MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

The Horizon Ballroom
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International Trade Center
1300 Pennsylvania Avenue, NW
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9:21 a.m.

COMMISSIONERS PRESENT:

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AGENDA PAGE

P R O C E E D I N G S

[9:21 a.m.]

DR. CROSSON: Okay. Let's reconvene. Welcome, everyone, including our guests, to the opening session of MedPAC's April meeting.

We're going to begin with a presentation which is the beginning of an anticipated stream of work that the Commission is going to be doing over the next couple of years on expanding the use of value-based payment in the Medicare program, and Eric Rollins is going to take us through our initial discussion. Eric.

MR. ROLLINS: Good morning. Today I'm going to talk about expanding the use of value-based payment in Medicare. There has been widespread interest in this issue among Commissioners, CMS, and other health care experts, and your discussion today will help us develop our work plan for the next meeting cycle.

Before I begin, I'd like to note that many of my colleagues provided valuable contributions to this presentation. The number of people who helped is actually large enough that I'm not going to run through everyone's names, but I did want to recognize and thank them

collectively.

I'll start by giving an overview of the presentation. I'll begin by explaining what we mean when we use the term "value-based payment" or VBP. I'll then talk about the Commission's previous work on Medicare payment and how that informs our future work on VBP. After that, I'll discuss Medicare Advantage and ACOs and how those programs could provide a foundation for the broader use of VBP. Finally, I'll examine what it would mean for VBP to replace the traditional fee-for-service program.

During this meeting cycle, Commissioners have expressed interest in expanding the use of value-based payment. This term has been used in many contexts and does not have a standard definition, so it's helpful to clarify at the outset what we mean by it. For our purposes, VBP refers to methods of paying for health care services that provide stronger incentives to control overall costs than traditional fee-for-service payment, while also maintaining or improving quality. VBP is thus a broad concept rather than a specific policy, and as we'll see later on, there are many ways to expand its use in Medicare.

Reviewing our work over the past decade makes it

clear that the Commission has consistently been interested in moving away from the traditional fee-for-service model and giving providers, health plans, and beneficiaries stronger incentives to control costs and improve quality. For example, we have done work to reduce the incentives in fee-for-service that encourage greater volume, to make MA plans more efficient and improve our ability to assess their effects on service use, and to develop better ways to measure quality. Determining how to expand the use of VBP will likely require us to consider a range of issues, but the examples of our prior work in your mailing materials show how this work can proceed on multiple tracks while still being part of a larger overall effort.

Our future work on VBP will also be guided by the same fundamental principles that serve as the foundation for all of our policy development: ensuring that beneficiaries have access to high-quality care, paying providers equitably and giving them incentives to deliver care efficiently, and assuring the best use of the taxpayer and beneficiary dollars that finance the program.

Although the traditional fee-for-service program has long been Medicare's primary delivery system, more than

half of all beneficiaries are now either enrolled in MA plans or assigned to ACOs. These programs have stronger incentives to control overall spending than traditional fee-for-service because MA plans receive capitated payments to provide the Part A and B benefit package and because ACOs can qualify for shared savings payments. However, as we'll see, the performance of both programs has been mixed, and they need to be improved before they can realize the potential benefits of value-based payment.

One of the biggest strengths of the MA program is the ability of plans to provide the Medicare benefit package at a lower cost than the fee-for-service program. For example, the bids that plans submitted for 2019 averaged about 90 percent of fee-for-service costs, once you account for differences in coding. Another positive feature is that most plans offer additional benefits that aren't available in traditional fee-for-service, like reduced beneficiary cost sharing or dental coverage.

On the other hand, a major weakness of the current MA program is that it actually increases overall Medicare spending relative to fee-for-service. For 2019, we estimate that Medicare pays 1 to 2 percent more for MA

than fee-for-service coverage due to rebates, quality bonuses, benchmarks that exceed fee-for-service costs in some areas, and coding differences. However, our work has highlighted how plans can reduce their costs in response to changes in the MA benchmarks, which suggests that changes to the benchmarks and MA's quality bonus program can both lower program spending.

Here are two examples of our work to improve the MA program. Over the past couple of years, we have examined the encounter data that MA plans submit to CMS. This data should make it easier to understand how service use differs between the MA and fee-for-service programs and to calculate quality measures, but we have found that the encounter data that has been collected so far is incomplete. This work has led to a draft recommendation to improve the quality of encounter data that you will vote on later today.

Another issue that we will discuss at this meeting is the MA quality bonus program. This program is overly complex and differs from Medicare's other quality incentives because it provides additional funding instead of being revenue-neutral. We will explore ways to simplify

the program in a manner consistent with the Commission's quality principles and to make it revenue-neutral.

As for accountable care organizations, the ACO model is appealing because it creates incentives to control overall spending and improve quality that are not present in traditional fee-for-service. However, researchers have found that Medicare's ACOs have generated modest savings of roughly 1 to 2 percent after four years of operation, and that does not include the cost of shared savings payments. It's worth noting that those are overall figures, and some ACOs have been more successful.

Whether ACOs will produce larger savings in the future is unclear. CMS recently made significant changes to the largest ACO program, the Medicare Shared Savings Program. While those changes have some positive elements, such as encouraging more ACOs to bear financial risk, on balance they may result in lower savings. Policy changes that incorporate features from a more advanced ACO program, the Next Generation model, may be more effective at improving ACO performance but may not appreciably change the program's modest savings. Given these challenges, the Commission may want to have a broader discussion about the

role that ACOs should play in Medicare. For example, efforts to expand ACO participation may not reduce program spending if they result in more ACOs that do not generate savings.

Here are some examples of potential improvements to ACOs. The first change would assign beneficiaries to ACOs on a prospective basis instead of a retrospective basis. We will discuss this issue in more detail in our next session. The second change would waive some of Medicare's regulatory requirements for ACOs that use prospective assignment and accept two-sided risk. One example would be to allow these ACOs to have gainsharing arrangements with post-acute-care providers.

Since the MA and ACO models are viewed as alternatives to traditional fee-for-service, it's worth spending a minute to briefly review the strengths and weakness of that model as well. The program does a good job ensuring access to care because it operates throughout the country and provider participation is high. Another positive feature is the use of administered pricing, which has helped constrain spending growth, especially in recent years as providers have consolidated and increased their

market power. In addition, the program's fee schedules and claims data play important roles in other parts of Medicare and are often used by other payers. For example, CMS uses fee-for-service spending data to calculate the MA benchmarks that plans bid against and the ACO benchmarks used to calculate shared savings.

The fee-for-service program also has its weaknesses. The program has no entity that is responsible for overall spending, and beneficiaries and providers both have incentives to use or deliver more services. However, policymakers have taken a variety of steps over the years to address these weaknesses. For example, they have put some limits on supplemental insurance, used bundled rates to pay for multiple services, and developed quality incentives like the Hospital Readmissions Reduction Program that aim to improve the fee-for-service program's value. Continued reforms along these lines could be considered.

Moving now to Slide 11, Medicare has relied on a fee-for-service model to pay for services throughout its history, but supporters of VBP often describe it as a way to "replace" or "eliminate" the fee-for-service model. However, it is not clear what this would mean for Medicare,

particularly since the current MA and ACO models, which are the obvious successors to fee-for-service, are, in fact, closely linked to the fee-for-service program. To provide some clarity, we developed four illustrative scenarios to inform our initial discussions on this complex topic. Each scenario would expand the use of VBP in Medicare, but they differ in how far they would go to replace the fee-for-service program, and highlight some of the issues that policymakers would need to consider.

The first scenario would be the closest to the current Medicare program. Medicare would continue to operate the traditional fee-for-service program, along with MA plans and ACOs where they are available. Beneficiaries could enroll in fee-for-service or an MA plan, just as they do today, and provider participation in ACOs would still be voluntary.

Under this scenario, the Commission would look for ways to expand the use of value-based payment within all three payment models. We believe that each one can be improved to provide better value to beneficiaries and taxpayers. I touched on some potential changes to the MA and ACO models earlier in the presentation. With respect

to traditional fee-for-service, some possible areas for future work are alternative payment models for clinicians, expanding the use of bundled payments, and improving the quality incentives that now exist in fee-for-service.

Under the second illustrative scenario, Medicare would require all fee-for-service providers to participate in ACOs. The traditional fee-for-service program would no longer be an option. Providers would have to join ACOs to receive fee-for-service payments. Medicare would assign all beneficiaries to ACOs and would continue to pay claims for ACOs using standard fee-for-service rates. Beneficiaries could still enroll in MA plans.

This scenario could affect Medicare's longstanding policy that allows any willing provider to participate in fee-for-service and may have implications for beneficiary choice. Policymakers would also need to consider that MA plans and ACOs could be more challenging to operate in some areas. For example, almost all beneficiaries have access to an MA plan, but that is partly due to the fact that MA benchmarks in rural areas are often significantly higher than fee-for-service costs. Ensuring universal access to ACOs might also require higher spending

in some areas -- for example, by using higher benchmarks or not requiring the ACOs in those areas to bear as much risk.

Our third scenario is similar to the prior scenario except that Medicare would also stop paying providers directly. MA plans and ACOs would instead pay for all Medicare-covered services. Even though CMS would no longer make direct fee-for-service payments to providers, the agency would continue to produce the fee-for-service fee schedules so MA plans and ACOs could use them as a reference when they develop their provider payment rates.

Under this scenario, CMS would stop collecting fee-for-service claims data since it would no longer pay providers directly. ACOs could be required to submit claims-like data as a substitute, but our work with MA encounter data suggests this would be challenging, and without adequate data CMS could have difficulty producing the fee schedules. There would also be major challenges in the MA and ACO programs because fee-for-service claims data is used to develop their benchmarks and risk-adjustment models. One potential alternative for setting benchmarks would be to implement some form of premium support and use

competitive bidding.

This scenario would also effectively turn ACOs into capitated health plans because they would become responsible for functions like paying claims and would receive some sort of overall budget for their beneficiaries. This raises the question of whether beneficiaries would need to actively enroll in ACOs instead of being passively assigned as they are now.

Our fourth and final scenario is identical to the third scenario, except policymakers would go one step further and stop producing the fee schedules. Here policymakers would need to address all of the issues that we discussed for the second and third scenarios, but there would be other challenges related to the elimination of the fee schedules.

Perhaps the biggest challenge is that MA plans and ACOs might have to pay providers using rates that are much higher than fee-for-service rates. With the current fee-for-service program, Medicare uses its purchasing power to set payment rates that are often much lower than commercial rates. These rates are also used in various ways to limit MA and ACO spending. Without the fee

schedules, Medicare's purchasing power would be fragmented and providers would likely be able to use their market power to force MA plans and ACOs to pay higher rates.

Now that we've looked at each scenario individually, we wanted to put them next to each other and show you how their implications differ. You can see the four scenarios listed on the left side; remember that as you move down the rows, you're taking more extensive steps to eliminate fee-for-service.

The first area where the scenarios differ is whether beneficiaries could receive services from any willing provider. They could under the first scenario if they were in fee-for-service or an ACO. They might not be able to under the second scenario and would not be able to under the third and fourth scenarios. The number of delivery models that Medicare uses would also differ. The first scenario would have three models, while the second scenario would use two models, and the third and fourth scenarios would essentially use just one model, since ACOs would effectively become capitated health plans.

With respect to implementation, the third and fourth models would be much harder for CMS to implement

because they would go much farther in curtailing or eliminating the fee-for-service program. Finally, the effects on program spending would depend on the specific changes made to each model, although it seems clear that costs would rise significantly under the last scenario due to the complete elimination of the fee-for-service fee schedules.

That brings us to the discussion portion of our session. The Commission is interested in expanding the use of value-based payment in Medicare because of its potential to reduce spending growth while maintaining or improving quality, and we plan to make work on VBP a priority for the next meeting cycle. For our discussion today, we would like your guidance on how the use of VBP would affect each of Medicare's delivery systems, but we are particularly interested in your thoughts on the illustrative scenarios and the extent to which value-based payment should replace traditional fee-for-service coverage.

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

DR. CROSSON: Thank you, Eric. Excellent analysis.

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

DR. DeBUSK: First of all, thank you for an excellent chapter. I know you discussed this in the reading, but I'd like you to elaborate on it a little bit more. How would this apply, say, to the most rural areas or to, for example, extraordinarily high-cost cases, you know, say high-cost outlier policies, rural areas, and even potentially some of the short-stay issues that we may run into?

MR. ROLLINS: Well, I think that's one of the issues that sort of the rest of you around the table would need to grapple with. If you want to replace the traditional fee-for-service program, the lesson of MA suggests that you may have to spend more money to make sure that model is available in all areas, and that might hold true for ACOs as well. So to the extent that one of your goals is to sort of reduce program spending growth, that's a little bit at odds with ensuring sort of universal access to, say, MA plans or ACOs.

DR. CROSSON: And, you know, I think another -- this is a set of issues we're going to have to discuss.

Another option would be that there could be certain areas of the country, you know, particularly really, really rural where the population density is very, very small and the number of providers is very small and some of the models would be not feasible. There could be a continuation of another model in that area.

Okay, Kathy and then...

MS. BUTO: So, Eric, thank you for this work. I wondered whether you, in looking at the options and scenarios, had looked at the work that you all did earlier on the use of premium support. And the reason I bring that up is, as I was reading the paper, I wondered how would the areas do that have -- of the three, MA, ACO, fee-for-service, where fee-for-service is the lowest-cost option, what would the impact of these different scenarios be on areas where fee-for-service is a pretty cost-effective option now? And did you have a chance to think about that? And I guess a related question would be: Which of these scenarios would do the most to sort of bend the cost curve in Medicare in your view?

MR. ROLLINS: We did very much think about the work that we had done previously on premium support, and I

think we mentioned it in a couple of places in the mailing materials.

In particular, the work that we did on premium support, as you know, some of the premium support proposals would eliminate the fee-for-service program, and I think sort of where the Commission ended up after looking at it over a number of years was that it was worth keeping. And one of the reasons is what you said, that there are areas where fee-for-service is actually the low-cost model.

So if your goal is to sort of control overall program spending, you probably want to take advantage of that in the areas where it is available.

Whether or not that gets used as part of this shift of value-based payment is very much a policy question.

I'm sorry. Kathy, could you repeat the end?

MS. BUTO: Yeah. The second question -- and, actually, so that was sort of an analysis, sort of a static analysis of what it looks like now. But, if we shifted to a more coordinated care model, ACO, MA, potentially that whole outlook could change.

So my second question was really whether you

thought about which of these scenarios produced the best long-term savings potential for Medicare if we moved to one or the other. My own take would be the capitated models, but I don't know if that's what you concluded.

MR. ROLLINS: I think that is a far too complex question for me to respond to knowledgeably.

[Laughter.]

MR. ROLLINS: Although I will say that of the scenarios we fleshed out here, I think the last scenario is the most problematic because of the upward pressure on provider payment rates.

Leaving that aside, the rest of it would depend very much on what exactly would be -- what changes would be made.

DR. CROSSON: So some of these issues are in fact the body of work that we are going to entertain.

But I did like the fact that you pointed out that our work on premium support in the past was essentially looking at the situation as it was then or a few years previously.

I think part of this work, if it is going to end up in a successful place, is going to include work to try

to improve the ability of the alternative models, both MA and ACOs, to actually produce the kinds of savings that they're capable of, at which point an analysis might show something different, as you point out.

I've got David.

DR. GRABOWSKI: Great. Thanks, Eric. I really enjoyed reading this chapter, and I think it is a great piece of work.

I wanted to ask you about Slide 16. This was a really nice way of laying out the different options, and I think the step from Option 2 to Option 3 is a very big step, as you note. I think the key distinction there is having ACOs serve as these capitated health plans.

I guess my first question is, Are they up to that task? I would like you to help us think about what is the better risk-bearing entity or capitated health plan. Is it a traditional kind of MA plan, or is it an ACO? Because I think that is an important distinction.

MR. ROLLINS: Well, I think in terms of what's the better risk-bearing entity, the work that we have done on MA versus ACOs -- and this feeds back into the work we did on premium support -- is there is no one right answer.

There is no model that is the best in all areas. So it is hard to say that we should always use one particular approach.

The MA model works in areas that have high-service use. As you know, the plans incur nontrivial administrative costs, and so the question is sort of are the savings they are able to achieve in utilization enough to offset that.

There are going to be areas of the country where that tradeoff doesn't really work. Again, that was part of the thinking for premium support was you may want to sort of let the market kind of decide which model works best in each area.

DR. GRABOWSKI: As a follow-up to that -- I think I asked it, but I will ask it again -- do you think these ACOs, especially those in rural areas, can manage this type of risk and this function?

I think about the savings you documented, and we will talk more about that in the second session this morning. It has really been around the physician-led ACOs, taking on one-sided risk. It is a very different model than the one you are proposing here.

MR. ROLLINS: It would be a very substantial change for them. I am not sure exactly how that would play out. You could ask Jeff, Luis, and David the next session what they think.

DR. GRABOWSKI: All right.

MR. ROLLINS: But the lesson of MA is that if you pay plans enough, they will serve -- they will go serve an area, so --

[Laughter.]

DR. GRABOWSKI: We should put that in Latin above --

One other question on scenario four, and you already touched on this, the cost to the higher provider rates. That is not a given, right, that the provider rates would necessarily be higher if we didn't have the fee-for-service? I mean, those would be negotiated. You sort of put it as just a higher cost here.

MR. ROLLINS: They would be negotiated. I think given the market power that many providers enjoy, I have difficulty seeing a scenario where they negotiate something that is lower than what they pay now. I think in a lot of

cases, the pressure is going to be upward.

DR. CROSSON: Okay. I have Sue, Dana, Jonathan. Let's do Sue, Dana, Jonathan, and then I will work my way up here and back this way. Sue?

MS. THOMPSON: Thank you, Jay, and thank you, Eric. I, too, enjoyed this chapter. I think this is great foundational work for a lot of good discussion to come.

My question is very, very foundational and clarifying, and that is just simply the definition we are attaching to ACO. I infer by the discussion and by the reading and the footnote in terms of we believe next-gen is more likely to achieve savings that we are talking about an ACO that will have both downside as well as upside risk. That wasn't real clear to me in the reading, but that was my impression. I wanted to confirm that.

MR. ROLLINS: I think that's fair. We didn't get super-specific on sort of what exactly is the ACO because, as you know, there's multiple models --

MS. THOMPSON: Exactly.

MR. ROLLINS: -- and they are all kind of evolving.

MS. THOMPSON: Thank you.

DR. CROSSON: By the way, that is the current Commission's position.

Dana.

DR. SAFRAN: Thank you.

I add my congrats on a really helpful and informative chapter.

I had a couple of questions just about whether some of the things I was thinking about are things that you looked at and decided worthy of mention or haven't been looked at.

One is we assume that the fee schedule, when it exists, is what gets used for payment. In the private sector, risk-taking organizations sometimes are doing their own negotiating with other providers for the rates that they are willing to pay them. I wonder if that is contemplated at all as a mechanism or whether it is even legally allowed in Medicare. If it were allowed, then the savings those entities might get in their negotiated rates, assuming there are savings, could be shared back with Medicare program.

MR. ROLLINS: So, as you know for ACOs, at least for Medicare ACOs, that is not a feature. They are paid at

standard fee-for-service rates.

MA plans do have the leeway to not use the fee-for-service rates when they are negotiating with providers.

That being said, the research that has been done suggests that in many areas, they will, nevertheless, end up with something that is relatively close to fee-for-service. Particularly for hospitals, it seems they are paying very close to fee-for-service rates.

It might differ a little bit for certain other sectors. I think our impression is that physicians might get paid a little bit more than fee-for-service fee schedule by some MA plans.

On the flip side, MA payment rates for SNF care are often noticeably lower than what is on the fee schedule.

So there is that flexibility now in MA. It is very sector-specific sort of how much of a difference it makes for sort of standard fee-for-service rates.

DR. SAFRAN: Yeah. That's helpful. Thank you.

Then the two others are these. As we think about access and the ability to implement these models in certain areas -- and rural has been mentioned a couple times today

-- it struck me that we are presuming very much the status quo in terms of bricks and mortar is the way we deliver health care, and I just wonder whether in this work, did you model, did you contemplate how it might work in this areas, rural areas in particular, if we relied much more heavily on technology to create virtual care and enable those organizations to be part of larger organizations that were based elsewhere?

MR. ROLLINS: That's not a level of specificity we got to for these scenarios. These were just sort of very broad brush, high level. If that is something that you all are interested in, that could certainly be an issue that we explore in the future.

DR. SAFRAN: Great.

Then the last question has to do with data from the EHR. As we think about the possibility of what happens without fee-for-service, an underlying fee-for-service system and the data that it generates, have you explored at all the possibility for the rule that data coming out of the EHR, especially as the regs start to liberate that data in ways that we haven't seen before, might be used in place of what we rely on from claims data today?

MR. ROLLINS: I think that would be another area for future work that didn't really get to at this work for this session.

DR. SAFRAN: Thanks.

DR. CROSSON: Jonathan.

DR. JAFFERY: Yeah. Thank you, Jay.

Eric, this was wonderful. It really gave, I think, everybody clearly a lot to think about.

I am thinking about, as you know, the ACOs have a minimum-size requirement of 5,000 members right now. I am thinking about what it would take for an ACO to become a -- we think through the scenarios about becoming a capitated health plan and all the capabilities that what in many situations are relatively small organizations would have to develop that they don't have now.

I guess thinking about even just in general full risk to form my question, have you thought about or done any -- is there any empiric data around what size an ACO would really need to be if they are going to take on that kind of full risk? I'm struggling with that. I don't know that there are a lot of MA plans out there that would just pop up and have 5- or 6,000 members and really be able to

manage that with all the administrative capabilities and such.

MR. ROLLINS: In terms of empirical data, I don't think we have that data.

But in terms of the MA program, there are some plans that are very small, but they're very much sort of a very small slice of what goes on in the MA program. Most plans are serving a much larger number of enrollees than 5,000, and even if they're not -- even if their MA line of business is fairly small, they have other lines of business as well.

DR. CROSSON: One of the ideas that I think could eventually be explored in this regard is the notion of gradual assumption of risk through the application of risk-mitigating corridors and reinsurance program.

If you remember how Part D was put together, there was a concern at the time that there would be no plans that would want to accept risk for pharmaceuticals, and so there were belts and suspenders, three tiers of risk sharing, some of which we now feel need to be removed.

But, at the time, I think there was a legitimate concern, and that created this infrastructure, which was

notably helpful in getting plans to sign up and to be engaged. Again, we're in a setting now where I think a lot of that can be backed up.

So the notion of full risk, I think needs an asterisk applied to it in this context, which means that maybe some of these processes that were used in the past for Part D could be at least thought of in terms of how that full risk could be managed.

Now let's go with Pat and come back up this way.

MS. WANG: It was a great paper, and I really like that you laid out a whole spectrum of alternatives.

In scenario two, there is a bullet that it might affect beneficiary choice to require that every provider participate in an ACO, et cetera. Can you say more about why that would be the case? Because today somebody who is in an ACO can use an out-of-network provider and that service will be paid by fee-for-service. That is the first question. Did you contemplate that that would change somehow?

The second question is, in the third and fourth scenarios which really talk about insurance risk -- and I think I have a bias in that direction because it's really

expensive to set up those kinds of infrastructures, and insurance risk is really big risk. But did you think about and maybe discard -- I'm just curious like what other alternatives you might have thought of, of different types of bigger risk, like global budgets for certain kinds of providers that may be dominant in a community and they are really the main provider, so that they wouldn't be processing claims, necessarily.

I have heard some large provider organizations talk about the notion of global budgets. I just was curious if there were other alternatives to insurance risk that maybe you had considered for three and four.

MR. ROLLINS: So on your first question of the choice of any willing provider, as we thought about it, for the second scenario, in contrast to the current ACO model, every provider that wants to get paid by fee-for-service has to belong to an ACO. So if you are not willing to participate in an ACO, you could not get Medicare payment for your services. In that sense, it would be different than what we have now where you can go see somebody who is outside your ACO, and they are just in traditional fee-for-service.

Under the scenario, at least as we sort of thought about -- and, again, these are only for discussion purposes -- you could still potentially go outside of your ACO, but whoever provider you are seeing still has to belong to some other ACO.

In terms of how entities would bear risk, these are illustrative scenarios. There's other things you could contemplate. Global budgets might be one of them, but presumably, global budgets carry some element of risk as well.

DR. CROSSON: Warner.

MR. THOMAS: I concur. A great chapter, a lot of great information, and certainly applaud the staff's direction in taking this one.

A couple of question on Slide 6 on the first bullet. You mention MA plans provide care compared to fee-for-service at a lower cost, yet Medicare then pays 1 to 2 percent more than overall MA. Can you just clarify that and give me a little bit more color on those two bullets together?

MR. ROLLINS: Sure. When the plans submit bids, they are submitting bids to provide the standard Part A and

B benefit package, and that is the element where the data from the bids that the plans submit suggest that the vast majority of plans can beat the fee-for-service cost in their area.

But then on top of that, given the way that we pay MA plans, they receive part of the difference between what they bid and what their benchmark is as a rebate, and their rebate can be used to provide extra benefits to beneficiaries. These are things like the reduced cost sharing, dental coverage, hearing aids, things like that.

So when you factor in these other payments that the plans get in addition to just providing the standard Medicare benefit package, it actually, based on our latest estimates, is about 1 to 2 percent more expensive than the cost of providing fee-for-service.

MR. THOMAS: But that differential is essentially additional benefits or additional cost reduction to the beneficiary? It is either benefits or cost reduction?

MR. ROLLINS: Not all of it. Some of the rebates can be used by the plans for administrative cost and profits. There's also the effect of upcoding.

MR. THOMAS: Okay. The second question is on

Slide 8 on the ACO model. Obviously, I have information about the next chapter that kind of plays into this chapter.

The ACO savings have been modest. That is kind of outlined there. I guess the question I have there, you got kind of roughly 1 to 2 percent, but there is really not an appreciable cost savings. I guess, what would be considered appreciable? I mean, because 1 to 2 percent on trend over time to me seems material. So I'm just trying to figure out what would be appreciable.

MR. ROLLINS: Well, I think what is appreciable is going to be, to some extent, in the eye of the beholder. So I'm not sure I have a firm answer for that.

I think one thing I just want to make sure is clear is -- you are talking about sort of saving 1 to 2 percent on trend -- these are not savings that you are getting year-over-year. You are not getting another 1 to 2 percent a year, another 1 to 2 percent a year, and this is sort of after 4 years of operation. Compared to what we think you would have spent without the ACO, instead of spending $100, you are spending somewhere between $98 or "99. Whether or not that differential --

MR. THOMAS: And that is not annual? That is over a 4-year period?

MR. ROLLINS: No. That's in the fourth year. You're down roughly 1 to 2 percent from what we think you would have spent otherwise.

Whether or not that differential continues, whether it gets smaller or bigger, we don't know.

MR. THOMAS: Okay. Go ahead.

DR. CROSSON: Marge.

MS. MARJORIE GINSBURG: I have two questions. The first is related to this and the savings accrued to ACOs and MA plans.

So the assumption is, to make all this worthwhile, the -- let's say MA plans, using that as an example -- have to be showing continual rates lower than what the fee-for-service benchmark was, because right now we know they are getting more, sometimes much more, because of either risk adjustment or the bonuses, and I know we are going to be working on the bonuses.

But I just wanted to make the point that the pressure really needs to be on to justify this by making sure that what the government is paying for through these

other two models will, in fact, be lower than fee-for-service. So that's kind of a question. Maybe it's a statement.

Now I have a real question. Dumping the fee-for-service model I suspect is going to get considerable pushback from the public, and I wondered whether staff has done any research on public perceptions about what it means to not have fee-for-service anymore. Certainly, anybody who is following the discussion around Medicare for All, blah-blah-blah, tremendous division right there of people who unwilling, ever, to be able, you know, to not be able to go to their own doctor.

I love this report, and Dana said earlier about it being great reading. It really was a page-turner, and you all just did a fabulous job. But I feel like that's one piece that might be missing, and that is the public's views on doing away with fee-for-service. And I wonder whether you had done any research about that, done focus groups with the public about the fee-for-service model.

Thank you.

MR. ROLLINS: Off the top of my head I don't know, but there may be other people here who can answer

that. But certainly the fee-for-service program is very popular with many of the people who are enrolled in it, and so these are scenarios meant to spur discussion amongst all of you, and certainly some of the changes that we have outlined would be fairly far-reaching, and, you know, there would certainly be opposition.

DR. CROSSON: To be clear, Marge, this is an issue that we are going to have to address, to say the least.

Warner, did you want to comment again on this?

MR. THOMAS: I just remembered my other question.

DR. CROSSON: Okay. All right. Go ahead.

MR. THOMAS: It's on a different topic, so I don't know if you want to continue to address this or if you're done.

DR. CROSSON: Well, do we have further comments on Marge's point? I couldn't quite tell from the hands.

So you want a mulligan?

MR. THOMAS: Yeah, I want a mulligan. Usually when I play I need like four or five, but anyway, so back on this slide. Just on the trend, I just want to make sure I've got this right. So when we talk about the savings, 1

to 2 percent, is that an often-inflated trend or is that off of the actual cost? So is that a true 1 to 2 percent reduction from what the baseline cost was or is that a 1 to 2 percent reduction off an inflated cost that has some sort of trend built in?

MR. ROLLINS: It's based off of our, or researchers' estimate of what fee-for-service would have spent on those beneficiaries if the ACO program did not exist. It is the counterfactual.

DR. CROSSON: Okay.

MR. ROLLINS: Yeah. I'll be happy to talk about it more.

DR. CROSSON: Okay. Jonathan?

DR. JAFFERY: Yeah. So this actually, I think, goes back to what Pat was asking about. In Scenario 2 you talk about the beneficiary choice being limited. So I get what you're saying that providers would be forced to be in ACOs but that it still would -- that still wouldn't limit beneficiary choice in this model, is my understanding.

So the question is, did you contemplate something where not only would providers have to be in ACOs, or in MA, but something short of a capitated point, so maybe

something more like Scenario 2 but where beneficiaries also need to choose one of either two or three options? And maybe this starts to play into the premium support conversation as well.

MR. ROLLINS: I think that's a -- I mean, there are obviously a lot of variations of all of these scenarios that you could entertain, and that would be one of them. I think for Scenario 2 beneficiary choice could be implicated if there are providers out there who simply decide they do not want to participate in any ACO. So in that sense you could have maybe fewer providers available than you have now in certain areas. I don't want to overstate it because I don't know how much that would be an effect.

But then in terms of sort of how tightly you want to tie beneficiaries to ACOs and sort of really have them see the providers who are participating in the ACO, those are issues to discuss.

DR. CROSSON: Karen.

DR. DeSALVO: Just to follow on to that, I can see a scenario, though, where that could exacerbate inequity, so those who had a means to pay could go outside of the system and pay, and those who didn't have a means to

pay would be locked into their provider network. So choice might be differentially limited based upon your ability to pay.

Eric, thank you for launching us into this discussion. I am beyond excited about the chance to think about a future world where there are entities accountable for the total health and cost of the beneficiary, to have a long-term relationship with them.

But I had some things I didn't particularly see in the chapter and I wondered if they were relevant and if you all had looked at them, and maybe they weren't included. One of them had to do with the impact on what I might call special groupings. Some were mentioned already, but like rural providers who may be in cost-based reimbursement models or federally qualified health centers that aren't easily in the value-based payment world.

And then, in a related fashion, I wondered about whether there is any consideration for the impact on graduate medical education funding, if we move along the continuum to Scenario 3 or 4. That's my first question.

MR. ROLLINS: Those are terrific issues that are sort of not at the level, sort of -- it's just not at the

level of specificity that we got to for these scenarios, but are absolutely fair game.

DR. DeSALVO: Okay. I had a question also about being able to lift up the beneficiary's voice in some of these scenarios. We won't get into a discussion about quality, though that will be relevant over time, but wondered about whether there is any way to compare their experience using measures that we might be capturing, so that we could get some sense about, you know, whether their experience has improved. I was thinking about, you know, the work that we did in the past, along with the Administration, and weigh not only cost and quality but also beneficiary experience. And in some of those models that are better coordinated it's a better experience for them.

So is there data that could allow us to use that as a comparator?

MR. ROLLINS: I am not sure, off the top of my head, but that's something -- we can look into that.

DR. DeSALVO: Like the CAHPS?

MR. ROLLINS: I mean, certainly CAHPS would be sort of getting at things like patient experience. I don't

know what data we've got that would look specifically at sort of the issue you are getting at.

DR. DeSALVO: Like so if I'm in a fee-for-service -- we always say people in fee-for-service are very happy, though I suspect that people are just happy if they can get their services and see the doctor that they want to see.

So, anyway, it would be nice to have a little bit more of a dimension that was about their voice. I like the idea of focus groups also, but I think something quantitative.

I just had one more question about whether there's any lessons learned from what Medicaid MCOs do in states, about setting payment rates. This gets to your point about how does the commercial market do it, how does Medicaid do it, and if we try to disarticulate from this whole benchmark idea in the first place is there some other lessons that we could learn that might free us from the benchmark and allow us to create a future system that was predicated on future needs?

MR. ROLLINS: Yes. Medicare managed care would be an area that would be interesting to look at. For example, a lot of times Medicaid managed care programs

would serve the entire state, which can, for a lot of states, include highly rural areas. And a lot of times what the tradeoff is there is they will say to the state you are bidding to serve the entire state. You can't pick and choose certain areas.

And the tradeoff is that, as you know, a lot of the Medicaid managed care contracts are very long -- three, four, five years, or something in that range. So that's kind of the tradeoff, is we will make you maybe serve areas that you aren't really sort of happy about or maybe aren't the most profitable, but you'll have a long period of time to sort of try and sort of recover costs.

Also, and this is an area we could look into more, particularly for some of your traditional populations like low-income children, pregnant women, things like that, states are basically now at a point now where they don't have a Medicaid fee-for-service program and so they are finding new ways to sort of set the payment rates for their plans, based on sort of their financial performance data, encounter data, things like that.

DR. CROSSON: Jaewon.

DR. RYU: Yeah. I just wanted to revisit the

access and availability and the willing part of the any willing provider dynamic. I don't know if there have been any studies or survey data or maybe it's focus groups around providers and specific pain points that might precipitate them to depart and say, "You know what? I'm just not going to participate at all." But I was just going to tee up that as a question. Do we have any information that might help us forecast that kind of migration out of the program to say, you know, that might impact this group of beneficiaries differently than this? Any commentary on that?

MR. ROLLINS: It's not an area I could comment on. I don't know. Other people might want to comment on it.

MS. TABOR: I'll just say a little bit about our position focus groups over the past couple of years, and they don't think physicians generally know whether they are in ACOs and why they're contracting with certain MA plans versus taking fee-for-service. I think it's handled much more at the practice management level. So I think it's a harder question to answer, just because physicians seem to be focused more on providing the care as opposed to who is

the payer.

DR. CROSSON: Thank you, Ledia. Sue, are you up? No. Bruce.

MR. PYENSON: Eric, thank you very much for the chapter. You make the point in some of the, I think, Scenarios 3 and 4, that there might be an issue if fee-for-service goes away with how do you create fee schedules, and fee schedules are incredibly useful throughout the health care system.

But I don't see the -- I wonder if you could explain the connection between the reimbursement model and the fee schedule, because I don't see them as necessarily linked at all. I see a fee schedule as an accounting exercise that's essential for accounting and the data collection on that and the reimbursement as a different issue. For example, in bundled payments there is bundles that are defined and there is a background accounting that's done on a fee-for-service issue.

So do you see the question I'm asking, that I guess I don't see the -- even if fee-for-service Medicare goes away entirely, I could see the fee schedule and the collection of data maintaining itself very well.

MR. ROLLINS: Well, I think the question would be what data are you using to come up with the fee schedules, if, quote/unquote, fee-for-service goes away. So, for example, we rely on data on inpatient hospital claims to help set the weights for each DRG, and so sort of where are you going to get that information if Medicare is no longer paying those claims and getting those claims from the providers directly?

One thing we talked about in the paper is maybe you could get ACOs to submit data that looks kind of like that, but that would certainly be a challenging endeavor.

So I think that's one example of sort of how there is, I think, a link between sort of the reimbursement you are using, where sort of, you know, if ACOs are in charge of paying claims, so what data are you going to use to help come up with some of your rates?

MR. PYENSON: If you could elaborate, like in the case of hospitals, hospitals have costs and they allocate costs, and how they do that, you know, is presumably following accounting rules, so the cost basis gets reflect ultimately in financial results and gets aggregated and compiled.

It's not clear to me that any of that has to go away in the context of different reimbursement systems, because money is fungible, and how you pay revenue can get allocated as well to that level of detail. So I don't see the connection.

