

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Thursday, March 5, 2020
9:33 a.m.

COMMISSIONERS PRESENT:

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[9:33 a.m.]

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DR. CROSSON: Okay. I think we should get started now.

Let me welcome our guests to the March MedPAC meeting. This morning we're going to be taking up two issues which are part of our continuing work on accountable care organizations. The first one will be addressing MSSP vulnerabilities. We've got David, Luis, and Jeff here. Who's going to begin? David.

* MR. GLASS: Yes, good morning. Today we are going to talk about addressing vulnerabilities in the Medicare Shared Savings Program.

I will provide a brief background on ACOs. Then Luis will present our concerns with patient selection and one method of addressing some of those concerns that is using NPI-level benchmarks. We will then present the Chairman's draft recommendation on requiring NPI-level benchmarks, which will lead to your discussion.

During the discussions in January, you asked for more information on several topics. You expressed interest in knowing more about the mechanics of assignment when done

1 prospectively compared with retrospectively and on the
2 results of the alternative quality contract. So we have
3 provided that information in your reading material and can
4 take any questions later during the discussion. Larry also
5 asked about the size of shared savings payments per primary
6 care physician, and we will present our findings on that.
7 The recommendation and other topics will be included in a
8 June chapter.

9 So, for review, ACOs are collections of providers
10 willing to take accountability for the spending and quality
11 of care for an assigned patient population. Actual
12 spending is compared to a benchmark. If spending is under
13 the benchmark, the difference or savings is shared between
14 Medicare and the ACO. If spending is over the benchmark,
15 there are two cases. If the ACO model is one-sided, then
16 spending above the benchmark is absorbed by the program.
17 If the ACO model is shared risk -- also known as two-sided
18 risk -- the ACO may have to pay CMS for some of the
19 spending above the benchmark.

20 Today we are going to concentrate on the Medicare
21 Shared Savings Program which is by far the largest ACO
22 program in Medicare and the only one set up in statute.

1 The others are demonstrations under CMMI.

2 In 2020, there are 517 ACOs in MSSP, one fewer
3 than in July 2019, but the number of beneficiaries is at a
4 high of 11.2 million

5 New rules for the MSSP went into effect in 2019.

6 There are two new tracks, basic and enhanced, and
7 they replaced the old tracks. The idea is to move ACOs
8 faster and with more certainty to two-sided risk.

9 We're not yet there. In 2020 two-thirds of the
10 MSSP ACOs are still in one-sided risk models.

11 MSSP benchmarks are a blend of spending for
12 beneficiaries who would have been assigned to the ACO in
13 the baseline years -- that is, the three years prior to an
14 ACO's agreement period -- and fee-for-service spending in
15 the ACO's region, which includes spending on beneficiaries
16 in ACOs.

17 To understand if an ACO model as a whole is
18 saving money for Medicare, a counterfactual is necessary;
19 that is, what spending would have been in the absence of
20 the ACO model.

21 Over all ACO models -- PGP, Pioneer, MSSP, and
22 NextGen -- studies relative to a comparison group of

1 beneficiaries not assigned to an ACO estimate 1 to 2
2 percent savings, or about 1 percent after shared savings
3 payments. Results depend on the program and the
4 evaluation.

5 Relative to a counterfactual, for the MSSP, we
6 found slower spending growth for beneficiaries assigned to
7 an ACO in 2013, by about 1 or 2 percent through 2016. That
8 estimate does not include any shared savings payments,
9 which would have decreased estimated savings.

10 We also found that beneficiaries who were
11 continuously assigned to an ACO had lower spending than
12 those who were newly assigned to the ACO or lost assignment
13 to an ACO and that a health event such as a hospitalization
14 could lead to a switch in a beneficiary's ACO assignment
15 and correspond with higher spending.

16 The point is savings are relatively small but
17 still more than most care coordination models, and those
18 savings need to be protected. If shared savings payments
19 are unwarranted, they could put Medicare savings at risk
20 and shift the MSSP from small savings to program losses.

21 Luis will now explain our concerns with patient
22 selection because it has the potential to create

1 unwarranted shared savings and put program savings at risk
2 in the future.

3 MR. SERNA: The modest savings achieved in MSSP
4 thus far could be vulnerable if ACOs can engage in patient
5 selection that is not reflected in their benchmarks and
6 leads to unwarranted shared savings payments. This could
7 result from having low-cost patients enter the ACO without
8 changing the benchmark or having high-cost patients exit
9 the ACO without changing the benchmark. We have not seen
10 evidence of pervasive selection thus far, but we are
11 concerned about the incentives as ACO experience matures.

12 Patient selection in MSSP can lead to unwarranted
13 shared savings payments.

14 Selection is problematic because it can
15 inaccurately improve an ACO's performance year spending
16 relative to its baseline years.

17 Selection can occur by adding clinicians that
18 disproportionately have low-cost patients or by removing
19 clinicians that disproportionately have high-cost patients.

20 Selection can also occur via beneficiary
21 assignment to ACO clinicians by keeping low-cost patients
22 and losing high-cost patients.

1 As previously stated, we do not believe selection
2 in MSSP has been occurring on a widespread basis, but under
3 current rules, Medicare is vulnerable to such manipulation.

4 We first consider the selection of low-cost
5 beneficiaries in ACOs via annual wellness visits, or AWVs.

6 In our June 2019 report, we found that ACOs had
7 higher rates of wellness visits in 2016. In addition, ACOs
8 were more likely to perform the visits at the end of the
9 year.

10 Patients who received wellness visits toward the
11 end of the year had disproportionately lower spending than
12 patients who received the visits toward the beginning of
13 the year.

14 Building on that work, we examined beneficiaries
15 who were continuously assigned to the same ACO from 2014 to
16 2016. Beneficiaries who received an initial wellness visit
17 were relatively healthier before they had received the
18 visit.

19 Cumulatively, this evidence suggests that AWVs
20 could help retain low-cost patients in MSSP ACOs -- beyond
21 what was expected in ACOs' benchmarks

22 While the selection effects of wellness visits

1 has the potential to be offset by lower spending growth and
2 improved care, the evidence to date suggests this has not
3 yet occurred.

4 Among beneficiaries continuously assigned to an
5 ACO, we found that having an initial wellness visit in 2015
6 was not associated with slower spending growth through
7 2016. In fact, average spending growth during ACO
8 assignment was actually \$174 higher for beneficiaries that
9 received the wellness visit in 2015. Wellness visits were
10 not associated with lower spending growth during ACO
11 assignment even when examining different lengths of time
12 before and after the visit or restricting the analysis to
13 physician-only ACOs.

14 In addition, researchers at Harvard University
15 found that wellness visits had no overall effect on
16 Medicare spending, screening rates, emergency departments
17 visits, or hospitalizations.

18 Furthermore, beneficiaries in MedPAC focus groups
19 over the last few years have generally reported that
20 wellness visits were not useful for their own care needs.

21 Thus far, the evidence we have suggests that
22 wellness visits have not demonstrated Medicare savings or

1 care improvement thus far, increasing the likelihood that
2 use of AWVs in MSSP has had a greater effect on patient
3 selection than in generating savings for the program.

4 In our January meeting, the question arose of
5 whether clinicians in an ACO had sufficient monetary
6 incentive to take any actions to select against high-cost
7 beneficiaries.

8 We found that in 2017, 50 ACOs received shared
9 savings of over \$50,000 per primary care physician in the
10 ACO, increasing the incentives for patient selection among
11 these ACOs.

12 Comparing beneficiaries that exited MSSP ACOs in
13 2017, beneficiaries who exited MSSP ACOs with the highest
14 shared savings per PCP had unusually high relative
15 spending.

16 Overall, the correlation between shared savings
17 and favorable patient selection is problematic, even if the
18 selection is not intentional.

19 In the next section, we will discuss selection
20 via the removal and addition of clinicians.

21 We provide one way of addressing the
22 vulnerabilities of patient selection -- the use of NPI-

1 based benchmarks. I will go over how patient selection may
2 be exacerbated through an ACO's Taxpayer Identification
3 Number -- TIN -- to create benchmarks. It's important to
4 understand that this discussion strictly addresses how the
5 claims of ACO clinicians are used for beneficiary
6 assignment to compute benchmarks and performance year
7 spending.

8 Before discussing our concerns with TIN-level
9 assignment, it's important to understand how ACOs are
10 defined. First, let's review some terminology for
11 identifying providers.

12 Each clinician has a unique National Provider
13 Identifier, or NPI. An NPI can bill under one or more
14 TINs. A TIN can range from a solo practitioner to hundreds
15 of clinicians within an integrated delivery system.

16 MSSP identifies participants in an ACO as a
17 collection of one or more TINs, which are used to construct
18 benchmarks and determine beneficiary assignment.
19 Beneficiaries are assigned to ACOs based on the TINs under
20 which their claims are billed. However, TINs were not
21 designed for that purpose.

22 A concern of inaccurate benchmarks arises when a

1 clinician shifts the TIN she bills under or starts to bill
2 under multiple TINs.

3 When this occurs, the changes in how NPIs bill
4 through TINs are not reflected in ACOs' benchmarks.

5 In MSSP, TINs are used to calculate an ACO's
6 benchmark and performance year spending. Assignment is
7 obtained by having the plurality of primary care visits to
8 the ACO's TINs.

9 Benchmarks are the spending for beneficiaries who
10 would have been assigned to the ACO's current list of TINs
11 in the base years.

12 Performance year spending is calculated via the
13 beneficiaries who are assigned to the ACO's current list of
14 TINs in the performance year.

15 Changes that an ACO makes to its list of TINs
16 takes effect in the subsequent year, when CMS annually
17 recalculates an ACO's benchmark based on its updated list
18 of TINs.

19 CMS does not recalculate benchmarks based on
20 changes in the NPIs billing under the TINs.

21 What this means is changes in how NPIs bill
22 through TINs are not reflected in the benchmark

1 calculation.

2 However, the use of TINs to identify an ACO's
3 clinicians weakens the utility of historical assignment and
4 benchmarks, potentially creating unwarranted shared
5 savings.

6 When individual clinicians leave or join a TIN,
7 the beneficiaries historically assigned to that TIN do not
8 change, and the ACO's benchmark is also unchanged. We have
9 seen anomalies where this has occurred. For example, one
10 ACO with high shared savings that we discussed in your
11 mailing materials reduced its primary care physicians by 42
12 percent the year its benchmarks were rebased. The drop in
13 ACO participants coincided with a drop in average risk
14 scores by 19 percent. However, the benchmarks of the ACO
15 did not decline. The ACOs collected over \$35 million in
16 shared savings over the next three years and dropped out of
17 MSSP when its benchmarks would have been rebased again.

18 The figure in this slide illustrates how changes
19 in clinicians who make up a TIN could lead to unwarranted
20 shared savings.

21 In the benchmark year, the TIN is comprised of
22 Clinician A and Clinician B. If Clinician A's

1 beneficiaries are high-cost and Clinician A is removed from
2 beneficiary assignment for the performance year, these
3 high-cost beneficiaries remain in the ACO's benchmark.

4 Further, if the ACO adds Clinician C -- who has
5 historically low spending -- to its TIN, the ACO's
6 benchmark would not reflect the low cost of this provider's
7 beneficiaries, but performance year spending would. This
8 mismatch between the benchmark and performance year
9 clinicians raises potential concerns about the accuracy of
10 baseline spending used for benchmarks.

11 Rather than using TIN-level benchmarks to
12 identify ACO clinicians, the Next Generation ACO
13 demonstration uses combinations of TIN and NPI.

14 Unlike TIN-level benchmarks, benchmark changes do
15 appropriately occur when clinicians are removed from TINs.
16 However, identifying ACO clinicians through TIN and NPI
17 combinations have some concerns. Benchmarks do not change
18 when NPIs outside the ACO are added to TINs.

19 Additionally, benchmarks increase when NPIs with
20 low-cost patients are removed from benchmarks but remain in
21 the ACO as a new TIN and NPI combination. Because they are
22 a new TIN and NPI combination, they cannot be in the

1 benchmark.

2 Moreover, benchmarks do not change when NPIs
3 selectively bill expensive patients using a TIN outside the
4 ACO. One ACO interviewed in a 2018 RAND study created a
5 separate TIN for clinicians that disproportionately saw
6 high-cost patients.

7 As we discussed in January, rather than basing
8 historical benchmarks on TIN or a combination of TIN and
9 NPI, NPI-based benchmarks would most accurately capture the
10 ACO's historical spending.

11 Any changes in an ACO's performance year
12 clinicians would correspond with changes in the clinicians
13 used for historical benchmarks. If an NPI bills under a
14 TIN participating in an ACO, CMS could use all primary care
15 visits from that NPI, regardless of what TIN they are
16 billed under, to assign beneficiaries to that ACO.

17 Using NPIs to compute benchmarks and performance
18 year spending would reduce selection from removing high-
19 cost clinicians from ACO TINs, adding low-cost clinicians
20 to ACO TINs, and billing high-cost beneficiaries outside of
21 ACO TINs.

22 It is important to understand that redefining the

1 ACOs on the basis of clinicians' NPIs would not require any
2 changes to the structure of the ACO, its clinicians, or the
3 specialists clinicians recommend for beneficiaries. Here
4 we illustrate an example of the current definition of an
5 MSSP ACO, which is a collection of TIN 1 and TIN 2.
6 Currently, both the ACO and the ACO's beneficiary
7 assignment are defined on the basis of TINs.

8 NPI A historically only billed under TIN 1. NPI
9 B historically only billed under TIN 2. As long as NPI A
10 and NPI B continue to bill under one of the ACO's TINs in
11 the performance year, no mismatch of clinicians' claims
12 occurs between the benchmark and performance year.

13 If beneficiary assignment for MSSP ACOs were
14 redefined on the basis of all the ACOs' NPIs, the ACO and
15 its affiliated clinicians would have the exact same
16 structure and billing arrangements.

17 In this example, NPI B subsequently begins
18 billing under TIN 3, which is outside the ACO, creating a
19 mismatch in clinicians' claims between the benchmark and
20 performance year.

21 Under the NPI option, the only difference is that
22 rather than the ACO's assignment being computed based on a

1 collection of TINs, the ACO's assignment is now computed
2 based on a collection of clinician NPIs.

3 All claims billed by the ACO's clinicians are now
4 used for both benchmark and performance year assignment.

5 In summary, ACO savings have been modest.

6 Unwarranted shared savings payments to ACOs could
7 result in costs that exceed MSSP savings.

8 To avoid putting MSSP at risk of being a net cost
9 to Medicare, CMS needs to reduce vulnerabilities that can
10 result from patient selection, even if the selection is not
11 intentional.

12 To help limit vulnerabilities, both MSSP baseline
13 and performance year spending could be computed using the
14 performance year NPIs rather than TINs.

15 The integrity of using historical benchmarks
16 requires reliably matching the ACO's performance year
17 clinicians with the ACO's historical primary care visits.
18 Calculating benchmarks based on a collection of NPIs is the
19 only method available for ensuring that performance year
20 clinicians are captured in benchmarks. Allowing ACOs to
21 benefit from changing NPI participation in TINs creates the
22 potential for patient selection and unwarranted shared

1 savings.

2 That brings us to the Chairman's draft
3 recommendation, which reads: The Secretary should use the
4 same set of National Provider Identifiers to compute both
5 performance year and baseline spending for accountable care
6 organizations in the Medicare Shared Savings Program.

7 This recommendation may result in a small
8 reduction in Medicare spending from lower shared savings
9 payments relative to current policy, but the magnitude of
10 spending reduction is unclear. Specifically, the degree of
11 unwarranted shared savings that would be averted may be
12 small in early years but could be somewhat larger in future
13 years as MSSP participation matures.

14 The recommendation would not have any effect on
15 beneficiary access to care.

16 The impact on providers would likely be small;
17 some providers may receive smaller shared savings.

18 That brings us to our questions for your
19 discussion.

20 Are there any clarifying questions about the
21 material informing the draft recommendation?

22 Are there questions about the information on

1 assignment to ACOs included in your mailing material?

2 Are there other policy ideas that the Commission
3 has for future analyses?

4 We anticipate the recommendation would be
5 included in a chapter in the June report.

6 We look forward to the discussion on these
7 points, and now I turn it back to Jay.

8 DR. PAUL GINSBURG: I want to open it for
9 clarifying question now. Jonathan and then Brian and Dana.

10 DR. JAFFERY: Yeah. Thanks. Thanks for a great
11 chapter. I'm excited about this discussion.

12 I have a few questions. The first one has to do
13 with some of the stuff that was in the reading about the
14 prospective versus retrospective assignment. I'm curious
15 how that impacts waiver use, and the reason I bring that up
16 is thinking about the SNF three-day waiver. We have
17 prospective assignment in Next Gen, and there's sometimes
18 issues about who is on the list. So then we're wary or
19 unable to utilize the waiver if it turns out that somebody
20 is not going to be on the list finally and worried that the
21 beneficiary might end up with a big bill. Can you comment
22 on that at all to start with? How might that work? Have

1 you thought about how waivers might be impacted?

2 MR. GLASS: Well, in the past, our position has
3 always been that prospective makes it a lot easier for
4 granting waivers if you know whether the person showing up
5 in the hospital is an ACO-assigned beneficiary or not.

6 DR. JAFFERY: So that's sort of my question.

7 MR. GLASS: Right.

8 DR. JAFFERY: In retrospective, has that been an
9 issue?

10 MR. GLASS: I'm not sure how that works.

11 MR. SERNA: It hasn't been an issue thus far
12 because you're required to have two-sided risk in order to
13 be eligible for the waiver, and under previous rules, you
14 had to be under prospective assignment if you had two-sided
15 risk, so tracked through ACOs when prospective assignment.
16 Now that things are changing, that's changed a little bit.

17 DR. JAFFERY: Okay. Shifting gears to talk about
18 some questions about the annual wellness visits. Two
19 questions on those. One, do you know how many of the AWWs
20 are associated with an additional billable visit and, thus,
21 a charge to the beneficiaries?

22 MR. SERNA: Yeah. So it's roughly between 40 and

1 45 percent.

2 DR. JAFFERY: Okay. And then have you looked at
3 and noticed or do you know about any association with the
4 annual wellness visits and specialty referral patterns?

5 MR. SERNA: We haven't looked at that.

6 DR. JAFFERY: Okay. Finally, shifting to the --

7 DR. NAVATHE: Jonathan, can you just clarify why
8 you're asking that question?

9 DR. JAFFERY: Yeah. So one of the things I'm
10 thinking about that could be happening is if you bring
11 somebody in, some potential issue is identified. They're
12 referred to a specialist, and one of the phenomena that
13 happens when you go down to see a specialist potentially
14 downstream, utilization and testing, and as a specialist,
15 there's a sense sometimes that somebody is being sent to me
16 for something, and there actually tends to be sometimes --
17 I think people feel pressure, in one sense, to do testing
18 maybe that they wouldn't do if it's a borderline referral,
19 or just bias towards your practice pattern, which is to
20 test for things in your area that maybe aren't totally
21 necessary, but you get put in a different category once
22 you're actually seeing the specialist, and so thinking

1 about how that would create some downstream utilization
2 that maybe is avoidable and why you might see people, who
3 then get the annual wellness visit, look less healthy in
4 subsequent years. But you're not seeing that pattern
5 necessarily.

6 So thinking about the PCP incentives, two
7 questions about that. First, to pick those PCPs that were
8 in ACOs, they had greater than 50,000 savings. How did you
9 end up defining PCP?

10 The reason I'm asking that is some of the larger
11 group practices, like our own, try to include all of their
12 practitioners and could include a fair number of, for
13 example, pediatricians. Clearly don't have a lot of ACO
14 beneficiaries attributed through them or take care of them,
15 but it might change the number of PCPs.

16 MR. GLASS: CMS puts out a file, with the ACO
17 number and the number of PCPs in it. We took the number of
18 PCPs they had in the file.

19 DR. JAFFERY: Okay. Interesting.

20 MR. GLASS: We didn't go into great detail on how
21 they came up with that number.

22 DR. JAFFERY: All right. Finally, there was

1 something in the reading that talked about not knowing how
2 ACOs distributed shared savings, but that is publicly
3 available. Every ACO has to publish a website that
4 actually describes how they do that. I don't know if you
5 start to look at that maybe for this subset of ACOs to see
6 if they distributed a lot to their providers or not.

7 MR. GLASS: We looked at a couple on the websites
8 of several of the ACOs. The one I remember is they gave
9 all the money to the -- they took some off the top for ACO
10 administration and data, that sort of stuff, and then what
11 was left, they gave to the PCPs. But we did not do an
12 exhaustive check on how they all did it.

13 DR. JAFFERY: Understanding that maybe the
14 accuracy of those might be limited, it might be worth it.

15 I did a little bit of a random sampling too, and
16 it does look like it's all over the board. Some give it
17 all back. Some don't give any and talk about it all being
18 back to either administrative costs or reinvestment. It
19 might be worth looking at.

20 Thank you.

21 DR. CROSSON: Brian?

22 DR. DeBUSK: First of all, congratulations on a

1 great chapter. It was a really, really good read.

2 I'm going to keep all this to Round 1. I have my
3 own separate Round 2 thought.

4 But a quick question -- or two questions. First
5 of all, you built the argument around the NPI-10
6 vulnerability. I thought you really built a great case.
7 You built an argument, and it led to this recommendation.

8 On the average wellness visits, I thought you
9 built an equally sound argument. I felt like I was being
10 led up to a prospective attribution recommendation too, and
11 I even re-read the chapter because I thought maybe I missed
12 a paragraph or two.

13 But for my first question, did the idea of a
14 prospective assignment recommendation die?

15 And now for something completely different,
16 Appendix A -- and then I'll be done, I promise. Appendix
17 A, I have my own thoughts on it, but I want your thoughts
18 on -- when I look at the most successful ACOs here and I
19 look at this list in terms of payments for PCP and I look
20 at the top ten, eight of the top ten are in Florida.
21 What's going on there?

22 [Laughter.]

1 DR. DeBUSK: I have my own thoughts, but I want
2 to hear what you think.

3 DR. MATHEWS: Well, David, let me take the first
4 question.

5 Brian, recall that at our January meeting, we did
6 present two policy options for the Commission's
7 consideration, prospective versus retrospective as well as
8 TIN/NPI. And the Commission had expressed the need for
9 additional information about how prospective and
10 retrospective worked, and my takeaway was that the
11 Commission collectively was not yet ready to advance to a
12 recommendation.

13 In contrast, there was a strong consensus on TIN
14 versus NPI, and that's why we, in coordination with Jay,
15 have presented that here. We could come back to
16 prospective, retrospective at a future point if the
17 Commission is now settled.

18 DR. DeBUSK: Could that be a Round 2 discussion
19 today, or is that out of this analytic cycle?

20 DR. CROSSON: Yeah. I mean, I think you can
21 bring up anything you want.

22 Just as Jim said, as I remember the January

1 discussion, towards the end of discussion, we got into some
2 complexity about what prospective and retrospective really
3 meant, and in the field, there were examples of - and I
4 think, Dana, you brought this up. There were examples that
5 kind of were in the middle of that, and I think at that
6 point, many of us had the sense that we weren't ready to
7 kind of move right on and all get behind prospective,
8 although I have to say I think there was a plurality in
9 favor of that.

10 But, as Jim said, I think to do the topic justice
11 and to proceed in the way that we normally do so that we
12 have everything on the table and everybody understands
13 everything, we need to do some more work.

14 So I think if you have points of view about that,
15 it's perfectly fine to bring those up, but I don't think
16 we're ready to nor will we be ready in April to bring it
17 forward as a recommendation.

18 DR. DeBUSK: Florida.

19 MR. GLASS: Florida.

20 So, in past work, we've shown that there's a good
21 correlation, I guess you'd say, between the service use in
22 an area where service use is defined as kind of

1 standardized spending, and the success of ACOs relative to
2 their benchmarks. So it's not too shocking to see that,
3 and a lot of these seem to be concentrated in areas that
4 have traditionally high service use.

5 DR. DeBUSK: So Florida is the only state with
6 high benchmarks?

7 MR. GLASS: It's not a question of the high
8 benchmarks.

9 DR. DeBUSK: It's 80 percent.

10 MR. GLASS: It's a question of service use.

11 The distinction is benchmarks include the pricing
12 effects. San Francisco can have a high benchmark, but it's
13 a very expensive area. The service use actually is fairly
14 low relative to other parts of the country, but if you look
15 at service use, then Florida and certain parts of Texas are
16 really quite high. Louisiana could be quite high. So this
17 isn't too shocking to see this.

18 DR. CROSSON: Okay. Dana?

19 DR. SAFRAN: Thanks.

20 A few questions. I'll start with the second part
21 of the chapter where you're talking about the TINs and
22 NPIs. The first question related to that, can you explain

1 what would happen when somebody, a provider, clinician
2 actually changes their affiliation from one ACO to another?
3 That happened frequently in my commercial world. People
4 would get recruited away from one system to another. So
5 how does that work in this scenario?

6 MR. SERNA: So if they move into an ACO, their
7 historical claims would be excluded, right, because they
8 weren't part of any of the ACOs performing to your TINs.

9 If they move outside of the practice, which is
10 not affiliated with the ACO, then they would no longer be
11 in the ACO's performance here. So they would not be in the
12 performance here or the benchmarks.

13 DR. SAFRAN: Right. So would that ACO's
14 benchmark get reset?

15 MR. SERNA: So CMS annually recalculates
16 benchmarks as is for the new sets of TINs. So it would get
17 reset at the beginning of the next performance year.

18 MR. GLASS: Are you asking about under our
19 proposal?

20 DR. SAFRAN: Yeah, under your proposal.

21 MR. SERNA: Yeah. It's under our proposal.

22 DR. STENSLAND: It would get reset.

1 DR. SAFRAN: For that performance year or in the
2 future?

3 MR. SERNA: In the subsequent performance year.
4 I mean, it's kind of impossible to make changes as they're
5 happening, as is now.

6 DR. SAFRAN: Yeah.

7 MR. SERNA: Right.

8 DR. SAFRAN: So I guess I'm not entirely clear
9 how it solves the problem that you're trying to solve. It
10 just takes it down one unit of measurement, but you still
11 do have the issue of providers, whether you're talking
12 about a group of providers or an individual provider who
13 during their course of a measurement year will change where
14 they're practicing, and therefore, the entity has been
15 baselined with them in and now is getting measured with
16 them out.

17 MR. GLASS: You do it during the performance
18 year. It would be in the next performance year.

19 DR. SAFRAN: People move in the middle of the
20 year all the time.

21 MR. GLASS: Right. But, I mean, that's okay.
22 So, yeah, you couldn't be able to catch that immediate

1 effect.

2 So the person moves in -- I don't know --
3 September or something, but at the beginning of the year,
4 they were associated with that ACO. I think their claims
5 would continue to be assigned to that ACO for that
6 performance year, even if in November or December --

7 DR. SAFRAN: Okay, okay.

8 DR. NAVATHE: In other words, it's sort of like
9 an intention-to-treat kind of design where if you start
10 out, then regardless of whether you move or not, you get
11 attributed back. So that's why it does solve that change
12 problem, I think.

13 DR. SAFRAN: Okay, I got that.

14 One other question, and then I have a question
15 about the annual wellness visit.

16 I did not see in the chapter a recommendation
17 that NPI should only be aligned to one ACO. Is that part
18 of the proposal?

19 MR. GLASS: Yeah. I think that would be part of
20 the text around the recommendation. Yeah.

21 DR. SAFRAN: Okay, okay. Good. Glad to hear it.

22 And then annual wellness visit, I guess my

1 question there was I get the inference that you think
2 there's some gaming going on with respect to annual
3 wellness visits, but what's the evidence base for that as
4 opposed to knowing that somebody's in your population?
5 What I saw a lot in the commercial world was we've got
6 these quality measures we're accountable for. The year is
7 waning. We better get these people in and make sure that
8 we take care of these things, which I think is part of the
9 intent of the program.

10 So I'm trying to understand what's behind the
11 concern about having people in late in the year and whether
12 we have evidence that some of the good quality that we want
13 to see happening in the preventive screenings and so forth,
14 that the visit is being used for that purpose, not just for
15 documenting that we want this low utilizer to stay
16 attributed to us.

17 MR. GLASS: Well, the intention for doing the
18 annual wellness visit at the end of the year may be all --
19 just as you said, you want to keep your quality measures
20 up, and you want to keep people attributed or assigned to
21 your ACO, which is fine. But we're just saying the effect
22 of it could be what we're seeing, that it keeps low, lower

1 than average spenders.

2 DR. CROSSON: Sue?

3 MS. THOMPSON: Well, I'm going to continue on
4 this conversation about this thought process around annual
5 wellness visits because that was one of the basic
6 foundational building blocks of the work in ACOs in terms
7 of aligning the beneficiary to the primary care. There
8 were a lot of good things about that work.

9 If, indeed, the beneficiary is low cost, it's
10 contributing to little contribution to the benchmark, and
11 so I'm having a hard time understanding entirely this fear
12 of if they're high cost, they're going to be avoided, and
13 if they're low cost, they're going to be wanted. If you
14 take that to the extreme, I get it, but as in Florida, I
15 think the fact they've been successful has something to do
16 with they've had an opportunity to reduce costs.

17 The shared savings only happens if you beat the
18 benchmark. So there's got to be something there to beat.

19 Where is the sweet spot in that thinking?
20 Because in the real world, we need both. We need some low
21 cost and some high cost, and to think the data is so real
22 time that we can make those kinds of fine movements in who

1 we have in and who we have out is really quite fascinating.

2 [Laughter.]

3 MS. THOMPSON: So I'm interested to know which
4 ACOs you talked with because the gaming at this time and
5 where we have data and where analytics are. Did you visit
6 with any ACOs that are doing that sort of work? Give me a
7 little bit more, because in theory, I agree with the
8 recommendation, but in practicality, I want to hear more
9 about who you visited with.

10 MR. SERNA: So it's important to understand that
11 we're looking at MSSP, and we're looking at primarily
12 retrospective assignment. So they will receive claims fees
13 quarterly based on a three-month claim lag. So by the
14 fall, they will know the beneficiaries that have not come
15 in. They will know their claims history.

16 That's not to say that anything nefarious is
17 happening. We're not saying that the annual wellness visit
18 should not occur. What we're saying is that, inevitably,
19 regardless of intention, what happens is towards the end of
20 the year, there is a disproportionate number of wellness
21 visits that occur, especially among ACOs relative to non-
22 ACOs. Those beneficiaries tend to be low cost, often

1 because they're coming in for the wellness visit, and they
2 haven't had a visit throughout the year. So they're pretty
3 low users.

4 MS. THOMPSON: And there might be other reasons
5 why they're coming in towards the late summer, early fall.
6 It's flu shot time. It's October. Women are doing their
7 annual visits. I mean, there are other variables feeding
8 that third-quarter, fourth-quarter scheduling of wellness
9 visits.

10 Talk to me more about which ACOs you interviewed.
11 I think I just want to understand that a little better.

12 DR. STENSLAND: Maybe one clarification. It's
13 not just that there's more wellness visits in the third and
14 fourth quarter. It's that there's more wellness visits for
15 people assigned to MSSPs in the third and fourth quarter
16 than there is for people not assigned to MSSPs in the third
17 and fourth quarter. So there's something unique about the
18 MSSPs.

19 There's also, when we talk about the
20 retrospective, prospective, it's important, I think, as he
21 said, we don't expect this opportunity to really be there
22 that much if you're in a Next Gen ACO and it's prospective

1 assignment because you're assigned to the person before you
2 know they're spending. In this place, you know part of
3 their spending before.

4 Now, people did not come up to us and say, "Oh,
5 we're doing annual wellness visits because we want to game
6 the system." No one said that to us.

7 [Laughter.]

8 DR. STENSLAND: But people did say, "Part of our
9 strategy is annual wellness visits," and I think they often
10 think that that is a positive thing. That might be a
11 profitable and a positive thing in their mind.

12 But what it does do is it does give them an
13 unfair advantage if you're bringing people in at the end of
14 the year who haven't had any spending through the first
15 half of the year. Maybe you're saying because we got to
16 make sure they get the quality metrics or we want to keep
17 them in our network or whatever it is. You're getting a
18 disproportionate share of low-cost people assigned to you
19 as opposed to your comparison group, which isn't doing
20 this.

21 So there is an advantage for the ACO. Whatever
22 the motivation is in the end it's an advantage to have the

1 low-cost people assigned to you, compared -- a
2 disproportionate share of the low-cost people assigned to
3 you relative to the comparison group.

4 DR. NAVATHE: Out of curiosity -- sorry, Sue, to
5 jump in --

6 MS. THOMPSON: That's fine.

7 DR. NAVATHE: -- have we looked at this under
8 other models where there is prospective assignment, so even
9 like a CPC or CPC+ or a Next Gen? Because if we are --
10 hypothetically speaking, if we are seeing it as part of
11 this quality effect that Dana is citing, then it should be
12 happening under those models where they have a quality
13 effect, quality benefit to go after. And if it's purely
14 from this strategy around the benchmarks then we shouldn't
15 see it in those areas, where there is prospective.

16 DR. STENSLAND: We haven't done it. That's a
17 good idea. But however it turned out, it wouldn't make the
18 problem go away.

19 DR. CROSSON: But it would feed into perhaps a
20 later discussion going back to the issue of prospective
21 versus retrospective assignment.

22 All right. On this point.

1 DR. GRABOWSKI: Quickly on this point. A third
2 explanation could just be some regression towards the mean,
3 right, that you haven't had this done and you're expecting
4 it to go up late in the year. So I was getting a strong
5 regression to the mean sort of vibe when I was reading
6 this, but maybe others --

7 DR. STENSLAND: I think if it was regression --

8 DR. GRABOWSKI: [Off microphone.]

9 [Laughter.]

10 DR. STENSLAND: -- I think if it was regression
11 to the mean we would see it for these other people that
12 aren't being assigned to the MSSP. You know, you have this
13 group of people that weren't preliminarily assigned to the
14 MSSP and you would see, oh, they didn't have a wellness
15 visit before and now they're going to have it toward the
16 end of the year, and then you have this group that is
17 assigned, and the fact that there is the difference between
18 the two groups that depends on whether you're assigned to
19 the MSSP or not, preliminarily.

20 So, you know, there's a bunch of people in town.
21 We give you a list of these people that are preliminarily
22 assigned to you and you know their claims history. And

1 then there are other people where you don't know their
2 claims history, and their physicians probably don't either,
3 and those other people aren't coming in as often to get
4 their wellness visits at the end of the year, where the
5 people that you had this list of these are the people and
6 this is how much they've spent so far, they are coming in
7 more often at the end of the year. And I'm saying it's not
8 necessarily -- certainly there is financial incentive there
9 to do it, but that's not necessarily the reason why they're
10 doing it.

11 DR. NAVATHE: So Jeff, I think my point is that
12 there's the quality incentive piece and there's the cost of
13 care incentive, and the way we're looking at it right now
14 we kind of can't disentangle the two, because in the non-
15 ACO group there's not really a strong quality incentive to
16 go after. So that regression to the mean effect that David
17 is after doesn't apply in that group. You would have to
18 look at a group that has the quality piece but doesn't have
19 the financial piece to be able to capture that regression
20 to the mean.

21 DR. RYU: It seems like there's a selection issue
22 too, though, because the folks who have not yet been seen

1 during the year, they are going to be healthier because
2 they haven't utilized because they haven't had an issue.
3 So the healthier folks are going to be loaded towards the
4 back end of the year versus the folks who have already
5 utilized, they have utilized because they've had an issue,
6 and so they will naturally be in the front half of the
7 year. I don't know if that's regression to the mean. I
8 don't get those same vibes, but --

9 [Laughter.]

10 DR. CROSSON: Okay. Enough regressive thinking.
11 Jaewon.

12 DR. RYU: So I had a question around just
13 logistically whether it's feasible, and maybe it's not. It
14 kind of gets back to Amol's point and Dana's point, the
15 intention to treat kind of mentality. I don't know if this
16 is doable, but could it be done that if you have movement
17 out of the ACO assignment of a high-cost beneficiary they
18 would come out of the performance year -- I get that -- but
19 couldn't you just recast the benchmark and they would just
20 come out of your benchmark at that point too, as opposed to
21 worrying about, you know, is it the TIN?

22 I mean, I agree with those recommendations, but

1 if you just had a system where it's almost like looking at
2 a concurrent group of beneficiaries to measure benchmark
3 and performance, and if someone wasn't in the performance
4 because of any kind of migration, either at the provider or
5 of the beneficiary, you would just go back and take them
6 out of your benchmark.

7 DR. STENSLAND: That would change the program
8 quite a bit, because then we would essentially be looking
9 at a constant cohort of people, saying what's the cost of
10 change for the constant cohort of people, as opposed to
11 this group of people that you -- opposed to a constant
12 cohort of clinicians, maybe a constant cohort of patients.
13 And it would be more -- it would be a bit change. It would
14 be a big change in the program.

15 MR. GLASS: I think that's, in fact, how they
16 originally had the Pioneer set up, and they ran into the
17 problem of what happens when beneficiaries die, as one of
18 the issues. There was this whole thing about a decedent
19 adjustment. No one could understand it. And they
20 eventually -- remember this, right? Yeah. And eventually
21 they came around to trying to do it this way. So they
22 tried it.

1 DR. CROSSON: I mean, it seemed to me it would be
2 a big change, because wouldn't it also affect one of the
3 primary purposes and motivations for all of this, which is
4 to be -- you're assigned people who are unhealthy. Your
5 motivation is to try to improve their health, keep them
6 healthy during the year. If, in fact, we have a system
7 where they just drop out and you don't worry about them
8 anymore, then philosophically that's a very different
9 program.

10 DR. RYU: Well, they wouldn't drop out unless you
11 -- if they drop out, they would drop out of both
12 performance and benchmark. If they're in they would be in
13 performance and benchmark, just to keep consistent.

14 DR. CROSSON: I understand that, but I think -- I
15 still think it fundamentally changes the nature of the
16 motivation of the direction of the program, although it
17 solves the technical -- potentially solves the technical
18 problem.

19 MS. THOMPSON: On that point, a practical
20 application of that concept, I mean, these beneficiaries
21 are attributed to ACOs via the relationship they have with
22 the primary care physician, and for a primary care

1 physician to say you're too high cost and we're moving you
2 -- I mean, just in theory I get the concept mathematically,
3 but in practicality, it's very --

4 DR. RYU: Well, if you're that primary care doc I
5 think you'd keep them in your ACO for both, is what I'm
6 saying. So if they're in your benchmark then they'd still
7 stay in, but if there's any kind of this migration, like
8 what we're talking about, that would pull them out of your
9 performance year, what I'm suggesting is, you know,
10 couldn't you just go back and pull them out of your
11 benchmark? Maybe not. I don't know.

12 DR. CROSSON: Well, so we are getting -- we are
13 kind of leaking into the prospective versus retrospective
14 piece, because I was hearing echoes in this of what Dana
15 was talking about two months ago in terms of quarterly
16 changes in the retrospective assignment. And I think all
17 of this is -- this is a valid discussion, but I think this
18 is part of the next piece we need to do, which is to come
19 back to this and make sure we understand all of the
20 different options.

21 MS. BUTO: And just one other thought. As I was
22 listening to you, Jaewon, it just struck me that it creates

1 both some incentives for physicians who are not so, you
2 know, I don't know --

3 DR. CROSSON: Professional.

4 MS. BUTO: -- professional, shall we say. But
5 the other thing is it kind of tilts the ACO program away
6 from accountability of the physician to sort of whatever
7 happens to the patient, and it takes some of that
8 accountability out of it. I think, to me, that's a bigger
9 issue is changing who is responsible.

10 DR. CROSSON: And no implications that's that is
11 what you were suggesting, but I think it's a good example
12 of why this issue of assignment is so complicated and we
13 need to spend more time on it.

14 Pat, on this point, or do you just want to be on
15 the list?

16 MS. WANG: I don't -- it's just -- I don't know
17 if it's on this point or not.

18 [Laughter.]

19 MS. WANG: I'm on the list.

20 DR. CROSSON: Okay. Go ahead then.

21 MS. WANG: I was just curious, on the NPI/TIN
22 issue, it does seem like the work has been very iterative,

1 you know, the original approach then evolved into TIN/NPI
2 and now based on the analysis and learning we're migrating
3 to NPI. And it seems very logical to me. Is there any
4 practical implication to this? Is it more difficult to
5 implement? Is there a reason that the program didn't start
6 this way? I'm just curious whether --

7 MR. GLASS: Oddly enough, we looked back at the
8 2011 final rule on this, and CMS explained that, well, this
9 is the way it was done in the PGP demonstration, using
10 TINs, and that's what they have been doing, and they
11 thought it would be more administratively simple to do it
12 that way. And that was kind of what the argument was.
13 Yeah, I think there was some administrative --

14 DR. CROSSON: Okay. I've got David, Bruce,
15 Warner, and Amol, and then I think we need to proceed to
16 the discussion. So David.

17 DR. GRABOWSKI: Sure. I was just going to ask,
18 picking up on this TIN versus NPI, do we need to think at
19 all about the interaction with the historical benchmark
20 versus introducing a regional benchmark? You talked about
21 that in your presentation. I'm trying to think about, as
22 we go down to the clinician level, we have this regional

1 benchmark. Does that sort of present incentives that you
2 wouldn't get if you just had an historical benchmark?

3 MR. GLASS: Yeah. The implications of the
4 regional benchmark are manifold, and we haven't gotten into
5 that yet. For example, risk adjustment becomes more
6 important if you're comparing the spending on these
7 beneficiaries to the spending of beneficiaries in the
8 region. And we just haven't gone through all of that yet.

9 DR. GRABOWSKI: But does it increase the
10 incentives around selection, if I go to the NPI level
11 versus staying at the TIN level? Is there any sort of
12 issue there? Have you thought through that?

13 MR. SERNA: No, because the set of TINs for the
14 ACO stay exactly the same. So the incentives, once you
15 throw in a regional blend, wouldn't really change. I mean,
16 what the regional blend obviously -- as you know, the
17 incentive is to have that low cost, as low cost as
18 possible. That way you can do status quo and still receive
19 shared savings payments. But that doesn't really change
20 under this scenario.

21 DR. CROSSON: Okay. Bruce.

22 MR. PYENSON: Terrific report. I've got three

1 topics I want to ask about. A question about the annual
2 wellness visit, a question about risk adjustment perhaps in
3 future models, and a question about sources of physician
4 profiling data.

5 I think on the first one, the annual wellness
6 visit, you've presented evidence or information that the
7 annual wellness visit is of questionable value to
8 controlling cost, and there's been some studies about that.
9 I think this Commission -- correct me if I'm wrong -- we
10 recommended that the annual wellness visit not be used by
11 MA plans for risk adjustment because -- do you remember
12 why?

13 MR. SERNA: So the recommendation was to not use
14 health risk assessments in the risk adjustment model. And
15 so how risk assessments are to be part of the wellness,
16 it's an essential part. And so de facto wellness visits
17 wouldn't be used in the risk adjustment model.

18 DR. MATHEWS: Luis, if I could just clarify,
19 wasn't it, more specifically, that diagnoses collected
20 solely from health risk assessments should not be used?

21 MR. SERNA: That's correct.

22 DR. CROSSON: That did not appear somewhere else.

1 MR. SERNA: Correct.

2 MR. PYENSON: So we -- maybe some people thought
3 that MA plans were gaming the system, but certainly ACO
4 wouldn't, perhaps. But are we -- did we challenge whether
5 Medicare should even pay for annual wellness visits? That
6 wasn't part of that?

7 MR. SERNA: No.

8 MR. PYENSON: Okay. Thanks. A question on risk
9 adjustment. I think some of the newer models, maybe some
10 of the older models, had risk adjustment as part of the
11 benchmark calculation. And I think that -- how does that
12 raise the issue of selecting physicians or NPIs? Because
13 the unadjusted benchmark is what it is in terms of its
14 dollars, but it strikes me that a risk-adjusted benchmark,
15 the issue is whether the patient's risk score is higher or
16 lower than the claims. So could you comment on how that
17 issue might complicate some of the -- affect some of the
18 discussion we're having here?

19 DR. STENSLAND: Well, I think the idea is you
20 would want patients that have low costs relative to their
21 risk score, and if you look at all these -- all your
22 physicians in your practice, and you hire somebody smart,

1 say a guy like Bruce, and you say, "Tell us what the
2 relative spending is of our various physicians, relative to
3 how much they're contributing to our benchmark," and you're
4 going to be able to say these guys' patients are spending
5 more than you would expect relative to what they're
6 contributing to the benchmark.

7 So if you got rid of those people you would get
8 rid of more spending than you would get rid of benchmark,
9 if that makes sense.

10 MR. PYENSON: Which models would that apply to?

11 DR. STENSLAND: I think it would apply to all the
12 models.

13 MR. PYENSON: Okay. So a third question is
14 you're probably familiar with the profiling, the provider
15 profiling data that Medicare has made available through the
16 qualified entity program, and that's comprehensive and
17 identifiable. Do you see that data as being used to
18 manipulate ACO panels or TINs, or could it be used for
19 that?

20 DR. STENSLAND: I don't think we have a good
21 handle on that. You might have a better idea on that. But
22 I think in terms of the ACO themselves, they necessarily

1 wouldn't need that if they know their individual
2 physicians, how the patient was attributed to those
3 physicians, and what the spend of those patients are for
4 each one of them attributed to each physician.

