this particular issue would benefit from examples. So the issue of paying dermatology for different-sized lesions or warts or whatever, I mean, I think a lot of people would understand why that doesn't need to be separately paid for. But the idea of, say, paying for angioplasty and bypass surgery at a similar or same rate, I think would strike people as fairly extreme.

So I think one needs to think about what we're talking about and identify criteria that might be applied if you were to pursue this because I think it's a worrisome area, and I would not -- we have a tendency to compare physician services in Part B to hospital DRGs or outpatient PPS, and they're very different. Hospital services payments are for operating costs and a lot of fixed costs. Physician services are for a discrete service to a patient, and I think we want to be careful about assuming that if you group them together, you're going to get the efficient outcome or the best value for the patient. I don't think

we know that. I think it will drive practice, but is it going to drive practice the way we think that people objectively would say is the right thing to do?

So I think if the problem we're trying to solve is really paying primary care more appropriately and then going after those overvalued procedures, I think that's doable. This one feels like we potentially could open up a can of worms, but again, I think it would benefit from examples.

DR. CROSSON: Kathy, just on that last point, you know, I agree with you, and that's why I was tussling with Rita about what was extreme or what was not extreme. I think anything that we do in this grouping area first of all has to pass a clinical reasonableness test, and that clinical reasonableness test may be a different kind of admittedly subjective analysis than we have applied to other thinking about other so-called -- sorry, Paul -- reference pricing approaches, like with pharmaceuticals and things of that kind.

Yes, Rita.

DR. REDBERG: I just wanted to respond to that, because, I mean, obviously, doing surgery takes more time

and intensity than medical management. But my point -- and that's a problem, I think, with fee-for-service system, is because if you're going to encourage things that are paid more, you know, intentionally are not -- when there may not be any benefit. In fact, you might be worse off because they're riskier and more --

But to really accomplish, you know, a value system where we're doing the best for beneficiaries and using our money most wisely without encouraging a lot of unnecessary or dangerous procedures, we need to talk about a capitated payment system, you know, a per beneficiary per month or a bundled payment system, which I think CMS is not experimenting with, in limited ways. And I don't think that's extreme at all. I mean, if we're looking at being responsible stewards of the Medicare program we want to spend the money in the way that's best for beneficiaries and best for the solvency of the program.

You know, we have large populations to cover and so we could estimate, you know, how many people would you better, you know, with bypass surgery, how many people will do better with medical management, how many people -- you know, and that currently very different from what we're

actually doing, because many people are getting unnecessary procedures and doing worse.

So I don't think that's -- I think that makes a lot of sense, at least to me, and not extreme, I mean, not if you're just going to compare payments and that, but, you know, sort of focusing on -- instead of encouraging this very high volume but not very high value system that we currently have in our current system, I think we have to think about alternative payment systems that don't encourage that but focus on what we're trying to achieve, which is better value, care, meaning giving our beneficiaries what they need and don't what they don't need and are suffering from.

DR. CROSSON: And as you might imagine, I heartily agree with everything you said. My only point was that this particular tool, whatever we call it, choose to call it, of, you know, lumping things together into one payment system, fits better with some clinical problems of utilization that we have to solve, than others, you know, and -- well, that's enough. Okay.

Coming up. Yes, Amy.

MS. BRICKER: So I'm reminded of yesterday and

the framework that was laid for us about, you know, the future of the Medicare program and, you know, going back to what others have already shared, what is the objective of this discussion and this venture. Is it, in fact, the question that Warner raised around is it 5 percent or 30 percent. Is it that primary care is undervalued? I think when you look at the comparison, or we think, anecdotally, yes, maybe it's not. Maybe it's that everything else is over-valued. I think you have to follow the dollar.

And going back to what Rita and others have said around alternative payment approach, I just don't know if a complete overhaul of the system is going to be something that will gain traction if we've attempted, over the course of seemingly a decade, to make recommendations incrementally that have been not adopted. I don't know if a complete overhaul, at this point, would gain much traction.