MR. ROLLINS: Maybe I'm not following entirely. I mean, I think you would probably still need a scenario where facilities like hospitals are submitting their cost reports. But in terms of coming up with the payment rates for an individual service, under our system you need to essentially know what is the average cost of providing that service. And so you would have the cost reports that give you sort of the overall cost picture for the facility but you need something like claims, charges, and cost-to-charge ratios to figure out sort of roughly what is the average for each individual service that the hospital provides. And it's that second piece of data that would need to be worked out.

MR. PYENSON: Why would it have to change compared to what's happening now?

MR. ROLLINS: Well, that's a policy question for you to consider. I mean, we were talking about situations

where, for example, if ACOs take over the responsibility for paying all claims CMS would no longer be getting that data stream that it now uses, and so you would need to find another replacement for it. If CMS continues to pay all the claims they would collect all the data that they do now and they could, you know, continue to operate more or less in the manner that they.

MR. PYENSON: But just on that point, there's all sorts of mechanisms to have, you know, virtual payments made and claims submitted and trued up retrospectively or possibly prospectively. So that's the financing mechanism.

Anyway, I'm puzzled.

DR. CROSSON: Maybe we could take this offline and you and Eric could talk about it.

Okay. That's a pen up? Pen up? Okay.

DR. PERLIN: Let me add to the chorus of appreciation for this work.

When you think of this as a continuum of evolution, perhaps, I appreciate the point that was made earlier about a need to consider not only an end state but a trajectory toward getting to that end state, I think a point that Jay made.

It also brings to mind, you know, what are the problems that you are seeking to solve, and in this sort of hierarchy from 1 to 4 you have an end state that embraces a world where a plan would have incentives to solve some of the problems that we consider at every meeting.

One, of course, is the ability to really coordinate the care across all circumstances and even address some of the social determinants types of issues, and that's there. On the other, you know, one of the things that is so much a part of our continuing conversation are the elements within the cost of care that are really the most challenging cost drivers. They have their upsides -- new technologies and curative drugs. On the other hand, the cost of these new technologies and drugs is rather daunting.

As the team considered this hierarchy of perhaps even of evolution, did you consider whether individual plans would be equipped to really grapple with those cost drivers like drugs and devices independently or is there, with this sort of hierarchy conceptualization of some capacity to work together perhaps in ways that aren't currently acceptable to be able to manage drug costs, for

example, not independently as a single plan but in the aggregate of multiple plans?

MR. ROLLINS: That's not a level of detail we got to for these scenarios but that's something that -- I think something for you all to discuss.

DR. CROSSON: Okay. Paul and then Amy and then I think we're going to move on.

DR. PAUL GINSBURG: This is clearly a Round 2 question but it's been relevant to at least half a dozen questions in Round 1. If we're going to get to Round 2 soon I'll wait. If we're going to get to round two soon I'll wait.

DR. CROSSON: We're going to get to Round 2 questions, or Round 2 definitive statements. We'll get to Round 2 in, I think, in a minute.

Amy and then -- go ahead. Yeah, Amy.

MS. BRICKER: Yeah. So, Jon, I think just to start with going there, I was curious as to our appetite to take on potentially value-based design, if not in D, realizing this is an MA chapter, but in B, and the ability to allow plans to, either independently or in collaboration with others, to negotiate with manufacturers for, you know,

value-associated contracts. So I realize the focus here is in physician and in provider risk, but why not it also include manufacturer risk?

So have we contemplated that or, if not, I can elaborate in Round 2.

MR. ROLLINS: That's not something that at least I am going to speak on knowledgeably, but I think that's a good Round 2 item.

DR. CROSSON: Yeah, so feel free to make your point and bring your idea forward.

Okay. We're going to move on now to the discussion period, and I think it's useful to point out that the questions have been excellent and point the way to future work. You know, today's presentation and today's discussion is kind of laying the groundwork for one area, which has to do with the issue of how far the Commission thinks we should go in this transition away from fee-for-service, right? So I'm going to look for that. You've got options from nothing to everything, so to the extent that you have a sense of that based on the discussion so far, that would be helpful.

The recognition here is that, you know, as we saw

from the first round of questions, there are a lot of issues that would need to be resolved, such things as where would exceptions need to be made, you know, what about the rural aspects of this, you know, as well as trying to find ways to really improve these alternative models so that they represent, you know, not a loss to beneficiaries but an obvious gain in terms of the levels of service, such things as care coordination, obvious improvements in quality, and reductions in costs both to beneficiaries and to the Medicare program, and the ability, I think, to discern how we might do that over time, make recommendations in that area, I think is critical to the notion -- to the idea that this notion would be something that people would want to accept, and that's a good portion of the work that we need to do over the next cycle or beyond that.

So let's have a discussion period here. We're going to run a little over time, but I think we need to on this important topic, and we're going to start the discussion with Warner.

MR. THOMAS: Great. Thanks, Jay, and once again, thanks for the chapter.

First of all, I applaud the work, and I think that we have to think a little bit about the philosophy of how we approach this. And I think Karen actually mentioned this, that it's positive to see a chapter where we're talking about entities actually taking responsibility for the cost of providing care and taking responsibility for the quality as well. And I think that that's really, you know, an important philosophical change in how we think about moving to this model versus fee-for-service. And I think moving to that model, you also find, I believe, physicians, hospital systems, building capability to do that and to do it better because they'll be forced to essentially be held accountable for it.

But I think the other two things that are philosophical that we need to ask ourselves is: Is coordinated care better than fragmented care? Because coordinated care and accountable care organizations or in organizations that work closely with MA plans, it appears, you know, looking at some of the information, does yield better results. And I think philosophically we have to ask ourselves if we think coordinated care is better than fragmented care where people go all over, then this

direction for reimbursement seems to make a lot of sense.

I think the second is, Do we want to be reactive or proactive about how we take care of people? Because fee-for-service is all about being reactive. People have an issue, they come to us, we take care of them; versus being proactive where an organization is accountable and kind of focuses on taking care of somebody in a more cost-effective fashion and with better outcomes.

So I think those philosophical pieces are important as to how we think about approaching this issue and changing -- obviously, these would be major changes in the model, but once again, I think this philosophy of coordinated and proactive is important how we think about care going forward.

I'll comment just briefly on the four scenarios and then, you know, just give kind of my view of how I think organizations may look at them.

First of all, if you think about Scenario 1, continuing fee-for-service, and maybe moving to bundles or those sorts of things, to me the challenge you see in that is that bundles do not deal with the issue of duplicative care or chapters we've had previously of unnecessary care.

And I think if you have a situation where providers take financial responsibility, they're much more likely to move to a model where they are trying to reduce unnecessary care and try to reduce duplicative care.

Also, you know, at least in our system, we find coordinated care, we definitely see a reduction in duplication of testing for people that are coordinated and have all their medical information in one location.

Some people would argue that bundles does that, but the issue with bundles, you still in many cases have unnecessary care in bundles or care that just doesn't need to be provided. I mean, we see this in many of the commercial or private studies for Centers of Excellence that many patients that are referred, you see 30 or 40 percent of the referrals do not yield an actual procedure. They actually go to a different type of care, a less invasive type of care, and there is no surgery. I think I've seen many articles on Walmart on this, for example.

The third and fourth scenarios, you know, where you're actually either eliminating the fee-for-service system or moving payment to the providers, as indicated in the chapter, just seemed to be very, very complicated and

fraught with a lot of issues of -- I think that Pat said, you know, when entities take risk, there's a reason risk is a four-letter word. There are a lot of challenges that can go with that, and I think moving to a model where you move all the risk and all the payments to the provider system, I think that can be really challenging, and it is, frankly, a core competency that most physicians or hospitals or integrated organizations do not necessarily have. Some have it, so maybe you could make it an option if people can demonstrate competency, but I would encourage us to steer away from 3 and 4 just given the complexity and some of the risk.

So that kind of comes back to Scenario 2, which I personally think is the right direction, to move to a model of evolving the ACO and MA models. I think that they're the right models just because, once again, it's coordinated and it's proactive. If you think about it, for physicians they're rewarded for creating value. If it's a physician-based ACO, to the extent that they reduce utilization or to the extent that they do a better job creating value, both cost and quality, they're paid more for that, and that seems appropriate.

For hospitals, they'll be forced to work with physicians or to integrate with physicians, and essentially they get more focused on reduction of utilization, they get more focused on post-acute, as I think Jay mentioned. If you look at the ACOs, there has been a pretty significant reduction in post-acute care, and to me it just puts the incentive in the right place. And I think all of these models forces coordination and collaboration. I mean, we find in post-acute care, post-acute providers then want to start working with hospitals and physicians because they realize if they're not good utilizers of service, if they can't show quality, then essentially they will not get referrals going forward out of these types of models. And I think we've seen post-acute providers get much more sophisticated on quality and much more integrated with systems.

So I believe that really exploring a lot of detail, Scenario 2 makes a lot of sense. There are challenges with that, and I understand that, but I think it does have the right philosophy.

I would actually go to Jonathan's comment and the questions about cost drivers, and I would encourage us to

think about still, even with these scenarios, making sure that we can take on the largest cost driver and the fastest-growing cost driver, which is drug cost. I think in these models you certainly can see an improved utilization from a drug perspective, but that's not going to take on the pricing issue if we don't take that on as a Commission.

And, lastly, I would say it would be nice to see if there's a way to go -- I know some comments Pat has made in the past, Part D, have Part D folded into this in some way to create the right incentives for the delivery system to work on the Part D cost. It would be interesting to see that happen.

So I applaud the work. I would encourage us to be expeditious and to move this forward, not to do it in a fashion that's not careful, but I do think this will be an evolution. It's not like we're going to solve it all on day one. Whatever would be a recommendation, more than likely we will continue to evolve it and build on top of that. But we have to change the incentives, and we have to put the providers in a position where they've got to be held responsible for the quality and the cost of care that

they deliver.

So, once again, I applaud the work, so thank you.

DR. CROSSON: Thank you, Warner.

So I think we'll move this way this time, so we'll start with David.

DR. GRABOWSKI: Great. Eric, once again, a great chapter. I think I fall pretty much in the same place as Warner, that I think Scenario 1 isn't far enough and Scenario 3 and 4 are a little too far, and I just don't have a lot of confidence right now that the majority of providers really manage risk in the way you've outlined in the chapter.

So I like this idea of further pushing providers towards ACOs. I want to pump the brakes a little bit, however, and you noted this earlier, Eric. The savings to date, 1 to 2 percent, Warner pushed you earlier about whether that's small or big. Warner, I think we get so few victories at MedPAC, let's take a small victory and celebrate it. I think 1 to 2 percent is great. However, let's think a little bit more about that 1 to 2 percent. That's based on ACOs that were physician-led. It was largely in one-sided risk models from the Medicare Shared

Savings Program. And perhaps most importantly, and Warner touched on this, it's really come on the backs of post-acute-care providers.

And so as we push providers into these arrangements, we're going to push post-acute-care providers, too, into these kind of systems or ACOs. It's great for a physician-led ACO to push down on post-acute-care spending outside the ACO. It's a little bit harder when that post-acute-care provider is part of that ACO. So it's a very different arrangement. It could lead to better care coordination. It could lead to more appropriate care. But the idea that we can take that 1 to 2 percent savings that we saw in the MSSP program and apply it here, we need to think a little bit more about what are going to be the true savings here and the true implications for beneficiaries of going to these mandated kind of more global ACO models.

Thanks.

DR. CROSSON: Amy.

MS. BRICKER: So building off of the questions around how do you address and begin to truly manage drugs within the Part A and B space, the struggle that has

remained generally in the regulated market with respect to D and B is our inability to negotiate with manufacturers in the same way that you do in the commercial market for fear of kind of running up against, you know, safe harbors and also anti-kickback statutes. Specifically, if a drug does not work in the commercial market, you're free to negotiate with a manufacturer for refund. We have done this time and time and time and time again with tremendous success in the commercial market. I would love for us to take a position that those tools and having the manufacturer truly put value on the table in response to, you know, the prices that they're setting and the utilization of their products, truly put value on the table. You know, we've evolved to a place where we have wonderful data and the ability to track patients throughout the continuum, regardless of if they, you know, are jumping from plan to plan or, you know, fee-for-service or not, patients, the progression of their disease, these things can be managed. And while I would -- the most successful contracts are those that have a finite, specific outcome, not things like, you know, if you have a heart attack, because, you know, who knows what really contributed to the heart attack, but did they stay on

therapy? Did they have to add additional therapies? In the case of hepatitis C, when the patients had to be retreated, all of that was funded by the manufacturer in large part.

So there absolutely is a mechanism in the commercial market that I think we should take on in the regulated market such that plans, ACOs, health systems who have done a very good job of managing formularies, especially within hospital settings, could take on that additional -- the conversations, negotiations, either singularly or in collaboration with other health systems.

I realize that this is already a big chapter, but the title value-based, it just reminded me that there's a segment here that we haven't addressed that I think everyone's collective point, it's not managed and there's a real opportunity.

DR. CROSSON: Thank you, Amy. Paul.

DR. PAUL GINSBURG: Yes, again, I thought the materials were terrific. I enjoyed reading them. I have a concern, though, that discussing scenarios at this point is really premature, because I found myself saying, well, current ACO models look like they have slight savings.

That's not the context to talk about Scenario 2, you know, having all providers being in ACOs. We should be talking about significant changes in the models. We should be talking about better ACOs. We should be talking about doing something more aggressive on prescription drugs, as Amy was talking about, because then we can have the discussion of scenarios and it would not be so hollow. I think it's very hollow today.

You know, the point that Marge brought up about concerns about there being a fee-for-service alternative, to me that issue is going to look very different if, in fact, we have much more compelling alternatives to fee-for-service than we have today.

So my advice is let's not burn a lot of time and energy talking about scenarios now, with one exception, which I will get to in a second. Let's go right into -- not today, but right into bolder options than we've discussed before about how to move this value direction more quickly. I agree with Warner as far as having coordinated care, managed care, is the way to go. But we haven't really talked much about how to go faster.

Now, the one exception as far as talking about

scenarios is that we have a situation now, which hopefully we'll get to in a lot of other areas, in MA, in areas where the MA penetration is very high, because the whole system of, you know, setting a benchmark based on the fee-for-service experience when MA is, you know, 60, 70 percent of the enrollment doesn't make sense. That's something we should be talking about because it's here now.

I think in the other areas, maybe it's going to be many years before we're really confronting these issues about what should we do with what's left of fee-for-service.

So, anyway, that was my thought.

DR. CROSSON: Thank you, Paul. And, indeed, any recommendation to come out of this Commission to change the balance between value-based payment models and fee-for-service would indeed be hollow unless and until we had built the case, as I said a little earlier, that not only is this a good policy idea, but it's essentially good for the Medicare program, but also good for beneficiaries. And that has to be patently obvious at the time.

Dana.

DR. SAFRAN: Thanks. Great material and great

discussion. I really appreciated how Warner teed this up and Karen's comments earlier where we say accountability from the providers to Medicare beneficiaries for the total cost of care, for quality, and for outcomes really has to be our guiding light. And for that reason, I actually do favor Scenario 2 as a place for us to be driving.

I would offer a couple of points. One is the fact that, you know, we talk about 1 or 2 percent savings in the chapter. It does, after we factor in the shared savings distribution, drop that down to, you know, somewhere between 0 and 1. But I'm not intimidated by that because I think that there was a lot of variability, and so we can point to the configurations where we're seeing bigger savings. But we also, I think -- I haven't heard any mention today of one of the really important anchors on ACOs' both ability and willingness to drive to higher savings, which is that fee-for-service still sits there. And, you know, in the market where I'm most familiar with this in Massachusetts and my own work previously leading payment reform, we could see very clearly providers who were riding both horses -- right? -- riding the population-based payment horse, but the fee-for-service horse is still

there. So I think that we can't ignore that as a constraint on the kinds of savings that we're seeing, and so I would just offer that.

A couple other thoughts. One is it was a surprise to me in reading this to really come to grips with the fact that the Medicare Advantage program is actually costing more. And I think there are some structural fixes that we're going to talk about with some of the other chapters, but I think we have to think quite seriously about that. One of the things I wondered about -- and there was some mention to spillover effects, but I did wonder whether, even though it's costing more, does its presence actually act as a constraint on the fee-for-service system and its rate of inflation? I don't know the answer to that. I think that's an important issue for us to try to analyze if we can.

But I guess the last thing I'd say is that, you know, like others have said, I think contemplating -- the material and this discussion really helped for me to recognize that right at the moment contemplating a Medicare program that doesn't have the fee-for-service fee schedule as its underpinning is kind of too vulnerable a place to be

right now in terms of the potential for us to see, you know, cost increases the way they were occurring before there was administered pricing. You know, the chapter discusses that.

So, I, you know, regrettably sort of got comfortable that we're not at a place where we can contemplate that yet, but I'll end by saying the four things -- and I foreshadowed a couple of these -- that I think we need to think about, if not in this chapter then in our upcoming work -- are these four things in terms of how they could support continued really evolution and strengthening of accountability models. One is we have to come up with a model to change the way hospitals are paid. They are for sure a rate limiter on ACO success.

We have to contemplate the role of clinical data sources, data coming out of the EHR as potentially our path forward where we can get comfortable in a world that doesn't have the claims data that today we cannot possibly be without for purposes of measurement, risk adjustment, and everything that comes with it.

We have to start to think about health care in a way that isn't so in our own minds tied to bricks and

mortar, and that can help us with our challenges, thinking about our rural providers.

And then, finally, I agree with the points that have been made about pharmacy, and, you know, ACOs that are not also taking accountability for pharmacy are missing a big lever for managing cost, quality, and outcomes. And we're missing their alignment with the Medicare program and concern about pharmaceutical costs. So there's a lot of good reasons to bring that into the picture.

Thanks.

DR. CROSSON: Thank you, Dana.

I have one comment on your metaphor. The previous metaphor I've heard for the situation you describe as "a foot in two canoes."

DR. SAFRAN: Yeah.

DR. CROSSON: I can visualize that. Riding two horses, I can't. I'm not sure how to do that.

[Laughter.]

DR. CROSSON: Brian.

DR. DeBUSK: First of all, thank you again for an excellent chapter. You could really argue that this is the most important issue in front of the Commission today. I'm

really excited to see us spend time on it.

I want to start off just by talking a little bit about fee-for-service. I do think in the most rural areas and for certain low low-volume providers, we will need to keep some type of fee-for-service option.

I do think that maintaining the fee schedules is important because I think we need those reference and transfer prices, and I do think Medicare has an excellent history of using fee schedules to contain costs. I mean, I think it is a living testament to the power of administered prices as opposed to a purely market-driven price.

Now, having said that, I do think we need to send a message, we the Commission, that fee-for-service is an inherently uncoordinated care method, and it is the method last resort for delivering health care. I also think we need to send a message that it is not a mainstream option in the long term.

As far as the scenarios that were discussed today, I really see scenario two and scenario three as bookends. I think two is the least we should do. I think three is the backstop. And I think a lot of what we see in the next-gen ACO is an excellent blueprint for balancing,

for this option two and three.

For example, in next-gen ACOs, I mean, they have a lot of the things we like, like prospective attribution, but if you notice -- and I am not sure if they can do them today or if this is a 2020 feature, but they can move to that per-member-per-month payment, and they can take on a TPA and actually adjudicate claims themselves. I think there's a lot of power in being able to use, again, almost the next-gen as bookends here because I think ultimately the most sophisticated ACOs are going to want to take over the payment of claims and to be able to build more sophisticated networks and basically be able to build more sophisticated payment methods with their participants.

So, again, just to reiterate, I do think options two and three are bookends. I would love to see next-gens, for example, explore more with specialist integration through programs like sub-capitation, where if you're in a per-member-per-month model, you could take a portion of your benchmark, say, for orthopedic services or cardiothoracic services and sub-capitate that. Again, I think that comes back to it being critical that they do have the ability to take on per-member-per-month payments

and handle their own claims.

The final comment that I want to make here is that I do think we need to be ready to experience a slight increase in spending, if necessary, to get our hands around these alternative payment models and value-based payments. I look at this as a new product launch, basically.

In the commercial sector, you wouldn't launch a new product without expecting to incur at least some losses or some initial setbacks and increases in spending. I don't think ACOs are going to be any different.

So I think the idea of being afraid to invest more money in this model initially I think is something we shouldn't be afraid of it.

Thank you.

DR. CROSSON: Kathy.

Thank you, Brian.

MS. BUTO: So, Eric, this is a great paper. You can tell by the discussion that we're all pretty excited about looking at these scenarios.

I have to say that as I look at this, I think there's a lot of agreement that we're already in number one scenario, which is all three programs trying to continue to

improve, fee-for-service and even ACOs, and that really the question is, Should we try to push more aggressively toward any of the others?

I would, like many people, favor scenario two, but I would also say I think we can think of all these scenarios as potentially transitional; in other words, scenario two. And if it turns out it makes sense to evolve down the road to scenario three, then I would say let's be open to that. These are not mutually exclusive for all time.

I'll also say that I think scenario two could be a coster; in other words, you're going to pay more for quality and accountability. It could cost the program money, not necessarily save even 1 or 2 percent, especially the way MA is currently structured.

So I really feel that if we continue this discussion, we need a stronger connection between these ideas and premium support, which is the earlier work that you all have done to look at ways to constrain overall spending over time. I don't think we can keep going down the road, even with better, more accountable models, and

not think we are going to spend more money. We are. So I think we really need to look at that alongside this.

I like Pat's idea that another way to think about this is beyond these models to things like global budgets. There may be areas where that makes sense. I've heard of people considering regional models, so a metropolitan area where there can be a fixed budget, where Medicare can, in a sense, decentralize control of the program.

I'll say that to the extent that we move toward more decentralized models, it strikes me that there may need to be more centralized functions; for example, advisory bodies on drugs, devices, medical education, other things where there needs to be coverage policy, there needs to be uniformity. So even though the payment is decentralized, the program offers basically the same benefits and equitable access and so on and so forth.

Like Bruce, I don't get why you couldn't keep cost reports and other things, even in some of these scenarios; in particular, scenario two, which pretty much looks like today only with more emphasis. ACOs currently don't operate without fee schedules. So you clearly need those.

If we need to, I think as Dana mentioned, reform hospital payment or, as Paul mentioned, do a better job of looking at the ACO model, that has to happen. But I don't get why you wouldn't continue to be able to have fee schedules as long as fees are being paid.

Until you move to a pure premium support, where it's really a capitated amount, I don't get why you wouldn't have fee schedules because everybody wants them. Providers like to have them for some assurance. Payers like to have them so they have a least a benchmark, and beneficiary need them so they can anticipate things like cost sharing and so on.

Anyway, we can talk about that some more, but I think that there isn't a good reason to just do away with those.

DR. CROSSON: Thank you, Kathy.

Okay. I just want to make one of my usual comments about time. We are over 20 minutes, and I anticipated that would be the case. But I think if we go too much more than another 20 minutes or so, then we are going to run into scheduling difficulty. So all I would ask is to be succinct.

Jon.

DR. CHRISTIANSON: So I think one of the things that the discussion illustrates is how audacious this move actually is because we talk about value-based payment, and the examples we use are MA plans and ACOs. And yet we know that there is not strong evidence that either one of these kinds of organizations have or can reduce costs for the Medicare program or improve quality.

We have had over 30 years of MA plans, and we're still paying them more than the cost of fee-for-service Medicare. But somehow we are assuming that whatever we do going forward, that will change. We have sort of mixed evidence on whether ACOs can serve Medicare in terms of reducing costs. It's going to be research study of the week in terms of what the evidence looks like, and we have struggled for years trying to figure out how to measure quality, particularly in MA plans. But somehow we are going to be able to do that, and we are going to be able to prove that quality increases as the same time that we can reduce Medicare cost.

This is a really audacious move on the part of the Commission, and I'm with Paul. I think we have to, at

the same time, really try to accumulate an evidence base that suggests things will be different in the future, we will be seeing better quality and lower costs, or a very compelling story about why we are going to make changes or that Medicare is going to make changes that will result in moving things in that direction.

At the same time, I think the challenge to the Commission is the fact that the delivery system is changing very rapidly, and we have to be very certain and very clear that whatever we are suggesting is not based on what the delivery system looked like one year ago or five years ago, and the assumptions about the delivery -- I don't think many of us would have anticipated the sort of sort of Aetna-CVS kind of vertical merger, much less all of the horizontal mergers that we've seen in the hospital industry.

Going back to Kathy's comment about premium support, that was based on an assumption about the delivery system, which is that the health care plans would compete, and the competitive bids will drive down the payments for health plans, and they would then turn around and negotiate very aggressively with hospitals to keep down hospital

cost, which is a scenario that made a lot more sense when they were multiple hospitals in the community and they all had excess capacity. It doesn't make much sense now when we have one or two large systems in a community that are trying to manage their capacity so they don't have excess capacity.

So I think that's an example of a policy solution that needs to continually be rethought, and I think this solution, the challenge to the Commission, will be to continue to rethink what we think these systems can do in a context of a changing configuration of a delivery system, which will be very hard to stay ahead of.

DR. CROSSON: Thank you, Jon.

Bruce.

DR. PYENSON: I wanted to pick up on a couple of points that Paul and Jon have both made and propose that in the absence of scenarios, we have a fifth scenario, and that is if we just have a much, much more aggressive fee-for-service program, this could be the counter-factual.

We have seen some real successes in the fee-for-service program, such as readmission reduction, and I think optimizing what fee-for-service can do, such as lower the

price, which Brian mentioned, or bring back RAC audits to make payment denials for medically unnecessary services, that as a counter-factual would set a level for what is possible and what an alternative to integrated care could be, not that we'd want to endorse that.

The other point I wanted to make is that I think for the Medicare program to be successful, it has to have more influence over the private commercial market and for reasons that we all understand. Looking at the traditional fee-for-service Medicare Advantage and ACOs, I think it would be worth our while to explore ways that that can happen, perhaps through insurance law or perhaps through terms of participation or other means, perhaps through some ACO rules. I think there's historical precedent for those kinds of influences.

But I think we've going to be very frustrated in the ability of the Medicare program to transform for the system if we don't also have some bigger influence on the commercial world.

DR. CROSSON: Bruce, thank you.

Sue.

MS. THOMPSON: Thank you, Jay.

I just think it's worthy of a call-out, and it's in our reading. But the acknowledgment that 55 percent of Medicare beneficiaries now are either in ACOs or in MA and despite -- I don't know when we hit a tipping point there, but despite our lack of evidence, as Jon just pointed out, that we don't have evidence that's just screaming at us that we're saving a lot for the Medicare program, we're here with this enthusiastic conversation. So there is something else going on that I just think it's really important for us to pay attention to in terms of understanding the real benefit of value-based programs in this arena.

In the category around rural, I just want to say thank you to all my fellow Commissioners for your acknowledgment of the concerns for taking this sort of work on in our rural states and our rural communities, and I think it's a great opportunity.

On page 16 of our reading, you referenced the challenge of incorporating services such as telehealth into this analysis, and that we continue to debate whether or not telehealth actually increases volumes and increases expense.

In a value-based environment, where the partial or full cap, that incentive goes away, and it becomes just an enabler to provide better care to the right patient at the right time and the right place, and it improves our access issues in all of our primary care discussions we've had. So I encourage us to elaborate on that concept as we continue to build out this chapter.

In our discussion about improving ACOs, page 9 of the reading, there was discussion about the ACOs, opportunity to generate more savings. If you've been in ACO work, this business of shared savings is a whole discussion about some of the flaws of the ACO. After a while, there isn't any more savings to share.

So, in that structure, I think the rebasing of the formulas and more recently the impact of the growth of the thresholds to continue to quality and as an advanced APM, we need to be paying close attention to them in terms of the pacing of our work and the pacing of the calendar as it moves forward as we hit those thresholds, so that we don't create counter-incentives, particularly for physicians, encouraging them to participate in ACOs.

Just finally, I think there was a statement in

our reading that began to explore the question of, Are ACOs stepping stones into Medicare Advantage? I think so, but I think that's a conversation and a whole lot of work that we have yet before us.

DR. CROSSON: Jaewon.

Thank you, Sue.

DR. RYU: Yeah. Thank you, Eric.

Within the scenario paradigm, I think I also gravitate somewhere between scenario two and three, but as we explore this further, I think what I'd like to see is just more of a focus on the design features, rather than the scenarios, per se. And to me, the design features that make sense are -- and I think this gets to Sue's point earlier, but it's downside accountability. And maybe we're just assuming that, but I do think we need to call that out, getting more people into the model, whether it's beneficiaries or providers.

I still have concerns around the engagement of the provider, and I know Ledia mentioned earlier some of the focus group results where they're not even aware. But I think a lot of the success of this work hinges on whether the providers and the beneficiaries will be engaged and how

we can create a program that's going to foster that kind of engagement. So those would be some of the design features I was thinking about.

DR. CROSSON: Thank you, Jaewon.

Karen.

DR. DeSALVO: That is a perfect segue because that's part of my comment also.

Just stepping back, I think that I would be inclined to move pretty far towards a more capitated model, mostly because I think the dynamism in the marketplace about how to deliver services and care and meet members where they are geographically, socially, medically is just so evolving. It's very hard to keep very specific payments for services up to date with that, and what you see in models that are capitated, there's more flexibility about the who and the where and the when provision happens. And so my inclination is that that's part of the added benefit.

As we're thinking about this, though, scenarios aside, the dynamism in the market is that there are more integrated delivery models, where it's not only that I have an insurance risk as an entity but also providers.

And that kind of gets to the design issue, is

that this word "value-based payment" or this term "value-based payment," I want us to get more clarity as we go forward because when I think about this future state, what I would love to see is that -- back to this an entity accountable for the total health and total cost of beneficiary and partnership with them, and that that kind of a system means all the incentives are aligned for the beneficiary, for the front-line providers, the clinical team, and for the system that's managing the risk and the population.

That's not a quality bonus kind of value-based payment. That's, to me, more on that end of capitation, and that's where new delivery design has to fit in because you have to have a system that is not just paying providers by the piece but really on those front-line docs and clinical teams also have aligned incentives.

And just the last thing, Eric, because I mentioned it earlier, but I think it's going to be so important that we have a really balanced scorecard about this because it may be a coster. It may save money, but we also want to make sure paying attention to the impact on not only quality, but the experience and the beneficiary

because those things all matter to health outcomes. And that's just as to me -- not just. I think it's just as important as making sure that we're saving money.

Thanks.

DR. CROSSON: Thank you, Karen.

Jonathan.

DR. JAFFERY: Yeah, thanks, Jay. So I do agree that I think we want to focus on something that ultimately gets us to align incentives so that all the players are working towards this accountability for total cost and quality and affordability for everybody.

As I think through the scenarios and some of the discussion about ACOs moving towards being like capitated health plans or being, you know, stepping stones to MA, I do hear a lot about that from other people in the ACO world and think about that.

It also makes me a little bit scared when I think through some of the things we've talked about, that we would have to start to do in terms of claims processing or negotiating fees. And I guess I'm struggling to think that there are a lot of ACOs out there that have -- could get to those capabilities very quickly right now.

And I guess I also don't want to lose this idea of, you know, why do we have these two different things? Do we think that there is something different about ACOs from MA plans that maybe each have positive attributes, each are bring different expertise to the table?

You know, we've been talking about things like care coordination and care management. I think that is an important piece that we definitely feel like the fee-for-service system has not encouraged, and we want to see that happen, whether it's in ACOs or MA plans or whatnot.

But I do think there's something beyond just care coordination, and I'm thinking about things that are going to take time and are taking time, that some ACOs, at least, are doing, which is really trying to build a different care model, which is different than care coordination. I mean, you're thinking about what does it look like to have a primary care practice where there's behavioral health, and that you're connecting to community-based organizations. That's a different thing and it takes time and investment.

And the other thing that ACOs do that, you know, maybe different from MA plans is that they are contracting with multiple plans. They are working in different

populations. They're working in the commercial population space and in Medicaid.

So I think, to sum up my thoughts in terms of the recommendations, I do lean towards Scenario 2 as well here. I think that we can think through the design elements so that we can give more providers maybe some more nudges towards that accountability, or maybe more than a nudge. Maybe a loving shove.

But at the same time I think maybe there is a two-tiered approach. So maybe we can do that for the bulk of providers and at the same time go back to the fact that we've got folks in an advanced model right now, in the next-gen ACO, who are taking two-sided risk, who have prospective attribution, and are in a demonstration model that's going to end in 21 months. And we've got 50 or so organizations covering I'm not sure how many beneficiaries, but those folks are engaged and are going to need to do something January of 2021, and maybe we can think through how we could have a track for them that would be getting us maybe more towards Scenario 3.

DR. CROSSON: Okay. Marge, and then Warner and Pat, and we'll finish.

MS. MARJORIE GINSBURG: I'll try to make this brief. I also support Option 2, and, I mean, right now, under Option 2 we actually still have fee-for-service, so as long as beneficiaries can go outside their ACO still, and see anybody they want. So that hasn't been closed off.

But I think as we move forward, in order to make the ACO effective we are eventually going to have to find a way to close off that option, and it may be that you can still go outside your ACO but you have a higher co-pay, something to discourage it before we completely shut it off, which I think eventually that's what's going to happen.

But I think the issue I raised earlier about public perception is just a really hot-button issue and we have to be extremely careful in how we present this going forward or we're going to get hammered.

Thank you.

DR. CROSSON: Thank you, Marge. Warner?

MR. THOMAS: I'll be brief because I made most of my comments before. But just on Scenario 2, the reason I went in that direction is because even though -- and I will just use our system, for example -- we would be willing to

take full risk for many folks, we're still going to have fee-for-service business always because we're going to have referrals. So I think this idea that you are going to have all global payments is just not feasible.

I think you're always going to have some fee-for-service and global payments, and so that's why I lean towards you need to keep the fee-for-service system in place, just because there's going to be referrals that go between ACOs that -- and you could call it a transfer price or whatever, but it's probably paid on a per-unit or a bundle or whatever, but it's going to have to be on some sort of fee-for-service to go between the ACOs. So just another comment.

DR. CROSSON: Thank you. And Pat.

DR. WANG: Just a couple of points. I don't like thinking about the discussion as move away from fee-for-service and towards something else. I don't think that there's inherently anything wrong with a fee-for-service system that is formed to promote the goals of what we describe as VBP, which is more efficiency, better quality outcomes. And I just want to say that.

The second thing is that the discussion sort of

starts to blur ACO and MA plans, and I think that they are two very, very different things. So put MA aside for a second. I think that the discussion around ACO and sort of the concepts in what's described as Options 3 and 4, you know, maybe things go that way, but I think that we should not get distracted by the shiny toys of paying claims, and it seems like you're more like a risk-bearing organization or something.

Because the fundamental truth is that ACOs, to me, are how the delivery system reforms itself. MA plans cannot reform the delivery system. There are a lot of different ways to get there but I just want to -- you know, before people rush into sort of like take on the attributes of an insurance company, which, as you know, I think that that's not a good idea and that's not necessary, that it's missing the point of the goal of any work on ACOs should be how providers start developing different care models in a heterogeneous environment, given the various patient populations and modes of payment that they deal with.

In that regard, I think that there is an importance to focus on real-time data feedback to provider systems that are reorganizing. Some people, I think, get

fascinated with the idea of paying claims. Let me tell you, I don't know why anybody would want to pay claims, honestly. There are a lot of people out there who really would be eager to do it for you.

But I think that the real things that providers at risk want is real-time feedback on what's going on. You know, they may imagine that they control utilization by denying claims -- that's not the way that it works. It's the data. So I think that as we continue this work we should talk about ways that future ACO models can give that feedback on a more real-time, more digital way.

Similarly, for Part D, I would not encourage provider organizations to take on risk for Part D. But again, getting visibility into how your prescribers are behaving is really important. You know, you want to know what your doctors are prescribing, and you want to talk to them if there are more cost-effective or clinically effective approaches. It's amazing what that information can do.

In any scenario that we discuss, I hope that we will -- and, you know, I'm a broken record on this but I'm going to keep saying it -- I hope that we will continue to

look at ways to improve the fee-for-service system to remove disincentives to move towards risk. And I have raised before the topic of IME, direct GME, DSH, any payment system that is reliant on an inpatient statistic. And I'm not saying let's get in there and change all of the payment, you know, sort of like the amounts, but I think that we should at least identify, in this work, whether there are things in the fee-for-service system, which everybody reviles, it seems, that are keeping people locked into that system, and then once they're out there decide whether there's something that we want to say about them, or further work that we want to do.

And the final thing that I would say is I think that we need to keep in mind like beneficiary engagement, because, you know, we keep talking about the Medicare program and making it more effective and lower costs and all the rest and we never talk about the role of the beneficiary.