5 MR. PYENSON: Perhaps I was thinking of more of
6 the consolidation of inviting other organizations to come
7 into the ACO. Okay. Thank you.

8 DR. CROSSON: Okay. Warner.

9 MR. THOMAS: Two quick questions. One, I guess,
10 how difficult do you think this change is to implement,
11 just from an administrative perspective? Is it feasible?
12 Do we know?

13 MR. SERNA: So we are not looking at changing the
14 structure of the participants or anything about the
15 program. It's strictly a calculation of how the NPIs are
16 applied to benchmarks. So I think from our standpoint it's
17 just a couple of lines of programming.

18 MR. THOMAS: Okay. And then two, I guess, you
19 know, as I sit here and listen to this we talk about
20 assignment. I mean, did you vet or think about just going
21 down the road of assignment of primary care physicians for
22 traditional Medicare patients, which would essentially

1 probably solve a lot of these issues, generally, and may
2 solve other issues as well.

3 MR. SERNA: You mean having every beneficiary
4 designate a certain primary care physician?

5 MR. THOMAS: That's what I mean.

6 MR. SERNA: Yeah, that's certainly a feasible
7 idea, and in direct contracting they seem to be thinking
8 that's going to happen a lot more. I guess we'll see how
9 that turns out. They've tried it in Next Gen and there
10 just hasn't been much take-up, I don't think. And where
11 the beneficiaries have designated the provider it's kind of
12 the same one that was --

13 MR. PYENSON: It's voluntary, though.

14 MR. GLASS: Yeah, it's voluntary. Right.

15 MR. PYENSON: And hasn't had much take-up at all.

16 MR. GLASS: Right.

17 MR. THOMAS: And I just bring it up because, I
18 mean, it's -- and me and Pat speak about this, but it's
19 pretty typical in Medicare Advantage, especially if there
20 is risk orientation. So I know there's been a little bit
21 of aversion to that, but I think as we move down this road
22 of more global payments, more alternative payment

1 mechanisms, this idea of having a beneficiary identify with
2 a physician who is their personal physician, I think
3 becomes more and more important, and it would solve some of
4 these issues that we're talking about.

5 MR. GLASS: And I think what has been brought up
6 in our focus groups there hasn't been unanimous delight on
7 the part of the beneficiaries on the idea of doing it, but
8 it's certainly an idea that could be looked at.

9 DR. CROSSON: Amol.

10 DR. NAVANTHE: So I have a very nuts and bolts
11 question, and I apologize because I think it is captured
12 somewhere in the appendices of prior work, but I couldn't
13 quickly track it down. So when we're looking at the
14 assignment algorithm, there's the third step, which is the
15 specialists assignment piece, and it's defined, as I was
16 reading it, by primary care services provided by
17 specialists. And then it goes on to describe that by
18 regulation there's a specific set of specialists, medical
19 specialists basically who primarily account for that.

20 My question is about the actual notion of
21 differentiating the types of care provided by other
22 services, by other billing codes. Are there particular

1 codes that we're looking at here? Or how is that actually
2 being differentiated? Because standard E&M type visits
3 could be primary care, they could be non-primary care, and
4 I'm curious how that's actually teased out and whether it's
5 teased out or purely based on specialty.

6 MR. GLASS: Yeah, there's a list of which E&M
7 codes qualify to be counted for assignment. I don't know
8 the list off --

9 DR. NAVANTHE: Do we have a sense of how primary
10 care they are? Again, standard E&M codes could certainly
11 be used for a cardiologist in the context of a cardiology
12 visit, which is not really primary care.

13 DR. STENSLAND: I think it's just -- it's
14 probably better just to call it an E&M code as opposed to a
15 primary care.

16 DR. NAVANTHE: That's what I was hypothesizing,
17 and that actually, at least in the way -- this is not your
18 literature, but the way that it's written, I think it's a
19 little bit misleading then, because the specialists who are
20 included, many of whom are relatively high-cost
21 specialties, then they actually have -- could have a pretty
22 meaningful impact on assignment as a sort of third catch

1 bucket. So I'm curious, the winding way I was trying to
2 get, the point I was trying to get to is: Do we have a
3 sense of how much of that attribution is being driven via
4 that third bucket of specialists? And, in particular, when
5 we start to look at the questions we've been asking around
6 high-cost patients and/or high-cost physicians, how many of
7 them end up interacting with that third specialist
8 assignment part?

9 MR. SERNA: So it's 10 percent of beneficiaries
10 that are assigned to ACOs are assigned through that third
11 step, through the specialist --

12 DR. NAVANTHE: Do we have a sense of are they
13 higher cost or are they lower cost? Do we have a sense of
14 those patients as well as the specialists?

15 MR. SERNA: We didn't specifically look --

16 DR. NAVANTHE: NPIs.

17 MR. SERNA: -- at that, but it didn't seem like
18 there was a specific pattern. Obviously, some of them
19 tended to be low use and others didn't. But it kind of
20 varied.

21 DR. STENSLAND: And the key point is that there's
22 balance, because those -- they'll be in your benchmark, and

1 they'll be in your performance year. As long as whether
2 you're high-cost or low-cost is consistent in your
3 benchmark and your performance year, we're okay. As long
4 as there's not some sort of a shifting. If the hypothesis
5 was, oh, your hematologists have high-cost patients, what
6 you wouldn't want to see then is you're in your benchmark
7 year, and then by the time your performance year comes
8 around -- they still treat all their same patients. They
9 don't say to no to any patients. They just start billing
10 under a different TIN, and then they're not in your
11 performance year. That's what we would get around with
12 this recommendation.

13 MR. GLASS: The intent on the specialty
14 assignment part was -- I'm going back -- that there were
15 people who just see their cardiologist; they don't see
16 their primary care physician. They have to see their
17 cardiologist a couple times a year, so that's the only
18 person they see. And they didn't want to leave those
19 people out, and part of that was because you wanted to
20 increase the number of people assigned to the ACO. You
21 know, you wanted to get to your 5,000 minimum.

22 DR. NAVANTHE: Right. I guess in some sense I

1 can see this be a supporting point to the NPI-based rather
2 than TIN-based methodology perhaps, but the types of
3 selection, I guess I was thinking about, you know, if you
4 have patients who attributed by the specialist and you just
5 exclude the specialist in the performance year as an NPI,
6 then you would potentially avoid having those high-cost
7 patients in your performance year. And I think the NPI,
8 the way we're doing sort of intention to treat, NPI would
9 address that problem. But I just didn't have a sense of
10 how important magnitude-wise this population was in terms
11 of interacting with the selection effects.

12 DR. CROSSON: Okay. Somewhat increasingly
13 characteristically, we used up almost the entire part of
14 our assigned time for the questions. What we do have is a
15 recommendation, and so I would like to have a discussion
16 period, but I would ask you, since we've had a lot of good
17 discussion in the question period that goes beyond
18 questions, I'd sort of like to hear discussions on the
19 recommendation, particularly people who think that they
20 cannot support the recommendation when it comes forward
21 next month. Marge.

22 MS. MARJORIE GINSBURG: This doesn't really

1 address your question, but I'm going to ask it anyway.

2 [Laughter.]

3 MS. MARJORIE GINSBURG: I've been struggling with
4 the title, "Addressing MSSP vulnerabilities," and I
5 particularly feel the word "vulnerabilities" just doesn't
6 capture it or it suggests something that's not -- so I just
7 wanted to make a suggestion for a different title:
8 "Improving MSSP accuracy." And part of it is I wonder how
9 much thought we give to what we title our things so that
10 sort of the psychology of people looking at this and
11 accepting it, saying, "Oh, this looks good," focusing on
12 the positive, improving something may be more appealing.
13 So enough said on that.

14 My second comment was just a concern. We're
15 already seeing a very small improvement of 1 to 2 percent,
16 and so I worry a little tongue in cheek that if we actually
17 get more accurate, we're going to see the savings disappear
18 entirely. So that's all.

19 DR. CROSSON: So on your first comment, I think
20 it's a good point, and I personally favor more positive,
21 and I would ask maybe we could reconsider the title in the
22 direction you're describing. But just in general, in terms

1 of ACOs or MA or any other area that we try to take on, we
2 often will have two things going on at once: one which is,
3 you know, focused on making sure that the Medicare program
4 is not overpaying and other sets of activities -- and we're
5 going to talk about them particularly next month, but we
6 have talked about them before -- to try to improve the
7 program, whether it's ACOs or MA, to make it more
8 successful, to make it better for beneficiaries. You know,
9 so we might very well in this particular situation have the
10 result that you're looking for, but in some of the other
11 activities that we're engaged in, we would hope it to go in
12 the other direction.

13 Yes, Brian.

14 DR. DeBUSK: On Marge's point, you started it; I
15 wasn't going to say anything. But I agree with your second
16 point, the observation that you made.

17 First of all, I support the Chairman's draft
18 recommendation. I think it's wonderful. I'd love to see
19 prospective assignment revisited well because I think you
20 made the case for both really well in the chapter. But
21 here is -- and I've done something like this before. You
22 know, you look at the MSSP Shared Savings Program, and you

1 guys check my math as we go. Medicare pays 91 cents on the
2 dollar and still contributes 8 percent to the fixed cost of
3 the hospital. I think that's what we're going to publish
4 in March. It was 8 percent, I think at least was the
5 number in the reading material. So if I can avoid an
6 admission or an ED visit, I'm going to shed 83 percent of
7 my variable cost, so I'm going to incur 17 percent of my
8 fixed cost, regardless -- that's what fixed cost is.
9 You're going to give me back 48 percent in shared savings,
10 which is going to give me a 31 percent margin. So I'm
11 going to go from minus 9 percent margins, which 91 cents on
12 the dollar is, to 31 cents. You're going to swing my
13 margin 40 points. And you've done a great job of
14 documenting these vulnerabilities that are in the system.
15 Right? The ability to manipulate TINs and to manipulate --
16 I'm sorry, inaccuracies, Marge, seriously sorry --
17 inaccuracies that are in the system.

18 When I look at other areas -- and this is a
19 philosophical question for next month's discussion, too.
20 When I look at other areas, like when I look at hospitals
21 buying physician practices and turning them into provider-
22 based departments, when I look at MA plans figuring out how

1 to cross-walk enrollees, when I look at even we're going to
2 take up the TDAPA issue in dialysis centers, I mean, these
3 guys are reacting in months, maybe even weeks, when there's
4 an inaccuracy presented in the system. This program's out
5 there for nine years that appears to create a 40 percent --
6 40-point swing in margin in a 5 percent industry. I can't
7 figure out why we aren't having public meetings on how we
8 slow this thing down and how it's just, you know, exploding
9 the payments that we're making. What's wrong? Is the math
10 -- does it not add up?

11 DR. STENSLAND: Different story. You actually
12 have to find some unnecessary service use and agree on what
13 it is and reduce it. It seems to be a hard thing to do,
14 whether it's an ACO, whether it's a bundle that Amol looks
15 at, whether it's MA plans.

16 [Off microphone]: Unless you live in Florida.

17 DR. STENSLAND: If you live in Florida and you
18 have some extra to cut, it's a little easier. And
19 especially if you're an entrepreneurial person, you may
20 have been entrepreneurial on the upside, and maybe you're
21 entrepreneurial on the downside.

22 DR. DeBUSK: I would be curious, and this is a

1 comment, not a rhetorical question, but I kept it out of
2 Round 1 because I'm behaving. It would be interesting for
3 you guys to look at the successful ACOs that are in Florida
4 and try to gauge those providers and look at their MA
5 footprint, because I have a working theory or hypothesis
6 that because you see progressive MA, at least in parts of
7 Florida, and progressive MA at least -- I'm not saying
8 exhaustively -- in parts of California, I think that what
9 you may be measuring is some spillover from progressive MA
10 translating into successful ACOs as well.

11 DR. CROSSON: Okay. David, Jonathan, and Jaewon.

12 DR. GRABOWSKI: So I'm a little bit more neutral
13 on the Chairman's recommendation. I wouldn't say I'm
14 against it, but I sort of go back to the comment that Dana
15 made in the first round about it seems like we're just
16 trading one level of problem for another. And, ultimately,
17 we're worried about risk selection here, but I think we're
18 just kind of changing the level. And, you know, I like
19 Marge's word, "inaccuracies." I was going to use
20 "mismatches," but we're really worried about these
21 mismatches. And I feel like we're trading mismatches over
22 time and clinicians in the same TIN for mismatches in TINs

1 for the same clinicians. And I don't know that we're
2 actually solving the problem. The problem here is risk
3 selection. I would like to see us invest in better risk
4 adjustment. I know we're going to have a session later
5 today on a different application of risk adjustment, but I
6 would like to see us improve the risk adjustment in ACOs,
7 and I don't know that this kind of movement across levels -
8 - once again, I'm not against it. I just don't know that
9 it solves the problem that we're going after here. Thanks.

10 DR. CROSSON: Thank you, David. And I see that
11 point. And I don't want to put words in the staff's mouth,
12 but I do think that they have the sense that, while that
13 may be true, using the TINs seems to be more likely, and
14 there may be some evidence that that manipulation exists;
15 whereas, manipulation on the other side could become
16 manifest in the future.

17 Now I got lost. Jonathan, Jaewon, and then
18 Bruce. And then I think we have to finish.

19 DR. JAFFERY: Great, thanks. So I am supportive
20 of this change. I think in terms of the Chairman's
21 recommendation, I would like to see some wording that
22 references what you have in the reading about adjusting for

1 regional movement. You were clear about how you'd do that,
2 but it doesn't come out right there. And I think the fact
3 that, like you said, administratively it would probably be
4 a pretty simple fix as a positive.

5 I guess I wanted to just talk about a couple
6 other pieces that I heard as a thread that I feel pretty
7 strongly about, and I think -- Marge, I'm glad you brought
8 up this notion of talking about vulnerabilities, because I
9 hadn't thought of phrasing it in a more positive way. I
10 think that's a great idea. But as I was looking at the
11 title, what jumped out at me is that there are a whole
12 bunch of vulnerabilities that we're not addressing that I
13 think are a little bit more existential to the program
14 overall. We've seen really an amazing increase in the
15 number of CMS ACOs MSSPs over the years until now. We've
16 actually seen a drop. And so it feels -- and I think I've
17 mentioned this in previous meetings. It's starting to feel
18 a little less stable and a little more threatened as a
19 program overall. We're talking about modest savings and
20 small savings, and I guess I'm still not sure what we're
21 comparing that to when we don't have other programs that
22 have released any savings. And what is the number that's

1 going to not be modest or small? As somebody who's trying
2 to run this program, how do I know when that's going to be
3 successful? Is it 4 percent? Is it 5 percent? And I
4 don't know that we have an empiric number, but I guess
5 sometimes I look at the 1 or 2 percent and think this is
6 actually a win that we haven't had other places.

7 I'm looking at things around the new programs,
8 the direct contracting and pathways to success that are all
9 pushing us to risk more quickly, and I wonder if that's not
10 nuanced enough. And maybe there are some parts of the
11 country where going to risk quickly is an early win and is
12 important and maybe places where there's lower benchmarks
13 where maybe -- I'm not suggesting that we create benchmarks
14 that just make it so that low baseline places automatically
15 get savings, because that would not be in keeping with the
16 goals of the program or the opportunities, but maybe going
17 to risk in two years if your benchmark is in the lowest
18 quartile to start with, your baseline spending is not
19 realistic. I think we've seen experience in our region,
20 Dana has described it with her group in the commercial
21 world, that maybe it takes a little bit longer.

22 And then I think to channel a couple things that

1 Bruce and Warner said, do we think about some bolder type
2 of recommendations? The annual wellness visits, what
3 purpose are they serving exactly? I don't think that
4 there's at present a lot of gaming going on in terms of the
5 way that we've talked about, but a lot of places do use
6 them not only for quality measurement but risk adjustment
7 and straightaway revenue enhancement. If beneficiaries are
8 getting a bill that they weren't expecting 40 or 45 percent
9 of the time, and their focus group suggests they're not
10 seeing any benefit, what's the big purpose of having them
11 in the first place? And do we think about even eliminating
12 them and still allowing for no co-pays for preventive care
13 or what-not?

14 And then, finally, this notion of choosing
15 primary care docs, I think this is a really important one
16 that Warner brought up again. And maybe it's beyond
17 assigning primary care docs. Maybe we get to the point
18 where we think about do beneficiaries actually -- are they
19 required to actually choose whether or not they participate
20 in an ACO? We make them choose between MA and traditional
21 fee-for-service. Once they choose traditional fee-for-
22 service, they may or may not end up in an ACO. I'm not

1 sure the fact -- how did you put it, David? There hasn't
2 been unanimous delight. I'm not sure that we wait for
3 unanimous delight for anything. That's going to be a
4 pretty high bar. And if people were actually choosing, I
5 think it would force us to create programs that make sense
6 to people. We probably need to not call them "accountable
7 care organizations" and, even better, not call them "direct
8 contracting entities." But it would be a lot more
9 transparent if people were actually choosing what they
10 wanted to be part of.

11 So not for today. I think that's a future
12 discussion as we think about how do we really get rid of
13 some of these vulnerabilities or the program overall.

14 DR. CROSSON: A lot of good points there. Okay.
15 Jaewon and then Bruce, and then we have to end.

16 DR. RYU: So three points. One, I like the
17 recommendation, so I think that makes a lot of sense. It
18 does seem to get closer to -- and I'll use David's term --
19 being able to better match. So I think it feels
20 comfortable without undermining or potentially putting at
21 risk the progress that's been made in the program.

22 The second point around selection and getting to

1 even better matching, it just feels like if you look at
2 this as high level simply as possible, at least to me, it
3 feels like the more you can have whoever's in the
4 measurement here, the performance year, should also be in
5 the benchmark year, and whoever is not in the measurement
6 year should not be in the benchmark year. Just at a very
7 high level, it seems like that's the goal, to get the best
8 matching possible. I don't know what the levers are, and
9 I'm sure in the subsequent discussion, you know, when we
10 get to prospective versus retrospective, it feels like that
11 is the guiding principle, which, you know, led me down the
12 path of, well, is it just concurrent beneficiary pools that
13 you need to look at to get that perfect match. But I get
14 that that introduces a whole host of other issues. So I
15 think that's the discussion to be had for the next phase.

16 Then the other is just a quick comment on Brian's
17 margin analysis. I think there is something to spillover
18 effects from infrastructure that's been built to manage MA,
19 and places or ACOs that are able to leverage that to help
20 them do what they do on ACOs, because I'm not sure if it's
21 a 40 percent lift for organizations or hospitals going
22 from, you know, traditional fee-for-service payment into

1 the ACO world, because there's a whole lot of
2 infrastructure and capability that needs to be built to
3 figure out where is the unnecessary utilization and how do
4 you manage that in a different environment and better. But
5 to the extent places have done that because they've been
6 managing MA populations, I do think there's some ability to
7 cross-leverage those capabilities, and maybe that's, you
8 know, why we're seeing that Florida seems to have a lot of
9 these, in addition to the fact that they're starting from a
10 point where they have a lot of utilization that can
11 probably come out of the system. So I just wanted to make
12 that comment.

13 DR. CROSSON: Thank you. Bruce -- Pat, on this
14 point?

15 MS. WANG: No.

16 DR. CROSSON: Okay. Bruce.

17 MR. PYENSON: Yeah, I strongly support the
18 Chairman's recommendation. I think it's a step in the
19 right direction. It might be characterized as a Band-aid,
20 but it's a really important one to stabilize the system.

21 I think the ability of ACOs in the current
22 structure to optimize results without necessarily improving

1 care is a risk. It's a risk we've certainly seen in the
2 Medicare Advantage program with optimizing risk scores and
3 other characteristics. So I wouldn't be -- I don't think
4 any of us should be surprised at that, as people are eager
5 to see ACOs and should be eager to see the ACOs prosper.
6 But I think the kind of risk that has been identified here
7 is probably the tip of the iceberg. I see that sources of
8 data such as the qualified entity data which is available
9 to consultants is potentially being used to identify which
10 individual practitioners, physicians, to invite into ACOs
11 and which to disinvite. And given the ongoing
12 consolidation of the market, I think that's a profiling
13 tool that's out there and available. So I would recommend
14 that we look at that and perhaps issue recommendations to
15 CMS that controls that on its proper use or allowed uses.

16 I can say as a consultant in this business, I
17 know I'm getting inquiries for exactly that sort of
18 profiling. It's happening. I'm not saying all of the ACOs
19 are doing that or most of them are doing it, but there's
20 certainly interest in understanding that and using that
21 data.

22 Finally, I echo Jonathan's comments about taking

1 a hard look at the annual wellness visit. Is it something
2 we should recommend continue to be used? Does it have
3 value? I think there's similar low-value items like shared
4 decision-making visits that have no evidence, and I think
5 it's part of our charge when we see things like that to ask
6 those questions.

7 Finally, I do strongly support a prospective
8 structure.

9 I'm going to say one more "finally" thing, which
10 is that this picks up on Warner's recommendation on an idea
11 on assigning primary patients, beneficiaries to primary
12 care.

13 In the long run, it's not clear to me that
14 attribution is a model that can work. Attribution has been
15 used to create virtual capitation or virtual insurance, and
16 it's just not clear to me that it can be used in a stable
17 way. And I think that's something the Commission could
18 usefully look at, whether we need to move away from
19 attribution and more towards the model of people are
20 assigned to primary care physicians or other physicians.

21 DR. CROSSON: Bruce, this is a point I happen to
22 agree with, and it's come up a number of times. We started

1 at one point to move in the direction of attestation, which
2 would preserve, because we have to at the moment, the right
3 of beneficiaries to go wherever they want, but to put in
4 the mind of beneficiaries at least that there is one
5 physician or one group of physicians who are primarily
6 responsible for them. I think maybe that thinking could be
7 brought back again.

8 DR. DeBUSK: On that specific point, you could
9 attach attestation to the Part B premium. You don't really
10 have the cost-sharing labor because only 12 percent of our
11 beneficiaries are exposed to cost sharing, but you could
12 attach that to Part B premium and just basically do a
13 buydown if you attest to a primary care physician. That
14 would solve a lot of these issues.

15 DR. CROSSON: We walked up to this and then -- I
16 can't remember -- a year or two ago kind of backed away
17 from it. I think it is fertile ground.

18 Kathy?

19 MS. BUTO: On this same point?

20 DR. CROSSON: Yeah, all right.

21 MS. BUTO: Very briefly, I think it would also
22 allow you to consider the issue of incentives for primary

1 care physicians and adding a larger payment to primary care
2 physicians in the case of attestation for a range of
3 things.

4 DR. CROSSON: Yeah.

5 MS. BUTO: So I think it opens some other doors.

6 DR. CROSSON: Multiple utility.

7 Okay. Pat, last, and then we do have to move on.

8 MS. WANG: Real quickly.

9 I support the draft recommendations, and just
10 picking up on some of the other comments, I think that one
11 of the areas that I'd be interested in us understanding
12 better and pursuing is when I look at the list of these
13 really successful ACOs in Appendix A, just eyeballing the
14 names, it's consistent with the findings that the physician
15 ACOs have generated more shared savings. So maybe there is
16 a different equation or value proposition in understanding
17 what makes a hospital-based ACO successful. To Jon's
18 question, how do I know success when I hit it? It might be
19 a different thing.

20 My personal view is that this is all good, the
21 work in the ACOs, but that the effort to make sure that
22 people have a real primary care physician is really not the

1 end of the story. I actually think that we need to move
2 more towards system-ness, so that your primary care
3 physician belongs to a system of care through which you
4 move, and that includes specialists and acute care
5 hospitals and vehicles to get to tertiary or quaternary
6 care. This is only the start, I think, of the sort of
7 observation or the narrative of what makes good care.

8 So I think it's very important. All of these
9 things are very important, but a little bit more of a focus
10 on maybe there is a different definition of success for a
11 hospital-based ACO than for a purely physician-led ACO.

12 And the second comment, is there more that we can
13 think about in the attribution model to encourage system-
14 ness? Because that's really where I think the system needs
15 to go.

16 DR. CROSSON: These are all good points.

17 I think I might expand. Having said we shouldn't
18 be talking; I'm going to talk.

19 I really do believe that the fundamental
20 incentives in physician-only ACOs and in hospital-led ACOs
21 are substantially different, and as we've said in prior
22 work -- and we're going to come back to this in April for

1 the June report -- the issue of how hospitals are paid and
2 what their incentives are and the incentives inherent in
3 our idea of ACOs are in conflict. Until we can move
4 forward with models -- and there are some out there already
5 -- where the hospitals have an incentive to improve the
6 appropriateness of care services and not maximize care
7 services, we're going to have a continued problem.

8 Having said that, wonderful work. Thank you. I
9 think we have a direction for the April meeting, and we'll
10 now move on to the next presentation.

11 [Pause.]

12 DR. CROSSON: Okay. I think, in some ways,
13 similar to the end of the last discussion, there have been
14 questions raised here at the Commission and more broadly
15 about the role of specialists in alternative payment models
16 and particularly in ACOs and to what degree specialists are
17 or should be involved in the incentives and rewards and
18 penalties of those sorts of payment models.

19 The Commission has not done a lot of work on that
20 yet. There is the intention to do that, and again, I think
21 we'll see this topic appear in the paper for April.

22 But Ariel is here to begin to lay the groundwork

1 for this work by describing the current situation with
2 respect to the role of specialists.

3 Ariel?

4 * MR. WINTER: Good morning.

5 This is an informational session about the role
6 of specialists in alternative payment models, or APMs and
7 ACOs.

8 Before I begin, I want to thank several people
9 who helped with this work: Kevin Hayes, Sam Bickel Barlow,
10 Carolyn San Soucie, Rachel Barton, as well as Luis, David,
11 and Jeff.

12 During previous meetings, several Commissioners
13 have asked about the role that specialists play and should
14 play in APMs and ACOs.

15 In addition, some specialty societies have
16 claimed that specialists have very limited opportunities to
17 participate in APMs and ACOs.

18 So today, we'll focus on two main questions, and
19 I'm going to give away the answers right at the beginning.

20 First, do specialists have opportunities to
21 participate in APMs and ACOs? They do, and in fact, they
22 account for the majority of physicians who participate in

1 Medicare ACOs, but each ACO determines the role of
2 specialists and other physicians; for example, whether they
3 are involved in ACO leadership or receive a portion of
4 shared savings. And we don't have details information
5 about these arrangements.

6 Second, are ACOs with specialists more likely to
7 reduce volume and spending than other ACOs? Thus far, the
8 limited evidence from the literature suggests the opposite,
9 that they are less likely to reduce volume and spending.

10 To begin, we need to explain why APMs are
11 important.

12 MACRA set up two payment paths for clinicians.
13 The first path is for clinicians who participate in
14 advanced APMs, or A-APMs, which I will define in just a
15 moment. These clinicians may qualify for an incentive
16 payment worth 5 percent of their professional services
17 payments from 2019 through 2024. They will also receive a
18 0.75 percent annual update to their payment rates starting
19 in 2026.

20 The second path is the Merit-based Incentive
21 Payment System, or MIPS. Clinicians in MIPS receive a
22 payment adjustment based on their performance. In 2021,

1 for example, these adjustments will range from minus 7
2 percent to plus 7 percent, or higher. Beginning in 2026,
3 these clinicians will receive a 0.25 percent annual update.
4 In 2018, the Commission recommended eliminating MIPS and
5 establishing a new voluntary value program.

6 An advanced APM is a subset of APMs that requires
7 an entity to use certified electronic health record
8 technology, makes payment based on a set of quality
9 measures comparable with MIPS, and requires an entity to
10 bear financial risk for monetary losses in excess of a
11 nominal amount or be a medical home expanded under Section
12 1115A. Clinicians with a minimum share of Medicare
13 payments or patients coming through an A-APM qualify for
14 the 5 percent incentive payment.

15 CMS has developed several APMs with tracks that
16 qualify as advanced APMs and that have opportunities for
17 specialists to participate. There is more detail on these
18 models in your paper, so I am going to go through them
19 pretty quickly.

20 We group these APMs into three categories. The
21 first is APMs that include services typically furnished by
22 specialists. First, the Bundled Payments for Care

1 Improvement Advanced model is a voluntary program that
2 includes episode payment models for 31 inpatient and 4
3 outpatient episodes. This model includes episodes related
4 to spine, bone, joint, neurologic, cardiac, and
5 gastrointestinal procedures.

6 The Comprehensive Care for Joint Replacement
7 model is a mandatory program that applies to lower
8 extremity joint replacement episodes that occur in an
9 inpatient setting.

10 The Oncology Care Model is a voluntary model for
11 physician groups that provide chemotherapy to patients with
12 cancer.

13 CMMI has also proposed future models that would
14 qualify as A-APMs, such as the Radiation Oncology model and
15 Kidney Care First model.

16 The second category includes the Maryland all-
17 payer model in which hospitals in Maryland are paid using
18 global budgets and the Maryland total cost of care model
19 which sets a limit on Medicare's total costs in the state.

20 The third category is ACOs. The Medicare Shared
21 Savings Program, as we just talked about, is a permanent
22 model and is the largest ACO program. Some of its tracks,

1 such as the enhanced track, are two-sided risk models that
2 qualify as advanced APMs.

3 The Next Generation ACO model is a temporary
4 model run by CMMI.

5 In the Comprehensive ESRD Care Choice model,
6 nephrologists, dialysis clinics, and other providers join
7 together to take responsibility for quality and spending
8 for ESRD beneficiaries.

9 And finally, there is the Vermont All-Payer ACO
10 model.

11 Now I'm going to switch gears and talk about
12 specialists' participation in ACOs.

13 Beneficiaries are mainly assigned to an ACO based
14 on primary care visits with primary care clinicians who
15 participate in the ACO, but ACOs may also include
16 specialists on their list of participating physicians.
17 Each ACO can determine the nature of its relationship with
18 participating physicians, including specialists; for
19 example, whether they are involved in ACO leadership or
20 receive a portion of shared savings.

21 So why would specialists want to participate in
22 an ACO? First, ACO participation might lead to more

1 referrals from primary care physicians in the ACO. Second,
2 specialists could potentially share in savings if the ACO
3 receives shared savings, and third, they might qualify for
4 the 5 percent incentive payment if their ACO qualifies as
5 an A-APM.

6 On the flip side, do ACOs want to include
7 specialists? They might want to include specialists
8 because they can give them incentives to constrain volume
9 growth, which could help the ACO reduce spending. However,
10 ACOs don't need specialists for patient assignment because
11 beneficiaries are mainly assigned to an ACO through primary
12 care clinicians.

13 And even if specialists don't participate in an
14 ACO, the ACO can still influence their practice patterns by
15 encouraging primary care physicians in the ACO to refer
16 patients to less costly specialists.

17 Interviews and focus groups with ACOs and
18 physicians shed light on the role of specialists in ACOs.
19 These findings come from interviews conducted by Commission
20 staff with ACO leaders in 2018, focus groups that we
21 conducted with physicians in 2019, and an OIG report from
22 2019 that was based on interviews with 20 ACOs.

1 We learned that ACOs led by primary care
2 physician groups are more selective about their
3 participating physicians than other ACOs, and may not
4 include any specialists.

5 On the other hand, ACOs affiliated with health
6 systems tend to include all of their employed physicians in
7 the ACO, and these ACOs tend to have more specialists than
8 primary care physicians.

9 We also learned that ACOs use various approaches
10 to manage referrals to specialists. For example, some ACOs
11 give primary care physicians data on specialists' use of
12 services to help them consider cost and quality when they
13 make referrals.

14 When specialists know that ACOs are sharing this
15 information with primary care physicians, they have an
16 incentive to reduce spending and improve quality.

17 We analyzed data from CMS on the share of
18 physicians participating in MSSP ACOs in 2018 who were
19 specialists. Overall, we found that 63 percent of
20 participating physicians were specialists, as shown in the
21 bar on the far left. This is similar to the share of all
22 physicians enrolled in Medicare who were specialists in

1 2018, 64 percent.

2 But the share of specialists varies by type of
3 ACO. It was 65 percent in hospital-affiliated ACOs,
4 compared with 50 percent in physician-led ACOs. A
5 potential explanation for the higher share of specialists
6 in hospital-affiliated ACOs is that these types of ACOs
7 tend to include all their employed physicians.

8 This chart shows the share of physicians
9 participating in Next Generation ACOs in 2018 who were
10 specialists. Similar to what we saw for MSSP ACOs, 60
11 percent of physicians in Next Gen ACOs were specialists, as
12 shown in the bar on the far left.

13 A much higher share of physicians in hospital-
14 affiliated ACOs were specialists than in physician-led
15 ACOs, 63 percent versus 36 percent.

16 I just want to remind you that these charts are
17 based on a list of physicians who participate in an ACO,
18 and we don't know how extensive their relationship with the
19 ACO. Nevertheless, these charts suggest that there are
20 substantial opportunities for specialists to be part of an
21 ACO.

22 Research on the impact of specialists on ACOs'

1 volume and spending is limited, but we know of two studies
2 that examine this issue in the context of MSSP ACOs.

3 First, McWilliams and colleagues used a difference-in-
4 differences approach to compare changes in total Medicare
5 spending between different types of ACOs and a control
6 group. They found that primary care physician group ACOs
7 reduce total Medicare spending, but multispecialty
8 physician group ACOs did not.

9 Second, an article by Barnett and McWilliams also
10 used a difference-in-differences approach to compare
11 changes in the use of office visits with specialists
12 between different types of ACOs and a control group. The
13 authors hypothesized that ACOs that are mostly made up of
14 primary care clinicians have a stronger incentive than
15 other ACOs to reduce the use of specialty care because they
16 do not lose fee-for-service revenue when they provide less
17 specialty care.

18 By contrast, multispecialty ACOs could lose
19 substantial fee-for-service revenue if they make fewer
20 referrals to specialists.

21 The article found support for this theory. ACOs
22 with a high share of primary care physicians reduced the

1 number of specialist visits, but ACOs with a high share of
2 specialists did not.

3 So to conclude, we'll return to our original
4 questions. Do specialists have opportunities to
5 participate in APMs and ACOs? They do, but each ACO
6 determines how involved specialists are going to be in that
7 ACO and whether they can receive a portion of shared
8 savings.

9 Are ACOs with specialists more likely to reduce
10 volume and spending than other ACOs? Thus far, limited
11 evidence suggests the opposite, that they are less likely
12 to reduce volume and spending.

13 This concludes my presentation, and I'd be happy
14 to take any questions.

15 DR. CROSSON: Thank you, Ariel. Very clear.
16 We'll take questions. I see Brian, Jonathan, Amol. Brian.

17 DR. DeBUSK: First of all, great chapter. Thank
18 you. I enjoyed reading it. I have two questions, and you
19 mentioned this briefly in the chapter, but do we have any
20 way to measure how much of, say, the MACRA bonus or any of
21 these bundles that are being reconciled or any of these ACO
22 reconciliations, do we have a way to measure how much of

1 that actually makes it to physicians, and do we have any
2 tools to direct it to ensure that it makes it to
3 physicians? That's my first question.

4 The second question and then I'll hang up, is,
5 are there examples of population health models, say ACOs
6 and episodic models, say bundles, successfully interacting?
7 I mean, is there anything out there we can go on to show
8 the two living together?

9 MR. WINTER: Your first question, was that
10 directed towards any shared savings distributed to
11 physicians or the 5 percent incentive payment?

12 DR. DeBUSK: Basically any of those incentive
13 payments. Is there any way to measure how much of that
14 actually makes it to the physician, with the data we have
15 now?

16 MR. WINTER: I'm not aware of any data that would
17 measure how much of the savings retained by the entity is
18 distributed to individual clinicians. And some of the
19 models we've talked about only hospitals could be the
20 participating entity, like the CJR model.

21 But with regards to the 5 percent incentive
22 payment, CMS has released information for at least the

1 first two performance years of how many clinicians qualify
2 for that payment, and it was 99,000 clinicians in the 2017
3 performance year, which means they'll get the bonus, and
4 they got the bonus in 2019, and I think it was 183,000
5 clinicians who qualified for that 5 percent incentive
6 payment in 2018, which means they'll get the bonus this
7 year.

8 DR. DeBUSK: Are they not paid out by TIN,
9 though? I thought that MACRA bonuses --

10 MR. WINTER: Paid out NPI.

11 DR. DeBUSK: Okay. Thank you. Thank you for
12 clarifying that.

13 MR. WINTER: And we are working with CMS to get
14 data on the NPIs of those specific clinicians who got the
15 bonus, to be able to identify what specialty they belong
16 to, so we could come back to you hopefully with some
17 analysis, some findings on, you know, what percent were
18 PCPs versus specialist, by type of ACO, by CJR, by BPCI
19 Advanced, for example.

20 In terms of the dollar amount, CMS has not
21 publicly released the dollars that were paid out through
22 the advanced APM bonus, but they have made estimates. And

1 so, for example, for 2020, they estimated that total
2 payments would be between \$675 million and \$900 million for
3 between 185,000 clinicians and 250,000 clinicians. So
4 based on that, the average per clinician would be about
5 \$3,600. But as I said, the actual number of clinicians who
6 got the bonus was somewhat lower, was at the lower end of
7 the range, 183,000 clinicians.

8 So the total dollar amounts might have been
9 higher per clinician. But until we get the total dollar
10 amount from CMS that was actually paid, or that will
11 actually be paid in 2020, we won't be able to calculate the
12 actual average.

13 DR. DeBUSK: So just round numbers, MACRA money
14 is around \$5,000 per qualifying -- I mean, I bumped it up
15 from \$3,600 assuming that --

16 MR. WINTER: Well, I think that the total amount,
17 the total payments were based on how many clinicians would
18 actually get bonus, so it's probably -- I'm not sure I
19 would bump it up. It's probably closer to the \$675 million
20 end of the range than the \$900 million end of the range.

21 DR. DeBUSK: So \$3,600 --

22 MR. WINTER: That's where we're at.

1 DR. DeBUSK: -- is the totality of the MACRA
2 bonus for the ones who qualified.

3 MR. WINTER: That's what we're estimating, but
4 we'd like to get final -- the final aggregate number from
5 CMS so we can calculate the actual average.

6 To that part, but was there a second question?

7 DR. DeBUSK: And then the second question was,
8 can you speak to examples where population health models
9 and episodic models are working together?

10 MR. WINTER: Okay. I've not look at that in
11 detail but I know Amol does have an article about that,
12 specifically looking at the interaction between, I think
13 was it CJR or BPSI, one of the BPSI episodes, and ACOs, and
14 Amol can talk to that more specifically. And we can look
15 at the larger and see if there are other examples.

16 DR. NAVATHE: Yes. So we have just simply tried
17 to measure the overlap at the beneficiary level. So there
18 is overlap at the provider level, meaning hospitals or
19 physician groups that are actually participating in both
20 simultaneously, because you are allowed to participate in
21 both simultaneously. That is not a huge amount. I think
22 it's something south of 20 percent of the ACO providers are

1 in BPCI or BPCI Advanced episode as well.

2 At the beneficiary level it is higher. It truly
3 is a percentage of the bundles program, so 30, 40 percent
4 of beneficiaries are both attributed to an ACO and
5 receiving care from a bundled payment provider. As the ACO
6 population as the denominator it is a little bit smaller.
7 It is more like 10 percent.

8 DR. DeBUSK: So this cross-attribution issue is
9 here, whether we like it or not.

10 DR. NAVATHE: Absolutely, and our estimates, just
11 to be very clear, are from 2016, because that's the data
12 that we had at that time. So it's only likely to have
13 increased, because BPCI Advanced has scaled participation
14 relative to original BPCI, and as Jonathan pointed out, at
15 least until 2019, we had increasing participation and
16 attribution of beneficiaries, up to I think about 30
17 percent of beneficiaries.

18 DR. DeBUSK: Final question. If you were tasked
19 with equitably distributing these payments, is this like
20 the rest of your career tied up, or do you think this is
21 something you could knock out?

22 DR. NAVATHE: It's undoubtedly hard. So I think

1 my research team is actually working on the fundamental
2 question first, which is other benefits to overlap. And we
3 are about -- well, we are in the process of unpublished
4 work, preliminary data, suggests that there are benefits,
5 and particularly the benefits are outsized for more
6 complicated patients and medical conditions.

7 So relative, for example, to bundles alone, where
8 we've seen very small effects or no effects for medical
9 conditions, we actually are seeing cost savings for
10 patients who are attributed to ACOs and then go to a BPCI
11 provider for medical conditions, the most common ones like
12 sepsis, CHF, pneumonia, COPD, although we actually look at
13 it across all 48 conditions. So it is the totality of the
14 program.

15 We also see quality effects. So it seems like
16 quality costs are tied up, but usually admissions tend to
17 be lower by about a percentage point, which is not trivial,
18 for medical conditions. And actually we see a reduction in
19 readmissions also on the surgical side, for hip and knee
20 replacement and others. There's actually a little bit
21 smaller, about 0.7 percentage point reduction in
22 readmissions.

1 So it's all preliminary data, so take it with a
2 grain of salt, but it does look like there are synergies
3 between the program. And then the other thing that we've
4 done is we've looked at hospitals that have participate in
5 both simultaneously, and it looks like their patterns of
6 care are actually quite -- are different, not quite
7 different -- are different in the sense that the hospitals
8 that are also in ACOs, they achieve pretty similar results
9 to hospitals and bundled payments alone, but they tend to
10 use the ambulatory infrastructure a lot more. So they use
11 less home health, for example, and they use more office
12 visits with ambulatory ACO per participating provider. So
13 it does look like there's some synergy, is my takeaway.

14 What the accounting looks like to actuate the
15 savings is a whole other beast.

16 DR. CROSSON: Well, we really, I think,
17 collectively look forward to that work, because, I mean,
18 we've had concerns, as you know, about perhaps a negative
19 consequence of being engaged in two different payment
20 mechanisms. And, in fact, if there is synergy it would not
21 only be useful to know but perhaps to try to understand how
22 that synergy plays out.

1 Jonathan?

2 DR. JAFFERY: Yeah, thanks. This is a great
3 chapter. It is really exciting to be getting into this
4 discussion and beyond the things that we've heard about in
5 the chapter and the things you just brought up. Amol
6 raised all sorts of exciting things.

7 I have a couple of quick questions for round 1.
8 One, actually, I think you addressed. I was wondering
9 about the data on the advanced APM bonus payment, specialty
10 versus primary care. It sounds like that's forthcoming.
11 You don't quite have the data yet. And my guess is you
12 probably won't have this either, but any information yet
13 about groups that are not hitting thresholds, and if not --
14 I'm assuming you don't have that yet, but assuming you
15 don't, do you anticipate being able to get data about that?
16 Because I can see where there would be some significant
17 issues for specialists, additional issues with specialists
18 hitting the thresholds, assuming they take regional
19 referrals or things like that.

20 MR. WINTER: And which thresholds are you
21 referring to?

22 DR. JAFFERY: I'm sorry. The thresholds to

1 qualify for the advanced APM bonus payments, the number of
2 patients, the amount of revenue. If they're getting
3 referrals for patients outside of the ACO that they are
4 affiliated with they may have -- yeah, the percent of
5 revenue is going to go down.

6 MR. WINTER: That's a really good question. As
7 you know, the thresholds are increasing steadily over time,
8 so it's going to be more challenging. So that's something
9 we could put on a list for future work.

10 DR. JAFFERY: Okay. Great. And then the other
11 quick question is about the mix of episodes in BPCI-A. So
12 do you update about the mix between patient, outpatient and
13 chronic and acute?

14 MR. WINTER: In terms of the number of types of
15 episodes or the actual number of episodes that are being
16 done in each category?

17 DR. JAFFERY: Like I said, the types of episodes
18 that are being done, in the types that are actually being
19 done.

20 MR. WINTER: So I'm not aware of any data on that
21 yet. The BPCI Advanced just started in 2018, and I don't
22 think there's an evaluation report yet. But we will track

1 that closely and as soon as we see anything, we can get
2 back to you with that information. I don't think we have
3 put anything on the website in terms of how many actual
4 episodes are in each of the 31 inpatient categories or the
5 4 outpatient categories.

6 DR. NAVATHE: I think that's right. The most
7 recent information we have on that is just based on
8 participation, because it's voluntary. So there's been
9 some sizeable shifts. For example, in the original BPCI
10 program there was a lot of participation in lower extremity
11 joint replacement, especially amongst hospitals, so it
12 slowly shifted towards physician groups.

13 In the latest wave, in particular, of BPCI
14 Advanced, for example, hospital participation in LEJR has
15 dropped dramatically. Sepsis is the number one condition
16 for hospitals. Participation in the outpatient episodes
17 seems to be more driven by physician groups than it does by
18 hospitals, for example. So there's PCI and outpatient hip
19 and knee.

20 So the dynamics are shifting. I agree with Ariel
21 that we don't know the actual episode volume in any of them
22 yet, but the participation mix itself is evolving pretty

1 rapidly, even wave to wave in BPCI Advanced.

2 DR. CROSSON: You're up, Amol.

3 DR. NAVATHE: So I had a true, true clarifying
4 question, no undercurrent of a comment in here. So on page
5 5 of the reading there is this note about some physician
6 specialty societies have expressed the view that many
7 specialists have very limited opportunities to participate
8 in A-APMs, leaving MIPS as kind of the default path for
9 them.

10 I was just curious, there's a reference to
11 Alliance of Specialty Medicine and I was curious what are
12 the specialties that are represented by Alliance of
13 Specialty Medicine, to get a sense of who are we talking
14 about here.