And so I am in support of looking at the 7000 codes. I don't know how in the world anyone could actually, even with a RUC or no RUC, you know, make some headway when you're looking at the vast number of codes and seemingly the disparity between them.

So I'm in support, at least of that step, maybe short-term, long-term, looking at something as an alternative payment from a bundled perspective or capitated approach.

You know, I also found it interesting that upon survey, no one answered the phone, and I think -- or attempting to survey, no one would engage -- and I think that's human nature. If you're getting paid a lot, and there isn't any pain, why, in fact, would you answer the phone? When you're not able to keep your lights on and you're not getting paid enough, you would probably take that call and provide some feedback to the RUC or others that are attempting to gain some information about your satisfaction relative to payment. So I just found that to be interesting.

Lastly, ensuring that, you know, other comments have been made about, you know, taking from the other group, non-primary care will be difficult, I think if we, in fact, believe that primary care is undervalued, we've got to figure out a way to approach in a budget-neutral fashion, not just continuing to raise cost for other and primary care.

Thank you.

DR. CROSSON: Thank you, Amy. Jon.

DR. CHRISTIANSON: Yeah. I think the comments people have made about why are we doing this are really important. I don't think correcting mispriced services is going to have a huge effect on changing the income distribution among different physician specialties, but I think we need to do it, or try to do it.

When we think about stuff that we say we support strongly, like ACOs, these are built on a fee-for-service system, and if we have mispriced services, we're paying the wrong amount, and we're paying the wrong amount for bundled payments too, and we need to do the best we can to pay the right amount for those things. I think that's going to be very important for the credibility going forward. So I think for that reason alone it's worth tackling this.

DR. CROSSON: Craig.

DR. SAMITT: So I want to go back to something that you said earlier, Jay, and I'll try to paraphrase, which is whether this mispricing of services is driving the behaviors inconsistent with what's best for beneficiaries, or that's driving behaviors that are inconsistent with a

more coordinated clinical model, and I really do believe that they are. And so I think there is a misdistribution, a maldistribution, as a result of this mispricing that needs to be addressed and I think the question that we're all struggling with is how to address it.

And as I look at the list of things on Slides 18 and 19, you know, I just begin to wonder which ones are fixable and which ones will most influence an improvement in the problem. And I have to say, I'm admittedly skeptical about whether revisiting our prior recommendations will have an effect. You know, I think others have mentioned that before. I don't think there's a harm in us revisiting the recommendations, but for all the reasons that we described about, you know, how do we differentially determine value of services, I think it's just going to be a very difficult debate.

I also don't see how combining CPT codes solve the redistribution problem, and it may do it in certain small instances but I don't think it does it at a substantive enough scale. So I'll sort of focus on my area of strength, which is the issue of population health, and I think when you look at -- you know, and Paul alluded to

this earlier -- I do think that we can take a page out of the private system here, because I think where you do see some substantive changes in income redistribution is in those environments where organizations will take a cap, and then forcefully redistribute that cap to reward the behaviors that are most consistent with better care at a lower cost.

And so I think the greater merits would be in studying what else we can do in terms of this partial capitation approach outside of the Medicare Advantage space, because I think that's -- I'll say I agree with others that have said, "I think we're more at the 30 percent maldistribution level, not at the 5 percent." And it's, frankly, probably why we're stumbling a little bit in the ACO world, that ACO gain-share is in the 5 percent range. If we really want to see a change in the transformation of population health, we probably have to go far further than 5 percent. And so I do think that's the one that I would ask that we concentrate our energies on.

DR. CROSSON: Thank you. Pat.

MS. WANG: So I am in agreement with the other Commissioners that this is very important for MedPAC to

tackle, notwithstanding that past recommendations have gone unheeded.