Marge, you know, is a great voice, and I really appreciate all your comments. I hope that we can continue that, because people have responsibility for their own health care choices and maybe there are things that we can

do in the design that help folks make better guided choices.

DR. CROSSON: Okay. Thank you, Pat, and thank you to all the Commissioners. Thank you, Eric. This is very much a prologue, and I really appreciate the input. It's going to help shape our work over the next two years, at least.

Thanks very much and we will move on to the next presentation.

Okay. We do need to move forward. So we are going to continue the theme this morning, at least part of the theme with respect to ACOs, and we're going to take a look again at the issue of the performance of Medicare shared savings programs, that David, Luis, and Jeff -- and, David, it looks like you are going to begin.

MR. GLASS: Yes. Good morning. Today we continue our review of the performance of the Medicare shared savings program that we last spoke about in January. As Eric just discussed, ACOs may be a way forward toward value-based care and we need to understand how well the various ACO models are working and how they might be improved. But I would like to thank Emma Achola for her

help on this project.

I will briefly give some background on the MSSP and review where we stood in January. Then Luis will walk you through our new analysis and estimates of savings from the MSSP, Jeff will look at some of the policy implications of our findings, and we will end with your discussion.

The Medicare shared savings program, or MSSP, was established in 2010, and the first cohort of MSSP ACOs entered the program in 2012. The program has grown rapidly and there were 432 ACOs in 2016. It has continued to grow but our analysis looks at 2012 through 2016, so I will reference 2016 data.

Almost all of the ACOs in the program through 2016 were in one-sided risk models. That means they could share in savings but had no liability for any losses. They also had retrospective assignment of beneficiaries meaning that ACOs only knew which beneficiaries were definitely assigned to them after the end of the year.

Bonuses for ACOs are called shared savings and savings are calculated as the benchmark CMS had set for the ACO minus actual spending on the beneficiaries assigned to the ACO. Precise definitions of all these terms are in

your mailing materials.

With that as background we turn to the question of the day. Did the MSSP save money for the Medicare program or not?

To answer this question we examined the changes in spending for beneficiaries who were alive and eligible for assignment to ACOs from 2012 through 2016. As Dana had suggested the last time we spoke, we have excluded beneficiaries who moved during this period and we describe the exact specifications of the population in some detail in your mailing materials. I will mention that we have also excluded decedents and we can address the implications of that on question.

We define savings as the difference between growth in spending for beneficiaries assigned to ACOs compared to what would have been spent on those beneficiaries in the absence of the MSSP. that is it is a counterfactual analysis.

As the other David pointed out, we do not compare spending to benchmarks, because benchmarks are set in advance to create incentives for individual ACOs. They are not designed to look back and assess the performance of the

MSSP as a whole.

We then find the difference in spending growth between a "treatment" group, that is, the beneficiaries who were in ACOs, and a "comparison" group that is made up of beneficiaries who were not. Luis will show shortly that how exactly those groups are defined is critical for estimating savings.

And like they always say on your stock prospectus, past performance is not an indicator of future performance. We looked at what happened from 2012 to 2016, under the MSSP rules of that time. The rules have just changed in 2019, and future performance could be very different.

So to start out let me review what we discussed with you in January. We observed that beneficiaries commonly switch in and out and between ACOs. More precisely, CMS assigns beneficiaries to ACOs or removes them from assignment to ACOs based on the beneficiaries' claims history. But we will call those beneficiaries "switchers" throughout this briefing for simplicity.

We also observed that beneficiaries who switched tended to have higher growth in spending from 2012 through

2016 than those who did not, and that was true for those who switched into ACOs and for those who switched out of ACOs.

We speculated that a change in health status could make beneficiaries switch. Getting sick could make a beneficiary start to use different physicians and lead to a change in assignment and getting sick could change spending, which is the outcome of interest. You asked us to look at what some of the changes in health status might be, and we have looked into that, and Luis will review those results.

The conclusion in January was that this interaction between assignment change and spending complicates estimates of savings. In this presentation we will enlarge on that and show how because of that interaction, different estimates of savings can arise.

Luis will now walk you through our results.

MR. SERNA: First, we looked at the churn in MSSP assignment over time. We examined a cohort of beneficiaries who, from 2012 to 2016, were alive, resided in the same county, and were eligible for assignment.

This table shows the percent of beneficiaries who remained continually assigned. For example, among beneficiaries assigned to ACOs who entered the MSSP in 2013, only 59 percent remained assigned in 2016, despite being eligible for assignment.

In addition, continual assignment was slightly lower for beneficiaries assigned to ACOs that entered MSSP in 2014 and 2015. For example, let's look at the continual assignment rate in Year 3. For 2013 ACO entrants, 72 percent of beneficiaries were continually assigned by Year 3. Compare this with only 66 percent continued assignment for 2014 ACO entrants by Year 3.

With an understanding that MSSP assignment is dynamic, we now look at how assignment switching affects spending growth. We used descriptive statistics to look at the effect of moving in or out of an ACO. First, we show beneficiaries who had no change in ACO assignment.

This table shows the percentage point change in spending from 2012 to 2016, a negative number implying savings. The first row is those who stayed in the same ACO from 2013 to 2016. They have lower spending growth than their market average by 10 percentage points. These may

disproportionately be beneficiaries without a change in health status.

The second row shows beneficiaries never in an ACO. We see that their spending growth was 1.3 percentage points slower than the average for their market.

Overall, beneficiaries without an assignment change have spending growth slower than their market average. This implies that assignment switchers must have higher relative spending growth.

An examination of switchers does indeed show spending that is larger than the market average. The first row looks at any switching prior to 2016, including beneficiaries who were assigned to a newly formed. These beneficiaries had spending growth 1.2 percentage points higher than their market average.

In comparison, we see a large jump in spending for beneficiaries that lost assignment in 2016. As shown in the second row, even switchers with three prior years of ACO assignment had spending growth 13.8 percentage points higher than their market average.

In row 3, we see that switchers who were first assigned to a newly formed ACO in 2016 had spending growth

2.1 percentage points higher than their market average. In contrast, those first assigned to an existing ACO in 2016 had spending that was 16 percentage points higher than the average in their market. The assignment switchers in yellow show that there is an association between changes in assignment and changes in spending. One possibility is that a change in health care use triggered a change in physicians.

We examined whether ACO assignment switching in 2016 coincided with a change in health care use. We looked at ACOs that were in MSSP in 2015 and 2016. We tracked whether beneficiaries were continually assigned, joined one of the ACOs in 2016, or left an ACOs in 2016.

We measured change in health care use as having one or more of the following in 2016 but not 2015: inpatient hospital use, home health use, specialist assignment, or plurality of E&M visits in a skilled nursing facility. This table shows the percent of beneficiaries that had at least one of these changes in health care use.

We found that switchers, especially those losing ACO assignment, were more likely to have had at least one of these changes in health care use. Among those with

continual assignment, 16 percent had one or more selected changes.

In comparison, for those joining an ACO and those leaving an ACO, 22 percent and 28 percent and one or more changes in health care use, respectively. We also see that switchers are particularly more likely to have had a new specialist assignment in 2016. We can discuss this further on question.

Given the association of switches with spending growth and health care use, we used this to inform our estimates of MSSP savings from 2012 to 2016. When estimating MSSP savings, researchers compare spending growth for the treatment group to its comparison group to develop a counterfactual. The comparison group is a proxy for how much spending would have grown if beneficiaries had not been assigned to an MSSP ACO.

To test how sensitive estimates of savings were to assignment switching, we created three different definitions of an ACO treatment and comparison group. First, we examined the effect of any exposure to an ACO. That is, we compared beneficiaries who were ever assigned to an ACO with those who were never assigned to an ACO.

Second, we examined the effect of being originally assigned to the MSSP in its first full year. In other words, we compared beneficiaries who were assigned to an ACO in 2013 with those not assigned to an ACO in 2013. Finally, we compared spending growth for those assigned to an ACO in 2016 with those not assigned to an ACO in 2016.

We found that savings was highly dependent on the balance of ACO switchers in the treatment and comparison groups. As more switchers were removed from the ACO treatment group and placed in the comparison group, MSSP savings estimates increased. For example, when comparing beneficiaries ever in an ACO with those never in an ACO, all switchers are in the treatment group. In this case, we find no savings. Spending growth in the treatment group is at least 2 percent higher than the comparison group.

However, when comparing beneficiaries assigned to an ACO in 2013 with those who were not, we place switchers in both groups. In this case, we find some modest savings of 1 to 2 percent. Further, when comparing beneficiaries assigned to an ACO in 2016 with those who were not, the comparison group includes beneficiaries who were assigned to high-cost-growth physicians that dropped out of MSSP.

This creates a survivor bias and results in the most estimated savings.

Our finding that the balance of switchers affects savings estimates likely explains the variation in MSSP savings found in the research literature. Our three treatment group definitions are analogous to those used by researchers, and our savings estimates were similar. The treatment definition in white font based on 2013 assignment provides the most balance of how switchers are used and reflects our closest estimate of MSSP savings.

In addition to estimating MSSP savings based on different treatment group definitions, we investigated whether changing our statistical method affected the estimate of MSSP savings. Our first method was descriptive statistics of changes in spending for the ACO group versus other assignment-eligible beneficiaries in the market. Our second method was descriptive statistics after using market-level propensity weighting based on ACO-assigned beneficiary characteristics. For our third method, we used a propensity-weighted difference-in-difference regression model controlling for changes in beneficiary characteristics over time. More detailed specifications on

our models can be found in Appendix D of the paper.

While the definition of who is in the treatment and comparison groups affected whether we found savings or not, the three methods of statistical testing did not affect the direction of our findings.

For example, our treatment definition of assignment to an ACO in 2013 calculated savings of 2 percent using the descriptive method, 1.3 percent using the propensity-weighted average, and 1.7 percent using the propensity-weighted regression. As previously mentioned, this reflects our most likely estimate of MSSP savings over the period.

We note that these estimates are a national average and do not account for shared savings. Savings will vary by market and ACO. However, counterfactual estimates are difficult to discern for individual ACOs because smaller sample sizes increase statistical variation.

Taken together, the modest savings in MSSP and the degree of assignment switching pose potential future risk for the program. Savings have likely been small, signaling that asymmetric shared savings should be

carefully monitored as the program matures. In addition, the higher relative spending of assignment switchers could result in favorable or unfavorable selection for an ACO. For example, high-spending joiners could be unfavorable while high-spending leavers could be favorable. This could result in unwarranted shared savings or losses for individual ACOs.

Further, retrospective assignment used in MSSP may exacerbate the program's vulnerability to favorable and unfavorable patient selection. Next, Jeff will discuss one potential vulnerability: annual wellness visits.

DR. STENSLAND: Okay. Annual wellness visits can serve two purposes. They may be used for patient assessment and to better do care planning. They can also be used to try to assure beneficiaries remain assigned to the ACO. In particular, wellness visits could be used to retain attribution of beneficiaries with relatively low spending during the current year. For example, if a past patient had little health care spending during the first half of the year, the ACO could invite them in for a wellness visit. The beneficiary would not have to pay a co-pay for the wellness visit, and under new rules the ACO

could also give the beneficiary a cash bonus for coming in.

So a couple of questions are:

First, are the ACOs actually providing more wellness visits? And, in particular, are they providing more wellness visits at the end of the year when partial-year spending data may be known?

And, second, would this result in favorable selection? Is it material?

With respect to the first question, we find that ACO beneficiaries are almost twice as likely to receive a wellness visit. This could be an effort to better assess patient needs and improve their care planning, or it could be an effort to try to maintain assignment of low-cost beneficiaries; and, of course, it could be both.

As we said, the most potential for creating favorable selection is to bring in patients with low spending for a wellness visit at the end of the year. We do see slightly higher share of ACO wellness visits occurring in the fourth quarter.

So it looks like wellness visits could be used for patient selection in ACOs with retrospective assignment. For beneficiaries with a wellness visit in the

last quarter of 2015, we found they had 19 percent lower spending in 2015. They also had relatively high spending growth from 2015 to 2016, meaning after their wellness visit, but they still had 8 percent lower spending than was expected in 2016 due to starting at a low level of spending in 2015. This combination of low spending in 2015 and high spending growth after the wellness visit suggests that the wellness visits have a stronger association with past health than with future health or changes in spending.

What this tells us is that the wellness visits may be used to gain assignment for relatively healthy people. The risk is greater in a retrospective assignment world. This is because the ACO can see a partial year of spending data before it decides whether to ask the beneficiary to come in for a wellness visit. A smaller degree of favorable selection is possible in a prospective assignment world, but that is a lower risk. This is a lower risk because projecting future spending is just more difficult than projecting current year spending.

So, in conclusion, as Luis explained, our current model with the least potential for bias suggests ACO savings in about somewhere in 1 to 2 percent range before

shared savings payments. Our work should be seen as one of several studies, each of which has limitations and have a different methodology. What is reassuring is that work by other researchers at Harvard of the MSSP program yielded similar results, as did past work by the Office of the Actuary, and, finally, looking at a whole different group of ACOs, the next-generation model ACOs, that evaluation, which Jon Christianson actually participated in, also found savings in the 1 to 2 percent range for the first year of the next-gen model. The bottom line is that in the early years of the Medicare ACO programs, there appears to be a small but positive level of savings.

For the Medicare program to generate net savings, these shared savings payments to providers will have to be less than the small reductions in service use generated by ACOs. Any opportunities for ACOs to increase their shared savings payments through favorable selection could put the net program savings at risk.

There is also a risk of unfavorable selection for some ACOs. Under retrospective assignment, if an ACO physician tends to attract patients when they develop new serious conditions, those ACOs could have a unfavorable

selection of patients. Under retrospective assignment, the ACO physicians would be responsible for that patient spending during the year, and that is even for the portion of spending that occurred prior to that patient ever seeing an ACO physician. In contrast, under prospective assignment, the ACO physicians are only responsible for spending that occurs after the ACO physician has seen the patient.

Prospective assignment, therefore, may help mitigate some of the risks of both favorable and unfavorable selection while still encouraging care planning that could occur during the wellness visits.

So now we invite your discussion and how different definitions of treatment and comparison groups can affect the analysis, our estimates of shared savings, and the policy option of moving toward prospective assignment and other issues. I turn it back to Jay.

DR. CROSSON: Thank you, Jeff, Luis, David.

We're now open for clarifying questions. I saw Brian, Dana.

DR. DeBUSK: First of all, thank you for an excellent report. It was a very, very interesting read. I

had two questions.

First of all, the switchers, you know, it seems to me like a lot of the action, a lot of the activity around the switchers, do we have a way to determine how much of that is due to gaming? I have run into an ACO that was fairly proud of their ability to "punt," I think was the term they used, certain beneficiaries that were undesirable and for retrospective attribution. Do we have a feel for that, I mean, either through interviews with ACOs, or is there any way to potentially measure the effect of gaming creating the switching behavior?

MR. GLASS: Well, I don't think there's any way to quantify it, but, I mean, yeah, you can hear anecdotally about --

DR. DeBUSK: Well, to be more specific, if, say, 50 percent of everyone who gets diagnosed with cancer in a particular ACO happens to be referred to a group that just so happens to not be affiliated with the ACO, would that be a sign of systemic --

MR. GLASS: Or improper treatment, I guess, depending on where you were. But I think, Luis, you had one article, one study showing that, not only beneficiaries

with high spending but physicians with beneficiaries with high spending who tended to be shifted out of the ACO.

MR. SERNA: Yeah, that's right. That was a study by researchers from the University of Michigan that showed that beneficiaries with higher risk scores tended to leave the program, and physicians who had beneficiaries with higher levels of risk scores also tended to leave MSSP.

DR. DeBUSK: Okay. And also, to Chart 11, I had one other question. The area highlighted in white you were saying was sort of the nominal way of estimating the savings of the program. I think you found 1 to 2 percent growth. What are the error bars on that in terms of geographic variation? Is it 1 to 2 percent plus or minus 5 percent? Or is it 1 or 2 percent plus or minus a half a percent?

MR. SERNA: So it's definitely going to vary geographically, and I can get you the confidence interval, if you'd like.

DR. DeBUSK: Okay. Well, just a swag would be fine. I do not want to create --

MR. SERNA: Yeah, yeah.

DR. DeBUSK: Okay.

DR. CROSSON: Dana.

DR. STENSLAND: Just to clarify, I don't want people to be too pessimistic about the savings and the gaming, because one of the studies that we said that kind of looked at it found somewhat similar savings was the Office of the Actuary, which just looked at the market and said this market that has more ACOs, did they have lower spending? And they found, in general, the whole market on average has some lower spending. So it doesn't -- you know, I'm not saying there's not gaming, but it doesn't look like it's all gaming that's causing all the savings.

DR. CROSSON: Okay. On that?

MS. THOMPSON: On the whole discussion about switchers, I just think the whole business of who the switcher is -- I mean, somehow in the reading it felt like the switcher was the beneficiary, when the switching implication is really a product of the attribution model. And I think we've had some discussion about the pros and cons of prospective versus retrospective attribution. So it's really in that attribution the switching occurs. So in the narrative of the paper, I just think that's really an important point, because the beneficiary is either

choosing to seek another opinion, see another doctor, or has been referred perhaps for better care to a provider outside the ACO. So there's an important distinction there that's broader than just called a beneficiary a switcher.

MR. GLASS: That was our shorthand for CMS assigning someone to a different ACO.

DR. CROSSON: Important clarification. Dana.

DR. SAFRAN: Thanks, and really important work that you're doing and methodologically so complex, so you've done a really nice job.

I have kind of two and a half questions, and the first one goes to where Sue's point just went. Can you remind us whether assignment is based solely on touch points with primary care physicians or whether it also is made based on touch points with specialists when there is or isn't primary care involve -- I can't remember that, and it's really important to this issue of whether -- when a "switch" occurs.

MR. GLASS: Yes, it's in Appendix C of the paper. So the beneficiary has to have a qualifying time to visit with a physician, specifically a physician from the ACO to start with. Once that happens, then they count up visits

with primary care, and then there's finally visits with a specialist as well. So assignment can work several ways. But it's mostly, you know, the primary care-ish sort of visits.

DR. STENSLAND: So if you have one primary care visit and five specialty visits, the primary care visit rules. But if you have zero primary care visit, then they switch to look at your specialist.

DR. SAFRAN: Yeah, so I think that is really important with respect to how we think about switching, because there's a lot of research from, you know, a decade before we were even thinking of the word ACO about switching in and out of Medicare Advantage plans and the traditional fee-for-service system. And we do know that when -- that the people who switch between systems tend to have a precipitating event that result in their switching, and typically it's because they got sick. So I just think that we have to be clear about what we can see in the claims data about what precipitates a switch and, you know, it appears that a patient got a diagnosis that led them to seek care, and did they seek care outside of the network of where their PCP was? Was the original attribution because

of a PCP relationship and then they needed specialty care that they hadn't needed before? You know, there's a clear scenario there as opposed to something that might look more like gaming.

So I think we have to get even clearer about what happened before and after a switch so that we can really understand this phenomenon, because you've proven to us that it matters greatly in terms of how we end up evaluating the program.

My other question is a much simpler one, which is about the annual wellness visit. There's a hypothesis that I didn't see you address there that I know I saw quite a lot in practice, which is ACOs bringing patients in later in the year because they need to close gaps in care in order to improve their quality scores. So that's less about sort of gaming, I would say, and more about population management and recognizing this patient is mine and there are gaps and I need to close them.

So I just wonder, is that something that you looked at? And if not, would you?

DR. STENSLAND: I think it would be hard -- you know, we could -- it would be a lot of work to do between

now and then. You might have to almost survey people to say, well, why did you ask this person to come in? And then would they -- what answer would they say? They would definitely say, "We want to improve their care coordination," and, you know, "We have the quality metrics we have to adhere to." So I think it seems difficult.

DR. SAFRAN: But you could look at what services were provided when that patient was brought in to see whether it looks like there are gaps being closed that had been open before. But irrespective of whether we do that work, I just think it bears mention that there could be perfectly valid and, in fact, reasons that we would want to encourage for bringing in patients who are yours toward the end of the year for an annual wellness visit.

DR. CROSSON: Yeah, okay. Jonathan and then Karen.

DR. JAFFERY: Thanks, Jay. So this was a great report. You guys know that I've already spent some time thinking hard about it, and I'll probably bring up some more things in Round 2. But just two quick questions. I guess actually one was going in the same place that Dana was. There may actually be multiple reasons, I think, and

maybe some of them are more positive than others. Dana brought up a very positive reason why we would be bringing people in as ACOs are starting to think about how do they capture care gaps for risk adjustment, which we may or may not think is a great thing to encourage. That may be another reason. And so I think just in terms of the report, thinking through, there does seem to be an implication that the annual wellness visits and that increase near the end of the year may be more about gaming. There's multiple reasons. So I won't ask the question about that.

But the other question, in terms of retrospective versus prospective assignment, I know you have spent some time talking to different groups, different ACOs. Did you see much -- did you ask, first of all, but if so, did you hear much interest in continuing retrospective? Or do people really prefer one versus the other? Do you have a sense of that?

MR. GLASS: I think early on, there was certainly really adamant positions for and against, and since then, after our latest kind of round of talking to ACOs, but not scientifically selected, was I think that has gone away a

little bit. People were more comfortable either way.

Then in the final rule recently, they are allowing them to choose between retrospective and prospective in the MSSP annually, which that seems unusual to me.

I'm not sure. I think there may be still some people who would have great objections against prospective, but in our look at this, it certainly would seem to be a better system.

DR. CROSSON: Okay. Jaewon.

DR. RYU: Yeah. I had a question about the annual wellness visits. You made a comment -- and it was in the materials -- that it is correlated with past and current spending but not necessarily with future spending. I found that a little confusing because you would think -- well, I'm not going to bias you.

What are your working hypotheses on why that is?

DR. STENSLAND: My working hypothesis would be, first, if you're going to come in for a wellness visit, you're probably more likely to do that if you haven't seen the doctor three times already that month. So if you haven't seen the doctor for a while, that may be why you're

coming in. So you're probably healthier there.

You also might want to do it just to maintain a relationship with your physician. You're thinking, "I want them to know me. I want to know them. I'm going to come in periodically for a wellness visit," but if that's your purpose of coming in, it's probably because you haven't seen them a lot either.

Then I think the people that are really sick, they're not going to be going in for a wellness visit. No one checks out of the hospital to go to a wellness visit and then comes back to the hospital.

So I think you're just going to have a group of people that are doing the wellness visits that aren't all healthy, but I think they're just going to be disproportionately healthy. And I think that's what we see in the numbers.

Then we would want to see something like, oh, well, if they have these annual checkups, we would hope that then this would lead to better care, better care management, better outcomes down the line, and I think that's a universal hope.

But in terms of the data of what we see in it, we

don't see a lot of data there. The one study, there's a Cochrane study that looked at like who had physicals or wellness visits, and they randomized the people, "We're going to give you reminders to go get your wellness visit, and these people, we won't." People with reminders end up getting more wellness visit and then look to see who -- you know, do they have different mortality rates? Are they more likely to die of cancer if they didn't have these checkups to catch things early? And they really didn't find much of anything in there.

So that's why maybe you don't see so much down the line, and I want to emphasize, though, that we do still see slightly lower costs in 2016 for people who had a wellness visit in 2015. It's just they started really low. They grew more than average, but they didn't grow all the way up to the average.

DR. CROSSON: David.

DR. GRABOWSKI: Thanks.

I really liked the way this chapter has progressed, and it's good that you have Slide 11 up because I really think this intent-to-treat model is the correct one, and I just wanted to ask a couple of clarifying

questions about it.

You define it a little bit differently than the McWilliams study, and that you define it based on beneficiaries, and I think he and his colleagues do it based on kind of the practices.

Is that basically the same? There's a lot of overlap there, and you get the same result. I guess there's not perfect overlap in those groups.

DR. STENSLAND: There is not perfect overlap, but I kind of like the fact that it was done two different ways because we basically say we're keeping the beneficiaries the same. Once you're in, you're in. And he's saying we're keeping the tax ID numbers the same. Once you're in ACO, we're always going to consider you an ACO. That eliminates some of those biases, so there is some difference there.

Ours, I think, has a limitation, doesn't have decedents. He has decedents. He has a different method of assigning people, like he doesn't assign anybody by a specialist. So that's a little differently, where we use the CMS assignment algorithm. So there's differences, but the general idea is similar. We put you on this path, and

then we're going to follow you out.

DR. GRABOWSKI: I very much think it's the right path to studying this. I think the chapter does a really nice job of outlining the biases with the other approaches.

It would be interesting to just -- I don't want to send you down a rabbit hole, but just thinking about what's the overlap there, because you're getting the same findings. But if it's 80 or 90 percent of the same individuals are in your groups here, in some ways that would be interesting. But I don't want to create a lot of work if that's hard to do.

DR. CROSSON: Okay. Thank you, David.

We will move to the discussion period. I want to suggest a focus here. I have the sense -- and I may be right or wrong -- that based on this discussion and some previous discussions, there's a growing sense in the Commission that prospective attribution makes more sense than retrospective. I happen to share that.

For example, it makes this issue of why the wellness visits, what the purpose and uses would be. It kind of becomes moot in that situation.

I think I am going to pose the question here. Is

that a general sense that people share? And if so, I think I would suggest that we move forward in the next cycle to analyzing that a bit more thoroughly and perhaps move towards a recommendation to that effect.

You can discuss other aspects, but I would like to get a sense on that.

Who would like to comment? Dana, Paul.

DR. SAFRAN: I don't fully share it and would love to confer with my colleague who is an actuary from Blue Cross from when I was doing this work more actively because there were some important reasons that we favored -- we wouldn't ever call it retrospective. We called it concurrent attribution, but it ended up that it's not until the end of the year that you settle up on who was this organization's member for enough of the year that they're attributed there. And providers preferred that as well.

So I just would like to understand a little better some of the math as well as some of the care flow of where that thinking was coming from before going to prospective.

Prospective always sounds like it makes sense, like how can you take care of the population if you don't

know who they are, but there are ways that you know that with a model that's settling concurrently or retrospectively. So I'm not ready to jump on board with prospective.

DR. CROSSON: Would you or would you not object to us looking at it?

DR. SAFRAN: Absolutely should do that, yeah.

DR. CROSSON: Thanks.

Paul.

DR. PAUL GINSBURG: I think it would be very worthwhile looking at that. I think when we do look at it, I'd like to go a little broader. I'd like to consider what about giving beneficiaries the opportunity to identify a provider as their primary care provider and in this way.

I don't know. I think we'd have to work it through whether that's a good idea or not, or is there a way to make it feasible enough to actually do a lot of that? But I'd like to broaden the discussion when we get into attribution.

DR. CROSSON: I think that's perfectly reasonable, and previous iterations, we called that, I think, attestation or self-attestation or beneficiary

attestation. With or without incentives, that fits in there. Right.

Karen and then Bruce.

DR. DeSALVO: I concur with what Paul just shared and just want to relate back to the prior discussion, which is that if we are going to think about a world in which we're going to do a comparison of ACOs and MA, to me there has to be some accountability for the person from the get-go, not just in hindsight.

A nuance to that, which I don't know if it's available in the data, my guess would be that people who have less resources are less likely to get wellness visits and be a part of the system, so they might get left behind if we didn't prospectively identify them and link them to a primary care physician and then make sure they were part of a population going forward.

DR. CROSSON: Other discussion? Oh, I'm sorry. Bruce.

DR. PYENSON: Yeah. I agree with Dana's view of prospective versus retrospective.

In particular, if our goal is a system change, it doesn't particularly make sense that a prospective or

retrospective attribution should make a big difference.

A question, Jay. Was one of the discussion points you had whether or not the annual wellness visit should be discontinued?

DR. CROSSON: No.

DR. PYENSON: I would like to raise that.

DR. CROSSON: Okay.

DR. PYENSON: I thought you had asked that. It seems as though that's perhaps something that does not have a lot of evidence. Perhaps it's not a lot of expense, but both empirically and probably in the literature.

DR. CROSSON: I mean, that's a fair point, and I've heard people basically say -- I've heard beneficiaries say to me, "They told me to come in, and when I left, I don't know what happened."

[Laughter.]

DR. CROSSON: So I think that's an attendant issue that we could consider looking at.

Other discussion, commentary?

MR. GLASS: And we have started to look at annual wellness visits in some of our site -- in the focus groups, the beneficiary focus groups.

MS. TABOR: [Speaking off microphone.]

DR. CROSSON: Okay. So we will take a look at that, then. Thanks.

I think that sounds like we've wrapped this up. We've got a direction for some future work. David, Luis, Jeff, thank you for the presentation.

That concludes the morning session, and we're now open for public comment. If there are any of our guests who would like to make a comment, please come to the microphone.

Hang on for one minute, and I will provide some instructions, if that's okay.

Please identify yourself and any organization or institution that you are affiliated with, and I would ask you to make your comments concise and limit them to approximately two minutes. When you see this light come back on, then the two minutes will have expired.

MS. BRENNAN: Great. Thank you.

Wonderful discussion this morning. My name is Alison Brennan. I'm with the National Association of ACOs, so very interested in the work that you're doing right now and just wanted to make a couple different comments about

the discussion this morning and share some perspective from what we hear from our members.

First of all, as we're looking at the savings, when we're focusing on the first couple years of the program, it is just important to recognize that when we look back at ACOs getting up and running in 2013, that's a long road. So when we talk about savings being small over the course of those first few years, it has to be put into context that this was a transition period as they were embarking on this journey.

I think we will see greater savings over time as the program continues. We all look forward to getting data from 2017 to look at using kind of some of those sophisticated statistical approaches, which we all used in this recent report, but we do see from CMS that the 2017 performance data, based on benchmarks, does yield savings, which is important. So I think we'll continue to see positive trends.

Also, that when we couple in results from MSSP and next-gen, that's an even stronger message for overall results of ACOs.

Just a couple things on assignment, I think it is

a really important topic. One reason that I think ACOs -- some were reluctant to take on prospective assignment early on is because it was always coupled with having to assume risk, and so they weren't necessarily concerned about the assignment moving to perspective. While it would have been new, they were concerned about having to jump into a risk-based model. So I think now that there is more flexibility there, we could see more ACOs choose prospective assignment.

I do think there is a reason to keep retrospective assignment or at least to put in safeguards with prospective assignment because a lot of ACOs will be reluctant to have prospective assignment if they're worried about being accountable for patients that are then going all over the community and outside of the ACO to receive their care. It's harder to control their costs if they're not seeing providers in the ACO.

So those are just a couple comments and appreciate your attention to these issues. Thanks.

DR. CROSSON: Thank you.

Seeing no one else at the microphone, we are adjourned, then, until 1:15.

[Whereupon, at 11:59 a.m., the meeting was recessed, to reconvene at 1:15 p.m. this same day.]

AFTERNOON SESSION

[1:16 p.m.]

DR. CROSSON: Okay. I think we can get the afternoon session together. Looks like we have everybody here.

The first part of the afternoon is going to be focused on the Medicare Advantage program. The first presentation by Carlos and Ledia is going to talk to us about potential redesign for the quality bonus program, and Ledia -- Carlos is going to start.

MR. ZARABOZO: Good afternoon. Ledia and I are here to continue the discussion that began last November regarding the Medicare Advantage quality bonus program. We would like to thank Emma Achola and Alison Binkowski for their contributions to this work.

This presentation is linked to the material Eric presented today regarding the Commission's vision of promoting greater accountability among plans and providers in Medicare and to promote the participation of Medicare beneficiaries in entities such as accountable care organizations and MA plans. Eric pointed out ways in which MA could be improved, and this presentation is one of the

next steps in outlining ways to accomplish the task of improving the MA program.

Our presentation will first review the issues of concern with the QBP, then describe a possible way to redesign the program to be consistent with the Commission's principles, in a manner similar to the Commission's proposed redesign of Medicare's hospital value incentive program. We will then discuss financing issues and the plan for future modeling.

We are seeking your input on the measure set, the approach to peer grouping, and the concept of making the program budget neutral.

The MA star rating system is a method of rating Medicare Advantage plans using a 5-star scale. The rating system has been in place for a number of years. Originally it was developed as a means of providing information to Medicare beneficiaries about their health care choices, and the Congress specified what kind of information beneficiaries should receive, specifically information about MA plans in each geographic area as well as information about the quality of fee-for-service in a given local area.

In 2010, PPACA called for the use of a 5-star rating system that would be the basis of bonus payments to higher-rated plans. The bonus would be in the form of increases in plan benchmarks, which are the plan bidding targets and the maximum level of Medicare program payment. The law specified that plans at 4 stars or higher would receive the higher benchmarks. By giving plans more money, plans would be able to offer better benefit packages, and Medicare beneficiaries would be more likely to choose higher-rated plans because of those better benefit packages. While beneficiaries might use a plan's star rating as a factor in choosing among plans, premiums and benefit packages are usually more important factors affecting beneficiaries' decision-making.

The law also specified that the MA bonus payments would be financed through additional program expenditures, that is, new money over and above the basic MA payment rates. Currently, the program spends about $6 billion per year on MA bonus payments.

For a number of reasons that the Commission has been examining over the past several years, the star system and the quality bonus program are not adequately serving

their intended purposes. A major reason is that stars are assigned at the MA contract level. Currently, MA contracts can cover wide geographic areas, and often cross state boundaries. Nearly half of all coordinated care plan enrollees are in contracts that include states across the country that do not border each other.

To cite an example from the paper, for a contract serving 11 states, the star rating represents the average result for a given quality measure across the 11 states. So the current star ratings often do not provide accurate information about plan quality if the desire is to have information that is valid for a local market area.

A policy that has compounded this problem is that organizations have been allowed to consolidate or merge contracts to boost the star ratings of lower-performing contracts. A contract that is below 4 stars can be raised to 4 stars or higher through a consolidation, and the consolidation immediately affects the star rating that beneficiaries would see at the Health Plan Finder website, as well as immediately providing unwarranted bonus payments for a plan that would have been below 4 stars, and, therefore, not eligible for a bonus, in the absence of the

consolidation.

The Commission made a recommendation to the Congress last year to address the consolidation issue. Subsequently, a legislative change has partly, but not completely, addressed the issue.

Ledia will now discuss the ways in which the MA QBP program is not consistent with the Commission's principles, and how those principles can be applied to develop a redesigned system for MA.

MS. TABOR: We recently redesigned the hospital quality programs into the HVIP, and now intend to design a new Medicare Advantage Value Incentive Program, MA-VIP, which I'll talk about over the next few slides.

Besides the contract consolidation issue that Carlos spoke about, we are concerned that the QBP includes too many measures, scores results using a tournament model, and is possibly not effectively accounting for differences in enrollees' social risk factors.

I want to highlight the long-discussed goal of the Commission is to compare MA and FFS quality in local geographic units and has recommended that the Secretary take several action steps to foster Medicare's ability to

compare the quality of care across sectors. Consistent with this goal we are designing the MA-VIP with the anticipation that we can compare across MA, fee-for-service, and ACO in the future as we continue to work through data limitations.

The Commission maintains that Medicare quality programs should include a small set of population-based measures that are patient-oriented, encourage coordination across the providers, and promote change in the delivery system. The measures should not be unduly burdensome for providers, so they should largely be calculated or administered by CMS, preferably with data already being reported, mainly claims and encounter data and survey results.

Outside of the outcome and patient experience measures scored in the MA-VIP, Medicare can use other more granular quality measures and compliance standards to monitor MA plan performance and to publicly report plan information to beneficiaries.

As Carlos described, the QBP is tied to the star rating system which is used for public reporting quality information to beneficiaries. Today, we are going to focus

our discussion on the payment aspect of the program with the assumption that the beneficiary reporting would continue and be improved.

We propose a set of risk-adjusted, population-based outcome and patient experience measure domains to score in a MA-VIP. Most of these are existing measure domains that the Commission has in the past discussed as a basis for comparing MA and fee-for-service. Where practical, these measures are also scored in the HVIP. The MA-VIP measure set can continue to evolve as more measures and data sources become available.

The measures are: readmissions, potentially preventable admissions, potentially preventable ED visits, patient experience such as getting needed care and rating of the health plan, and patient-reported outcomes such as improving or maintaining physical and mental health.

As Carlos described earlier, the Commission has raised concerns that the star ratings are determined at the contract level, so in the MA-VIP we will measure the quality of each MA organization within a local market area. Comparing the quality of care within market areas allows us to evolve to eventually compare the quality of MA and fee-

for-service.

As described in your paper, the current QBP scores plans on a "tournament model," under which plans are scored relative to one another. For example, for a given HEDIS measure, plans are grouped into the five star categories through a statistical algorithm to determine clusters of levels of performance. Under this scoring methodology, a plan's reward depends only on its performance relative to the performance of other plans; thus, no plan knows how its performance will be judged until after other plans' performance has been assessed. This makes it difficult for providers and plans to manage their quality improvement efforts.