15 MR. WINTER: Yeah. It includes -- I'll give you
16 a list of most of them. I think there are 10 altogether,
17 but it includes orthopedic surgery, neurologic surgery,
18 gastroenterology, cataract refractive surgery,
19 echocardiography, plastic surgery, urology, and there are,
20 I think, a few others. I can get you the full list.

21 DR. NAVATHE: Thanks.

22 DR. CROSSON: Okay. Dana.

1 DR. SAFRAN: Thank you. So I've been thinking
2 about the hospital versus physician savings, and I'm
3 wondering what we know about the extent to which the
4 specialists who are part of hospital ACOs are compensated
5 on a salary model versus not. And here's my logic train,
6 is the 5 percent increase in rates, if that's really going
7 to the hospital then of course the hospital wants every one
8 of the physicians that are part of that organization to be
9 counted as part of their ACO. And so then the question is,
10 how they pass down to those specialists any incentives
11 around appropriate utilization?

12 And I don't want to take us afield but it does
13 bring us back to an issue I know I raise very often, which
14 is hospital-based payment reform, because the hospital is,
15 in this care, really only at risk for the patients of its
16 primary care physicians, but the rest of what they're
17 doing, and, you know, the data I know from the commercial
18 space, is it's far more than half of what they're doing, of
19 total revenue, is not related to their PCPs' attributed
20 population. You know, they're still riding the fee-for-
21 service horse for that population.

22 So as I think through this issue I feel the need

1 to understand what we know or don't know about how
2 specialists who are in the hospital models are compensated,
3 and whether that 5 percent that they get by being in an
4 advanced ACO is something they are directly seeing versus
5 that's going to the hospital and the hospital is paying
6 them on a salary with RBU, you know, performance
7 compensation, et cetera. Thanks.

8 MR. WINTER: So because the first 5 percent
9 advance -- the first 5 percent A-APM payments were not
10 distributed until like late last year, September, I think,
11 it's all a recent phenomenon. So we will certainly keep
12 track of the literature and see if there's any articles
13 that are written about this, and perhaps it's something we
14 can add to the list of topics we ask physicians about when
15 we do our annual physician focus groups this summer. If we
16 get physicians who are employed by hospitals, if we can ask
17 them about how any revenue that they might -- the hospital
18 might receive through an ACO, how is that distributed to
19 them.

20 DR. SAFRAN: It's a shame Larry is not here
21 because I suspect Larry would know quite a bit about this,
22 so maybe let's tap him as well.

1 DR. CROSSON: Okay. Seeing no further questions
2 we'll proceed with the discussion, and Paul has asked to go
3 first.

4 DR. PAUL GINSBURG: Yeah. Thanks, Jay. When I
5 read the materials that Ariel sent out it really stimulated
6 me to think about, well, okay, what should we do about
7 this, policy wise? So I sketched out a few ideas yesterday
8 and thought I'd just put them in front of you to just start
9 a discussion.

10 I started from the premise that our goal here is
11 to get specialists more engaged in ACOs, and the one tool
12 that we've put out, policy wise, with the A-APM bonus, we
13 want to make sure the A-APM bonus is connected to
14 specialists really being engaged in an ACO, or doing
15 something else that earns the bonus.

16 An alternative way of thinking about this is that
17 we could view ACOs as really primary care-driven
18 organizations, and whether they want to engage specialist
19 or just steer patients to efficient specialists is their
20 decision, and I'll come back to this in a minute.

21 So I think the key problem is that -- this is
22 what I've learned so much from Ariel's work, is that the

1 ACO's decision to list the specialists in its reports to
2 CMS, which triggers the bonus, if it's the right type of
3 ACO, seems to me very kind of casual. You know, these
4 could be people that are sharing savings with. These could
5 be people they're not sharing savings with. You know, if
6 they're not sharing savings, sometimes the ACOs list
7 specialists; sometimes they don't. So I think for those
8 that do not share savings, you know, that's what I'm
9 saying.

10 So I think the possible approaches you can go is
11 you can either take an active approach, which is say a CMS
12 rule describing which specialists should be listed. It
13 would include those that share financial risk and those who
14 are some measure of having patients steered to them from
15 the ACO, you know, whether it's an objective thing or
16 whether it's a more passive thing.

17 And actually the passive approach would be just
18 looking at the data and saying that for specialist who
19 would qualify for an A-APM, if a higher percentage of
20 services delivered to ACO patients than average, if they
21 have a higher percentage of ACO services than other
22 specialists in a similar specialty in their area. So in a

1 sense, if a specialist de facto is seeing a lot of ACO
2 patients, then they would say they are engaged in this ACO
3 and we're going to give them a bonus. If they're not, if
4 they're not getting referrals from ACOs for a specialist
5 then whether they're listed in the ACO or not, they will
6 not get the bonus.

7 So anyway, those are just some thoughts to start
8 us off.

9 DR. CROSSON: Thank you, Paul. Again, this is
10 the beginning of some work that's going to proceed, the
11 question being with respect to the role of specialists in
12 ACOs or other alternative payment approaches, what are some
13 policy issues that we should be considering here at the
14 Commission in the future?

15 So Jonathan, Amol, Warner, Marge, Brian.

16 DR. JAFFERY: Well, again, it's a great chapter
17 and a great start of the discussion, and Paul, I think, you
18 know, helpful, thanks for kicking those things off. That
19 starts to stimulate a few things, and I want to maybe build
20 on some of that, because I think this really is -- as Paul
21 framed it, the key question to me is how do we engage the
22 specialists with ACOs? And I have a couple thoughts that

1 maybe are a little bit different direction than some of the
2 reading and what we've heard, because there's a lot of
3 discussion about this idea of how primary care docs steer
4 referrals to, you know, "more efficient" specialists. And
5 I think we're seeing and have talked about how there's some
6 problems there, so if you're part of a big group, that may
7 not be the same as if you're interacting with one or more
8 specialty groups that are not part of your group.

9 And I guess at a broader level, I'm just not sure
10 that's really the kind of engagement that I think about
11 when I think about what's the best way to do this with
12 specialists, and, you know, full disclosure, I'm struggling
13 with this, not doing a lot of really great work here yet,
14 partly because I think we've been preoccupied by things
15 like building the primary care model and dealing with the
16 programmatic changes that happen every couple years. But
17 it strikes me that this referral steerage idea is sort of
18 more like an ACO version of utilization management, but not
19 a particularly efficient one or effective one. And what
20 I'd really like to get to is thinking about how do we
21 engage the specialists to work with the primary care
22 providers, the team, the ACO, however you want to put it,

1 to really create new care models, better care models that
2 care for their specific population of patients.

3 And so just two ideas to throw out there. One is
4 a little more -- well, neither of them are particularly
5 concrete, but the first one goes back to a discussion we've
6 had in the past this year, which is: Should Part D drug
7 spending be part of ACO work? And, you know, there's a lot
8 of the very high cost drugs that are prescribed by
9 specialists, and so I think that that's something for us to
10 think about, and I'm not particularly in favor of the idea
11 of just having ACOs partner with a whole bunch of different
12 Part D plans. I think there's a lot of complexities and
13 challenges. I'm not sure that's where I would go
14 immediately. But if we can think about how to include
15 that, it creates maybe some opportunities for ACOs and
16 primary care docs to work with specialists to say how can
17 we address this area of increasing cost to the program that
18 is not part of the ACO world right now, so it could have
19 benefits in both those areas.

20 And then I think the biggest question is the one
21 that Brian started to raise, bring up earlier, which is,
22 you know, how do we really incorporate bundles and

1 integrate them within ACOs? How do we take episodic care
2 and integrate it? And there's a whole lot of technical
3 questions that I think we have to work through. The
4 attribution is clearly one. The distribution of savings,
5 how do we get an idea where the financial model doesn't
6 incent -- have some unintended consequences in terms of
7 incentives?

8 And then I think also two other points to that.
9 You know, we have to think about to what extent some of the
10 existing specialty models are helpful towards that end, or
11 do they sort of create some other silos?

12 And then, finally, is there an opportunity to
13 align some of that same kind of incorporating the episodic
14 care into the total cost of care with the MA plans?

15 So just a few things to think about. Again, not
16 super concrete yet, but let's wait until next hearing.

17 DR. CROSSON: Amol.

18 DR. NAVANTHE: Yeah, so I echo a lot of what
19 Jonathan said. I would say first off great chapter, I
20 think a really important topic given that, you know, we
21 know that primary care is something like 8 or 10 percent of
22 spend, influences more, but probably doesn't influence

1 everything. And so the specialists play such a critical
2 role, and so I would love to see this work developed.

3 I think there's a lot of open questions. You
4 started to tee up many of them. I think some of them we
5 can partially answer; some of them we probably can't answer
6 at all. And it's great to see us going down the path of
7 trying to actually put a framework out there and really
8 take on how do we get the specialty care into the care
9 redesign and care model process, because I think that's
10 what we're ultimately seeking to do.

11 Generally speaking, I think there are a number of
12 different ideas, but I think there's the biggest open
13 question in some sense in my mind is, you know, do we -- if
14 we take on an ACO structure which has total cost of care,
15 which intrinsically includes specialty costs, can we
16 effectively and tractably address the types of or stimulate
17 the types of practice redesign that we need to capture
18 those savings? I don't know that we totally know the
19 answer to that. I think it would actually be useful to
20 complement the work, as you have already done to some
21 extent, by talking to health systems and specialists
22 specifically, and ACOs as well, to try to understand, you

1 know, how to best engage them not only in the ACO broadly,
2 but how to engage them in the right types of practice
3 redesign processes. It may just turn out that in the
4 context of specialty care -- this would be my hypothesis --
5 that thinking about populations is much more challenging
6 and it's easier to think about these care episodes.

7 We've seen some of that movement, I think, and it
8 would be good for us as MedPAC, I think, to shift in the
9 direction of being able to align our level of effort and
10 our work with what CMS has been doing to date. So, for
11 example, we noted -- I think you noted in the material the
12 number of different specialty-oriented programs that are
13 out there. Some of them are kind of a blend of ACO and
14 bundles, like the ESRD work. Some of them are much more
15 purely episode, like the OCM. But then in the shadows of
16 that, even in the context of MIPS, for example, Medicare
17 has been thinking about episodes in the context of these
18 episode-based cost measures which could eventually become
19 part of the measurement for all physicians as part of MIPS,
20 which are clinically defined episodes not paid that way but
21 measured in terms of cost and quality that way.

22 So one view of the world could be maybe what we

1 really need is we need ACOs as the primary vehicle and we
2 need these episode-based cost measure type pieces as a way
3 to create incentives around them or to create quality
4 metrics around them, and that's going to be enough to
5 stimulate the types of specialty care redesign that we
6 need. Or an alternative view would be, no, we actually
7 need episode-based payment structures a la bundled payments
8 or OCM or what have you, and then we get to the point that
9 Jonathan and Brian had raised. Then how do we actually
10 coordinate those models? Big policy questions, I think,
11 that we don't have answers to, so I think it's important
12 that we take those on because Medicare is already starting
13 to move in that direction either by legislation or by
14 executive action.

15 So I think it's a very worthy cause. I think
16 there's a lot of different options out there. Very excited
17 that we're pursuing this line of work. Thank you.

18 DR. CROSSON: Thank you, Amol, and I would add
19 one other element to what you listed here, and that has to
20 do with understanding how specialists are paid in
21 successful models versus unsuccessful models. To what
22 extent is salary used, partial capitation, other kinds of

1 incentives which either are built on fee-for-service or not
2 built on fee-for-service but fundamentally begin to alter
3 the motivations, as bundled payments can in some
4 circumstances.

5 DR. NAVANTHE: I think that's a really good
6 point, and I would actually -- I can tell a story that is
7 kind of funny that brings in the organizational cultural
8 sort of economics of how things work.

9 So, for example, I have a friend who's an
10 oncologist who's in an ACO, in a health system in an ACO,
11 and at one point went to his division chief and said, "Hey,
12 you know, I should really ramp down my volume here. We're
13 in an ACO, right?" And the division chief said, "Well, you
14 know, if our revenue as a division drops within the health
15 system, then are you willing to give up your medical
16 assistant? Are you willing to give up your nurse?" And
17 they were, like, "No, not at all. So we're not going to do
18 that," because, you know, the ACO incentive is so far away,
19 the incentive of "I need my MA to function" is too
20 proximal. So I think we do need to get under the hood and
21 understand how people are paid, how organizations actually
22 function, how specialists engage. Otherwise, we're at risk

1 of designing models that sound great in theory but aren't
2 going to end up being implemented in a way that we need to
3 actually benefit beneficiaries.

4 DR. CROSSON: All right. Thanks.

5 DR. PAUL GINSBURG: Can I follow up --

6 DR. CROSSON: Yeah, go ahead.

7 DR. PAUL GINSBURG: -- on what Amol said before?
8 When you were mentioning the other payment types, the
9 bundles, et cetera, to what extent should we be worrying
10 that in a sense a bundle pulling the locus of, you know,
11 care away from the ACO as opposed to really making the
12 bundle one of the tools the ACO can proceed with?

13 DR. DeBUSK: I can tell you that one. The ACO
14 needs to gate the number of episodes that the bundle does.
15 To me, a bundle is just a sub-routine within a large
16 program. The program is the ACO. But there should be a
17 way to hand off -- whether it's the oncology care model or
18 the CJR model, there ought to be a way, once the ACO deems
19 that this episode is necessary -- and I do think everything
20 should be subject to the ACO. Once the ACO says this
21 episode is necessary, then you run that bundle. When the
22 bundle runs its course, you do a reconciliation, and you do

1 some type of -- you have to reconcile the payments, too.
2 Some of that needs to go to the ACO; some of that needs to
3 go to the physicians. But now you'd be living in a world
4 where the actual behavior of the specialist is tied back to
5 financial means.

6 You have got to look at this from a compensation
7 theory perspective. Imagine me as an oncologist doing a
8 great job choosing all the right drugs and doing all the
9 right care at a hospital, and then someone says, "Well,
10 yeah, but for wet macular degeneration those guys chose the
11 wrong drug, so we blew our number. You don't get
12 anything." And there has to be -- I mean, this is just
13 compensation system theory. We're designing a system.

14 DR. NAVANTHE: Yeah, I think that's right. I
15 think one thing -- so I like the view and I would say I am
16 optimistic and hopeful that we end up in an end-state model
17 that has an ACO total cost of care structure that is
18 aligned with episodes to actually drive the right types of
19 specialty care model behavior change. The part that gives
20 me a little bit of pause is, on the one hand, I was
21 describing -- quoting some statistics on participation and
22 overlap. You could actually have the opposite view, which

1 is that it's surprising there hasn't been more co-
2 participation and there isn't more overlap, and maybe there
3 are distinct communities of providers that engage in
4 different types of models.

5 So I don't know that there's that one-size-fits-
6 all solution necessarily, and at least if we look at how
7 providers have been voting with their feet thus far, it
8 looks like they're pretty different communities. There's
9 overlap, but they're pretty different communities, and so I
10 don't know, Paul, if there's a right answer there yet.

11 DR. CROSSON: Okay. Warner is next. I have you,
12 Kathy.

13 MR. THOMAS: Just a couple of points, and I think
14 the whole comment around -- and I think Dana brought this
15 up about, you know, do we understand how specialists are
16 paid kind of within these arrangements, and the reality is
17 until we get a much bigger percentage of the overall
18 payment for physicians into some type of global risk model,
19 like ACOs and that there's enough upside there, you know,
20 it is not going to change because the fundamental
21 reimbursement and the fundamental compensation that people
22 have for physicians is not going to change within these

1 arrangements.

2 And I agree with Brian's point. You can go to a
3 bundle, but the issue is that it all comes down to
4 avoidance of unnecessary procedures. That's really where
5 it comes down to from a specialty perspective. We're in
6 the Walmart Center of Excellence situation for joints, and
7 about 30 to 40 percent of the patients that we see, we
8 don't do procedures on that have been, you know,
9 essentially okay to have procedures done. I think Jaewon
10 has seen some of the same situations at Geisinger.

11 So, you know, I think this concept -- I think it
12 is important to have specialists in the model. I really
13 think the issue is we've got to create enough upside for
14 these models for more organizations to lean into them and
15 to lean into them with downside risk. And I think also not
16 take a short-term view that if we don't save money in the
17 first year or two, that they're a failure. I think we have
18 to understand that we need to move the payment mechanism,
19 and they may even cost a little bit more in the first year
20 or two. But over time, if you move more risk to the
21 provider system, including specialists, I think they will
22 pay off over time. But I think we sit here and we say,

1 "Well, ACOs haven't been successful because we haven't seen
2 huge savings." But we're in the infancy of this process,
3 and I just think we need to think as a Commission do we
4 just want to take the approach that we want to agree to
5 move more risk to the providers and know that over time,
6 changing the incentive will over time change the cost
7 structure. And specialists I think have to be a part of
8 that. If you look at primary care ACOs, yeah, they're
9 successful because they are steering to lower-cost areas.
10 But that is a short-term solution. That will not have a
11 long-term solution.

12 So I just think we've got to continue to make
13 sure there's enough upside globally for the ACOs and keep
14 specialists engaged and try to incent systems and ACOs to
15 move to sharing more of those dollars so they do, you know,
16 change behavior over time.

17 DR. CROSSON: Thank you, Warner. Marge. On this
18 point, Sue?

19 MS. THOMPSON: Just go ahead [off microphone].

20 DR. CROSSON: Okay. Marge.

21 MS. MARJORIE GINSBURG: Well, I confess when I
22 read this, I couldn't figure out where the "there" there

1 was. Every indication indicated that involving specialists
2 simply costs more to the system, that there was no great
3 benefit, and that there was also this issue of I wasn't
4 sure how much of the bonus money comes to them relative to
5 their total income or the issue, in fact, do they care more
6 about the quantity of referrals than they do about whether
7 they're going to get a little bit more money at the end of
8 the year, though now hearing the others, and Warner in
9 particular, summary of this makes me more enthusiastic,
10 shall we say, about whatever research we can do to try to
11 improve this. My own bent is let's keep it with the
12 primary care docs to really run the show. But if that
13 ultimately shows that we get better care at lower cost when
14 specialists are involved, great. I'm just not sure we've
15 seen that yet.

16 DR. CROSSON: Thank you, Marge. Brian.

17 DR. DeBUSK: Well, to the point that I made
18 earlier, I do think it's time that we explore ways for
19 population health and episodic models to co-exist. And,
20 again, I do think it's -- this is basic compensation
21 theory. People need to understand how they're getting
22 paid. And I think primary care doctors need to understand

1 it. Is it the medical expense ratio that they're managing
2 to? Is it avoidable ED visits? Is it avoidable inpatient
3 admissions?

4 On the specialist side, I do think there's some
5 great models out there. The bundled payments in joints
6 really move orthopedic surgeons. There are orthopedic docs
7 I've known for 25 years who will not change practice
8 patterns, and the moment you show them that target price on
9 that joint, they start looking at everything from blood use
10 to SNF utilization to home health. You know, they get away
11 from writing standing orders of assess and treat, you know,
12 and they get involved in whether or not the patient's
13 getting speech therapy for a stroke they had ten years ago
14 in a nursing home. I mean, these things happen. And I
15 have seen it move these people. And I think if we can
16 figure out how to make these bundles co-exist with
17 population health -- because not everyone is going to be in
18 the same place at the same time. I might not be ready at a
19 system level to do an ACO, but I might have a great group
20 of orthopods and a great group of oncologists who want to
21 do their own models. And I think one of the biggest favors
22 that we could do for payment reform, aside from global

1 payments, one of the other biggest favors we could do is
2 modularizing these APMS so that they can co-exist together
3 and people understand how they're paid. And I think that's
4 just a fundamental thing that we have to focus on.

5 I also want to echo Warner's point, too. I think
6 you made a great point. We're launching a new system, a
7 new product here. We're going to have to put our thumb on
8 the scale for the first couple of years. You don't launch
9 a new heart program and say, "Hey, we're going to be
10 profitable in the first 90 days." I mean, it's back to the
11 thumb on the scale doctrine that we talked about a couple
12 years ago.

13 Thank you.

14 DR. CROSSON: On that point?

15 DR. NAVANTHE: On your first point, actually,
16 related to your point, Marge, so you're describing the sort
17 of behavioral anecdotal evidence that you've noted. I
18 think there's pretty systematic evidence that that happens,
19 so, you know, we've described some of that. There's pretty
20 good literature. David has done in the context of
21 mandatory bundled payment, the CJR bundle. So I think it
22 is important, Marge, to also realize that the specialty-

1 oriented models have generated savings. The ACOs and the
2 specialists in the context of the work we looked at here,
3 maybe a little bit less so, but the specialty-directed
4 models themselves have been -- some of them, at least, have
5 been successful. And so the question is how does that fit
6 into the overall puzzle.

7 DR. CROSSON: Thank you. Kathy, you're up.

8 MS. BUTO: Okay. You know, this discussion
9 reminds me of something that I've been thinking about for a
10 long time, and that is that ACOs are intended not to be
11 visible to beneficiaries. In other words, it was supposed
12 to be a nice glide path to better care management, more
13 system-ness in care and so on. But that to me is a
14 fundamental flaw of the ACO, and so this whole discussion
15 about how do we get or include specialty care, not include
16 it, is it going to save money, will it improve quality, is
17 all around the beneficiary sort of unaware that this
18 structure is in place.

19 And so what I've been thinking is it would be
20 good if we could also think about ACOs as a ramp to a more
21 beneficiary-centered approach, and the issue with
22 specialists is what brings this to mind. In my mind,

1 specialists are playing increasingly important roles in
2 managing chronic care and chronic disease, and I don't
3 think we ever actually think of it that way. We tend to
4 think of specialists as something that, you know, might be
5 an episodic need and then maybe move on, keep the primary
6 care physician involved.

7 I think we have to start thinking about it from
8 the beneficiary standpoint. What sort of managed system-
9 ness would work for the beneficiary? And so I hope that as
10 we evolve our thinking -- and we had a good discussion
11 about beneficiaries electing physicians and having a more
12 active role. I think you can move in that direction. But
13 I hear all our discussion about what the appropriate
14 payment is, and I agree with Brian. I think BPCI, the
15 bundled payment approach, is one that begins to capture
16 that sort of focus on the beneficiary-centered care in the
17 payment system and drives, you know, a certain management
18 and system-ness that wasn't already there. But I'm not
19 sure ACOs do that, and so talking about the role of
20 specialists is important, but I really think you have to
21 take it back to what about the beneficiary's perspective.
22 And here is where they're at least engaged and aware of

1 their involvement.

2 So I think we have to deal with that, and I think
3 it goes back to the earlier discussion.

4 DR. CROSSON: Thank you, Kathy.
5 Dana?

6 DR. SAFRAN: Thanks.

7 All of my comments focus on the issues around
8 compensation and the behavioral economics that I raised
9 during the question round and that I think we've heard a
10 lot of here.

11 I'll start by recounting a very quick anecdote
12 from early, early years of Blue Cross alternative quality
13 contract. I was at one of our hospital systems that was
14 very successful in the model that talked about the day that
15 bonus check went out to the primary care physicians, the
16 specialists, they said, "Wait a minute. How do I get more
17 involved in this? What is it I can do to be helpful so I
18 can get a check next year?" And that's just really always
19 stayed in my mind. How do you get folks' attention that
20 way?

21 I think it depends. It depends on whether
22 they're part of a hospital or other provider system that's

1 paying them on salary with some other compensation or how
2 they're being rewarded versus whether they are living in
3 the community and living off of the fee-for-service revenue
4 that they can generate, because in the latter scenario, it
5 is very hard to imagine how you can provide bonuses that
6 are sufficiently high that it outweighs the compensation
7 they get or what they get from doing that next procedure,
8 unless referrals start to dry up because the PCPs referring
9 to them know that they're overusing procedures.

10 That's the problems we all know and the
11 complexity we all know. I'll try to put a couple ideas on
12 the table. One is that if I go back to the conversation we
13 are having about NPI and I think that if a hospital system,
14 let's say, lists a group of specialists, NPIs, as part of
15 their ACO, might they then be required that for every one
16 that they're listing as part of their ACO that they have
17 some requirement to indicate that the compensation for that
18 individual aligns to the incentives of the ACO; that is,
19 it's not RVU-based? That the way that provider is
20 compensated -- let's say they're on salary, and there's a
21 bonus -- that that bonus is tied to the same kinds of
22 quality measures and overall cost control that the ACO is

1 trying to accomplish so that the incentives move down the
2 line. That's one thought. I know there's administrative
3 complexity to that but something to think about in terms of
4 the hospital is going to get that 5 percent for every one
5 of those NPIs that they list. So what do they have to
6 attest to in return for that?

7 The other thing that I'm attracted to out of this
8 conversation is the idea of the episode payments within the
9 ACO. I've never been a big proponent or fan of episode
10 payments on their own, because of the fee for bundles
11 problem, but I think, you know, I like -- to Brian, put it
12 about -- you know, the ACO is sort of the gatekeeper to the
13 episode, and then once they know that they want an episode
14 to be kicked off, the specialist group that's going to be
15 accountable for that is held accountable for how that
16 episode is going to go, the cost and quality of that
17 episode. That has a lot of appeal, all the complexity
18 notwithstanding of how the savings then gets shared.

19 And also, the other complexity I'd want to guard
20 against is having so many episodes that people are really
21 just -- we're back to a world that's fragmented, and
22 people, patients looked at as like body parts and not

1 individuals. Besides the fee for bundles problem, that
2 sort of whole person care problem is the other piece that's
3 always been a concern.

4 But I think we have the start in this
5 conversation of some ideas for solutions and couldn't agree
6 more with the conversation that we have to address how to
7 get specialists meaningfully engaged in ACO programs,
8 because without them, we can't succeed, I think.

9 DR. CROSSON: Thank you, Dana.

10 Sue and Pat.

11 DR. NAVATHE: Can I add to that?

12 DR. CROSSON: On this point, okay.

13 DR. NAVATHE: Just only on the fee for bundles
14 thing, David's paper looked at it. We've looked at it
15 directly. Arkansas has state bundles mandated across
16 commercial and Medicaid. They've looked at it. Nobody has
17 ever found a fee-for-bundles effect yet, at least in four
18 big evaluations that we've seen.

19 I think conceptually, it could be worrisome. I
20 think the question is, from a behavioral perspective, if
21 you're paid under a general fee-for-service system anyways,
22 so your incentive is to do the procedure to make money,

1 does the bundle really have a margin of action on it? I
2 think to date, we have not found that that actually has --
3 there's no evidence to suggest that it exists.

4 DR. SAFRAN: Is there evidence that it's driving
5 inappropriate procedures down, or is it just making the --
6 within the episode, it might be making us more efficient,
7 but is it actually getting rid of some overuse?

8 DR. NAVATHE: We don't have data on that piece.
9 We know that there can be some small case-mix shifts.
10 Whether those case-mix shifts are appropriate, is it
11 appropriate not to do high-risk procedures when they're
12 elective? We can't comment from the data that we've seen.
13 The literature thus far has not been able to address that.
14 So I think that's a fair point.

15 I would say we're probably more confident that
16 conditional on doing a procedure or having a
17 hospitalization, there's greater efficiency from episodes
18 than we can comment on the other pieces.

19 DR. CROSSON: Okay. I've got Sue and Pat, and
20 then we're going to have to end. Sue?

21 MS. THOMPSON: All right. I want to echo my
22 support for this work on this chapter and our commitment to

1 diving deeper into the role of specialists and value-based
2 contracting and the work of ACOs.

3 I'm also supportive of thinking of a new way to
4 talk about ACOs. I think it's a little bit of a worn-out
5 term that has taken on some baggage, but in the spirit of
6 doing good work to save the Medicare program, I think this
7 is important work.

8 It's important we align incentives, and I think
9 this conversation this morning certainly has demonstrated
10 we have so many counter-incentives.

11 From a specialist standpoint, not only do the
12 incentives have to be in line, but the programs they engage
13 in need to be meaningful. And they need to be meaningful
14 from a standpoint of how they care for their patients as
15 well as how they are compensated. So I don't think we can
16 overstate the need to align incentives as an operating
17 principle for all of this work.

18 Just as a point of context, in terms of
19 specialists, in the ACO that I work with, out of roughly
20 8,300 providers, 3,600 of them are specialists who we do
21 not employ, but who have come to the table and have wanted
22 to become a part of our network because of the work we're

1 doing and for all of the other opportunities of being part
2 of an advanced APM.

3 So the appetite for this work by the independent
4 specialists in addition to those that we do employ is
5 there, and I think we need to take advantage of it while
6 they're still interested and becoming part of the solution.

7 We care for roughly 550,000 lives, and we've been
8 in the work since 2011 as one of the pioneers, but it was
9 not until 2017 that we actually covered the cost of the
10 infrastructure and ongoing operating expenses to do the
11 care coordination and analytics required to be in this
12 business. So this is not something you see a return on in
13 the first nine months. This is an enormous investment
14 made, and I want to call out how important I think the work
15 is, how meaningful I think the work is, and frankly, thank
16 you.

17 DR. CROSSON: Thank you, Sue. Good points.

18 Okay. Pat?

19 MS. WANG: I should have verified this in Round
20 1, but to the extent that I am a hospital-based ACO or any
21 ACO that includes specialists, are all of those specialists
22 automatically entitled to the A-APM treatment and MACRA

1 boost, the bonuses as well as the update factor, just by
2 virtue of being on my list?

3 DR. CROSSON: Pat, he couldn't quite hear you.

4 MR. WINTER: I think the question is if the
5 specialist is on the list of a hospital-oriented ACO that
6 qualifies as an APM, does the specialist automatically get
7 the 5 percent incentive payment? And the answer is yes, as
8 long as they meet that threshold.

9 In 2018, to get the 5 percent payment in 2020, in
10 2018, at least 25 percent of their Medicare professional
11 services payments had to come through that ACO or 20
12 percent of their patients had to come through the ACO.

13 MS. WANG: Okay.

14 MR. WINTER: There is that threshold requirement
15 as well as being on the list.

16 MS. WANG: So my next question, how are the extra
17 MACRA bonuses treated in the calculation of shared savings
18 for the ACO?

19 MR. WINTER: Right.

20 MS. WANG: Is it an expense? Is it in the
21 benchmark? How does it --

22 MR. WINTER: I think David might know the answer

1 to this. I don't know offhand. David, do you know if
2 they're counted as part of the performance?

3 MR. GLASS: [Speaking off microphone.]

4 MS. WANG: So the benchmark is calculated without
5 my specialist, my 65 percent of my physicians in the ACO.
6 My benchmark does not have the bonus included, but my
7 performance year will. Is that right?

8 DR. CROSSON: No, I don't think so.

9 MS. WANG: Okay.

10 DR. JAFFERY: I think we should clarify that
11 because I'm not sure that's --

12 DR. CROSSON: That doesn't sound right.

13 MS. WANG: The only reason I was asking that
14 question is that to the extent that it puts more pressure
15 on the ACO to demonstrate shared savings because the total
16 payments that are being made to providers in the ACO has
17 gone up, that that would probably be a good thing. And I
18 would leave it to the ACOs. I'm a little bit more in favor
19 of market-based solutions to figure out how to leverage
20 that to do things with their specialists to kind of keep
21 that thing going.

22 DR. CROSSON: We'll try to get that fully

1 clarified, Pat.

2 All right. This has really been a very valuable
3 discussion. Ariel, thank you, and we look forward to your
4 future work.

5 Thank you, Commissioners, for a very rich
6 discussion that went well beyond, I think, what we might
7 have expected. Appreciate it.

8 So we now have time for a public comment period.
9 If there are any of our guests who wish to make a comment
10 about the material we've discussed today, this morning,
11 please come to the microphone.

12 * [No response.]

13 DR. CROSSON: Seeing no one approaching the
14 microphone, we are adjourned until one o'clock.

15 [Whereupon, at 12:10 p.m., the meeting was
16 recessed, to reconvene at 1:00 p.m. this same day.]

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1 to discuss draft recommendations to realign incentives in
2 Medicare Part D. The approach used for these draft
3 recommendations was discussed extensively in our June 2019
4 report to the Congress and in 3 meetings we've had this
5 cycle. This iteration reflects your earlier discussions
6 and throughout this presentation we will flag where we've
7 tried to reflect your comments.

8 Part D is different from fee-for-service Medicare
9 because it uses private plans to deliver drug benefits that
10 compete for enrollees based on premiums and other factors.
11 Plans set up networks of pharmacies, develop formularies to
12 encourage use of preferred drugs, and negotiate with
13 manufacturers for post-sale rebates.

14 Part D law restricts the federal government from
15 interfering in negotiations among private plans,
16 pharmacies, and drug manufacturers. The commission's 2016
17 recommendations kept with this overall structure -- Part D
18 plans would bear more financial risk for their enrollees'
19 drug spending--much as they did at the start of the program,
20 yet gain flexibility in their tools to manage spending.

21 The draft recommendations we will present today
22 are also consistent with Part D's market-oriented approach

1 and, of course, we will continue monitoring drug prices,
2 beneficiary access, and Medicare program spending.

3 Trends in Medicare's program payments to plans
4 suggest that Part D needs to be restructured. Medicare's
5 cost-based reimbursements for reinsurance in the
6 catastrophic phase and for low-income cost-sharing
7 subsidies have grown, while the risk-based portion of
8 Medicare's payments has declined. Those trends are counter
9 to the original intent for Part D that plans bear insurance
10 risk and cost-based payments undermine plans' incentives to
11 manage benefits.

12 Part D's benefit design, with its coverage gap,
13 has also dampened incentives to manage spending. Because
14 brand manufacturers discount prices by 70 percent in the
15 coverage gap, the relative price of brands to generics is
16 artificially lower. Also plans have low or no liability
17 for benefit spending in the coverage gap and catastrophic
18 phase.

19 Plans typically compete for enrollees based on
20 premiums, and plan sponsors tend to use rebates they
21 negotiate from drug manufacturers to offset premium costs.
22 Pursuing rebates has become more of a focus of plan

1 sponsors and in some cases, rebates can be larger than the
2 benefit costs plans are responsible for covering.

3 Manufacturers know that Medicare provides a lot
4 of cost-based reimbursement in Part D and that plans want
5 to pursue rebates to keep premiums down. In turn, those
6 factors may affect drug manufacturers' decisions about how
7 they price their products. Sometimes drugs with competing
8 therapies have high list prices but the manufacturer
9 provides large rebates to the plan. However, beneficiaries
10 often must pay a percentage coinsurance of the gross prices
11 at the pharmacy, which are higher than prices net of
12 rebates. And those list prices also affect Medicare's
13 program payments.

14 Let's look at the benefit structures for
15 enrollees without the low-income subsidy on the left and
16 with the low-income subsidy on the right. These figures
17 depict the benefit for brand-name drugs and biologics. The
18 region between the initial coverage limits and the out-of-
19 pocket threshold is called the coverage gap.

20 In the coverage gap, plans, which are shown in
21 blue here, are responsible for just 5 percent of spending
22 on the left and, on the right, none of spending for low-

1 income subsidy enrollees. Plan liability is 15 percent in
2 the catastrophic phase for both types of enrollees.
3 Rebates for some brand-name products can exceed plans'
4 benefit liability.

5 For beneficiaries without the low-income subsidy
6 on the left, the 70 percent manufacturer discount in the
7 coverage gap applies only to brand-name drugs. Instead of
8 5 percent, plans are liable for 75 percent of the cost of
9 generic drugs in the coverage gap. The discount distorts
10 price signals between brands and generics.

11 There's no manufacturer discount for low-income
12 subsidy enrollees on the right. Medicare's low-income cost
13 sharing subsidy pays for nearly the entire coverage gap.
14 Medicare's reinsurance pays for 80 percent of the costs
15 above the out-of-pocket threshold.

16 What this shows is that the current structure
17 doesn't give plans strong incentives to push back on high
18 drug prices or to manage spending.

19 As we showed you last month, plan sponsors are
20 responsible for much less benefit spending today than at
21 the start of the program. On your left we compare
22 estimated benefit costs net of rebates for beneficiaries

1 without the low-income subsidy, with LIS enrollees on your
2 right. Just to remind you, we assumed that plan spending
3 and Medicare reinsurance were reduced by the average
4 percentage rebates reported in the Medicare Trustees
5 report. We applied the same percentage rebates to non-low-
6 income subsidy enrollees and LIS enrollees.

7 Looking at the blue portions, we estimate that
8 among beneficiaries without the low-income subsidy, plans'
9 responsibility for net spending decreased from 53 percent
10 in 2007 to 29 percent by 2017. Among LIS enrollees, plan
11 liability fell from 30 percent of net spending to 19
12 percent. Medicare's cost-based payments in gray
13 (reinsurance on the left-hand side and the combination of
14 reinsurance plus low-income cost sharing on the right) have
15 increased substantially.

16 One way to restructure the benefit would be to
17 eliminate the coverage gap. Plans would become responsible
18 for 75 percent of benefits up to the out-of-pocket
19 threshold for all beneficiaries.

20 In the catastrophic phase, Medicare would provide
21 lower reinsurance, and the remainder would be a mix of plan
22 liability, which would be financed through higher capitated

1 payments from Medicare to plans, and a new manufacturer
2 discount.

3 We think this approach would restore the
4 incentive structure that plans faced at the start of the
5 Part D program and remove features of the benefit design
6 that distort incentives and create inflationary pricing
7 pressure and higher program costs.

8 MR. ROLLINS: During our January meeting, the
9 commissioners discussed whether our Part D recommendations
10 should have specific parameters for the redesigned benefit,
11 but there was no clear resolution. Since then we have
12 considered this issue further and, after consulting with
13 the chairman, decided to supply specific parameters. One
14 reason we made this decision is because we need to have
15 specific parameters so that CBO can estimate the budgetary
16 effects of our recommendations.

17 Having said that, the parameters we have chosen
18 are the same ones we used in the illustrative reform
19 package that we discussed at the January meeting, so they
20 should look familiar.

21 This table shows the key elements of the
22 restructured benefit and how they compare with the current

1 benefit. Under these reforms, the annual out-of-pocket
2 threshold would roughly equal the amount that beneficiaries
3 now pay under current law.

4 Starting with the top half of the table, under
5 the restructured benefit, the coverage gap discounts for
6 non-LIS enrollees and the coverage gap for LIS enrollees
7 would both be eliminated. These changes would make plans
8 responsible for a consistent 75 percent of spending between
9 the deductible and the out-of-pocket threshold.

10 Moving now to the second half of the table, let's
11 look at the changes in the catastrophic phase. Enrollee
12 cost sharing would be eliminated to provide complete
13 insurance protection. Medicare's reinsurance would be
14 lowered from 80 percent to 20 percent, as in our 2016
15 recommendations. There would be a new manufacturer
16 discount of 20 percent for brand-name drugs and high-priced
17 generic drugs.

18 Note that the new discount program would differ
19 from the current coverage-gap discounts because it would
20 apply to high-cost generics, as opposed to just brand
21 drugs, and because it would apply to all beneficiaries,
22 both LIS and non-LIS. The remaining costs, 60 percent for

1 brand drugs and high-priced generics, and 80 percent for
2 all other drugs, would be plan liability.

3 So here's a graphic where you can see how the
4 restructured benefit would look. The bifurcated structure
5 that you saw earlier is gone and there's a single benefit
6 structure for everyone. The coverage gap has been
7 eliminated, discounts have been shifted from the coverage
8 gap to the catastrophic phase, and plans have more
9 liability than they do now. Medicare would still cover
10 74.5 percent of the costs of the basic Part D benefit, but
11 more of its subsidies would be provided through capitated
12 payments instead of cost-based reinsurance. Note also that
13 the LIS would continue to cover most or all out-of-pocket
14 costs for low-income enrollees.

15 We think that some related policy changes would
16 help make the implementation of the restructured benefit
17 successful. First, there would be a transition period
18 where the share of spending covered by reinsurance would
19 gradually decrease and plan liability in the catastrophic
20 phase would gradually increase. This would give plan
21 sponsors time to adjust. Second, as Pat has emphasized,
22 CMS would also need to recalibrate the Part D risk-

1 adjustment model to ensure that payments to plans are
2 adequately adjusted for differences in enrollees' health
3 status. As we have noted previously, CMS made a similar
4 adjustment when it implemented the ACA's provisions that
5 filled in the coverage gap for non-LIS enrollees.

6 Finally, commissioners such as Pat and Larry have
7 expressed concern about the ability of smaller regional MA
8 plans to bear more financial risk. After considering
9 alternatives such as private reinsurance, we think that
10 policymakers could guard against unexpected financial
11 losses by temporarily making Part D's risk corridors more
12 generous during the transition period. This could be done
13 by reducing the losses that plans must bear before they
14 qualify for risk sharing, having the government cover a
15 larger percentage of plan losses, or both.

16 The Commission also believe that there should be
17 reforms that make it easier for Part D plans to control
18 drug spending and thus manage the additional risk they
19 would bear. During our work, we have identified three
20 changes that we think would be helpful.

21 First, LIS enrollees could be required to pay
22 somewhat higher cost-sharing for nonpreferred drugs. These

1 beneficiaries now pay the same nominal amount for all
2 brand-name drugs, which, as Commissioners such as Pat and
3 Amol have noted, gives them no incentive to use a preferred
4 product.

5 Second, plans could be allowed to use formularies
6 that have separate preferred and nonpreferred tiers for
7 high-cost specialty drugs. Plans are currently required to
8 put all specialty drugs on the same tier, which makes it
9 harder to obtain rebates. Adding a nonpreferred tier could
10 help plans encourage the use of biosimilars for Part D
11 drugs when they become available, which is an area of
12 concern that Bruce has raised.

13 Third, plans could have greater flexibility to
14 manage spending in the protected drug classes. The
15 Commission's 2016 recommendations included changes to the
16 protected classes, and last year we also expressed support
17 for a CMS proposal that would have given plans more
18 flexibility.

19 Stepping back a bit now, we wanted to highlight
20 how the restructured benefit would affect two specific
21 groups of plans: those that serve low-income beneficiaries
22 and employer-sponsored plans. Plans with heavy LIS

1 enrollment would see larger increases in plan liability
2 because LIS enrollees are more expensive and are more
3 likely to reach the catastrophic phase.

4 However, we have found that the overall drug
5 costs for LIS enrollees are actually less variable than the
6 overall costs for non-LIS enrollees. In other words, LIS
7 enrollees are more expensive on average, but their costs
8 are in some ways easier to predict.

9 Recalibrating the risk-adjustment model would
10 help ensure that payment rates remain adequate, and we
11 think this is feasible given CMS's prior experience
12 updating the model. The temporary enrichment of the risk
13 corridors would also provide additional protection,
14 particularly for smaller regional plans.

15 We also talked to several Part D sponsors and
16 consulting actuaries about whether plans could bear more
17 risk for LIS enrollees. Our interviewees largely thought
18 plans could bear the added risk, but many said that such a
19 change should be accompanied by a transition period, a
20 recalibration of the risk adjusters, and more tools for
21 plans to manage drug spending. The restructured benefit
22 that we are discussing here has all of those elements.

1 Part D also has substantial enrollment in
2 employer group waiver plans, or EGWPs, which provide
3 coverage to an employer's Medicare-eligible retirees.
4 These plans receive a disproportionate share of the
5 coverage-gap discounts because they typically provide
6 richer coverage that keeps their enrollees from reaching
7 the catastrophic phase due to Part D's true out-of-pocket
8 provision. These plans would receive fewer manufacturer
9 discounts under the restructured benefit, but they should
10 have a couple of years of lead time to modify their benefit
11 packages.

12 MS. SUZUKI: This brings us to the Chairman's
13 draft recommendations. There are three parts. The first
14 part would restructure the Part D benefit and the other two
15 parts would make concurrent changes to provide plans with
16 more tools and flexibility to manage spending while
17 providing greater risk corridor protection during
18 transition to the new benefit.
19 Concurrent changes are structured this way because some
20 changes fall under the purview of the Congress while others
21 fall under the purview of the HHS Secretary.

22 The recommendations are intended as a package of

1 policy changes that are essential to balancing the goals of
2 ensuring financial sustainability with beneficiaries'
3 access to needed medications.

4 The combination of Chairman's draft
5 recommendations would lead to savings in program spending
6 relative to baseline. For the April meeting, we will have a
7 single estimated spending impact that reflects the combined
8 effects of the entire package of recommendations.

9 The Chairman's first draft recommendation reads:
10 The Congress should make the following changes to the Part
11 D prescription drug benefit: below the out-of-pocket
12 threshold, eliminate the initial coverage limit; eliminate
13 the coverage-gap discount program; above the out-of-pocket
14 threshold, eliminate enrollee cost sharing; transition
15 Medicare's reinsurance subsidy from 80 percent to 20
16 percent; require pharmaceutical manufacturers to provide a
17 discount equal to no less than 20 percent of the negotiated
18 price for brand drugs, biologics, biosimilars, and high-
19 cost generics.

20 This last piece could be a higher rate, for
21 example, based on how quickly spending in the catastrophic
22 phase grows, like Bruce suggested earlier.

1 The Chairman's second draft recommendation reads:
2 Concurrent with the first recommendation, the Congress
3 should establish a higher copayment amount under Part D's
4 low-income subsidy for nonpreferred and nonformulary drugs;
5 give plan sponsors greater flexibility to manage the use of
6 drugs in the protected classes; modify Part D's risk
7 corridors to reduce plans' aggregate risk during the
8 transition to the new benefit structure.