A couple of observations or comments would be, number one, I do not think that -- I think it's confusing to put up the slides on relative income by specialty. You know, it's informative but I think it gives the wrong impression, that that is how we are defining what's undervalued and overvalued. There's a lot of -- you know, I think the income slide is fine to show, but I don't think that that should drive a determination of something as underpriced versus overpriced.

I think it's important to continue the work, whether it's through an expert panel or otherwise, to perhaps focus on some more specific issues that we see. So, for example, I think there's a general feeling that in today's world, and if you talk to primary care doctors, they are overwhelmed, because everybody is saying, "The whole responsibility for fixing the system is in your hands," which is, I think, completely unfair and unrealistic. But what they are now developing their practices to do with different kinds of practitioners and educators and clinical health workers and so forth and so

on is kind of new. And so maybe there should be focus on what are the specific elements of today's primary care practice that are underpriced, and maybe there are new element to introduce into the definition of work and intensity that are not now captured, you know, something qualitatively different.

To the extent that we feel that there is some overpricing in the specialty world, I would try, maybe, if we could, to sort of understand a little bit more what that is about. If it's volume driven, if the specific RVUs for a specific thing that a specialist does are, you know, according to the process that's followed, kind of science, is the issue that it's volume, and if it's volume, maybe there's a very specific element of adjustment, you know, picking up on Bruce's point earlier, about efficiency gains, that should be, you know, introduced or focused, and maybe that's an area of examination.

In terms of the new approaches, you know, the bundling approach, I think, to the extent that there are some obvious ones -- the example that Ariel gave about the dermatology excisions -- you know, it sounds like it's around the edges. I think it's worth looking at. I don't

think it gets us out of the work or the need to still continue to value the individual RVUs underneath, though, because the code still exists and they would roll up into some sort of bundle.

Partial cap I understand the appeal of, and I think that it is worth examining. Personally -- personally -- as an HMO in the Medicare Advantage space, I think that there's a lot of complexity to trying to introduce something like a capitation model in fee for service. What's the attribution? You know, I could say, you know, Dr. Buto is my doctor but I'm still going to see Dr. Crosson, and, you know, Dr. Samitt, because I rally like them, and I'm just going wherever I want. There's no control in the fee-for-service system around that.

I also, you know, just personally, we are an HMO. We do compensate our primary care doctors in many ways, although we do refer to the Medicare fee schedule as a starting place. But whether it's, you know, surplus sharing or quality bonuses or what have you. But we expect a lot in return. I mean, there's a tremendous amount of accountability, I think, that goes with a capitation payment. How do you make sure that there is no stinting?

I mean, in a fee-for-service system, those are the kinds of concerns that I have. I also think that it starts to bump into the things that ACOs are trying to develop, so I would just be careful about introducing more confusion and kind of noise into the reform efforts. I think it's worth looking at, but I just want to suggest my skepticism there.

But as far as the work of sort of looking at the values of these, and the prices of these individual services, perhaps we could focus, as Kathy suggested, on what are the specific questions, and maybe really try to hone in on those.

DR. CROSSON: Pat, I want to draw you out a little bit on one thing I thought I heard you say.

So it's always been interesting for me -- and I guess this goes back to some of our former Commissioners -- that the payment schedule, the payment formula is called resource-based, relative value scale. The valuation is a different kind of valuation than the value that I've heard many Commissioners talking about today, that is the value to the beneficiary, the value to society.

I thought I heard a little bit in what you were saying, and I may have over-misestimated what you said, to

quote a term --

MS. WANG: That's okay.

DR. CROSSON: Anyway -- something about the notion of potentially introducing into the payment formula, into the fee schedule, some sort of element of the relative value of what's actually being produced by that particular service. Did I hear that or not?

MS. WANG: I think that it was -- I mean, that's one way to interpret it. But again, the word "value" is, I think, dangerous. Is that a moral value to society that we're kind of making judgment calls on, or is it really just an observation about pricing accuracy?