As with the hospital value incentive program, the MA-VIP will be designed to reward or penalize a plan based on the individual performance the plan achieves relative to a prospectively set system of targets for each measure domain.

Medicare will define a continuous scale of targets that converts performance to points.

The QBP takes into account differences in a plan's patient population, including social risk factors,

not through adjustment measure results, but through payment. CMS instituted a type of peer group mechanism that adjusts a contract's overall star rating based on a contract's share of low-income and disabled enrollees. Even with this adjustment, plans that have a higher proportion of lower-income beneficiaries continue to have lower overall star ratings.

The MA-VIP will use an alternative peer grouping mechanism to convert performance to rewards and penalties.

In the HVIP, at a national level, we classified hospitals into 10 peer groups based on their share of fully-dual eligible beneficiaries treated. We created the peer groups at a national level because we did not believe geography itself should be a factor in the quality of care hospitals provide.

However in MA, it makes more sense to create peer groups within local market areas. Plans can choose to leave or enter market often leave or choose to not operate in certain markets. In a sense, they choose their patient populations. Also, beneficiaries can and often switch plans within their local market areas because of changes in cost.

Therefore, we propose to calculate the MA-VIP within a local market area with stratified scoring and pools of dollars for fully dual-eligible beneficiaries, Peer Group 1, and non-fully dual-eligible beneficiaries, Peer Group 2. The MA-VIP peer groups are groups of beneficiaries, not groups of providers like in the HVIP; however, the same principle of accounting for differences in social risk factors through payment adjustment applies.

As in the HVIP, for the MA-VIP we anticipate that peer groups with more social risk factors will receive a higher reward for higher quality. Under the MA-VIP, we also anticipate grouping different populations a plan serves within a local area makes payment adjustments more equitable compared with the existing QBP.

The MA-VIP will link payment to quality of care to reward plans for efficiently providing high-quality care to beneficiaries.

I will now turn it back to Carlos to financing the MA-VIP.

MR. ZARABOZO: From a financing and payment point of view, in addition to the concern over unwarranted bonus payments and the adequacy of the peer grouping mechanism,

there are other concerns with the current QBP. We have mentioned that the QBP is financed with new money, adding $6 billion per year to Medicare program expenditures.

This financing mechanism creates a non-level playing field between fee-for-service and MA in how quality incentive programs are financed. In fee-for-service, such programs are budget neutral and can involve penalties, resulting in reduced program expenditures rather than increased program expenditures. This difference in financing mechanisms also means that while the fee-for-service programs can exert financial pressure on providers, the MA bonus program does not.

Another issue is that there is a misconception that bonus dollars always end up as extra benefits for beneficiaries enrolled in MA. However, there is no requirement that bonus dollars have to be used to finance extra benefits, as we will illustrate on the next two slides. A reason to talk about this point is that if the QBP financing was budget-neutral, there would be a concern that a major impact would be that beneficiaries would see a reduction in the extra benefits they receive from MA plans.

This chart shows the relationship between changes

in benchmarks, which are the basis of Medicare's payments to plans and plan bid, which are what plans state as the revenue they need to provide the Medicare benefit. To use shorthand terminology, the solid red bars show how much Medicare payments increased, and the cross-hatched bars show how much the plans said their cost of providing the Medicare benefit increased or decreased.

If a plan's bid shows that it costs are below the benchmark, the plan is required to use the difference to provide rebates, that is, extra benefits, to their enrollees. That was the case for all the groups shown here. The first set of bars show that when plans had no change in their bonus status, Medicare payments increased by 6 percent. So if a plan's benchmark in 2018 included a bonus, and the plan is still a bonus plan, payments rose 6 percent. If the benchmark in 2018 did not include any bonus, and the plan is still below 4 stars, payment rates also went up 6 percent. In other words, the base Medicare payment rates went up by 6 percent. In the first group, on the left, plan costs rose by 4 percent, leaving room for the provision of extra benefits.

For the other two sets of bars, their benchmarks

were influenced by changes in their bonus status. The middle group had only a 1 percent increase in its standardized benchmark rates, because the plans are leaving bonus status and are thus not entitled to the 5 percent add-on to the benchmarks that they had in 2018. They still were able to provide extra benefits in 2019, primarily because they reduced their bid, unlike the two other categories shown here, which increased their bids.

The last set of bars shows that the group that newly acquired bonus status had the 6 percent increase in their benchmarks, plus the 5 percent bonus, or an 11 percent benchmark increase. At the same time, their stated cost of providing the Medicare benefit rose by 10 percent, leaving just a little room for extra benefits.

The two main takeaway points are that between 2018 and 2019, when plans received extra money in the form of a boost in their benchmark by moving from non-bonus to bonus status, the money was not all used to provide extra benefits. In fact, most of it was not used for that purpose. The other takeaway point is that when plans lose their bonus status and have less money coming from the Medicare program, they reduce their bid, or stated cost,

for providing the Medicare A and B benefit. That is, you could say that they react to financial pressure by becoming more efficient.

The next slide gives more detail about whether Medicare's bonus payments to plans resulted in higher levels of extra benefits for enrollees.

The two takeaway points from the last slide are presented here, showing dollar amounts based on plans' actual bids compared to expected benchmark-based payments. The first row shows that plans losing their bonus status had a bigger increase in their extra benefits than plans gaining bonus status. Plans gaining bonus status had a large increase in their bid, or stated cost, of providing the Medicare benefit, $83, as shown in the second row. The next three rows decompose the components of the bid for each group.

The non-bonus group had a much lower change in net medical expenses, rising by $30 as compared to the over-$50 rise in the new bonus group. The $30 rise for the non-bonus group was primarily due to a higher expected risk profile for its enrolled population. The non-bonus group did not apply any of incremental dollars towards the plan

margin or profit. Instead they actually reduced their margins by $10 per member per month. By contrast, the new bonus group applied a significant portion of their bid increase, $33—per member per month, towards the plan margin or profit.

For your reference during the discussion period, here is an abbreviated version of the abbreviated table in your not-so-abbreviated mailing material that summarizes the issues that we have discussed and how they might be addressed in a redesigned quality incentive program for MA. The new system would be simpler and more patient-oriented. It would encourage quality improvement and reward efficient, high-quality plans.

As we did with the HVIP, it is our intention to model the effect of the proposed MA VIP, though we may have issues with data completeness, given that MA encounter data would be one of our main sources of information on MA.

For your discussion, we would like your feedback on the proposals we have presented, including the measure set, the proposed peer grouping, and the change to financing.

Thank you, and we look forward to your

discussion.

DR. CROSSON: Thank you, Carlos and Ledia. We are now open for clarifying questions. Brian, Dana, Paul, Pat, Marge.

DR. DeBUSK: First of all, thank you for an excellent report. I am wildly supportive of the direction this is going.

I had two pretty technical questions and then one an open-ended question. The market areas that you are referring to, I am assuming those are MedPAC units?

MS. TABOR: Yes. That is what we are planning to use for the modeling, so it's MSA divided up into different areas of the state and any MSAs across lines we split. So it's about 1,200 areas.

DR. DeBUSK: And then you take all the other outlying areas and you sort of create a quasi-MSA for those?

MS. TABOR: Exactly.

DR. DeBUSK: Okay. Good. So they are MedPAC units.

MS. TABOR: Yes.

DR. DeBUSK: And also -- and I think I know the

answer -- do you do the risk adjustment to all of the data, to all of the five domains and then do the peer grouping, just like you do in HVIP?

MS. TABOR: That was the plan, yes. So the readmissions and the PPA and PPV measures would be risk-adjusted for the standard clinical conditions, and then the HOS data, which is the health outcome survey and the CAHPS data is actually case-mix-adjusted.

DR. DeBUSK: Okay. So you do all the adjustment first and then you peer -- so again, it is apples to apples with HVIP.

MS. TABOR: Exactly.

DR. DeBUSK: Okay. The final question is more of an open-ended question. I don't mean to put you on the spot. If you could take HVIP and you could take this MA program, put them side by side, can you describe to me how you could move them each one step closer to each other, to where you were getting closer to an apples-to-apples comparison?

MS. TABOR: I guess I would think about -- I think about it more as what incentives are we sending to

the delivery system, and because both programs include generally the same types of measures, like readmissions, like patient experience, we're having all of the delivery system kind of focusing on these issues. There may be nuances in kind of what weights are applied to the risk adjustment and whether we're doing peer-grouping at a local versus a national level, but I think that they are consistent enough sending this message of these are the important things that you should be doing and how it defines value for the Medicare program.

Does that answer your question? Okay.

DR. CROSSON: Dana.

DR. SAFRAN: Thanks.

I'm really excited about this redesign work, so thank you.

I have a few questions. The first questions relate to the new measures that you're working with the contractor to develop. One question about that is, Do you plan on trying to get NQF endorsement? To use new measures in a high-stakes way like this could be challenging, especially when one of the new measures is a measure that already exists with other specifications, the readmissions

measure. I'm just curious how you're thinking about sort of progressing to the point of readiness for the MA-VIP.

MS. TABOR: Yes. I think we were not intending to submit it for NQF endorsement because I think we're seeing it as really just modeling out a proof of concept, and then CMS should take what we've done and have it go through the normal rulemaking process to really kind of create the perfect system. But we're doing something that I think tests the model.

DR. SAFRAN: That makes sense.

Another question also about those new measures is -- and you reference this right at the very end -- does the absence of good encounter data stand in the way of realizing this vision for those first three measures?

MS. TABOR: I think the particular, the PPV measure, the potential preventable ED visits is the one where we could potentially run into the most issues. We haven't started kind of really diving into it yet, but because of what Andy and Jennifer have found, the Part B data is less accurate.

We think that the PPA and the readmissions measure that combine the encounter data with the MedPAR

data are going to be able to have pretty good results, but again, we'll find out this summer.

DR. SAFRAN: Great.

Then two other quick questions. One is I'm curious about -- I understand your rationale for wanting to do the social risk factor stratification at the market level. It makes good sense. I just wonder whether you've looked at viability of that in terms of sample sizes.

MS. TABOR: We've done some thinking about that, more like thinking about how many insurers do you actually need in the market to kind of make this work, and we think that enough of the markets will have enough insurers to do it. We may have to combine a couple market areas, which we could think of rules on how to do that.

As far as sample size for the population, that is going to be something that we're going to struggle with in some areas, particularly for the CAHPS and the HOS data, because we are limited by what is collected right now. And since there is the contract's level across contiguous states, that Carlos has spoken about. There may be some markets where we can't test this out because we don't have a minimum for that.

DR. SAFRAN: Yeah.

MS. TABOR: So, again, we'll find out more this summer.

DR. SAFRAN: Yeah. Great.

Then my last question is just more about how things currently work, not about the new model. I probably should know this, but I don't. Do plans deliberately bid below the benchmark in order to give themselves that cushion to offer additional benefits? That seemed to be your point in Slide 14 and in the chapter materials. I just am trying to understand that.

MR. ZARABOZO: Well, if you bid over the benchmark, you are required to charge a premium for the Medicare benefit package. So you can only have extra benefits if you're bidding below the benchmark.

DR. CROSSON: Paul.

DR. PAUL GINSBURG: I've got two questions. One is that this relationship between low-income subsidy people being in the lower-rated plans, and the concern, I guess, is that whether they are pulling down those plans, star ratings, because of the challenges of treating them.

Is it also a possibility that because the prices

of higher star rating plans are higher and the fact that some low-income people don't have the tools to find the best plans, that that could be a part of the relationship as well?

MR. ZARABOZO: If it's a matter of price, a low-income person is entitled to the Part D subsidy. So you have plans that are again directed to them, and then you have the dual eligible special needs plan. So there are many plans that are actually directed towards this population. So you would be disinclined to choose a plan, for example, saying we have a foreign travel benefit; we have SilverSneakers, whatever else. It may not be of great interest to that particular population.

DR. PAUL GINSBURG: Thanks.

The other question is about the tournament models. It seems to me that in the budget-neutral world that we're envisioning, how can you have anything but a tournament model other than just saying, well, okay, for any one year, you're going to know your target, but over time, it's obviously at tournaments?

MR. ZARABOZO: That's correct. If you're going to redistribute all of the money in a given year based on

relative performance, then, yes, that is essentially a tournament model.

But the issue is -- you know, you can set the targets in advance. So the relative performance will be different among the different plans. So you have more money going to the better-performing plans. So part of it is how good are you at setting targets in advance to promote improvement.

DR. PAUL GINSBURG: Yeah. I think that the -- presumably, you will get good at that over time, and in a sense, I mean, I have no problem with tournament models, in general, as you may know from the past because of the fact that I think when we have policymakers setting targets, they're going to set them to be too easy. And a tournament model at least avoids that.

So, in a sense, I think that's a reasonable accommodation. Then, in any one year, every plan knows exactly their targets. It will be fine if plans actually do better than on the average, what was projected, because they're responding to these incentives. But then, in a sense, that gain is one time, and they're in the tournament again next year, again, with a fixed target. But the

tournament actually sets the targets for the future.

DR. CROSSON: So let me ask a question on this. You've introduced a new thought here for me. Is it possible to combine the two models and to have essentially a target set? And it might be set too low, but a target set and then a tournament model built above that? In other words, unless you reach the target, you don't qualify at all, and then, but above that, you have a relative performance and a relative gain or lack of gain.

MR. ZARABOZO: I was thinking that the tournament aspect comes in over time, so that you just have a fixed target. As I say, if it goes well, you'll actually -- it won't be budget-neutral in that year. The quality will have improved more than it has, but that come the next year in setting the target again --

DR. CROSSON: Yeah, I get that. No, I was just trying to think about is there a hybrid model where you could construct it in such a way that you could reach budget neutrality.

Yeah, Jon.

DR. PERLIN: Wouldn't the scenario actually be the other way around? Because in the beginning, you may

not know where to set the targets, and part of the problem with the tournament model is once you reach the cap of performance, 100 percent or whatever --

DR. CROSSON: Right.

DR. PERLIN: -- then a single case really can swing from a 25th to a 75th percentile or something that's really not proportionate or commensurate with measures. So it would seem like you may want to calibrate it if you don't know the performance level going in and then switch to an absolute performance once you've hit a measure that's near top.

DR. CROSSON: And I think Paul has made that similar point in the past.

Okay. Dana, on that?

DR. SAFRAN: On that point, there are really sound empirical methods that you can use even at the very beginning if you have a dataset with the measures in it to define absolute targets. I'm happy to talk about that at some point.

DR. CROSSON: So are you saying that absolute targets are or are not compatible with budget neutrality?

DR. SAFRAN: I think they can be, absolutely.

Yeah.

I think one of their advantages is that they're transparent to the provider community like, "This is what we expect of you. You can plan multiple years of performance improvement," et cetera.

DR. CROSSON: Right. I was trying to work off of this issue that -- and I thought, Paul, you were initially saying we have a null set here in the sense that if we wanted to have absolute targets and budget neutrality, we have to pick one or the other.

DR. PAUL GINSBURG: No.

DR. CROSSON: No. Okay.

DR. PAUL GINSBURG: I was really saying that I think we do -- what makes the situation challenging is that we're hoping to get quality to improve, and that's a dynamic thing. We'll set fixed targets for a year, and whether it's exactly budget neutral that year or not, we won't know. We'll actually hope it's not because then we'll achieve quality.

But still, on the next -- well, I don't want to repeat myself again. I think when you move into year to year, you get budget neutrality over time. You just don't

do it again every single year.

DR. CROSSON: Right. So I think maybe we're saying that there may be an incompatibility within a given year, but you're saying over time with adjustments, you can get to budget neutrality over some period of years.

But I thought I heard Dana saying something different from that. Is that not the case, or is that the case?

DR. SAFRAN: I believe it can be designed so that you're using absolute targets and having budget neutrality each year, but I would defer to staff and their modeling, though I'd be happy to provide information on how to get absolute targets.

DR. CROSSON: Okay. So you two can duke it out while you're sitting next to each other.

[Laughter.]

DR. CROSSON: But I suspect the answer is subject to analysis, and we could get there.

Paul.

DR. PAUL GINSBURG: Yeah. I think it all depends on the behavioral response. That's very hard to predict. I mean, I think that with no behavioral response, Dana's

method could predict it pretty well. But we're hoping to have a behavioral response, a positive one, so that's what makes it -- well, you won't hit it every year, but I think you can design it so that you hit it over -- cumulatively you hit it over many years.

DR. CROSSON: Okay.

MS. TABOR: And I'll just add in the HVIP. I think it does accomplish what both of you were saying, and I think the MA-VIP would also do the same thing. It's designed to be budget neutral, but if performance goes above a certain target, then it may not be. But that's kind of a good thing because that means quality has improved, and then you can adjust the targets next year to help make it more budget neutral.

DR. CROSSON: Okay, good.

Pat.

MS. WANG: Thank you.

With the approach of moving to local market areas and redoing things this way, what are the implications for the policy for new plans, which are granted a four-star rating?

MR. ZARABOZO: One way to do this is to say that

new plans will not participate because we don't have any information about them, so they won't be penalized or they won't be rewarded until they can participate in the program.

MS. WANG: Okay. Thank you.

What happens to the Part D measures? I mean, most MA plans are MA-PD. So are you planning on incorporating something on med adherence or med whatever, you know --

MS. TABOR: So since we're focusing just on the QBP, the payment part of the program in our work today, I think we wouldn't necessarily have the individual Part D process compliance measures as a part of this MA-VIP because, hopefully, if the Part D plans or MA-PD plans are doing a good job, we are going to have low readmissions, low potential preventable admissions, ED visits.

But there is still this idea that those Part D measures that are in existence now can continue for public reporting if Medicare wants to continue with it as well as compliance overall from CMS.

MS. WANG: Okay. Because it's much more than compliance. There's medication adherence, medication

reconciliation. Those are more outcomes measures.

MS. TABOR: Right.

MS. WANG: So you're saying that those would become sort of reporting or display informational because those are tournament models? So, in your thinking, that would go away sort of or get converted to something?

MS. TABOR: Right. For some, tied to payment.

MS. WANG: Okay. A question about PPVs. I heard a lot about them. Are they in use? I've heard about Medicaid programs talking about them, but I'm not really aware of anybody who's actually using them.

MS. TABOR: So we are planning, hopefully September, October, to come back to you with more discussion about what the measure looks like and we've ran some fee-for-service data on it. So I don't want to kind of preempt that discussion too much.

But we have heard that some ACOs are starting to look at it internally. We know that ACOs and MA plans are looking at ED utilization overall, and one of the HEDIS measures is a risk-adjusted ED utilization measure. This potentially preventable concept is a little newer, but again, I think people out in the delivery system are

starting to use it more because it's more actionable by the providers if you have a distinct list of things that you should be working to prevent.

MS. WANG: Final question. In the identification of possible peer groups for the HVIP model ten -- and here, you would be modeling two. So the characteristics of dual eligibles are much more uniform than non-dual. Within the non-dual, there's a whole range. There's partial dual. There's LIS look-alike, and then at the top, there's folks who otherwise would be buying a Medigap policy are in an MA plan.

I realize that you're kind of shrinking it to the comparison to local market area and then peer groups, so you probably don't want to load it up. But I just wondered if you had thought about that.

MS. TABOR: We've had a little bit of internal discussion about it, and we kind of thought that this two-peer-group approach would be a little simpler, and it's also more consistent with HVIPs, since that was how we defined -- or what kind of variable we used to define the peer groups. But we can discuss if there's other ways that we should be defining the peer groups.

MR. ZARABOZO: And this is mainly for modeling because, as you know, in the MA world, disability is the other factor that is a peer grouping factor, essentially. So we could consider to look at that as a possibility too.

DR. CROSSON: Okay. Let me see now. I've got Marge, Warner, David, and I see Bruce. Is that everyone?

Okay. Marge.

MS. MARJORIE GINSBURG: Thank you.

Actually, this question sort of relates to what Pat just said. My first question is, in looking at the peer group structure of duals and non-duals, it occurred to me that one of the other categories that might be very relevant to this is age. I know you obviously look at age when you look at risk adjustment and things like that, but, of course, we're not looking at risk adjustment. We're looking at quality, and that's different than risk adjustment.

So I wondered whether -- because I would imagine typical 70-year-olds have different health care needs mainly than 85-year-olds, and so for MA plans that particularly have an older population, I would imagine the kind of work evolved in optimal health is going to be

different in the 70-year-old.

So I just wondered whether you had considered broad age categories as one possibility.

MS. TABOR: I think we have because we think that -- so there's -- I think about the risk adjustment for the actual clinical quality measures. So the readmission rate is calculated as an observed over expected, and the expected is based on the plan's population of who they expect to go to the hospital or be readmitted. And that's based on age, clinical categories, HCCs and male versus female. So we're hoping that the age piece is already kind of taken care of in the clinical risk adjustment.

MS. MARJORIE GINSBURG: The Commission has emphasized that we're financially neutral between MA and what is still fee-for-service. So I'm curious whether the new system that's going to bring these bonus payments now -- so it's not going to make the MAs above 100 percent anymore, we assume. That we will eventually be paying MA plans less than the benchmark for fee-for-service. If that happens -- and I can envision it happening -- is that consistent? Is that model still consistent with maintaining financially neutral choice, or was that even

discussed about how this was going to change the relative payment between MAs and fee-for-service?

MR. ZARABOZO: Well, the current situation, you could say it is relatively close to being financially neutral because we're paying, on average, across the country a little bit more than fee-for-service to the MA plans.

But within that payment, it's not really equal because within that payment to the MA plans, they're providing extra benefits. So from a beneficiary point of view, it is not financially neutral if you're just saying, "Well, the value to me, it's better to be in MA because I'm getting all these extra benefits that otherwise would have come out of my pocket." So it's not a strict --

MS. MARJORIE GINSBURG: But would we ever have any MA plans that puts their bid forward at the benchmark and then still gets a bonus on top of that, bringing them above the 100 percent, with no extra benefits?

MR. ZARABOZO: Well, they could get -- yes. They could get a bonus. They could get a bonus.

MS. MARJORIE GINSBURG: And then the last question sort of related to that is that, were the bonus

dollars then required to be under the medical loss ratio of 85 percent? Assuming that they're bidding with that percent in mind, if you get a lot of bonus dollars, are those dollars -- MA Plans get to spent however they want? In other words, the bonus dollars are or are not part of the medical loss ratio?

MR. ZARABOZO: They would be in the medical loss ratio. Again, they can also spend them however they want.

Now, you see in the illustration that we gave, the plans had to reduce their administrative cost to stay within the medical loss ratio.

MS. MARJORIE GINSBURG: Okay.

MR. ZARABOZO: So that medical loss ratio still comes into play.

MS. MARJORIE GINSBURG: Okay, good. Thank you.

DR. CROSSON: Thank you.

Warner.

MR. THOMAS: I think that answered my question on Slide 15. On the general features of the MA value incentive plan, where do we see capturing ambulatory quality? I see hospital readmissions, preventable admissions, ER visits. I guess just in typical ambulatory

quality, where do you see capturing that?

MS. TABOR: I guess through those measures, hoping, again, if the whole delivery system is working together, the whole ambulatory care system is working together, that those things would be affected, and also just kind of thinking about what measures do we have available to us that we can calculate with claims-based administrative data.

MR. THOMAS: And how would you see the patient-reported outcomes, you know, on physical and mental health status? How would you see that working? Is that like just a general questionnaire that everybody is supposed to fill out?

MS. TABOR: So we would base that -- so there is currently the Health Outcomes Survey, which MA plans currently collect and report as a part of Medicare, and it is -- actually some of the measures are scored now in the quality bonus program. So the survey follows a cohort of beneficiaries over time to assess change or improvement in mental health status and improvement in physical health status over time.

I will say that there are some concerns with the

validity of the kind of current sample size that are required for those surveys, so that's something we need to kind of think about more, and we will as we're modeling this out.

DR. CROSSON: Karen, on this?

DR. DeSALVO: Just that the Health Outcomes Survey has a subset of questions that are pretty close to the Healthy Days instrument from CDC, which some plans also use, and that latter one -- they're not exactly the same, but the cluster of four questions has been studied by a group like, you know, the Robert Wood Johnson Foundation, and the inputs to the responses to that in senior populations are things like food insecurity and social isolation, some social drivers, and then it's related to utilization and expenditure on the other end. So there is a little bit of science to show that even those questions relate to utilization and spend but also personal health, a sense of well-being.

MR. THOMAS: But are they really more social determinants or are they really ambulatory quality?

DR. DeSALVO: Oh, I'm sorry. They're not ambulatory quality. They're patient-reported health

outcomes. But they reflect -- so, yeah, they definitely -- which was my question.

DR. CROSSON: Okay. David. Oh, I'm sorry.

DR. DeSALVO: I wanted to add on for you all to think about, in the social risk stratification, if you're going to have data on self-rated health or healthy days, or some subset from the Health Outcomes Study, that might be an approach to stratifying the population. If you're trying to do a social stratification, you might look at whether that's an additional, besides just income, opportunity to understand more of the nuances of the non-low-income subsidy.

DR. CROSSON: Okay. I have David and Bruce.

DR. GRABOWSKI: Thanks. This is exciting work, and I'm particularly intrigued by this opportunity to compare the quality of MA with the quality of fee-for-service, especially and including ACOs in local market areas. I think that's a really exciting development. Obviously, valid encounter data would solve a lot of our problems.

In the meantime, however, you do have a series of utilization measures based around HEDIS data, and I just

wanted to think about how does HEDIS -- measures generated from HEDIS data in MA compare with kind of claims-based measures in fee-for-service and ACOs. And I've used some HEDIS data, but I would like to hear you guys tell us a little more about that kind of difference there.

MS. TABOR: I'll start off on this one. So with the HEDIS data, our internal analysis, I think the biggest issue that we have is that HEDIS risk-adjusted measures are based on a small subset of MA encounter data, which is kind of like what's available for them to use for risk adjustment, or as we have all of fee-for-service to use to calculate our risk adjustment model. So I think what we can do in-house with encounter data and what CMS can do perhaps is a little stronger, especially if we're trying to compare across the three models. I would say that's the biggest issue. There may be little nuances like who's included in the population versus not between HEDIS measures and maybe what we use in-house. But I would say the biggest difference is kind of the risk adjustment model and the weight behind it.

DR. GRABOWSKI: Do you think we could get there with -- I mean, actually put something up that says this is

a -- we can do a valid comparison here with the risk adjustment issues?

MS. TABOR: Yes, I think -- and I'm open to the Commission's thoughts on this -- what we're going to try is to use this fee-for-service -- so use a risk adjustment model based on the entire fee-for-service population, just thinking it's so big that it's got to be good, and use that to apply -- use that to calculate the expected results across all three sectors, and then use, you know, claims and encounter data to calculate the observed. So that's something we're hoping to do as a part of this work.

DR. CROSSON: Bruce.

MR. PYENSON: Thank you. Terrific work. I've got two questions.

One is if you could help me connect between what's on Slides 14 and 15, which I view as a segment of an underwriting cycle and management response to bad news or good news in the market, to the recommendation, the summary issues in 16. Is there any connection -- so you have this -- identify this dynamic. I don't see the connection of that to the summary.

MR. ZARABOZO: Well, there are two reasons that

this is being presented. One reason is that there is -- many people have the opinion apparently that all the bonus dollars go to extra benefits. So, no, all the bonus dollars do not go to extra benefits from year to year.

MR. PYENSON: Why would people have that idea?

[Laughter.]

MR. ZARABOZO: Well --

MR. PYENSON: I'm just puzzled. Why is that even an issue? You know, it's --

MR. ZARABOZO: One trade group in the industry has said specifically that bonus dollars all go to extra benefits. Another entity that sort of monitors the MA program that is neutral has also said all these dollars go to extra benefits. So the answer is, no, they do not go to extra benefits.

The other point is the question if the bonus dollars go away, that produces financial pressure on the plans, so we're just illustrating here in this middle group that when there is a financial pressure on the plans, they do become more efficient. They reduce their bids, which is sort of your underwriting cycle in a way.

MR. PYENSON: Well, but you don't know whether

that's moving money from surplus to regain market share. I mean, you don't if that's what's going on or if they're becoming more efficient.

MR. ZARABOZO: Well, our only measure of being more efficient is your bid is lower this year than it was last year is this particular approach to evaluating efficiency.

MR. PYENSON: Okay. But under the -- we're not saying the bonuses go away. We're saying we have a different --

MR. ZARABOZO: Well, the financing of the bonuses could be budget-neutral, that is, there will not be the $6 billion add-on. You will be taking money from the sector and redistributing the money within the sector.

MR. PYENSON: But do you think the behavioral response, what I call the underwriting cycle, would change under the different bonus system?

MR. ZARABOZO: Well, I think, I mean, it is similar to what happened with the PPACA changes in payment. You had different reactions, you know, different behavior based on the reduction in payments. So you would see a similar thing happening here, which is reduced payments; if

you want to maintain market share or if you believe you have to have a certain level of extra benefits, you would take a reduced margin, for example.

MR. PYENSON: My second question is, you know, in the stars there's all sorts of measures on -- a few measures on things like cancer screening or flu shots. And what do you think would happen to performance if plans weren't being measured on them?

MR. ZARABOZO: Well, I mean, a lot of those -- if the medical community believes those are important measures and they are valid for tracking the continuing health of the membership -- for example, a flu shot is -- you know, that's a very important thing to have. And a lot of health plans remind people every time they come in, "Did you get your flu shot? You can get it anywhere you want to get it, but you really need to get your flu shot." So I would imagine they would continue to pay attention to those measures even without a financial incentive specifically tied to those measures. A flu shot, for example, if you don't get a flu shot, you could have a hospitalization that really could be considered as a preventable hospitalization, for example.

MS. TABOR: And also, you know, there's the idea that public reporting of these types of things could continue. I know in discussions with plans that, you know, the public reporting really does drive their own internal improvement. So hopefully there would be aspects of that that are still tied, even though we're only tying payment to these big population-based measures.

DR. CROSSON: Okay. Thank you. We are ready to move on to the discussion phase. Dana and Paul are going to lead that. I'd like to ask you to put up Slide 16, Ledia. I'd like to see if we can't direct the discussion to the right-hand column and the five numbered points there -- lack of support, support, relative support -- so we get a sense of the Commission.

Dana, you look ready to go.

DR. SAFRAN: Ready to go, so thanks. I think, you know, we've all emphasized over the course of this discussion the important advance this could make over the current QBP program. As the payment reform has taken shape both in public payment and private payment, I think the corresponding outcry about too many measures and, you know, not the right measures has really been noteworthy and with

ever-increasing volume on how important that issue is, tying it to physician burnout, et cetera. And, you know, at the end of the day, I think we all share a point of view that moving toward outcome-oriented, big-dot measures, when you're asking provider organizations to be accountable for a population for the total cost and health outcomes and quality for that population, it makes sense not to micromanage and, you know, measure on each little component of care.

So I'm extremely excited about what you're putting forward here with, you know, a parsimonious outcome-based, patient-centered set of measures.

I think that the inclusion of the Health Outcomes Survey is a very exciting prospect and bold, and imagine that if we could have this play out at the market level the way you're designing it, which I think is a very interesting and laudable approach, for individuals to be able to be choosing their plan based on this set of things, including how well one plan versus another does at helping people avoid decline in functional status or even achieve improvement is profound in how it could change health care. So very exciting set of prospects.

I think I'll mention just a couple things that I think need a little bit of attention as you do the work over the summer. One is in my experience you don't ever want an accountability measure to start with the word "potentially" in it. Providers will not accept, you know, in my experience, being assessed in a high-stakes way on something where it's potentially this but potentially something else. So I think you just want to give that some thought. And, you know, I understand your response about the NQF piece, but I do think some process to really validate and gain acceptance of these new measures is going to be critical.

I would also highlight that the three new measures that you're talking about do kind of double down on the cost incentive in Medicare Advantage in a way that's sort of twice paying for savings, you know, avoiding readmissions, for example. And I don't really have a problem with that. I think of those as efficiency-tinged quality measures. But I think that's okay.

I do, as I think some of my colleagues intimated, think you might want to add in something that gets into other aspects of primary care and ambulatory care,

particularly around prevention. So maybe there is a preventive care composite that encompasses some of the types of preventive services that have been included here, because I think if we're only focused on these sort of avoidance of hospital, avoidance of complications, we're missing something important in the quality space.

And then I guess two final thoughts. One is a question, and maybe there's some modeling you could do about whether the perceived takeaway that this will now be budget-neutral, do we think that could drive some MA plans to leave the program? And sort of corresponding to that, it would be very interesting to have some focus groups with consumer advocacy groups or consumers themselves to just understand how would Medicare beneficiaries respond to this and to the opportunity to have this kind of information to inform their choice of plan.

And then, finally, I didn't see anything in here on the possibility of multiyear targets, but I do think that's one of the advantages when you're setting targets in absolute terms, that if providers sort of know what the targets are and there's a range of targets, which I think is part of the value of what you're putting forward here,

then, you know, if you have multiple years to plan your quality improvement journey, that we could really see this start to -- help us make progress on the important measures that you're looking to include here.

So those are some starter thoughts. Thank you.

DR. CROSSON: Thank you, Dana. Paul.

DR. PAUL GINSBURG: Yes, I'm really glad you took up this topic, and you did a great job on it. To me, the star system is out of control. You know, for one thing, it has a weak foundation as far as what you've shown of the report with not a strong link to outcomes. And I think the rewards are much too large today, basically rewarding plans twice. You give them a star bonus, and they're also going to get more enrollees because enrollees do pay attention to star ratings. I think just attracting more enrollees should be enough of a reward. So I support all of your recommendations on page 16, right-hand column. I think this is the way to go.

DR. CROSSON: Thank you, Paul.

Further discussion? We'll start with Jon -- no, oh -- okay.

DR. CHRISTIANSON: You like that phrase.

[Laughter.]

DR. JAFFERY: I'd like some more discussion in this chapter about peer grouping at the local level. I like peer grouping at the local level, but peer grouping when you have, you know, 12 or 20 competitive plans versus when you have two, what are the implications of that? Is there anything there that we need to be concerned about? Stability of ranking over the years in terms of no strength of signal versus random noise going on in terms of how people get -- how plans get evaluated? I mean, there's lots of things, I think, to think about what I'd like to have you write about next time.

DR. CROSSON: Jonathan.

DR. PERLIN: Let me thank you for a terrific presentation on this. Your question, generally support the recommendations, but I do have a couple of additional. I want to associate with Dana's comment on the vetting and testing of accountability metrics.

Second, in the reading material, there was discussion of a particular proprietary, black-box adjustment mechanism. I have a categorical dislike for those because, really, we want both the accountability and

implicit in that is improvement. And you don't want people to know at the end of a marking period how well they've done. What you want is them working on the features that contribute to the improvement over that marking period, and so I would really recommend categorically against sort of black-box proprietary, closed adjustment systems because I think they defeat the ability to use the accountability to drive the improvement that you want.

Dana also brought up the notion of prevention, and the challenge of prevention is that it's really difficult to get to the outcome measures because, you know, if you do the prevention right, then you thwart the immediate or even near-term occurrence of things. Things like immunization, cancer screening, and substance use screening are great categories of prevention. Of course, those then become process measures.

The reason I feel they're so important is that I generally support the approach to the peer grouping, and this is going to sound somewhat heretical, but, you know, we don't want to inadvertently disadvantage disadvantaged populations with inferior outcomes, and the great part about process measures that focus on prevention is that,

one, you don't actually need to risk-adjust them, but you do know that they may actually carry more impact in the disadvantaged population. So I think linking those two thoughts together is important in terms of creating that slate in terms of ultimately a balanced scorecard of good care.

Thanks.

DR. CROSSON: Thank you. Kathy.

MS. BUTO: I probably should have brought this up in Round 1, but it occurred to me as I was looking at the outcome and patient experience measure domains that you set out that they're really very hospital-focused, and I understand why, because that's where a lot of the money is, and that makes us better able to compare across fee-for-service and MA. But I'm wondering if you thought about including some element that I think we associate with MA, which is more related to coordination of care or some aspect, and I guess where I would see this as being more concrete is, say, post-acute care as related to hospital inpatient care, something where what we think of as MA strength should actually be better measured than just following a lot of domains that focus on hospital

readmissions and preventable ED visits and things like that. So I just wondered if you had done that.

By the way, I support the recommendations as laid out, but I just felt like there was something missing.

MS. TABOR: I guess the one -- just to help answer your question, the good thing about the CAHPS survey that we would score for this is an MA CAHPS survey, so it focuses on more broader aspects of care than the HCAHPS. So there actually is a part of the MA CAHPS survey that asks about care coordination. So was your care coordinated, or do your doctors -- like no lab results after -- when you've gone to different doctors, did the doctor follow up with you about lab results? So we're hoping that that measure as well as kind of overall access measures that are asked in the MA CAHPS could get at that.