9 The Chairman's third draft recommendation reads:
10 Concurrent with the first recommendation, the Secretary
11 should allow plans to establish preferred and nonpreferred
12 tiers for specialty-tier drugs; recalibrate Part D's risk
13 adjusters to reflect the higher benefit liability that
14 plans bear under the new benefit structure.

15 The recommendations are intended as a package of
16 changes that would provide better formulary and pricing
17 incentives which in turn would lower costs and premiums and
18 cost sharing paid by beneficiaries. But there are many
19 moving pieces and uncertainty in how stakeholders may
20 respond. In this and the next few slides, we highlight some
21 of the key implications for Part D beneficiaries, plan
22 sponsors, and manufacturers.

1 One major implication is that the elimination of
2 cost sharing in the catastrophic phase would provide all
3 non-LIS beneficiaries with more complete financial
4 protection. That, in turn, would improve access to both
5 clinically appropriate and inappropriate therapies. LIS
6 beneficiaries using preferred drugs would not be affected
7 by the change to add a higher cost-sharing tier for
8 nonpreferred drugs.

9 Similarly, beneficiaries using drugs on preferred
10 specialty tier would either see no change or a reduction in
11 their out-of-pocket spending. However, beneficiaries
12 taking medications on nonpreferred tiers would need to
13 switch to another medication, pay higher, nonpreferred cost
14 sharing, or seek tiering exceptions.

15 Finally, the effects of restructuring on
16 beneficiary premium would depend on the policy parameters
17 like the catastrophic discount rate chosen, and other
18 factors such as changes in drug prices and the distribution
19 of spending across different phases of the benefit, and how
20 well plans are able to manage benefit spending.

21 For plan sponsors, the restructured benefit would
22 restore the risk-based payments and provide stronger

1 incentives to manage spending. It would also reduce the
2 financial benefit of including high-price, highly rebated
3 drugs on their formularies.

4 However, because there would be no cost sharing
5 once a beneficiary reaches the out-of-pocket threshold,
6 plan sponsors would have fewer tools to manage catastrophic
7 spending. Formulary flexibility and new tools may give
8 plan sponsors greater leverage to negotiate higher
9 manufacturer rebates for some products.

10 Risk-adjusted payments would compensate sponsors
11 for new plan liability and reduce incentives for risk
12 selection, and modified risk corridors would provide
13 greater financial protection during transition. The
14 protection would be available to all plans, but in
15 practice, it would be more valuable for smaller plans with
16 lower capacity to absorb large and unexpected costs of new
17 therapies.

18 There may be effects on manufacturers that are
19 broader than Medicare, such as the effects on investment
20 and R&D, but here we will focus on the effects that are
21 specific to Medicare. In general, eliminating the coverage
22 gap discount and replacing it with a new manufacturer

1 discount in the catastrophic phase would shift much of the
2 discount liability from manufacturers of brand-name drugs
3 and biologics with relatively low prices to manufacturers
4 of drugs and biologics with higher prices.

5 We anticipate that that change would affect
6 manufacturers' pricing behavior, but the effects on pricing
7 probably would vary, depending on factors such as
8 Medicare's market share and the degree of competition
9 within the therapeutic class.

10 Because plans would have stronger incentives to
11 manage spending and have more tools, some manufacturers may
12 experience lower Part D revenues or diminished ability to
13 raise prices.

14 At the same time, some manufacturer may launch at
15 a higher price.

16 This final slide provides a summary of all of the
17 Chairman's draft recommendations. As I said earlier, the
18 recommendations make up an interrelated package that is
19 designed to restore market-based incentives.

20 Here, we list major changes. Under the
21 restructuring, plans become responsible for 75 percent of
22 spending between the deductible and the out-of-pocket

1 threshold. Enrollees would be protected from high out-of-
2 pocket costs. Insurance risk for the catastrophic benefit
3 would shift from Medicare to plan sponsors and
4 pharmaceutical manufacturers. At the same time, the
5 recommendations would provide plans with more tools and
6 flexibility to manage spending.

7 These changes would restore the risk-based
8 capitated approach envisioned in the original design and
9 eliminate program features that distort market incentives
10 that create inflationary pricing pressure and higher
11 program costs.

12 We'll keep this slide up for your discussion
13 today. We're particularly interested in getting your input
14 on the specifics of the Chairman's draft recommendations
15 that would inform our preparation for the next month's
16 meeting.

17 DR. CROSSON: Thank you, Shinobu, Rachel, Eric,
18 not just for the presentation but for the development of
19 this rather excellent body of work.

20 We are now open for clarifying questions, and I'm
21 going to emphasize to the Commissioners that we want to try
22 to preserve as best we can the time for discussion.

1 Questions? Brian. Brian, Bruce, Amol.

2 DR. DeBUSK: First of all, thank you for a great
3 chapter.

4 If you could go to Chart 12, just for
5 clarification, when you say a discount equal to no less
6 than 20 percent of the negotiated price, this is pre-rebate
7 price. This is not net of rebates.

8 MS. SUZUKI: Yes.

9 DR. DeBUSK: Okay. And second question, are we
10 going to assume that DIR is back-allocated in a manner
11 similar to how it's done now? Are we going to be silent on
12 how we --

13 MS. SUZUKI: So, currently, CMS allocates the DIR
14 based on the spending in the catastrophic phase that's for
15 the insurance versus the rest of the spending, which is
16 gross spending.

17 In changing the benefit structure and reducing
18 the reinsurance of 20 percent, plans would keep the rest of
19 the DIR, but they would also be liable for spending on the
20 remainder of the benefit.

21 So if CMS doesn't change the formula for
22 reallocating, they would continue to use the proportion of

1 DIR that's attributable to reinsurance, and the remainder
2 is kept by the plan sponsors.

3 But I guess what I'm trying to say is under the
4 policy, plans are liable for a much bigger share of the
5 benefit cost.

6 I think you're remembering a couple years back
7 when we raised this as an issue, and I think that is no
8 longer a major concern.

9 DR. DeBUSK: Okay. Thank you.

10 DR. CROSSON: Bruce?

11 MR. PYENSON: I've got a question on Slides 9 and
12 13. If we could go to 9.

13 Could you describe what your criteria for
14 successful transition is? Does that mean that the LIS,
15 that people stay in the same plans, they like their plan
16 and they stay in it, or does it mean a lot of choices?
17 What is your criteria for successful transition?

18 MR. ROLLINS: I think for successful transition,
19 you're hoping to avoid sort of unexpected outcomes. So, in
20 this case, I think mostly what we had in mind were
21 unexpected large losses in certain types of plans.

22 To the extent that you have evolution in the

1 plans that are offered during beneficiary choices about the
2 plans, where they want to receive their Part D benefits,
3 you would expect some changes, I think, as a natural course
4 of some of the recommendations we're remaking. Plans will
5 take another look at what they put on their formularies and
6 what their coverage looks like. So it's reasonable to
7 expect that beneficiaries may change which plans they're
8 enrolled in, and I think that's part of the normal course
9 of Part D.

10 I think we're looking to guard against sort of
11 unexpected sort of bad outcomes.

12 MR. PYENSON: It sounds like more the financial
13 outcomes for the plans.

14 MR. ROLLINS: Yes, I think so.

15 MR. PYENSON: Thank you.

16 On Slide 13, the items there on particular
17 changes to allow Part D plans to better manage formularies
18 and spending and utilization, we had some discussion on
19 mandatory generics, which are routine in the commercial
20 world. Is that included in one of these bullets, or is
21 that undefined? I'm curious why that's not in the
22 Chairman's recommendation.

1 MR. ROLLINS: That had been a topic that had been
2 raised at some of our previous discussions, but I don't
3 know that it ever really at least sort of -- in my mind
4 sort of crystallized to a point of something where I
5 thought there seemed to be a consensus. So that's
6 certainly something that's been discussed, but it's not
7 specifically part of this recommendation.

8 MR. PYENSON: Finally, on Table 5 of the reading
9 material, there's a list of 1,021 plans that the LIS are
10 enrolled in, including 187 basic PDPs and 126 PACE
11 programs. Do you have a thought on how many plans there
12 really are in terms of the administrators? My impression
13 is the market is heavily consolidated, and there's only a
14 handful of PBMs that are behind that.

15 DR. SCHMIDT: Yes. I think that's accurate.

16 In our March report to the Congress, which will
17 come out any day now, we've got some discussion about the
18 relative concentration of plan sponsors, enrollment, plan
19 sponsors for PDPs versus MAPDs. It's less concentrated for
20 MAPDs and PDPs, but you're correct that many of the MAPDs
21 are contracting with large PBMs. So it's a bit more
22 concentrated than even we show in that report.

1 DR. CROSSON: Thank you, Bruce.

2 Amol?

3 DR. NAVATHE: On page 51 of the reading, you had
4 outlined -- I think it's also in Table 9. You looked at
5 the variation, the coefficient variation in the spending
6 for LIS and non-LIS beneficiary enrollees as a way to think
7 about the adequacy of risk adjustment, essentially, and I
8 was curious. So I agree with the interpretation that you
9 guys had, which was it doesn't suggest that this would
10 create an automatic disadvantage, but part of what I was
11 wondering, have we looked at either the outliers or the
12 residual? Because while variation could be larger, what
13 we'd be more interested in from a risk adjustment
14 perspective is what of that variation is not explained by
15 the risk adjustment model. So, in some sense, we're most
16 interested in the variation of the residual as opposed to
17 the outright variation itself in the spending. I was
18 curious if you guys have looked at outliers or variation of
19 the residuals.

20 MS. SUZUKI: We have not looked specifically at
21 the residuals, but what we have looked at is above the
22 catastrophic threshold. Spending for LIS has a lower

1 average and lower variant than spending for non-LIS
2 enrollees, which seems to indicate that they, again, will
3 probably not be disadvantaged relative to non-LIS enrollees
4 in the risk adjustment model.

5 DR. CROSSON: Kathy?

6 MS. BUTO: I wonder if you can remind us how much
7 Medicare spends in Part B and then sort of what is the rate
8 of growth in Part D versus, say, in pharmaceutical spending
9 overall, even though I know it's harder in the overall
10 because that's combined with health plan spending. Do we
11 have a sense of that?

12 Then, secondly, whether this proposal
13 restructuring would have an impact on the rate of growth, I
14 suspect it would, although it looks to me as if we're
15 mostly about restructuring the incentives here. But I'd
16 just be curious to know if you think it's going to make a
17 difference in the spending growth.

18 DR. SCHMIDT: So total spending, we have, again,
19 from our March report in 2018, about \$98 billion, and part
20 of that is including enrollee premiums. So net of enrollee
21 premiums, it's closer to 80-ish.

22 Let me pull up the tables on rate of growth and

1 spending. Do you remember that off the top of your head?

2 MS. SUZUKI: Six to 7.

3 DR. SCHMIDT: Six to 7 percent, I think, is the
4 overall average. How that compares relative to commercial
5 spend --

6 MS. BUTO: Is it about the same?

7 DR. SCHMIDT: It's maybe roughly the same.

8 MS. BUTO: But you'd expect this to have an
9 impact in lowering that rate of growth since Medicare will
10 absorb less than the catastrophic or will take on less risk
11 in the catastrophic phase, or have you not thought about
12 that or estimated it?

13 MS. SUZUKI: I think there are a lot of moving
14 pieces, and we do think that providing plans with stronger
15 incentives would tend to slow the growth potentially
16 because of their formulary decisions. And that may in turn
17 affect manufacturer pricing and rebate decisions.

18 But at the same time, with the cap discount,
19 there are certain cases where manufacturers may launch at a
20 higher price, and depending on the market share for
21 Medicare, they may continue to increase prices. So there
22 are a lot of uncertainties where it's really difficult to

1 say how growth rate would change.

2 DR. CROSSON: Assuming that next month we approve
3 this, there will be, I can guarantee, many analyses of the
4 impact of this set of proposals.

5 But I would point out the one, which is the
6 potential for higher launch prices, and I do anticipate
7 that that's likely to happen, and that this Commission or
8 Congress will need to address that at some point as, in all
9 honesty, is already being considered. And we've already at
10 this Commission discussed some ideas about how to deal with
11 that.

12 Marge, Pat.

13 MS. MARJORIE GINSBURG: Yeah. This is a very
14 quick question related to this discussion.

15 On page 17, down at the bottom, it says that
16 Medicare's total payments to plans for the basic benefit
17 would remain unchanged if there are no behavioral responses
18 by plan sponsors, manufacturers, and beneficiaries. Is
19 that what we're talking about here? Is the behavioral
20 responses to this, it assumes it will be static, therefor
21 will do fine? If in fact manufacturers, plans change their
22 MO, then, of course, it's a different ball game. I just

1 wanted clarity to make sure that's what we were referring
2 to here.

3 DR. SCHMIDT: Give us a second. We're catching
4 up with you with where you saw this. Right. Bottom of
5 page 17, we're seeing.

6 So that was, frankly, giving us a little
7 headroom. We don't know what all of the behavioral
8 responses will be. Obviously, the goals of this is to try
9 to encourage some behavioral response. That's the point of
10 having this in the first place, and we're hoping that plans
11 by bearing more risk will have greater incentive to take a
12 look at their formularies and try and ensure that it's both
13 giving beneficiaries access to good therapies but also
14 looking for those therapies that are lower cost. So that's
15 the overall goal here.

16 We're trying to make the point that when we are
17 changing the nature of the subsidy, we're keeping the
18 overall subsidy the same, and it's just more of it taking
19 place in a capitated form as opposed to a cost-based form.

20 DR. CROSSON: Pat?

21 MS. WANG: On Slide 9, can you say a little bit
22 more about the transition period and what would be

1 transitioned? So this might contemplate that the benefits
2 are standardized like right off the bat, and that the
3 reinsurance layer is what transitions?

4 Okay. So the first bullet describes phasing in
5 the higher plan liability vis-a-vis CMS. What about the
6 manufacturer discount? Where's the cap discount in the
7 transition?

8 MR. ROLLINS: So I think as we have thought about
9 the transition, there would be certain -- obviously, we
10 have a lot of moving pieces in this package. There would
11 be certain things that would be implemented immediately or
12 all in one go, and one of those would be the discount
13 program. The current coverage gap program would run
14 through December 31st of a particular year, and then
15 starting January 1st, you would have a new discount up in
16 the catastrophic phase of the benefit.

17 Similarly, in our thinking, the filling in of the
18 coverage gap and having plans be responsible for that
19 interval of spending would also be implemented all in one
20 go. The part that would be transitioned in would be in the
21 catastrophic phase once you have the discount there of the
22 remaining sort of 80 percent of spending, what mix is going

1 to be reinsurance, and what mix is going to be plan
2 liability.

3 DR. CROSSON: Okay. Let's proceed with the
4 discussion again. What we're doing here at this meeting is
5 preparing the minds, collectively, for the vote that we're
6 going to have next month.

7 We've got a summary slide up there that you can
8 refer to, any one of the three recommendation pages, if you
9 wish, but I would like to see Commissioners' level of
10 support for this package.

11 It is a package. To the extent that you support
12 that, I'd like to hear it. To the extent that you would
13 not, I would like to know that and any suggested changes
14 that you have in mind.

15 Brian?

16 DR. DeBUSK: Again, fantastic chapter. I've
17 watched this work evolve since 2016. It just keeps getting
18 better and better.

19 I did do a really clean read twice of this
20 chapter because I've been seeing the incremental version
21 for so long. You guys put it together. Not only is it
22 technically outstanding, but it also -- I mean, it's just a

1 very well-written document.

2 I do support all the changes -- I mean all the
3 recommendations as proposed.

4 What I want to ask is that we keep a close eye on
5 rebates because -- they're running about 27 percent. We
6 have built a structure that should create a drag on
7 rebates, and I think if we see rebates creep up above the
8 27 percent mark, it means that someone has figured out how
9 to undo the reforms that we've done.

10 But it looks very well thought out and very, very
11 methodical, and I really appreciate the way you guys
12 brought this together and just incrementally kept making it
13 better and better.

14 So, again, I wholeheartedly support all the
15 recommendations.

16 DR. CROSSON: Amol?

17 DR. NAVATHE: I also agree. Very well written.
18 I think very well done. Excited to support this
19 wholeheartedly.

20 I think the part that I'll just circle back to my
21 question on is I think it will be crisper for us in terms
22 of articulating the rationale behind the risk adjustment

1 model to actually look at the unexplained variation.

2 From everything you are describing here, it looks
3 like we'll be fine, so to speak, but if we're really going
4 to talk about risk adjustment model, suggest that it's
5 equitable, looking at variation by itself is not enough.
6 So we would need to take that next step, and it seems like
7 analytically it should be a feasible step. So I suggest
8 that we do that.

9 DR. CROSSON: Let's see. I've got --

10 DR. PAUL GINSBURG: Jaewon.

11 DR. CROSSON: Yeah. Bruce is in there too. Hang
12 on a second. I'm trying to catch up here. I've got
13 Jaewon, Kathy, Bruce, Warner. Did I miss somebody? Pat.

14 Okay. Jaewon?

15 DR. RYU: So I would echo that, and in
16 particular, I just appreciate that I know in the earlier
17 discussions, there was some concern around the regional and
18 smaller health plans and the exposure to a lot more risk,
19 and I think you've done a really great job capturing some
20 of the ways that we could dampen that through the
21 transition, whether it's the risk corridors or the stop-
22 loss protections or some of these tools. So I just

1 appreciate that.

2 One thing that I wanted to -- sort of a quasi-
3 question and comment. On Slide 17, when you talk about the
4 higher launch prices -- and I know in the reading
5 materials, there was some discussion about, well, it could
6 cut both ways as far as the implications on the launch
7 price, but I thought there was a concept in the reading
8 materials that I think is worth maintaining as a design
9 feature of sorts, which is the discount, the manufacturer's
10 discount in the catastrophic, if there's a way to sort of
11 anchor it against a benchmark, and then if there's a rate
12 of inflation beyond the benchmark, to proportionately
13 increase that discount. I thought that sounded like a way
14 that we can mitigate some of the effects of potentially
15 higher launch prices, and in the slides at least, it didn't
16 make its way in there.

17 I know there was some discussion in the material,
18 but I think it would be helpful to keep an eye on that.

19 DR. CROSSON: I agree with that, Jaewon, and I
20 think we should make sure it's emphasized at least in the
21 text. It is one type of approach that's being talked about
22 more broadly in government circles about indexing

1 increases, and I think in this regard, it's useful to
2 emphasize it. I agree.

3 DR. SCHMIDT: Could we mention something in the
4 first recommendation? If you look at the wording of
5 Recommendation No. 1, the last, very last bullet there at
6 the bottom, it says no less than 20 percent. So we were
7 trying to give some wiggle room to that concept there, and
8 I think our intention was to have wording around the
9 recommendation.

10 If you guys want to do this, that's along those
11 lines. That's consistent with what you're talking about,
12 Jaewon.

13 DR. RYU: Gotcha.

14 DR. CROSSON: Okay. Bruce. I've got Bruce,
15 Warner, and Pat. Kathy, I'm sorry.

16 MS. BUTO: Very short. I want to support the
17 overall structure. I really commend you because I think
18 this is a brilliant rethinking of the benefit and will
19 address some of the big distortions in the current benefit
20 package.

21 I think you've done a really good job of
22 addressing the issues around LIS plans and some of the

1 mitigating factors in the structure. So I just want to
2 thank you for that. And, yeah, I support it.

3 DR. CROSSON: Thank you, Kathy. Bruce.

4 MR. PYENSON: Yeah, thank you very much. I am an
5 enthusiastic supporter of the structure that has been
6 created here, and the work that's gone into it is
7 fantastic.

8 I am very much opposed to a transition as it has
9 been described. Part of my enthusiasm for the new
10 structure is that it creates an opportunity for new market
11 entrants who have a different model of bringing
12 prescription drug benefits to Medicare beneficiaries.

13 As Brian has talked about and others have talked
14 about, the current model is heavily based on rebates and
15 driving financial feasibility. The transition that's being
16 proposed basically creates a barrier to new market
17 entrants. It does that because any new market entrant is
18 going to need to succeed at the current rebate game or face
19 large financial losses in the transition period. And that
20 means it either has lots and lots of capital, or if it
21 doesn't have a lot of capital, it's going to be impossible
22 to play in both -- have a foot in both boats.

1 So I'm very much opposed to the transition of
2 catastrophic, and I think it's really not necessary. I
3 think there's other ways to protect the financial viability
4 of plans. Risk corridors is one way, but there's other
5 ways to do that. But I think if we go with a transition,
6 we're going to miss the kind of opportunity that we saw
7 when the ACA was launched, the marketplace, and we saw new
8 entrants coming into the market and launching new products
9 and new ideas and new styles. And if we had a transition
10 from the old individual small-group insurance into ACA,
11 that probably wouldn't have happened.

12 So I think there's a real value in not having a
13 transition, which would encourage new entrants. And some
14 of the ways that can happen is with organizations that may
15 go direct with delivery as opposed to through drug stores.
16 There's all sorts of things being out there and talked
17 about, but having the transition in catastrophic is going
18 to either force large losses on new entrants or discourage
19 them.

20 DR. CROSSON: Okay. You both want to come in on
21 this point? So do I.

22 So, Bruce, what you're talking about is not a

1 permanent phenomenon, correct?

2 MR. PYENSON: It's permanent. We have an
3 opportunity, a one-time opportunity to allow new entrants.

4 DR. CROSSON: That's what I don't understand.
5 Why do you see it as a one-time opportunity?

6 MR. PYENSON: Because there's going to be --
7 currently, for example, you look at the stability in the
8 market for LIS. The LIS had been an attractive market for
9 new entrants because there were plans coming and going and
10 there was auto assignment and things of that sort. That
11 has gone away. So the ability to go out and sign up lots
12 of people, which is critical for any kind of insurance
13 business and volume, depends on either the fluctuation in
14 LIS or having a really attractive product out there.

15 Now, take those one at a time. To have an
16 attractive product at launch means a low premium and great
17 benefits. Currently, you can do that if you're very
18 successful at getting rebates. So that's the old market,
19 and the financial viability depends largely on the low plan
20 liability and catastrophic and also the gap. So a
21 transition basically preserves that, and it's very hard for
22 a new plan without volume to get the rebates to make an

1 attractive offering. Therefore, you have to plan on large
2 losses for a couple years while the transition goes on.

3 DR. CROSSON: I see that, but, you know, given
4 the number of Part D plans that already exist, I think --
5 and my inference here is that you believe that these new
6 market entrants would be so dramatically more effective,
7 lower cost, providing better service, or whatever, that
8 that's an opportunity that should not be let go. Is that
9 what you're saying?

10 MR. PYENSON: Yeah, I think there's organizations
11 with ideas on how to do this and how to deliver, and we
12 shouldn't anchor them one foot in the old model and one
13 foot in the new model.

14 DR. CROSSON: Okay. I understand. Kathy and
15 Brian wanted to come in.

16 MS. BUTO: This is on this point also.

17 DR. CROSSON: Just on this point. All three of
18 you on this point.

19 MS. BUTO: I guess my question to Bruce would be,
20 or maybe to Rachel and Shinobu, would be: Would it be
21 possible to allow new entrants that want to adopt the total
22 model -- the new model right off the bat to come in without

1 having to go through that rebate transition while allowing
2 existing plans that need that transition to adopt it? If
3 they really want to get in without having to go through
4 that model that they don't want to adopt, is there a
5 disadvantage or additional risk to a plan that wants to go
6 whole hog? That's my question. If they're anxious to get
7 in and they can offer a better model, is that a
8 possibility?

9 DR. CROSSON: Okay. So Dana, Brian, and Pat also
10 want to come in on this topic. Dana first.

11 DR. SAFRAN: I was going to ask the same
12 question, and the idea was it could actually accelerate the
13 move to this for the existing plans because, otherwise,
14 they risk losing market share to the new entrants who are
15 giving a much better deal to the beneficiaries.

16 DR. CROSSON: Thank you. Brian.

17 DR. DeBUSK: That's exactly where I was going.

18 [Laughter.]

19 DR. DeBUSK: Bruce, you started the point. You
20 two finished it really well. There's an opportunity here
21 to tease apart the plan risk by using the risk corridors.
22 You can mitigate as much of that risk as you want to with

1 the risk corridors. But the transition, you do have an
2 opportunity to disrupt the rebate-based business model. So
3 it's exciting to be able to not disrupt the plan but
4 disrupt the business model, and I think Bruce touched on
5 it, and you guys really drove that point home.

6 DR. CROSSON: Is there agreement breaking out
7 here?

8 [Laughter.]

9 DR. CROSSON: I'm not exactly clear, but go
10 ahead, Pat.

11 MS. WANG: So, you know, if it's feasible without
12 creating market distortions to do some sort of hybrid
13 model, I guess I wouldn't object to that. But, you know,
14 I'm not really sure what kind of innovative, new sort of
15 thing you're describing there and whether it's mainly on
16 the PDP side, Bruce. But as an MAPD, I have to tell you I
17 really want a transition. The risk adjustment is not known
18 and how well that's going to cover things. So I think it's
19 sort of going all the way, sort of let's just go straight
20 into this with so many unknowns out there, you're kind of
21 betting the farm on a lot of plans that today serve a lot
22 of people very well. And I for one would not be in favor

1 of that.

2 The other thing is I'm not really sure we could
3 have this conversation of the new entrants from the ACA
4 that you thought were so kind of disruptive, because the
5 ones that I'm familiar with all went bust -- the co-op
6 plans, some of the new hospital launches, sponsored plans.
7 The plans that have succeeded in the ACA are Medicaid plans
8 that were here for a long time. There are regional Blues
9 plans. So I guess I'm not sure -- you know, it's good to
10 hope for disruption in the market, but I'm not sure that I
11 -- maybe I'm not familiar with everything in the ACA, that
12 came from the ACA, but like I said, the plans that I'm
13 familiar with that have actually succeeded and managed to
14 stay without disrupting the whole market because they left
15 a lot of providers unpaid and created a lot of chaos were
16 here before and belonged to that old-fashioned -- sorry --
17 traditional model.

18 MR. PYENSON: You're right. A lot of the new
19 entrants went away. There's a few notable exceptions. But
20 I think getting an opportunity that the Medicaid plans had
21 to get into the commercial world was not a bad thing, and
22 that's probably one of the successes of the way ACA was

1 done. I'm not sure that they would have been able to do
2 that if there had been a slow transition. And for sure,
3 the ACA had its issues with rollout.

4 DR. CROSSON: Okay. So I think what we'll do
5 here, and recognizing that we've only got a few weeks
6 before the material for the next meeting needs to be put
7 together, is to take a look -- if I've got it right, to
8 take a look at -- Eric is making a face like I've never
9 seen.

10 [Laughter.]

11 MR. ROLLINS: I just wanted to clarify it is a
12 single week.

13 DR. CROSSON: Very quickly, approach the question
14 of whether or not there could be a mechanism by which new
15 entrants, as yet to be defined, could come in under a
16 different set of rules and still maintain market
17 equilibrium or fairness in the market, and if we can
18 develop such a model, then we will have it in the text in
19 the next version. And if not, we can't.

20 MR. PYENSON: If we're going to do that, I'd like
21 discussion of a no-transition.

22 DR. CROSSON: You'd like discussion -- I'm sorry.

1 What? That's what we're talking about. I'm missing -- go
2 ahead.

3 MR. PYENSON: So you proposing the hybrid model,
4 but in addition, you know, there could be reasons why a
5 hybrid wouldn't work, but to put on the table the no-
6 transition model that we --

7 DR. CROSSON: When you say put it on the table,
8 you've already done that, so I'm fast-forwarding this to
9 April. Let me try to put words in your mouth. I think
10 what you're saying is, were we to come up with some
11 feasible hybrid model, if you want to call it that, you
12 would still want to make the case in April for no
13 transition. Is that right?

14 MR. PYENSON: For sure if we decided a hybrid
15 wouldn't work, I'd want --

16 DR. CROSSON: Yeah, okay.

17 MR. PYENSON: -- push for the --

18 DR. CROSSON: Well, then, get yourself warmed up.

19 [Laughter.]

20 DR. CROSSON: Because that could happen. I mean,
21 you know, this is how we do it. Everybody says what they
22 think, and in the end, when we come to the package at the

1 end of the April meeting, we'll have to take a vote. But
2 if you are not satisfied with what we come up with or what
3 we come up with doesn't work and we all agree with that,
4 then you are absolutely free to bring forward this point of
5 view and then determine how it affects your vote.

6 MR. PYENSON: Well, I heard something else,
7 though. I heard that the staff is going to look at the
8 feasibility of a hybrid model.

9 DR. CROSSON: We're going to try in the time
10 that's available.

11 MR. PYENSON: I would ask staff to also look at
12 the feasibility of the no-transition model.

13 MS. BUTO: Bruce, I think you would have a lot --
14 I mean, I'm speaking for myself, but a sense that that's a
15 bigger discussion. I think at least my comfort level was
16 increased because of the transition model and the risk
17 corridors and a number of other things. If we go back to
18 how about no transition, I think that's a whole different
19 discussion and just an added section in the --

20 DR. CROSSON: I'm not sure -- actually, help me
21 here. I'm not sure what the feasibility of no transition -
22 - what kind of analysis that would be.

1 MR. PYENSON: Well, there's been representations
2 that the need for a transition is because of the financial
3 stability of plans, and that's something that is a routine
4 modeling exercise to show that, whether or not that is
5 important, because if we don't show it, then all it is is a
6 giveaway to the status quo.

7 Now, I can accept evidence that there is a need,
8 you know, and maybe that modeling will show that there's
9 actually a need from a financial stability standpoint for
10 transition.

11 DR. CROSSON: Bruce, I -- sorry. I understand
12 the point you're making. My only concern is that to do an
13 analysis in the next week of the financial -- or the likely
14 financial stability of not one plan but many different
15 varieties of plans is not practical. I'm not sure that we
16 would all feel, if the staff tried to do that, that it
17 would be comprehensive enough to answer the question that
18 you're fundamentally raising or to support or, you know,
19 work against the point that you're making. I can't
20 determine that. I'll talk to Jim. We'll talk to the
21 staff. I can't commit to that. If there's anything simple
22 based on just existing information that we could add to

1 help you in your determination, we'll do that. But an
2 understanding is that we have been working on this for a
3 long time, and I realize that the issue of transition came
4 up more recently than some other issues. But we are faced
5 with the schedule that we have. Okay? Yeah, Paul.

6 DR. PAUL GINSBURG: One more thing that I want to
7 say is that, you know, the issue of transition, it's not
8 just from things that we can model. It's really a vast
9 array of uncertainties faced by each individual plan as to
10 how effective will their new approaches to formulary
11 management be. And I don't think it's -- I think, you
12 know, in the policy world, the reason we have transitions
13 often is that uncertainty and the ability to get support or
14 to defuse opposition to a policy that in the aggregate is a
15 real improvement. And I think that's why we talk about
16 transitions to be able to generate more support for what to
17 me overall is a very compelling policy.

18 DR. CROSSON: And where there are a significant
19 number of uncertainties and the potential during a
20 transition phase to make mid-course corrections. You know,
21 you may say -- you may point how difficult that would be to
22 do, but it can be done from a regulatory perspective if, in

1 fact, during the transition period of time unknown
2 consequences are manifest early and can be corrected. So
3 that's --

4 DR. PAUL GINSBURG: Yeah. I think the other
5 point I wanted to make is the analogy with the ACA, one of
6 the problems is that there was a significant part of the
7 individual market that were products that were not worth
8 protecting. I don't think we have that situation here if
9 only because the program is new and it's been getting
10 regular policy attention.

11 DR. CROSSON: Okay. Warner.

12 MR. THOMAS: Just a couple of points. Generally
13 I'm supportive of the policy. I know we've worked on this
14 a long time, and I think it's great to shift more of the
15 risk away from the Medicare program. Just a couple of
16 comments I would make.

17 One, I actually disagree with Bruce. I think
18 that there should be a transition given the amount of risk
19 moving from the Medicare plan back to the health plans,
20 because it's a significant amount of risk above the
21 threshold. It goes from 15 percent to 60 or 80, depending
22 upon whether it's high cost or generics. I think that's a

1 lot of risk to just kind of do day one. So, anyway, sorry
2 to my colleague to my left here, but it's just a different
3 view of that transition.

4 I would say on the manufacturer discount, I would
5 actually advocate that it's higher than 20 percent. I
6 think the rate you indicated, you created some flexibility
7 there. This has obviously created a big opportunity in the
8 manufacturer area. I think raising their amount of
9 responsibility or discount over that threshold should be
10 something we should consider. I don't necessarily have a
11 number in mind, but maybe it should be split equally with
12 the plan. Or maybe it should be, you know, 80-20 -- you
13 know, I think there should be more than just this 20
14 percent component, so I would really advocate to put more
15 responsibility over the threshold onto the plan -- or onto
16 the manufacturer. Onto the manufacturer.

17 DR. CROSSON: Thank you, Warner. Pat.

18 MS. WANG: So I want to thank you for all of the
19 iterations of the work here, and I do think that the
20 chapter now is really pretty phenomenal. I'm still nervous
21 about the fundamental change, but I really feel much more
22 comfortable because of many of the mitigating things that

1 you've put in here, including a transition, which I feel
2 strongly needs to be in here.

3 I am in agreement with Warner's comment about --
4 I think that you used the example of 20 percent and 35
5 percent, just, you know, sort of by way of example in the
6 chapter, and I think would really support, absent some
7 compelling reason to the contrary, like it's going to
8 trigger some undesired behavior or impact to increase the
9 manufacturer discount. I think the cap discount itself,
10 the concept of it is a brilliant concept and very, very
11 important in the entire proposal.

12 I want to echo Amol's comment about trying to
13 understand more about risk adjustment because it is really
14 important. Risk adjustment doesn't really today pertain to
15 the catastrophic layer very much, and so sort of like, you
16 know, modeling it all the way out into the unknown and
17 understanding as much as possible to I think be able to
18 maybe make some helpful suggestions to CMS would be
19 critically important.

20 I know that we're still having a discussion about
21 the formulary presentation. I appreciate the ability to do
22 that. Notwithstanding the recommendation that I support of

1 being able even for LIS beneficiaries to differentiate cost
2 sharing for preferred and non-preferred, there's a very
3 large component of LIS beneficiaries who have no cost
4 sharing. The footnote made that clear, you know, nursing
5 home residents, those who are receiving LTSS services in
6 the community, and so I don't want to lose sight of the
7 fact that there's still -- I believe strongly should be
8 some way that plans can at least demonstrate to prescribers
9 with no cost-sharing impact that there's a difference,
10 there's a nudge, there's a suggestion that these are the
11 preferred drugs because the plan has gotten large rebates
12 or whatever on them and would help to manage the risk.

13 On Slide 14, which is Recommendation Number 3,
14 since this is a package I just wanted to suggest that maybe
15 the wording be slightly modified to say "concurrent with
16 the first and second recommendations." The way it reads
17 now it's like, you know --

18 DR. CROSSON: Sorry, Pat. I can't quite hear
19 you.

20 MS. WANG: Okay. Recommendation Number 3, the
21 introduction should say "concurrent with the first and
22 second recommendations." Right now it simply says first.

1 DR. CROSSON: Good point.

2 MS. WANG: Thank you.

3 DR. CROSSON: So Pat, first of all, I think we've
4 already said, as Commissioners, how grateful we are to the
5 staff for this work, but I'd also like to thank the
6 Commission for the many discussions we've had and how rich
7 this has become.

8 And Pat, I would like to single you out, because
9 I think your contributions to that, based on concerns -- we
10 all understand that -- have really brought this forward
11 into something that is one of our best pieces of work in
12 the last few years. So thank you for that.

13 Paul.

14 DR. PAUL GINSBURG: Oh, this is anticlimactic. I
15 just wanted to congratulate the staff and Commissioners and
16 especially Pat.

17 DR. CROSSON: All right.

18 DR. PAUL GINSBURG: Back to the one thing of
19 substance I want to say, is that we need to play with the
20 writing to indicate that, whereas we are talking about a 20
21 percent discount, that Congress could very well decide to
22 go for a larger one, and it wouldn't compromise the

1 workability of this approach.

2 DR. CROSSON: So that's a point I think I'd like
3 to test right now. So I've heard a number of comments,
4 including Paul's just now. When we come back with the
5 recommendation for final vote in April, how many
6 Commissioners would like to see that 20 percent number
7 higher?

8 [Show of hands.]

9 DR. CROSSON: Fair enough. Okay. Thank you very
10 much Shinobu, Rachel, Eric. Wonderful work again.

11 We will move on to the next presentation.

12 DR. CROSSON: Okay. Now we are going to return
13 to our body of work designed to improve the Medicare
14 Advantage program, and we're going to specifically focus
15 once again on the notion of changing the quality bonus
16 program. And we have, again, in this case, a set of draft
17 recommendations to discuss.

18 So Ledia, Andy, Carlos, Sam, hiding in the wings,
19 bullpen, something. Okay. And who is going to begin?
20 Ledia? Thanks.

21 * MS. TABOR: Good afternoon. We are here to
22 continue the discussion of the redesigned value incentive

1 program for MA, or MA-VIP, which addresses the flaws of the
2 MA quality bonus program. The MA-VIP design was initially
3 published in the June 2019 report to the Congress, and
4 discussed at the last November and January Commission
5 meetings. We have incorporated your feedback into the
6 latest chapter you received before the meeting and will
7 highlight some of these changes in today's presentation.

8 Before moving on, we would like to acknowledge
9 Sam Bickel-Barlow for his work on this analysis.

10 Reforming the current quality bonus program is a
11 matter of urgency. One-third of Medicare beneficiaries are
12 now enrolled in Medicare Advantage, and that number is
13 growing. MA plans are also viewed as having the potential
14 to be more efficient than fee-for-service while providing
15 high-quality care. However, the Medicare program does not
16 have the tools to judge the quality of care MA plans
17 provide, and beneficiaries do not receive accurate
18 information about their options.

19 The QBP uses broad, contract-level quality
20 results that have led to contract consolidation and
21 unwarranted bonus payments, which I'll discuss more on the
22 next slide. The QBP ineffectively accounts for social risk

1 factors of plan populations, because QBP plans that serve
2 high-needs population are less likely to be classified as
3 high-quality plans. Also, the QBP adds \$6 billion per year
4 in program costs, unlike nearly all FFS quality incentive
5 programs, which are budget-neutral or produce program
6 savings.

7 Many contracts between 2013 and 2018 have been
8 consolidated meaning lower-rated plans are moved to bonus-
9 rated plans and subsumed under the star rating of the
10 higher-rated plan, and therefore receiving unwarranted
11 quality bonus payments. The majority of 2020 MA enrollees
12 are in plans that have some level of consolidation.

13 Although recent legislation narrowed the
14 opportunities to obtain unwarranted bonus payments through
15 the consolidation strategy, the legacy remains, which means
16 the Medicare program has increased expenditures in
17 unwarranted bonuses; the program and beneficiaries have
18 inaccurate information on quality; the quality data is not
19 representative of performance in a local area; and some
20 plans have unfair competitive advantage in a given market.

21 The Commission's MA-VIP will address the flaws of
22 the current QBP design, which are presented on the left-

1 hand side of the table. The redesigned MA-VIP will meet
2 the five key elements of design presented on the right-hand
3 side of the slide, which we'll walk through over the coming
4 slides, followed by modeling results of an illustrative MA-
5 VIP. These design elements form the basis for the draft
6 Chairman's recommendation.

7 The MA-VIP scores a small set of population-based
8 measures that focus on patient outcomes and experience, as
9 opposed to the current QBP set of 45 measures which
10 includes administrative measures such as Call Center
11 Foreign Language Interpreter Availability.

12 This table displays an illustrative MA-VIP
13 measure set that incorporates the Commission's discussion.
14 This is not intended to be a definitive list of measures,
15 and CMS should develop the MA-VIP measure set through a
16 public review and input process. We anticipate that the
17 MA-VIP measure set would continue to evolve as better data
18 becomes available.

19 It is also important to note that this measure
20 set is being used for payment. Medicare could publicly
21 report additional measures of interest to beneficiaries,
22 such as plan disenrollment rates.

1 In our illustrative modeling of the MA-VIP, we
2 scored the six measures noted with an asterisk. Because
3 plans currently collect and report quality results at the
4 contract level and not at the market-area level, we could
5 only use measures where we had beneficiary-level encounter
6 or survey data that we could reassign to a plan within a
7 market area to calculate a quality score. When the MA-VIP
8 is implemented, CMS would be able to score a full set of
9 measures based on plan-level quality information collected
10 at the market level.

11 The MA-VIP evaluates quality at the local market
12 level meaning it scores a plan's performance for the
13 beneficiaries they cover in a local market area, as opposed
14 to the contract level, because as I mentioned earlier,
15 plans have also been practicing contract consolidations to
16 receive unwarranted bonuses. Using market-level measure
17 results provides a more accurate picture of quality for
18 beneficiaries who are selecting a plan where they live and
19 also for the Medicare program to understand plan
20 performance.

21 Under the illustrative MA-VIP modeling results
22 we'll present today, our reporting unit is a parent

1 organization within a local area that had sufficient
2 enrollment to reliably calculate measure results.

3 Medicare should take into account, as necessary,
4 differences in enrollee populations, including social risk
5 factors. One way to do this is to stratify plan enrollment
6 into groups of beneficiaries with similar social risk
7 factors to determine payment adjustments. Comparing groups
8 with similar patient compositions accounts for social risk
9 factors without masking disparities in plan performance, as
10 would be the case if measure results themselves were
11 adjusted.

12 In our illustrative MA-VIP modeling, we
13 stratified each parent organization's enrollment into two
14 peer groups, and then calculated measure results for each
15 of the groups. We use eligibility for full Medicaid
16 benefits as a proxy for social risk factors because it is a
17 readily available data source and captures a characteristic
18 that may make a plan's enrollees more difficult to treat.
19 Policymakers could continue to explore other factors that
20 could be used to in the peer grouping.

21 The MA-VIP uses a performance-to-points scale for
22 each measure to convert a plan's result to a score which

1 determines the rewards and penalties the plan receives.
2 There are two key features of this scoring mechanism.
3 First, plans know that if they improve it can impact their
4 rewards, which can drive quality improvement. Second, the
5 MA-VIP scale is continuous, meaning that every change in
6 performance will affect the number of points achieved and
7 the size of any reward or penalty. There are no
8 performance cliffs like the QBP.

9 In our illustrative modeling, we set each
10 measure's scale based on a beta distribution of current
11 national performance. Policymakers can consider other
12 methods to set the performance scale.

13 I'll now turn it over to Andy to discuss the last
14 design element and modeling results.

15 DR. JOHNSON: Rewards in the value incentive
16 program would be financed through a pool of dollars that is
17 funded by a share of plan payments. A key change from the
18 current quality bonus program is that the bonus increases
19 to plan benchmarks would not be used. Instead, the value
20 incentive program would redistribute a share of plan
21 payments based on quality performance.

22 Reward pools could be distributed within each

1 local market based on local performance. With this
2 approach, rewards and penalties would be equal in each
3 market, with some parent organizations receiving rewards
4 and others receiving penalties. We conducted our modeling
5 using this local approach.

6 Given Commissioner interest during the last
7 meeting, we also discuss an approach that would incorporate
8 national distribution. Using a blended approach, reward
9 pools would be split, with one part distributed based on
10 local results and the remainder distributed based on
11 national results. Either approach is consistent with draft
12 recommendation we are presenting today.

13 This slide compares some key implications of a
14 local or blended distribution approach.

15 Local distribution controls for varying market
16 conditions, that could cause a plan applying a uniform
17 quality strategy to have different results across markets.
18 Market conditions include the availability of Medicaid and
19 food assistance programs, transportation infrastructure,
20 the level of social risk factors in the population, and the
21 underlying organization of providers.

22 Local distribution does not redistribute plan

1 payments across markets, and maintains equal treatment of
2 the MA and fee-for-service programs in each market.

3 A blended approach would incorporate some
4 distribution of the reward pool based on national results.
5 A national distribution holds plans accountable for local
6 market conditions, and redistributes plan payments from
7 markets with the lowest average MA plan quality to markets
8 with the highest MA plan quality, leading to some markets
9 that have only rewards or only penalties for all parent
10 organizations in the market.

11 A blended approach shares the strengths and
12 weaknesses of local and national distribution, where plans
13 are held partially accountable for local market conditions,
14 and there would be some redistribution of plan payments
15 across markets.

16 Now we will turn our modeling of the value
17 incentive program for MA. Our modeling relied on claims and
18 survey data for various measures. The scope of our
19 modeling was limited to the availability of survey data,
20 which are currently collected at the contract level, not at
21 the market level. To address this limitation, we assigned
22 each available survey to a parent organization and to a

1 market area.

2 We used local distribution of reward pools in our
3 modeling and limited our analysis to market areas with
4 three parent organizations having sufficient data. This
5 prevents the direct transfer of reward pools from one
6 parent organization to another when only two organizations
7 are present in a local market.

8 We were able to include 78 unique parent
9 organizations in 61 market areas, for a combined 258
10 reporting units in our modeling.

11 When implementing the value incentive program, MA
12 plans would collect survey data in every market to provide
13 sufficient data for local quality assessment.

14 Over the next few slides, I will discuss the
15 distribution of points scored in a few example markets and
16 the distribution of overall rewards and penalties. In
17 these slides, a zero percent adjustment means that a plan's
18 payments are unaffected by quality performance. Positive
19 adjustments, or rewards, increase a plan's overall
20 payments, and negative adjustments, or penalties, reduce a
21 plan's overall payments.