What I was suggesting is, to the extent that it has not happened, maybe there should be a more robust effort to really talk to primary care societies and primary care physicians about what their work day today looks like, and what they anticipate their work day looks like six months and a year from now, because maybe there are elements in the definition of work that should be introduced into the idea of what is work, what is intensity. You know, work is -- maybe it's more than time. Maybe it's physician extenders. Maybe it's, you know, a

different augmentation or a multiple of I'm spending an hour interviewing a new patient but it's a multiple event because I now have to spend time, you know, educating the clinical educator who's going to work with the family, or setting up for them to go to a diabetes group management session, those kinds of things.

DR. CROSSON: Thank you. Sue?

MS. THOMPSON: A couple of points have been made by previous Commissioners as well, but just to underscore, like Amy, I cannot help but tie back to the opening chapter we started with yesterday, and the urgency that we face, and having come through and continuing to be within an ACO experience, especially in rural America the challenges around primary care.

And not to belabor this, but there was, you know, inference in the report, in 2015, about how nurse practitioners and PAs are starting to play a growing role in primary care, and I'm curious how big a role is this and what's the pace at which that's occurring, and then, what consequences are there to this piece that has happened as a result of a lot of medical students not choosing primary care.

The other piece in the ACO environment -- and Jon referenced this, as well -- as long as we're battling the fee-for-service incentive for our specialists, it's difficult in the ACO world. So again, I think another rationale for staying after this.

One of the comments that Kathy made about an experience with a physicians, or we have compensated physicians based upon a discrete experience or an episode, I think that's true in the specialist, or in the procedural world, but my relationship with Marcus Welby, as you commented yesterday, or that the depleting number of Marcus Welbys is a long-term relationship. And I'm curious, if we're thinking about the cognitive primary care, relationship-oriented practitioner in a way that doesn't work, when we try to put it into value units, depending on how you define value. But when you said that I thought, that's not how I think about my relationship with my primary care physician. So I just comment about that.

And last, and this is really, just, it caught my eye, on page 92, when you talk or look at, we haven't had numbers drawn since 2013, about physicians that are opting out of Medicare. But as of 2013, while it said that

there's not a lot, half of those who had opted out were psychiatrists and oral surgeons, and I'm looking forward to the discussion we're going to have around mental health with our geriatrics. Since 2013, how many more psychiatrists are dropping out -- and they play a huge role in working with primary care around some major medication issues that we have with our Medicare beneficiaries.

So those are my points. Important, important work, so thank you.

DR. CROSSON: Thank you, Sue. Jack.

DR. HOADLEY: So, again, I want to thank Kevin and Ariel for framing this. I mean, it's obviously gotten us really thinking hard about this.

I go back to what Paul started the discussion with. I mean, we've tried a bunch of ways and made a bunch of recommendations over the years to try to fix some of the issues that we've identified, and I do think there's a lot of value in sort of doubling down on that effort, seeing if there are ways.

I mean, Paul, you've made one comments about maybe reframing some of these with more specificity or other ways to try to get more attention.

Sometimes because we have already made the recommendation and we just sort of point to it, I don't know if that gets the same attention as kind of figuring out a way to reframe it and put it back in with a new vote and new kinds of things. I mean, that's at a sort of trivial, sort of marketing level almost, but if we can figure out some ways to put some different meat on the frameworks that we've already established, that might be useful.

And I think a couple people made the point that because the fee schedule still is the underpinning in ACOs and to a great extent within MA, this is not like a fading-out thing as fee-for-service gets to be a smaller and smaller share. It continues to be the framework.

A lot of people made points about grouping codes into families and so forth, and I guess the question we asked on a couple of things yesterday, is it worth the squeeze? I worry that we go through a pretty major restructuring and yet the incentives to update the system, the way people play within it don't necessarily change. We might just do a lot of effort, even if you could imagine the politics working to go for a major restructuring, and

then not really have changed the underlying incentives or the underlying things.