MS. BUTO: That's something we want to keep our eyes on, because I feel like as we talk about accountable care, we're not just talking about did something bad happen. We really want to know is something good going on as a result of this approach.

DR. CROSSON: Brian.

DR. DeBUSK: First of all, I'm really excited to

see all this. You harmonize all this work, really excited to see the similarities between HVIP and the new MA program, so congratulations. I hope you keep going.

A couple things. I do want to just once again caution, when you're using these observed versus expected, you know, basically the random effects model, it does still concern me doing a risk adjustment across such a broad population. I mean, when you go all the way from a dual, you know, to a very healthy beneficiary, I mean, just -- what I've said before is on the record. I would just be careful with using the random effects model across populations that are so broad in a homogeneous way.

The other thing I was going to throw out there -- and this is maybe wishful thinking on my part, but if we ever did get encounter data, which I genuinely hope we do, we may be able to calculate an MSPB using reference values, just the standard Medicare fee schedule for the cost data, and it would be interesting to be able to look at an MSPB across an MA plan versus an ACO. And if I'm not mistaken, I think MSPB is one of the HVIP domains anyway. So, again, it's another step toward comparability.

The other thing I remember from the HVIP, I know

we stratified into ten deciles, but if I remember correctly, there were pretty much -- there was a low lobe and a high lobe, and then there was sort of this big, vast middle that really didn't change that much. If you're already at two peer groups in the MA plan and the HVIP sort of looked a little, you know, three -- maybe if you looked at some, maybe it had five lobes on it at best, I'm just wondering if you could ever get to peer groups that were roughly comparable, because it just seems like ten to two is a little bit of a spread. And if you have the opportunity as you develop this work, you know, I hope we're constantly holding HVIP up against this new plan and looking at opportunities to move them incrementally closer.

And I do think, my final point, there's some real novelty in what you've done with these market areas with the plans and the way you're breaking them up. And when I was doing the reading, the one thing that popped into my head, I remember Jonathan, when we were talking about HVIP, talking about, well, what do you do about these beneficiaries who are coming in saying to our health system and this is maybe the one and only contact they'll have, or this is an infrequent contact that they would have, just,

again, as you're holding these two plans beside each other, we might want to do HVIP and introduce that concept of a market area, because, I mean, in theory a hospital could have more than one MSA that it's serving. Sort of picture one hospital say in a metropolitan area that is maybe pulling patients in from two or three other highly rural, highly dual-eligible MSAs. Well, you may average that population together and think you're sitting at, say, a 30 percent dual-eligible rate, when what you're really -- or 40 percent, and what you're really sitting at is a 10 percent dual-eligible rate plus three outlying counties that are sitting at 50 or 60 percent.

And so, anyway, the novelty in what you were doing with applying the MedPAC units to create these boundaries on the MA plans, it makes me wonder if there's some applicability. And, Jonathan, I don't mean to put words in your mouth, but I just remember the point that you made. It really stuck in my head, and I saw that again with this reading.

Thank you.

DR. CROSSON: Thank you, Brian. Further discussion? I see Pat, Warner, and Jonathan and Bruce.

DR. WANG: Very thought-provoking, great step forward.

This is just a minor thing but I think it's important. We use the term "patient" a lot in the slides as well as in the chapter, and I think when you're thinking about MA land we're not talking about patients because that's not the universe that an MA plan hopes to see. You know, so it's a subtle difference but beneficiary or member or enrollee, I think, is a better term.

Along those lines, I think Kathy and some others mentioned this, the focus on the measures that are in there, very hospital-focused, not ambulatory-focused, it might be worth looking again at the -- there are some good, tough outcomes measures. They're hybrid measures, you know, blood sugar control, things like that, that, in theory, you know, would be reflected in readmission rate, but maybe it would be worth looking at that.

I'm very glad that you are sensitive to the issues around sample size on the HOS. I think the HOS is a very important instrument, but I do happen to think there is an issue with sample size and extrapolating from those.

I think the goal of sort of trying to align the

measures as much as possible with the provider system are very important, and along those lines I would ask that in CAHPS that you look at some of the questions to where there is overlap, to really make sure that they are as similar or identical as possible. And the couple that come to mind for me are in the access and availability measures.

So in the MA CAHPS it's like in the past six months did you get seen within 15 minutes of your scheduled time? You know, that is, I think, in the physician CAHPS but it's not counted towards anything. The sort of satisfaction with access to care, you know, did you get an appointment as quickly as you wanted in the last six months? It's a very different question than I think what exists in some of the physician CAPHS measures, which are more specific to an appointment, a point in time. It would really help with conversations between plans and their delivery system to align those metrics and have everybody paying attention to the same thing and be incentivized to pay attention to the same thing.

I look forward to hearing more about the PPVs. As I had mentioned before, I do think -- I realize that for modeling purposes you need to kind of make this

straightforward and doable, but I am little worried about the dual versus non-dual hard and fast line as to peer groups. I kind of feel like it will not really capture the complexity, and as Carlos said, I mean, in the current CMS, you know, the categorical adjustment index, which is their SES adjustment, which many people believe is not refined enough, there are nine deciles of dual-ness, five quintiles of disability-ness, and folks feel like that's not enough. So I would just mention that.

On the readmission measures, I guess that the thing that I am a little confused about, and it's just maybe you can help me understand later, all of the work that went into the HVIP to make sure that hospitals were appropriately grouped so that the readmission statistic reflected their patient population, I don't really quite understand how that gets reflected in the peer grouping suggestion for the MA program. And I may be getting confused, but, you know, if an MA plan that serves a lot of low-income folks are using those hospitals that are in the highest decile of low-income members in the HVIP, is that going to get picked up in the evaluation of their readmission experience? It's just a question and I can

follow up with you.

You posed questions about financing and how to get to a place where this is a budget-neutral program, and I think it's a really important -- really important question -- and ultimately, I think, to move to a system where there is a withhold of some kind. A couple of considerations. I think it is essential as a threshold before talking about withholds to talk about benchmarks, because there's the phenomenon that Paul raised in the last conversation. There are some areas that are 60 percent MA now. Like what is the meaning of a fee-for-service benchmark at all? The benchmarks that are in existence now, as a result of PPACA, range from 95 percent to 115 percent, and that range contributes to some of this observation that, overall, payments to MA plans are higher than fee-for-service, and in some areas they are quite a bit lower than fee-for-service.

You've written about this before. I think it's very important. It's a great opportunity in talking about moving to a different quality program to standardize those or look at those again, and, you know, from my perspective, move much closer to 100 percent of fee-for-service

equivalent or something even more refined than that, to take into account these highly penetrated markets before talking about a withhold, because right now the withhold would be -- have very arbitrary effects in benchmarks that were somewhat arbitrarily set back in the day.

The other thing -- and just because you asked for ideas about how to move to that system -- is potentially to think about the money that is in the quality bonus, passing through the quality bonus program now and that is part of MA financing and part of the baseline for MA, and maybe sort of starting to blend what's there into the new program along with benchmark reform simultaneously, so that you can ultimately wind up in a place where the money is in the system but it's coming out in the form of a withhold instead of an add-on.

Thanks.

DR. CROSSON: Thank you, Pat. Warner.

MR. THOMAS: Just a couple of comments, briefly. I would agree with a lot of what Pat just went through.

On the quality metrics, I do think the ambulatory metrics being more specific, it's important. I would go to Jonathan's comment around process measures, which I

understand the hospital readmissions and preventable admissions are in the outcome measure eventually. But, you know, I think the process measures, which can be specifically measured, such as certain screenings and those types of things, are very important. We know that they eventually lead to improved outcomes measures, and especially if we can catch certain diseases in earlier states that's important as well.

So I would encourage us to add that and maybe even think about it replacing the physical and mental health stats, just given some concerns about the sample size. And, once again, I'm not sure how that feedback kind of gets back to the plan and back to the delivery system. I'm not sure that information ever gets back to the delivery system. And I think, once again, we want to have information there that can be actionable and can motivate folks to do a better job.

And plus I think you'd probably get a lot of those components, or some of those components on the patient experience and people's specific ideas, or how they think about their experience with the delivery system and with the MA plan.

So those would be my comments. Thank you.

DR. CROSSON: Thank you, Warner. Jonathan.

DR. JAFFERY: Yeah, thanks, Jay. So, generally, I'm very supportive of all these recommendations on the right side of the slide and in this direction. I really appreciate, we have seen over the course of the year multiple situations where we are moving more towards these common set of Commission principles.

In terms of the metrics, and particularly about people's comments and concerns about not having enough ambulatory measures, and thinking about Dana's comment about the word "preventable" -- or "potentially," rather -- and how providers may react to that, I don't know if this is where you were going with this but, you know, the notion of ambulatory care sensitive conditions seems like maybe gets to both of those questions and has maybe some acceptance in a way that we would think, even though it's really about preventing an activity that would be in the hospital, it's really driven by that care coordination that happens in the ambulatory setting.

The only other comment I wanted to make was maybe to tie back to this morning and thinking about, as we're

going forward, you know, one of the Commission principles is about equitable treatment to providers and thinking about how this ultimately can connect with our ACO programs, where we don't have a budget. I mean, we don't have extra money going in for quality payments. In fact, it is based on usually some withhold or withhold measure against the benchmark.

And then also just thinking about how do we get our measures aligned so that everybody feels like they're moving in the same direction, providers, whether they're taking care of patients in an ACO or an MA, or what happens very often, both, are moving towards the same measures and then beneficiaries can ultimately judge quality and performance based on the same set of metrics.

DR. CROSSON: Thank you, Jonathan. Bruce.

MR. PYENSON: Thank you very much. This is great work, and I support the five points out there.

I do have three points I want to make, and one is to pick up on Paul's comment on the tournament model, and especially in the context of the Medicare Advantage plan. We are talking about organizations that are inherently competitive. Their life is a tournament, competing against

other health plans. Although the benchmarks are known in advance the benefits of their competitors are not known, or their offerings, in advance. So they are inherently in a tournament of much bigger stakes than the quality bonus -- in addition to the quality bonus, but probably a bigger order of magnitude competing for members, and that also applies to PDPs, perhaps even more so.

So given their inherent ability to manage risk -- after all, they're insurance companies -- I think in that context some of the concerns about tournament models are probably not as applicable, and that's something to think about in the context of MA plans.

Another point I would like to make is I would hate to see an underlying assumption in this work that we can't do certain things because we don't have encounter data, because we have another stream that's going to make sure we are getting encounter data pretty quickly. So I wouldn't want that to be used as a reason why we shouldn't get certain information, especially on the population health. We are going to get it. It will be there. So let's assume that and let's go for the merits of what works best.

And, finally, I'd like to echo Pat's Round 1 question about Part D quality metrics. I think Part D in an MA-PD takes on a different character and I think there are quality metrics there that would make a lot of sense, probably involving a polypharmacy or other things that you could pull out of the data and actually attribute to the MA plan, because the MA plan's also responsible for the prescribers. So I'd echo Pat's -- I think that's what you were saying, Pat.

DR. WANG: And there are existing outcomes measures that are quite tough but that would get -- you know, I mean, medicate adherence, for example, there are three, triple-weighted medication adherence measures that are highly correlated with outcomes. I mean, they exist. They don't have to be developed, and PQA has been very actively involved. So it might be something to take a look at, to fold into this, because they are included together now in the stars bonus.

DR. CROSSON: Dana. Last comment.

DR. SAFRAN: Yeah. This is just a quick comment about some of the discussion on health outcomes survey and sample size concerns. So I just want to reassure folks

that based on some work that I have done, and I would be happy to share, we don't have to worry about that, that, you know, you can, at the MA plan level, you get to stable, reliable information on outcomes on HOS with 1,000 beneficiaries.

So while the current sample sizes are not adequate, I think I actually, in a paper I wrote fairly recently, cited a MedPAC report, saying that 99 percent of plans included some vast number of beneficiaries so that we could certainly get to 1,000 in pretty much any plan, and 1,000 is what you need at the plan level. You actually need much less, about a third of that, at the clinical level or practice level, to get stable, reliable information on HOS.

DR. CROSSON: Okay. Good discussion. I think we've got broad support for this general direction. I think in the next cycle we're going to see us moving towards recommendations.

There was a theme here, which I think we need to be consonant of, with respect to balance between hospital-based and ambulatory-based outcome measures. Having said that, I think it's important to recognize that,

readmissions aside, preventable admissions and preventable emergency department visits are part and parcel to the work in the outpatient arena. I mean, that's not the only thing but that's a lot of what caregivers are working towards. So it's mix. Those are mixed in my mind, something to do with how well the hospitals took care of people and that they don't come back, and perhaps the same thing for emergency, but they fundamentally reflect, to a large degree, the quality of outpatient care, and I think patient experience and reported outcomes do as well.

That said, you know, I think that we have to strike a balance between slip-sliding back into a whole list of process measures, which is what we're trying to get away from, but to the extent, Carlos and Ledia, you can think of something maybe more to add in the ambulatory arena, I think that would be welcomed. So we look forward to seeing that in the next iteration.

Thanks very much. Carlos and Ledia, good work. We will see you again in the fall, I believe.

We will move on to the next presentation.

[Pause.]

DR. CROSSON: Okay. The second presentation this

afternoon, again, is focused on the Medicare Advantage program, and we are, I think, about to reach a conclusion on work that we've done over the last year or so on trying to provide stronger incentives for plans to provide complete and accurate encounter data.

Andy and Jennifer are going to take us through that, and then we will have a recommendation and a vote.

MS. PODULKA: Thank you, Jay.

Today, Andy and I will present information on Medicare Advantage encounter data in follow-up to our multiple presentations over the past year. Because much of the information was included last month, we'll move more quickly through several slides to allow more time for the new material.

We'll cover the encounter data background, our efforts to validate the available files, and the expected outlook going forward.

And, finally, we'll review the draft recommendation, which has been modified a bit to reflect your discussion last month.

First, a note on terminology. MA organizations sign contracts with Medicare to deliver the MA benefit to

enrollees. These contracts can include one or more multiple plan benefit packages, and all of our analyses were conducted at the contract level. But we'll use the terms "contract" and "plan" interchangeably.

MA encounter data have a long history that began with the Balanced Budget Act of 1997.

Initial efforts to collect encounter data proceeded with some fits and starts until in 2008, CMS called to resume collection of detailed encounter data for all Medicare services. And the collection began in January of 2012.

I want to highlight the value complete encounter data could have for the MA program. Detailed encounter data are the best vehicle for learning about how care is provided to the one-third of Medicare beneficiaries enrolled in MA. Ensuring that the Medicare benefit is administered properly to all beneficiaries is an important function for program oversight.

Second, plans have the flexibility to implement practices that could allow them to provide care more efficiently than in the traditional program, moving the program from strict fee-for-service to value-based payment,

and we would like to evaluate how these techniques are employed in addition to what their effects are, using encounter data to potentially inform and improve Medicare policies more broadly.

Finally, complete encounter data could replace various data collection efforts and would ensure that the program relies on data that are internally consistent and conform to program rules.

We have evaluated the MA encounter data files to determine if they are ready for use in various analyses and risk adjustment. Our methodology includes two main categories.

First, we checked if each plan successfully submitted any encounter data for each of the six settings. We also compared plans' reported enrollees to CMS's database that track plan offerings and beneficiary enrollment.

For a second step of the validation, where available, we compared MA encounter data to other data files that also include information on MA utilization. For these comparisons, rather than trying to validate all data elements, we focus just on first- and second-order

questions, which means we check to see that the same enrollees who received a service that's documented in the encounter data are also identified in a comparison dataset.

And where possible, we checked that dates of service matched or at least overlapped.

You've noted concerns about the completeness of these comparison datasets, and we recognize that like all datasets, they do have shortcomings, which is why our comparisons aren't designed to match up each and every variable in the encounter data and the comparison datasets. Again, we're checking to see, for example, that a hospital reported that they treated a person, that that same person shows up somewhere in the MA plan's reported encounter data.

So on the comparisons of encounter data to other sources, the four shown here are independent or external data in the sense that they are derived from information reported by providers; in this case, including hospitals, dialysis facilities, home health agencies, and skilled nursing facilities.

In 2015, 90 percent of enrollees included in independent data reported by hospitals were also included

in encounter data. However, of the inpatient stays in the hospital-reported data, only 78 percent had matching or overlapping dates of service for the encounter data.

The enrollee match rates were 89 percent for dialysis, 46 percent for home health, and 49 percent for skilled nursing.

We note that the results in 2015 are a bit better than they were the prior year, and we expect that once we're able to review more recent data files, we'll find improvements year to year.

However, given the importance of encounter data and the amount of time that has already passed since its collection began, the Commission has grown increasingly concerned about the pace of that incremental improvement. The current outlook for encounter data does not suggest that the pace will pick up without some intervention.

First, there are report cards that CMS uses to provide feedback to plans which tally total records and compare these to regional and national averages, but they only include one comparison to external, those for inpatient stays.

Second, CMS recently implemented a set of

performance metrics that assesses the timing of submissions and compares encounter data to plan-submitted risk adjustment, or RAPS data. However, the thresholds for these metrics are designed to identify only plans that are outliers due to very low submission rates.

And, finally, encounter data are used to identify diagnoses for risk adjustment, which provides an incentive to submit some inpatient, outpatient hospital, and physician records, which are only three of the six required settings. There is no risk adjustment incentive to submit records for the other settings or for encounters from these three that do not reveal additional diagnosis codes.

So, again, based on the current set of feedback and incentives, we expect that encounter data will continue to improve. However, your recent discussion has reflected a concern about the pace of that incremental improvement and a preference for taking additional steps to increase encounter data completeness and accuracy, which Andy will now discuss.

DR. JOHNSON: The next few slides review the three main policies included in today's draft recommendation. These policies are designed to improve the

assessment of completeness and increase incentives to submit encounter data. Information about the first two policies is largely unchanged from our presentation last month. These policies are expanding the performance metric framework and applying a payment withhold.

However, the policy to use Medicare Administrative Contractors to collect encounter data directly from providers has been updated based on the Commission's discussion in the March meeting.

The first policy is to expand the performance metric framework. Performance metrics currently focus on the timing of encounter submissions and comparisons to RAPS data. Compliance in the current performance framework uses a single threshold to identify low-performing outlier plans. However, our analysis found incompleteness to be an issue for nearly all plans, not just a few outliers.

One way to improve this framework is to add metrics that compare encounter data to external and plan-generated data sources. CMS could publicly report statistics showing aggregate performance for the MA program on these metrics. Feedback to plans could be more specific, including information about each instance of

missing encounter data.

To improve compliance with the performance metric framework, we find that a payment withhold would more appropriately address the scope of incompleteness in the encounter data.

To apply a payment withhold, the amount withheld could be based on a percentage of each plan's monthly payment, making the size of the withhold correlated with enrollment in the plan and the expected number of encounter records. The amount to be returned to the plan would be based on a plan's performance relative to a range of standards.

For example, plans with better performance would receive more of their withhold in return, and plans with worse performance would receive less in record.

Initial withhold return standards could be set at a generous level, with a high rate of return being easy to attain, and then standards could increase over time. If MA plans collectively submit complete and accurate encounter data, the withhold policy could be phased out.

The final policy for improving encounter data submission is for providers to submit claims for MA

enrollees directly to Medicare Administrative Contractors, or MACs. Providers currently submit to MACs all fee-for-service Medicare claims and information-only claims for MA enrollees using inpatient hospital and skilled nursing services. MACs currently forward fee-for-service claims to Medigap plans and Medicaid agencies that have cost-sharing obligations.

To use this process in MA, MACs would receive claims from providers and apply fee-for-service data edits to Part A and B services, ensuring that those records are complete. Then MACs would forward claims to MA plans for payment processing and would also forward a duplicate claim to CMS for compilation into encounter data. For supplemental services, MACs could forward records directly to MA plans with minimal data checks.

The MAC process would collect payment data, similar to the current process. In either case, the plan's fee schedule or contractual amount would be the source of payment data collected. Many providers currently use a claims clearinghouse to submit claims to MACs or other payers. This policy would not require any change to these clearinghouses in claims processing.

In March, we described implementing two parts of this policy. First, MA organizations that prefer to use a MAC to process claims and to submitting encounter data could elect to do so.

Second, a set of completeness thresholds would apply at the MA organization level. If an organization fails to meet a threshold, only that organization would be required to use MACs.

Based on the Commission's discussion last month, we have added a third part to this policy. Another set of completeness thresholds would apply to the entire MA program. If all MA organizations, collectively, fail to meet a program-wide threshold, all MA organizations would be required use MACs.

Last month, several Commissioners also commented that the MAC policy should be implemented sooner than the proposed 2024. On this slide, we lay out an ambitious timeline of actions to implement the draft recommendation, showing that many recommendation activities would take place sooner than 2024.

Starting immediately, CMS would develop new performance metrics and provide feedback to plans about

their performance for the most recent year of encounter data. Spring 2020 is the next opportunity for CMS to notify plans about the specification of new metrics and the payment withhold standards. Policies announced at this time apply to payment year 2021, which is the first payment year that the payment withhold would apply. The withhold policy and feedback reporting would continue in each subsequent year.

During the next notification of changes to payment policy, in the spring of 2021, CMS would inform plans about the mechanism for using MACs and the thresholds that would trigger their use. The MAC thresholds and the option for MA organizations to opt to use MACs would first apply in payment year 2022 and would continue for subsequent years.

In early 2023, CMS would assess whether MAC thresholds were met and notify any organizations that failed to meet thresholds. If there were any such organizations, MAC use would be triggered for payment year 2024, which given this timeline is the earliest year we think CMS could implement the MAC policy.

That brings us to the draft recommendation, which

reads: "The Congress should direct the Secretary to establish thresholds for the completeness and accuracy of Medicare Advantage encounter data and rigorously evaluate MA organizations' submitted data and provide robust feedback; concurrently apply a payment withhold and provide refunds to MA organizations that meet thresholds; institute a mechanism for direct submission of provider claims to Medicare Administrative Contractors as a voluntary option for all MA organizations that prefer this method, and starting in 2024, for individual MA organizations that fail to meet thresholds or for all MA organizations if program-wide thresholds are not achieved."

This recommendation may reduce program spending relative to current policy, if the performance of some plans results in less than the full withhold amount being returned to those plans. Given that withhold standards may be generous at first, this policy may reduce spending by less than $50 million in one year and by less than $1 billion over five years.

The recommendation would not have any direct effect on beneficiaries.

The impact of the potential use of MACs to

collect encounter data on plans and providers would vary depending on each entities' current procedures for processing claims and submitting encounter data.

Before we wrap up, I want to point out two issues requiring future work that go beyond the topics covered in the draft recommendation.

First, independent data sources for assessing encounter data for physician, outpatient, and certain other Part B services are lacking. We would like to develop metrics for these services that could be added to the performance metric framework.

To develop these metrics, it may be necessary to patch together comparisons of subsets of these services; for example, using Part D event and inpatient data to identify evidence of a physician encounter. Alternatively, we could develop aggregated comparisons to utilization information at the service-type level from plan bids.

Such comparisons to plan bids would also help address the second issue, which is evaluating whether incentives and performance metrics are having the intended effect. In this context, comparisons to plan bid information can assess whether the encounter data are

generally consistent with each plan's spending.

An alternative approach to address this issue would be to develop an additional program audit area to assess consistency between encounter data and the plan's financial data for payments to providers.

We highlight these two issues for future work to differentiate them from the policies included in today's draft recommendation.

And now I'll turn it back to Jay.

DR. CROSSON: Okay. Thank you, Andy, Jennifer.

Let's go to clarifying questions.

Jaewon and then Kathy.

DR. RYU: Yeah. I had a question about you referenced with the use of the MAC that there be a potential delay of a few days in the claims processing cycle or the submission cycle.

I think there are programs with some MA plans that rely on that timeliness for a clinical event to take place. I think the best example might be ED visit, working together with hospitals and so forth, to get timely notification that might then trigger and outreach to the patient for follow-up.

Have we gone through and looked at what some of those programs might be that have a dependency on the time where that delay may end up being a factor?

DR. JOHNSON: My understanding of those types of notifications is that they would be based off of the electronic health record technology and that if an inpatient admission took place and it was notifying the plan or primary care provider that it would not use the claims process but would use other health information technology.

DR. CROSSON: Kathy.

MS. BUTO: I just wondered whether you all had checked to see whether the MACs could absorb this workload and how long it would take them because it's been a while, but my experience working with contractors is it always takes longer than you expect to make systems changes so they can accommodate a new function. So I wondered if you had worked that into your time frame.

MS. PODULKA: Well, the MACs, of course, are contractors to CMS. So, we discussed with the CMS MAC group rather than the MACs themselves.

They note that we have ambitious goals and an

ambitious timeline, but as usual, they stand ready to serve if called upon by the Congress to do something that they had not yet done before.

MS. BUTO: That sounds like an answer -- [speaking off microphone.]

DR. CROSSON: Right.

[Laughter.]

MS. BUTO: I would definitely have given that answer to you if I had met with you when I was at CMS.

DR. CROSSON: Karen.

DR. DeSALVO: I wondered to understand a little more about this new concept around the failure of the whole program-wide and how you solve the peer pressure playing out. That's what I'm guessing is what you think you would want to see happen, or how did that become I think a priority, and how do you expect that to help?

DR. JOHNSON: I think the rationale for the program-wide threshold was that if -- that we think that having this data complete for all plans and all MA enrollees is important enough that we wouldn't want a situation to be going on where a certain number of plans just decided they didn't ever want to figure out this

process and make it efficient, and that they could continually pay a withhold and not get the sufficient return back, but that at some point, you would want a threshold that applies to everyone and says that these types of providers want to -- types of plans wouldn't be holding back the completeness of the entire data.

DR. DeSALVO: A follow-up question that I generally don't understand, which I probably should, but if Medicare's increasingly using encounter data to set payment, isn't that also an incentive for their overall payment? And I just wondered what would keep a plan wanting to not submit good encounter data if that's also going to be not part of the penalty piece but the reward of payment.

DR. JOHNSON: So the payment data is based off of diagnoses submitted on outpatient, inpatient, and physician encounters. So there is some incentive to submit those encounter records. But if a plan has submitted all the diagnoses for a particular enrollee but not all the encounter records, there really isn't another incentive to submit those additional encounter records for those service types. And as Jennifer noted, that also doesn't address

the home health, skilled nursing, and other PAC settings that aren't used for setting MA payment rates.

DR. CROSSON: Okay. I see Pat. I'm sorry. Are you passing? Round 2, okay.

So we have clarifying questions, we have the recommendation on the table here, which will be the order of business. And I would ask for discussion here, and discussion should be directed towards the draft recommendation, support, lack of support, and then we'll proceed based on that discussion to a vote. Pat?

[Laughter.]

MS. WANG: I apologize. The wording is kind of general about more robust feedback from CMS to plans to assist in, you know, getting encounter submission where everybody wants it to be. You guys probably have a list of specific suggestions, and I just want to make sure that you have shared those with CMS. I mean, they know what to do, too. Last time we met, I had suggested that they add dollars into their reports back to plans so that it's not just matching the member and the dates, but dollars are a way of just identifying am I talking about the same encounter or are we off? I think that would be very

valuable information. I'm hoping that you would kind of compile those in a more specific way to give to CMS, because I think that, you know, there's stakes all around, but more robust feedback is desired by many and is not quite there yet.

In terms of the recommendation, I had also suggested -- mentioned that in the MAC process I would still consider -- well, there's two things. The program-wide trigger is -- you know, Karen's question I think is a good one. It's an unusual step to take when sort of the sector -- if somebody in California is not submitting, that's going to affect plans in, you know, New Hampshire. It's an interesting notion. We still have provider types that don't submit cost reports, and we don't penalize the entire provider community. We don't even penalize them for not submitting cost reports. I'm thinking about our perennial discussion around am-surg centers. So I think it's a bit of a -- it's a little bit out there in terms of sort of a last hammer.

And then the final thing is I continue to think that if a MAC process is used and maybe it will be a better and more efficient process for encounters, if everything

works the way it's supposed to, that plans still be allowed to submit their own encounter data for purposes of risk adjustment, because I think many plans would be reluctant to just turn over that function to a MAC when they themselves, you know, like go back and forth, you know, multiple, multiple, multiple times every week to make sure that their submissions for risk adjustment are correct. So I would kind of carve that out of the general MAC.

DR. MATHEWS: Pat, if I could just say one thing on the middle point you raised about the industry-wide trigger being potentially problematic here. I'll take some responsibility for how that has been articulated in this revised element of the draft recommendation. Recall that in March there were some Commissioners who had expressed reservations about using the MACs at all in this capacity, and there were other Commissioners who said, "Why are we not going to use the MACs right now?"

And so what we were trying to do here is let the current process continue to unfold, given the investments that have been made, but try to goose that by having, you know, more robust targets and feedback to incentivize plans to hit those targets, but then given the importance of

having robust, complete program-wide encounter data, that at some point if the industry as a whole had not achieved those targets, then this option would be triggered.

DR. CROSSON: Karen.

DR. DeSALVO: Yeah, just to continue that conversation, I appreciate that, and I was thinking also of provider categories, for example, where if one of my peers, physician peers, didn't submit data, then would I have to change all my processes? But I wonder also, equity aside, I wonder about timeline. And if the process is, as I understand it, starting to work better between CMS and the plans for the data to be received and more accurate and people trust it more, if 95 or 99 percent of the industry got all that right and one didn't, there'd have to be a new process started with the MACs, and I wonder if that would delay the timeline further.

DR. MATHEWS: So If I understand your question correctly, you're asking if a very, very small percentage of the industry had failed to meet the target, would that trigger -- so it would depend on how one, you know, defined the thresholds in question. Would it be, you know, a percentage of MA plans? Would it be a percentage of MA

enrollment whereby if some of the larger organizations had managed to get -- to meet all of the targets, would they sort of carry the industry as a whole and prevent that from happening?

So there are a number of operational decisions that would come into play in terms of defining how and when this kind of option would be triggered.

DR. DeSALVO: The second part of my -- and it doesn't quite read that way to me, by the way, so I would just wonder about some clarity. But the second part of my question was about timing. So if, you know, whatever threshold isn't met, however we would define that, and then we had to move to MAC pathway, MAC would have to get stood up. They'd have to build the interfaces. There would be a series of steps that would then have to resume, which might push the timeline out further, would be my -- because I'm thinking somewhere in '25 we'd say, "Oh, we're not there," so then we have to start this other pathway for everyone, not just for those who can't comply.

DR. MATHEWS: Sure, that is a possibility, but one would hope that under this revised system of incentives, you know, clear targets, withholds that would

be redistributed based on performance, that this would help increase the completeness of the data that's being submitted.

DR. CROSSON: Marge.

MS. MARJORIE GINSBURG: This may be a part one question. Do we have any knowledge as to why some MA plans are so slow or unable to submit data on time? And I ask this question because I was originally thinking about let's add another part, because if you don't do it, we'll cut you off. I mean, do you ever -- does CMS ever disenfranchise an MA plan for whatever reason?

But before that option, do we have any idea, have they said why this is so challenging for MA plans to get their information in?

DR. JOHNSON: There have been some challenges early on working with CMS and the feedback they were given that many plans have acknowledged. But I also think it goes to the incentives for them to submit certain types of data and that as their risk scores and payments were -- the portion of their payments that rely on encounter-based risk scores has increased, some of those types of services have increased incompleteness as well, and those have been what

plans have openly said, you know, as we're going provider type by provider type, we started there because that's what matters the most for our payments. And once we get that settled, we'll, you know, maybe work through some of the other provider types.

But to the extent that there is right now not any feedback about how complete are your skilled nursing encounters or home health encounters, that that's why we think some of the new performance metrics need to focus on those services, and part of it incentives.

MS. MARJORIE GINSBURG: And do you think these incentives are strong enough to stimulate better responses?

DR. JOHNSON: I think the -- well, whether the incentives are strong enough might depend on how the withhold policy and MAC thresholds are established, and we hope that they can be established in a way that incents plans to improve their data. I'll leave it at that.

CMS does have the authority, on your second question, for plans who have a 2.5 star rating for several years in a row to discontinue their contract.

MS. MARJORIE GINSBURG: [off microphone]?

DR. JOHNSON: Once or twice? Carlos says yes.

DR. CROSSON: Kathy.

MS. BUTO: I'm sort of thinking along the same lines that you are, Marge, and I was wondering -- we just talked about the quality bonus program, which really kind of depends on good encounter data to track some of these outcomes. And I'm wondering whether we ought to consider either, you know, tying star ratings or the quality bonus program results or payout in part to -- this is a process measure, obviously, but in part to the submission of encounter data to the extent that we define complete encounter data or relatively complete encounter data.

There ought to be some cross-reference here between the bonus program and whether or not you're submitting data that helps you know whether you're actually achieving outcomes.

DR. JOHNSON: I think that is a good point for everyone to discuss. I think the one concern that we have discussed internally is whether or not stars are used as a signal to beneficiaries if a plan's submitting complete encounter data, it fits that role like it does about readmissions and some other things.

MS. BUTO: I understand. But we're talking about

sort of a withhold both with the bonus program and with this. There ought to be some kind of convergence there, I think.

DR. JOHNSON: Sure.

DR. CROSSON: I think, Kathy, you're making a distinction between a star rating and how much you get paid?

MS. BUTO: I'm just saying there ought to be a penalty that people care about, and it usually follows payment. If you don't get some payment that you think you're entitled to, then you might pay attention and do what you're supposed to do.

DR. CROSSON: What I'm saying is you could still have a plan rated four stars, but they wouldn't get the four-star payment because you could have a corollary to that, which is, you know, it gets reduced proportionate to encounter data submission.

MS. BUTO: I don't want to design it. I just think there ought to be a consequence if you don't submit the data beyond just not getting your withhold back.

DR. CROSSON: And I think this is a concept that could be incorporated into the text as a suggestion. I

think it's a good one.

Okay. I see no other -- yes, I do. Brian.

DR. DeBUSK: One other quick comment. I made it the last time we looked at this chapter, too. On page 21, you talk about calibrating the HCC, the risk adjustment model, against the encounter data itself. I still want to point out that's a circular reference. I realize it doesn't affect the recommendation, but it's just the quality of the materials is so incredible, I'd hate to see a logic flaw make it into the published June report. If I have fee-for-service data -- a thought experiment here. If I have fee-for-service data, I calibrate against that. Let's say I find the coefficient for diabetes. So now I have the payment adjuster for diabetes. Well, if the MA plans develop some breakthrough and now they're managing diabetes at, you know -- and their adjuster is a half of the adjuster that fee-for-service has, well, you'd want to leave that in place because, I mean, that arbitrage, that's administration cost, that's plan profit, and that's essentially what we're paying them to do, is do things differently and do things better. So if we were continuously calibrating the HCC model against the

encounter data itself, it's a self-referring cycle. I mean, we would just be absorbing the improvements they made into new HCC coefficients.

DR. JOHNSON: I think you're right, and there are some people who argue that there is a benefit to that circularity and that there is payment accuracy that comes along with it and argue that that's more important than having that arbitrage opportunity as you described. And then there's other people who say the opposite, so --

DR. DeBUSK: Well, I would be in the camp of if we're paying them to do things better and different -- and I wouldn't want to calibrate a model that basically knocks them back down every time they do something better or different. As a matter of fact, we'd actually be incentivizing them to do things more poorly, because if they would calibrate against the model, the more inefficient they got, the more they'd get paid for diabetes, essentially.

DR. JOHNSON: The section in the chapter should reflect that this is one policy change that might be coming in the future and that we haven't heard much about it recently, but it's intending to describe what it is and

what the implication of it would be. But we'll make sure that there's not language that says one way or the other whether or not we have opinions.

DR. CROSSON: Okay. Seeing no further discussion, we'll proceed to vote on the recommendation that's before you. It's depicted on the slide and on page 13. All Commissioners in favor of the recommendation, please raise your hand.

[Show of hands.]

DR. CROSSON: All Commissioners opposed?

[Show of hands.]

DR. DeSALVO: [off microphone].

DR. CROSSON: I understand. Abstaining?

[No response.]

DR. CROSSON: The recommendation is passed. Andy, Jennifer, thank you very much. We'll proceed with the next presentation.

Okay. The next item, we're going to return to the issue of post-acute care, and particularly whether or not functional assessment of patient status is going to be a tool that would be useful to employ in the assessment of post-acute care providers. Ledia and Carol are here, and

Ledia -- carol is going to start.

DR. CARTER: This presentation follows up on a discussion we had back in November on patient assessment data submitted by PAC providers. We had proposed an approach to examine the quality of these data and now we are presenting the results of that analysis.

Functional status is an important dimension of post-acute care. The information is used to adjust payments, gauge provider performance, and establish care plans for patients.