22 In this example, we look at how the MA value

1 incentive program would distribute rewards and penalties
2 using local distribution.

3 This figure shows the results for parent
4 organizations in three example markets for the non-fully
5 dual-eligible peer group. In Market 2, the middle column,
6 there were seven parent organizations, represented by the
7 seven circles. The size of each circle is proportional to
8 the enrollment in that parent organization.

9 The center point of each circle is aligned the
10 number of points achieved, according to the scale on the
11 vertical axis. The top parent organization in Market 2
12 achieved about 7.3 points, and the bottom achieved about
13 4.5 points.

14 With local distribution, the reward or penalty
15 threshold, shown by the three lines, is unique to each
16 market, guaranteeing rewards for the highest performers in
17 each market and penalties for the lowest performers.
18 Parent organizations in green above the line receive a
19 reward, and those in red below the line receive a penalty.
20 The size of any reward or penalty increases the farther the
21 circle is from the line.

22 Finally, average MA performance varied

1 significantly across markets in our sample, ranging from
2 about 3.5 to 7.5 points across the 61 markets. We think
3 variation in average market performance is due in part to
4 differences in local market conditions.

5 This figure shows the range and frequency of
6 payment adjustments for the 258 reporting units. The black
7 bars show results for the fully-dual eligible peer group,
8 and the white bars show results for the peer group
9 containing all other enrollees.

10 Our modeling used a reward pool funded with 2
11 percent of total MA payments. Results from our modeling
12 show that payment adjustments tended to be small, ranging
13 from negative 1.5 to 1.5 percent for parent organizations
14 in a single market. Nearly 80 percent of all payment
15 adjustments were between negative 0.5 and 0.5 percent.

16 We chose modeling parameters based on other
17 quality programs, but given the small size of the payment
18 adjustments in our modeling, policymakers could increase
19 the size of payment adjustments, by either modifying the
20 performance to points scale so that points achieved were
21 distributed more widely toward the extremes, or by
22 increasing the size of the reward pool. For example, if

1 the reward pool were increased from 2 to 4 percent, the
2 magnitude of each payment adjustment in this figure would
3 double.

4 Now, I'll turn it over to Carlos.

5 MR. ZARABOZO: There are differences in how plans
6 fare in the MA-VIP as compared to the current QBP. Plans
7 enrolling large shares of duals fare better. Large
8 organizations that had an advantage in the QBP system have
9 less of an advantage in the MA-VIP, and a number of
10 organizations not in bonus status under the QBP have
11 positive financial results in the MA-VIP. These
12 organizations are all what are known as regional plans,
13 that is plans that operate in single markets or limited
14 geographic areas.

15 To look specifically at certain populations, the
16 MA-VIP proposed design stratifies results for two
17 populations, the full duals and all others, comparing
18 results for each population at the market level. Our
19 modeling found that this approach narrows the disparities
20 in financial performance between dual populations and
21 others.

22 In this slide, the first two sets of bars

1 illustrate that in the QBP a little over half of full duals
2 were in bonus level plans in 2017, the solid blue bar at 54
3 percent for full duals in the QBP results, as compared to
4 the 82 percent in the solid blue bar for non-duals in the
5 QBP in the next set of bars. This large difference is
6 narrowed in the MA-VIP. For full dual eligible
7 beneficiaries, 53 percent are in plans with positive net
8 payment adjustments in the MA-VIP, compared to a similar
9 share, 57 percent, for non-duals.

10 The last two pairs of bars show that employer-
11 group- or union-sponsored MA plans continue to fare better
12 than plans for other populations, while the under-65
13 beneficiaries, those entitled to Medicare on the basis of
14 disability, fare worse than other populations. This may
15 argue for additional adjustments in payments or
16 stratification in a MA-VIP system.

17 The QBP benefits larger organizations, which are
18 also the organizations more likely to have been involved in
19 consolidations to boost star ratings. In January 2020, 85
20 percent of enrollees in the 10 largest parent organizations
21 are in bonus status, compared to 73 percent in other
22 organizations.

1 Under MA-VIP, organizations receiving net rewards
2 have lower enrollment on average than organizations with
3 net penalties.

4 In our modeling there were 20 parent organization
5 that received no 2017 QBP bonus payments in any of their
6 markets. Of the 20, eight would receive net rewards under
7 the MA-VIP. The eight organizations were small and
8 operating, as I mentioned, in single markets or a small
9 number of markets.

10 This brings us to the Chairman's draft
11 recommendation, which reads:

12 The Congress should replace the current Medicare
13 Advantage quality bonus program with a new MA value
14 incentive program (MA-VIP) that scores a small set of
15 population-based measures; evaluates quality at the local
16 market level; uses a peer grouping mechanism to account for
17 differences in enrollees' social risk factors; establishes
18 a system for distributing rewards with no "cliff" effects;
19 and distributes plan-financed rewards and penalties.

20 And so the rationale for the draft
21 recommendation, the QBP is flawed and does not provide a
22 reliable basis for evaluating MA quality in meaningful way.

1 Plans have also received unwarranted bonus payments under
2 the QBP system.

3 The QBP costs the Medicare program \$6 billion a
4 year in added program payments. Making the MA-VIP a plan-
5 financed system that does not involve additional dollars
6 will mean that the Medicare program will be equitable in
7 its treatment of quality incentive programs by putting the
8 MA program on a par with nearly all fee-for-service quality
9 incentive programs, which are budget-neutral or produce
10 program savings.

11 Compared to the QBP, the proposed MA-VIP will
12 provide the program and Medicare beneficiaries with more
13 accurate information on MA quality, and it is designed to
14 produce a fairer distribution of incentive payments across
15 markets and across the different population groups enrolled
16 in MA.

17 The implications of the draft recommendation are
18 that it would reduce payments relative to current law. It
19 is not expected to affect beneficiaries' access to plans or
20 plan participation in MA.

21 It is possible that beneficiaries will see a
22 reduction in extra benefits because plans will have lower

1 payments. How much of a change there would be in extra
2 benefits depends on how plans respond to lower benchmarks.
3 Bids could go up, but plans may also choose to reduce
4 profits or otherwise lower their cost of providing the
5 Medicare benefit; that is, they become more efficient.

6 To the extent that more money flows to plans
7 serving high-needs populations, enrollees in those plans
8 could have better extra benefits. From the plan point of
9 view, in addition to possible payment increases, the plans
10 serving high-needs populations would be on a more even
11 footing in competing with other plans in their area because
12 of the stratification approach in determining rewards and
13 penalties.

14 With the MA-VIP, beneficiaries will have better
15 information on the quality of plans in their area. Plans,
16 however, will have higher administrative costs because of
17 the use of the local area as the reporting unit. For
18 example, more surveys will have to be administered.

19 We will now put the Chairman's draft
20 recommendation for your discussion. Thank you.

21 DR. CROSSON: Let me start with one question.
22 Carlos, on the higher administrative costs, I guess I had

1 the notion that by shrinking the number of quality
2 measurements so dramatically that we might actually see
3 lower administrative costs with the new program, but I
4 think what you're saying is that you think that would be
5 outweighed by the cost of additional surveys?

6 MR. ZARABOZO: Right.

7 DR. CROSSON: Okay.

8 MS. TABOR: I will say it all depends on what the
9 illustrative measure set ends up being. If there are the
10 patient experience and patient-reported outcomes, which are
11 survey-based measures, that will raise administrative
12 costs. If there are measures that require a medical record
13 review, like diabetic control, those will impact plan
14 administrative costs for collecting the results.

15 DR. CROSSON: Got it. So this is a question of
16 getting to an adequate end because we're going to be
17 dealing with this. Okay. All right. Thanks.

18 Other clarifying questions? Let's go to David,
19 Jaewon, Brian, Dana. Marge, did I miss you? David, Marge,
20 Jaewon, Brian, Dana, Bruce. Got that. Where do we start?
21 David.

22 DR. GRABOWSKI: Great. Thanks.

1 First of all, great work. I really like the way
2 this has progressed.

3 I think this is a simple question. Maybe I've
4 just forgotten it or missed it in the chapter, but are the
5 special needs plans in this program or not? And if they
6 are, then I guess a follow up to that would be just do you
7 expect any kind of movement, that this will be advantageous
8 for plans serving high-needs groups, and will we see
9 greater entry or just anything to entice duals into those
10 models?

11 DR. JOHNSON: So far, the special needs plans are
12 in this modeling and would be included in the MA-VIP. In
13 each local market, all of the plans under a parent
14 organization would be grouped together, and then the
15 stratification would happen, so that in our modeling with
16 just full duals and non-full duals. But if additional
17 groups were warranted -- or it could be accommodated, I
18 think that's where it would. Concerns about the selection
19 of plan types would be addressed there.

20 MS. TABOR: One nuance is the demonstrations were
21 not included in the modeling.

22 DR. JOHNSON: Correct.

1 MS. TABOR: Yeah.

2 DR. CROSSON: Okay. Jaewon? No. Marge. I did
3 it again. Sorry. Marge.

4 MS. MARJORIE GINSBURG: Thank you. This is such
5 exciting work. It takes my breath away.

6 A question on page 84 of the report. About
7 halfway down under Conclusion, the Commission has discussed
8 moving Medicare into more value-based payment arrangements
9 where an entity is accountable for both cost and quality of
10 care. I actually don't understand where cost actually
11 comes in here because, theoretically, a health plan can do
12 all these things fabulously and turn around and raise the
13 cost sharing for their beneficiaries, but that's not --
14 doesn't seem to be reflected in here anywhere about the
15 impact that this may have on the beneficiary.

16 The original question, other than the overall
17 cost to Medicare by getting rid of the bonus issue, I'm not
18 sure this sentence refers to cost provided to Medicare
19 beneficiaries. Where do you see that?

20 I have a couple other questions after that, but
21 let's --

22 DR. JOHNSON: That's a fair characterization. I

1 think the sentence is more of a general statement about
2 what we believe about MA plans in general, and the cost,
3 holding plans accountable for cost is addressed elsewhere.
4 In this section, we're just looking at the quality of care.

5 MS. TABOR: One small piece also would be, again,
6 depending on what measures make it into the measure set, is
7 readmissions, for example, does affect beneficiaries if
8 they have cost sharing associated with any subsequent
9 hospitalizations.

10 MS. MARJORIE GINSBURG: Okay.

11 MS. TABOR: It's a small piece.

12 MS. MARJORIE GINSBURG: Well, sort of indirectly.

13 MS. TABOR: Yeah, exactly.

14 MS. MARJORIE GINSBURG: And this may be beyond
15 where we are right now, but as we know, with a five-star
16 plan, health plans that are five-star, maybe even those
17 with four-star, have the bragging rights, and with that
18 comes the ability for people to pick their plan outside the
19 annual enrollment period. Are we estimating any kind of
20 effect this might have that allows health plans to have
21 that same power, if you will, that they currently have, or
22 is that an issue for a later day?

1 DR. JOHNSON: I think an issue for a later day.
2 We have mostly been focused on the ways to redistribute
3 payments as a way to incentivize higher quality.

4 MS. MARJORIE GINSBURG: Okay. I think that's
5 fine for now. Thank you.

6 DR. CROSSON: Thank you, Marge.

7 Jaewon?

8 DR. RYU: Yeah. You referenced, I think, \$6
9 billion of additional payments flowing through the system
10 right now, and it seems like there's still some elements of
11 what I'll call "gamesmanship" that you also talk a lot
12 about. If those elements of gamesmanship were to come out
13 of the system -- let's say we were able to close those off
14 -- what would the number be? It would be less than 6. What
15 would that excess dollar amount be?

16 And that gamesmanship, some of it was the
17 consolidation that was minimized through some of the recent
18 rule changes, but I think you also mentioned there's still
19 this dissipation effect, the residual carryover effect
20 until that completely washes out.

21 There's a new contract kind of dynamic. There's
22 deconsolidation. I think these are some of the things you

1 talked about in the reading.

2 If you were to close all of that off, what would
3 that \$6 billion turn into?

4 MR. ZARABOZO: Well, the point about mentioning
5 the, currently, 83 percent using the 2020 stars are in
6 bonus status, and that the dissipation effect that we
7 talked about, the only effect left over from consolidations
8 where we definitely know they move from non-bonus to bonus
9 is that 2 percent.

10 So going forward, it is at least \$6 billion a
11 year because we know 81 percent in the bids coming up will
12 be people in bonus-level status.

13 So it would be difficult for us to figure out
14 what it would be had there been no consolidations in the
15 past, for example. We would have to go through and figure
16 out, well, where would this contract have landed if this
17 was their service area and here is what they are reporting
18 on, and we really wouldn't be able to do that because we
19 would have to deal with whatever data that we have, which
20 are reported again at the contract level.

21 So we have these 411 medical records coming from
22 across the United States. So we really have no way of

1 saying, "Well, what would have happened had these
2 consolidations not happened?"

3 DR. RYU: What about the other --

4 MR. ZARABOZO: Well, that's sort of forthcoming.
5 It would increase from 81 percent to a higher proportion,
6 so over \$6 billion, in other words.

7 DR. CROSSON: Okay. Brian.
8 Pat, on that point?

9 MS. WANG: Is it all useful to look back to when
10 the ACA was passed? Because the quality incentive program
11 was created there in its current structure as an add-on to
12 the benchmark rates. Was there maybe a score or some
13 projection of how much it would cost? Would that be
14 informative to answer Jaewon's --

15 MR. ZARABOZO: I believe -- well, looking at the
16 scoring, I believe I could only find like a combined
17 scoring, without separating the quality bonus. But,
18 anyway, at that time also, very small share of people in
19 bonus-level plans. So the expectation would have been
20 lower than where we're at today of 83 percent.

21 DR. JOHNSON: I think there is a figure in the
22 chapter that shows the share in bonus status over time.

1 But the hard part about answering the original
2 question, I think, is that even in the initial years of the
3 program, it was still based on contracts, which is not
4 necessarily the level of assessing what the amount of bonus
5 dollars should be in an ideal situation.

6 DR. CROSSON: Brian?

7 DR. DeBUSK: Great presentation. It's really
8 nice to see this work evolve.

9 I have three questions. Number one, I'm assuming
10 market area is MedPAC units? So our bids are county. Our
11 quality is now MedPAC units.

12 DR. JOHNSON: That's correct.

13 DR. DeBUSK: Okay. Second question. Are we
14 doing the risk adjustment before or after we separate the
15 populations into the two peer groups?

16 MS. TABOR: Concurrent with traditional quality
17 measure -- methods were doing it before.

18 DR. DeBUSK: So you're doing the risk adjustment
19 before, even though the HCC models are split now. For
20 example, there's a dual eligible actually gets a different
21 set of HCC coefficients for -- say for risk adjustment in
22 MA, but for peer grouping this, we're going to wait. We're

1 going to do them all at once and use one set of
2 coefficients and go down.

3 MS. TABOR: That's the way we did it in the
4 modeling. That's not saying that's the right way to do it,
5 but that's the method we chose.

6 DR. DeBUSK: Okay. Just for methodological
7 consistency with the previous?

8 MS. TABOR: Like with the HVIP.

9 DR. DeBUSK: That's fine. With HVIP, yeah.
10 Now, third question, page 44 of the reading
11 material -- and I promise this is not a Round 2 because I
12 have a Round 2 on this, but I want to make sure that I
13 don't embarrass myself by not understanding page 44.

14 So page 44, you walk us through what happens when
15 a plan goes from bonus to non-bonus, and when they're risk-
16 adjusted benchmark, instead of increasing \$72, let's say
17 they -- let's say they stayed at the same status. The
18 risk-adjusted benchmark would go up \$72. If they go from
19 bonus to non-bonus, instead it goes up to \$46. So,
20 obviously, the rate of increase is curtailed.

21 And I understand that. I really appreciate all
22 this that you did about the behavioral response, so thank

1 you. This is great.

2 But I want to make sure. I'm reading the third
3 row from the bottom. It looks like when their benchmark
4 goes relatively down \$26 from \$72 to \$46, it looks like
5 their dollar change in net medical expenses goes from \$53
6 to \$30. So the delta is \$26 in the benchmark, and it seems
7 to translate to a \$23 delta in net medical expenses. That
8 tells me that 88.5 percent of the benchmark decrease gets
9 passed on to physicians and other providers? Am I reading
10 that right or no?

11 MR. ZARABOZO: That would be one way to read
12 that.

13 [Laughter.]

14 DR. DeBUSK: But is that the correct way to read
15 that?

16 MR. ZARABOZO: So this would be looking at the
17 very same plan, so to speak. Let's say they made a mistake
18 in the bidding, it turns out. Well, we did this bidding
19 this way, expecting a bonus, and now it turns out we didn't
20 get the bonus. So, yes, this is our circumstance.

21 So, yes, if you subtracted \$53 from the \$30, you
22 get a \$23 change in the cost of the provision of the

1 Medicare A and B benefit. That does not mean that
2 providers will get \$23 less. It just means that the plan
3 incurs the cost that is \$23 lower. How they arrive at
4 getting the \$23 lower, because it's in their bid, they're
5 saying we can do it for now, \$23 less, than these other
6 plans. They could say, "Well, we've been bad on
7 readmissions and avoidable admissions. We're going to
8 curtail that. We're going to save money there," or "We're
9 having too many specialty referrals. We're going to
10 curtail that. We're going to become more efficient in
11 different ways, which enables us to bring down our bid."

12 DR. DeBUSK: Yeah. The -- okay.

13 MR. ZARABOZO: That's what this component is, is
14 the bid for the A and B benefit.

15 DR. DeBUSK: So the \$23, though, is coming out of
16 something --

17 MR. ZARABOZO: Right.

18 DR. DeBUSK: -- whether it's readmissions or
19 specialist visits or something.

20 MR. ZARABOZO: Right. Yes.

21 DR. DeBUSK: Okay. Thank you.

22 MR. ZARABOZO: In other words, they have lowered

1 their bid.

2 Now, historically, MA has been lowering their
3 bids year over year. We're now at 88 percent compared to
4 fee-for-service is where the bids are. So they do lower
5 bids over time.

6 DR. DeBUSK: Thank you.

7 MR. ZARABOZO: Yep.

8 DR. CROSSON: Okay. Bruce. Oh, did I miss Dana?
9 Dana, I'm sorry. And then Bruce.

10 DR. SAFRAN: Thank you.

11 Just a couple of questions. One is I may have
12 missed this before, but is the characterization of the
13 measure set as illustrative new?

14 MS. TABOR: I believe that in the January -- I
15 think we've always kind of referred to it, but I think in
16 January, I know we made a case to make sure it was called
17 illustrative because -- and if there were even different
18 opinions within the Commission about what measures should
19 or should not be included.

20 DR. SAFRAN: Push that a little bit farther
21 because every other quality program that we've put forward,
22 unless I'm mistaken, we've put it forward as here are the

1 recommended measure -- like here's the recommended domains.
2 Here's the recommended measures within the domains. So I'm
3 not understanding why we're treating this one differently.

4 MS. TABOR: So I will say in the HVIP
5 recommendation, the language is actually very similar here.
6 We say it should score a small set of population-based
7 measures, and the language underneath the recommendation
8 talks about here are the types of outcome measures we could
9 include. And we plan to say the same thing here.

10 DR. SAFRAN: Okay. Got it.

11 DR. CROSSON: Dana, we did have one discussion
12 that I remember. I can't remember if it was January or
13 when it was. I think it was before that where we went
14 through the issue about whether to include preventive
15 measures.

16 DR. SAFRAN: Yeah.

17 DR. CROSSON: There was a large number of
18 Commissioners, including myself, that felt we did do. So
19 we did have some discussion about content.

20 DR. SAFRAN: Yeah. I remember that.

21 DR. CROSSON: Okay.

22 DR. SAFRAN: That may be part of my confusion,

1 but I get that we added a domain because of that.

2 DR. CROSSON: Yes.

3 DR. SAFRAN: But I was just not following before
4 now that this was illustrative and not the recommended set.

5 Second question, are you presuming that because
6 most of these are claims-based measures that an additional
7 benefit of this will be improved quality of the dummy
8 claims data based encounter data?

9 DR. JOHNSON: We hope so.

10 [Laughter.]

11 DR. JOHNSON: I don't know that we're presuming,
12 but that is one of the indirect goals. Yeah.

13 DR. SAFRAN: Okay. And then since I don't expect
14 to have anything at all I need to say on the second round,
15 this is a quasi-comment/question, and that is, what you
16 said about your assumption about increased administrative
17 cost seems like it was primarily based on surveys. I just
18 want to highlight that that doesn't have to be the case,
19 meaning these organizations should be having electronic
20 ways of communicating with their beneficiaries, and that
21 will make the surveys virtually free.

22 Thanks.

1 DR. CROSSON: Thank you, Dana. Sorry for the
2 confusion.

3 On this point, Amol?

4 DR. NAVATHE: Yeah. On the point of the quality
5 of the claims measures, I feel like I have a recollection.
6 I'm having some memory loss issues myself. But haven't we
7 at some point put in text of a recommendation or at least
8 in a chapter that we recommend sort of higher quality
9 claims data or the encounter data?

10 DR. JOHNSON: We have recommended that in the
11 past, yeah.

12 DR. NAVATHE: Just out of curiosity, is there a
13 reason not to include that as part of this recommendation
14 set? Just because it's so fundamental to the quality
15 measurement? It's sort of hard to --

16 DR. MATHEWS: We can easily cross-reference it
17 and make the point that by including among our small set of
18 measures, measures that rely on encounter data, that that
19 might provide an additional incentive for plans to produce
20 complete and accurate data and cross-reference the prior
21 rec.

22 DR. NAVATHE: Great. That would be awesome.

1 DR. CROSSON: Bruce.

2 MR. PYENSON: A question on the domains, and this
3 picks up on, I think, Dana's question. I recall the last
4 time we discussed this there was an interest in expanding
5 the domains, and I think that led us into some of the
6 expensive ways of getting information such as controlling
7 high blood pressure, hemoglobin A1c.

8 I wonder if there's measures that can fill in
9 some of the domains without that, without the chart audit.
10 Dana suggests probably surveys of patients can be done
11 inexpensively. But I think there's also -- I wonder if
12 there's ways to put a price tag. There's probably -- I
13 don't know if you've seen dollars per chart audit or
14 something like that. That might be in addition to this.
15 So I think you're nodding your head yes.

16 MS. TABOR: Well, I will say that I've looked at
17 this before in a previous job, and I think it would vary a
18 lot by plan, by how much it costs to collect a medical
19 record. It depends on how centralized your EHRs are, how
20 integrated your systems are, whether you actually have to
21 go send the nurse out to do a patient record review. Even
22 with the CAHPS surveys, you know, plans spend different

1 amounts because they may have the survey vendors work
2 especially hard and contact members multiple times to get
3 the surveys back.

4 So I would just say that there are additional
5 expenses in going to the market-level approach, but I think
6 it would vary a lot by plan. It would be hard to estimate.

7 DR. CROSSON: Pat, on this point?

8 MS. WANG: I think that the cost is going to be
9 felt more by plans that are bigger than the market. There
10 are a lot of plans that are in the market right now, and so
11 they're going to have the same level of expense. I don't
12 think it's going to change for them because they're doing
13 whatever sample sizes there are and they're in that local
14 market. So it won't apply to everybody.

15 MR. PYENSON: Yeah, another question on the
16 applicability of this approach, the MA-VIP, to setting the
17 percent of rebate retained by the plan. Do you have
18 thoughts on applying this instead of stars?

19 DR. JOHNSON: We haven't discussed it much. We
20 thought that could be taken up at a later date once MA-VIP
21 was settled on.

22 DR. CROSSON: Pat, new point?

1 MS. WANG: No.

2 DR. CROSSON: Sorry. Go ahead.

3 MS. WANG: And I apologize if this was covered
4 when I stepped out of the room, but on Slide 10, can you
5 remind us what the different advantages and disadvantages
6 would be for a local versus a blended approach?

7 DR. JOHNSON: So I think the biggest one we
8 discussed is the varying local market conditions. We
9 highlighted availability of Medicaid and food assistance,
10 transportation infrastructure, and different levels of
11 social risk factors in different markets. And to some
12 extent, using a local approach would account for some of
13 the differences across markets. And we did see in our
14 modeling results, of the 61 markets that the average MA
15 quality varied quite a bit, so there's a case to be made
16 that some of those different market conditions played a
17 role in the average difference across markets.

18 The other aspect we highlighted here was the
19 distribution or redistribution of payments across markets
20 so that those markets that have lower average MA plan
21 quality would see a net decrease in payments across the
22 parent organizations. Those markets and that money would

1 flow to other markets where the average MA plan quality was
2 higher.

3 MS. WANG: And then it's somebody's judgment call
4 whether that's desirable or not desirable, right?

5 DR. JOHNSON: Correct.

6 MS. WANG: Okay.

7 DR. JOHNSON: I should say the redistribution
8 would take place under a national distribution. The local
9 distribution would maintain the dollars that come from each
10 market would be redistributed within that market.

11 MS. WANG: Okay. I have two other quick
12 questions. Have you thought about what happens to the Part
13 D star measures? Where are they in this redesign?

14 MS. TABOR: So we have thought about -- you know,
15 we're focusing on just replacing the quality bonus program,
16 which applies to MA and MAPD plans, and, you know, the
17 stars for Part D is kind of a separate question that we're
18 not tackling today. And we do think that there are
19 measures in the illustrative measure set that do apply to
20 Part D and prescription benefits in general, like if you
21 have good diabetic medication adherence, then hopefully
22 your diabetes is going to be controlled. So I think we're

1 capturing that in the illustrative set.

2 MS. WANG: Okay. Just maybe something to look at
3 because if you're an MAPD, it's just one measure set. I
4 don't think that MAPDs consider them to be separate. It's
5 one bonus program, so it's just something to think about.

6 The final question that I had is: In the
7 Commissioner's recommendation that the new program be plan
8 financed, is there an opinion that the financing comes from
9 the current benchmark system or are you just reiterating
10 the principle that it should be self-financed? There has
11 been work here on benchmark rates and all the rest, so I'm
12 suspecting that this is agnostic to what the plan payment
13 is so long as this program is self-financed or not, is the
14 question.

15 DR. JOHNSON: I think that's the right way to
16 look at it, that it is not taking into account some of
17 those other discussions. It's more of a principle.

18 DR. CROSSON: Okay. Marge.

19 MS. MARJORIE GINSBURG: Yeah, I just remembered
20 another question I wanted to ask. So we're talking about
21 doing it in locations where there are a minimum of three
22 plans, and I believe there was also discussion that if

1 you've got too smaller locations, that you might combine
2 together so that you can make them -- but there may also be
3 places where there is no way to logistically combine it,
4 which means we might have some isolated plans scattered
5 throughout that would not be a part of this.

6 So are they just simply not a part of this, we
7 don't take money from them, we don't give money to them?

8 MS. TABOR: We considered that kind of an
9 implementation issue. We chose three as kind of a good
10 amount of parent organizations you need to move rewards and
11 penalties around within a market. It could be that there's
12 another number that we should use, and that's something
13 we'd want policymakers to look at. But I think that's --
14 it could be that you continue to combine up until you get
15 all beneficiaries covered, or it could be that you decide
16 if a plan in a market area doesn't cover at least 100
17 beneficiaries, they're just left out of the program. So I
18 think that's kind of an open question.

19 DR. JOHNSON: When we looked at the current
20 enrollment within parent organizations in a market, we
21 thought about 89 percent of beneficiaries would be included
22 in their parent organization in their market before doing

1 any of the aggregating of geographic areas for small
2 numbers. We didn't model the extent to which we could
3 combine areas and how many more we could gather into the
4 program, but --

5 MS. MARJORIE GINSBURG: That [off microphone.]

6 MS. TABOR: Yeah.

7 DR. CROSSON: Okay, good questions. Now we'll
8 move on to the discussion period, the draft recommendation
9 up there, looking for support, lack of support; if lack of
10 support, why; and how you would recommend a change. I saw
11 Warner's hand first and then Brian.

12 MR. THOMAS: Yeah, I would just say generally I
13 support this. I think this makes sense. I think we've had
14 -- I think actually Brian has brought this up in prior
15 meetings, you know, this idea that we've got several
16 different changes going on in the MA plan world that are
17 being proposed and what's the aggregate impact of that. So
18 I think that's the thing I get concerns about: Are we
19 getting these rolled up and looked at them kind of in
20 total? Understanding that, you know, they may not all be
21 accepted. You know, maybe none of them will be accepted.
22 But if they're all accepted, I guess the question would be:

1 What is the impact on MA plans in aggregate?

2 DR. CROSSON: Brian -- sorry. Go ahead.

3 DR. JOHNSON: I took that as a question.

4 DR. CROSSON: Perfectly right.

5 [Laughter.]

6 DR. CROSSON: I couldn't tell if it was a rising
7 voice at the end, but it's okay.

8 DR. JOHNSON: In our March chapter, we looked at
9 current MA plan payments and found that they're about 2 to
10 3 percent higher than the average fee-for-service rate.
11 And so if we were to remove the effect of coding intensity,
12 which is the unaccounted-for share of coding intensity,
13 which is related to one of our standing recommendations,
14 and if we removed the effect of payments related to the
15 quality bonus program, that would bring average payments
16 down to about 98 percent of fee-for-service. That's from
17 our chapter.

18 The two other outstanding recommendations that
19 have a direct impact on plan payments are to base the
20 benchmarks on A and B enrollees, which would increase plan
21 payments. The other one is to get rid of the benchmark
22 caps, which would also increase plan payments. I don't

1 think we have an exact estimate of the amount of payments,
2 but it is greater than 98 percent of fee-for-service, maybe
3 up to 99 or even with fee-for-service, with those four
4 potential -- three recommendations and the issue on the
5 board today taken into account.

6 MR. THOMAS: So I guess --

7 DR. CROSSON: Let me just add -- sorry -- that
8 the next topic we have to discuss, which is basing payments
9 on two years of data, would also have an impact. Is that
10 not correct?

11 DR. JOHNSON: That would be taking into account
12 during the coding intensity recommendation. So that would
13 not be an additional impact out of the four that I just
14 walked through.

15 DR. CROSSON: Okay. I'm sorry. I didn't
16 understand that. Thank you. Go ahead. I'm sorry, Warner.

17 MR. THOMAS: So I guess it comes back to is your
18 goal then to target the 100 percent of fee-for-service? Is
19 that the goal? Or is the goal that there should be
20 something slightly above fee-for-service because there's
21 risk being assumed? Or how do you think about that?

22 DR. JOHNSON: I think from some of the comments

1 we've heard over the years on the Commission, there's some
2 recognition that the fee-for-service program has a lot of
3 induced demand related from incentives to provide more
4 services. I think Bruce has mentioned the effect of
5 Medigap and having -- limiting the impact of cost sharing
6 for beneficiaries further increases the number of services
7 used in fee-for-service.

8 I think in some ways it's up to the Commission to
9 decide what the right level is, but leveling to fee-for-
10 service does not seem like a standard that demonstrates a
11 certain amount of efficiency.

12 DR. CROSSON: Okay. Brian and Amol, and then
13 Jaewon, Bruce.

14 DR. DeBUSK: Again, really good chapter. I'm
15 going to focus on the way the reductions stack up in a
16 moment, but I do want to say the chapter was technically
17 excellent. I mean, I really like where you guys are going.
18 It's very consistent with the methodology. You're moving
19 toward standards. And I noticed you're getting really
20 close to having ACO comparability. I mean, we could
21 actually do some -- well done. It's just really well
22 thought out.

1 Just to provide a little help here, I do think
2 you're going to have to do a blended approach. You know,
3 you talk about local versus national. I think blended is
4 probably -- for the reasons that you described really well
5 in the chapter.

6 I do want to talk about how the cuts stack up.
7 You know, I have talked around this for a while about this
8 idea of progressive MA versus regressive MA, because I
9 definitely think that there are plans that are providing
10 global payments and incentives, at least partial global
11 payments and incentives, to manage a panel of enrollees to
12 a medical expense ratio. I think they're doing some really
13 progressive things in payment. But I also think there's a
14 very regressive MA out there that just codes high and pays
15 low.

16 It concerns me when we stack up the different
17 cuts that I've seen, because, you know, I see 6 billion in
18 the quality bonus program; I see about another 5, 5.5
19 billion using two years of fee-for-service diagnosis data
20 to calibrate the HCC model. And to your point, obviously
21 that would come out of the coding intensity adjustment that
22 we would do the other way. But if I'm not mistaken, I

1 think moving from RAPS to EDS and using two years of that
2 data I think also takes about another 2 percent out. I
3 think I'm looking at 5 billion on either end, and then I'm
4 looking at about 6 billion in the cuts, and then I thought
5 it saw 3 percent in the benchmark reductions. I understand
6 that chapter has been pulled, but we presented it, you
7 know, several months ago. Was it 3 or was it 5 in the
8 benchmark reduction when we linearized the benchmarks?

9 DR. JOHNSON: I don't know that we came to a
10 conclusion on that. There was some discussion from the
11 Commission about that.

12 DR. DeBUSK: Did the material present 3 or 5 in
13 the --

14 DR. JOHNSON: As an example?

15 DR. DeBUSK: As an example.

16 DR. JOHNSON: I think it was 5 percent --

17 DR. DeBUSK: Was it 5? So there's another 7 or 8
18 billion. You know, billion here, billion there, it adds
19 up. And I'm looking at a stack of about, as I do my math,
20 20-ish billion. And I don't know that anyone here -- I
21 don't want to put words in anyone's mouth. I don't think
22 anyone here says, hey, let's cut MA by 20 billion. I do

1 think having a discussion here and doing a chapter on what
2 the appropriate level of funding for MA is would be really,
3 really important. And I do think that directionally this
4 sense that there are excessive payments in the program, I
5 think that's absolutely correct. Just my personal feeling.

6 But my head's spinning a little bit because we're
7 doing, you know, a few billion here and a few billion
8 there. It would really be nice to see all these really
9 wonderful technical things you're doing, and this is
10 excellent work. What would be nice is to see the technical
11 work not interfering with the overall level of funding of
12 the program. Then let's have the discussion on what the
13 overall level of the funding of the program is and then
14 decide where to insert the reduction. Is it on the quality
15 side? Is it on the benchmark side?

16 Because getting back to this idea of progressive
17 versus regressive MA, I would like to selectively address
18 or engage or cut the regressive MA, because for the people
19 who are out there trying to work to move toward global
20 budgets and change the relationship with physicians and
21 hospitals, I want those guys unimpeded. And it really
22 struck me on page 44 when I watched the plans that lost

1 their MA bonus status, when \$26 came out of their
2 benchmark, they appeared to take \$23 out of their medical
3 expense. And to your point, we don't know if that's
4 utilization or price. But I think we need to understand
5 that a little bit better. And I don't -- again, and I'll
6 be quiet in a moment. I don't want this to be perceived as
7 resistance to reducing MA payments, because I think a
8 reduction is appropriate. But I'd like to see it done in a
9 separate context, even to the point of maybe splitting the
10 draft recommendation that we've seen into one that
11 addresses the technical aspects of the MA-VIP and then a
12 second recommendation that talks about determining the
13 adequate or the appropriate level of funding for MA and
14 then doing that within the context of some of the other
15 technical changes we've made as well.

16 DR. JOHNSON: Before we get too far away, I just
17 want to say I don't think the \$20 billion is a correct
18 summation of the outstanding recommendations. I think that
19 the two big proposals we have or recommendations that would
20 cut out a coding intensity, which address a few of the
21 items you mentioned, and the other one is this one, the VIP
22 program, and collectively that would take MA payments from

1 about 2 to 3 percent above fee-for-service to 2 percent
2 below fee-for-service.

3 DR. DeBUSK: So that's about a 5 percent swing?

4 DR. JOHNSON: Between 4 and 5.

5 DR. DeBUSK: What's the coding intensity
6 adjustment? How much would that number be?

7 DR. JOHNSON: Unfortunately, both numbers come
8 out to exactly 2.3, which gets confusing. But it's between
9 4 and 5.

10 DR. MATHEWS: Andy, let me jump in here if I
11 could. So Andy is correct that there is a certain nuance
12 to how one might, to use your phrase, stack these things
13 up. And there are recommendations that we've made that
14 would increase payments to plans, but all of these are done
15 under the auspices of increasing the accuracy of payments
16 to MA. So we'll posit that.

17 The second thing is that when we made any single
18 one of these recommendations, the impacts are assessed and
19 scored by CBO in isolation -- no offense to CBO, but in a
20 fairly isolated and static way. At this point in time, if
21 you did this thing, it would save this many dollars or cost
22 that many dollars. But no one would expect that all of

1 these recommendations would be implemented at the same time
2 without considering interactive effects or changes in
3 practice that have occurred over time.

4 So, for example, the coding offset, at the time
5 we made the recommendation, the differential between MA and
6 fee-for-service coding might have been this much; now it's
7 this much.

8 Similarly, with respect to the recommendation at
9 hand, everyone is a little bit fixated, understandably,
10 because we've emphasized this number exhaustively, on the
11 \$6 billion figure. But when this recommendation is
12 implemented, given all of the other puts and takes that are
13 likely to transpire, the kind of washing out of the excess
14 quality bonus payments, you know, that have occurred via
15 consolidation versus the new quality bonus payments that
16 are occurring under the auspices of deconsolidation, the
17 number isn't necessarily going to be \$6 billion. And so
18 the recommendation language is agnostic. It's simply plan-
19 financed, and the exact dollar amount might change at the
20 point in time that any such legislation is passed.

21 I'll say one more thing, and then I'll stop
22 talking. It is obviously a completely rational thing for

1 all of us at the table to want to think logically about how
2 all of these things fit together, and I absolutely
3 understand that. I agree with it. But we also have a
4 certain utility for, you know, the Congress, and so the
5 Congress is often looking for options, and they aren't
6 necessarily looking for a complete synthetic set of
7 recommendations that would be implemented all at the same
8 time, but they might have a number in mind: I need to get
9 \$10 billion out of MA. And one of the functions that we
10 can perform is say, well, you could do it this way, you
11 could do it that way, here's the pros and cons, and to some
12 extent we are providing Congress with options.

13 And so that's a slightly different way of
14 thinking about, you know, our own policy development
15 process, and I guess it's easier for me to do that because
16 I'm operating in both worlds. You know, from an analytic
17 perspective, I do like to think about how the totality of
18 things fit together. But at the same time, in a very
19 pragmatic perspective, I like to be able to say, hey, you
20 could do it this way, you could do it that way.

21 So, with that, I will stop.

22 DR. CROSSON: Sorry. Before you respond, Paul

1 wanted to come in as well.

2 DR. PAUL GINSBURG: I was going to say some of
3 the things that Jim said. You know, when we're developing
4 recommendations that are somewhat unrelated to each other -
5 - and by unrelated, I mean you could do some and not others
6 -- you know, our track record with Congress is very good.
7 It's not 100 percent in the sense that, you know, I don't
8 think we should be worried about what happens if they take
9 them all.

10 You know, I think we do have --

11 [Laughter.]

12 DR. PAUL GINSBURG: Congress will worry about
13 that.

14 DR. CROSSON: Go ahead. That was an ambiguous
15 statement, but that's okay.

16 DR. PAUL GINSBURG: Okay, yeah. But the other
17 point I made is that I think this Commission -- I don't
18 remember the specific -- has already had an opinion about
19 how MA should be funded in the aggregate compared to fee-
20 for-service, and presumably that still stands unless we go
21 back to it and make a change in that. So I don't think we
22 should lose too much sleep or energy into adding up every

1 single thing we're thinking of recommending in MA and worry
2 about what they all add up to, because that's just not
3 going to be used in Congress. As Jim said, they're going
4 to see what appeals to them, and if they have a budget
5 goal, they'll make it fit their budget goal.

6 The other thing I wanted to say is that you also
7 brought up this issue about the progressive MA plans and
8 the regressive ones. I think that's a totally different
9 topic, and that's probably worth discussing, probably at
10 another time. I come into it with some skepticism about
11 what happens. If you try to describe a good plan and a bad
12 plan and everyone lobbies and gets into the good plan
13 rating, you know, I don't know how effective that could be,
14 but it's certainly worthy of a discussion.

15 DR. DeBUSK: To that point, I mean, you could
16 identify something relatively simple like, say, 30 or 40
17 percent of their medical expenses flow through global
18 budgets. I mean, there aren't -- it wouldn't be that
19 esoteric how to differentiate.

20 And Jim, back to your point, I really appreciate
21 what you're saying in that these are independent plans, and
22 I understand you sort of grabbed this chapter off the shelf

1 or grabbed that chapter.

2 For the purposes of portability, though, is there
3 any harm in structuring the technical fixes so as to not
4 affect the net flow in or out of the MA program, and then
5 do a chapter that says here is the aggregate net flow and
6 here are the mechanisms you may choose to use to do it.

7 I think we're saying the same thing. I just --
8 it's a little odd for me to have -- and I don't know, I
9 mean, Andy, back to your point, it may not be \$20 billion.
10 It maybe \$16 billion, or whatever the number is on the
11 shelf. It's a little uncomfortable for me to have that
12 almost like overlapping additive recommendations like that.
13 And if I'm the only one then I'll vote yes with the rest of
14 you.

15 DR. CROSSON: Go ahead.

16 MS. BUTO: I just wanted to add a couple of
17 thoughts to your point, Brian. One thought is, when you
18 started talking about maybe we ought to look at total
19 payments to MA, my back when up, because having spent as
20 much time in the program as I did on the operational side,
21 the idea that we could somehow figure out what that right
22 number is really -- I'm convinced we could not, number one.

1 Number two, why wouldn't we want to do that for hospitals,
2 for pharmaceuticals in total? I mean, there are just whole
3 categories of things that you would want to take on, if you
4 had that kind of wisdom, which I don't think we do.

5 And then, thirdly, I think the other thing that I
6 keep thinking about is this is the MA program and the
7 formula for paying plans now. There may be, as we've done
8 work in the past, a movement towards something more like
9 premium support or some other form of competitive process,
10 for setting the MA plan rates, that we wouldn't want to
11 spend our time doing that kind of what's the right level
12 of, you know, payments to MA plans, because there might be
13 a better way to pay MA plans than we're currently paying,
14 and I think there is.

15 So I would rather the Commission actually
16 continue work in that area, which is, you know, what's a
17 better way to pay MA ACOs and fee-for-service going
18 forward, and then let the chips fall where they may, rather
19 than focus just on what's the right level of payment for MA
20 plans.

21 DR. DeBUSK: And I do agree about finding a
22 better way or a more novel way to pay MA, to pay

1 physicians, to pay providers, all that.

2 I do note, you know, in our hospital report that
3 we're going to publish, we did add money back in through
4 the bonus program. I mean, any day it's going to come out,
5 where we saw the efficient providers dipping into negative
6 margins.

7 So, I mean, there's precedent here for using this
8 to adjust the level of funding up or down. Again, if we
9 could make it a little easier to understand and sort out it
10 would be beneficial to me, because I do agree that the
11 levels may be excessive. I just -- it's a little
12 uncomfortable to have them coming from every side.

13 DR. CROSSON: Let me -- I want to -- go ahead,
14 Carlos.

15 MR. ZARABOZO: I wanted to mention one thing,
16 that the changes to the QBP, in terms of taking the dollars
17 away, are not quite the same as all the other changes that
18 might reduce payments to MA. Because, of course, not every
19 contract, not every plan gets money from the QBP. And so
20 if you move -- moving from the QBP to the MA-VIP is
21 beneficial for some contracts that are not currently in
22 bonus status and they will, in fact, get more money.

1 And then the other issue is we've said \$6
2 billion, but something else that can happen is the star
3 system could be such that instead of 83 percent of the
4 people being in bonus status, depending how you do this
5 because of the model, it could be reduced to a far fewer
6 number of people in bonus status.

7 So this is not -- you can't sort of look at this
8 in the same way as you do the other changes that you might
9 be making, which are across-the-board changes to payments
10 in MA.

11 DR. CROSSON: I might have, but it's still \$6
12 million savings to the Medicare program.

13 So let me -- I want to try to see if I can't
14 adjudicate this. God help me. Because I do see several
15 points here. We do have, on the record, and coming up --
16 which is going to be folded into one other -- a number of
17 recommendations that impact the total payment to MA plans.
18 I don't think that it's going to be terribly valuable, nor
19 do we have time, to try to quantitate that and argue about
20 how many billions it is in the three or four weeks we have
21 left before we have to get to this recommendation.

22 I also -- I am disinclined to break this

1 recommendation into pieces. I think we've come this far.
2 I think our position here with respect to how the quality
3 bonus program should be financed is consistent with
4 principles this Commission has used for the last 16 years,
5 because I first dealt with this in 2004, when I was a new
6 Commissioner.

7 Having said that, I do think that in the final
8 iteration of the chapter that, Jim, we should use language
9 similar to what you just used with us, which is to
10 essentially say we are not taking a position with this
11 recommendation on what the correct level of payment to MA
12 plans ought to be. We have, and acknowledge, that, in
13 fact, we have other recommendations as well that could
14 theoretically impact the total payment to MA plans, and
15 that in the consideration that Congress should take from
16 our recommendation, it should be to take this
17 recommendation as it is, but in thinking through how it
18 goes about its approach to MA payment, should understand
19 that the process of determining what that level ought to
20 be, which we don't know, is likely to be an iterative
21 process.