And I think about, on the one hand, some examples you've used where we could address some of the incentives for using the higher-value codes, but I also think about you can imagine families of codes where you really are saying you're not paying enough to do this higher-end service when it's needed, and it's the whole stenting kind of thing.

In this whole discussion, whether we call it reference pricing or common codes and so forth, we've had the conversation on the Part B side of where is it that it's under a design of trying to put incentives on the consumer, on the beneficiary in our case, to make choices around one model of reference pricing or in the Part B drug discussion we talked about putting things under a common code, so that the purchasers, the providers are faced with an incentive of which choice to make.

In all of these questions about overused or inappropriately used procedures, maybe it's not really the fee schedule where we need to think about the structure, but some other kinds of mechanisms to address that.

On the paying for primary care, your new directions and personal capitation, I mean, I think one thing -- I mean, it's frustrating to me, I thought, when we made the recommendation on the per beneficiary, per capita payment that that might be something. Given that the old bonus was going away, it might be something that would actually hit the sweet spot politically. Obviously, it didn't, and I don't know if there's any way, again, to reintroduce that as an idea to give it -- again, almost from a marketing approach, to get people to stop and pay some attention to it.

And I do think we should probably continue to think about the kind of partial capitation things. I am really struck by these notions of primary care practices in the way Sue and Pat and so forth talked about it. It's the long-term relationship. It's the investment, so many of the things that aren't in the encounter, as several people have said, the bringing in of other personnel into a medical home-style practice. It seems like when we talk about the partial capitation, it was still at a pretty small level that wouldn't have really addressed those kinds of things. And I don't know, short of shifts into Medicare

Advantage, whether there's other models to try to think of a payment within the traditional Medicare side of the program that could come up with a better way to compensate a primary care practice to really encourage all those outside the encounter kinds of activities or the extension of the encounter beyond the initial provider that's making the visit into something that we could do.

I don't have like a magic idea for how to do that, but I think that's probably a worthwhile area to think some more about.

DR. CROSSON: Thank you.

Warner.

MR. THOMAS: Just a couple of comments. It sounds like there's been pretty good support that we think the primary care reimbursement issue is material, not 5, maybe more in the 30, and I would just encourage us to take that on, seeing that it's so central to all the things we want to do around our ACO development, around chronic disease management.

Whether that's budget neutral or not or whether it's budget neutral within physician fees or budget neutral within Medicare, maybe it should be budget neutral just

within all Medicare spending. I would encourage us to take that on and to drive that forward.

The other thing, I would agree with Bill. I don't know if going through and looking at the other 5,000 codes is really going to yield a lot of benefit, given the amount of time that that's going to take. But perhaps one of the things that could be looked at, going to David's point, is the ones that really are -- they seem -- maybe "egregious" isn't the right word, but certainly very significantly overvalued. And compare and contrast that to areas where we know we have significant demand and not enough supply, and the things I think about, like neurology where it's another cognitive or mental health, as Sue mentioned. I think we ought to be thinking about what are those specialties that we just do not have the right supply of folks versus a demand of services, and I think that may evolve over time. But, certainly, today, we know some of those more cognitive disciplines, that's certainly a big issue.

I also would just make the comment that I think instead of spending lots and lots of times on the fee-for-service model, that we fix what we need to fix here, but

spend our time on the ACO and the global budget or global payment model, which I think ultimately is where we need to get. I understand this is the underpinning. We need to fix some of these things, but to me, they are not ultimately where we should be spending our time around physician reimbursement, in my opinion. It doesn't mean these things shouldn't be fixed, but I think that we need to spend our time and put the right incentives on the total cost of care and getting our physicians focused on that.

DR. CROSSON: Thank you. Thank you, Warner.

Bruce.

MR. PYENSON: Well, I want to thank Kevin and Ariel. It's really great to have your expertise and in-depth understanding and background here. It just really comes out, and I want to thank you for that.