However, we know that providers respond to the incentives of payment policies and quality reporting. If providers respond to incentives by recording function in ways that do not reflect patients' care needs, then program payments will be unnecessarily high, payments for individual stays will not be aligned with resource needs of the patient, and providers will appear to have achieved better outcomes than they have. Beneficiaries could select a provider that is not, if fact, as good as reported. And ACOs and MA plans could build their networks of PAC providers around data that is, in fact, inaccurate.

The setting-specific PPSs and quality reporting

programs create incentives for providers to pay attention to the way they record a patient's functional status. Three of the prospective payment systems include functional status as a risk adjuster, so providers have an incentive to adapt their recording of functional status to maximize payments.

Change in function is an outcome measure that is reported in each setting's quality reporting program. The IRF and SNF quality reporting also include a measure of attainment of function at discharge. The change and attainment measures create incentives for providers to record function to show improvement, higher function at discharge compared to admission.

In November, we discussed examples of the reporting of functional status that appear to be influenced by value-based purchasing and PPS incentives. We also reviewed numerous examples of provider responses to payment policies. We outlined strategies CMS could pursue to improve the quality of the functional assessment data and discussed a measure of function that avoids provider reporting, and that would be patient-reported outcomes.

Today we present our evaluation of the functional

assessment data, and the question to keep in mind is, should function data be used to establish payments and measure patient outcomes?

We plan to include this information in this year’s June report.

Each PAC setting uses its own patient assessment tool that include different questions, definitions of activities, look-back periods, and scales to record information on the same domains of activities, such as walking. Therefore, we needed a systematic crosswalk so we could compare the items recorded by the different assessments. For each tool, we defined each level of function in terms of points, for example, 15 points for the independent category, 10 points for requiring limited assistance, 5 points for extensive assistance, and 0 points for total dependence. And we did this for four activities: eating, transferring, walking and toileting.

Then, for each patient's assessment, we assigned points to the level of function recorded for that patient. We created a total score by summing the points for each activity. Then, based on a patient's total score, we assigned that patient's functional ability to one of 5

broad categories.

Three of the assessment tools also now include additional uniform items that are used for quality reporting. Because the items are uniform, they are directly comparable. They also allow us to compare items recorded for payment -- those are the setting-specific items -- with those recorded for quality improvement -- and those would be the new uniform items.

To evaluate the function data we focused on the consistency of the assessment information in three ways. First, we compared assessment information with other beneficiary characteristics, such as their age and risk scores.

Second, we looked at the assessments of beneficiaries who transitioned between PAC settings. For the same patient, we compared the assessment at discharge from one setting with the admission assessment at the next setting. In the diagram, you see two stays, with the discharge assessment of the first stay highlighted in yellow and the admission assessment to the next in green. We included only pairs of assessments that occurred within three days of each other.

The third analysis focused on the consistency of reporting of information that is used for payment -- the setting-specific items -- with the items used for quality reporting, and again, these are assessments items reported for the same beneficiaries.

To gauge consistency, we looked for general agreement between the broad categories of function assigned by different assessments for the same patient. We were not looking for perfect matches. While no one analysis is definitive, together they raise questions about how and whether this information should be used to adjust payments or to measure provider performance.

Our first comparison looked at whether the broad levels of function -- that's low, medium, high, and so on -- were related to other patient characteristics, and we found that they were. For example, the highest-functioning beneficiaries were younger, with an average age of 73 years compared to 78 for the lowest-functioning group. The highest-functioning beneficiaries also had lower risk scores, on average, compared to the lowest-functioning beneficiaries. Beneficiaries in the highest-functioning group were less likely to have diagnoses that involved

multiple body systems, have a cognitive impairment, or a higher severity of illness compared to beneficiaries in the lowest-functioning group.

These results suggest that when looking at groups of patients, the functional assessment data generally track other patient characteristics. But you will see that when we look at the differences in the recorded function for the same patient we have concerns about the consistency of this information.

Our second analysis compared assessments conducted at discharge from one PAC setting and at admission to another for the same patients. This chart compares the function level recorded for patients assessed at discharge from IRFs with the functional level recorded at admission to home health agencies. We show the percent of assessments at admission that were two or more levels lower than the assessment at discharge, and one level lower, the same level, and one and two or more levels higher.

We found that the reported levels of function were inconsistent and favored recording lower levels of function at admission. Only 7 percent of patients

discharged from an IRF and then assessed were assessed at the same level when they were admitted to the home health agency.

The level of function recorded on the home health admission assessment was lower than what was recorded on the discharge assessment of the prior IRF stay for 92 percent of patients, the 66 plus 26 percent.

The large share of assessments for the same patients that vary two or more levels, and the bias of the differences raised questions about the consistency of the recording of function by providers. A lower function recorded on admission to home health agencies would establish higher home health payments for them and be more likely to show improvements in function. A high function at discharge from the IRFs would likewise be more likely to show improvement for IRFs.

This is a similar comparison but this one shows assessments completed at discharge from IRFs and at admission to SNFs. Discharge and admission assessments for the same patients agreed less than one-third of the time. The recorded function on the SNF admission assessment was lower than the level recorded on the prior IRF discharge

assessment for 58 percent of the patients. That's the 21 plus the 37 percent. The recording of lower function at admission establishes higher payments for SNFs and would be more likely to show improvement, while the higher level of function recorded by IRFs would be more likely to show improvement.

Now let's look at beneficiaries who transition between institutional PAC providers, before for them we have uniform assessment items that are directly comparable. There is no issue in using a crosswalk between the different assessment tools. We would expect the function levels recorded at discharge from one setting and at admission to the next would be the same, and for the mismatches to be more or less evenly distributed in both directions.

Yet even comparing these uniform items for the same patients, we found that the function levels recorded at discharge from one setting and admission to the next were the same less than half of the time. And again we found that the mismatches predominantly occur in the direction of function being assessed lower at admission to the second setting. A much larger share of assessments at

SNF admission recorded lower function -- that's the 12 plus the 32 percent -- compared with the share that recorded higher function -- that's the 9 plus the 2 percent. IRFs would have an incentive to record high function at discharge while SNFs would have an incentive to record a low-function admission, both to show improvement.

MS. TABOR: We also examined the consistency of reporting of function items within each setting. We compared the admission assessment results for function items that are used for payment -- the setting-specific items -- with those used for quality reporting, or the uniform items.

We found that, for both IRFs and SNFs, less than half of the admission assessments recorded the same function category in the information used for quality reporting and the setting-specific items used for payment. Again, the recording favors one direction. The items recorded for quality reporting were more likely to be recorded one function level higher than the information used to establish payments.

These results indicate that even within a setting the uniform items are reported inconsistently.

Our results may be explained by the financial incentives of the payment systems to record function as low at admission. Quality reporting and value-based purchasing may encourage providers to record function to show improvement. It is possible that some of the differences in levels of function recorded may be due to differences in the setting-specific assessment tools. Further, the recording of the uniform items is relatively new, and assessors may be gaining experience with it, so these data may be improving over time.

Finally, there will always be some degree of subjectivity of the assessments. Even with these factors, the magnitude of the differences and the directional differences raise questions about the integrity of these data.

Our examination of the functional assessment information submitted by PAC providers indicates that the information is currently inconsistent and shows signs of being influenced by payment incentives. Therefore Medicare should not use this information to adjust payments.

Our results also raise questions about whether this information is reliable for quality measurement.

However, maintaining and improving function is a key outcome measure for PAC providers, so Commissioners may want to encourage CMS to improve the reporting of this information.

In November, the Commission discussed three strategies that CMS could employ to improve the accuracy of the patient function assessments or alternatives to those assessments. Per the Commission's feedback, in the chapter we have added more detail on the implementation issues CMS should consider with these strategies.

First, CMS could improve its monitoring of provider-reported assessments by performing analysis of the consistency of the data like we did in this paper. CMS could conduct on-site audits of providers that have submitted aberrant data and assess penalties on providers with poor data quality. CMS should require medical records to include sufficient documentation to support the patient functional assessment information.

A second strategy is to require hospitals to complete assessments of patients when they are discharged. Because a large share of PAC is not preceded by a hospital stay, this strategy has limited applicability.

A third strategy is to gather patient-reported outcomes, or PROs. PROs would sidestep the problem of providers' financial incentives influencing their reporting of patients' functional status. However, there are currently no PROs collected in PAC settings or included in PAC quality programs. Further, many PAC patients have high severity of illness and cognitive impairments that would affect the ability to collect accurate PRO results.

More research is needed to determine if proxies, like family members, can reliably complete assessments.

This brings us to your discussion. Carol and I can answer any questions you have about our analysis. We would then like you feedback on whether the Commission should move towards a future recommendation on the use of function to adjust payments to PAC providers, as well as whether the Commission should encourage CMS to adopt strategies to improve, or alternatives to provider-reported data.

DR. CROSSON: Thank you, Ledia and Carol. We now move to clarifying questions.

I see Sue and Marge and David.

MS. THOMPSON: Thank you, ladies.

In terms of the difference in the assessment tools and the subjectivity that might be applied, how significant is that in this whole scenario? I mean, how many different tools do we have and how much variability is being introduced into this formula?

DR. CARTER: I'm pretty comfortable with the crosswalk that we used. We did define, for each tool on its own, definitions of independence and sort of moderate supervision required, moderate assistance, more assistance, and then total dependence, and we tried to be, and really worked hard, to make sure that within each tool we were defining things in the same way but also that the definitions were consistent across them.

But also because we are adding the scores for each dimension together to create a total score, no one thing can get you in one of the categories. It has to be a combination of your dependence on each of the four activities. And so we are trying to develop broad-brush definitions of somebody's functional status, and by, I think, relying on a broad definition I think it helps with being more confident in these results.

MS. THOMPSON: And does that apply to the health

care professional who is doing the functional assessment as well? Do you feel confident?

DR. CARTER: Each of the tools was validated way back when, and the uniform items that were developed as part of the PAC payment demonstration, the PAC PRD, those were validated both within setting, across setting, and across disciplines. So probably the most bulletproof comparison is the uniform items, because there aren't any differences in the definitions, and those were validated because they wanted that tool and those items to be able to travel with the patient as they went across the different assessment tools.

But even for the setting-specific comparisons, because we were trying to do the comparisons at a general level, I'm pretty comfortable with them.

MS. THOMPSON: Okay. I have one more question. I don't know why this caught my eye, but -- and I probably should know this, for all the time we have spent on this work -- but on page 29 of our reading you referenced that a large share of post-acute is not preceded by a hospital stay. And there was something about that statement that seemed almost like counterintuitive. I mean, post-acute

implies acute. So just kind of expand on -- I mean, what is that large share?

DR. CARTER: It's about half, and it's because two-thirds of home health space are not preceded by -- that's the benefit. You can be community admitted, and the majority of home health patients are. But I think about 15 percent of ERF and LTCH patients are also admitted from the community, so that's where it comes from.

MS. THOMPSON: Thank you.

DR. CROSSON: Thank you. Marge.

MS. MARJORIE GINSBURG: Well, there may not be much data on this but I was curious, in your research, whether patients who are not under Medicare but are under commercial plans, they are still under 65, and we do have a few of them in home care, but I wonder whether commercial plans have the same problem of the assessments being wildly variable, or is that situation so different in terms of who gets paid when and they're separate payers or whatever?

But I wondered whether -- if Medicare is compensating post-acute providers at a relatively -- at a much lower level than if they were commercial patients, you know, is this mis-assessments being done to try to make up

for that by getting the higher level?

So, anyway, the question is, do we know anything about whether this happens in the commercial market at all?

DR. CARTER: I don't know about that, but I will say that my guess is the commercial rates are actually lower than Medicare's rates in post-acute care.

DR. CROSSON: Okay. David.

DR. GRABOWSKI: Thanks for this work.

I wanted to ask you about one of the strategies you put forward, audits, and I feel like that's something groups like us call for a lot, especially in this area, and I feel like there's a lot of examples of calls to CMS to increase oversight that really haven't been met.

So I'm curious. Do you have ideas of how to actually put some teeth behind that? First of all, am I correct in that, that generally speaking, we don't see a lot of auditing here, whether it's the staffing data, whether it's the assessment data? And then on top of that, what can we do to put some teeth behind that?

MS. TABOR: I think there is no auditing going on right now for this patient assessment data. It is an attestation that it is valid.

We've spoken with providers as well as CMS contractors, and they do a lot of training and put out a lot of FAQs on kind of how to interpret these questions and how to report reliable information, but yet we're still finding these big differences.

So I think although it would require more resources for CMS to do this auditing, I think that they can do the types of analysis that we did to perhaps identify providers who need more help or just have misreporting that needs to be fixed.

So although it is something that we as a Commission say could occur more, I think this could be another opportunity for us to say we need to do more auditing.

DR. GRABOWSKI: And as you said, maybe this is a Round 2 comment, but actually put some money behind it and maybe mandate or have some triggers in there.

I did have a second question. We've been talking a lot, obviously, over the last couple of years and even longer than that on the unified PAC system, and I guess, Carol, maybe I should know this. But do we also call for a unified assessment instrument as part of that, or would you

still keep the OASIS and the MDS and the different assessment instruments? Would you need to sort of unify the assessment as well? Not just the items, but the actual instruments.

DR. CARTER: When we were first talking with the writers about the IMPACT Act, I think providers -- there was quite a bit of pushback for having a unified instrument, and I think people thought that if you just glue to the bottom of the individual tools that every industry was used to, that that would be sufficient.

So I think you'd have to balance out having uniformity across the entire instrument or whether -- where I think there might be continued pushback or whether you can live with having separate items, but with uniform items at the bottom.

I mean, things like diagnosis and theory should be uniformly collected, right, across the things, and I know that at least in the SNF space, I think they've moved from write-ins to checkboxes to try to narrow down kind of how much variation there is across sort of "What do we mean by hypertension?" But right now, those -- even the collection of what might be seemingly a slam-dunk, like a

diagnosis, each of the items collects those differently.

DR. CROSSON: Okay. We'll move to the discussion, and I'd like to suggest that we have two parts to that, which we'll run simultaneously.

If you'll throw up Slide 13. I think the middle bullet point there is -- we have a suggestion that Medicare should not use this information to adjust payments. What do people feel about that? Because that's going to -- depending on what people say here, it will take us in one direction or the other.

Related to that to some degree, but not completely, is the information on the next slide, which is irrespective of the use of the information -- and I would say, for example, either to improve the information for payment purposes, or if we decide that we don't think that's going to work because the incentives are too strong for manipulation, as pointed out in the presentation, but we do think that provider-reported assessments of functional status could play a legitimate role in other areas; for example, the assessment of quality.

Then what tools? Are these the right tools, or are other tools needed in order to even get that

information to have utility?

I'm sorry to make it complicated, but I think we'd like to try to get the answers in both those areas. And David is going to start out.

DR. GRABOWSKI: Great. Thanks.

Once again, I really enjoyed this chapter, and I think it's a really important piece of work.

I wanted to start with a little bit of history. Obviously, in the late 1990s, early aughts, we moved from cost-based post-acute care payment to prospective payment in each of the four sectors, and we spent a lot of time in this Commission talking about the need to unify the four PAC payment systems.

We didn't just decide to pay the four systems differently. We also chose to assess them differently, and that's obviously led to a lot of problems around payment and quality reporting. And it's only taken us 20 years. I don't know if that's faster or slow in health policy time, but we finally have some common items in place across the four assessment instruments. And that's obviously an exciting development.

The less exciting part of this or less good news

here is that the data are still self-reported, and as Ledia suggested, there's real issues with the integrity of these data.

I thought the chapter did a great job at just laying out the case for why we shouldn't trust these data, and I just wanted to pull out two examples because they were so compelling. I won't repeat what Carol and Ledia just worked through.

The first, this idea that I could move from an inpatient rehab facility to a home health agency a day or two days later and be assessed two days apart and have dramatically different levels of functioning is really worrisome.

The other example is even within an assessment as an inpatient rehab facility or a skilled nursing facility, there will be items for quality and items for payment, and they would indicate a different level of functioning, also incredibly troubling.

So, Jay, to answer your question very directly, I don't think these data are ready for payment purposes. I would not recommend that.

I do, however, think there are some steps, and

I'm really excited about some of the steps that Carol and Ledia have laid out here to help improve these data and move us down that path towards using them for different purposes.

In terms of auditing, I think that's a great idea. As I touched on in my first round of questioning, however, I feel like we make this recommendation a lot, and yet we don't often put anything behind it.

And so, first, I think we need to give the auditors resources. I think that's the first important part of this, and then, secondly, I do think there have to be kind of real penalties for poor quality data. I think that's really important here that there's some teeth behind this and some implications for having bad data.

So I am in favor of auditing, but I think we need to do that in a serious and meaningful way.

I think, Ledia, you did that part of the presentation. I think you said it very well that it's just really hard, given with the hospital discharge assessments, given the fact we just don't have them for almost half of the post-acute care episodes, it's just really hard to imagine using that hospital data as a way of assessing

functioning. So I don't think that's actually a viable way forward.

I'm not an expert on patient-reported outcomes. I know Dana and others around the table have quite a bit of background in this. However, I did want to make two points.

I'm intrigued by it, but with kind of two issues. The first -- and I think you raised this in the chapter, and you raise it specifically to LTCH patients about their high level of cognitive impairment. And, Ledia, you raised this during the presentation.

We've seen in our data a high level of cognitive impairment across the post-acute care spectrum. It wouldn't just be an issue for LTCH patients. It obviously would be an issue for inpatient rehab and skilled nursing and home health.

And then this idea of proxies also seems intriguing or interesting. I worry there, however, that there are individuals in our system that don't have proxies, especially those dually eligible beneficiaries, and they're disproportionately the individuals who have to go to institutional post-acute care. And so I just would

worry if we relied too heavily on proxies, whether we'd introduce some potential biases.

So I would like to sort of explore that option more, but I'm a little worried about some of the issues underlying the data.

But I think I'll stop there, Jay. Once again, I don't think these are ready for payment purposes, but I'm really excited about some of the checks that are outlined here.

Thanks.

DR. CROSSON: Thank you, David.

I do take the point -- and it occurred to me also when I read it -- about what you call teeth, which is, you know -- what would actually really make the providers pay attention to the accuracy of the information they're submitting for whatever purpose, and it just struck me that one of the things that I've seen in my past life and I think exists broadly in the financial world is attestation by the accountable individuals. I'm talking about CEOs, owners, boards, and this type, to the accuracy of their information, which can carry with it civil monetary penalties.

I'm just saying that depending on how seriously we take this -- and there's a lot of money at stake here for the program -- we might want to ratchet up something in that direction, requiring that sort of periodic attestation that in fact the data that's being submitted is accurate and that there is an individual or set of individuals responsible for that who can be held accountable for that information.

Okay. Further discussion? Karen.

DR. DeSALVO: I keep borrowing Jaewon's mic.

First of all, this is really incredible work, so thank you guys for the thoughtful methodology to clarify an issue, apparently a series of them.

I agree. I don't think this can be used for payment, but I had an out-of-the-box idea about a validation which is, Is this a place where maybe technology could be helpful to do short video clips of people doing the function and be required to store it in the way that you might store pathology or radiology images, or do that as a part of a random audit process?

DR. CROSSON: Interesting.

I wasn't quite sure. Amy.

MS. BRICKER: I was sitting here thinking about how we could use technology. I don't know how cumbersome that would be, but I like that or some sort of remote monitoring, something that you could then say take the subjectivity out of it. I like that general direction of if there is something there or others have thoughts on how we could maybe do that.

DR. CROSSON: Jon and then Dana.

DR. PERLIN: Let me add -- thanks for this -- on this point. I was thinking the same thing about the technology. I was also thinking how does this and how would this work in a commercial world.

You wouldn't play the post hoc game. You'd actually have someone check out, and I was thinking you would have case managers assess the patient. In fact, I think Karen has added the golden piece to that, is that you could actually do some of that remotely and just remove.

The part that troubles me is that we're very consistent about our use of risk adjustment in virtually every other domain. What we're really talking about is a risk adjustment here. So it seems unfortunate to forego that.

So I think the question we need to answer, getting to part two of Jay's outline, is how do you get to data that have the characteristics -- that are robust enough that they use it responsibly. And I think this thread of conversation is really the one that could help you get there.

Thanks.

DR. CROSSON: Dana and then Paul.

DR. SAFRAN: Yeah. So I was thinking down the same path about can technology help us. I love the idea, the metaphor of storing the video clip like radiology, because I was thinking video, but then that seemed cumbersome. But maybe it's not.

I was also thinking I know there's some technology sort of Fitbit-like that can sense somebody's gait and other things. So what we're talking about is how do we validate the information.

So I should have started by saying I totally agree. This isn't ready for payment, and so then how do we validate? Technology might help us. I also, like Jon, thought about could there be case manager, could that happen remotely, and could we take a page from our Medicare

encounter data quality conversation to say that there's some kind of penalty for data that aren't accurate and complete.

So those are just a few ideas that were floating around my mind.

DR. DeSALVO: I just have a follow-up. I think it's a follow-up to this, which is maybe also to try to take out some of the operator error, in this case, manager model, to see that the same person does the assessments at each of the points. Even if they don't work in that particular organization, they're assigned as a case manager, and they transcend the settings, and they are accountable for making sure that the person is improving or not.

DR. CROSSON: Interesting. Okay. Some good avenues here to think about that have come forward.

Warner.

MR. THOMAS: I like some of the ideas around video.

Another thing to think about is whatever the assessment is done on the person continues with the person, so that there isn't an assessment done in IRF and then an

assessment done in skilled. There's an assessment done that stays with the patient. That way, the entities have to agree on the assessment if there's a transition, either from acute care to post-acute or from a post-acute setting to a different post-acute setting, that there is a consistent assessment that everybody agrees on, because then I think you get out of this information that it just is -- it's kind of hard to sit there and understand how it can be that different, and I would agree it doesn't make sense to tie payment to this.

But that would just be an idea to just have it follow the patient, regardless of which setting that they sit in.

DR. CROSSON: Paul.

DR. PAUL GINSBURG: Yes. I really like the way the discussion is going. I think the emphasis needs to be on the checking of bad data and penalties for it, but rather than, as David pointed out, just saying audit, we need to spend some time of ways to actually do this.

I think what Warner suggested of the comparison of the assessments for the same patients, it would be very much -- have great incentive effects as well as auditing

benefits. So I'd really like to invest more and figuring out ways to identify and penalize bad data.

DR. CROSSON: Okay. Excellent discussion, a lot of innovative thinking here, particularly this late in the afternoon. I'm pretty damn impressed.

[Laughter.]

DR. CROSSON: Ledia, Carol, thank you very much. We'll see you again on this topic, I'm sure.

And we'll move on to our final presentation of the day.

[Pause.]

DR. CROSSON: Okay. Dan is here. Just to remind the Commissioners and for the benefit of our guests, at the previous meeting in March, we had a discussion about Medicare spending for emergency department services, and part of the discussion focused on the question of whether or not there ought to be national guidelines for coding emergency department visits. And it was the sense of the Commission at the time that there was a strong enough consensus that we should, in fact, move at this meeting to a recommendation and a vote.

Having said that and having had a thorough

discussion in December, we have elected to take this issue, similar to issues that we have taken before where we have consensus at a prior meeting we need to come to a voting recommendation, we'll have a rather circumscribed presentation.

Then I will take questions in the context of our -- somewhere between Round 1 and Round 2, questions or comments on changes that have occurred or have not occurred in the material between the March and April meeting, and then we'll proceed to a vote. Dan?

DR. ZABINSKI: Thank you. Okay. Today we'll have our final presentation for options for slowing the growth of Medicare fee-for-service spending on emergency department services. At the March meeting, we had a thorough presentation of non-urgent care in emergency departments and hospital ED coding practices. At the end of that presentation, the Commission saw a draft recommendation about ED coding around which there was general agreement.

Today we'll have only a brief discussion of hospital ED coding practices, and the Commission will consider the recommendation.

So when a Medicare beneficiary receives care in a hospital emergency department, the hospital codes the visit into one of five levels, and each code reflects a different level of expected resource use needed to treat the patient.

In 2005, the coding of these ED visits across these five levels approximated a normal distribution, as illustrated in this diagram. CMS found this a reassuring result because it indicated that hospitals were billing the full range of visit codes in an appropriate manner.

The Commission expressed interest in the coding of ED visits because it has steadily shifted to higher levels. Since 2005, the shift has resulted in the distribution of ED visits being far from a normal distribution now in 2017. For example, the share of ED visits coded as Level 5 increased from 11 percent in 2005 to 30 percent in 2017.

In your paper and at the March meeting, we had a full discussion about the coding of ED visits that had shifted to higher levels, and this slide is a summary of that work.

Now, some have argued that the coding of ED visits has changed because patients are sicker, lower-

acuity patients have shifted from the ED to urgent care centers, and the care that is provided to ED patients has become more intensive and has produced better outcomes.

Alternatively, others have countered these arguments, saying that because hospitals use their own internal guidelines for coding ED visits, some hospitals have taken advantage of this lack of strict rules.

Our data analysis shows that: the conditions that are treated in EDs has changed very little over time; the increased use of urgent care centers has had very little effect on the coding of ED visits; and despite no change in the conditions treated, the number of services provided during ED visits has increased, especially EKGs and CT scans.

So because we now have a high share of ED visits coded at Level 5 with no change in the patient conditions, it's likely that Medicare payments are too high for many ED patients.

So to improve the coding of ED visits, CMS could replace the internal guidelines that hospitals currently use with national guidelines. Potential benefits of national guidelines include that payments would accurately

reflect hospital resources used to provide ED care, hospitals would have a clear set of rules for coding ED visits, and CMS would have a firm foundation for assessing and auditing hospitals' coding practices.

So we have this draft recommendation that the Secretary should develop and implement a set of national guidelines for coding hospital emergency department visits under the outpatient prospective payment system by 2022.

Implications for this recommendation are that there would be no effect on spending because it would be implemented budget-neutral; for providers, the recommendation would improve equity because all providers would have the same rules for coding ED visits. Also, there would be reduced opportunities for hospitals to upcode ED visits; and, finally, payments for ED visits would more accurately and consistently reflect provider costs. And for beneficiaries, we anticipate no effect on their access to ED services.

That completes the presentation, and I turn it back to Jay.

DR. CROSSON: Thank you, Dan.

So as I mentioned, we'll take questions or

comments on the changes to the reading material between the March version and the April version. Marge.

MS. MARJORIE GINSBURG: I'm a little concerned that the draft recommendation language might not be strong enough and wondered whether we ought to consider changing the word "guidelines" to "standards." "Guidelines" is really -- there's a lot of wiggle room in a guideline.

DR. CROSSON: Interesting. Dan, can you remind me what language we used in March? What is "guidelines" or "standards"?

DR. ZABINSKI: Yeah, we used "guidelines," and the reason you say "guidelines," it's sort of the term that is just used for these -- well, guidelines. I don't know. That's just, you know, how they're described and defined. Personally, I have nothing against "standards," but --

DR. CROSSON: Well, I mean, we're really sort of talking a term of art thing here. So is what you're saying that in comparable areas from CMS the term "guideline" is the term of art, generally speaking, or not?

DR. ZABINSKI: Yes. Perhaps let me give you an example. You know, the American College of Emergency Physicians has a set of guidelines for ED visits that were

offered up quite a few years ago for, you know, national guidelines for ED visits, and the general idea of those guidelines is that they sort of -- ACEP ranks all the interventions that can possibly occur during an ED visit, and they base the -- under those guidelines, they base the level on whatever is the highest-level intervention that's provided during the visit. And they call those "guidelines." If that, you know, meets the level of "standard," I'm not sure. But that's sort of the way they -- I think the end result would look something like that for a national set of guidelines.

DR. CROSSON: Okay. Jon.

DR. PERLIN: Just first to respond to Marge's point, the terminology may be less relevant than the consequence. The consequence is that if there are guidelines or standards, whatever they're called, and hospitals or providers were to go outside of that, then the penalty would be very severe, as, you know, occurs when any misrepresentation of coding would occur.

I think the problem that, you know, I understand this Commission is trying to resolve is that for whatever reasons, the current state of the art is that there are no

standard standards. There are at least three standards to choose from and probably variable implementation of those standards. And, you know, we had, moving to the second point, pretty robust discussion in past sessions that, you know, hospitals in particular, to avoid concerns about being, you know, subject to penalties for inappropriate recording of services rendered, you know, adopt either AHA or ENA or ACEP and, you know, test themselves against them. The problem is that's not a standard standard. It's like that old saw on informatics: "Aren't standards wonderful? There are so many to choose from."

If there are that many to choose from, it's obviously not a standard, and so whatever it's called, this would resolve that.

I want to move to a couple points because I think, you know, the Commission has provided pretty clear direction in this area.

First, in the reading materials, I want to thank you for incorporating some of the discussion. I think there may have been a couple things that were inadvertently left out, you know, for example, the prevalence of CTs on urinary tract infections. It's actually pretty

understandable when a Medicare beneficiary presents with altered mental status, you know, you rule out the neurologic and you work your way to a diagnosis, and UTI in an older patient is a pretty frequent occurrence.

Second, I think our conversation before also included a discussion that the EHR, many of its attributes -- it has many attributes, but one is a full recording of all of the conditions that a patient may present with, and that may itself change, you know, some of the way in which a visit is recorded and ultimately coded.

Finally, this is a big deal. We note that, according to Harlan Krumholz's group, in 2017, 22 percent, roughly -- a little over 22 percent of Medicare beneficiaries went to an emergency department. So assuming that a quarter of the population goes to the emergency department every year, that's a lot of emergency department visits. I've forgotten the exact number. It's over 30 million. In fact, probably much higher than that. But the assumption that we can come out with a guideline or set of standards that works perfectly the first time out of the gate I think is dangerous. And while we've had discussion of making sure that we don't needlessly delay, I would

recommend that, you know, CMS do a PIT test of the model used because the goal of this model ultimately is -- I understand the exercise is to really be able to distribute the levels of acuity from lowest acuity to highest acuity, with some sort of distribution amongst the different -- you know, obviously it would be a failure if it re-created exactly what we have now.

So those are my recommendations on that. With those recommendations, I can support the overall bold-faced recommendation.

DR. CROSSON: Thank you, Jon.

Other comments?

[No response.]

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

[Show of hands.]

DR. CROSSON: All opposed?

[No response.]

DR. CROSSON: Abstentions?

[No response.]

DR. CROSSON: Seeing none, the recommendation

passes unanimously.

That brings us to the end of our agenda for today. We now have time for a public comment session. If there are any of our guests here who would wish to make a comment to the Commission, please come forward to the microphone.

[No response.]

DR. CROSSON: Seeing none, we are adjourned until 8:30 tomorrow morning. Thank you very much.

[Whereupon, at 4:06 p.m., the meeting was recessed, to reconvene at 8:30 a.m. on Friday, April 12, 2019.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, April 5, 2019
8:31 a.m.

COMMISSIONERS PRESENT:

FRANCIS J. CROSSON, MD, Chair
JON B. CHRISTIANSON, PhD, Vice Chair
AMY BRICKER, RPh
KATHY BUTO, MPA
BRIAN DeBUSK, PhD
KAREN DeSALVO, MD, MPH, Msc
MARJORIE GINSBURG, BSN, MPH
PAUL GINSBURG, PhD
DAVID GRABOWSKI, PhD
JONATHAN JAFFERY, MD, MS, MMM
JONATHAN PERLIN, MD, PhD, MSHA
BRUCE PYENSON, FSA, MAAA
JAEWON RYU, MD, JD
DANA GELB SAFRAN, ScD
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AGENDA PAGE

P R O C E E D I N G S

[8:31 a.m.]

DR. CROSSON: Okay. Maybe we can start the meeting. I'd like to welcome our guests. This is the final meeting of the Commission for the 2018-2019 cycle. As a consequence, we have almost every year some Commissioners whose terms have expired, and what I'd like to do right now is to take a moment to have those two Commissioners stand up so they can be recognized. Jon Christianson, the Vice Chairman of MedPAC, and Amy Bricker, please stand up and be recognized.

[Applause.]

DR. CROSSON: Thanks to both of you for fabulous service to this Commission, to the Medicare program, and the beneficiaries. Your work is appreciated and will last for a long time.

This morning we are going to take up once again our efforts to try to overcome the increasing cost of pharmaceuticals, particularly in this case in Medicare Part D. Rachel and Shinobu are here, and you have the floor.

DR. SCHMIDT: Good morning. In response to the Commission's continued strong interest in addressing drug

pricing, we're introducing two new ideas for you to consider in Part D. One is relatively narrow in scope, aimed at limiting cost sharing on specialty tiers. And the second is a much broader structural change to the benefit that builds on the Commission's 2016 recommendations.

In this presentation, we'll give you background about spending for specialty-tier drugs in Part D and describe beneficiary cost sharing for those medicines. Then Shinobu and I will introduce two distinct approaches that try to address the affordability of specialty drugs. We're looking for your feedback on whether to pursue these ideas further, and we plan to put this material into a chapter in the June report to the Congress.

Specialty drugs are used for conditions such as cancer, hepatitis C, HIV, rheumatoid arthritis, and multiple sclerosis. Some of them are self-injectable biologics, but the term "specialty drug" also includes oral and inhalable drugs. Patients who take specialty drugs often require closer clinical management, and the drugs tend to have much higher prices.

For Part D, CMS allows plans to put drugs on a specialty tier of their formulary if the drug's average

price at the pharmacy is $670 per month or more. Since Part D began, spending for drugs on specialty tiers has grown from about $3 billion in 2007 to $37 billion in 2017. That is shown by the blue bars. The red line shows that in 2017, specialty tier drugs made up about a quarter of Part D gross spending. However, according to the Congressional Budget Office, spending for specialty drugs makes up an even higher share on a net-of-rebate basis. On the right, you can see examples of specialty tier drugs with the largest Part D spending in 2017. Average prices at the pharmacy for these drugs range between about $1,500 to $31,000 per claim.

Now let's consider cost sharing for specialty tier drugs. Here we'll use the example of a beneficiary who does not receive Medicare's low-income subsidy. She uses a tumor necrosis factor inhibitor to treat rheumatoid arthritis, and the full price of her drug at the pharmacy before rebates runs about $5,400 for a 30-day supply.

Her cost sharing is front-loaded in the year because plans can charge 25 percent to 33 percent coinsurance initially for each specialty tier prescription and then 25 percent for brand-name drugs in the coverage

gap. Once this patient hits the catastrophic phase, she pays 5 percent for each prescription on an open-ended basis. The price of her drug is high enough that she reaches the catastrophic phase early in the year. So even though her out-of-pocket costs seems like a lot, over the full year she pays an average coinsurance rate of about 7 percent.

For some but not all specialty tier drugs, plan sponsors negotiate rebates from manufacturers. However, beneficiaries pay coinsurance on the undiscounted price. So early in the year when this patient pays 25 to 33 percent coinsurance, she's effectively paying a higher percentage of the net-of-rebate basis.

How does cost sharing affect patients' use of specialty drugs? Out-of-pocket costs matter, but other factors also affect the decision to use medicines. Some specialty drugs treat conditions that are life-threatening or progressively disabling, and filling those prescriptions may be a very different decision from ones for other diseases. There's not a deep literature on cost-related nonadherence for specialty drugs, especially in the Medicare population. But, still, some literature suggests

an association between higher out-of-pocket spending and greater likelihood of a patient not initiating therapy or abandoning a prescription at the pharmacy.

There are multiple goals that we try to achieve for the Part D program. As use of specialty tier drugs has grown, one policy goal that's become more apparent is to provide coverage that reduces some of the financial barriers to filling appropriate prescriptions. However, within the context of Part D, we would like to do this in a way that still provides strong incentives for plan sponsors to manage their enrollees' spending. And since Part D relies on private plans to negotiate drug prices, if we take steps to make specialty drugs more affordable to beneficiaries, we want to do that in a way that leaves tension on drug manufacturers with respect to their pricing decisions. If manufacturers choose to raise prices, that should have implications for plans' formulary decisions. Finally, we want to retain or strengthen Part D's original approach of a competitive system that keeps downward pressure on enrollee premiums and Medicare program spending.

One approach that certain employers and states

have taken is to limit the maximum amount a plan may charge in cost sharing for each prescription. For example, if policymakers set a $200 per prescription maximum in Part D, the beneficiary would pay the greater of 25 to 33 percent cost sharing or $200 for a 30-day supply. The out-of-pocket limit could be indexed over time and adjusted for the number of days' supply.

In 2017, about 400,000 Part D enrollees would have had lower cost sharing under such a policy, and on average the amount of cost sharing they paid would have been about two-thirds lower. If this more generous coverage had been financed through higher premiums paid by all Part D enrollees, premiums and Medicare program spending would have increased. Alternatively, plan sponsors could be required to adjust their cost sharing to pay for the new benefit -- through higher deductibles, copayments, and coinsurance on non-specialty tiers.