22 The reason and the example, Brian -- and I agree

1 with your example you used about our changing course in
2 terms of how we pay hospitals, which has basically been
3 across the board, and as we did that we watched the
4 Medicare margins fall for efficient hospitals, fall below a
5 level that we thought was appropriate, we midcourse
6 adjusted.

7 And so we engaged in an iterative process of
8 saying we don't know what the right level of payment to
9 hospitals is, but now we think the right level -- we're not
10 at the right level, and we need to change that.

11 So I think in the next of how we describe this,
12 making it very clear that again we have multiple
13 recommendations. Neither one individually, nor the sum of
14 them all, should be an indication from this Commission that
15 we think we know what the right level of payment to MA
16 plans ought to be, but that as Congress goes forward and
17 considers our recommendations it ought to make sure that
18 that consideration includes a recognition, over time, of
19 what that level ought to be, and it's likely to be an
20 iterative process.

21 Does something like that work for people? Okay.
22 Thank you.

1 DR. PAUL GINSBURG: Amol is next.

2 DR. CROSSON: Amol.

3 DR. NAVATHE: So I definitely broadly support the
4 approach and I like what you just outlined, because it
5 struck me that there is a bunch of other design
6 considerations or ways we could structure even the slopes
7 of the point system in terms of what boundary you get,
8 higher bonus or something like that, and a lot of that is
9 not going to be adjudicated in time for this to be -- and
10 shouldn't be, I think, because it's important to get this
11 out there.

12 I had a couple of points. One thing, I would
13 actually be kind of curious to hear Brian's rationale about
14 wanting to support the blended piece, because as I read you
15 guys', it seemed to me that your conclusion, after going
16 through that analysis -- and I think I may have been one of
17 the people who suggested looking at the blended piece --
18 was that you landed, say, on recommending more of staying
19 exclusively with the local approach, which I have to say
20 your exposition convinced me of that. And so, Brian, I
21 would love to hear your thoughts on that, actually, as to
22 what, in the chapter, actually convinced you to actually

1 support the blended rather than the local.

2 DR. DeBUSK: My concern was the complexity,
3 obviously, of having to do both. But my thought -- you
4 know, you run the risk if you do the national program, or
5 if you do the measurements nationally, you could create
6 these deserts where no matter how well I do I'm not going
7 to stack up well nationally. Obviously, locally you don't
8 want to pay bonus payments in reward for care.

9 So my thought was if you just -- if you had a
10 blend there, plans could see the opportunity to excel in
11 their own market and then work their way up the national
12 ladder, or plans that are there already at a good spot on
13 the national ladder would see themselves jockeying for
14 position, even within good.

15 I just like the fact that it could float, was my
16 rationale.

17 DR. NAVATHE: I see. Yeah, I think the part that
18 convinced me was actually some of the variation analysis
19 that you guys did, that looks like there's so much of the
20 variation is driven by these local market factors, that at
21 the end putting any portion of that payment that's driven
22 at the national benchmark level in some sense is -- it's

1 moving money or sort of subsidizing certain markets where
2 the conditions might be more beneficial, and it's not
3 really per se rewarding higher quality.

4 And to the extent that you create this situation
5 where you have on average, lower-performing plans in a
6 particular market, and it's not because of the local market
7 factors, and you might imagine that there would be plan
8 entry to capture on that arbitrage, I would think.

9 So I felt reassured by the analysis that we could
10 probably be a little bit more assertive if we wanted to. I
11 don't know that we have to, but to be more assertive about
12 sort of exclusively focusing on the local market as the
13 means of sort of adjusting and financing the bonuses around
14 that.

15 DR. DeBUSK: I could get on board with that.
16 That wasn't -- that was my impression. That wasn't a hard
17 and fast position.

18 DR. NAVATHE: Got it. Okay.

19 DR. CROSSON: But to be clear, at the moment we
20 do not have it in the recommendation. We basically have it
21 in the text, leaving it open to policymakers to take our
22 arguments, which I agree, to open that direction, but to

1 take it under advisement, essentially.

2 DR. NAVATHE: Right. So I guess we're saying we
3 evaluate quality at the local market level but we're not
4 necessarily specifying the payment mechanism.

5 DR. CROSSON: That's correct.

6 MS. TABOR: I think we envisioned that we could,
7 if the Commission wanted to, at the last bullet, add "and
8 distributes plan finance rewards and penalties at a local
9 market-area level," if the Commission wanted to add it in.

10 DR. NAVATHE: I would be supportive of that,
11 based on what we've understood thus far. I don't know how
12 the other Commissioners feel. I'll let them speak for
13 themselves.

14 One part, I think, that is worth noting, though,
15 in the paper itself, is on page 51 there was a discussion,
16 particularly starting with the second paragraph, where it
17 talks about distribution according to a plan's performance
18 ranking in the local market. And then I think we started
19 using this language around ranking and eventually moved
20 away from it.

21 But I got confused temporarily, because it
22 sounded like we were literally going to rank the plans and

1 not look at the spread between their performance, which
2 could create all kinds of distortions. I figured out
3 eventually that's not at all what we're doing. So if we
4 can ditch that language I think that would be helpful,
5 because it's totally misleading, and not consistent with
6 what we're doing anyways. So I don't think we need it.

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

8 DR. RYU: Yeah. I think at a broad level I like
9 the draft recommendations as well, you know, small set. I
10 do kind of gravitate towards the local market measurement
11 for the same reasons that Amol had said. Peer grouping --
12 you know, those things all resonate.

13 I think two points I would make. One is I forget
14 if it was one, two, or three meetings ago, but it was Jon
15 Perlin mentioned, you know, any implications on what we pay
16 the MA plans, just reminding folks that that does
17 eventually get passed on to the provider. So there is, you
18 know, an impact that's not solely health plan. It is
19 provider as well. And as we take all of these things into
20 account, whether it's with the payment updates that we just
21 discussed in the last meeting, or otherwise, I think that's
22 good context to maintain.

1 The second is around the \$6 billion number. So I
2 think what troubles me a little bit is if you go to page 13
3 of the readings, you say that 37 percent of enrollment in
4 contracts with the current bonus had no history of
5 consolidations; 44 percent had at least one consolidation.
6 And maybe I'm not reading it right, but I kind of
7 interpreted that as, you know, roughly 37 percent or so
8 truly would have earned the bonus -- and I'll use the term
9 "earned" -- versus another 44 percent gamed to get the
10 bonus.

11 And so if the 37 percent that truly earned is
12 baked into that \$6 billion, and there were some folks who
13 have gamed to get it, but if the program had been plan
14 financed from the beginning then those that had gamed
15 presumably would have gotten penalties, and those that had
16 earned would still have earned. And now to go back and
17 take the \$6 billion off the table feels like we're
18 rewarding those, or actually not rewarding, but penalizing
19 similarly those who earned and those who gamed.

20 And so that's the part that doesn't quite feel
21 right to me, and I don't know if you all have any thoughts
22 on that. But it feels like, you know, that would speak

1 towards a slightly different baseline as opposed to, you
2 know, taking the \$6 billion off the board. That's all.

3 MR. ZARABOZO: Well, I would say, on that point,
4 that those who earned are also more likely to continue to
5 earn. That is, they will be in a positive situation like,
6 you know, the 1 percent added to their, yeah --

7 DR. RYU: Positive situation but from a baseline
8 that's \$6 billion in the aggregate lower.

9 MR. ZARABOZO: Right.

10 DR. RYU: Yeah.

11 MR. ZARABOZO: So instead of being 2.3 percent
12 more, let's say, in payment, it would be maybe 1 percent
13 more in payment.

14 DR. JOHNSON: I think the other consideration is
15 that 37 percent earned a bonus based on a different set of
16 measures that we think are less relevant to than the MA-VIP
17 measures, and that 37 percent is based on contract
18 configuration that existed at the time, which does not
19 necessarily represent an ideal contract configuration.
20 There could be some historical consolidations or, you know,
21 aggregation of contracts nationally that existed at that
22 time.

1 DR. RYU: Yeah. Just in no way am I defending
2 the current program. I totally agree, there's a lot of
3 flaws inherent with the current program. It's just the way
4 it was set up, you know, there was still this segment that
5 sort of earned within those confines, and then it feels
6 like there's a segment that's sort of gamed within those
7 confines, and we're treating those two groups similarly,
8 which doesn't feel -- it feels a little draconian. That's
9 all.

10 MR. ZARABOZO: And we did try to estimate, if CMS
11 were using just the measure set that we were using for
12 determining stars, it would be something in the range of 35
13 percent of enrollees would be in bonus-level plans. So a
14 lot of the, you know, administrative measures and all these
15 other measures that go into the stars, at least
16 administrative in particular, raise a lot of plans to star
17 level.

18 DR. CROSSON: Pat, on this point?

19 MS. WANG: So I appreciate what you're saying
20 about, you know, the plans, in Jaewon's words, that earned
21 are likely to still earn. The difference is, though, that
22 the plans that did not earn are going to actually lose from

1 their benchmarks, because this is, quote/unquote, "self-
2 financed." And the difficulty that I have, and why I asked
3 before, is the term "self-finance" really more a matter of
4 principle with being agnostic as to what the plan financing
5 is, what the premium level.

6 Is that -- I just can't help but sort of continue
7 to point out that the current benchmark system produces
8 very, very different comparisons to a fee-for-service
9 equivalent spending. So if in the aggregate, you know, as
10 we've been talking, there are -- you know, it's higher than
11 fee-for-service now, that is certainly not true in 95
12 percent counties. They are below 100 percent of fee-for-
13 service, and have been consistently.

14 This proposal does nothing about that fact, and
15 says, well, you're going to go down even further if you
16 don't earn this bonus -- what, 93 percent of fee-for-
17 service?

18 And, you know, I understand that we can't do
19 everything at once, but I'm also a little sensitive to the
20 wording, Jay, that I think is helpful that you suggested,
21 that it kind of, at least, emphasized that this concept of
22 plan finance is really not a commentary on the adequacy of

1 the current payment system. And like Jaewon, I am
2 concerned about plans that are not national plans -- they
3 are market-level already -- that kind of have worked their
4 butts off to get the star bonus, and better for their
5 members that are, you know, facing the prospect of a cut.

6 So it just doesn't -- I feel like at least part
7 of -- and it's deserved. There's been so much gaming of
8 the star system. I think it's really very unfair, and it
9 has cost the program unwarranted amounts of money. But I
10 can't help but feel that the emotional reaction to the
11 gaming is perhaps sort of giving an extra impetus to sort
12 of say, just get rid of it all. I may be wrong about that.

13 So I think that from my perspective, it's a lot
14 to tackle in here to sort of say we're going to perfect the
15 underlying payment system. But at a minimum I'd really
16 request that we make it clear in the clarifying language,
17 Jay, along the lines that you suggested, that there does
18 need to be a close look at the overall payment system.
19 Maybe in the aggregate people want to bring it down. But
20 looking at the sort of equity across different regions.
21 We've talked about it a lot here. The benchmark system
22 that was enacted with the ACA may not really make very much

1 sense anymore and it might be time to go to something
2 that's a little more uniform across the country, what have
3 you.

4 So that's my comment. But as far as the
5 programmatic aspects, I really do want to hasten to say
6 that I think it's great and that what Brian was describing
7 as the technical aspects or just the redesign of the MA
8 quality program is really terrific. I do think we should
9 address Part D. I would have preferred to separate the
10 programmatic change from the financing change, but I'm
11 respectful of the Chairman's preference here, with the
12 caveat that I mentioned.

13 DR. CROSSON: Thank you, Pat.

14 Kathy, are you commenting on that?

15 MS. BUTO: I'm commenting on this.

16 I wonder if there's a way -- first of all, I
17 cannot remember why we didn't finish -- haven't yet
18 finished the benchmark work, so somebody can remind me.

19 But in your caveat or your additional language,
20 it might be useful to say something like the Commission
21 continues to look at some of the flaws or shortcomings of
22 the current benchmarking system and would -- I don't know

1 how to say this without being a little too squishy, but the
2 notion that before eliminate the \$6 billion altogether,
3 that we would -- we think that benchmarking should be part
4 of the consideration, something along those lines, maybe
5 not going quite that far. But it just strikes me that
6 there is a relationship between some of the flaws in the
7 benchmarking system and how well we're going to do with
8 eliminating the \$6 billion.

9 DR. CROSSON: Personally, I would be in favor of
10 the first part of that, which I think is accurate, but I
11 wouldn't necessarily go so far as to undercut our own
12 recommendations and say don't do that until you do
13 something else, because we haven't done that work. The
14 reason we haven't done that work is we can't do everything
15 at once.

16 MS. BUTO: Yeah. That one is super critical,
17 though.

18 DR. CROSSON: Okay. Bruce is next.

19 MR. PYENSON: Yeah. I want to congratulate the
20 authors for extraordinary work. In particular, you've
21 convinced all of us of the virtue of a tournament model,
22 which I think is appropriate.

1 [Laughter.]

2 MR. PYENSON: Just a couple of things along the
3 lines of nuances. I think finding a way or language to
4 suggest harmonizing the bonus program with the rebate
5 percentage -- and perhaps there's various ways to do that.
6 Make sure stars include all of these or vice versa, all of
7 the domains in particular measures. I think that would be
8 important to avoid proliferating yet another set of metrics
9 out there. That's one issue.

10 I do want to say I do support Brian's thought of
11 having a penalty for MA plans that don't have a portion of
12 capitated kinds of arrangements or global arrangements,
13 something like that. In particular, that might address
14 some of the -- ties in with the benchmark issues since PPO
15 plans tend to be in rural areas and may be less likely to
16 do that. So I think that's another avenue, another issue
17 to put on our list.

18 DR. CROSSON: So, Bruce, I'll pile on there
19 because I've tried this before, to not much effect. But I
20 do believe -- and I'm translating, I think, what you're
21 saying is that we have a little dualistic thinking here.
22 We can't resolve it now or even in this term.

1 The question that I have posed in the past, do we
2 care, should we care as a Commission how MA plans pay their
3 providers? We have split opinions because one point of
4 view is perfectly reasonable is know the risk is being
5 transferred to the plan. The plan ought to be free to
6 decide how it pays its providers.

7 The other point of view is, well, wait a minute.
8 We spend a lot of time on ACOs and alternative payment
9 models, and they're all focused in on what's the most
10 efficient way to pay providers to try to get the best
11 quality and cost. If that's what we believe in fee-for-
12 service Medicare, why do we simultaneously say on the MA
13 side, we're agnostic to how the plans choose to pay?

14 I'm bringing this up because -- I brought it up
15 before, and I would commend it to the Commission for future
16 consideration because I happen to think it makes a lot of
17 sense, although I know not everybody does.

18 Yes, Amol.

19 DR. NAVATHE: Just out of curiosity, when you say
20 should we care --

21 DR. CROSSON: Yeah.

22 DR. NAVATHE: -- I'm curious what all is tucked

1 under that. Is it should we be collecting that information
2 and measuring variation based on how different plans pay,
3 or is it stepping as far as saying should we be making
4 recommendations around legislation on how Medicare
5 Advantage should be required to pay providers? I guess --

6 DR. CROSSON: That is what --

7 DR. NAVATHE: -- that is too extreme.

8 DR. CROSSON: -- or incented is what you just
9 heard from Bruce. Incented.

10 DR. NAVATHE: Incented.

11 DR. CROSSON: Incented. And I purposely was
12 vague.

13 Marge?

14 MS. MARJORIE GINSBURG: My question would be --
15 or is it gathering this information just because it's a big
16 piece that we know nothing about and that we have, if you
17 will, a moral obligation to understand this as completely
18 as we can how Medicare actually functions in this country.

19 DR. CROSSON: Well, and that would be a starting
20 point. That would be a starting point. Sure. But it has
21 to fit into the workflow.

22 Jon?

1 DR. JAFFERY: Yeah. I can't recall where I've
2 seen this, but I have heard some reports that -- and I
3 think it would be good for us to try and collect that data,
4 but the number of -- the percent of MA plans that then turn
5 around and pay their providers fee-for-service is very,
6 very high, in the neighborhood of 85 percent.

7 I had another comment, and I'll wait my turn.
8 But on this point, I would also be very supportive of this
9 direction, and I will sort of put out there a pragmatic
10 reason that most systems, delivery systems operate in both
11 -- if they're operating in an MA world, they're also
12 operating in the fee-for-service world, and if they're in
13 an ACO trying to get movement in a certain direction. I
14 mean, frankly, it's just not working the other way. So it
15 would be really helpful to have that impetus to help us
16 move in that directly.

17 DR. CROSSON: I don't want to try to adjudicate
18 it now, but I thought I heard it in a little bit in what
19 Brian was saying as well in terms of is that one way that
20 plans are different.

21 DR. DeBUSK: I think that is a really good basis
22 of differentiation, and there are some progressive MA plans

1 out there. I think we need to learn from them. We need to
2 be learning from them.

3 DR. CROSSON: Yeah.

4 David, on this?

5 DR. GRABOWSKI: Yeah. Just quickly to react to
6 Jonathan's point about the 85 percent, that's totally true
7 for hospitals and physician payment. I think in post-
8 acute, they often pay quite a bit below fee-for-service.
9 So I think that's worth understanding some of that
10 variation where these plans might have market power.

11 DR. PAUL GINSBURG: Yeah. I thought Jonathan was
12 talking about the mechanism --

13 DR. CROSSON: Mechanism, yeah.

14 DR. PAUL GINSBURG: -- is fee-for-service rather
15 than the rate.

16 DR. CROSSON: Okay. Paul is next.

17 DR. PAUL GINSBURG: I just want to say, first, I
18 suppose the recommendations and appreciate the great work
19 that's been done.

20 I've thought about the issue of local versus
21 blend with national since we discussed it last meeting, and
22 I came down in favor of local myself. Part of it is that

1 the MA program has always been a local program, and the
2 competition envisioned is between the MA plan in an area
3 and fee-for-service in the area.

4 I'm not concerned about a desert in an area. If
5 there are no MA plans that can compete with fee-for-
6 service in an area, then we don't need them. That's not
7 going to be the case in many places, but I suspect we
8 should allow that to happen.

9 I would be comfortable with actually putting the
10 recommendation -- if everyone feels that way as far as
11 local, we should probably move it back into the
12 recommendation.

13 DR. CROSSON: Paul, I'm going to bring that up at
14 the end of the discussion for a straw vote.

15 Jonathan, on that point, then?

16 DR. JAFFERY: So I'm just trying to make sure I
17 understand it.

18 If we think about our other value-incentive
19 programs or quality programs in different areas, they are
20 generally national?

21 MS. TABOR: They are.

22 DR. JAFFERY: And the rationale, as I recall from

1 the reading and discussion prior, that a big rationale is
2 that unlike hospitals or ACOs, plans are pretty mobile?

3 MS. TABOR: That's the predominant reason as well
4 as the other listed out in the paper.

5 DR. JAFFERY: So, Paul, your comment about if
6 they're not competitive, we wouldn't have them in that
7 area, it seems that that might favor a blend.

8 I'm not convinced that that's a good enough
9 reason to necessarily just have it all local and not have
10 any national piece of it, just because the plans could
11 move, and if we think that a national approach makes sense
12 in other areas, which I think we have --

13 DR. PAUL GINSBURG: Well, the moving wasn't a
14 concern of mine.

15 I think we have national standards for hospitals
16 because our policy thinking has always been about what
17 should hospital quality be.

18 MA has always been seen as an option for
19 beneficiaries compared to fee-for-service. So we have a
20 situation where fee-for-service from a national perspective
21 is really good as far as high quality, low cost. Why
22 should we care whether we have MA plans at all in that

1 area? It seems as though, in a sense, to have an MA plan's
2 bonus in a local area, depending on other MA plans in other
3 areas, it just doesn't move my boat or something.

4 [Laughter.]

5 DR. JAFFERY: That's not the right vibe.

6 So would the same thing be true for ACOs, then,
7 and quality metrics around ACOs?

8 DR. PAUL GINSBURG: No. I would think ACOs would
9 be national, the way we do hospitals nationally, just
10 because our whole approach to -- I think we've had a
11 national approach to how good quality should be.

12 MS. BUTO: Also, the rates are national.

13 DR. PAUL GINSBURG: And the rates are national.

14 MS. BUTO: They're not for MA plans at the
15 moment, anyway. It's a whole different dynamic there,
16 national rate that are wage-adjusted and so no. So I think
17 it's a very different --

18 DR. JAFFERY: But this is really talking about
19 that quality outcome, not the benchmark or the -- not sure
20 why the rates are the big -- are a big factor here.

21 MS. BUTO: Well, and --

22 DR. JAFFERY: I think it's because it interacts -

1 -

2 MS. BUTO: -- these guys really covered a lot of
3 the local factors that convince me that local made more
4 sense. I was sort of more in the blended camp, but I
5 thought they did a good job of going through many of the
6 local considerations and the fact that MA plans really are
7 a local choice. In a way, you're choosing a system of
8 care, if you will, in a way that you don't necessarily with
9 total fee-for-service, where it's a local system, but
10 they're all paid at national rates. Anyway, I just --

11 DR. DeBUSK: But if we took an ACO and build sort
12 of like a virtual MA plan out of out, sort of back-
13 constructed its network, I mean, we could apply these same
14 quality measures at the local level. I mean, that's a good
15 local argument just to say let's compare the three MA plans
16 and the two ACOs in this geography just head to head. I
17 mean, there would be some advantage to that.

18 DR. NAVATHE: I agree with that. I think in the
19 long run, you could end up there when you have the ability
20 to compare across these different programs head to head,
21 but I think Kathy's point is very important, which is the
22 participation mechanism here is tied to the benchmark, is

1 tied to the bid, is tied to the payment mechanism, and the
2 quality piece is also part of the -- effectively part of
3 the payment mechanism here. And that's different than the
4 ACO program, which is still built on the pure fee-for-
5 service chassis, which is all nationally standardized in
6 terms of rates. So although it's still a voluntary
7 program, as you point out, I think that distinction and how
8 bids and how all that stuff happens at the local level can
9 create a dynamic that supports a local head-to-head
10 competition situation. Whereas, in the national ACO
11 program, that would be harder to construct.

12 DR. JAFFERY: So, again, I'll go back to the
13 benchmarks. So ACO is a local phenomenon, and I guess I'm
14 still not convinced that there should be a difference here.
15 And the benchmarks for at least some of the ACO programs
16 are adjusted --

17 DR. NAVATHE: Yeah.

18 DR. JAFFERY: -- by quality metrics.

19 DR. NAVATHE: I actually don't disagree with you
20 in the sense that as we're seeing the ACO benchmarks also
21 themselves move to more of a regional -- have a regional
22 component to that, I think the argument could be made that

1 the problem is not that MA should be national, but rather
2 that ACO should be migrating to more of a regional,
3 because, again, I'm so convinced by the data that shows
4 that so much of a variation --

5 DR. CROSSON: All right. I'm sorry. We're
6 getting a little off track here.

7 DR. NAVATHE: All right. Sorry.

8 DR. CROSSON: We need to move on. I mean, it's a
9 good discussion, but we're behind time.

10 Before we do finish, I think we've got to -- I
11 want to get a straw poll. So I'm going to give you a
12 choice here in a minute.

13 Right now, we have the issue not of measurement
14 but of distribution in the text open, preferring local, but
15 making the comparison to a blended distribution, blend of
16 national and local.

17 We've had a proposal to elevate that preference
18 to a part of the recommendation, which would be attached to
19 the last bullet point there. Is everybody clear on that?

20 So those of you who would like to leave things as
21 they are in the text and not change the recommendation,
22 please raise your hand.

1 [Show of hands.]

2 DR. CROSSON: I'm guessing that everyone else
3 prefers the option of adding that to the recommendation.
4 Please raise your hand if that's what you think.

5 [Show of hands.]

6 DR. CROSSON: Okay. I see pretty much everybody
7 there, and therefore, that's what we'll do. So you'll see
8 that again. You'll see that change reflected in April.

9 Okay. Ledia, Andy, Carlos, Sam, and the bullpen,
10 thank you very much for your work on this, and we'll see
11 you again in April. And we'll move on to the next
12 presentation.

13 [Pause.]

14 DR. CROSSON: Okay. We're ready to move on here.
15 We're going to take on -- I think our final discussion,
16 Jim? Yeah. On a mandated report which asks us to look at
17 the impact of changes that the 21st Century Cures Act
18 required the Secretary to make all, but -- most, but not
19 all of which have been made, and Dan is going to take us
20 through that work.

21 * DR. ZABINSKI: All right. Thank you.

22 The 21st Century Cures Act of 2016 directed the

1 Secretary to make several changes to the risk adjustment
2 system for the Medicare Advantage or MA payments, and the
3 Cures Act also directs MedPAC to evaluate the effects of
4 those changes and report our findings to the Congress. And
5 today we'll discuss our work on that mandate.

6 Before specifically talking about our work on
7 this report, I think it's a good idea to discuss how
8 capitated payments work in the MA program and the role
9 played by risk adjustment.

10 MA plans are paid monthly capitated amounts for
11 each enrollee, and these payments are the product of a base
12 rate and a risk score, where the base rate is the payment a
13 plan would receive for an enrollee who is expected to cost
14 as much as the national average beneficiary in fee-for-
15 service Medicare, while the risk score is an index that
16 indicates how much an enrollee is expected to cost relative
17 to the national average fee-for-service beneficiaries.

18 The purpose of the risk scores is to adjust each
19 MA payment to approximate expected costliness. This
20 minimizes incentives for payment selection in which plans
21 would try to find favorable financial risks.

22 In MA, risk scores are based on beneficiary

1 characteristics. First, demographic data in the current
2 year, also called the payment year, including age, sex,
3 institutional status, Medicaid status, and a few others,
4 but also beneficiaries' conditions that were diagnosed in
5 the previous year also called the base year.

6 The mode used by CMS to produce risk scores is
7 its own version of a hierarchical condition category risk
8 adjustment model, or the CMS-HCC model. This model
9 collects conditions that were diagnosed in the base year
10 into larger categories called HCCs that reflect conditions
11 such as stroke, acute renal failure, and 3 HCC for
12 diabetes.

13 CMS uses regressions to determine how much each
14 demographic variable in each HCC in the model affects a
15 beneficiary's spending on average, and then to determine
16 risk scores for a beneficiary, CMS just adds coefficients
17 from the regression for the beneficiary's demographics in
18 HCCs that apply to them.

19 The Cures Act requires CMS to make several
20 changes to the CMS-HCC model. One is that the law requires
21 risk score adjustments that are distinctly different for
22 beneficiaries who have full Medicaid benefits from those

1 who have partial Medicaid benefits.

2 Previously all beneficiaries who had Medicaid
3 benefits had the same risk score adjustment.

4 Second, CMS must add or modify HCCs for
5 beneficiaries who have mental health disorders, substance
6 abuse disorders, or chronic kidney disease. Also, CMS is
7 required to add adjustments based on the number of
8 conditions or HCCs for each beneficiary.

9 And, finally, the Cures Act does not require but
10 does suggest that two years of diagnosis data could be used
11 to determine beneficiaries' HCC when it's available. The
12 CMS-HCC model has always used a single year of diagnosis
13 data.

14 And CMS has incrementally addressed the changes
15 required by the Cures Act, adding mandated changes one at a
16 time. With each change, CMS kept the previous changes in
17 place. Before 2017, CMS used a version of the CMS-HCC
18 model that didn't include any of the required changes in
19 the Cures Act. Then in 2017, CMS created a version that
20 addressed the requirements for separate risk score
21 adjustments for beneficiaries who have full Medicaid
22 benefits from beneficiaries who have partial Medicaid

1 benefits. CMS did this by creating separate estimates for
2 six population segments defined by whether they have full
3 Medicaid benefits, partial Medicaid benefits, or no
4 Medicaid benefits, and also by the beneficiary's reason for
5 their Medicare eligibility -- aged or disabled.

6 Then in 2019, CMS created a new version by
7 building on a 2017 version and adding new or modified HCCs
8 for mental health, substance abuse, and chronic kidney
9 disease. And in 2020, CMS created another new version by
10 building on the 2019 version and adding indicators for the
11 number of conditions for each beneficiary.

12 CMS has not created a version that uses two years
13 of diagnosis data, but the Cures Act allows until 2022 to
14 fully implement the changes in the law.

15 Nevertheless, we created our own model that
16 includes all of the changes made by CMS in the 2017, 2019,
17 and 2020 versions and then used two years of diagnosis to
18 determine HCCs in that model.

19 So to fulfill our mandate for the Cures Act, we
20 evaluated the performance of the five versions of the CMS-
21 HCC model -- one that CMS used before implementing any of
22 the changes indicated in the Cures Act, and then one each

1 for the four changes that are indicated in the Cures Act.

2 We used an analytic file of 27.2 million fee-for-
3 service beneficiaries, and these beneficiaries participated
4 in both Part A and Part B of fee-for-service Medicare for
5 all 12 months of 2016, which is our base year, and they
6 also participated in both Part A and Part B of fee-for-
7 service Medicare in at least one month of 2017, which is
8 our payment year.

9 We then randomly divided that file in half and
10 used one-half for each of the five model versions, where we
11 performed regressions to determine coefficients on each
12 demographic variable and each HCC.

13 Then using the other half of the file, we used
14 the results from the regressions to determine predicted
15 Medicare spending and risk scores under each model version
16 for each beneficiary in our file.

17 Now, to minimize incentives for patient
18 selection, a risk adjustment model should produce predicted
19 costs that are, on average, accurately reflective of the
20 actual costs for a group of beneficiaries.

21 To evaluate how well the different versions of
22 the CMS-HCC model predict beneficiaries' costs, we used a

1 variable called "predictive ratios," which are the total
2 predicted costs for a group divided by the actual costs for
3 the group.

4 If a group of beneficiaries has a predictive
5 ratio greater than 1.0, then predicted costs are greater
6 than actual costs and costs are said to be overpredicted by
7 the model. In this situation, Medicare would overpay
8 plans.

9 And if a group of beneficiaries has a predictive
10 ratio less than 1, then predicted costs are less than
11 actual costs, and costs are said to be underpredicted. In
12 this situation, Medicare would underpay plans for that
13 group.

14 Then if a group has a predictive ratio of 1.0,
15 predicted costs equal actual costs, and that's what we
16 want.

17 We started our analysis by evaluating the model
18 that CMS used before 2017, which was before CMS implemented
19 any of the required changes under the Cures Act.

20 In this model, we found that costs are
21 underpredicted by about 5 percent for beneficiaries who
22 have full Medicaid benefits, and also costs are

1 overpredicted by about 5 percent for beneficiaries who have
2 partial Medicaid benefits.

3 In 2017, CMS implemented a model that provided
4 separate adjustments for beneficiaries who have full
5 Medicaid benefits and for beneficiaries who have partial
6 Medicaid benefits. We found this version accurately
7 predicts for both of those who have full benefits and those
8 who have partial Medicaid benefits, meaning predictive
9 ratios are 1.0 for both groups.

10 However, this version of the CMS-HCC model
11 produces systematic cost prediction errors for some
12 beneficiary groups, especially underprediction of costs for
13 beneficiaries who have ten or more conditions, high base
14 year costs, or conditions that are not represented by the
15 HCCs in that version of the model; and also overprediction
16 of costs for beneficiaries who have relatively low costs in
17 the base year.

18 Of particular concern is the underprediction of
19 costs for those who have a lot of conditions or who have
20 high base year costs. This tells us that the model does
21 not adjust payments adequately for beneficiaries who are in
22 poor health.

1 In 2019, CMS began using a version of the CMS-HCC
2 model that continued to have separate adjustments for full
3 and partial Medicaid benefits, but this version also added
4 or modified HCCs for mental health, substance abuse, and
5 chronic kidney disease.

6 This new version improved on the 2017 version by
7 accurately predicting the costs for beneficiaries in these
8 new HCCs in general.

9 However, systematic prediction errors remained
10 under this 2019 version. Costs are underpredicted by
11 beneficiaries who have many conditions or high base year
12 costs and overpredicted for those who have low base year
13 costs.

14 Finally, in 2020, CMS made a change to the CMS-
15 HCC model, resulting in a version that includes the changes
16 from the 2019 version plus indicators for the number of
17 conditions for each beneficiary, which is determined by the
18 number of HCCs.

19 This version improves on the previous versions by
20 predicting costs quite accurately for beneficiaries who
21 have ten or more conditions in the model.

22 In addition, there is a small victory under this

1 version because it slightly improves the cost prediction
2 for beneficiaries who have high base year costs.

3 Nevertheless, there is still a fairly large
4 underprediction for beneficiaries who have high base year
5 costs and continued overprediction for beneficiaries who
6 have low base year costs.

7 Now, up to this point, we've discussed what CMS
8 has done, and the Cures Act does indicate that CMS has
9 discretion over using two years of data to determine HCCs,
10 but CMS has not implemented such a model.

11 Use of two years of diagnosis data has been a
12 feature that MedPAC has advocated for risk adjustment as
13 far back as 2000, so we felt it would be beneficial to
14 evaluate such a model.

15 In general, use of two years of data produces
16 similar cost prediction results as the other versions that
17 we evaluated, with one exception being that this version
18 has larger underpredictions for beneficiaries who had high
19 base year costs.

20 Your paper has an explanation for why this
21 happens, and it's kind of complicated, but the underlying
22 reason is that the use of two years of data produces lower

1 coefficients on the HCCs in the model, which produces
2 smaller adjustments on those predicted costs for each HCC,
3 which results in lower predicted costs for those who have
4 many conditions and high base year costs.

5 However, use of two years of data has the benefit
6 that it is a simple, effective alternative for addressing
7 the problem of differences in coding intensity between fee-
8 for-service and Medicare Advantage, which leads to
9 overpayments for MA plans. In addition, use of two years
10 of data produces more accurate estimates of the costs for
11 each condition and would help produce less volatile revenue
12 streams for plans.

13 When we weigh the benefits and disadvantages of
14 using two years of data, we still believe that use of two
15 years of diagnosis data would be beneficial for MA risk
16 adjustment.

17 Now, our focus for this report is to satisfy the
18 requirements specified in the 21st Century Cures Act.

19 For today, we will address the Commissioners'
20 questions and concerns about the method and the content of
21 the report.

22 Then we will address the feedback that we

1 received and finish the analysis, which will be in the June
2 2020 report.

3 In addition, we would like to discuss any issues
4 or ideas for improving risk adjustment in the future.

5 Thank you.

6 DR. PAUL GINSBURG: Thank you, Dan.

7 We are open for clarifying questions, and Brian
8 and Jonathan and David and Amol.

9 DR. DeBUSK: First of all, thank you for a really
10 interesting report. Great read.

11 The first question is going to be super, super
12 technical, so surprise. The V24.1 model, the 2020 model
13 that began to incorporate the number of clinical
14 conditions, the HCC conditions themselves are dichotomous
15 variables, right?

16 DR. ZABINSKI: Right.

17 DR. DeBUSK: One or zero. You have it or you
18 don't. So the count of your conditions is really just
19 equal to the sum of those dichotomous variables.

20 DR. ZABINSKI: Correct.

21 DR. DeBUSK: So if you do get a coefficient when
22 you do the regression that ties back to that count,

1 couldn't you just distribute that coefficient right back
2 across the individual coefficients that go with the
3 dichotomous variables? Aren't those mathematically
4 equivalent?

5 DR. PAUL GINSBURG: Yeah, Bruce?

6 MR. PYENSON: They would be if it was one factor.
7 But the model actually has a variable factor, depending on
8 the count, the number of conditions.

9 DR. DeBUSK: But you have to pick the top one in
10 the hierarchy. You don't get to pick like two diabetes and
11 then count it as one --

12 MR. PYENSON: Well, but if you look at the
13 coefficients where the number of HCCs -- it's not a -- it's
14 a funny shape curve.

15 DR. DeBUSK: Okay, so there is a nonlinearity
16 introduced there.

17 MR. PYENSON: Yeah.

18 DR. ZABINSKI: Tell me if I'm wrong on this. I
19 think there's some interaction amongst the conditions that
20 can go on that can --

21 DR. DeBUSK: Well, there are interaction terms.
22 There are HCC interaction terms on top of that.

1 MR. PYENSON: The old model had those, too.

2 DR. ZABINSKI: Yeah, yeah.

3 DR. DeBUSK: Yeah, they've always been there --
4 well, not always. They've been there for years. I'm back
5 to -- I couldn't quite understand why we would use the
6 number of conditions, and I was going to ask if we've
7 looked at anything like an inverse sigmoid or introduced
8 some nonlinearity in there, is what I was getting at,
9 because then you could address that where a phrase on the
10 end was really concerning because it does create an
11 incentive to sign up healthy people and enjoy the
12 overpayment.

13 DR. ZABINSKI: Personally I'm not against using
14 any sort of nonlinear model, but I do know that CMS likes
15 to keep life simple for everybody.

16 DR. DeBUSK: Well, okay. But this was going to
17 cross over into discussion, but I think using like an
18 inverse sigmoid, like a logic function, would get them,
19 because I was trying to figure out what the congressional
20 intent was around capturing the number of conditions. If
21 you're going to use a sum of dichotomous variables in a
22 linear model, it seems like you don't get anything out of

1 that.

2 DR. DeBUSK: Well --

3 DR. SAFRAN: Can I interject?

4 DR. DeBUSK: Yes.

5 DR. SAFRAN: From having built models like that,
6 you do, because the coefficient is going to be -- is
7 different from the coefficients you get on the individual
8 binary variables. The individual binary variables are
9 carrying the effect of that specific condition, and what
10 the sum of the number of conditions that you have is trying
11 to get at sort of the -- it doesn't really get at what
12 you'd get if you had interaction terms, because the
13 complexity of CHF plus diabetes is different from the
14 complexity of diabetes plus depression. But it still gets
15 you a different effect from what you get from the
16 individual binary variables. And models that have the sum
17 of conditions -- I've seen six or more; I've never seen ten
18 or more -- really get a lot more explanatory power than
19 models without the count of conditions.

20 DR. DeBUSK: Okay. Thank you.

21 DR. PAUL GINSBURG: Good. Jonathan?

22 DR. JAFFERY: Yeah, I had the same exact

1 question. Not really.

2 [Laughter.]

3 DR. PAUL GINSBURG: Should we move on?

4 DR. JAFFERY: I was just happy that I could
5 follow it somewhat. Mine just uses like really small
6 words.

7 So in the reading it talks about adding -- and in
8 the report -- chronic kidney disease, and the reading talks
9 about adding CKD 3. And I'm just curious why it would not
10 have CAD 4 as well. Do you know the history of that?

11 DR. ZABINSKI: My guess is that, you know, it --
12 there might be a couple reasons I can think of. One is
13 that CMS doesn't --

14 DR. JOHNSON: 4 is already in the model [off
15 microphone].

16 DR. ZABINSKI: Is it? Thanks, Andy.

17 [Laughter.]

18 DR. ZABINSKI: Andy says 4 is already in the
19 model.

20 DR. CROSSON: David.

21 DR. GRABOWSKI: So thanks. I also like this work
22 quite a bit. In terms of evaluating the models, you relied

1 on the predictive ratio. Typically when we see risk
2 adjustment models, we have an r squared that's reported.
3 Did you run that and look at that? My prior is that it
4 didn't probably move a lot, but I think a lot of readers
5 will want to see that in this work.

6 DR. ZABINSKI: Yeah, maybe I hid it too much.
7 It's in a footnote. The r squared, depending upon hat
8 segment of the population you're talking about, like from
9 0.09 to 0.12, in that range, is kind of what --

10 DR. GRABOWSKI: 0.09 to 0.22.

11 DR. ZABINSKI: 0.12.

12 DR. GRABOWSKI: 0.12.

13

14 DR. ZABINSKI: And, you know, that's what was even
15 before they made this. Making these adjustments had pretty
16 minimal effect on the r squared.

17 DR. GRABOWSKI: The other question, you used the
18 base year. Why not use the spending year in terms of using
19 the model to predict spending? What's the rationale for
20 using --

21 DR. ZABINSKI: Okay. Base year spending could be
22 used as a way of observing people who are -- you know,

1 beneficiaries who are really sick or really healthy. They
2 offer an opportunity for selection. And so if you're not
3 paying -- say you've got somebody who's really sick, you
4 know, last year, and a plan might really want to avoid
5 them, so, you know, that's the sort of information that
6 could be used for selection.

7 DR. GRABOWSKI: But this is a risk adjustment
8 issue, right? You're just evaluating how much predictive
9 power you're getting from -- but you could do this as a
10 modeling exercise right on that spending year, right?

11 DR. ZABINSKI: Oh, sure.

12 DR. CROSSON: Amol.

13 DR. NAVANTHE: So I'm going to continue some in-
14 the-weeds questions. A couple questions. One, the ESRD
15 status, it looks like on page 14 you're outlining the 2017
16 beneficiaries must not have had ESRD. So what happens to
17 the ESRD folks in terms of the risk adjustment model?

18 DR. ZABINSKI: Oh, they have a separate, totally
19 separate, model, and they were not included in the bill, in
20 the legislation.

21 DR. NAVATHE: Great. Second question. You also
22 noted that, on the slides in here, that the 2017 group only

1 required one month of enrollment, yet the 2016 required
2 continuous enrollment in the entire year.

3 DR. ZABINSKI: Right.

4 DR. NAVATHE: So have we looked at the ability to
5 predict that partial enrollment, because that clearly also
6 impacts the spending.

7 DR. ZABINSKI: Let's see. How to say it? I hope
8 this answers your question. Okay. They're all the same
9 people. They have to be all in 2016, the whole year, and
10 then they also have to have at least one month in fee-for-
11 service in 2017. Okay? And the reason why we want the
12 entire 2016 is so that we can get a full year of diagnosis
13 data. Okay? And then in 2017, we need a year of -- one
14 month of fee-for-service to get some spending data. That's
15 the year that's used to -

16 DR. NAVATHE: No. My question is why not
17 requirement enrollment in 2017?

18 DR. ZABINSKI: I guess because so you can get --

19 DR. NAVATHE: Effectively some part of the --
20 there's a likely nonrandom censoring that's happening in
21 2017, how many months of data you have, and so how many
22 months of data you have is going to be intrinsically

1 related to the opportunity for spending, right? Somebody
2 who is only enrolled for one month can't spend as much as
3 somebody who is enrolled for 12 months.

4 DR. ZABINSKI: Yeah. But we annualize it, the
5 spending. If they're in one month they get divided by --
6 their spending amount gets divided by one-twelfth.

7 DR. NAVATHE: So again, I guess this is in the
8 weeds, out of curiosity. That would be fine as long as
9 exit from enrollment is effectively random across the
10 duration of enrollment in 2017.

11 DR. ZABINSKI: True. The only -- again, I could
12 talk all day about this.

13 DR. NAVATHE: Unfortunately, me too.

14 DR. ZABINSKI: Yeah. Just one question I would
15 have, where do you want to stop on, okay, to run two
16 months? Three months? You know, what's --

17 DR. NAVATHE: I guess, I mean, we could
18 dichotomize it. We could quartile. I would just be
19 curious to see if there's differential performance across
20 that enrollment piece itself, because that could be
21 introducing some bias into the model as well. So if it
22 doesn't matter, it doesn't matter, which is great, but if

1 it does matter then it would be to know that it does
2 matter.

3 DR. ZABINSKI: I mean, I guess the bottom-line
4 reason why we selected this method is it largely matches
5 the way CMS does it, and we didn't want to deviate from
6 what they do. You know, we want to show, okay, here's what
7 CMS does, and here's what results out of it. And, you
8 know, if we use some method that's a little bit different
9 than what they do then it may not be indicative of, you
10 know, what they would produce with their method.

11 DR. NAVATHE: Okay. Fair enough.

12 So the last question I have is, so there's --
13 when we look at the number of conditions and are adding
14 that to the model, one of the suppositions, in some sense,
15 is that -- and I'm not sure I understood how exactly that
16 variable was added, if it was categorical, if it was
17 continuous, or what have you. But nonetheless, the
18 thought, in some sense, is that the number of conditions
19 itself, all conditions are, to some extent, counted
20 equally. And in other risk adjustment models that are
21 used, you can actually have conditions that are identified,
22 that are negatively associated with outcomes.

1 And so I was curious if we know if there's any
2 HCCs that have a negative relationship, because if there
3 are any that have a negative relationship then that could
4 potentially be a little squirrely in terms of what we're
5 doing there.

6 DR. ZABINSKI: You mean a negative relationship
7 in terms of adding to the patient's cost?

8 DR. NAVATHE: Yeah.

9 DR. ZABINSKI: Again, following CMS's usual
10 procedure, if a coefficient on an HCC comes out as
11 negative, it's dropped, because CMS is not -- by rule, you
12 know, by their own belief on how a model should work, they
13 don't want to have a situation where, you know, plans would
14 not want to diagnose a condition or potentially avoid
15 somebody who's got a condition because actually their costs
16 are going to be lower.

17 DR. NAVATHE: Okay.

18 DR. ZABINSKI: Or the payment is going to be
19 lower because of it.

20 DR. NAVATHE: So that mechanically answers the
21 question. Thank you.

22 DR. CROSSON: Okay. Seeing no more questions

1 we'll go on with the discussion. David, I think you're
2 going to lead off.

3 DR. GRABOWSKI: Great. Thanks once again, Dan,
4 for this work. I'm going to make just two sets of
5 relatively quick comments, the first on the evaluation
6 criteria that you used and then the second on the ideas
7 that were raised in the 21st Century Cures Act.