We heard from some of the veterans of the development of the fee schedule -- Paul and Bill and Kathy. I think I want to thank you because the structure that you set up is still the foundation of what we're talking about for the future. So that was good work. I know not everything went the way you had hoped, but, boy, it's still around. And we're still using it and looking at it for the

future, and I think the lesson there is that it doesn't have to be perfect. And --

MR. GRADISON: Something happened on the way to the forum.

[Laughter.]

MR. PYENSON: And I think if we look at it in the future, my issue of the productivity gains, looking around, we're all baby boomers here, and we're all carrying one of these or having it literally in front of us here. Of course, none of us are multitasking. We're in a generation in an era where we're going to have self-driving cars in five years or less. We're going to have self-driving diabetics. My cardiologist is probably going to be in the cloud and have a voice like Siri, and that's the future transformation that's happening now. Having some flexibility that recognizes the kinds of changes that are going to go on, I think the structure we have can deal with that. But I think that's going to be important.

Just a comment on -- I think the approach with looking at the aggregate time is really very efficient, and I think it's a very good way to go forward. So that takes away a lot of the concerns about looking at thousands of

codes and so forth, and that's good enough to get it right to do that.

So I support the potential next steps. Thank you.

DR. CROSSON: Thank you, Bruce.

Other comments? Bill.

DR. HALL: I'm the last --

DR. CROSSON: Oh, I'm sorry.

DR. HALL: I think this has been one of our, really, greatest discussions we've had since I've been on the Commission, and I would echo Bruce's comments about the legacy that's been talked about here and the ideas that have been expressed.

I'm not going to obviously repeat what everybody has said, but a couple of things that stood out for me in listening to all of this is a couple of principles that came out. One is that there is a history here, and if we ignore the mistakes of others, we're found to repeat them. So that maybe says that we need to think in a slightly different way, maybe even out of the box. Certainly, I think that Bill and Paul have given us some good things to think about.

Craig brought in the issues of population health as one of the key factors in solving this problem. I certainly agree with that.

Kathy, I think your comment that you've repeated several times, anything worth saying is sometimes worth repeating several times, that what problem are we trying to solve? Why the hell are we here? I guess I would answer that, that we are at a very unique time in the history of Medicare; that is, that there will never be as many Medicare recipients in the entire history of the world as there is going to be in the next 20 years. That is going to culminate right about the time that we're supposedly running out of funds to continue Medicare.

The way I would try to think of reframing this problem is that we're here to service Medicare recipients now and in the future. We're not necessarily here to adjust payment structure disparities of physician payment, all of the other kind of political issues that sometimes muddy up the water here, not that they're not important, but when we say what are we going to do about Medicare recipients who don't seem to be getting the care that they need or at least we think that that's probably what's going

on here.

So ways that we might want to think a little bit out of the box here is to say maybe we don't have to repeat the mistakes of others either. For example, there are some established countries that have taken a very different view of this whole thing; the National Health Service in England, for example. Australia is in there, France to some extent. In England, the rate of house calls for older people, for example, is something like 500 percent higher in England than it is in the United States, where it's almost nonexistent.

So one of the things we might want to say is the issue and the problem, Kathy, that we're trying to solve here is how do we provide the best care to Medicare patients, and by that, I mean the value equation, the value proposition really works out.

And I would say that maybe this isn't a primary care problem or how much money primary care doctors are making. Maybe it's not a doctor issue. It's a health care issue that can be solved in a whole variety of ways by a mix of providers.

So I think we should take it really out of the

box here and say that it looks like this is not a problem that's going to be solved in the fee-for-service system. It's probably a problem that's going to look at large organized motivated health systems who can redistribute resources necessary to get at the problem.

This is not a doctor problem only. There are so many other professionals in the business now who might be able to actually do some of this a lot better than physicians, quite frankly.

So I think we should both narrow our focus and not worry so much about the disparities of the physician payment but also broaden it and say that this is a really incredible opportunity to develop a new system. Yes, it's probably going to have a capitated mode to it. It's probably not going to be fee-for-service. So this is our chance, I think.