In your mailing materials, we give you a sense of the magnitude of such a policy's effect in 2017, but we also note that it is not a formal cost estimate. To build a cost estimate, CBO or others would need to think through the likely behavioral effects of the policy. Also, the

drug development pipeline is full of new specialty treatments, so more enrollees will likely take specialty drugs in the future. Also, here we have not applied the per prescription limit to LIS enrollees, but that may also be a policy option.

There are advantages and disadvantages to using a per prescription cap. The policy would provide more generous coverage to beneficiaries who take specialty drugs and pay cost-sharing amounts that can be burdensome on a limited income, especially when lower-cost therapies are less effective for their condition. A per prescription cap would even out their cost sharing over the year, which may affect their decisions about initiating therapy and not abandoning prescriptions at the pharmacy.

While capped cost sharing may encourage more use of appropriate treatments, it may also encourage greater use of drugs that are not as appropriate or effective. When there are competing therapies available, a dollar limit on cost sharing may make it more difficult for plan sponsors to encourage beneficiaries to use a preferred drug and negotiate for rebates. All enrollees in Part D would pay either higher premiums or higher cost sharing for non-

specialty drugs to finance the more generous benefit, and taxpayers would face higher Medicare program spending. And with capped patient cost sharing, manufacturers may find it easier to increase prices or launch high because prices and price growth would be less obvious to beneficiaries.

The first option focuses narrowly on cost sharing for each prescription. However, in a minute Shinobu will describe a broader approach that restructures the benefit and includes an annual limit on out-of-pocket spending. Both of these ideas help with the affordability of specialty tier drugs, but we think of the two approaches as distinct because the per prescription limit doesn't address some fundamental issues about the structure of Part D that may be contributing to high launch prices and growth in drug prices.

Today plan sponsors negotiate for rebates from manufacturers in certain drug classes that have competing therapies. The fact that Part D plans attract enrollees through premium competition has meant that plan sponsors have generally used rebates to help keep their premiums low.

Over time, there have been changes in law that

have resulted in two different benefit structures -- one for low-income subsidy enrollees and another for those without the low-income subsidy. The coverage gap was only phased out for non-LIS enrollees, so the underlying benefit for LIS enrollees still has a coverage gap like the one that existed at the start of Part D. Brand manufacturers do not pay any discount for LIS enrollees, and plans are not liable for any benefit spending in the coverage gap. Instead, Medicare's low-income cost-sharing subsidy pays for most everything in an LIS enrollee's coverage gap except for their nominal copayments. In contrast, a non-LIS enrollee has the manufacturers' discount in their coverage gap.

If you look at both of these two benefit structures, there are large portions -- the coverage gap and the catastrophic phase -- where plans have low liability for their enrollees' spending. Other sources of financing cover the spending: brand discounts, LIS cost-sharing subsidies, and reinsurance in the catastrophic phase. Meanwhile, plans negotiate for rebates on prescriptions filled across all of those phases, even when the plan's liability is low.

We think that leads to misaligned incentives. In some cases, plan sponsors may make decisions about which drugs to put on their formularies that emphasize high-rebate drugs. And certain rebates, combined with Medicare's reinsurance in the catastrophic phase, may mean that plan sponsors do not confront manufacturers' launch prices and price increases as much as they would otherwise.

MS. SUZUKI: One unique feature of Part D is the brand discounts paid by manufacturers that Rachel just talked about. The discount rate is 70 percent today, and that sounds like a substantial discount. But because the discount only applies to a limited range of spending in the coverage gap, below the out-of-pocket threshold, it mostly affects non-specialty tier drugs rather than specialty tier drugs with higher prices.

For example, in 2017, the coverage gap discount totaled about $5.8 billion. Over half of that amount was for drugs in three classes: diabetic therapy, asthma/COPD therapy, and anticoagulants. Most commonly used drugs in these classes had prices that ranged from about $480 to $580 per claim.

Drug classes that are typically placed on

specialty tiers -- like antivirals, cancer drugs, and therapies for inflammatory conditions -- each accounted for 3 percent or less.

The second policy option would restructure the Part D's benefit to achieve the goals Rachel outlined earlier, including providing better formulary and pricing incentives. This approach would retain parts of the Commission's 2016 recommendations, but there are also differences.

One notable difference is that under this option, the coverage gap discount would be eliminated and replaced with a cap discount that manufacturers would pay in the catastrophic phase of the benefit.

There would also be a new catastrophic benefit, which, as Rachel described earlier, is where most of the costs of high-priced products occur. This option is similar to the recent idea proposed by the American Action Forum to change the Part D benefit, and I'll come back to the details of the benefit structure under this option shortly.

But the idea is that, under this policy option, there would be: stronger incentives to use generics, an

increase in the affordability of high-priced products for enrollees and Medicare; stronger incentives for plans to manage high spending; and it may also provide disincentives for manufacturers to set high launch prices or increase prices as rapidly as they have in recent years.

Rachel also talked about how there is now a different benefit structure for LIS and non-LIS beneficiaries. And because plans have no benefit liability for LIS enrollees during the coverage gap phase, they may face worse incentives for LIS enrollees.

To simplify and remedy this misaligned incentive, this option could also equalize the LIS and non-LIS benefits.

Under the policy, risk corridors would remain, and it would continue to protect plans from large losses, at least initially.

The figure on the left shows the 2020 benefit structure under current law, with the coverage gap discount in black. The restructured benefit under the policy is shown on the right.

Note that under the policy, plan liability would fill in for what used to be paid by manufacturers in

coverage gap discounts. Under the policy, beneficiaries would -- the benefit would cover a consistent 75 percent between the deductible and the out-of-pocket threshold, and it would be the same for brand-name and generic drugs.

Above the out-of-pocket threshold, shown as the cross-hatched piece, is where policymakers would need to decide how to finance the new catastrophic benefit.

Currently, enrollees pay 5 percent cost sharing. Under the new benefit, policymakers could use a lower coinsurance rate, select a dollar co-payment amount, or eliminate cost sharing altogether as in our standing recommendation from 2016.

Medicare's reinsurance would be reduced. It could be 20 percent as in our standing recommendation or a percent that's lower, or it could be eliminated. Any reduction would be offset by an increase in the direct subsidy so that the overall subsidy rate would remain at 74.5 percent.

The reduction in enrollee and Medicare's reinsurance shares would be offset by some combination of higher plan liability and the new cap discount. These are the two key parameters, which I'll turn to next.

Striking the right balance between plan and manufacturer liability will be crucial in providing better plan incentives while restraining high price growth.

The figure shows the range of options. At the extremes are where plans or manufacturers pay for all of the costs in the catastrophic phase of the benefit, other than the amounts paid by Medicare's reinsurance or enrollee cost sharing.

As you move from the center to the left, you have plan liability taking on a greater share. Less paid by manufacturers means higher benefit costs and higher enrollee premiums.

But because plans are taking on more insurance risk, that provides them with stronger incentives to manage spending.

Plans may also negotiate harder for larger rebates, but this only works for therapies in competitive classes. Plans would have limited ability to negotiate rebates for unique therapies.

As you move to the right, manufacturers will pay an increasing share in cap discount. More paid by manufacturers means lower benefit costs and lower enrollee

premiums. But lower plan liability would also mean weaker plan incentives to manage spending.

At the same time, there would be a guaranteed discount, which would be valuable particularly for therapies in classes with few or no competitors. Given that the amount of discount increases proportionately with prices of drugs that fall into the catastrophic phase of the benefit, it may slow price growth. But that would likely vary across manufacturers and likely also depend on Medicare's market share of a given product.

The new cap discount would increase the incidence of discounts on high-priced drugs and biologics.

This pie chart shows the cap discount simulated using the 2017 claims data. And as you can see, the incidence of the discount is very different from the distribution that you saw with the coverage gap discount.

The cap discounts are more likely to apply to high-priced drugs typically placed on specialty tiers and less on more traditional drugs like diabetic therapy.

Many drugs that would be subject to the cap discount would have price per claim in the thousands of dollars to over $30,000.

Four classes -- antineoplastics, antivirals, anti-inflammatories, and therapies to treat multiple sclerosis -- would account for more than 50 percent of the discounts, up from about 12 percent under the coverage gap discount.

Note that the incidence across therapies would be different if prescriptions filled by LIS enrollees are not included in the cap discount program.

There is another key benefit parameter that policymakers would likely need to consider, and that is where to set the out-of-pocket threshold.

As we discussed in your mailing material, eliminating the coverage gap discount would result in some individuals paying more to reach the out-of-pocket threshold.

Policymakers could lower the out-of-pocket threshold, but there are tradeoffs. An obvious benefit is that it would reduce the cost for those enrollees affected by the policy. It may also lower benefit and premium costs, and this is somewhat counterintuitive, but it happens when the benefit liability above the out-of-pocket threshold is lower than 75 percent. That means as you

lower the out-of-pocket, that expands the benefit phase with lower benefit liability. But this assumes no behavioral change.

Certain behaviors could push up benefit and premium cost, and these are the potential disadvantages.

Because enrollees would pay lower or no cost sharing once they reach the out-of-pocket threshold, a lower threshold could lead to an increase in use of both clinically appropriate and inappropriate therapies.

The policy may also weaken plans' incentives to manage high spending if their liability above the out-of-pocket threshold is set too low.

So this slide summarizes at a very high level the two policy options measure in achieving the program goals laid out earlier.

Relative to the current benefit structure, both policies would reduce financial barriers to use clinically appropriate medications that are placed on specialty tiers.

But other goals, like addressing plans' incentives to manage spending, manufacturers’ pricing decisions, and keeping downward pressure on program costs and enrollee premiums, would only be addressed by the

option that restructured the benefit.

Another key difference relates to implementation. We think that the per-prescription cap could be implemented in a relatively short time frame, while restructuring the benefit would be more complex, and would likely take years.

So we have introduced two new policy ideas today to get your feedback and see if you would like to pursue these ideas in the next cycle. We are also looking for suggestions and guidance on any information that you think would be helpful in thinking about these policy options.

DR. CROSSON: Thank you, Rachel and Shinobu. I just want to compliment you on this work and particularly in the chapter. I thought it was quite brilliant really, and it also required me to read it three times because this area we are talking about right now is extremely important and also very complex. Solutions by their nature, it would seem, are going to be complex as well. I think this breakthrough thinking takes us into a whole new area, and I appreciate that.

So we'll start with clarifying questions. Jonathan.

DR. JAFFERY: Thanks, Jay, and I agree. This was

an incredible chapter, and I'm glad to hear I wasn't the only one who had to read it multiple times.

I have two questions. Can you speak little bit, explain a little bit more about how the risk corridors would work to help protect the plans?

The other question is, Is there something about or could you speak to the drugs that are in protected classes and if things change there, how that may or may not impact what you presented?

MS. SUZUKI: So under the policy, a lot more of the spending is going to be paid under the direct subsidy payments, which are the capitated payment, and that's the amount that's in the risk corridor. So bigger amounts, bigger share of the benefit spending would be inside the risk corridor. So they would get protection for those spending.

The protected classes, some of them are on specialty tiers, like the cancer treatments. Those are typically on specialty tiers. They would now, under the policy, incur cap discount if you go with the second option.

Under the first option, beneficiaries would get

protection on cost sharing.

DR. SCHMIDT: And just as context, some of those oncology drugs are orals that have gone generic, but the newer ones are not, obviously. If they don't have competitors, generally there aren't rebates associated with them. There's been a little bit of published work kind of suggesting that the magnitude of rebates associated with protected class drugs in general -- the number of drugs that have rebates is small within the protected classes, and the rebates are much lower than other classes.

DR. CROSSON: Questions? Bruce.

DR. PYENSON: Yeah. I give my compliments as well. This was a wonderful chapter, and I really enjoyed how you created -- presented the options.

I have a question about Slide 11. In particular, when I first read this, I was scratching my head saying, "What's that shaded region on the right?" and then realized that's kind of the discussion for the next year on what goes in there.

A question I have is the American Action Network proposal is for a coinsurance approach, similar to what exists now in catastrophic, where there is a flat

coinsurance. One piece is plan; another piece, government; another piece, the patient.

Have you thought about a graded scale in that so that the higher the price of the drug, the higher the manufacturer contribution or a system where somehow there's a stop-loss on the total patient spending that a manufacturer might be responsible for? It could all be the same dollars, but sort of moving it around in different ways. I don't know if that's on the table for the next year or things you've thought about.

MS. SUZUKI: I think those are things that you could certainly think about.

In the example we presented today, we have taken the approach of setting some cost-sharing approach, I guess you mentioned. So it would be a fixed percent, but the idea was that as you -- the higher the price of the drug at the pharmacy, the larger the discount you would be liable for. And it was a simpler approach than maybe what you were contemplating, but I think various options could be considered.

DR. CROSSON: Brian, Kathy, Amy. Okay, Brian.

DR. DeBUSK: First of all, thank you. The work

was incredible, insightful, and I really appreciate and like the direction you're going. So the questions I'm about to ask are in no way a criticism of the work. It's genuine interest.

I too had some questions on Chart 11. Thank you for the cross-hatched area. That threw me too when I was looking at it because I wasn't sure where that money was going to come from.

If I read the color version of that chart correctly, though, I mean, we're basically exiting -- the government and Medicare is exiting the reinsurance business, or would there be a residual portion in that cross-hatched area that would be provided, would be Medicare money?

DR. SCHMIDT: I think we intended this as a policy decision for you to discuss.

DR. DeBUSK: Oh. Well played.

[Laughter.]

DR. DeBUSK: That was in the cross-hatch. I was looking. I was trying to figure out where the white, what was whiter. Well, I can see where this is headed, then.

[Laughter.]

DR. DeBUSK: I would be interested in understanding that. What portion would Medicare need to remain in to not have some adverse effect on premiums?

But the other thing, since this is related to that question, we all agree this 5 percent beneficiary exposure in the catastrophic phase is too much. Is zero too little? I mean, are there some unintended consequences or some behavioral shifts that we could inadvertently trigger if we truly remove the beneficiary from any exposure?

DR. SCHMIDT: You see different points of view strongly held on this very question, right? On the one hand, you'll hear beneficiary advocates in particular argue that by the time somebody has reached the catastrophic phase of a benefit, they're in a treatment pattern. They've paid a lot of money out of pocket, and anything more would just be a penalty on those particular people for unfortunately having this particular disease.

On the other hand, you hear others say that if you relieve them of any cost sharing whatsoever, it makes it relatively easier for manufacturers to raise prices because it's not so obvious when those price increases

occur.

I'm not going to state my personal opinion. I'm not sure that I have a strong one, but those are what you hear out there.

DR. DeBUSK: So future iterations of the work would address that.

The other question, knowing -- well, not knowing, but speculating that the government will have some component of reinsurance, even if it's 5 or 10 or 20 percent, that brings up the issue of DIR. Can you speak to how the current misallocation of DIR could potentially spill over into this program as well?

MS. SUZUKI: So I think under the restructured benefit, if plans were liable for a consistent share through the out-of-pocket threshold and some proportion that's greater than their current 15 percent, I would think the weighting based on what CMS is currently doing is on gross spending. But that would be proportionately more accurate reflection of their benefit liability compared to current.

DR. DeBUSK: So the DIR bug would correct itself?

MS. SUZUKI: Between Medicare and plan sponsors,

the ratio would be better because right now what's happening is in the coverage gap, there is very little benefit liability for plans, but there are rebates to -- for some drugs, there are rebates, and you're using gross spending above and below to allocate the dollar amounts to plans and Medicare. And that leads to a larger share of spending offset by DIR on the plan liability side rather than the reinsurance side.

DR. DeBUSK: So you think that would be somewhat self-correcting.

That last question is a "what if," but then I promise I'm done.

Assuming the government retains some portion of that reinsurance and assuming that we still have this DIR issue to content with, is there some theoretical rebate level -- 70 percent, 80 percent, 90 percent -- where they could still beat the system by simply driving up the rebate so high, counting on even a modest misallocation of DIR and basically undoing what we're trying to do here today?

DR. SCHMIDT: I think you're giving us a math problem as homework.

[Laughter.]

DR. SCHMIDT: I don't think that I can quite answer that on the fly.

DR. CROSSON: Bruce, do you want to comment on that question?

DR. PYENSON: Yeah. I think the devil is in the detail there, but as I understand the plan, it would maintain the federal share of total program cost. And that's the share that gets used to split the IR between the federal government and the plan. So that ratio now is about a third government, two-thirds plan.

So if you have 100 percent rebate -- you can't get higher -- well, I guess you could get higher than that, but say 100 percent on the list price. The plan share of that would be roughly two-thirds, 67 percent. If the plan's liability is 70 percent or 75 percent, the plan liability exceeds the retained rebate, and I think that's the key to solving that.

DR. DeBUSK: That's the hole we have to close.

DR. PYENSON: Yeah. That's why flipping the 15-85 to 80-20 or something would close that.

DR. DeBUSK: So what you're saying is there is a theoretical ratio that we could achieve that you couldn't

defeat the system with a rebate?

DR. PYENSON: Correct.

DR. DeBUSK: Thanks.

DR. PYENSON: Now, you could actually design a Part D plan, for example, that had no generics, it only had drugs that had rebates, and under the current world, that would be very profitable for the Part D plan. I think under this proposal, it wouldn't be.

DR. CROSSON: Okay. Let me see if I've got this. I got Kathy, Amy, Warner, and Pat. Have I got that right? On this point, Amy.

MS. BRICKER: Yeah.

DR. CROSSON: Yeah.

DR. SCHMIDT: That's not actually possible. There's not a formulary that you could create that today would just generate rebates. I just want to be clear.

And we're talking about specialty, and with respect to specialty as a percentage of drugs, very few actually offer rebates. So I just want to caution. There's a lot of misconception I think generally in this space around what's available in the market.

DR. CROSSON: Okay. Kathy.

MS. BUTO: Yeah. I had two questions. One was I recall from the reading materials that about half of -- at least the way the proposal was laid out -- beneficiaries who now reach the out-of-pocket threshold would not under the restructured proposal, so that's question one. I'm sure we could set the threshold in different places, and that would obviously affect.

The second question was about whether the cap discount approach would actually stimulate higher launch prices. I'm assuming it would. Obviously, there are tools, including cost sharing and greater beneficiary liability, that would work against that, but I'd be curious to find out from you what you've done to look at that, both of those issues.

MS. SUZUKI: So on the latter question about manufacturer launch prices, I think it's definitely possible that some manufacturers, knowing that they're liable for a fixed share of their cost -- or their price as a discount, that may affect their pricing decisions. But what we think is that may depend on their market power, market share in the Medicare market. They do have commercial to deal with. So we think it probably would

vary by manufacturer and by product.

And another thing, maybe for some very high-priced product, there may be PR issues to consider. If they raise a price to completely offset or more than offset the discount, that may get noticed.

MS. BUTO: What about the number of beneficiaries who don't reach the cap? Your assumptions about that?

DR. SCHMIDT: I'm not recalling exactly, but I think the answer that you proposed to adjust the out-of-pocket threshold would deal with the numbers involved. I mean, there is actually an increase, a bump up in the current-law out-of-pocket threshold, so you may want to consider that, anyway.

DR. CROSSON: Okay. Amy.

Dana, on this point or what?

DR. SAFRAN: In the queue.

DR. CROSSON: Okay. Amy, you're up.

MS. BRICKER: This chapter was really amazing work, and I just want to commend you both for putting it together in a way that I think is consumable, even though it is quite complex.

Just some clarifying questions, if I could. Page

13, you referenced that rebates grew 19 percent. Specifically in specialty, or was that just a general number based on --

DR. SCHMIDT: That was a general number of all DIR.

MS. BRICKER: Okay. So I think that's important because, again, to the point I was making just briefly a moment ago, while in pockets, you see tremendous value coming from manufacturers on branded product, in specialty that's not really the case. So I just want to provide that context.

Is there a clear line, a bright line, because drugs that are used more predominantly in the list population versus non? There was some reference. Do you have additional context on that?

MS. SUZUKI: So we had this in the March chapter. There was more use of antidepressant, antipsychotics, that sort of drug, by LIS population compared to non-LIS population, more diabetic therapies among LIS population.

For non-LIS population, we saw a lot of multiple sclerosis, inflammatory conditions in cancer drugs.

MS. BRICKER: So more specialty product

utilization by non-LIS?

MS. SUZUKI: Right.

MS. BRICKER: So that might get to the point, Brian, you were making. Is zero too low? In the LIS population, it is zero, right? And we are not seeing a disproportionate amount of people over-utilizing. If the theory is zero is going to result in over-utilization, you might need to maybe think more about why is that. Is it demographic? What other contributing factors result in the fact that we're seeing more specialty utilization, that those actually have a cost-sharing amount? I think that's interesting.

Foundation. So we know in the Medicare population, copay coupons are not permitted. Have we been able to get at any data on foundation dollars or charitable giving that's applied to this Medicare population? Because we do know that those dollars are in play.

DR. SCHMIDT: I haven't seen data along those lines other than some of the court cases that have been raised most recently against some of the foundations.

MS. BRICKER: Okay. I'll save that one, another comment on that, for Round 2.

And just one other. The cap, the $200 cap that's proposed, did we think about -- you raised the issue it could hamper the ability for a plan sponsor to manage the formulary, you know, preferred agents, non. So did we contemplate a non-preferred, out-of-pocket structure, maybe where the $200 is applicable to preferred agents but there's some other cost share for non-preferred, or it's, you know, the traditional cost sharing?

DR. SCHMIDT: For this paper we hadn't come up with that idea but that's, you know, potentially a good one we could explore.

MS. BRICKER: Okay.

DR. CROSSON: Okay. I have Warner, Pat, and Dana.

MR. THOMAS: I've just got a couple of quick questions. I think part of this, building off of Amy's question, on Slide 3 where we talk about the gross Part D spending, the question I had was what does this number look like net of rebates? And it sounds like, from Amy's comment, that maybe rebates are immaterial or not significant. Do we know what this number looks like net of rebates?

DR. SCHMIDT: There was a CBO study that just came out that was looking at specialty drug spending net of rebates, and that's slightly different from what we're saying here. These are drugs that aren't specialty tiers and there may be some specialty drugs that are not on specialty tiers. And I'm not remembering the magnitude of that spending but it's not much lower than this. I think it was $25 billion or so in 2015. We don't have quite comparable years. They have to do a lot of empirical work to come up with the estimate.

But there's been also a Milliman study, I believe, that was looking at the magnitude of rebates for a sample of plans that volunteered their information to Milliman on what specialty tier rebates look like, and I think it was something like 14, 17 percent, somewhere along those lines.

MR. THOMAS: Okay.

MS. BRICKER: On that point, just for clarification, where those dollars come from are like hep C. So when you have a very high list price competitive market, tremendous rebate values there. So we just will get into traps if you use average, because it's

predominantly that class, PCSK 9's, that you'll see high rebates, but overall, in specialty drug classes, you don't see rebates.

MR. THOMAS: So it might be better to try to understand the -- I mean, we have the specific drugs so it might be better to understand the specific drugs kind of net of rebates, or at least be able to note the drug classes that there are rebates in, and I guess ones that are not, right? Because I guess there are some that have rebates, some that do not have any.

MS. BRICKER: Right.

MR. THOMAS: Okay.

And then -- I think I know the answer to this question but I'm going to ask it anyway -- do we have any idea of the margins associated with any of these specialty drugs, from the manufacturer?

DR. SCHMIDT: High, I would imagine.

MR. THOMAS: Like bigger than a breadbox? Like really high? Really high. Okay. Because I think that's another -- anyway, I'll get that in Round 2. So we just know it's high but we don't really have a range or have any sort of -- okay. Thanks.

DR. CROSSON: Pat.

DR. WANG: Can you clarify, I guess maybe by using Slide 11, what the thinking around the cap proposal does to LIS?

MS. SUZUKI: So for the LIS population, I mean, it depends on the parameter, but generally speaking what Medicare pays would change. Medicare currently pays all of the 5 percent cost-sharing from LIS enrollees, and to the extent that you eliminate or just lower the cost-sharing for beneficiaries the low-income cost-sharing subsidy would go down.

For the rest of the benefit it is the same, so the reinsurance goes down similar to what happens to the non-LIS beneficiaries, and the benefit cost is somewhere between whatever reinsurance plus plan subsidy is, plan liability is, minus whatever cap discount is.

DR. WANG: This is really complicated so let me just try to -- and forgive me if I'm trying to oversimplify this, because I need it to be simple to understand it.

So if you look at the left side, where the manufacturer discount is, which I didn't know that the manufacturer discount was not available for LIS

beneficiaries, so that's really interesting. So that 70 percent, which, in the non-LIS converts to premium to the plan, right. What happens with LIS, because that portion is now being picked up by CMS. Does that also get converted into premium to the plan, to manage benefits?

MS. SUZUKI: So that was one of the ideas we proposed, that currently LIS has a different benefit structure and essentially 100 percent minus the nominal co-pays for LIS is paid by low-income cost-sharing subsidy. The idea was to equalize those two benefits, so that plans would have 75 liability for all of their enrollees in the gap phase.

DR. WANG: Okay. So LIS, non-LIS is all converted to premium.

MS. SUZUKI: Mm-hmm.

DR. WANG: Okay. Fine.

So on Slide 9, it says that in 2017 coverage gap discounts totaled about $5.8 billion. So for non-LIS, like just conceptually that's getting converted into premium to the plan. I was wondering what the equivalent number is that the low-income subsidy has been paying.

DR. SCHMIDT: We haven't calculated it but we can

get that for you.

DR. WANG: Okay. I'm just trying to figure out what's getting converted into premium in terms of the insurance risk.

The other thing I'm just a little bit confused about is -- so on Slide 9, it says that the coverage gap discounts were concentrated among non-specialty tier drugs, and then on Slide 13 it says that in the cap discount the discounts would apply to specialty drugs. So what's the implication of that? I guess -- and I'm just thinking aloud -- the implication is that what is today covered by coverage gap turns into insurance risks to the plans and then the special drugs are what gets discounted in the reinsurance phase?

I see. Okay. Thank you.

DR. CROSSON: Okay. Dana.

DR. SAFRAN: Thanks for this work. Unlike others, even with rereading I'm still trying to understand this. And I guess my question might be incredibly basic, but the question is, if you think from a behavioral economics perspective, which I think is something you're trying to do, in Slides 11 and 12 it brought this up for

me. What are the changes that we could make that would have plans have a stronger motivation to keep the overall price and use of, or inappropriate use of medications down? You know, so to sort of have plans rowing in the same direction as the Medicare program and as beneficiaries, in terms of really being a champion for keeping inappropriate use and to minimum -- and costs to a minimum.

Like what are the changes -- and maybe they're the ones that you are proposing -- I just want to be able to think about it through a behavioral economics lens of like -- you know, because I can see where, in Slide 11, with the way that the 70 percent works right now, it kind of removes an incentive from the plan to be concerned about the price. And so I can see that by moving to where you are going on the right side of that, maybe that's part of what's in your mind. I just hope you understand my question. I'm trying to understand how you think about that.

DR. SCHMIDT: So I think the more that you unify the interest of -- the more insurance risk that you're putting on the plan you're aligning the interests of the Medicare program, which has to pay for that risk, and the

plan sponsor. I think probably the plan sponsors would say "but you also need to give us the tools to manage." So you can incentive, lots and lots of incentive, but if it's, you know, very restrictive formularies allowed, or, you know, tools that aren't available to them that they use in the commercial markets then they're going to say "well, we have incentive but not the tools to do so." So it's a combination of trying to get that right.

DR. CROSSON: Jon.

DR. PERLIN: Well, let me thank you as well. This is a great exposition of an incredibly complex area. Whenever I find myself in an area that's so complex I try to get back to first principles. And so this really follows on from Dana's, but even goes back a step further.

As sort of a novice in this area, the rebates, without question, obfuscate the transparency, transparency of cost and pricing, and they distort the sensitivities of the different actors in the equation, really, to Dana's point, in terms of sensitivities of the prescriber, the patient, and the plan, in terms of your ultimate alignment.

So my question is this, is that if we get back to first principles, if rebates weren't a part of the equation

what would the impact be on the proposals you make, or, in fact, would you be thinking of a different set of proposals in absence of those? Thanks.

DR. SCHMIDT: I think we'd probably be getting somewhere similar. The weird structure of Part D, I think, is just developed because of the budgetary need to keep the program within a certain, you know, cost estimate, frankly, and so it had this coverage gap, and then we saw that that was creating issues for beneficiary adherence, potentially.

And so there was a political pressure to fill in that coverage gap over time, and the way they financed -- the policymakers chose to finance it was with this manufacturer discounts for the non-LIS enrollees. And then we've seen, as rebates have grown, that there has been this very strange incentive now for, in some cases, not all, to put higher-priced, high-rebate drugs on formularies. So that's kind of a synopsis of the situation of where we are today. So the current structure has poor incentives, that we argue, in terms of formulary decision-making.

But if you were creating the Part D benefit anew, you know, you'd probably want it to look like commercial insurance, which is not so different from what you see on

the right-hand side of this slide here. It's a relatively simple benefit, and where you put an attachment point for reinsurance, you know, might be debatable. The out-of-pocket cap might be debatable. But I don't think that it would be radically different from what we're proposing.

DR. CROSSON: Yeah, Paul.

DR. PAUL GINSBURG: I'm glad you mentioned, Rachel, the commercial structure, because that's something that would probably be useful to include in a discussion, saying that this is not something we just, the crazy Commission, made up. This has a reality sense because this is similar to what typical commercial structures are.

DR. CROSSON: Bruce.

MR. PYENSON: In our January reading material I think there was an article from the Wall Street Journal that talked about the risk corridors that are retrospective protection on plans. I'm not going to ask you if you've investigated that in this context, but I wonder if it would make sense to look at that process while we're looking at these alternatives. Your thoughts on -- does that make sense to do that in this context?

MS. SUZUKI: I think under the policy we think

there is less ability to benefit from higher rebates that are not in the bids. I think to the extent the plans now are liable for a much larger share of the benefit spending and there is pressure for premium competition, we think that under the policy there would be less ability for plans to gain from the risk corridor setup.

DR. CROSSON: I have one question. In the cross-hatched area, you know, where you're looking at the division between the financial responsibility of the manufacturer and the plan, did I hear you say, Rachel, because now I can't remember whether I heard right or not, that one notion would be that that percentage division would increase based on the cost of the drug. In other words, the manufacturer's liability as a percentage of that cross-hatched section essentially would go up, asymptotically as the price of the drug went up. Is that what you said?

DR. SCHMIDT: I think that was Bruce's idea.

DR. CROSSON: Was that Bruce's -- oh, I'm sorry. Okay. I get the two of you confused.

[Laughter.]

DR. CROSSON: So if that were the design it would

seem to me that that would be an additional disincentive for the manufacturer, you know, to keep -- obviously you're dealing with an asymptotic situation, but to keep the manufacturer from continuing to increase the price of the drug to try to deal with the discount in the catastrophic cap -- the catastrophic phase.

Okay. So we're going to go on to the discussion now. We've got Bruce and Amy who are going to lead the discussion, and then what I'd like to do is ask that we direct our comments to the two options that are on the table -- support, not support, I could support if it were done this way or that way -- that sort of thing, so Rachel and Shinobu can go off with some sense of the Commission's intent.

Bruce.

MR. PYENSON: Well, thank you very much. As I was thinking about the chapter, going back to fundamentals, as Jonathan mentioned, that the structure of Part D creates this moral hazard that is kind of Insurance 101, that an insurance company, you're taught as a young actuary that there's a reason why you don't sell insurance for a house that's already on fire and there's also a reason why you

don't sell life insurance to someone who might have an interest in someone dying.

But it strikes me as a very similar analogy to what we've gone through with skilled nursing facilities, where although there is a bundled payment, in a case rate for SNF, you know, or perhaps for home health, different types of reimbursement are much more profitable than others, different types of patients. So, for example, patients who are getting physical rehab in a SNF are much more profitable than patients who need intensive medical care. And we've tried to address that in the work we've done on PAC.

I think this is a very analogous situation when you boil it down. In simplicity, there's a lot of different -- there's a maze of how the money flows, but fundamentally it's the same kind of thing that we see over and over again, that we try to address in the work of the Commission, where somehow incentives are created to favor more of the more profitable services and less of the less profitable. This is slightly more complicated because of the structure of Part D but fundamentally the same.

So I see this as very much in line with the other

work that the Commission has done, and for very similar reasons, despite its complexity. So I am really thrilled we are going in this direction.

As early as the end of next week we might get the final rule on the point-of-sale rebates, or if not next week, sometime, but I agree with, Rachel, your comment that that rule would perhaps complement, but would certainly not replace the fundamental changes that we're seeking here. So I'm thrilled that you have set a clear agenda for the next year, maybe more, of MedPAC activity, and I think this could be an area where we actually succeed in inducing deflation into health care spending. So I want to thank you, and I really like Slide 11. Thank you.

DR. CROSSON: Thank you, Bruce. Amy.

MS. BRICKER: This is my last opportunity, so if you'll bear with me, I've got a couple additional things I'll add on her just because.

On behalf of Express Scripts plan sponsors, last year we delivered a negative trend for Medicare. So despite what you might read or believe, there actually are plans and in reality we see plans that deliver negative trends. That's not to say that government had a negative

trend, but those that are managing the benefit did. So there is hope.

The theme of getting back to basics, I think we've got to ensure a few things with respect to the ability to manage the benefit. First and foremost, formulary. I know in 2016 we made recommendations around protected classes. That's still continuing to bite specifically within specialty classification and cancer therapy. So, you know, this is a class that is growing. There are tremendous advances in medicine, but because the class is protected, we do not see rebates here, and we continue to see list prices.

There is some conversation that rebates are the result of -- I'm sorry, list price increases are the result of rebates, and that's a really good example of list prices continuing to inflate and there are no rebates. So while on the surface protected classes say, well, you know, those should be available to beneficiaries -- and I don't disagree that they should be available in part where it makes sense clinically -- having that protected class actually causes prices to inflate without a governor to get that back-end discount from a manufacturer.

Having the ability to exclude a product at launch is the single biggest tool that a commercial plan has and manufacturers fear. So you're right, where there are drugs that don't have competition, you have very little leverage. You absolutely can create leverage with the threat of excluding that launch. This is not unique to just U.S. commercial. This is what European nations do that get manufacturers to the table. So offering plans the ability to do that will go a very long way. It's just a really nice stick in the event you're not able to get there otherwise.

Having that cap -- I do love the cap, the idea of the cap. I hate the idea of a coinsurance for beneficiaries because, you know, in the material we talk about, well, if we have this coinsurance and it's really hard for beneficiaries, that will put pressure on manufacturers. It doesn't. A senior, one voice, you know, ten voices don't actually influence list prices. You can get a headline in the Wall Street Journal. You can, you know, hear about these stories in pockets. But it does not impact the decisions of a manufacturer. So I like the idea of capping the out-of-pocket for beneficiaries and ensuring

that the plans are advocating on their behalf and PBMs are advocating on their behalf, but we shouldn't put that on seniors in this country.

So what is the price? That is a really good debate. I think personally $200 is a lot of money, and so if you're faced with, you know, these disease states that require very expensive products, I think that's a tremendous amount of money to ask someone to pay. So I think we should debate what is the right number. But I am in favor of a cap. So that was formulary and benefit design.

Network is also really critical. So in specialty pharmacy, just like in traditional pharmacy, if you are any willing provider, you can dispense the product. We talk about in the paper -- they talk about in the paper some of the clinical attributes that you'll see as outcomes. What is the adherence of a specialty patient? Is it cost? Are there other factors that are contributing to clinical outcomes?

What specialty pharmacies can do are very different in their ability to manage a patient than a traditional retail pharmacy. So if you actually have a

cancer diagnosis, you don't want -- I promise you, you don't want your chemotherapy dispensed by your community pharmacy. You want the specialist pharmacist who all they do all day long is dispense chemotherapy to be your advocate in this space. It's less about on the surface narrowing access. It's about providing the best care for those beneficiaries. And so I would argue that there should be ability for us to look at outcomes at the pharmacy level and allow plans to narrow that network of pharmacies so that they can then get the best discounts, of course, but also the best care for their patients.

And, thirdly, they have the best access and infrastructure for foundation dollars. So one of the things that I asked in Round 1, I don't know, in fact, that Medicare beneficiaries are subject to the extent we believe to the out-of-pocket. I think there's an opportunity here to explore the dollars that pharmacy manufacturer-backed foundations that at the point of sale are covering much of the out-of-pocket. So if there's an ability to explore that, I'm happy to connect you with Accredo. I think that's also something for us to just consider as a third rail there.