8 So first on the evaluation criteria, I'm also not
9 a big fan of the r-squared but I do think it should be
10 brought out a little bit more in the report. There will be
11 careless readers, like me, that can't see it in the
12 footnotes. I would put it on every kind of column there,
13 table, such that -- that's just a statistic that needs to
14 be reported and evaluated by reviewers and readers.

15 The second point, and I touched on this with my
16 questions, I'm not certain that the base year is the right
17 year to use for the purpose of checking fits of different
18 parts of the spending distribution. I think the better
19 year is the prediction year. That is, after all, what
20 you're intending to match with these models. This is the
21 spending that determines plan impact.

22 And if, as you would expect, there is some

1 regression to the mean -- regression to the mean is on my
2 mind today -- very high spenders in that last year, that
3 base year, are going to tend to fall in spending, and
4 obviously the reverse is going to be true as well.

5 So I actually think the predictive ratio for that
6 prediction year, those spending percentiles, will look
7 better than those reported here. So I actually think we
8 could do a little bit better in terms of PRs, if we use the
9 sort of spending year versus the base year. So that's a
10 couple of comments on the evaluation criteria.

11 On the ideas in the 21st Century Cures Act, I
12 think adding additional variables and stratifying by group
13 is perfectly reasonable and a great idea.

14 I just wanted to react to the two-year lookback
15 period. I understand that we gained something in terms of
16 fee-for-service coding, and I think that's really
17 important. I would note, however, that that applies to
18 some HCCs but not all HCCs, so there are gains there to
19 increase coding but they're not across the board.

20 The potential downside I wanted to raise with the
21 two-year lookback, so basically you're turning on a flag
22 for an illness two years back but not in the prior year, if

1 I'm understanding it correctly. And my concern is that
2 less seriously ill individuals are going to be introduced
3 into the HCC group. This will tend to reduce the payment
4 weight on these particular HCCs. And the implication here
5 is that payments are going to be reduced for those more
6 seriously ill that are assigned to that HCC. So you can
7 think of this as diluting the meaning of any particular HCC
8 where this occurs.

9 And so I think it's a concern. It doesn't mean
10 it's a deal-breaker but it's something you could check, and
11 there's a pretty simple check here that, frankly, can be
12 done without any re-estimation. So what I would recommend
13 is take a look at the payment weights for some of the more
14 important illness groups that you have in your model, and
15 then just compare the two-year to the one-year model.
16 Falling weights here may signal a problem. And so I would
17 recommend we do that check and just make certain that we're
18 not introducing any kind of issues here around sort of less
19 seriously ill individuals in these particular HCC groups.

20 MR. PYENSON: Is it less serious individuals who
21 are just more individuals? Because when you pick up more
22 people that tends to dilute.

1 DR. GRABOWSKI: It's going to dilute --

2 MR. PYENSON: -- everything. It's not
3 necessarily more or less of --

4 DR. GRABOWSKI: So I think you're making a point
5 maybe about accuracy. Is this actually a more accurate
6 read of the HCC group, that we're getting a more complete
7 group, or is there something different about that
8 individual you're picking up two years back relative to
9 somebody who is in both years?

10 MR. PYENSON: The big operational thing, the
11 reason I'm very much in favor of the two-year lookback is
12 that some plans spend a lot of money looking for those
13 people that seem to have cured diabetes or other things,
14 you know, things like that, and some plans don't. So by
15 using two years of data you diminish the value of those
16 vendors that are in that business, and it's kind of fairer
17 across the board.

18 DR. GRABOWSKI: We could have a philosophical
19 debate on what's the preferred measure. I would love to
20 see the statistics here on kind of what the weights look
21 like across the two-year versus the one-year, and get a
22 sense of this issue.

1 DR. CROSSON: Other comments? So I take that as
2 suggesting that perhaps either everyone is tired and/or
3 there's general support for moving in this direction.
4 Bobbleheads? Yeah.

5 Okay. Dan is setting some sort of a record here
6 with your presentation and the discussion, but you deserve
7 it. So thanks very much for a very clear presentation,
8 thank you to the Commissioners, and we'll move ahead now to
9 the public comment period. This is an opportunity for any
10 one of our guests who wish to make a comment on the matters
11 before us this afternoon, please come to the microphone so
12 we can see who you are.

13 * [No response.]

14 DR. CROSSON: Seeing no one coming to the
15 microphone we are adjourned until 8:30 tomorrow morning.
16 Thanks.

17 [Whereupon, at 4:25 p.m., the meeting was
18 recessed, to reconvene at 8:30 a.m. on Friday, March 6,
19 2020.]

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22

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MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, March 6, 2020
8:30 a.m.

COMMISSIONERS PRESENT:

FRANCIS J. CROSSON, MD, Chair
PAUL GINSBURG, PhD, Vice Chair
KATHY BUTO, MPA
BRIAN DeBUSK, PhD
MARJORIE E. GINSBURG, BSN, MPH
DAVID GRABOWSKI, PhD
JONATHAN B. JAFFERY, MD, MS, MMM
AMOL S. NAVATHE, MD, PhD
BRUCE PYENSON, FSA, MAAA
JAEWON RYU, MD, JD
DANA GELB SAFRAN, ScD
WARNER THOMAS, MBA
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P R O C E E D I N G S

[8:30 a.m.]

1
2
3 DR. CROSSON: Okay. I think we can begin. I'd
4 like to welcome our guests to the Friday morning meeting of
5 the March MedPAC meeting. This morning we have two topics
6 on the agenda. The first one is going to focus on the end-
7 stage renal disease payment system, and Nancy and Andy are
8 here, and Nancy's going to begin.

9 * MS. RAY: Good morning. Today's presentation
10 will focus on the two policy options to improve Medicare's
11 payments for dialysis services.

12 I will take you through the first policy option,
13 which is to eliminate the transitional drug add-on payment
14 adjustment, the TDAPA, for new dialysis drugs in an
15 existing ESRD functional category that are already included
16 in the payment bundle. The Commission discussed this
17 option during the January 2020 meeting.

18 Andy will follow up with the second policy option
19 to replace the low-volume payment adjustment and the rural
20 adjustment with a single payment adjuster. The Commission
21 discussed this policy option during the April and October
22 2019 meetings.

1 We will present the Chairman's draft
2 recommendations for both policy options for your
3 consideration.

4 We anticipate that this material will form the
5 basis of a chapter for the June 2020 report.

6 So here is some background on the ESRD PPS. I'm
7 going to go over this quickly because you have seen this
8 all before.

9 The two items to focus on that is relevant to
10 today's presentation:

11 First, the Medicare Improvement for Patients and
12 Providers Act -- MIPPA -- required all ESRD-related drugs
13 to be included in the ESRD PPS payment bundle. That
14 includes drugs and biologicals that were paid separately
15 before 2011 and the drugs that were bundled before 2011.
16 So when implementing the ESRD PPS, CMS categorized all ESRD
17 drugs into 11 functional categories. The functional
18 categories are listed in your mailing material. They are
19 like therapeutic classes and important for paying for new
20 drugs.

21 Second, MIPPA required CMS to include a low-
22 volume payment adjustment and gave CMS discretion to

1 include a rural adjustment. Andy will talk more about
2 these adjustments soon.

3 So let's move to how Medicare pays for new ESRD
4 drugs. Their payment depends on whether the new drug is in
5 one of the 11 functional categories that I just mentioned
6 to you or not.

7 Looking at the center column, these are new drugs
8 that are not in an existing functional category. These
9 drugs are, by definition, outside of the current ESRD
10 bundle, and the cost of providing these drugs is not
11 included in the base payment rate. Beginning in 2016, CMS
12 established a policy to pay for these drugs for at least
13 two years. After CMS collects sufficient rate-setting
14 data, the drugs are then included in the payment bundle,
15 and the agency adjusts the base payment rate if
16 appropriate.

17 Our policy option does not change this policy.
18 Rather, our policy option focuses on the right column, the
19 ESRD drugs that are in an existing functional category.

20 New drugs in an existing functional category are
21 already included in the bundle, and payment for these drugs
22 is covered by the base payment rate. As of 2020, no drug

1 has qualified under either TDAPA policy.

2 Our policy option addresses two concerns
3 associated with the current policy of paying a TDAPA for
4 drugs in an existing functional category.

5 First, it reduces the competition that would
6 occur if all drugs with the same function were paid under a
7 single rate, and it fails to provide an incentive for drug
8 manufacturers to constrain drug prices.

9 In contrast, competition increased in 2015,
10 before the TDAPA policy was implemented, when a new
11 erythropoietin-stimulating agent that was not a biosimilar
12 -- and these biologics are used to treat anemia -- entered
13 the market and was directly included in the ESRD bundle.
14 Within one year, about a quarter of patients had switched
15 to the new, lower-cost biologic and total drug costs
16 declined.

17 A second issue is that the TDAPA payment is
18 duplicative of the payment for drugs already included in
19 the bundle. A patient needing a drug for a certain
20 function will either take a drug already included in the
21 bundle, and the facility will receive the base payment
22 rate; or the patient will take the drug receiving a TDAPA,

1 and the facility will receive the full base rate plus the
2 TDAPA.

3 Not only is the TDAPA duplicative, it creates a
4 financial incentive to provide TDAPA-covered drugs over
5 drugs in the bundle and potentially promotes the overuse of
6 TDAPA-covered drugs.

7 The policy option that we discussed in January
8 2020 calls for eliminating the TDAPA for new drugs in a
9 functional category.

10 Its goals are to maintain the structure of the
11 ESRD PPS and to create pressure on drug manufacturers to
12 constrain the prices of new and existing ESRD drugs.

13 Drugs entering the market would immediately be
14 included in the ESRD bundle with no changes to the base
15 rate.

16 It will be important to monitor how Medicare's
17 payments align with providers' costs and the need for
18 future rebasing. The Commission's annual payment adequacy
19 analysis can help inform policymakers. Each year we also
20 track dialysis drug use and changes in patients' outcomes
21 over time.

22 As I said up front, this policy option would not

1 change the TDAPA for new drugs that do not fit into a
2 functional category or the TDAPA for calcimimetics.

3 So this brings us to the first Chairman's draft
4 recommendation, which reads: The Congress should instruct
5 the Secretary to eliminate the transitional drug add-on
6 payment adjustment for new ESRD drugs in an existing ESRD
7 functional category.

8 The implications of this draft recommendation is
9 we anticipate it would decrease future program spending for
10 beneficiaries and providers. It is expected to generate
11 savings for beneficiaries through lower cost sharing. It
12 is not expected to affect beneficiaries' access to needed
13 medicines. We anticipate that it would reduce future
14 payments to dialysis facilities, but continue provider
15 willingness and ability to care for beneficiaries.

16 DR. JOHNSON: We are now going to discuss a
17 replacement for the current low-volume and rural payment
18 adjustments, including a draft recommendation for the
19 Commission's consideration.

20 Several factors motivated our analysis to develop
21 an alternative to the current low-volume and rural payment
22 adjusters.

1 First, Commissioners raised concerns about the
2 disparity between urban and rural facilities' financial
3 performance under Medicare, particularly those facilities
4 that are necessary to ensure beneficiary access to care.
5 Dialysis treatment volume is the main driver of the
6 Medicare margin in a given facility, and rural facilities
7 tend to provide fewer treatments and have lower Medicare
8 margins.

9 Second, the design of the current low-volume
10 payment adjustment, or LVPA, and the rural payment
11 adjustment does not align with the Commission's principles
12 on payments to rural providers.

13 These principles say, first, that the rural
14 payment adjustments should target facilities that are
15 critical for beneficiary access, meaning those that are
16 both low-volume and isolated; second, that the magnitude of
17 the payment adjustments should be empirically justified;
18 and, third, that the payment adjustments should encourage
19 provider efficiency.

20 We'll start by discussing the current LVPA. Of
21 the roughly 7,000 dialysis facilities in 2017, about 5
22 percent received the LVPA which increased the base payment

1 rate by 23.9 percent for all treatments. Eligible
2 facilities are those that furnished fewer than 4,000
3 treatments in each of the three years before the payment
4 year in question.

5 When considering proximity to the nearest
6 facility, the LVPA only considers facilities that are owned
7 by the same parent organization and within five miles from
8 one another.

9 We have three main concerns about the LVPA's
10 design.

11 First, the single volume threshold of 4,000
12 treatments may encourage some facilities to limit services
13 or report inaccurate data in order to maintain eligibility.

14 Second, the LVPA does not address the higher cost
15 of facilities with volumes between 4,000 and 6,000
16 treatments per year.

17 Finally, some facilities are receiving the
18 payment adjustment even though they are not isolated. In
19 2017, 40 percent of LVPA facilities were located within
20 five miles of another facility.

21 Now turning to the rural payment adjustment, in
22 2017, 18 percent of all facilities received the rural

1 adjustment, which increases the base rate by 0.8 percent.
2 All facilities located in rural areas receive this
3 adjustment, regardless of their treatment volume or
4 proximity to another facility.

5 Our main concern is the targeting of the rural
6 adjuster. In 2017, about 30 percent of rural facilities
7 were located within five miles of another facility, and
8 about half of rural facilities were higher-volume
9 facilities, furnishing more than 6,000 treatments per year.

10 Finally, as Nancy noted, the adjustment for low
11 treatment volume is mandated by law, but the rural
12 adjustment is not mandated. CMS introduced the rural
13 adjustment in 2016.

14 Now we are going to review the low-volume and
15 isolated, or LVI, policy option. The LVI is a single
16 adjustment that would replace the current low-volume and
17 rural payment adjustments and would be targeted to
18 facilities that are both low-volume and isolated.

19 To model the LVI adjustment, we required
20 facilities to be farther than five miles from any other
21 facility to be considered isolated and to exhibit a low
22 volume of treatments during each of the three preceding

1 years.

2 There are a few ways to implement the low-volume
3 criteria. One is to use a continuous function to determine
4 the adjustment size. There is more information about this
5 approach in your mailing material.

6 We used a categorical approach in our modeling,
7 establishing three different categories of treatment
8 volume, for facilities providing up to 6,000 treatments per
9 year.

10 Either approach would help mitigate the cliff
11 effect of the current low-volume adjustment and would
12 better account for the higher costs in relatively low
13 volume facilities.

14 This figure shows the number of facilities
15 eligible for various adjustments on the vertical axis,
16 grouped by the number of dialysis treatments provided in
17 2017 on the horizontal axis.

18 For the current low-volume adjustment (in blue),
19 nearly all eligible facilities provided fewer than 4,000
20 treatments in 2017. Some of these facilities were located
21 within five miles of another facility. The LVPA generally
22 doesn't apply to facilities with between 4,000 and 6,000

1 treatments per year that also have higher costs.

2 For the 0.8 percent rural adjustment (in red),
3 about half of eligible facilities were not low-volume,
4 providing more than 6,000 treatments in 2017.

5 The green bars show the number of facilities
6 eligible for the LVI adjustment. In the lowest treatment
7 category, somewhat fewer facilities are eligible for the
8 LVI because the adjustment targets facilities that are
9 isolated. In the middle two treatment categories (between
10 4,000 and 6,000 treatments) the expanded definition of low-
11 volume results in more LVI-eligible facilities than those
12 eligible for the current low-volume adjustment.

13 We think that the requirement that facilities are
14 isolated along with the expanded low-volume criteria more
15 effectively target facilities that are important for
16 ensuring beneficiary access to care.

17 That brings us to the second Chairman's draft
18 recommendation, which reads: The Secretary should replace
19 the current low-volume and rural payment adjustments with a
20 single adjustment for dialysis facilities that are isolated
21 and consistently have low volume or low-volume criteria are
22 empirically derived.

1 The draft recommendation is intended to be budget
2 neutral with current policy.

3 Beneficiaries' access to care would be maintained
4 at facilities that are critical for access to dialysis
5 treatment. Providers' willingness and ability to serve
6 Medicare beneficiaries would be unaffected.

7 Our analysis shows that payments would increase
8 for providers with lower treatment volumes that are not in
9 close proximity to another facility and currently do not
10 receive the low-volume payment adjustment.

11 Payments would decrease for providers currently
12 receiving the low-volume adjustment that are in close
13 proximity to another facility. Payments would also
14 decrease for providers currently receiving the rural
15 adjustment, but that have higher treatment volumes or are
16 in close proximity to another facility.

17 That concludes our discussion of the TDAPA and
18 low-volume payment policies. We would appreciate hearing
19 the Commissioners' discussion about the two Chairman's
20 draft recommendations.

21 The material covered in today's presentation will
22 be included in a June 2020 chapter on ESRD PPS design

1 issues.

2 Thank you. I'll turn it back to Jay.

3 DR. CROSSON: Thank you, Andy and Nancy. Very
4 clear. We'll now take clarifying questions. I see Brian,
5 Amol, Jonathan, Kathy, Bruce. Brian.

6 DR. DeBUSK: Warner, I know you want to go deep
7 on these regressions. I'm teasing. I will not go in that
8 direction.

9 I had a couple questions. Can you tell us the
10 background on the rural adjustment? You said it was
11 introduced in 2016. Was there a specific rationale? Did
12 it come out of nowhere?

13 And then, also, how difficult operationally -- in
14 the materials you spoke to this a little bit. If you were
15 to try to do the adjustment continuously as opposed to with
16 the thresholds at 4,000 and 6,000 procedures, how hard is
17 that to operationalize? Are there precedents or are there
18 other programs that have similar continuous adjusters?

19 And then my final question was: Walk me through
20 -- you know, I know there's a lot of consolidation in the
21 industry, and if there was a dialysis center with 3,000
22 treatments and say one of the two large independent

1 dialysis centers, and one of the two larger companies
2 decided to say move next door with another 3,000
3 treatments, I think under this new policy basically the
4 small facility that was already there would get a 23
5 percent cut basically in their payments simply by virtue
6 that one of the national chains -- if I misunderstood that,
7 correct me, but those were my three questions.

8 DR. JOHNSON: So taking them in order, I guess, I
9 think the motivation for the rural adjustment is somewhat
10 unclear. There was some mention of MedPAC's rural payment
11 adjustment policies in justifying the rural adjuster, but,
12 you know, in our review of that, we don't think that
13 MedPAC's principles on rural payments were followed as
14 closely as they could have been, and that the joint
15 consideration of isolation and low volume would be
16 important and that the rural adjuster does not do that. So
17 there's not a lot more we can say there, I don't think.

18 MS. RAY: Yeah, I mean, we can go back to the
19 proposed rule when they announced their intent to implement
20 it. The best I can recall, it addressed stakeholder
21 concern about rural payment issues.

22 DR. DeBUSK: Along that same line, because I

1 don't have the March report in front of me, when we broke
2 out rural versus urban dialysis centers, is there a margin
3 differential or is the industry so consolidated we can't
4 really look at it?

5 MS. RAY: There is a difference between urban and
6 rural margins, which is directly linked to the number of
7 treatments on average that rural facilities provide. They
8 provide lower number of treatments than urban centers.
9 That's not to say that there aren't rural facilities that
10 provide, you know, 7,000, 8,000, 9,000, 10,000 treatments.
11 But, on average, rural facilities, you have a lower average
12 number of treatments than urban ones.

13 DR. DeBUSK: But if you control for volume, and I
14 look at a rural -- say a cohort of rurals and a cohort of
15 urbans, is there are margin difference once I control for
16 volume? We do that in the March report, I'm pretty sure.
17 Don't we?

18 MS. RAY: Well, but you said controlling for
19 volume.

20 DR. DeBUSK: Yes.

21 MS. RAY: Right.

22 DR. DeBUSK: If I'm looking at a cohort of --

1 MS. RAY: Right. So what you're asking for is to
2 compare the margin, let's just say, for example, for a
3 rural facility that furnished 5,000 treatments and an urban
4 facility that furnished 5,000 treatments. I'd have to come
5 back to you with that answer.

6 DR. JOHNSON: On the second question about the
7 continuous variable, it's certainly feasible. I'm not
8 familiar with every other payment system to say whether or
9 not -- how frequently a continuous variable is used in
10 those payment systems. I think it is more common, at least
11 in the Medicare Advantage risk adjustment model we
12 discussed yesterday, for there to be mostly binary
13 variables and the rest of the variables in the ESRD PPS are
14 binary. But that doesn't mean it's not possible. It is,
15 and we modeled that out as an example.

16 The final question was about consolidation, and I
17 think, you know, the scenario you proposed was that if a
18 new facility set up shop right next to an existing low-
19 volume facility within five miles, that would mean that the
20 low-volume facility would low their low-volume adjustment.
21 However, for a facility to decide to move within five miles
22 of another facility, they wouldn't receive the low-volume

1 adjuster for at least three years. As a new facility, they
2 would have to establish three years of low volume in order
3 for them to be eligible for a low-volume adjustment. So
4 there's some disincentive to that type of competition where
5 you're taking a hit for a period of time in order to force
6 somebody out of business, I think is the way to look at
7 that.

8 DR. DeBUSK: I was just thinking through a
9 scenario if you had someone, say a local or a smaller
10 chain, and I was, say, one of the larger companies, and I
11 said, well, either you're going to sell out to me or I'm
12 going to put a place next door to you and you're going to
13 lose 23 percent of your revenue overnight, I was just
14 trying to play that scenario out and see if that was
15 possible. Thank you.

16 DR. CROSSON: Amol?

17 DR. JOHNSON: Using that 23 percent low-volume
18 adjustment, right?

19 DR. DeBUSK: Yes.

20 DR. JOHNSON: Yes. It seems like that would be
21 possible if such a strategy was so aggressively pursued, I
22 guess, to take the hit for so many years.

1 DR. CROSSON: Sorry. Go ahead.

2 DR. NAVATHE: So one quick thing. On Table 2 in
3 a reading on page 10, I think it might be just a typo, but
4 are the column headings switched between the -- are in an
5 existing ESRD-related functional category and are not in an
6 existing ESRD-related functional category?

7 DR. JAFFERY: That was my --

8 DR. JOHNSON: Sorry?

9 DR. JAFFERY: I had the same.

10 DR. NAVATHE: Okay, yeah. Because it doesn't
11 line up with the text or the table you showed.

12 DR. JOHNSON: I think that's right. Let me go
13 back to --

14 DR. JAFFERY: It's correct here.

15 DR. NAVATHE: Yeah. It was correct here.

16 DR. JOHNSON: And the main difference is that
17 last column, whether or not it basically is updated.

18 DR. NAVATHE: I think the entire -- the column
19 headings are just switched, but anyways --

20 DR. JOHNSON: Yeah.

21 DR. NAVATHE: If you could just correct that
22 typo, that would be great.

1 DR. JOHNSON: Right.

2 DR. NAVATHE: Just minor.

3 The other question I had is on the rural facility
4 piece. Have we looked at -- I guess this is a two-part
5 question. One, are there, quote, "validated" or good
6 measures of access, and have we looked at them in the
7 context of -- it seems somewhat -- understanding some of
8 the history here, but the 25 miles, 5 miles, all of that
9 seems somewhat arbitrary, and at the end of the day, what
10 we care less about, is there another facility close by and
11 we care more about if there is an ESRD beneficiary in that
12 locality, can they find a center bed. And in other cases,
13 we might use something -- we should be able to know the
14 number of beneficiaries in a particular area. So could we
15 not do something like a beneficiary to bed ratio or
16 something like that?

17 DR. JOHNSON: That's something we could look at.

18 DR. NAVATHE: Okay. Thanks.

19 DR. CROSSON: Okay. Jonathan?

20 DR. JAFFERY: So Brian did actually ask my
21 question this time, but it was about the continuous. So I
22 think you answered it, although I guess I'm still not

1 totally clear about -- I understand it could be done, and
2 it would be administratively more complex. But can you
3 give us a sense of how much better, if at all, you think it
4 would be? I'm trying to understand whether it would be
5 worth the squeeze for the administrative complexity.

6 DR. JOHNSON: In theory, it should more
7 accurately account for the costs of all of the amounts of
8 treatment volume for those that are eligible. There is a
9 first step, which I think is determining what exactly the
10 right level is to determine who's eligible. We chose 7,000
11 because it roughly lined up with our other policy, but
12 there's probably an empirical analysis that could be done
13 to determine that.

14 One concern is about the accuracy of the cost
15 data that is used to estimate this model, and there's a
16 longstanding MedPAC recommendation to audit the cost report
17 data. And there has been an audit going on for a number of
18 years, which we haven't heard the results from yet. So I
19 think the ability to come up with a very specific
20 adjustment, I think, in some ways relies on a valid and
21 accurate set of underlying data in order to correctly
22 specify that, and I think that there is some concern among

1 us and, I think, people in the industry about that level of
2 data qualities.

3 DR. CROSSON: Thank you.

4 Kathy?

5 MS. BUTO: So my questions are around TDAPA,
6 Nancy. The question about what we know about sort of the
7 motivation behind this change to allow drugs that are
8 already where there are already functional categories to
9 get the TDAPA kind of passthrough payment, whether that's
10 driven by biosimilars, number one.

11 Number two, when they're folded in, even when the
12 totally new drugs are folded in, how is that done? What
13 kind of adjustment is made that we know about to the base
14 rate, the bundled payment within -- or that payment bundle?

15 And then I guess I'm also wondering what other
16 categories -- if they're not in the functional categories
17 that exist in the bundle, what other categories are there
18 that you know of? So I guess I'm asking about what drugs
19 got the TDAPA before this other change was made. Do you
20 know anything about that?

21 MS. RAY: Okay. Good questions.

22 The motivation of the TDAPA as described in the

1 agency's rulemaking process, I think it was to promote
2 innovation, simple as that, and --

3 MS. BUTO: But that's even for the expanded
4 category where there's already a functional category and
5 there are drugs in that category?

6 MS. RAY: Yeah. Looking at this same again, so
7 recall that -- let's focus on the middle category for a
8 moment. The agency implemented the TDAPA for drugs not in
9 an existing functional category, and that was based on a
10 statutory mandate.

11 Statute essentially said, you know, "Agency, come
12 up with a way to fold in new drugs into the bundle," and so
13 through the rulemaking process, the agency said, "Drugs not
14 an existing functional category will get a TDAPA for at
15 least two years. During that two-year period, we'll
16 collect the necessary utilization and pricing data to then
17 when we put the drug in the bundle, we'll evaluate whether
18 or not there needs to be a change to the base rate, and
19 we'll add a new functional category." So that's what was
20 implemented in 2016 in the middle category.

21 MS. BUTO: And are there any drugs that met --

22 MS. RAY: No.

1 MS. BUTO: So there's been nothing?

2 MS. RAY: Nothing.

3 MS. BUTO: Okay. And that's even totally new, no
4 functional --

5 MS. RAY: That's correct. Nothing.

6 MS. BUTO: Okay, got it.

7 MS. RAY: So then in the 2019 rulemaking process
8 -- so a couple years later in the 2019 year of rulemaking
9 process, agencies said, "We want to promote innovation in
10 ESRD space, and so we want to promote innovation even for
11 existing -- for new drugs in existing functional
12 categories. So what we'll do is we'll pay for these new
13 drugs in an existing functional category for two years.
14 This is our way of promoting the drugs, and then
15 thereafter, they're folded into the bundle, no change to
16 the base rate."

17 MS. BUTO: Again, totally theoretical. Nothing
18 has happened in this category?

19 MS. RAY: Not yet.

20 MS. BUTO: Yeah.

21 MS. RAY: Not yet.

22 MS. BUTO: Do you know of any drugs that are in

1 line to the considered for this and kind of what is your
2 sense of the pipeline? Has it spurred a pipeline of
3 existing functional category drugs or --

4 MS. RAY: Well, given that this policy -- that
5 the right-hand policy was only -- it first implemented in
6 2019. I mean, these drugs would have had to have been in
7 the pipeline before that. So I can't answer the question
8 of did it spur innovation.

9 Again, I'm not a -- I'm neither a pharmacist nor
10 a physician, so I'm not an expert on this, but looking at
11 the dialysis websites I go to --

12 MS. BUTO: So sorry.

13 [Laughter.]

14 MS. RAY: I kind of like them.

15 It does seem like there may be a couple of drugs
16 that might qualify, but again might, you know.

17 MS. BUTO: Nancy, last question. So for the
18 existing functional category drugs, the ones that again
19 would start getting considered this year, I guess, was that
20 added by CMS, or was that a statutory requirement as well?

21 MS. RAY: That was added by CMS.

22 MS. BUTO: I'm asking because, obviously, if we

1 recommended a change, is it something that CMS could do was
2 my question.

3 MS. RAY: Oh, oh, oh. I'm sorry. You're talking
4 about the draft recommendation?

5 MS. BUTO: Yes.

6 MS. RAY: Yes. The Secretary does have the
7 discretion to eliminate it, yes.

8 DR. CROSSON: Andy, I thought I saw your light
9 come on. Do you want to talk about your Web-browsing
10 history or something else?

11 DR. JOHNSON: No, thanks.

12 [Laughter.]

13 DR. CROSSON: Okay. We've got Bruce.

14 MR. PYENSON: Thank you very much. It's a
15 terrific report.

16 I want to pick up on some of the questions and
17 line of questioning that Kathy had. I note on the bottom
18 of page 11, towards the top of page 12, you discuss how
19 several years ago, a new market entrant, an EPO beta, very
20 quickly was taken up by one of the big organizations. I
21 think it's public knowledge that the different
22 organizations have long-term obligations to use particular

1 drugs in long-term contracts.

2 So I'm wondering. If you've looked at that
3 impact with respect to TDAPA, so whether the situation, the
4 example form 2015 might not apply today?

5 DR. JOHNSON: We haven't looked at the
6 contracting policies, but I think that issue would arise
7 with any new drug coming on the market, whether or not it
8 is through a TDAPA policy or not, that if it is applicable
9 to dialysis patients, facilities might find themselves in a
10 situation of having to honor longstanding or long-term
11 contracts or switching to a new drug.

12 MS. RAY: Yeah. The only other thing I would add
13 to that is we are not privy to the contracting agreement.
14 Those are confidential, and it's not clear. If they are
15 long term, it's unclear to us whether there's provisions in
16 that contract that says -- I'm making this up -- something
17 to the effect that if a competitor comes out at a lower
18 cost, then there has to be some change in either the
19 payment arrangement or whatever.

20 MR. PYENSON: I was just thinking about that in
21 the context. Kathy was, I think, asking about motivation,
22 why TDAPA was expanded to existing categories and whether

1 that might explain part of the reason.

2 DR. JOHNSON: I don't think we know whether or
3 not that was part of the reason. I think there was one
4 other step in expanding to -- the TDAPA to existing
5 functional categories, as in the first year, CMS
6 established a criteria that it was only that a drug be new
7 and did not exclude -- it included generics. It included
8 biosimilars. It included classes of drugs that FDA
9 considers new but are only new due to packaging differences
10 or whether or not it has been changed to different
11 statuses, and those criteria were added in the second
12 round.

13 Given the history, it's not clear to me whether
14 or not that is part of the motivation.

15 DR. CROSSON: Warner?

16 MR. THOMAS: So I guess with implementation of
17 this policy, do you have any concerns that it would impact
18 innovation, or what concerns would you have in putting this
19 policy in place?

20 MS. RAY: I think what's important in
21 implementing this policy is monitoring the adequacy of
22 Medicare's payments over time. As new drugs and other

1 items are included in the bundle and practice patterns
2 change, I think there needs to be the year-to-year
3 monitoring of payment adequacy and of quality of care.

4 DR. CROSSON: Okay. Seeing no further questions,
5 we'll move to the discussion period. If you could up the
6 last slide? Just put up the last slide, the summary slide,
7 because I want to take them both together.

8 I think I will, for the discussion purposes, take
9 both together. We'll be looking for, as we've seen
10 yesterday, relative levels of support for the
11 recommendations. If not, why not? Suggestions. But we'll
12 take both recommendations simultaneously for discussion
13 purposes.

14 Kathy?

15 MS. BUTO: I support both recommendations, and I
16 actually would add -- and I'm not sure. We don't have time
17 in this cycle to do it, but it just strikes me that for the
18 category of totally new drugs, not within current
19 functional categories, we should consider looking at
20 tightening the criteria for those. I don't actually know
21 what the criteria are for those, and it's not all that
22 clear. And it sounds like we don't have any examples. So

1 that makes it hard.

2 Looking to the next session on the outpatient
3 criteria that we're looking at for trying to align it more
4 with drugs that add some unique benefit, et cetera, et
5 cetera -- and maybe there's a cost element to it too, but
6 that for some cycle going forward, you look at that
7 category because, at least for now, you have no candidates
8 that I can tell in that category. Now would be the time to
9 look at those criteria and considering tightening them. So
10 that would be my only add to the first recommendation.

11 DR. CROSSON: Jim?

12 DR. MATHEWS: Kathy, you have actually hit on one
13 of the implications of the next session, which is while
14 we're talking about the OPPS in particular, looking at
15 passthrough drugs and separately payable non-passthrough
16 drugs, if the Commission embraces the algorithm or this is
17 entry that we talk through, there is potentially much
18 broader implication or application of that concept to other
19 sectors, where you need to make a determination of
20 separately payable.

21 DR. CROSSON: Thank you.

22 Jonathan, Brian, David.

1 DR. JAFFERY: Thanks. I also am in support of
2 both of these recommendations, and I just want to
3 emphasize, I think, the points that both Kathy and Jim just
4 made. And even thinking about this in the second column, I
5 mean, I think one of the challenges here is trying to
6 define innovation a little bit.

7 If there's a new drug that really brings
8 something new, even if it's an existing functional
9 category, it may have a significant clinical or otherwise
10 significant benefit to beneficiaries. Maybe it would be
11 worthy of trying to spread that innovation.

12 I think one of the big concerns I have -- and
13 maybe hear this from others -- is that there's a "me too"
14 drug possibility, and that may be the likelier thing that
15 happens.

16 Again, very supportive of this, and maybe these
17 other discussions, the next discussion helps us think
18 through that. But if we can get to these ideas of how do
19 we define clinical innovation, that that becomes a
20 significant criteria as part of the proposal as well, the
21 recommendations.

22 DR. CROSSON: Thank you.

1 Brian?

2 DR. DeBUSK: First of all, I think your TDAPA
3 treatment is excellent. I think it's a good idea. It
4 fixes a badly needed or badly -- could be abused hole in
5 the system.

6 I do want to talk a little bit about that second
7 recommendation, and if no one else feels this way, then I'm
8 completely on board. So this is not stick in the mud.

9 I am a little concerned in that this does create
10 the ability to drive more consolidation. I mean, we're in
11 a highly, highly consolidated market, anyway, and it really
12 wouldn't be hard, because we're changing the definition of
13 "isolated." We're fundamentally changing because it's not
14 just isolated. It's isolated with respect to all of your
15 competitors too.

16 And it wouldn't be hard for someone with, say, a
17 large footprint to just look at where these outposts are,
18 these non-corporate dialysis centers, and can the 23
19 percent pricing decrease just simply by locating next to
20 them?

21 The rural thing concerns me a little bit too
22 because we fully adjust the payments for these dialysis

1 centers by the Hospital Wage Index, but then we don't
2 really capture some of the costs that are associated with
3 being in a rural location. I mean, I'm sure it's a little
4 harder to get service for equipment. I'm sure it's a
5 little harder to fill positions. So it almost seems like
6 they take the full rural hit but don't really enjoy any of
7 the rural benefit.

8 Again, if I'm the only one that feels this way,
9 then I'm going to vote yes next month, but I just didn't
10 know. And I really wanted to draw on Kathy and some of her
11 experiences too in this area, and Jaewon.

12 MS. RAY: If I can just add one other issue,
13 though. I mean, so in order to open up a new ESRD
14 facility, CMS requires a medical director, and that's
15 typically a nephrologist. And if you're located in an
16 isolated area, I mean, that's going to be an issue in
17 finding a qualified physician, a nephrologist, most likely,
18 to be the medical director. So in addition, as Andy said,
19 that a new facility that's going to open up next door and
20 try to furnish 3,000 treatments, they're not going to get
21 any payment adjustment for three years. That's the first
22 issue.

1 And then the second issue is trying to recruit
2 that medical director out there. In terms of business
3 decision --

4 DR. DeBUSK: If we're comfortable with the level
5 of consolidation and don't think this is going to be a
6 policy that drives even more consolidation then I'm on
7 board.

8 DR. CROSSON: I think we've got -- did you want
9 to come in on this?

10 DR. MATHEWS: Just a clarifying question and then
11 say one thing. So the two large dialysis organizations
12 together currently represent 80 percent of the sector, or
13 thereabouts?

14 MS. RAY: 75 percent.

15 DR. MATHEWS: Okay. And is it the case that when
16 we've looked at this in close detail it is volume that is
17 the largest driver of cost per case. Is that also correct?

18 MS. RAY: Yes.

19 DR. MATHEWS: So, you know, we think that this
20 combined adjustment does indeed capture the higher per-unit
21 costs that the targeted facilities are incurring, and we
22 think that the volume effect probably swamps any other of

1 the lesser inputs into cost. So I think, at least from the
2 analytic perspective that we've conducted, I think we are
3 okay.

4 DR. CROSSON: Hold on. Paul wanted to come in on
5 this. Marge, on this point?

6 MS. MARJORIE GINSBURG: No.

7 DR. PAUL GINSBURG: Yeah, I was on the list but
8 this is what I want to talk about. What I was going to say
9 is that, you know, given that there are very important
10 scale economies at the facility level, it seems as though
11 the current policy on LVPA is a very dangerous policy. I
12 say even if there are scale economies, if you're small
13 we're going to pay you more, indefinitely. And in a sense,
14 you know, I think getting rid of that incentive, so that
15 we'd say, you know, we'll pay you more, if you're in a
16 situation where higher volume isn't feasible, and that's
17 where we get the isolated situation. If they're at low
18 volume and they're isolated, we figure that's really the
19 best volume they can do, so we need to subsidize that for
20 access.

21 So I don't know if this is the best strategic
22 thing for a large company that wants to expand in these

1 isolated areas. I'm not sure why they would. But in a
2 sense, as Nancy has mentioned a couple of times, they're
3 going to have to have this way underscaled facility for
4 three years before they can start getting the subsidies
5 that they're going to drive out their competitor.

6 DR. CROSSON: Hold on now. We've got Marge on
7 this topic, Warner, and Jonathan on this topic as well?
8 Okay. Marge.

9 MS. MARJORIE GINSBURG: Definitely related to
10 this topic. What do we know about the individuals who need
11 dialysis, and whether, in fact, there is any way of knowing
12 whether there's a problem with access, that people in rural
13 areas able to access dialysis when they need it? So I
14 don't think any part of this actually discussed are needs
15 currently being met by the location and availability of the
16 dialysis centers.

17 MS. RAY: So we look at access to care in our
18 payment adequacy analysis, and we do this on an annual
19 basis, and we have not found any systematic problems,
20 issues in beneficiaries' access to rural facilities.

21 DR. CROSSON: Warner.

22 MR. THOMAS: So just a question, getting back to

1 Brian's point. On the LVPA, do we have an idea of how many
2 facilities the two large nationals have that receive that
3 type of subsidy payment? I mean, my impression is that
4 they are targeted more in urban areas, but that's just an
5 impression.

6 MS. RAY: Yeah. I do, back at the office.

7 MR. THOMAS: Okay.

8 MS. RAY: So we can include that in the next go-
9 around.

10 MR. THOMAS: I mean, I think it gets to Brian's
11 question.

12 MS. RAY: Yes.

13 MR. THOMAS: I mean, is this -- I mean, I see
14 where Brian is going with this. I think we don't want to
15 drive more consolidation. But it also comes back to, you
16 know, is that a big number? Are they pretty prevalent in
17 rural areas? You know, I just don't know if that would be
18 something to -- where has growth been over the past few
19 years. I mean, do they saturate urban? Are they going
20 into more rural areas?

21 DR. CROSSON: Jonathan, on this?

22 DR. JAFFERY: Yeah. So I think what I'm hearing

1 from Brian also is this notion that the LDOs would be able
2 to -- despite the fact that they wouldn't get the payment
3 adjustment for a few years, they could eat it. And so that
4 said, I think these protection that we talked about, they
5 need a medical director, I think the other thing to think
6 about, and it maybe gets back a little bit to Amol's
7 question about beneficiary-to-bed ratio is that if you've
8 got a small unit that's doing 3,000 session a year, there's
9 not going to suddenly be another cohort of patients there,
10 in that area.

11 And so I think that there are a number of things
12 that make some of the risks -- mitigate some of the risks
13 in some of the other payment policies around pushing
14 towards home dialysis also is a big direction that things
15 are happening in the industry. That said, I think it is
16 really worth monitoring the impact, particularly on
17 consolidation. I mean, that's come up several times this
18 cycle, is that we've got a very unique situation in this
19 sector, with the degree of consolidation, that I know has
20 been concerning for all of us. And so that may be
21 something we want to revisit a little bit in the next year.

22 DR. DeBUSK: And to that point, you know, one of

1 the large operators, 75 percent of the industry, is in
2 urban area. Let's go find a place on the fringe of this
3 urban area that does 3,000 treatments per year. If it's
4 one of the large operators, I can simply call them and say
5 you're either going to sell your business to me or I'm
6 going to build one next door to you, and if I do, you're
7 going to take a 23 percent price cut. So I want to buy
8 your business at an impaired rate. I mean, this is kind of
9 how M&A is done. I mean, this would not be that hard to
10 do.

11 DR. JOHNSON: I think one other issue is that the
12 facilities with 3,000 treatments are not majorly
13 profitable. These are not the facilities that somebody is
14 going to want to swoop in and "I want to take over your
15 zero or slightly negative margin."

16 [Laughter.]

17 MS. RAY: Yeah.

18 DR. DeBUSK: Well, until I can make sure and use
19 all of my equipment and drugs that come from my subsidiary,
20 you know --

21 DR. CROSSON: Okay. Paul wants to come in and
22 then Bruce, do you want to come in on this point as well.

1 DR. PAUL GINSBURG: I had a thought that might
2 help that might help out a little bit on this, which is if
3 you have a situation where someone is getting the subsidy
4 under our scheme, and is all of a sudden no longer
5 isolated, you could delay their losing the subsidy, which
6 would make it that much more expensive for predatory type
7 behavior, and make it really much cheaper for the large
8 entrant to just buy the small facility.

9 DR. CROSSON: Bruce.

10 MR. PYENSON: Yeah. I liked the solution that
11 Paul has proposed. I point out the profitability issue
12 changes with consolidation, and likely the underlying
13 financial dynamics of larger organizations. And don't
14 forget that when you have large organizations that need to
15 grow, that's sometimes when they expand into the areas that
16 might not be as profitable as the core one. So it's not
17 uncommon to see that happening in the business world, or
18 bad choices sometimes, expansion.

19 So I think considering those effects would be
20 important, so I agree with Brian that there ought to be a
21 solution to this.

22 DR. CROSSON: So here's my suggestion, that in

1 the next draft, the final draft that we see next month, we
2 insert this issue, this concern, and call on CMS to monitor
3 this. And, in fact, I don't want to give you more work but
4 I think perhaps inserting an example or two, like Paul
5 described, what kind of consideration might come into play
6 if this pattern of behavior manifests itself.

7 Okay. Let's continue with David.

8 DR. GRABOWSKI: Great. Thanks. I'm very
9 supportive of both of the draft recommendations. You
10 didn't speak about it today, just in the interest of time,
11 but you focused on the categorical adjustment, the low
12 volume and isolated. I really like the continuous. Like a
13 good MedPAC Commissioner I've gotten very suspicious of
14 cliffs and bunching around those cliffs.

15 So I really like the continuous, not just on the
16 number of treatments, but Amol really pushed it a little
17 bit in the first round about the five miles, and thinking
18 about whether or not that's just an arbitrary threshold.
19 And so I'd also want to think about how meaningful that
20 threshold is, and I think, Amol, you offered a very good
21 check for that. But is there a way to think a little bit
22 more about what's the right distance, and do we present any

1 incentives if we have sort of a threshold or cliff there as
2 well?

3 But overall very supportive. Thanks.

4 DR. CROSSON: Let me just -- I'll just say
5 something, and I think maybe you were going to say the same
6 thing. I think in terms of -- and we deal with these
7 issues of distance between facilities in a number of areas.
8 There is, at least in my thinking, a clinical and
9 beneficiary issue that comes in, depending upon the nature
10 of what treatment or what condition is under play, but also
11 the frequency. So, you know, I think perhaps one
12 justification for the five miles is the fact that we know
13 that the majority of patients seeking dialysis may have to
14 make this trip three times a week, on average, and
15 therefore that might be different from somebody seeking
16 care in an acute care hospital once in a year or once every
17 other year or something like that.

18 DR. GRABOWSKI: And I wasn't disagreeing with
19 that, only to say that could we do some empirical work to
20 kind of establish that five miles is the right. Maybe it's
21 three miles. Maybe it's seven miles. I just -- why five
22 miles? And I don't know if there's any empirical

1 justification but it would be nice to sort of push that a
2 little bit.

3 DR. CROSSON: Yeah. I don't want to be
4 argumentative either but one of the problems that we've
5 wrestled with over time is whether the criteria should be
6 miles or travel time. And so five miles in Los Angeles at
7 rush hour is one thing, and five miles in a rural area is
8 quite something else. We've talked about travel time and
9 finally pulled our hair out and given up. So there is a
10 certain arbitrariness to this, I agree.

11 DR. MATHEWS: If I could also just point out that
12 the recommendation as currently drafted is not specific or
13 somewhat agnostic on each of these points, the distance
14 threshold and how the low volume element would be
15 implemented. But we can enhance the supporting language
16 that say, you know, you could do it this way, you could do
17 it that way. We're talking five miles but it could be
18 three, it could be seven. We can add some of that nuance
19 if that helps.