DR. CROSSON: Great. Thank you very much, Bill.

Okay. I see no other comments, so let me just sum up a little bit here.

Just picking up on Bill's commentary, personally I -- and Warner made the same point and I think Craig as well -- I couldn't agree more with the fact that we really

need to replace the payment system with some sort of population-based payment system. We need organized delivery systems to be able to do that, whether they are accountable care organizations or whatever. The progress has been slow. If I had thought 10 years ago, 12 years ago, when I first came on the Commission, that 12 years later, we'd still be saying, "Boy, we really need this set of changes," I think I would have been somewhat disappointed. Nevertheless, it is proceeding. It's just proceeding slowly.

And, in the meantime, I think -- and I heard general support for this -- we shouldn't avoid trying to fix what is mispriced within the fee-for-service system in the meantime because I'm not sure how long the more substantial changes is going to take.

I'd make one point here. I think in terms of the balance between reiterating our prior recommendations and coming up with new ideas, honestly I think I've heard support for doing both. Not all of our recommendations have gone unheeded. The 10 percent primary care increase came pretty much from Commission recommendation prior to the Affordable Care Act. The problem is that it had a

sunset clause in it, and because of the dynamics we are seeing right now in the Congress, it has not been picked up again.

In general, philosophically, we often deal with this question of what is the political likelihood of some recommendation that we come up with. What's the political likelihood that it will be picked up, whether talking about the Congress or the administration?

I certainly can remember myself trying to deal with this early on, and I think Glenn used to say -- and I have come to agree with him -- our job is to try to get the policy right, and if we have to say it -- if we can get it right and somebody does something about it the first time, so much more credit to us. If we have to say the same thing over again two times or three or four or five, which is not an unknown phenomenon in the political process, then that's what we need to do. So I do think there's value in us reiterating and updating recommendations that we have made before to the extent that elements have changed, but I do think that there's also an opportunity and a need for some new thinking. And we heard a lot of that today, and I

think that's been very useful.

I heard general support for going in most of these directions. I think with respect to the grouping of codes, the family of codes, I think if and when we come back with that idea -- and I do think there's some -- as I said earlier, I think this idea, which we kind of put out here, is still very raw. I think if and when we come back with this as part of a set of potential solutions, we will come back with I with a pretty robust justification for why it would be useful and in what way, and, in addition, I think, as Kathy had suggested, with a good deal more specificity, examples and things of that nature. And so there's going to be a time, I think, for more thinking about that particular piece.

But I appreciate the input. I think it's been very helpful. I think we've advanced our thinking, and as I said before, I think we are going to be revisiting this issue of the physician payment process or whatever you want to call it, the fee schedule plus MACRA and everything else, a number of times at least through April, if not beyond that.

I think, Mark, you want to make -- you looked

like you were -- no.

DR. MILLER: The only thing I was glad you said at the end there that our recommendations haven't gone unheeded because if you hadn't said it, I was going to give you guys a little bit of a pep talk, and given my personality, you don't really want to do that because I'm not really that bubbly.

But I do actually want you to understand that they have. So the primary care adjustment went in. They sunset it. Okay. They also, Kevin, took the idea of the revaluation and turned that into the formulaic thing that got built into a law. Again, they took an idea, put their own spin on it, and did it. And there's other examples out there.

And he said it, and this is the last thing I'll say. They tend to pick up our ideas when they legislate in big steps. The ideas have to be out there, well-articulated -- or re-articulated, Jack, as you were saying, and ready to go. At ten o'clock at night, it's like, "Okay. Now we're turning to this." They know where they're reaching.

So I don't think you should look at this as they

aren't listening. I think in some ways, you have had a measurable impact here. So I was glad that you got that into your comment.

DR. CROSSON: Okay. So now it's time for the public comment period. So if there are any members of the audience who would like to make a public comment, I'd ask you now to come up to the microphone so we can see who you are or at least how many people there are. We've got one, two, three people moving. It looks like a couple of individuals. I'll wait for the commotion to quiet down for a second.