We should consider value-based contracts as part of this. So, again, commercial market, and I spoke about it yesterday, allow the plan to work with the manufacturer to develop programs that, if their drug does not work, there absolutely is some, you know, recourse that's available to the plan that helps the beneficiary, that helps the plan, that helps all parties and aligns the right incentives. So this is already complex, but, again, thinking about how you cannot just play whack-a-mole here, but look at the specialty benefit in total will, I think, drive some real savings for the plan.

Lastly, so I mentioned it, but I'll restate. So rebates are really hard to come by in this space. Protected classes, of course, are a part of that. The other is competition is really tough here. We still have not seen in the traditional pharmacy benefit side biosimilars. And we don't have a robust generic pipeline or a biosimilar pipeline, and we all know too well the success of the originating manufacturer to keep competition out. So I don't know that you're going to see, you know, in the near future this influx of rebates and discounts in this space.

So what we do know is that the pipeline is rich with really, really, really expensive products. Gene therapies are here. They are million-dollar-plus products. And so we really need to think about how we can get the manufacturers' skin in the game, and I think what you've suggested here with the restructure is exactly where I think we'll get the best outcome associated with balancing of dollars from manufacturers. I think it's brilliant. I love it. I think that it aligns all of the right incentives. It is complicated, though.

So kudos to both of you. I think this is -- I think it's great, and I'm enthusiastic about the direction. So thanks.

DR. CROSSON: Thank you very much, Amy.

Further discussion on the options before us? Kathy, Brian, Paul, Warner, Pat.

MS. BUTO: So I just want to add my enthusiastic praise to Rachel and Shinobu. I was blown away by this work. Then I stopped and said, you know, if we -- as you said, Rachel, if we had been designing the benefit in a rational way without budget constraints, this is more or less the way we would have designed it. I think the

difficulty we're going to have or Medicare will have in moving to something like this is that people are now entrenched in the current very bizarre structure that's been created. And so I think plans, beneficiaries, and manufacturers will all find something to hate about this approach.

Plans -- I think Pat touched on it -- face quite a bit of unknown, and it really depends on the specific parameters, additional risk. They were sort of more or less off the hook during the coverage gap and then much lower liability in the catastrophic phase.

Manufacturers have gotten used to the coverage gap, the discounts that are given there, and then being able to have beneficiaries quickly move to the catastrophic phase.

Beneficiaries are going to move, in my view -- under almost any scenario, fewer of them are going to reach the out-of-pocket threshold, so they'll have more cost sharing. It might be lower, but I don't think we know yet.

So I think as much as I like this, I think it's daunting moving from the current system.

I have to say one reason I really prefer this

approach of really a radical redesign of Part D and the structure of the benefit is that it does rely more on getting the incentives right in the whole drug benefit as opposed to trying to have the government set prices. Having been in the government regulator role, I just don't think the government does that very well. And so if we can really focus on getting the incentives right for this benefit, I think we'll have advanced a much better approach even than binding arbitration, quite frankly. I know we love it, but reference pricing, binding arbitration, these are all ways -- where you go when you don't have other options, quite frankly.

So what I'd like to see -- I would, first of all, say let's advance this approach and further develop it. What I would like to see us dive down a little more deeply on is the issue how to reach the right balance amongst greater beneficiary liability during the non-catastrophic part of the benefit and then plan risk in particular and how those -- and then, of course, Medicare, the government, how do you balance those out? So I really -- I think that's where the work is. I think the way you've structured it, the incentives look like they're really

going in the right direction.

Just a word on the cost cap. I don't support that approach. I think you laid it out pretty well. It is beneficial to the beneficiary, but it does really nothing about pricing, and it actually is bad for plans. I think it really increases the risk without giving plans additional tools to manage the costs. So I think -- I don't favor it. I think it's not a good approach. It appeals on an emotional level to want to have individuals not have to face high prices. And so we ought to think more about within the structure that you've laid out, are there other ways we can put more downward pressure on patient cost sharing or what patients have to pay? But I would try to do it within the context of this restructured incentive that you've laid out rather than putting a flat cap on cost sharing.

And I really agree with Amy; I think the value-based contract approach should be one that's made much more available, more flexibility for plans to enter into arrangements that are outcomes-based. Maybe they've got that flexibility. I don't even know that they don't have it, but maybe some incentives within the structure that

actually encourages them to pursue those approaches. And I think manufacturers would go for those as compared with having to pay unlimited rebates in a catastrophic phase. Maybe there is something else that they'd be willing to come to the table on to avoid those.

So I think there is in the structure increased pressure to come to the table, and we might be able to give plans the flexibility to use that.

DR. CROSSON: Thank you, Kathy. Brian.

DR. DeBUSK: First of all, again thank you for the work. It was a very impressive chapter.

Speaking specifically to Chart 15, I do support, prefer, strongly support the redesigned benefit with the cap discount option, really like it. I do want to make two points here.

Number one, I do think that Medicare is going to remain in the reinsurance business in some capacity. I think we can't make the numbers work without it. And as Bruce alluded to, there is a rule that would fix the issue with even having to allocate DIR that's still out for the comment period right now. If that rule goes through, I don't think we're going to have the DIR issue anymore. In

the event that we do, just one recommendation for future work. If you would plot out a scenario where the reinsurance program gets paid the DIR first and once that is fully paid off then we begin allocating it back to Medicare and the plan, you will get the same effect of this new rule around rebates, possibly finalizing it, because I think the original, as the Commission pointed out in the 2016 chapter, Improving Medicare Part D, there a fundamental hole in how the reinsurance program works. Eliminating the rebates would fix a portion of that, a small portion of that. But I think even if we don't, again, if the DIR has to be applied first to reinsurance, I think you would get a similar effect. I think you would close what might be the next potential hole in the program.

The other thing I wanted to mention -- I mentioned this two years ago -- I do hope we'll also look in this at polypharmacy. I would like to connect you, the staff, to what I know is a successful program run out of a large academic medical center where they're looking at the -- they're working with pharmacists and with the specialists to try to incorporate a beneficiary's capacity to manage all these different drugs. I mean, there are

beneficiaries who really can only take four or five medications at a time. There are others that can effectively manage 20. And I think that may be a source, especially in these really heavy utilizers, I think that may be another thing that we would like to incorporate into this to try to address some of the most expensive beneficiaries.

Thank you.

DR. CROSSON: Thank you, Brian. Paul.

DR. PAUL GINSBURG: Okay, thanks. A terrific presentation and paper. As context -- I think you have this in the paper, but I just wanted to say it -- it's really amazing how much has changed since 2003 when the Part D benefit was developed in Congress to now as far as the nature of drugs, the role and growing role of specialty drugs. So long overdue, revamping this Part D design.

I also noticed that you said that Medicare is responsible for about a third of revenues in pharmacies, and this is one of the few areas where we can make Medicare policy and perhaps have positive spillovers beyond Medicare as far as if Medicare can influence the prices.

You had a very extensive discussion of adherence,

which was worthwhile, but I want to make sure we always point out that it's not just adherence, that it's financial protection. And there's opportunities for great financial pain to adherent patients who have trouble paying the bills. So, you know, let's always keep in mind the insurance function, the protection, as well as, you know, its effect on utilization.

I certainly support your focusing on specialty drugs. That's where the issue is today. It's going to be much more extreme tomorrow, as pointed out. And to me, on Slide 15, with the four objectives, I have a particularly high priority on the objective of getting prices lower because I think that's a particularly compelling problem. And this is why I support the redesign benefit with a cap discount and not the per prescription out-of-pocket limit because that only deals with, one, about the barriers to patients and ignores these other really important aspects.

DR. CROSSON: Thank you, Paul. Warner.

MR. THOMAS: Thanks for the work. I think it's obviously a major issue and certainly a major issue of cost for the program.

It strikes me just looking at the trends, this

has pretty much been a windfall for the manufacturers, and just hearing that we're not sure what the margins are on these specialty drugs, but they're very large.

So I think getting back to this idea of what's the principle, I think Jonathan's point is a good one. What is the principle? You've got to align the risk, right? So where should the risk be on this? It shouldn't all be on the Medicare program with the escalation.

I think the idea I would support that Amy brought up about excluding drugs at launch, I think is a good one. I think that's one that should be included in here.

I agree with the structure that's been laid out here and basically sharing the risk going forward, but I also think that it disproportionately ought to be shared with the manufacturer and not the plan. I think they need to basically be involved financially and taking risk in this situation.

Other concepts we talked about, which have not been included -- I didn't see in the chapter -- is the idea of a cap on inflation. So should we be thinking about capping what the increase on a special drug should be going forward? So if you have the idea that you can essentially

exclude at launch and cap inflators, it would give you some control, potentially, going forward, and then if there's risk shared disproportionately with the manufacturer, I think they would probably be more aligned with the overall system.

I agree that I don't think we should put more financial burden on the beneficiary. I think the beneficiary has enough burden, and frankly, going from a 2- or $3,000 out-of-pocket to $6,000 is a big differential for a beneficiary -- or most beneficiaries. So I don't agree with that. I think we ought to continue to limit the risk that the beneficiaries have and put more risk on the manufacturers.

So those are a couple ideas that I think would go along with your construct of essentially having that shared risk, but I would really encourage us to put more of the risk on the manufacturer and not on the plan.

I do think the plan and obviously the PBMs have some control, but I still think the manufacturers need to have risk in this as well.

DR. CROSSON: Thank you, Warner.

Pat.

MS. WANG: So thank you also for very thought-provoking concepts and in particular the rethinking of the reinsurance layer and shared responsibility. I like Warner's comment.

I just want to focus a little bit on the implications of converting what is now manufacturer discount and LIS subsidy into insurance risk because just in general, shifting risk is not like sort of -- I think it sets off warning bells, and I know that the intent is that by shifting risk, plans will have more incentives and ability to really manage costs. And so I'll get back to that in a second.

But to me, some of the implications of converting this exposure into insurance risk for plans include, first, the necessity of really, really much better risk adjustment so that premiums have a reasonable assurance of covering the cost of the drug exposure that would be included.

I am a little concerned about timing. You see, there's an underlying theme in here that the way that the reinsurance benefit is structured today, it's basically cost based, and that's true.

But there is a reason for that. The cost of new

drugs, new launches, new therapies that just come on to the market are not knowable the way that a plan might know or be able to project their cost for inpatient, you know, physician, et cetera. It's a different kind of benefit, and it is evolving and changing every day.

When the hep C drugs came onto the market, it was miraculous. That was not included in anybody's premium because nobody knew about it. So I guess I have a little bit of a concern with just as a timing matter how premiums keep up with the tremendous development and new costs that are introduced into the pharmacy world every day.

In a sense, the system that we have today, it is supported by a lot of different components of this whole ecosystem.

The list that Amy described of things that would be necessary to really try to get your arms around this risk, manage this, et cetera, I think people should pause and think about because it's really true.

Right now, it is a cost-based system in a lot of respects, but that reflects how we have allowed the benefit to be structured. There's very little in -- I mean, there are a lot of beneficiary protections in there, so I think

people need to be sort of aware that everything has to be looked at, whether it's any willing pharmacy, including drugs at launch, dealing with anticompetitive behavior about competitor products, protected classes.

I know that the Commission made some recommendations in 2016 to remove protected status from a couple, but it still exists for some of the most highly utilized drugs. And you triggered that thought, Shinobu, when you reminded me that behavioral health drugs are really most used by the LIS population, and that those are protected, so for example.

I think as we proceed, we have to -- I'm sorry that Amy won't be here to remind us of this, but I think it kind of all goes together if you're going to ask people to manage the cost and the benefit a different way.

Then on that last statement about giving more incentive to plan sponsors to manage the cost, there's two components of that. One is managing utilization by their members. I think Kathy raised a good point that that might have implications.

The other is managing price. I would say I don't know -- I think that the large plan sponsors probably have

thoughts about what to do here. I'll just speak about my concern about the ability of smaller, regional, what have you, Medicare Advantage prescription drug plans, which are not PDPs, but offer prescription drugs as part of the benefit of manage their MA members who do not have their own formularies, who contract with a PBM, and who do not control their internal formulary, the ability to manage the risk.

In particular, I think there needs to be more focus on how to handle LIS. LIS is a difficult benefit to manage because the members have no financial responsibility. So the use of brand drugs, specialty drugs, where there are substitutions is very difficult to address.

You can interfere with prescriber preference and patient preference and say to people, "No, you can't have that," which nobody is willing to do as far as the discussion with the patient, restricting formularies. For example, if there's a generic substitution, there's no access. You could do things like that, but most organizations really don't restrict their formularies just for their LIS members.

So I think it's a difficult -- it's a more vexing population, and the benefit is more vexing because the tools to actually change enrollee behavior, changing prescriber behavior can be done, but it's really more at the margins. I mean, of course, if a prescriber really wants to prescribe a certain thing for their patient, you have to think twice about whether you really want to ask plans to sort of get more aggressive about getting in the middle of that, which is sort of the implication of if you're at risk for that, you have to do something.

So I'm a little concerned about LIS, and I don't know what the answer is, but I think that we should continue to think about how that should be structured.

Thank you.

DR. CROSSON: Thank you, Pat.

This was a good discussion. I believe we have helped here, Rachel and Shinobu, giving you a sense of a preference on the part of the Commission, and we look forward to the next phase of your work. Thanks very much.

While we are getting rearranged here, I just want to take a moment to recognize one of the MedPAC staff who is going to be leaving and ask Kate to stand up and be

recognized, now that you came in.

[Applause.]

DR. CROSSON: Thank you so much for your excellent work.

[Pause.]

DR. CROSSON: Okay. I think we're ready for the final presentation. We're going to be talking about the issue of improving payment for low-volume and isolated outpatient dialysis facilities. Nancy and Andy are here to help us through this, and Nancy is going to begin.

MS. RAY: Good morning.

During our December and January meetings, Commissioners raised concerns about the Medicare financial performance of low-volume and rural dialysis facilities.

During today's session, Andy and I discuss how the ESRD prospective payment system, the PPS, pays facilities that are low volume and rural, and we will also discuss an alternative approach that may better target facilities necessary to ensure beneficiaries' access to care.

So here is a roadmap of today's presentation. First, I'll first give you a very brief overview of the

ESRD PPS and review the most recent Medicare financial performance of low-volume and rural facilities.

Next, I will summarize the Commission's principles on payments to rural providers which guided our analysis of and concerns with the ESRD PPS's low-volume and rural payment adjustments.

Andy will present an alternative approach that would create one payment adjustment that could replace the two current factors, that might better target low-volume and isolated facilities.

We seek comments from Commissioners on the material presented. This is the first step in our discussion about improving the accuracy of the ESRD PPS.

Since 2011, the ESRD PPS payment bundle includes drugs and laboratory services that Medicare previously paid separately. Beginning in 2020, facilities will be paid separately, outside the bundle, for new drugs.

For each covered treatment that a facility furnishes, its base rate is increased using the patient- and facility-level factors listed on the slide.

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

rural location.

Over the next year, we expect to come back to you to discuss concerns with the drug passthrough policy and the payment-level adjustment factors.

So moving to the Medicare financial performance, you saw these 2017 Medicare margins in December and January. What really influences the Medicare margin is treatment volume. The Medicare margin is decidedly lower for facilities in the lowest-volume quintile, compared to facilities in the top-volume quintile.

Among rural facilities, the Medicare margin decreases as total treatment volume decreases. Rural facilities are on average smaller than urban ones.

This figure shows 2015, 2016, and 2017 cost per treatment, adjusted for differences in the cost of labor. The Medicare financial performance for rural and low-volume facilities that I showed you on the previous slide is in large part due to the correlation between dialysis treatment volume and costs.

Under the ESRD PPS implemented in 2011 and even the payment method prior to the PPS, we have consistently found that cost per treatment decreases as the number of

treatments a facility furnishes increases.

The smaller facilities on the left-hand side of this figure have much higher costs per treatments than facilities on the right-hand side of the figure.

As we evaluated the ESRD facility-level adjustments, we were guided by the principles that the Commission developed to evaluate rural special payments over the course of several meetings and that were published in 2012. The Commission stated that payments should be targeted toward low-volume isolated providers, that the magnitude of payment adjustments should be empirically justified, and that the adjustments should encourage provider efficiency.

In 2017, about 5 percent of dialysis facilities received the low-volume payment adjustment, referred to as the LVPA, which increased facilities' base payment rate by 23.9 percent. Eligible low-volume facilities are those that furnished 4,000 treatments in each of the 3 years before the payment year under question.

Our first concern with the low-volume adjustment is that it may not be targeting all isolated facilities necessary to ensure beneficiary access to care.

The low-volume adjustment only factors in the distance to the next facility if both facilities are owned by the same parent organization and within five miles from one another. This means that a low-volume facility can be located next door to another facility as long as they are owned by different parent organizations. In 2017, 40 percent of low-volume facilities were located with five miles of the nearest facility.

A second concern with the low-volume adjustment is that it uses only one volume threshold of 4000 treatments. This so-called "cliff effect" might be encouraging some facilities to limit services, and the current low-volume adjustment does not address the higher cost of facilities with volumes of between 4,000 and 6000 treatments per year that I showed you on Slide 5.

This slide shows that low-volume facilities are, indeed, more isolated compared to all facilities. However, note the two blue bars on the left showing that 40 percent of facilities were located within five miles of the nearest facility.

Moving to the 0.8 percent rural adjustment, this is also applied to the base rate and supplied to the base

rate of facilities located in rural areas. Eighteen percent of all facilities received this adjustment. Like the low-volume adjustment, our concern here is the targeting of this adjustment.

In 2017, about 30 percent of rural facilities were located within 5 miles of another facility, and in 2017, 20 percent of rural facilities were high volume, furnishing more than 10,000 treatments, and had substantially lower adjusted cost per treatment than lower-volume facilities located in rural areas.

DR. JOHNSON: Now we are going to discuss an illustrative policy option to replace the current low-volume and rural payment adjustments. This single adjustment is designed to preserve access to dialysis by increasing payment to facilities that are both low-volume and isolated, or LVI.

The LVI adjustment would jointly apply two criteria. First, eligible facilities must be farther than five miles from the nearest facility to be considered isolated. This definition is more strict than the current low-volume definition which, as Nancy described, in some circumstances can apply to facilities within five miles of

another facility.

Second, eligible facilities must have low volume of treatments during each of the preceding three years. To mitigate the cliff effect of the current low volume definition, and to better account for the higher costs of relatively low-volume facilities, the LVI adjustment would expand the definition of low volume by applying one of three categories.

The lowest category would apply to facilities with fewer than 4,000 treatments in each of the three preceding years. The next category would apply to facilities that had fewer than 5,000 treatments in each of the preceding three years, but do not meet criterion for the first category. The third category would apply to facilities that do not meet criteria for the first two categories, but that had fewer than 6,000 treatments in each of the preceding three years.

The next few slides will show how that the LVI adjustment would better target low-volume and isolated facilities compared to the current low-volume and rural adjustments.

This figure compares the current low volume

adjustment to the proposed LVI adjustment. Along the horizontal axis, facilities are grouped by the number of dialysis treatments provided in 2017, with a cap at 6,000 treatments. The green dotted bars show the number of facilities that received the current low-volume adjustment in 2017. As you can see, most facilities receiving the current low-volume adjustment continued to provide fewer than 4,000 treatments in 2017, but a few provided more treatments and migrated to higher categories.

The white bars show the number of facilities that would receive the new LVI adjustment. Because, the LVI adjustment would expand the definition of low volume, more facilities with greater 2017 treatment volume would receive the LVI adjustment. Recall from Slide 5 that all of these facilities providing fewer than 6,000 treatments annually have relatively high adjusted treatment costs.

There are somewhat fewer facilities receiving the LVI adjustment in the 0-to-4,000 treatment group because some current low-volume-receiving facilities are within five miles of another facility. These facilities would not receive the LVI adjustment.

Overall, the LVI adjustment would redistribute

payments from facilities within five miles of another facility to isolated facilities and to facilities that meet the expanded definition of low volume.

This figure is organized in the same way as the previous figure and compares facilities that received the rural adjustment in 2017, the green dotted bars, to the facilities that would have received the proposed LVI adjustment, the white bars. The right side of the figure shows that the majority of facilities receiving the rural adjustment had higher volume, providing more than 6,000 treatments, and for some facilities, providing more than 15,000 treatments. These higher-volume facilities have lower costs per treatment, suggesting that the 0.8 percent rural adjustment could more effectively preserve dialysis access if it were shifted to lower volume and isolated facilities.

Overall, the LVI adjustment would redistribute rural adjustment payments from higher-volume to low-volume facilities and from non-isolated rural facilities to isolated facilities.

One additional note about the size of the rural adjustment. This figure shows that rural facilities have a

wide range of treatment volumes, and therefore have a wide range of average costs per treatment. Payment adjustments, like the rural adjustment, that are empirically estimated, capture the cost variation that is common among facilities within the adjustment group. We think one reason why the rural adjustment is so small, just 0.8 percent, is that there is little similarity in costs among rural facilities.

We have not yet estimated the size of LVI payment adjustments. That is something we plan to do for this fall. We anticipate that the empirically estimated adjustments will be proportional to the average costs in each of the categories. Our preliminary analysis confirms that average treatment costs align with the LVI categories as expected, and are consistent with the overall relationship between volume and cost.

We believe that the LVI adjustment would more accurately target higher-cost facilities, and particularly, we think relatively low-volume facilities that are not receiving the current low-volume adjustment would see improvement.

Of the LVI-eligible facilities, the 2017 Medicare margin for those facilities that receive the current low-

volume adjustment was -3 percent. However, for LVI-eligible facilities that did not receive the low-volume adjustment the 2017l, their Medicare margin was -17 percent. These facilities would likely see substantially improvement in their margins due to the LVI adjustment.

This slide summarizes the key aspects of the LVI adjustment. First, there would be a single payment adjustment for low-volume and isolated facilities, that would replace the two current adjustments that apply separately for low-volume and rural location. Second, the LVI payment adjustment would consider a facility's proximity to any other facility, not just those under common ownership. Some facilities receiving the current low volume adjustment would not receive the LVI adjustment as they are in close proximity to another facility.

And finally, the LVI adjustment would expand the definition of low volume. The proposed three categories are designed to mitigate the so-called cliff effect and to account for the higher treatment costs of facilities providing between 4,000 and 6,000 treatments per year.

We intend to return in the fall to continue our discussion of a low-volume and isolated adjustment,

including our estimation of payment adjustment sizes. We also plan to address other ESRD PPS concerns, which are in the appendix to your mailing material. These include issues with patient-level adjustments and the PPS regression estimation method.

Finally, of particular interest to several Commissioners, we also plan to address ways to improve the transitional drug add-on payment adjustment, or TDAPA. We look forward to your comments, including suggestions for other factors we should consider as we continue our analysis. And now I'll turn it back to Jay.

DR. CROSSON: Thank you, Andy and Nancy. We'll take clarifying questions.

Okay. David, Dana, Marge. I'm sorry. David, go ahead.

DR. GRABOWSKI: Thanks. I appreciate this work. It's a really nice chapter and presentation.

I wanted to ask you about the five-mile threshold. Did you guys think about kind of variation on either side of that? I guess there's nothing magical about that five miles, but why is that the right number?

DR. JOHNSON: I think we started there now

because it is part of the current rules and so it was an easy number to estimate and has some basis in current policy, but that's something that we could consider modeling some alternatives for this.

DR. GRABOWSKI: And one other question, Jay. I like how you're trying to mitigate the cliff effects. I guess there's still, under your kind of step thresholds here, there's still kind of potential for cliffs there, especially at 6,000. And you probably can't get away from that cliff, but is there a way to do a more continuous measure underneath that? I'd want to think more about that, but is there a way to kind of go from steps to some sort of continuous share measure?

DR. JOHNSON: That's certainly something we can work on. I think, again, this illustrative policy was trying to take the ideas that the current policy is based on and just expand them as a conceptual way to illustrate what we're trying to do. But, yeah, a continuous adjustment might be better.

DR. GRABOWSKI: Thanks.

DR. CROSSON: Dana.

DR. SAFRAN: Thanks for this work. My question

is about the other aspect of the criteria and that's the volume aspect.

As I think about it, I'm not clear why we want to maintain volume as a criterion. What I worry about is creating incentives to be just enough below the volume cutoffs that you're getting extra support. And so understanding that what we're trying to do here is assure access for rural beneficiaries who need dialysis, I wonder why would we not want to consider the criteria just being one piece of it, however weighted, because you're rural, another because you are some distance -- and I had the same question about why five miles -- but some distance from the next nearest facility, and just drop the volume pieces. I wonder what you think about that.

DR. JOHNSON: So there are isolated facilities, at least based on our five-mile criteria, in all of the volume categories. And so I think if we just considered the isolated facilities there would be some facilities that are on the right end of Slide 5 that have very low costs and are able to achieve positive margins now that we would not want to focus the adjustment dollars towards those facilities. But I think, as David mentioned, maybe a

continuous adjustment might help mitigate some of the concerns about volume.

DR. CROSSON: Okay. I've got Marge and then Brian.

MS. MARJORIE GINSBURG: So currently the Medicare margin for the rurals are -5.5. What proportion of the dialysis programs are made up of Medicare versus commercial plans, and are these that have such a negative margin able to survive because commercial pays much more? So I don't know where that balance is, and do some facilities actually have mainly, if not entirely, Medicare? Some may be entirely commercial and are the price differences that significant?

MS. RAY: So commercial payers do pay, on average, a higher payment rate than Medicare. I would have to come back to you concerning the mix of patients and how that varies between isolated facilities and non-isolated facilities, in terms of the percentage that are Medicare versus commercial. Just off the top of my head I would think that in the more rural, isolated areas you're going to tend to see a slightly greater share of Medicare patients, but I would want to go back and double-check on

that.

MS. MARJORIE GINSBURG: Have any facilities closed because they were not able to make it financially?

MS. RAY: So certainly we see facility closures every year. We also see a net increase from year to year. That has been the trend through 2017.

DR. CROSSON: Okay. On that point?

DR. JAFFERY: Real quick, just to remind folks that ESRD is a Medicare eligibility category, so that changes things a little bit from some other circumstances.

DR. CROSSON: Brian.

DR. DeBUSK: First of all, I really enjoyed the chapter and, to David's point, I think a continuous adjuster for volume, I think it would be superior.

But I had a second question and I promise this isn't a rhetorical question. But when we talk about excluding, you know, this five-mile exclusion, are we showing a certain amount of indifference to consolidation or to maybe a policy that could inadvertently drive consolidation? I mean, when I was reading the first part of the chapter I thought, I wonder if these are the same people who don't keep a spare tire in their trunk.

And again, this isn't a comment. This really is. I mean, have we considered that the unintended consequence of driving more consolidation than we need? I mean, is competition good?

DR. JOHNSON: That's certain a concern, and I think a question for you is how does that concern balance with the benefit of redistributing some of the adjustment dollars to facilities that we think might be more necessary to preserve access to dialysis.

MS. RAY: And I --

DR. DeBUSK: Quick question -- sorry.

MS. RAY: And I also think another issue to consider is the incentive to promote provider efficiency. I mean, if you do have a low-volume provider and he is within two miles of a much bigger provider, you know, one has to wonder about whether or not that low-volume provider needs a little bit more incentive.

DR. DeBUSK: Agreed. Clearly there are efficiencies with scale. Do we also see some dis-efficiency, or dysfunction that goes along with that scale, would be my question back.

DR. JOHNSON: I think that's something we can

consider further.

DR. CROSSON: Paul.

DR. PAUL GINSBURG: On this point I can see the concern with monopoly. This sounds more like a situation of macro monopoly, you know, when you have few sellers in a market. It's because there are such economies of scale, and that's the only way to achieve them.

I think in this market, I mean, concentration is never a good thing but it's probably less harmful here because it's so dominated by Medicare, you know, much of the commercial services for people that haven't reached the two-year points, as far as gaining ESRD eligibility. So I think the data you showed showed that there are some very substantial scale economies here and I think we need to accommodate that.

DR. CHRISTIANSON: [Presiding.] Are there any other clarification questions? Comments? Amy.

MS. BRICKER: I was just thinking about in-home versus in-facility and how we should think about either access for in-home or costs associated with in-home versus within-facility. Is that a dimension that you've considered as part of this analysis?

MS. RAY: So when CMS implements the low-volume adjustment it does include home treatments, just as it includes in-center treatments.

MS. BRICKER: The costs associated with one versus the other for the facility, do you have insight into that?

DR. JOHNSON: The management of home patients still requires some cost from the facility, that those nurses are monitoring the patients. So it is not necessarily the same cost, but the facility is involved in treating those patients as well, even though they are at home.

MS. BRICKER: And one follow-on. Do we see that population growing, or the ability to service the patient in home as obviously more desirable, but is there anything within policy that we think will hinder further adoption of in-home? I'm just ignorant on the subject. Is it more about advancement of that patient and therefore they're not able to be serviced at home, and how can we keep more people at home if, in fact, the cost structure is less, and, obviously, I'm sure it would be more desirable for the patient.

MS. RAY: So under the PPS we have seen an increase, a modest increase in the use of home dialysis. One of the factors that I think has sort of hindered the growth in the last couple of years was a shortage of a particular solution that was needed by the predominant home dialysis modality, peritoneal dialysis.

I think you raise a good point, though, about considering, you know, any changes to the low-volume adjustment and, you know, and considering the effect on home dialysis.

DR. CHRISTIANSON: Okay. We don't have -- oh, I'm sorry. Go ahead.

MS. BUTO: Nancy, could you elaborate on that a bit? The low-volume adjustment doesn't affect the payment rate for home dialysis, does it?

MS. RAY: For adults it does not. Now facilities do receive a training add-on payment when they first train the patient, and they can also receive a payment for retraining a patient, but there is no difference in the payment right now for home versus in-center dialysis.

MS. BUTO: Yeah. Just one point of clarification. There was a period of time when home

dialysis was being paid almost at twice the rate as in-center, and it ended up being the subject of a lawsuit in order to rein payments back in. It was an area of abuse. So I'd just be careful in thinking about home dialysis, not to think that poor home dialysis isn't being reimbursed appropriately. It's now, I think, capped at the level of in-center, if I'm not mistaken.

DR. CHRISTIANSON: Okay. We don't have a leader of the discussion part here, so I think they give us some pretty straightforward direction in terms of where they want us to go, and that is on page 15. So I think the main thing is to be very clear about whether we think this is a policy direction we'd like to see them pursue further, and then beyond that, what specific areas do we think the most work is needed in. So, Jonathan, you were going to start?

DR. JAFFERY: Yes. Maybe I can make a few comments leading into the discussion questions particularly related to some of the things that people have brought up.

I think that, you know, generally speaking, we do want to think about how do we make sure that beneficiaries have the options that are best for them, whether those are in-center or home dialysis, and home dialysis comes in two

different modalities, as Nancy alluded to. There's peritoneal dialysis, and then there's also sort of the growing in-home hemodialysis modality that people are using.

But I think we just want to be careful that we just don't assume that in-home is not necessarily better for everybody. There are a lot of patient-specific characteristics and patient preferences that I think play into this. There's a lot, as you can imagine, to be done if you need to do some of these things at home. And your home environment may or may not actually be set up for this. That can be a pretty big hurdle sometimes.

I think, you know, the other thing, thinking about the five-mile distance, you know, there is an interesting balance here because my recollection of the history of some of this, which goes back before I was doing any sort of dialysis work, is that peritoneal dialysis -- this was before probably home hemo was really a thing, but peritoneal dialysis was a much bigger -- had a much bigger use in this country. And one of the things that decreased its use was we had dialysis centers kind of cropping up in more rural areas. So one might look at that and think that

maybe that was a negative to have them crop up everywhere, but, again, it can be somewhat of a hardship sometimes for folks, maybe particularly in rural areas, to get to places. So I think, you know, any number of miles is probably always going to be arbitrary, which is why I think the cutoff points -- we thought those were arbitrary, and I would definitely agree with David that having a more continuous approach to that is probably desirable.

But if we think about patient access to things, whether we're thinking about in rural areas or just in general, we often think about those as what people need to get to on an occasional event, and this is not an occasional event for people. This is somebody who is spending three days a week, half of a day each of those days, at this unit, and that's a big deal. And it's not just a big deal for the patient; it's a big deal that often family members have to be able to drive them, and you can think of some of these remote areas that may be in places where half the year there's lots of snow or maybe there's mountains, and so it can be a big deal.

To me, I think we want to be conscious of that, and so I'm personally supportive of continuing to think

about how to make adjustments and maintain that kind of access.

In terms of the specific proposal, I think simplifying things to have a single adjustment has an appeal to it, and I think that slide, whatever is the slide that shows the cost per -- yeah, Slide 5, it's pretty compelling that there's a volume-related cost associated for facilities. So I'm very supportive of developing further the proposal that you put forward.

And then, finally, just to speak to -- you know, you talked a little bit about other factors to consider, and I think that maybe piggybacking on this idea of how difficult it may or may not be for people to get places, thinking about some of the social factors for individuals and social determinants and how that may or may not make it easier for dialysis providers to manage patient populations may be helpful. There's a lot of time and effort that goes into trying to arrange transportation for people, and as one can imagine, it's hard to do that if somebody doesn't have stable housing, for example.

I'll leave it at that.

DR. CROSSON: Thank you, Jonathan.

Let's see. Paul, Dana. Paul.

DR. PAUL GINSBURG: I just wanted to compliment you that I think your proposal analysis was a great example of the MedPAC culture of, you know, ways to focus the Medicare dollars on where they'll do the most good, avoiding cliffs. I could probably go on.

I'm very comfortable with the direction and encourage you to continue to work and come back with recommendations.

DR. CROSSON: Thank you. Dana.

DR. SAFRAN: Yeah, I second that. And the only thing I'd add is in relation to this figure and some of the comments I included in my question about volume, I think this issue about home dialysis would be valuable to incorporate here because I just can't help -- I don't know the field of dialysis very well, but I know in the field of quality measurement in general we start to worry when there are low volumes about quality. So I still worry about this idea of using volume as a criterion to add additional payments. And maybe that is what we need to do to promote access, but I just want to turn over every rock before we decide that that's the right thing in terms of activities,

quality, safety, and cost. And it seems like exploring home dialysis in the areas where there are such low volumes, you know, what's the intersection there of the patients who could be treated at home and what that would cost versus being treated in centers that are low volume where they might need this adjustment seems worthwhile.

DR. CROSSON: Thank you, Dana. Kathy.

MS. BUTO: Maybe Jonathan could speak to this, but I don't think we should think of home dialysis as people being treated. A lot of it is self-treatment, as I understand it. I don't think the cost of an assistant is covered. I think there are training opportunities and so on, but I think a lot of it relies on the person. So it's not a complete interchange between a low-volume facility and somebody being able to get their dialysis at home. You have to have the capability, I think, to either have an assistant in your family or otherwise to help you.

DR. SAFRAN: Understood, but if we think about from the perspective of the program and the patient, what is more advantageous? If we should be really driving to more home dialysis as opposed to center dialysis, particularly in places where there's an access problem, we

should look at how to encourage that. What are the policy levers to encourage that?

MS. RAY: Right, and I just would like to clarify here that under the ESRD PPS, the payment bundle for home and in-center is the same. Medicare does not pay for any special assistant or helper for patients who dialyze in the home. Patients either dialyze by themselves or often with the aid of a caregiver. And we wrote in, if I'm getting my years straight, either the March 2017 or the March 2018 report, there are a lot of factors affecting the take-up on the use of home dialysis, and, in particular, it's a very -- as Jonathan stated, it's a very individualized decision as to whether or not the person feels comfortable and able and has the space and often the caregivers necessary to do home dialysis.

DR. JAFFERY: Just to add one other thing to it, and if we can talk about this a lot offline, I suppose it would be helpful, too, but there are some physical characteristics that prevent people particularly from doing peritoneal dialysis, and then there are situations where people may be doing peritoneal dialysis for a period of time, and then as times goes on it's no longer a viable

modality, and then they switch to in-center -- or switch to hemodialysis. There are a lot of hurdle sometimes for individuals to be able to choose in-center hemo versus -- or home hemo versus in-center hemo.

DR. CROSSON: Okay. Good discussion. Andy, Nancy, thank you for the work. We look forward to the next iteration when you come back to meet us in the fall.

That brings an end to this morning's discussion as well as the 2018-2019 MedPAC cycle. We now have an opportunity for public comment. If there are any of our guests who would like to make a comment now, please come to the microphone.

[No response.]

DR. CROSSON: Seeing none, we are adjourned, and I wish everybody a wonderful summer interlude. We'll see you again soon. And thank you again for your work as a Commission, and thank you to Jim and Dana and the staff, and safe travels, everyone.

[Whereupon, at 10:40 a.m., the Commission was adjourned.]