20 DR. CROSSON: Did I steal your thunder?

21 DR. JAFFERY: Yeah, pretty much. But, I mean,
22 even to just add a little bit more flavor to how complex I

1 think you can get, because even the time for travel will
2 change. You know, going through the mountains in winter is
3 different than in summer. So there is a level of arbitrary
4 nature to it. That will be tricky.

5 DR. CROSSON: Yes, Bruce.

6 MR. PYENSON: I would like to see some mention
7 using public sources, credible sources of the supply
8 contract issue that I mentioned, that I'd asked about in
9 the question session. I know among Commissioners, and in
10 MedPAC, we sometimes go into that and sometimes don't, but
11 I think in this case, since the contractual issues are very
12 close to the content that we're examining, just some
13 mention of that as best we can, as a consideration and
14 background for the reader.

15 DR. PAUL GINSBURG: Is it on the TDAPA, Bruce?

16 MR. PYENSON: Yes. On the TDAPA and the supply
17 chain issue.

18 DR. CROSSON: Okay. Good discussion. We will
19 revisit these recommendations again, as we said, in April,
20 for a vote, and we'll have the opportunity to enjoy in the
21 revised chapter some of the good ideas that have been
22 brought forward.

1 Thanks very much, Andy and Nancy, and we'll move
2 on to the next presentation.

3 [Pause.]

4 DR. CROSSON: Okay. We're going to proceed with
5 the final presentation for our March meeting. Dan is back
6 with us. It seems like he didn't have enough yesterday, so
7 he's back again all by himself.

8 As Jim mentioned, we're going to return to the
9 issue of separately payable drugs, this time with respect
10 to the hospital outpatient environment, and, Dan, you're
11 on.

12 * DR. ZABINSKI: Okay. I was just realizing
13 yesterday I had a presentation, and it was a mountain of
14 data. Now I have no data.

15 [Laughter.]

16 DR. ZABINSKI: But I always feel more comfortable
17 with data, so we'll see how this goes.

18 Anyway, today we're going to talk about how drugs
19 are paid in the hospital outpatient prospective payment
20 system, or the OPPS, and then discuss how that system could
21 be improved.

22 In the session you just listened to, Nancy and

1 Andy discussed separately paid drugs in the ESRD system,
2 and their presentation and this presentation are the start
3 of an effort to develop a consistent approach of paying for
4 drugs.

5 If you're like me, you'll find what we're about
6 to talk about pretty complicated, so I think it will be
7 helpful to provide an overview of what we'll be discussing.

8 We'll start by talking about the unit of payment
9 in the OPSS, and that will be followed by an explanation of
10 how drugs are paid in the OPSS.

11 In the OPSS, most drugs are packaged into the
12 payment system of the related service, but some are paid
13 separately, and we'll talk about the programs for
14 separately payable drugs and the problems we see with those
15 programs.

16 Then we'll discuss the system for separately
17 payable drugs in the OPSS and how it can be improved. And
18 then we'll finish with alternatives to the current system
19 for separately payable drugs.

20 Even though the focus of this presentation is
21 drugs, we think it will be helpful to first talk about the
22 payment bundles in the OPSS.

1 In the OPSS, most payments are for a primary
2 service, which is usually the reason for an HOPD visit.
3 And then the OPSS uses bundled payments in which the cost
4 of ancillary items are packaged with the primary service
5 into a single payment unit.

6 A real simple example is something like say a
7 patient is coughing and wheezing, they're congested and
8 whatnot. So they go to an outpatient clinic, and the
9 doctor orders an X-ray to check for pneumonia. In this
10 case, the visit is the reason the patient is there, so it's
11 the primary service and it's paid separately, while the
12 chest X-ray is an ancillary item, and the cost of it is
13 packaged into the payment rate of the clinic visit.

14 It's really important to remember that when an
15 item is packaged in the OPSS, that does not mean there is
16 no reimbursement for that item. Instead, the cost of the
17 item is reflected in the payment rate of the related
18 service with which it's used.

19 The payment bundles in the OPSS contrast with a
20 fee schedule, in which everything has its own separate
21 payment, including ancillary items.

22 The benefit of using payment bundles rather than

1 a fee schedule is that payment bundles provide powerful
2 incentives for providers to seek the lowest-cost, most
3 efficient way to furnish a primary service.

4 Now we'll finally turn our discussion to drugs.

5 Now, in the OPPS, most, but not all, drugs are
6 ancillary to a service. Like other ancillary items,
7 packaging drugs encourages hospitals to use them
8 efficiently. However, packaging of drugs can be taken too
9 far, and effective packaging of drugs would balance
10 incentives for efficiency with limiting providers' exposure
11 to financial loss, as well as providing incentive to use
12 the right drug at the right time.

13 That is, we have to be careful with packaging
14 because packaging drugs that are expensive or that are
15 rarely used with the related primary service can make
16 providers reluctant to use those drugs because the exposure
17 to potential financial loss may be very high.

18 Before leaving this slide, I want to be clear
19 that while most drugs are ancillary items, some are not.
20 In particular, some drugs are very expensive, and receiving
21 the drug is the reason for the visit. Many chemotherapy
22 drugs fit in that category. And because of their very high

1 cost and because they are not ancillary, we believe that
2 these drugs should be paid separately and not packaged.

3 By volume, most drugs in the OPPS are packaged
4 because they have low cost, at least relative to the
5 service that they're provided with. However, a minority of
6 drugs are separately payable, and these drugs are usually
7 expensive, but actually some aren't.

8 Over time, the importance of separately paid
9 drugs has increased, with program spending in the OPPS
10 increasing from \$5.1 billion in 2011 to \$12.9 billion in
11 2018.

12 Like most features of the OPPS, the programs for
13 separately payable drugs in the OPPS were developed on
14 somewhat of an ad hoc basis. The OPPS has two programs for
15 separately payable drugs: there is the pass-through drugs,
16 and there's the separately payable non-pass-through drugs.

17 The reason that the program for the pass-through
18 drugs exists is that during the development of the OPPS,
19 there was consideration for actually packaging all drugs.
20 But there were also concerns that for new drugs the needed
21 cost and use data would not be available to include them in
22 the payment rates for the related services.

1 So, in response, the Congress created the pass-
2 through program, and payments for pass-through drugs began
3 when the OPPS was launched in August 2000. This program
4 provides separate payments for new drugs, which mitigates
5 providers' financial risk. Also, some stakeholders argue
6 that these payments help maintain incentives for drug
7 innovation by manufacturers.

8 The program for separately payable non-pass-
9 through drugs began in 2004, and the focus for this program
10 is established drugs. The intent is to provide adequate
11 payment for relatively costly drugs to ensure their use,
12 which, again, mitigates providers' financial risk.

13 These two programs for separately payable drugs
14 have different criteria for eligibility and to some degree
15 serve different purposes.

16 For a drug to be eligible for the pass-through
17 program, it must be new to the market and also have a cost
18 that exceeds three thresholds that are related to the
19 payment rate of the applicable primary service.

20 Having pass-through status has a definite time
21 limit as drugs can have this status for only two to three
22 years. But for a drug to be eligible for the separately

1 payable non-pass-through program, it must, first, not be a
2 pass-through drug because this program is for established
3 drugs, not new drugs; and it also must have a cost per day
4 that exceeds a threshold, which is set at \$130 for 2020,
5 but CMS updates that threshold for drug price inflation
6 every year.

7 Then, finally, there is no specified time limit
8 for separately payable non-pass-through drugs. They can
9 hold this status as long as their cost per day exceeds the
10 required cost threshold.

11 Now, our goal for drug payment in the OPSS is to
12 balance the benefit of packaging, which is that it provides
13 efficiency, while recognizing that some drugs should be
14 separately payable drugs to avoid excessive risk on
15 providers and create incentives for clinical improvements,
16 as well as incentives to use the right drug at the right
17 time. That is, we want to have packaging, but we don't
18 want to go too far.

19 So we analyzed criteria for separately payable
20 items in other payment systems to get ideas about criteria
21 for an effective separately payable system for drugs.
22 These payment systems we reviewed are pass-through devices

1 in the OPSS, the new technology add-on payments in the
2 inpatient prospective payment system, and the ambulatory
3 patient group system developed by 3M Health Information
4 Systems, which was the blueprint for the OPSS.

5 Taken together, these systems use four criteria
6 to identify separately payable items: their cost per day,
7 the cost of the item relative to the related service,
8 whether the item is new to the market, and the items must
9 show clinical superiority over competing items.

10 On this table, we compare the four criteria that
11 are used in these other systems to determine separately
12 payable status to the criteria that are used in the two
13 programs for separately payable drugs in the OPSS.

14 A concern that we have is that the criteria that
15 drugs must meet to be eligible for either the pass-through
16 program or the separately payable non-pass-through program
17 can allow drugs to have separately payable status even
18 though, in our opinion, could be packaged without putting
19 providers under excessive risk or adversely affecting
20 incentives for innovation.

21 For example, for pass-through drugs, there is no
22 cost per day threshold that drugs have to exceed.

1 Therefore, low-cost drugs can be eligible for this program
2 and be paid separately, and this does occur.

3 For separately payable non-pass-through drugs,
4 there is no requirement that the cost of a drug be high in
5 relation to the payment rate of the related service.
6 Therefore, drugs that are low cost in relation to the
7 related service can be eligible for this program and be
8 paid separately.

9 And, finally, neither of these programs requires
10 drugs to show clinical improvement over competing drugs.
11 Without a requirement for clinical superiority, incentives
12 for innovation could be mitigated.

13 Finally, we really only want to pay separately
14 for a drug if there is a clear reason to do so, and we
15 question somewhat whether either of these programs
16 accomplishes that. In particular, showing clinical
17 improvement over other drugs is a strong reason to pay
18 separately, and neither of the OPPS programs require it.

19 On this schematic, we show how decisions on
20 making drugs packaged or separately payable would work in
21 the OPPS if we implemented all four criteria that are used
22 in the other systems for separately payable items discussed

1 on the previous slide.

2 Now, using all of this criteria would require a
3 drug to meet all four criteria to earn separately payable
4 status. So if a drug does not meet any one of the
5 criteria, the drug would be packaged.

6 There are two big questions that would need to be
7 addressed.

8 First, should we require a drug to meet all four
9 of these criteria to have separately payable status?

10 And, second, what should be the specific features
11 of each criterion? On this slide we have concepts, but how
12 would these concepts work in practice?

13 Over the next few slides, we'll discuss details
14 of a new program for separately payable drugs in the OPPS,
15 including answering these two questions.

16 One thing we want to be clear about is that not
17 all drugs are ancillary items. Rather than being
18 ancillary, some drugs are the reason for a visit. They
19 have a very high cost; they dominate the cost of the visit;
20 and these drugs are usually infused. Once again,
21 chemotherapy drugs are in this group.

22 Because these drugs aren't ancillary, we believe

1 they should be paid separately without being subject to any
2 other separately payable criteria.

3 We have a concern, however, about the lack of
4 price competition for some of these drugs. Many are
5 single-source drugs with therapeutic alternatives, and
6 usually, these drugs have their own billing code and
7 payment rate.

8 Price competition could be increased for these
9 drugs using policies that the Commission has discussed in
10 the past, including: consolidated billing, where drugs in
11 the same therapeutic class are in the same billing code and
12 have the same payment rate; or reference pricing, where a
13 reference price is established for drugs that are in the
14 same therapeutic class. And for drugs that are above the
15 reference price, the patient is responsible for the
16 additional cost.

17 Now, all other drugs are considered ancillary,
18 specifically those that function as supplies in a procedure
19 or a service or are not costly enough to dominate the cost
20 of a visit, such as an analgesic for surgical pain or an
21 injection of a corticosteroid. Typically, these drugs are
22 administered by simple injection, and the drug

1 administration is not the purpose of the visit.

2 For these ancillary drugs, it would be beneficial
3 to replace the criteria in the current programs for
4 separately payable drugs in the OPPS with a new system of
5 criteria for identifying which should be packaged and which
6 should be separately paid.

7 The four criteria on the previous slide can serve
8 as a starting point for what this new system would look
9 like, but we need to answer questions about which criteria
10 to include and what the criterion would look like.

11 One potential criterion for separately payable
12 status for ancillary drugs is that it has to be new to the
13 market. The benefit of this requirement is that it would
14 help maintain incentives for drug innovation.

15 But it also leaves a big question: What to do
16 about the established drugs that are already on the market?

17 One, you could grandfather them and let them keep
18 their current status, either separately payable or packaged
19 based on their cost per day. Another alternative is to
20 package them, either immediately or let them keep their
21 current status for a while and then package them; or you
22 could simply just drop the "new" requirement and subject

1 established drugs to the other criteria, including clinical
2 improvement. but that also raises the question of how to
3 apply a clinical improvement requirement to established
4 drugs.

5 Another possible criterion for separately payable
6 status is that a drug must have high costs per day.

7 The idea is to require separately payable drugs
8 to have a cost per day that exceeds a threshold, which is a
9 reasonable requirement.

10 Separately payable non-pass-through drugs have to
11 cost per day of at least \$130, and this may or may not be a
12 reasonable threshold. We do have a concern about it
13 because it's not based on empirical evidence. So we need
14 to determine what an appropriate threshold would be.

15 A third potential criterion for separately
16 payable status is that the cost of the drug is high in
17 relation to the payment rate of the related service.

18 This is a useful criterion because if the cost of
19 a drug is high in relation to the payment rate of the
20 related service, use of the drug may expose providers to
21 financial loss.

22 This criterion is used in the pass-through drug

1 program, which actually requires drugs to meet three
2 variations of this measure. And I've concluded that any
3 formula applicable to this measure is going to be pretty
4 complicated, but one possibility is in your paper: that
5 the cost of a drug is at a level such that the difference
6 between the cost of the drug and how much of that drug's
7 cost would be in the payment rate of the related service if
8 the drug were packaged has to exceed some percentage of the
9 payment rate of the related service.

10 An obvious question here, though, is: What
11 should that percentage be? In the paper I've suggested 10
12 percent, but that's definitely up for debate.

13 The final criterion to consider for separately
14 payable status is that the drug must show clinical
15 improvement over competing drugs.

16 Specifically, the clinical performance of a drug
17 would be compared to that of drugs that have similar
18 therapeutic uses. If the drug is clinically better in some
19 way, such as faster resolution of the disease process, then
20 the drug can be separately payable; otherwise, it would be
21 packaged.

22 Some systems require clinical improvement for

1 ancillary items to have separately payable status,
2 including new technology add-on payments in the IPPS and
3 pass-through drugs in the OPSS.

4 For our purposes, the new technology add-on
5 payment requirements for clinical improvement is a viable
6 option.

7 Finally, two other issues to consider are:

8 First, should there be a time limit on how long a
9 drug can be separately payable? For example, the pass-
10 through program has a limit of two to three years.

11 Second, should separately payable status be
12 limited to one time and you're done? Or should drugs be
13 evaluated periodically and, if they pass the criteria for
14 separately payable status, they can maintain that status
15 indefinitely?

16 Now I want to go full circle and explain why
17 we're doing this analysis.

18 One thing we know is that spending on separately
19 payable drugs in the OPSS has been rising rapidly. And we
20 also know that packaging and payment bundles can help rein
21 in that spending because they are powerful tools for
22 encouraging efficient use of resources.

1 But the criteria in the two programs for
2 separately payable drugs in the OPPS allow separate
3 payments for drugs that could reasonably be packaged.

4 So to close the presentation, we would like to
5 know the Commissioners' thoughts on several issues.

6 First, is it okay to exclude the costly, non-
7 ancillary drugs such as chemotherapy drugs that are the
8 focus of visits from the criteria for deciding whether a
9 drug is packaged or separately paid?

10 Second, should being a new drug be a criterion
11 for separately payable status, or should established drugs
12 be allowed?

13 Third, if established drugs can be separately
14 payable, how would we apply criteria for clinical
15 improvement?

16 We'd like to discuss the structure of each
17 criterion, such as the cost thresholds and how to determine
18 clinical improvement.

19 And, lastly, should there be a limit on how long
20 a drug can be separately payable?

21 I turn things over to the Commission.

22 DR. CROSSON: Dan, thank you very much for a very

1 clear and logically constructed analysis and presentation
2 of a complex issue.

3 So we'll start now with clarifying questions. I
4 see Kathy, Jonathan, Bruce, Jaewon.

5 MS. BUTO: Thanks, Dan. You did well with that,
6 having a lot of data in front of you. A really complicated
7 issue, and I would even describe it as a thicket of
8 policymaking.

9 But I have a few questions in Round 1. One, can
10 you tell us what happens to passthrough drugs after the two
11 to three years, even if they are dominating the rate of the
12 affiliated service? So that would be question one.

13 Two, can you tell us what the split is between
14 the \$13 billion between passthrough drugs and the
15 separately payable non-passthrough drugs?

16 Thirdly, I think there is, but I could not
17 remember what the NTAP cost threshold was in addition to
18 the clinical improvement criteria. So there's some kind of
19 a cost test that has to be met, and it's not like \$130. It
20 was a lot more complicated than that.

21 If you could, just those three?

22 DR. ZABINSKI: Remind me. The first question

1 was?

2 MS. BUTO: What happens to the passthrough drugs
3 after two to three years, especially if they're expensive,
4 they dominate the service?

5 DR. ZABINSKI: Yeah. They can become separately
6 payable non-passthrough drugs. Their time ends on
7 passthrough status, and there's a consideration.

8 Okay. We'll get down in the weeds a little bit
9 here. If they're basically a supply in a service or a
10 procedure, they're a "policy package." That's the term.
11 They basically are automatically then packaged. If they're
12 contrast agents in imaging or like a pain reliever in a
13 surgical procedure, they become automatically packaged.
14 Otherwise, they just run into the test of do they cost more
15 than \$130 per day.

16 MS. BUTO: So you could be a passthrough drug and
17 then just go right over to the non-passthrough category?

18 DR. ZABINSKI: Definitely happens.

19 MS. BUTO: Which has no time limit?

20 DR. ZABINSKI: That has no time limit, and that
21 happens. That's the most common case for passthrough
22 drugs.

1 MS. BUTO: So a lot of infusion drugs would be in
2 that category, would you say?

3 DR. ZABINSKI: Yes.

4 MS. BUTO: Okay.

5 DR. ZABINSKI: Then on the \$13 billion, the real
6 strong majority is on the separately payable non-
7 passthrough.

8 The passthrough drugs, it bounces around a little
9 bit, but it has really increased in recent years to around
10 about \$2 billion or so. Then the rest is the separately
11 payable non-passthrough.

12 On the NTAP cost threshold, I don't remember the
13 exact numbers, but it's kind of similar to the way the cost
14 criteria worked for passthrough drugs, where they compare
15 the cost of the drug in relation to the payment rate of the
16 applicable, in this case, DRG. At least I think that's
17 right. Anybody, does that sound -- yeah.

18 MS. BUTO: I was just going to say it would be
19 really helpful to know that because, obviously, as you
20 point out, \$130 threshold is pretty meager. If we could
21 figure out what that one is, especially if you're pointing
22 toward the clinical criteria.

1 DR. ZABINSKI: Right.

2 DR. CROSSON: Great. Thank you, Kathy.

3 Jonathan?

4 DR. JAFFERY: Yeah. Thanks.

5 Thanks, Dan. It is, along with what has been
6 said, a great presentation on a really complex and
7 important issue.

8 Could you go to Slide 14 for a second? Thinking
9 about this question about the cost of the drug, how you
10 would calculate this, are there situations that you thought
11 about where a drug might be used with different multiple
12 services? If so, how frequent is that, and how would we
13 think about that?

14 DR. ZABINSKI: I don't know how frequent it is --
15 well, back up. Yes, I thought about it. I'm not sure how
16 frequent it is. It's got to happen, definitely.

17 I will say that I keep on falling back when I
18 think about a lot of these issues to the ambulatory patient
19 groups, the APGs, which is like the blueprint for the OPPS,
20 and it's actually used in a lot of state Medicaid programs.

21 I think they thought about this a lot when they
22 were developing it, and they are kind of like -- and I

1 think it's that type of issue that you're asking about that
2 sort of said it gets real dicey. Sometimes a drug is
3 packaged, and sometimes it's not. So they just said,
4 "Never mind. We'll go something simpler."

5 So it's an issue, but I'm not sure how frequently
6 it happens.

7 DR. JAFFERY: So would you imagine that if it was
8 related with the different services that the calculation,
9 sometimes it might be part of a package and sometimes it
10 might not be based on that?

11 DR. ZABINSKI: Yes.

12 DR. CROSSON: Okay. Bruce?

13 MR. PYENSON: Yeah. Thank you very much, Dan.

14 Some of the treatments for sure are available to
15 patients in sites other than hospital outpatient, such as
16 physician office, which in fact compete with hospital
17 outpatient. Then there's discussion of consolidation, a
18 vertical consolidation of the hospitals. Do you have a
19 perspective on the split for these drugs, what portion of
20 the relevant treatments are physician office administered
21 versus hospital outpatient administered?

22 DR. ZABINSKI: No. I'll tell you what I do know.

1 In particular, chemotherapy is really shifting from the
2 community-based oncology to some sort of hospital-owned
3 infusion centers, and I'm not sure what the split is right
4 now. But it used to be very -- most of it in the community
5 oncology centers, physician owned, and a lot of it has
6 shifted over. But I'm not sure what the split is right
7 now.

8 MR. PYENSON: So, evidently, if reimbursement is
9 inadequate for hospital outpatient, that hasn't hindered
10 that consolidation, apparently?

11 DR. ZABINSKI: Apparently not, no.

12 MR. PYENSON: I think there's other sites of
13 service that might be relevant. For example, some of these
14 treatments are used in SNFs --

15 DR. ZABINSKI: Perhaps.

16 MR. PYENSON: -- and other settings. It seems
17 there's no add-on for reimbursement in a SNF.

18 DR. ZABINSKI: Right.

19 MR. PYENSON: I have asked the same question for
20 these treatments whether we see what portion is in those
21 other service areas.

22 I note some interesting language in the text that

1 I was curious why it was presented this way, that
2 basically, inadequate reimbursement may cause hospitals to
3 avoid using some treatments which can adversely affect
4 incentives for drug innovation. Is there any evidence that
5 reimbursement is inadequate or drug innovation is hindered
6 or that hospitals are stinting on drugs?

7 DR. ZABINSKI: I'm not aware of it.

8 MR. PYENSON: Okay.

9 DR. ZABINSKI: Because I'm not aware of it
10 doesn't mean it's not true.

11 Let's see. That was really the argument in
12 particular for the passthrough system. Like I said, when
13 they were developing the OPPS, they really thought about,
14 okay, we're going to package all drugs, and then there was
15 concern, though, for new drugs that the cost and the use
16 data wouldn't be available to incorporate the cost of those
17 new drugs into the payment rate of the related services.
18 The reimbursement might not be adequate enough or the
19 hospitals to consider using those new drugs, so they
20 developed this additional system. That's a theoretical
21 argument.

22 I don't know if there's any empirical evidence

1 one way or the other.

2 MR. PYENSON: Thanks.

3 You mentioned in the text, 340B reimbursement.

4 DR. ZABINSKI: Yeah.

5 MR. PYENSON: Though I'm not sure that was in the
6 -- did that flow through to recommendation or a policy
7 alternative? That is, in terms of setting what Medicare
8 pays, would that consider whether the institution was a
9 340B or not?

10 DR. ZABINSKI: No. It would not consider that.

11 The gist of this exercise is to really think
12 about how to set the criteria for what's set in the table
13 and what's not.

14 The level of payment, that's a good question. I
15 guess we'll have to consider it along the way, but I hadn't
16 really thought about exactly how the 340B hospitals would
17 be dealt with.

18 MR. PYENSON: Okay. Another question on an
19 analogue, I think there's some imaging procedures that
20 might have a situation where the professional component is
21 small relative to the technical component, which would seem
22 to be an analogue to some of the issues we're raising here.

1 DR. ZABINSKI: Okay.

2 MR. PYENSON: Meaning the technical drug is
3 bigger than the administration.

4 Does this issue that we're raising here ever come
5 up in that circumstance?

6 DR. ZABINSKI: I don't know. I'm not sure.

7 MR. PYENSON: Okay.

8 MS. BUTO: Bruce, you're pointing to the fact
9 that those are bundled together in the payment system, the
10 technical and the -- I think they are, but I'm just --

11 MR. PYENSON: Yeah, yeah. They are, and like it
12 or not, we've made decisions about supply-chain issues in
13 some circumstances and seemed to avoid them in others and
14 analogues.

15 DR. CROSSON: Jim, did you have a comment?

16 DR. MATHEWS: Yeah. Just one, to put a marker
17 down, as this discussion unfolds.

18 This is our first foray into this issue in quite
19 a while, and a lot of the work that we are doing here is
20 developmental. And what we are looking for from the
21 Commission are these kinds of things that we may not have
22 completely and comprehensively scoped out as we're putting

1 this in front of you, but if you buy into the concept, if
2 the idea seems feasible, something you want to pursue,
3 these are the things that we would look to do over the next
4 cycle.

5 DR. CROSSON: Okay, good. Jaewon?

6 DR. RYU: Yeah. Thanks, Dan

7 I had two questions. The first, what are the
8 implications, if any, on beneficiary cost share? I'm just
9 not clear how that works in this space.

10 Then the second, this general payment mechanism,
11 does this carry over to the MA world? Do we have any
12 insight or line of sight into how that works? And any
13 changes, would those also presumably then carry over?

14 DR. ZABINSKI: Okay. Implications on beneficiary
15 cost sharing. My guess is the way it would work, I think
16 beneficiary cost sharing would probably go down, but that
17 is really hard to say definitively ahead of time because
18 the way the package -- if you increase packaging of items,
19 it's going to increase the payment rate of the related
20 service, if you take a drug that used to be paid separately
21 and then you package it, but typically only a fraction of
22 the drug cost is going to be reflected in the payment of a

1 related service, because the drug typically isn't used
2 every time a service is provided. So there's going to be
3 probably some savings on the beneficiary cost sharing, but
4 it gets really complicated.

5 Then carryover to MA, I immediately start
6 thinking about the base rate. I guess it's going to filter
7 over to the base rates in MA.

8 DR. RYU: I was just curious. Do most MA
9 carriers? I'm guessing how they pay for these services and
10 drugs, but I don't know that. I was just wondering is this
11 --

12 DR. ZABINSKI: I'm not sure. I would guess a lot
13 of them just follow fee-for-service Medicare, in a sense.

14 Jeff is nodding yes. So, yeah, I guess so.

15 DR. ZABINSKI: Paul and Jim both wanted to come
16 in.

17 DR. PAUL GINSBURG: Actually, I was going to say
18 as far as MA, probably, depending on the contract with the
19 provider, the MA plan could either be following Medicare
20 policy or what's the norm in commercial. So I don't think
21 it's an obvious thing.

22 DR. CROSSON: Okay. Jaewon, are you done?

1 DR. RYU: Thank you.

2 DR. CROSSON: Oh, okay. So then we have Dana and
3 then Marge.

4 DR. SAFRAN: Thanks. I agree with all the
5 comments of praise about the importance and the nice
6 clarity you've provided on this.

7 My questions have to do with the likely cost
8 impacts here. As I think about your question to us about
9 how we would establish drugs, how we would do the clinical
10 improvement piece, I think that's really, for me, part of
11 the heart of the matter because I think without that
12 clinical improvement piece, I'd be very worried about the
13 inflationary aspects of this, but with that, I really like
14 it.

15 So I wonder if you could just talk a little bit
16 about for the new drugs. Since clinical improvement isn't
17 part of what Medicare currently evaluates, how would that
18 get evaluated? How would we go about that? And then we
19 can think about the established.

20 DR. ZABINSKI: Well, I'll just read off like in
21 the NTAP. They consider things like it offers a new
22 treatment option for the patient population unresponsive to

1 or ineligible for currently available treatments, or the
2 ability to diagnose a medical condition in a patient
3 population where that medical condition is currently
4 undetectable. It reduces at least one clinically
5 significant adverse event, including a reduction in
6 mortality or clinically significant complication or a
7 decreased rate of at least one subsequent diagnostic or
8 therapeutic intervention. It's a long list. It covers a
9 lot of items such as that.

10 My personal feeling, I think this would be a very
11 useful starting point.

12 DR. CROSSON: Paul?

13 DR. PAUL GINSBURG: I think since there is
14 experience, of course, with the inpatient program, NTAP, I
15 think a lot of it might come down to the fact that how much
16 in the way of resources has CMS or the carriers does it
17 take to make a judgment for one drug, because I think a lot
18 of the inpatient ones are very experience things, really
19 worth spending a lot of time.

20 It could come up that if we are talking about
21 \$100 or \$200 drugs on the outpatient, unless the volume is
22 high, that maybe this would be kind of overwhelming to CMS

1 and the carriers.

2 So it really comes down to what kind of resources
3 does it take to make these judgments in a way that the
4 public will have confidence that they had been made
5 carefully.

6 DR. CROSSON: Marge?

7 MS. MARJORIE GINSBURG: I just wanted to verify
8 my thinking on this. These are all Part B costs to
9 clients, so if they are paying separately under Part B for
10 the drug, plus they're paying their share of the bundled
11 service, if we put the drug within the bundled service
12 you're dropping the cost altogether, and taking them
13 separately the whole idea is to fold a more expensive drug
14 into bundled service so that the sum total of the costs are
15 actually going to be less, and going to be less for the
16 beneficiary. Is that right?

17 DR. ZABINSKI: Some degree, yeah. Think of it in
18 terms of you've got a service, say, without the drug
19 bundled in, costs \$100, and a drug is used with it that
20 costs \$20. And the drug is used half the time the service
21 is provided. So what would happen is you take 50 percent
22 times 20, and \$10 would be folded into the payment rate.

1 MS. MARJORIE GINSBURG: [Off microphone.]

2 DR. ZABINSKI: Typically, yes.

3 DR. CROSSON: Well, wouldn't it be lower for some
4 beneficiaries and higher for others, depending upon whether
5 or not they had the drug?

6 MS. MARJORIE GINSBURG: Whether or not they what?

7 DR. CROSSON: Whether or not they actually were
8 given the drug.

9 DR. PAUL GINSBURG: Yeah. I mean, I think
10 there's -- you know, so for the half beneficiaries that get
11 the drug I think for the system the savings come when the
12 drug is used less frequently, because it's in the bundle.

13 MS. MARJORIE GINSBURG: So going forward, I'd be
14 very interested in seeing how this plays out, at least
15 theoretically, on terms of the beneficiary cost-sharing.

16 DR. CROSSON: Okay. Amol and Warner.

17 DR. NAVATHE: So I think, you know, I sort of
18 echo the comments around the importance of the topic. One
19 of the things I was struck by is just if we look at the
20 last slide where you have the different dimensions that we
21 need to consider, I think in some sense it would be helpful
22 as we pursue this work to have examples or use cases of the

1 variation that we have along with these dimensions, to the
2 extent that we have them, for drugs that are meeting the
3 current separable payment criteria.

4 Because I think in some sense, like Jonathan's
5 question earlier about are there other drugs that would
6 sometimes meet this or used in different clinical settings,
7 it's hard to envision an abstract, to some extent, where we
8 might have unintended effects, and I think having a couple
9 of examples where the variation exists along these
10 dimensions might help us sink our teeth into this a little
11 bit more concretely.

12 DR. CROSSON: Warner.

13 MR. THOMAS: Just a couple of quick questions. I
14 mean, I think, number one, this will probably continue to
15 escalate, just given the growing number of drugs,
16 especially specialty drugs. But I guess the question I had
17 is, in the chapter you talk about things that have been
18 identified previously and/or recommended. I mean, did we
19 think about kind of a cap, an inflator cap, things like
20 that? Because I know when you said before, you know,
21 Medicare doesn't really directly buy drugs, but here you're
22 pretty close to pretty directly buying the drug. So did we

1 think about inflator caps, things like that?

2 DR. ZABINSKI: No. Nothing like that. I mean,
3 in this particular sector, on the drugs, it's been a long
4 time since we've done anything on that. I think, in fact,
5 I was the last one to do it, and that was like in 2002, or
6 something like that. So it's been a while.

7 DR. CROSSON: But, I mean, you did list some
8 potential approaches to drug cost control, and in the
9 context of other work that we've done on drug cost control,
10 some of those ideas, like you mentioned, would be relevant
11 to this, as well as everything else.

12 Okay. Seeing no further questions we'll go on to
13 the discussion. We've got the suggested discussion topics
14 here, and Kathy is going to begin.

15 MS. BUTO: Yeah. So let me start out by saying
16 thank you for starting this work, and I'm sorry I won't be
17 around to see it completed. But I will say this. I think
18 we should package as much of these drugs, as many of these
19 drugs as possible into the rate. I haven't heard
20 compelling reasons why that can't be done. So I'd start
21 there.

22 I also think back to something Dana said, that

1 while we need to obviously look at the costliness of any
2 drug that we allow to be paid separately, that there ought
3 to be that threshold, but then the next step should really
4 be applying clinical improvement criteria. In other words,
5 let's get a little simpler about the universe of drugs that
6 qualify for separate payment, and for everything else we
7 should do what we can to package those into the rate.

8 I think it's difficult as I compare inpatient PPS
9 to OPPIs, in inpatient PPS you are dealing with a diagnosis-
10 related bundle. Here it's a service-related bundle, so
11 that makes it a little more difficult, because when you're
12 talking about infusion drugs they end up being infusion
13 related to a service rather than infusion related to
14 treating a condition. So it's a little different, and I
15 think it's not entirely parallel using NTAP and using those
16 criteria in OPPIs. But I think that's a really good
17 starting point.

18 I think we all recognize that the cost of drugs
19 is driving a big cost in Medicare, and we wonder how can we
20 do something about that. Well, the separately payable drug
21 category on the passthrough drugs were specifically put in
22 there so that new drugs could get a leg up, and without

1 any, you know, new evidence per se, except the FDA
2 approval. So I think we can add a lot more discipline to
3 looking at that.

4 The other thing I think we have to consider is
5 the time frame. I know in the paper, Dan, we talked about
6 let's just collapse these categories, do away with the
7 passthrough potentially, make them all -- just decide what
8 the set of separately payables should be. But I think we
9 have to think about a time frame even for those. And then
10 the question becomes, well, what do you do if they're high-
11 cost drugs that dominate the service? There has to be a
12 set of alternatives for dealing with those.

13 And I am not a fan of either reference pricing or
14 the consolidated coding approach, because they become ways
15 to sort of assign a price to a drug based on other drugs.
16 There's a process involved. I would rather see those drugs
17 bundled, and like we just did in the ESRD example in the
18 functional categories, let the chips fall where they may.
19 Let the best drug win, if you will, in that circumstance,
20 but let that bundle be sufficient along with the service,
21 whatever it is, to allow choices to be made.

22 But if you pick winners and losers with a

1 passthrough system, and then if you have a high-cost drug
2 approach that really, in a sense, picks winners and losers,
3 using reference pricing, that has never been -- I don't
4 feel comfortable with that. I think we ought to let that
5 decision be made clinically, and if we can come up with
6 other ways to create a bundle that allows those decisions
7 to be made, a la what we just did in ESRD, I think that's a
8 better approach.

9 And the last comment I would make is I think we
10 should look at doctor's offices. So let's say we go down
11 the road of bundling or packaging more drugs into the
12 service. If there is a similar service provided in a
13 physician's office with those drugs, we should look at
14 packaging drugs in the physician's office. In other words,
15 let's try to align these policies across both settings.

16 But back to my original point, I think we really
17 need to try very hard to package as many drugs as possible
18 and not get into the separately payable, because that
19 really does pick winners and losers.

20 DR. CROSSON: Thank you, Kathy. Further
21 discussion, input for Dan? Jaewon, Warner, Sue.

22 DR. RYU: Yeah. It gets back to the beneficiary

1 cost-share question from earlier. I think as we go down
2 this analysis it would be important to just understand
3 deeper what would that impact be, or maybe there's no
4 impact. I think the more things that are packaged -- I
5 agree with Kathy. I think there is a cleanliness and a
6 simplicity there, in particular, how it pertains to
7 beneficiary cost share, to the extent you're pulling things
8 out, you know, is it Part B, is it Part D, is it a
9 separately administered cost share for that service,
10 because, you know, they got this facility. I think
11 understanding all of those moving pieces for the
12 beneficiaries, you know, through the beneficiaries'
13 perspective, would be helpful.

14 DR. CROSSON: Warner.

15 MR. THOMAS: So I think this is a great topic. I
16 think it is going to be continued cost escalation for the
17 program. I do think that we should be looking at other --
18 you know, using this idea we've used in other components of
19 the Medicare program around blunting the escalation of drug
20 costs. I think the idea of having -- we've used inflators.
21 I mean, we've made that recommendation and used an
22 inflation cap.

1 I mean, I think we can look at complicated ways
2 that we think about how much the drug is as part of the
3 payment, or we can basically just say we're going to go to
4 the drug cost and have an impact on what that drug cost is
5 and blunt it over time, which is, you know, going to be a
6 main part of what this overall cost is. So I'm encouraged
7 just to look at those drug caps, or inflator caps.

8 And I agree with Kathy that I do think looking in
9 a broader way to physician offices makes a lot of sense as
10 well. But I get concerned that we're going to make this so
11 complicated that it's going to be hard to administer. I
12 would really challenge us to think about simplicity, and I
13 think something like an inflation cap is understandable.
14 It's more simple, and I think it's easier to implement,
15 versus some of the calculations and ideas that are kind of
16 outlined in the paper.

17 DR. CROSSON: Thank you, Warner. Sue.

18 MS. THOMPSON: I just want to echo how well you
19 did in the chapter, Dan. I thought it was very, very clear
20 in how important this topic is. And I want to second the
21 motion to keep this simple. You know, I'm attracted to the
22 idea of examples for every one of these discussion items,

1 but we will get into a very complicated discussion of
2 anticipating what the provider responses will be. So I
3 just think before we begin the work let's decide, do we
4 need to get so complicated or can we keep this simple, with
5 the goal of some expediency to a pretty big problem for the
6 Medicare program.

7 And secondly, I also want to support Kathy's
8 thoughts about let's have a level playing field here in all
9 area that deliver this outpatient service, and so we're not
10 setting up a system where we're just going to be moving the
11 problem to another sector.

12 DR. CROSSON: Thank you, Sue. Kathy and Dana.

13 MS. BUTO: Sorry. I remember that I forgot to
14 mention one thing, which is for those really expensive
15 drugs that are part of a less-expensive service, I think
16 one way to consider that is if there's a case to be made
17 for some sort of separate payment -- again, going back to
18 the criteria that it has to be made clinically -- so just
19 to put that idea of using more proactively criteria, where
20 the burden of proof is on whoever is proposing that add-on
21 or that separate consideration for cost to bring forth the
22 evidence of that clinical distinction.

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

2 DR. SAFRAN: Yeah. So I think I fully agree with
3 the comments and issues that have been raised. The thing
4 that I guess I'll add in is just to say that I think that
5 we'd be well served to have the chapter create some
6 connections over to what we're seeing in the revamping of
7 the Part D chapter, because, you know, understandably, we
8 consider these two different parts of the benefits, but to
9 a manufacturer these are just drugs for Medicare
10 beneficiaries, and if one window has closed, another one
11 has opened for high-priced drugs.

12 So I think we need to be very clear in that, and
13 to the point that Warner and others have raised, that
14 inflationary effect this could have, and I do think, as my
15 question intimated and as Kathy picked up on too, that
16 clinical criteria are going to be extremely important here.
17 So I'd like to see us really put some good thought and
18 muscle behind those, and some of the comments already
19 around the table, I think, gave us some good ideas on that.
20 Thanks.

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

22 DR. PAUL GINSBURG: Kathy had really wise

1 comments on this, as did others. I wanted to reinforce her
2 point is that the core of that bundling, you know, the core
3 of our payment approach in fee-for-service Medicare is
4 bundling wherever we can. You know, hospital outpatients
5 is an area that we converted to bundled, so guiding
6 principle would be support the bundling, you know, put it
7 into the bundle unless there's a compelling reason why not
8 to.

9 I think there will be some drugs -- these will be
10 Part B drugs, particularly -- that will be -- you can't fit
11 into a bundle because often they're the dominant reason for
12 the visits. And in that case, I think this general thing
13 is that as we evolve in tools to address Part B drug
14 prices, we will want to automatically apply them to the
15 passthrough drugs as well. And I'm not getting us into a
16 debate about, you know, whether inflation caps or reference
17 prices or something else are the best way, but in a sense
18 whatever we come up with, or whatever anyone else comes up
19 with for Part B drugs, ought to be the criteria.

20 Kathy mentioned something really interesting
21 about physicians' offices, and what occurred to me is that,
22 you know, we have bundling in outpatient payments. We have

1 no bundling in physicians' offices. So in a sense it
2 brings up a big topic, as to the degree that we should
3 start introducing some bundling of ancillary services into
4 physician visits. I don't know if that's feasible. We
5 only have five visits going to three or four, so I don't
6 know if we can do that.

7 But in a sense I guess that's a caution, and it's
8 always going to be a problem having a completely different
9 approach to physician offices versus hospital outpatient
10 departments, is we're going to be continuing to create
11 incentives to move things one way or the other, likely to
12 the detriment of the program, and just something always
13 have to be very careful about.

14 One thought I have, that Dan might be able to
15 find for existing information, is the attempt to quantify,
16 you know, what portion of the dollars are we talking about
17 as far as, say, drugs that are clearly ancillary and not
18 that expensive, versus one that are, you know, the
19 opposite, very expensive, often the reason for the visits.
20 And to get a sense of, you know, where are the dollars?
21 You know, where should we pay the greatest attention to?

22 DR. CROSSON: Thank you, Paul. Very good

1 discussion again. Dan, thanks for the clarity here, and I
2 think you've had some good input, so we look forward to
3 your future work in this area and potential expansion of
4 it. Sorry about that.

5 So that concludes our presentation and discussion
6 for the March meeting. We now have time for a public
7 comment period. If there are any of our guests who wish to
8 address the Commission, please come forward to the
9 microphone. I will give you some instructions in a second.

10 I'm just looking to see. Okay. So we would ask
11 you, if you would, to identify yourself and any
12 organization that you are representing and to confine your
13 remarks to about two minutes. When this light in front of
14 me comes back on, that time will have expired. Thank you.

15 * MS. LESTER: Hi. I'm Kathy Lester. I'm here on
16 behalf of the Kidney Care Council. I think most of you
17 know that organization is more than 30 members, patient
18 advocates, dialysis facilities, the health care providers,
19 nurses, physicians, others, and the manufacturers.

20 I very much appreciate the dialogue today. As
21 many of you know, we do support addressing the low-volume
22 issue. We think money is leaking out of the system

1 inappropriately and not really getting to the patients in
2 rural areas who need it. And the proposal that is before
3 you does really seem to target those dollars appropriately.

4 In terms of the TDAPA payment, we, too, think
5 that it needs to be refined, but I would encourage you to
6 keep the patients first here. There has not been
7 innovation in this area other than in the anemia management
8 category, and the examples you've highlighted are in that
9 category. There are a few, and very few, other functional
10 category drugs that came into development when the PPS
11 started because there was an excitement that the new system
12 would allow for innovation and evolution over time.

13 The whole premise of the problem with the ESRD
14 PPS is it has been really in this lockdown mode. There
15 aren't additional dollars. As the Chairman recognized in
16 the last meeting, we're going to see this roller coaster
17 because of the way TDAPA is functioning, but it doesn't
18 mean the underlying bundle is appropriately priced. So if
19 you try to add a new drug into a category -- and there are
20 some, for example, that could be viewed as in the
21 antipruritic category -- an unmet need, the current
22 treatments do not work for patients. They're

1 antihistamines, and that's not what pruritus is. But that
2 drug is going to compete at less than a dollar? It just
3 isn't possible.

4 So I would encourage you, as you continue to
5 think about the recommendation, to take a nuanced approach
6 and to really take some of the ideas that were in the
7 outpatient discussion around substantial clinical
8 improvement and really think about ways to incrementally
9 adjust the bundle as needed and using a TDAPA period to
10 help that. We think TDAPA can be further narrowed, but we
11 also think there needs to be a pathway for innovation
12 that's sustainable.

13 So encourage continued dialogue, and thanks for
14 giving me a chance to make comments today.

15 DR. CROSSON: Thank you very much.

16 I think you heard the instructions, so please
17 proceed.

18 MS. BUNNING: Hi. My name is Sue Bunning. I'm
19 with the Medical Imaging and Technology Alliance, or MITA.
20 I'm going to reference one of the questions earlier today
21 relating to diagnostics. MITA represents the precision
22 diagnostic, medical imaging diagnostic drug companies. We

1 have done extensive work in this area recently, and in our
2 particular instance, the nuclear medicine bundles, these
3 newer precision diagnostics can't even hope to affect the
4 average of the APC. And we have done research on the data
5 demonstrating fall-off, what happens when they come off
6 pass-through.

7 So we want to serve as a reference as you proceed
8 on this topic, and we're happy to answer any questions. We
9 know that it is impacting patient access, and we're happy
10 to share with you anything that you might need.

11 DR. CROSSON: Thank you for your input.

12 Seeing no further people at the microphone, then
13 we are adjourned until the April meeting. Thanks to the
14 Commissioners, thanks to the staff.

15 [Whereupon, at 10:29 a.m., the Commission meeting
16 was adjourned.]

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