MS. KEYSOR: Can you hear me?

DR. CROSSON: Just one sec. Sharon, are you still in line or not?

MS. McILRATH: I'm still in line.

DR. CROSSON: Okay.

[Laughter.]

DR. CROSSON: Okay. So this is the public comment period. Thank you, those of you who are going to talk to us. This is a useful opportunity. I will make one point which is it's not the only opportunity. This is an opportunity to comment after the discussion. There are

opportunities to make comments to MedPAC and the staff prior to the discussion, through Mark and his staff, the website, as well as individual communications with Mark and his staff. However, the Commission values this opportunity as well.

We would ask you to identify yourself and your association or affiliation, if you have one. We generally ask you to hold your comments to about two minutes. We're going to turn this light off in a second. When I turn it back on, that's two minutes and we would ask you to wrap up your comments.

Go ahead.

MS. KEYSOR: Katie Keysor from the American College of Radiology. One of the prior recommendations mentioned in the presentation was expanding the multiple payment procedure payment reduction policy. I would remind the Commission that the PAMA legislation mandated that CMS publish the data used to justify the 25 percent multiple procedure payment reduction for the professional component of advanced diagnostic imaging services. CMS never complied with this mandate.

Then, in December, the Consolidated

Appropriations Bill, just passed this last year, mandated include a provision to roll back the professional component, NPPR, from 25 percent to 5 percent, which is backed by data. So any future NPPR recommendations should be backed by supporting data.

Thank you.

DR. CROSSON: Thank you very much. Sharon.

MS. McILRATH: Sharon McIlrath, AMA. So I wanted to first just address the process of the RUC and to repeat Dr. Coombs' invitation that, really, you should come and see it before you decide that it's not a robust process, and that it's not based on fact. The claim -- it's all based on claims data. There is a report that's on our website. I will try to get a link to people so that you can see that. It gives the most recent numbers on the adjustments that they have had. It's up to about 2,100 that they either have done or are looking at; 1,260 of those, I believe, resulted in either reductions or deletions of codes, and when they are deleting a code, often it is because they have bundled stuff back together. So on the multiple procedure reductions, what they have done is to go in, and when people are doing something at

the same time they've actually done a new code that includes it all, and they also have adjusted the practice expense and the work values to match that.

Altogether, so far, they have redistributed $4 billion, and the redistribution, yes, it goes across the fee schedule, but it also is used, in any given year when you have other things, new services that are being paid for, it's used to pay for those. So the new comprehensive care and transitional care codes, those would have been paid for with the reductions that came from the misvalued codes. So, in many cases, it is actually sort of going directly to those other services that, for the most part, are done by primary care.

I think that the policy of the RUC has tried to be, particularly in more recent years, to do what some of you have talked about, about identifying services that aren't currently being paid for -- new services as opposed to saying that, you know, what's there is misvalued. So that's where most of these codes, the new ones that CMS has adopted, are -- were originally suggested by the RUC. In some cases, the values that the RUC attached to those codes were higher than what CMS had actually adopted.

Also, in some cases, there's some additional things, such as anticoagulation management, that don't, you know, sort of ever get into that list but that also benefit the primary care.

DR. CROSSON: Thank you. Sharon, could you sum up? Thanks.

MS. McILRATH: Well, the -- I just would urge you also to look at what it is that they have -- many of the kinds of criticisms that were made here of the system are exactly the criteria that the RUC has used to do their misvalued codes, so the business about new services and that needing to come down. They have a new service review, so I just would urge you to -- I'll get this link to you -- to look at what they actually are doing and to please, if anybody would like to come and see one, we'd be happy for you to do that.

DR. CROSSON: Thank you very much.

Seeing no one else at the microphone, we are adjourned until next month's meeting.

[Whereupon, at 11:40 a.m., the meeting was adjourned.]